POLICY-MAKING FOR THE SCOTTISH HEALTH SERVICES AT NATIONAL LEVEL*

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Introduction

For many years, Scotland has enjoyed considerable *administrative* devolution on health matters. This has not been fully appreciated by the ordinary "man in the street" and indeed it has not been unknown for a Scottish MP to make the mistake of posing a parliamentary question on the health service to the Minister responsible for the DHSS rather than to the Secretary of State for Scotland.

The involvement of central government in the health service through the Scottish Home and Health Department (SHHD) can be contrasted with the nature of its involvement with many other services through its departments both in Scotland and the rest of the UK. Firstly, central government is responsible for financing virtually all aspects of the NHS. And secondly, the Secretary of State is ultimately responsible for the administration of the National Health Service via SHHD — the fifteen health boards are his agents. So, in effect, SHHD acts as the headquarters administration of the NHS as well as a central government department concerned with Ministerial policies. Another important feature of SHHD which distinguishes it from many other departments is its interdependence with the professional providers of health services. This is reflected in the employment of considerable numbers of professional advisers, mainly doctors and nurses, within SHHD itself and in the external professional advisory bodies set up by statute.

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Reorganisation of the NHS in 1974, while primarily aimed at the integration of health services, offered the opportunity to reform policy-making and planning at national level. At local level, fifteen health boards were created and, in addition to the professional advisory committees, such as the National Medical Consultative Committee and the National Pharmaceutical Consultative Committee, local health councils (LHCs) were introduced to provide for some public involvement in health board affairs. Some of the key agencies created at the national level were:

1. A small Planning Unit within the SHHD was to introduce a new planning system to facilitate planning activities generally — the staff being drawn from the Civil Service.
2. A planning Council which was to involve health boards in national policy-making and act as a source of advice to the Secretary of State. In the event, the Council has provided a framework within which a wide range of interests can be drawn together to study major planning issues through the use of working parties and programme planning groups.
3. A number of National Consultative Committees (NCCs) for each of the main health service professions. Each of these was established as a source of specialist advice to the Planning Council and also to SHHD.
4. A Planning Council secretariat, staffed from within the NHS and SHHD which services the Planning Council, its various sub-committees and most of the NCCs.

In addition, in 1978, an Association of Local Health Councils was formed to provide a central focus for the many LHCs.

It is against this background that this paper reviews policy-making within SHHD in the past, and considers the effects of changes in the organisational and procedural arrangements for the development of policies. A recent programme of research undertaken for SHHD by a team from the Scottish Institute for Operational Research (SIOR), in which the writer was intimately involved, provides the basis for this discussion. The paper draws on this research to discuss what we, the research team, learnt about collaboration between government departments in the framing of policy, about some of the opportunities for and impediments to a more participative and democratic approach to policy development, and about the complexities involved in the identification of health service priorities. An understanding of these issues is essential if the way policies are developed in the future is to be improved and will be of direct concern to a Scottish Assembly, should one be created, or indeed to any other political forum which might be established.

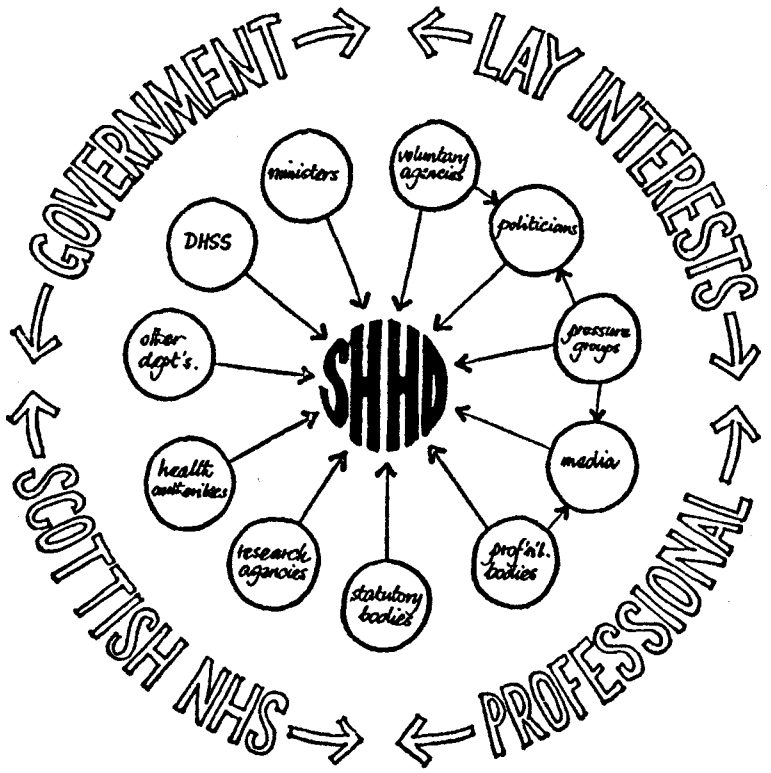
Policy-making in the Past

Various studies of central government (for example, Griffiths 1966) have recorded that policy-making has been more a matter of advocacy than of reliance on systematic research evidence. In a recent lecture Professor Lewis Gunn (1978) noted one or two examples of a more planned approach to the development of policies, but he indicated that for the most part central government took a "reactive" stance on matters of policy, that is it reacted to pressures for change in an *ad hoc* and unplanned fashion. In the NHS, the various crises that arose in the 1960s concerning the poor conditions and treatment of elderly and mentally ill patients in many institutions, provoked central government to introduce a number of policy changes (Klein 1974); these incidents provide somewhat extreme examples of this "reactive" approach. Another study (Maddox 1972) of the DHSS in the late 1960s suggested that decision-making was incremental, with only minor adjustments in policy occurring in response to various partisan pressures; policy-making was seen to be a process of "muddling through" (Lindblom 1965).

In one of SIORs recent studies within SHHD — undertaken at around the time of the NHS reorganisation — we discovered a similar situation (Wiseman 1979). The department's activities were very much geared to the administration and management of existing services; new policies were developed mainly in response to external advocacy pressures and stimuli. Thus, the issues that found their way onto SHHDs "agenda" for attention tended to arise in an *ad hoc* fashion and few resulted from a systematic evaluation of the existing situation. Figure 1 shows that the advocacy for change came from four main groupings. As one might expect the *government* could itself bring pressure to bear through Ministers, but more often pressures for change were created by the actions of other departments; the DHSS

Figure 1

advocacy of policy change



played a particularly important role by producing its own reports and guidelines since this often stimulated SHHD to review its policy statements too. Also by requesting advice from the department or raising difficulties concerning existing guidelines, the NHS field authorities often stimulated a change in policy. The health *professions,* particularly doctors, exerted a very significant influence on which issues were regarded as important both directly through the professional advisory committees which met regularly with SHHD officials and through the publication of reports by the Royal Colleges. Finally, *lay* interests were able to exert some pressure through selected voluntary agencies, through pressure groups and also indirectly through the media and the asking of parliamentary questions by MPs.

SHHD reacted to such pressures in a variety of ways — sometimes internal departmental discussions would be held or working parties formed. Sometimes an external professional committee might be formed with members from the statutory advisory bodies to advise on future policy. The topics on which studies were to be mounted in order to develop new policies tended to be chosen in an *ad hoc* way and the studies were often undertaken by uni-professional groups without the benefit of systematic methods or analyses. The reports that emerged from these external committees were usually circulated to the professions and field authorities for comment which allowed a further period of advocacy to take place. These comments then formed the basis of internal discussions within the department before the Minister was advised about future policy; new policies were for the most part promulgated by the issuing of a circular to Regional hospital boards, local health authorities and other agencies involved in the provision of health services at that time. Sometimes statements would be made in Parliament or even new legislation introduced. Of course for some issues SHHD might decide that no action or change was required.

While this description provides a general indication of how policy-making was undertaken within SHHD, there were exceptions where attempts had been made to introduce a more planned approach to various problems (see for example the SHHD reports on nurse manpower planning 1974-77).

Some might argue that the process described is not a bad way to go about policy-making and that a responsive approach

to problems is what is required of a government department. While we believed that such responsiveness was desirable and indeed essential since unpredictable pressures for change would always arise, we had a number of worries about the processes we had observed.

In the first place, the opportunity or power to bring pressure on SHHD was not necessarily equally distributed among all groups with a legitimate interest in health service matters. It seemed to us that 'decibel" planning could occur with those who were in a position to shout loudest influencing which issues got onto the "agenda" and that "urgent" issues might push out "important" ones.

Secondly, the basis for the selection of problems for attention was far from clear, yet often the decision to undertake a study seemed to give the particular problem the "inside track" for a more favourable reallocation of resources in the future.

Thirdly, the policy development activity or study was for the most part undertaken by professional groups and committees which could not be regarded as representative. Finally, there was no strategy for the development of services and to a great extent the future shape of the NHS was being determined by the tide of events.

However, reorganisation provided an opportunity to overcome some of these problems and did bring some changes in the process of policy-making; there seemed to be an increased interest in comprehensive planning systems, an apparent desire for more participation in policy-making — although the participation under discussion at this time was of health boards and professionals rather than of the general public — and a recognition of the need for more integration and co-ordination of health service activities with those of social work and other local authority departments. A singularly important innovation in Scotland was the setting up of Programme Planning Groups (PPGs) within the framework of the Planning Council to study and advise on new policies for major problems within the health service such as care of the elderly and child health; while the membership of these groups has been predominantly professional they have brought together representatives from a wide range of interests including voluntary agencies, health boards, local authorities and government departments.

It is now over four years since the NHS was reorganised.

During this time, we have worked closely with SHHD on the programme of research studies which were intended to help the department in developing planning processes for the Scottish NHS — as researchers we have enjoyed a privileged position and have been able to examine how certain aspects of policy-making have developed over this period and to reflect on experience with the changes.

In the course of this research, we put forward proposals for a systematic yet participative planning system (Wiseman 1979) which SHHD have drawn on in their development of planning within the new organisational structure at national level. Suffice it to say here that these original proposals were based on a mixed-scanning approach to planning (Etzioni 1967) and involved three components:

1. *A periodic review process* in which the pattern of health service activities would be considered across the board though not in great detail; by this means major problems would be identified or their likelihood anticipated. This general overview of the NHS would, it was hoped, encourage discussions about future developments in the services.

2. *A selection procedure* to identify important planning issues which would justify detailed planning attention, given the limited planning resources and skills likely to be available (Wiseman 1978).

3. The use of *systematic yet participative approaches* in the detailed planning on issues of major planning importance.

The proposals were designed to allow a wide range of interests to contribute to planning at appropriate stages. While we believed these proposals would overcome some of the deficiencies of policy-making in the past, we also recognised that our understanding of some aspects of policy-making was still somewhat limited. Viz:

1. We had so far viewed planning and policy-making very much in an SHHD context (although some need to build in information exchange with other non-health agencies at the time of a periodic review had been recognised in the

proposals). Yet many major problems, such as care of the elderly, mental disorder and alcoholism clearly involved other non-health agencies. What were the implications of such links for health service planning and could the existing proposals be adapted to cater for them?

2. The use of advisory groups in policy-making had only been outlined in our proposals and little practical experience was available, Programme Planning Groups were beginning to operate and learning from their experience might help to develop more detailed proposals. How were these innovations in participative planning working out? How should such groups be set up and operated to aid the development of new policies? Were there alternative ways of proceeding?

3. Proposals for a periodic review within SHHD would produce information which it was thought could be useful in the setting of priorities within the NHS. Yet priorities had never been set across the board before and had emerged largely by the piecemeal development of policies for particular sectors of the NHS. What did we mean by priorities? How would the setting of priorities differ from policy-making anyway? What kind of information would be relevant to the setting of priorities and would this be met by the existing proposals? Who should participate in the setting of priorities and how might such participation be organised?

Thus, we set in hand further research studies on each of these themes.

Research Studies Concerning Policy-making

(i) Collaboration between SHHD and Social Work Services Group in National Policy-making

In many of the official documents prepared at the time of reorganisation both in Scotland and in the south, considerable stress was placed on co-ordination and collaboration between social work and health services. It is interesting to note that words such as "conflict" and "competition" were rarely used in these documents, yet it is inevitable, and in some cases

desirable, that differences of interest occur. We undertook a number of case studies which were designed to explore the relationship of the respective central government departments concerned with social work and health viz. — the Social Work Services Group (which is in fact a section within the Scottish Education Department) and SHHD. These studies investigated how particular problems or activities in which there was an obvious joint interest were handled.

All the case studies pointed to some conflicts of view or of expectations between SWSG and SHHD officials. This was not an unexpected result since it ties in with other research findings and experience on the general problems of working across administrative boundaries.

However, we discovered that officials experienced difficulty in finding a constructive approach to handling these conflicts and in collaborating effectively. There seemed to be a number of reasons for this:

1. The organisational structure of the Scottish Office; this was departmental and the usual method of handling issues was for one department to take a "lead" — in other words "departmentalism" was a strong factor and mechanism for making a more "corporate response" to difficult issues seemed poorly developed.

2. The tendency for a "lead" department to consult with others rather than to participate jointly in exploring issues in which there was an obvious conflict. There was also a tendency to internalise the matter and try to resolve any problem before seeking views elsewhere — in particular there seemed to be a reluctance to involve any higher corporate level within the Scottish Office, or to consult with Ministers or indeed to seek views from amongst the wider range of interests outwith the Scottish Office.

3. The relationship with Ministers. Civil Servants were usually reluctant to consult Ministers in the early stages of policy development. They seemed to assume that any difference of views had to be resolved before making contact with Ministers and liked to put forward clear-cut recommendations rather than a set of options for consideration.

4. The many goals and objectives being pursued by SWSG and SHHD. Some of these concerned services to patients and clients and some the internal functioning and operation of the departments themselves. Therefore, even where potential changes might seem to be in the wider public interest conflicts could arise and prevent progress because of these "internal" objectives.

5. The importance of particular individuals in shaping a department's response on specific issues. Generally, the training and education of Civil Servants with its emphasis on avoiding risks and any possibility of political embarrassment could inhibit the generation of proposals with wide-ranging effects and hence the resolution of conflict at an official level. More specifically, individuals in key positions could exert a major impact on the way issues were handled and in providing (or not providing) the necessary motivation to resolve differences of view.

6. The different organisational and political contexts in which the departments were operating. There was a tendency on the part of one side to forget that life on the other side of the administrative boundary was quite different. This resulted in unreal expectations about what others could do. For example, the health service operates in accordance with an apolitical model in which the involvement of practitioners and professionals is of major significance whereas local authorities are democratically elected political bodies. Furthermore the degree of influence or control that can be exerted by SHHD and SWSG differs.

7. The reluctance to challenge previously agreed policy positions, for example SHHDs policy of not earmarking funds to health boards and the reluctance of SWSG to put out guidance to local authorities which could be construed as having financial implications.

Some of these practices have been developed for quite understandable and rational reasons. For instance, the fact that the Scottish Office has only a small number of Ministers covering a vast range of topics and that these Ministers must spend most of their time in Whitehall restricts the contribution they can make and the range of matters Civil Servants can bring to them for discussion. However, while the development of these practices may be understandable, they have certain disadvantages particularly for collaboration across government departments, and in our view warrant further consideration.

The nature of the impediments to collaboration listed above indicates that bringing together SWSG and SHHD within one department of the Scottish Office would not be the panacea that many seem to believe. It seems to us that the handling of issues on which there is a potential conflict between departments, such as SWSG and SHHD, could be improved:

1. If relevant departments, and, where appropriate, external bodies, could be involved in *joint explorations* through the medium of working parties or planning groups;

2. If more attention were to be given to the nature of the problem and the range of possible solutions by adopting a *more systematic approach to problem-solving;*

3. If there could be *more direct political input* at the formative stage of defining the problem and in considering the possible solutions or policies that emerge.

However, we are not suggesting that all the problems uncovered would be solved in this way nor that these proposals could be adopted in isolation — they have implications for the relationships between Civil Servants, Ministers and the Secretary of State and the corporate machinery of the Scottish Office. Also, the proposals raise questions about how such issues which cut across administrative boundaries can be identified and processed within the Scottish Office and how any *joint* study group would be set up and operated. The study of the use of groups in policy-making provided some insights into the latter question and is discussed next.

(ii) The Use of Groups to Aid Policy-making

Groups and working parties are often used by central government departments to aid in the development of new policies. Some groups are set up to operate within a department while others — usually acting in an advisory capacity — operate

externally. Reorganisation led to the setting up of Programme Planning Groups (PPGs) under Planning Council auspices — these were intended to be an improvement on previous advisory groups because they could have a more balanced and representative membership and use more systematic methods of working. Among the PPGs set up were groups concerned with care of the elderly, with mental disorder, with child health, and with cardiac surgery.

However, experience with such groups within SHHD was extremely limited and systematic planning approaches had been used only occasionally by small, mainly internal officer teams (see, for example, SHHD 1974). So PPGs lacked a well-defined basis on which they could be set up and operated with confidence. As they were essentially experimental, we undertook research to learn from their early experience, in the hope of improving the use of such groups for policy-making in future.

In the course of our studies, we found that expectations about what PPGs would achieve were many and various. Most prominent amongst these were that PPGs would develop policies for the provision of services both within the NHS, and where appropriate within social work services; that they would gain the commitment to any proposed changes of the various interests who were participating in the groups' activities and that they would enable inter-agency and inter-professional conflicts to be worked through.

One of our studies concerned a PPG in which there was a social work and health interest and indicated that the important implications of the *organisational and political* context for the eventual influence of the group had not been fully appreciated. This PPG had been set up at the behest of the Planning Council, but because its subject was as much a social as a health problem, it eventually came under the joint parentage of the Planning Council and the Advisory Council on Social Work (ACSW). The research, based on interviews with departmental officials and analysis of file material, suggested that PPGs being essentially a health service creation were by nature apolitical and professional in orientation and that this conflicted with the political nature of local authorities; that making ACSW a joint parent posed problems because in contrast to the Planning Council it was a professional advisory body which did not possess a policy or planning orientation and did not allow for the participation

of field authorities; and that differences in the political relationship between SHHD and health boards, and SWSG and local authorities created varying expectations about what a national PPG could do effectively. The research also indicated that these difficulties had been compounded by the 1975 reorganisation of local government (which occurred after the setting-up of this PPG) which had created the new more self-sufficient regional councils and a new national body, the Convention of Scottish Local Authorities (COSLA). This meant that the way the PPG had been set up, the joint parentage arrangement with ACSW and the lack of direct links with local authorities became even more questionable and reduced the likely influence of the group, particularly as far as social work services were concerned. This again reinforces the point made earlier, that there is great danger in assuming that local authorities or indeed other bodies operate on a similar basis to the health service.

Yet other studies considered the internal *operation* of PPGs and these indicated:

1. That PPGs operated in a free-flowing and relatively unstructured way. The groups seemed to be effective in enabling participants to share insights and understanding and in providing good group motivation, but were also open to domination by members with high status or strong personalities, and were relatively low in creativity;

2. That the tasks given to PPGs were of considerable complexity and in many ways were beyond the resources and skills available to participants. Consequently, the emphasis was often placed on looking for solutions with only limited consideration being given to the underlying problems of the client groups under study;

3. The dominant method of working was along the lines of a business committee with a formal agenda and minutes. This did not seem to be appropriate to the complexity of the task being faced nor did it help participants to keep track of the pattern of group discussions. Value conflicts and philosophical differences were for the most part not discussed, and arriving at a group view on specific issues proved difficult.

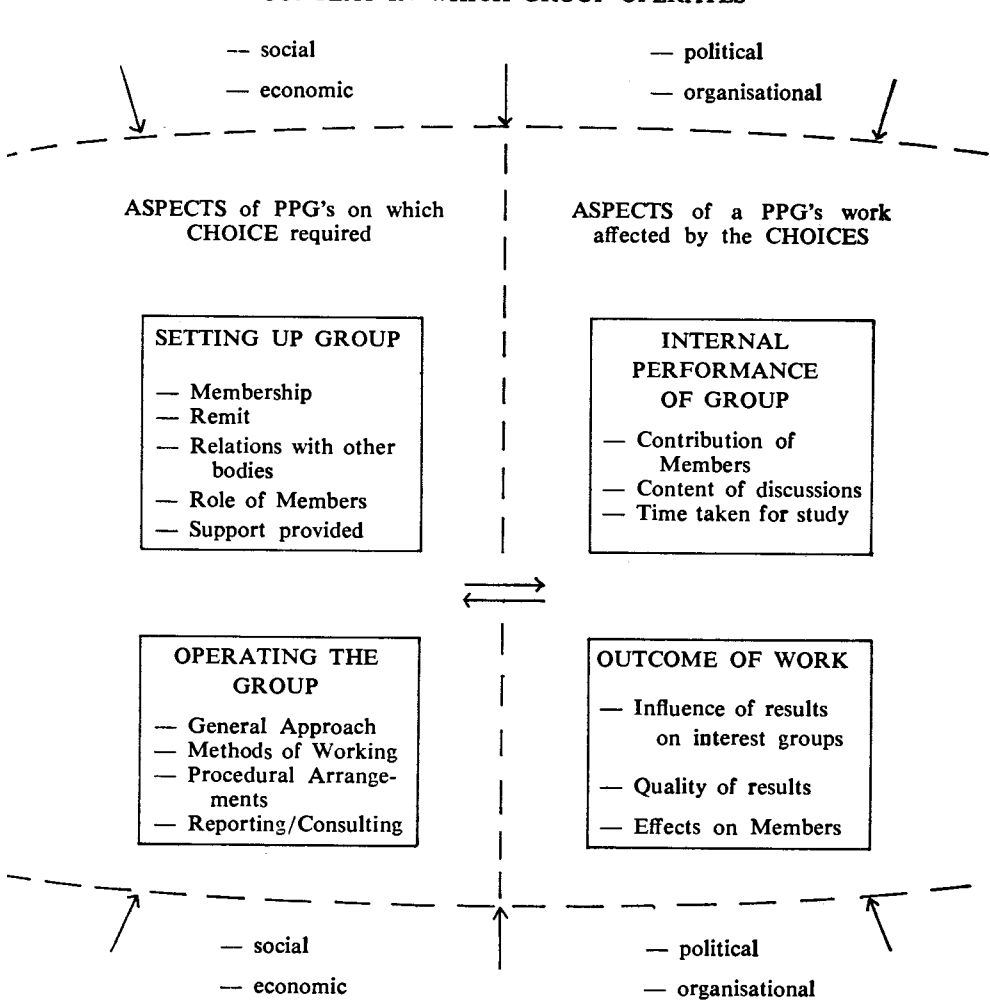
As indicated earlier in the paper, previous attempts at using advisory bodies for the purposes of policy development had been found wanting and so the aim of our work was to use these criticisms constructively so that future PPGs could learn from this experience and avoid some of the pitfalls discovered. While these findings were reinforced by a survey of participants which we undertook, the survey also indicated widespread support for the concepts underlying the PPGs creation. In particular, their multi-disciplinarity, the participation of different interests in national planning, the bringing together of field and central government perspectives — along with the opportunities they provided to influence developments — were highly valued by participants. Even so, to varying degrees and for various reasons, participants felt that PPGs were not yet realising their potential or exploiting the opportunities as fully as they might. The implication of these studies was that the likely contribution of a PPG to effective policy-making was largely determined by:

1. The choices made in *setting up* the PPG, for example in deciding its remit, timescale, membership and the role of members;
2. The choices made concerning the *operation* of the PPG itself, for example the methods of working or approach adopted, the procedural arrangements for meetings, the approach to reporting and consulting with other groups, the skilled support provided;
3. The expectations that existed about the *product* of the group, for example about the content of group discussions, the performance of participants, the report of the group, the influence the group would exert on individual participants or outside interests and agencies;
4. The organisational and political *context* in which the PPG worked, for example the relationships with other agencies and groups, and the external influences of the environment on the group or its members.

This framework is illustrated in Figure 2. On the basis of the studies undertaken, *we concluded that for a PPG to operate effectively then the way it is set up, the way it is to operate,*

Figure 2:

A BASIS FOR DECIDING HOW TO SET UP AND OPERATE A PPG



the expectations about what it can achieve and the organisational and political context within which it is to work have all to be in harmony one with another. We also concluded that the initial PPGs did not meet these necessary conditions.

The consequence of this work is that future PPGs should not automatically be set up on a uniform or consistent basis — the characteristics of the group should be selected to vary according to the particular circumstances. For instance, we would expect a group which is given a short-term and highly constrained remit and for which acceptability of the eventual proposals is of paramount concern to require a different membership, a different approach, a different level of creativity and a different relationship with interested bodies from, say, a group looking at the long-term future in a relatively unconstrained way with the primary aim of producing ideas to influence the climate of debate about the future NHS. Also when the organisations represented in a PPG enjoy considerable local autonomy in decision-making then expectations about the role that their representatives can play in the group as well as about the group's eventual influence on the local level must be tempered accordingly. For instance, where the task of a PPG is of particular importance to local authorities, then their central body, COSLA, could be asked to nominate representatives to the group. However, since the constitution of COSLA means it cannot take decisions which are binding on individual local authorities, it would be inappropriate and unrealistic to expect these representatives, in the course of the PPGs work, to enter into commitments on behalf of these authorities. Similarly, where a particular PPGs activities are of direct concern to the medical profession, the National Medical Consultative Committee could be approached to nominate representatives to the group, but in spite of their participation, here again the PPGs proposals could not bind individual medical practitioners at local level without infringing their clinical freedom. In these circumstances, the most that can be expected of the participants in a PPG is that they act as a channel of communication between the group and the national bodies they represent. In this way, the eventual proposals made by a PPG should stand a better chance of proving acceptable to the various national bodies represented on the group. Furthermore it would seem reasonable to hope that these bodies would be prepared to exert influence on

the individuals or agencies at the local level that they themselves represented.

These studies suggest that before introducing any new PPGs, or indeed similar groups, we need to consider carefully the requirements for a group. However, this is not a simple exercise and will involve considering the nature of the problem or task in hand, identifying the interests to be taken into account and deciding which of the interest groups it is hoped to influence through the activities of the group. The research also suggests that there are many ways in which groups can be set up and operated, and that therefore the possibilities which might meet the specified requirements will need to be explored and their respective pros and cons considered before deciding what kind of group will be most appropriate.

(iii) The Setting of Priorities

Use of the term "the setting of priorities" implies consideration of the possible candidates for priority before decisions are made about what to do. Until very recently though, no attempt had been made to issue statements of priorities for the NHS. Indeed as we discussed earlier in the paper, in the past national policies were usually developed in response to *ad hoc* pressures — this led to piecemeal changes in services and so the priority for resources accorded to different client groups was reached more by default than by design. This reaction to pressures is an inevitable part of any NHS planning process and thus will be a continuing influence on what services or groups do actually receive priority treatment. Nevertheless, we believed that our planning proposals which entailed an across the board review of what was happening and what the future might hold for the NHS would enable views to be formed about the directions along which specific sectors of the NHS might best develop, and about the overall priorities for resource allocation. In this way, some degree of control might be exerted over the future development of the NHS.

However, there were considerable uncertainties about these proposals to be explored. Firstly, the word priority was in common usage and seemed, like planning itself, to mean different things to different people. Secondly, there was uncertainty about the kind of information required to make judgements about the directions in which the NHS should develop. Finally, there were

questions about who should be involved and what part they should play in reaching such judgements. In seeking to research further into these questions, one of our main difficulties was that no statements of priorities across the board had ever been made for the NHS. Thus we were fortunate that DHSS, having developed its own comprehensive planning system, used this in 1976 to produce a consultative document "Priorities for Health and Personal Social Services in England" (DHSS 1976). This initiative coupled with the White Paper on Public Expenditure that year led SHHD to produce its own strategic document "The Way Ahead" (SHHD 1976) soon after.

These initiatives provided at least some empirical evidence on which we could draw and we were fortunate in being able to investigate how "The Way Ahead" was produced. What emerged from our analysis was that the decision to draft "The Way Ahead" was in part prompted by the DHHS producing its strategic document but also in part by the felt need to give some sense of direction to health boards at a time when public expenditure cuts were being made. We also found that, because time was short, outside interests (for example, the National Consultative Councils, the Planning Council) had not been actively involved in the development of priorities and consultation with these bodies had been curtailed; that the work had been undertaken and influenced by a small number of individuals within SHHD; that relatively little time had been given to deciding priorities and these were based mainly on the work of DHHS and on the previous SHHD policy statement about such groups as the elderly and mentally disordered. In short, this research told us more about the process of central government in dealing with pressing issues than about the kinds of information that might have helped in forming judgements about priorities. More importantly, it provided only limited insight into how such activity might be organised in the future if a more systematic and a more participative approach was desired.

As a result, we decided to look at the experience of priority-setting on a wider front and undertook a major review of the research literature on the topic covering the health field generally but also looking at a selection of other fields too (Lind and Wiseman 1978). The review was not restricted to experience in Scotland.

What the review revealed was that decisions about priorities

at a strategic level tend to be discussed along a number of distinct dimensions. Arguments have been put forward in an attempt to influence priorities between different geographical areas, between different groups of the population, between different disease/dependency groups, between different forms of intervention and between different agencies. These dimensions are clearly interdependent. For instance, an argument which suggests that more resources should go to the elderly implies a change in the pattern of service provision and similarly a move towards more preventive forms of intervention would affect people with certain kinds of disease or dependency conditions more than others. However, many of the studies identified in the course of the review focused on only one of these dimensions at a time. In general, the principal criteria used in arguing the case for shifting resources from one group or activity to another concerned the needs of the population, the quantity and quality of services, their effectiveness and their efficiency. Only a few studies were found which attempted to make direct comparisons between one disease/dependency group and another. Also it appeared there were major gaps in the quantitative information and research base available for making comparisons.

The research also considered the role of different agencies and interests in the priority-setting process. This again indicated the importance of pressure groups and interest groups in shaping the agenda of issues for consideration at the national level and the predominant "muddling through" approach adopted by decision-makers in responding to these pressures. More recently though, there has been a general trend towards the introduction of planning systems and also of organisational changes which allow for more participation and more consumer involvement in policy-making. How far these changes would produce a balanced set of pressures on central government departments and how far a more participative involvement in priority-setting would result it was too early to say. What was clear, though, was that priority-setting was a process requiring that political judgements be made.

On the basis of the review, we concluded that no consistent or coherent basis for setting priorities existed. In looking to the future, it would be possible to allow priorities to be set very much as before by a process of "muddling through" in which pressures from different interests would largely shape policies in

different sectors of the NHS and hence indirectly affect priorities. On the other hand, it would also be possible to take a more selective and controlled approach in which systematic consideration was given to the development of new policies (and hence priorities) in *selected* sectors of the service — the development of national standards and norms for specific services offers a good example of this sort of activity. But given the interest in a more comprehensive approach to planning, there remains the question of whether or not it would be possible to find a way of looking across the board at priorities. The review indicated two main possibilities — largely theoretical — which could be considered for this purpose. One of these is based on the development of a health status index which would enable an individual's state of health to be measured and allocated a score on a single scale running between normal health and death: this approach is heavily dependent on the gathering and technical analysis of qualitative and quantitative information. Methods for the aggregation and weighting of such data are still needed. The other approach, to which we referred as a "criteria model", covered a range of possible approaches — the common features of these being the explicit specification of a list of criteria which are relevant to the case for priority attention and the reliance on "political" processes to consider information on these particular criteria and to arrive at decisions about priorities. The evidence assessed in the review suggested that an approach based on health status indices would not be politically realistic even if other problems of measurement were surmountable — which they are unlikely to be. Whether or not a "criteria approach" is possible remains a moot point but one which we felt to be worth further investigation. The research has also highlighted a number of the practical problems of attempting to develop such an approach. Information about certain aspects of health service activity is lacking and there are problems in defining a comprehensive set of patient or disease categories for comparison and in enabling a wide range of interests to participate in the decision-making. If such problems cannot be overcome or if the effort required to do so is too great, then the alternative will be to abandon attempts at a systematic and comprehensive approach to the setting of priorities and to rely on "muddling through" or other more piecemeal ways of changing policies.

How Can We Improve Policy-making in the Future?

At the beginning of the paper we discussed policy-making processes in the past and identified various deficiencies. After this we put forward proposals for a planning system which we believed would result in improvements. However, as we have seen, the more recent research studies discussed above indicated to us that there were still aspects which were not satisfactory. We felt the most pressing needs to be:

1. To devise systematic approaches to the development of policies (and the setting of priorities) which would cater for the participation of a wide range of interests; this participation might require the formation of multi-disciplinary and multi-agency groups such as PPGs.

2. To provide for more direct political inputs into policy-making and administration — both at an early formative stage in these activities and also at a later stage when decisions about new policies are to be made.

3. To improve the way issues which cut across departmental boundaries are handled within the Scottish Office; this would require the introduction of mechanisms to facilitate a more corporate response from central government and to encourage *joint* studies on problems which are common to a number of departments and regarded as sufficiently important.

In response to 1. above, we have refined and developed further our original proposals for a planning system. We have suggested a framework for the setting of health service priorities and we have devised procedures to help decide how PPGs or similar groups tackling specific problems can be set up and operated most effectively. While these proposals are theoretical in that they have not been tested in practice, they are grounded in practical case experience and offer a possible way of improving policy-making still further. In introducing such approaches (or any planning system for that matter) many practical problems will need to be overcome, but they are likely to be surmountable. If such proposals are not introduced then the only alternative

will be to retreat to past methods of policy-making which have been found wanting. In recent years, SHHD has discussed with health boards and the Planning Council, the introduction of a strategic planning system which has taken on board some of the ideas contained in our proposals for a periodic review process within the department. However, so far progress in putting health planning into practice within Scotland has been very slow. This can be contrasted with the position in England. Although one can argue about the appropriateness of the English planning system, there is no doubting the progress that has been made, since reorganisation, in implementing the system. However, the introduction of a planning system and new approaches will not cure all the problems of policy-making that we have discussed above — changes in the organisational structure and in the relationship between politicians and government departments are also required.

At the time of writing, it looks as if the Scotland Act will soon be repealed. However, other reforms are under discussion and it seems to be fairly widely accepted that the present political arrangements for Scotland will have to be revised. Assuming then that some new Assembly of elected politicians is created, whatever form this takes and whether or not it is given legislative powers, how could it help to improve policy-making? The remainder of the paper draws on our research findings to make some suggestions on this question and to speculate on some of the implications of an Assembly.

The changeover to a new Assembly would in itself provide an opportunity to challenge and review the appropriateness of past policy-making practices. The Assembly would be in a good position to capitalise on the knowledge that now exists about the deficiencies and difficulties of policy-making and also about what would be involved in introducing the proposed planning system and associated procedures. So an Assembly could, if it chose, provide the necessary commitment and motivation to introduce a more planned approach to policy-making. An Assembly could also provide the stimulus to improve policy-making through the introduction of linked structural changes too. Clearly, the introduction of an Assembly would raise many questions about who was to be involved in policy-making and how that involvement was to be organised. Indeed, it is a moot point whether the complex national advisory structure that now exists should

continue in the new situation that would be created. However, too many organisational changes too quickly could lead to the baby being thrown out with the bathwater.

In fact, since the 1974 NHS reorganisation there have been a number of innovations which are worth retaining and developing. The introduction of PPGs and the wide participation in policy-making they make possible has been an important and exciting development. While the initial experience with these groups has thrown up difficulties and criticisms and while there has been a bias towards professional involvement, PPGs are valued by those involved in their activities and offer considerable scope for the worthwhile involvement of many disciplines and agencies in the shaping of national policy. An Assembly could build on this innovation to allow professionals, health board officials, trade unions, voluntary agencies and other consumer groups to advise on policies for specific problems. In some ways then, although the NHS is not under democratic control and the rationale behind its administrative structure is difficult to discern (Stewart 1977), the trend towards a more pluralistic and participative involvement in policy-making may hold lessons for any new political Assembly, and indeed for local government too. For groups like the PPGs, if operated in the right spirit could provide a possible alternative to the rigid committee structures that are generally to be found in local authorities in which usually only councillors can play a part.

The creation of an Assembly might also mean changes in the organisation of existing Scottish Office departments and in the nature of the relationship between Civil Servants and politicians. Ideally, an Assembly should arrange its own internal structures and stimulate organisational changes within departments in such a way that political inputs can be provided into policy-making at appropriate times and so that cross-departmental problem-solving will be encouraged.

If we look first at possible changes to the organisation of the departments within the Scottish Office then there are numerous possibilities to be considered. For example, departments could be organised on a functional basis (that is according to the service to be provided, such as health or education) or in relation to specific population or client groups. Whatever the basis decided upon, many issues that arise for consideration will cross such artificial administrative boundaries. Therefore,

it would seem sensible to encourage flexibility in the internal organisational structure of these departments so that they can respond jointly to these issues. An Assembly could also facilitate this more corporate capability by the way it established its own committees and this is discussed next.

The creation of an Assembly would mean that there were Ministers and other politicians with a direct interest in health matters in Edinburgh virtually all the time and this would in itself provide more time and more resources for political involvement in the consideration of health problems and in policy-making activities. If it were to be decided that the Ministers alone could not provide sufficient political input into the affairs of the relevant government departments then the introduction of a Health Committee drawn from within the Assembly, possibly with investigative powers, might be worth considering. However, there would be some dangers in an Assembly adopting a committee structure too closely aligned with government departments since many of the important problems would cut across departmental boundaries. Furthermore such committees can take on a somewhat negative watchdog role *vis-à-vis* Civil Servants and Ministers at the expense of a more forward-looking approach. Thus, an argument can be made that within the Assembly *ad hoc* committees should be formed from time to time with forward-looking remits to focus on key issues, such as the elderly, the multiply-deprived population, and alcohol-related problems, which cut across departmental lines. These committees could provide the necessary parentage and legitimacy for joint work by departments. However, what kind of groups should be set up in support of such committees, how active the committee members would be in any study and what would be required in the way of support services obviously requires further consideration — one possibility would be for the committee to steer the activities of a planning group, similar to a PPG. If the Assembly created did lead to the setting up of such committees, then these would need to be serviced and supported. There could be advantage in having a skilled secretariat which was independent of the Civil Service and Ministers — this would be particularly so, if it was intended to encourage the participation of a wide range of national bodies in policy development activities.

The creation of a new political Assembly would also change

the relationship of SHHD or its successor department with the UK Parliament and with UK government departments. In the past, as we have seen, DHHS has exerted considerable influence on the agenda of issues to which SHHD has given attention. Furthermore on many politically sensitive issues, SHHD has been able to adopt a low profile precisely because there was a DHHS. So while the presence of DHSS may on occasion have diverted effort and attention towards UK rather than Scottish health problems, SHHD has also benefited from time to time by being able to draw on the work of DHSS — certainly, DHSSs size allows much greater and more specialised resources to be brought to bear on certain issues. The one thing of which we can be certain is that the nature of this relationship would have to change if an Assembly were to be created.

The overall conclusion of this paper is that there is ample scope to reform and improve the way health service policies are developed in Scotland and that sufficient information and knowledge are now available to help guide the search for improvement. This search should take place whether or not an Assembly for Scotland is eventually created. If such an Assembly is created though, we should capitalise on the opportunity it provides for reviewing existing organisational arrangements and policy-making practices, and for introducing improvements. In any event, the opportunity exists for Scotland to be at the forefront in the development of a systematic yet politically realistic health planning process and in so doing to make sure the policies that are developed are sensitive to Scotland's future health needs and problems.

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