

THE LURE OF THE ORGANISATIONAL FIX: RE-REORGANISING THE SCOTTISH HEALTH SERVICE

DAVID HUNTER
DEPARTMENT OF COMMUNITY MEDICINE
UNIVERSITY OF ABERDEEN

For the second time within a decade the National Health Service has been reorganised and a third restructuring, albeit of a more limited nature, is in the offing. Events in Scotland have lagged behind those elsewhere in the UK, have followed a different course and have resulted in slightly different outcomes. The intention in this chapter is not to describe in great detail the nuts and bolts of the arrangements that have taken root. Some of this detail and the problems confronting the fifteen Scottish Health Boards in implementing the reforms are presented in another chapter. This chapter attempts to trace the origins of the latest reforms, describes their underlying philosophy and pinpoints where they differ from the rest of the UK. In so doing, the narrative provides a commentary on aspects of health policy-making in Scotland which is conducted in a wider UK arena where the central department in London, the DHSS, takes the lead.

The developments reviewed here focus on two separate, though related, reform initiatives. The first is directed towards the actual organisational structure of the Health Service; the second is concerned in large part with the managerial culture and the processes encased by these structures. Each is considered in turn and a third section assesses their significance for future health policy and for health care in Scotland.

Structural Reform

Between 1974 and 1984 the structure of the Scottish Health Service comprised three levels below the central department, as shown in the Diagram. From mid-1984 the structure comprised two levels below the

central department. Ten of the fifteen health boards, i.e. the multi-district areas, were affected by the changes. While the actual changes are of some interest, much more interesting is the rationale underlying them and the process of their adoption which makes for a curious saga of hesitancy, lack of direction and policy reversal. If, as has been alleged,⁽¹⁾ policy-making is as much about puzzlement as power then the 1984 reorganisation of the Scottish Health Service bears ample testimony to the salience of this view.

To understand events in Scotland over the past four years it is necessary to say something about those in England. As will become clear what happened in Scotland was a direct result of what happened in England; the same holds for Wales and Northern Ireland.

Not long after the NHS was initially reorganised in 1974 rumblings were heard from various quarters about the disaster it was proving to be. It was alleged, mainly by sections of the medical profession, that Sir Keith Joseph, then Secretary of State for Social Services, had created a bureaucratic Leviathan that was in danger of collapsing under its own weight. Criticism centred on the number of management tiers ('shed a tier' became a well-worn cliché in Health Service circles in the latter half of the 1970s), on the inflated number of administrative staff (i.e. the dog was getting smaller while his tail was growing bushier), on the remoteness of appointed bodies from the communities they served, and, by no means least, on the system of consensus management whereby decisions lay in the hands of teams of officers from the four main disciplines: administration, finance, medicine and nursing. There are those who maintain that the only way to manage a complex undertaking like the NHS is through multi-disciplinary consensus teams;⁽²⁾ others, who were vocal in the late 1970s, argue that consensus management is a negation of good management and that its introduction into the NHS in 1974 was the outcome of an 'implicit bargain'⁽³⁾ between the government and a suspicious medical profession jealously guarding its interests which it believed would be threatened by any form of chief executive system of management. Moreover, those belonging to this school of thought argue that the very nature of the NHS (chiefly its complexity and its multi-professional composition) which has led to great opposition to chief executives also happens to be the very reason why they are required.⁽⁴⁾ This debate is returned to later in the chapter.

It is hard to know whether the discontent over reorganisation was merely the frustration with their lot felt by some displaced groups who yearned for the cosy familiarity of a structure many had known for twenty years or more. There is no doubt that the 1974 reforms opened up decision-

making to other groups. The duopoly, or cosy cabal, of administrators and doctors gave way to a management team concept involving other disciplines. Moreover, the purpose of the 1974 reforms was to replace the former tripartite structure comprising local authority health services, primary care and hospital services with a more unified structure to enable integrated care to be provided to people whose needs transgressed professional and organisational boundaries. It should also be stressed that while the reorganised NHS was not enthused over by everyone in Scotland there was far less overt hostility towards it than was the case in England. In part this may have been because it was simpler but other reasons were probably important, too, including a healthier resource base in Scotland compared with England and a scale of activities generally which was claimed to be more manageable and which could be conducted more informally.

In England the rumblings became sufficiently loud for a Royal Commission to be set up in 1976 only two years after the NHS had been reorganised. The Commission's remit was to look at the management of the NHS, a Herculean task which was handled competently if not with aplomb. It reported in 1979⁽⁵⁾ by which time the Labour Government had been replaced by a Conservative administration. While in Opposition, the Conservatives had begun to form very clear ideas about what they saw as being wrong with the NHS and what they saw as the cure. Whereas the Royal Commission advocated a gradualist, evolutionary approach to reforming aspects of the structure in certain health authorities, the government sought a more dramatic remedy that would involve the entire NHS. Their thoughts on the matter were set out in a consultative document, *Patients First*, published in late 1979.⁽⁶⁾ It paid homage to the Royal Commission's recommendations but in general ignored most of what the Commission had to say. Clearly Ministers had already made up their minds and the Commission's report was only invoked where it bolstered their ideas.

Hard on the heels of the English consultative document came versions for the rest of the UK. In contrast to the English paper, the Scottish one⁽⁷⁾ was very thin – seven pages of text compared with twenty-five pages – and gave the appearance of being a 'knee-jerk' response to the English document. Whereas the English paper produced a firm rationale for the proposed reforms based on notions of *laissez-faire*, devolution and flexibility with a strong desire to loosen the centre's reins on the periphery, the Scottish paper lacked this dimension. It did not even have a thematic title. What was proposed for the NHS across the UK was a simplification of the structure: superficially, only the details and the titles differed in the four

parts of the UK. In Scotland it was proposed to retain the fifteen health boards but in the ten boards with district structures it was suggested that many, if not all, of them should abolish these and establish units of management.

In England the changes proposed were more substantial: the area tier of management below region was to be shed and a new district authority level created below it which would more or less correspond to the then existing district management teams. The new districts, however, were to be not merely management bodies but were to be member bodies responsible for policy-making and planning activities. Details of the arrangements below districts were to be issued at a later stage although three general principles were outlined: (a) maximum delegation of responsibility to hospital and community services; (b) no managerial tier between the hospital and community services level and the district level; and (c) hospital staff, other than clinical staff, to be accountable to the hospital administrator and not to district level managers (i.e. functional management in services like catering, laundries and cleaning was to be curtailed somewhat to reduce fragmentation).

The Scottish consultative paper was a curious document. Although reference was made to the Royal Commission, the opening paragraph made it clear that the Scottish Secretary of State's statement was triggered by the Secretary of State for Social Services' action in producing *Patients First*. More curious still was the strategy favoured for restructuring. If *laissez-faire* was the name of the game it reached extremes in Scotland where the ten health boards with districts (see Appendix for details of these) were asked to review their arrangements 'with a view to abolishing districts'. It was accepted that in a handful of cases boards would wish to retain districts and it was a matter of these boards stating their retaining reasons for the *status quo*.

In Scotland an option would have been to remove the area health boards, which, strictly speaking, are comparable to the area health authorities in England which were abolished in 1982, and centre operations on districts or on new authorities to be of a size somewhere between areas and districts. However because abolition of health boards would have entailed a considerable upheaval and because the areas had, in the government's view, worked well since 1974 it was decided to leave boards intact. In other respects the document kept close to its English counterpart from which it took its cue.

Within the NHS there was no real enthusiasm for a second

reorganisation in under a decade and, despite repeated assurances from Ministers, the upheaval that ensued was inevitably greater than had been predicted. Progress was swifter in England where a timetable was laid down and the new district health authorities assumed their responsibilities on 1 April 1982. In Scotland events proved to be more protracted than elsewhere in the UK and the main changes have only fairly recently been completed in some boards. A firm timetable was not set for Scotland at the start.

In England a circular⁽⁸⁾ appeared in July 1980 setting out the government's decisions about restructuring. Area health authorities and health districts were to be replaced by district health authorities. Below districts, services were to be organised into units of management comprising an administrator, a nurse and a senior member of the medical staff. Units could be organised in a number of ways: a large single hospital, the community services of a district, client care services, maternity services, geographical areas, or a group of hospitals. It was up to the new districts to produce plans for units which would then be approved by the regions.

In Scotland a circular appeared almost a year later in March 1981.⁽⁹⁾ This followed two statements in Parliament by the Secretary of State on progress in Scotland. The first of these, in July 1980, referred to the division of opinion among health boards over the fate of districts. Three out of the ten boards with districts favoured their abolition and were later joined by another two. The other seven, the so-called 'Magnificent Seven' (later reduced to five), opted to retain a district structure. The second statement, in March 1981, had nothing new to say beyond the fact that discussions between the Department and health boards were in progress. Decoding the language, this meant that the discussions had run into difficulties and progress had ceased.

The circular itself reaffirmed the Secretary of State's desire to see districts abolished or, if this was not possible, their number reduced. In other respects, in particular the emphasis on strong unit management, the circular followed the English one.

The impatience with some health boards and the future of their districts which could just be detected in the Scottish circular came to a head in November 1983 when the Secretary of State announced to Parliament in response to a question⁽¹⁰⁾ that *all* health boards were to operate without districts and were to be so instructed forthwith. Significantly, and somewhat curiously, the decision was taken with the concurrence of health board Chairmen including those from the five boards intent upon retaining

districts. The extent to which Chairmen gave their agreement willingly or with reservations is not clear. The Secretary of State may have enlisted their support in order to legitimise the decision in the eyes of those managing services and to avoid, or minimise, a hostile reaction to the abolition of districts. In short, the room for manoeuvre available to Chairmen might have been very limited.

The Secretary of State alleged that 'adopting a common form of organisation will also provide a firm basis for consideration of the recommendations of the NHS Management Inquiry led by Griffiths ...' (see below). The circular⁽¹¹⁾ which followed went further, asserting that the Secretary of State was 'in no doubt that the elimination of districts ... will contribute to the pattern of strong unit management recommended by the Griffiths Report'. The circular gave other more immediate reasons for the abrupt switch from a *laissez-faire* to a directive stance. In the period since the first circular it had become evident 'that the revised management structures being devised by individual health boards would create excessive disparities between them, and bring about considerable difficulties for both management and staff'.⁽¹²⁾ A key problem was reaching agreement on Whitley Council gradings. It seems surprising that these problems had not been anticipated, a reflection, perhaps, of the lack of thorough preparation in Scotland for the second reorganisation.

The ten health boards with districts were required to establish units of management which would be 'coherent and discrete areas of management responsibility, forming a distinct management level to which substantial decisions can be devolved'.⁽¹³⁾ A firm date – 1 April 1984 – was set for implementation of the reforms by the five health boards which had originally planned to abolish districts. An extension of two months was given to the other five boards which had hastily to draw up plans for units. From June all health boards were to be uniform only varying in the number and type of units they decided to establish.

How are these various moves in the second round of the reorganisation game to be interpreted? And what alternative options were available? At one level the moves can be seen as evidence of the lack of enthusiasm in the SHHD for a further reorganisation, an absence of clear thinking about what was wanted and as the consequence of ending up with a structure of health boards some of which would have two tiers below them (districts and units) while others would have just one tier comprising units some of which would resemble in all but name the districts they were replacing. At another level the history of events illustrates how difficult it is in practice to allow complete flexibility over structures, posts and gradings when there exist

powerful counterpressures, in the shape of Whitley Councils and professional bodies, for consistency and uniformity not only between but also within the four countries making up the UK.

The five health boards which initially decided to retain districts did so either on grounds of size (Glasgow and Lothian), geography (Highland), or a combination of both (Lanarkshire and Tayside). But with ten boards either already without districts or intent upon abolishing them the pressure was on the remaining 'recalcitrant' boards to fall into line whatever their reasons for retaining districts. Had a number of boards been permitted to retain districts then this would have made an already anomalous situation even more anomalous. Scottish districts would have resembled English districts in name only. Unit administrators below districts would have been a quite separate species from their counterparts in other boards or South of the Border. Doubtless such factors were in part responsible for the pressure exerted upon all boards to remove districts although, as mentioned above, this still left Scotland in a different position from that taking shape elsewhere.

There were many administrators who were of the opinion that the government had dismissed too readily a review of area health board boundaries and functions. The Scottish Division of the Institute of Health Service Administrators (IHSA) commented on the proposals in April 1980 and 'doubted the validity of the premises on which the proposals to retain existing areas and abolish their districts were based'.⁽¹⁴⁾ The IHSA described the area boundaries as a compromise between planning requirements and operational management and argued that a case could be made for reconsidering the boundaries.

Whatever the arguments for or against districts, the Scottish Health Service as it now stands is in some respects unique in the UK.⁽¹⁵⁾ With the abolition of districts there is a preponderance of areas very much larger than the average-sized district health authority (DHA) in England. This carries with it potential span of control problems particularly in Glasgow and Lothian which are the biggest day-to-day health management bodies in the UK (see Appendix).⁽¹⁶⁾ Moreover since there is no regional tier in Scotland health boards must assume a wider range of responsibilities than the English DHAs. Other regional functions are run by the SHHD or by the Common Services Agency which is jointly managed by the Department and by the health boards (see Diagram).

One way of removing the anomalies created by choosing to axe districts would have been to recast health board boundaries but, as noted

earlier, this course was rejected on the grounds that a major upheaval was to be avoided. However, in his first Parliamentary statement in 1980, referred to above, George Younger, the Secretary of State for Scotland maintained, as he had done in the consultative paper, that 'the changes to be made in district organisation and management levels below area will have substantial implications for staff'. In his second statement in 1981 he referred to the five boards without districts 'where the scope for major structural change does not exist' thereby clearly suggesting that the abolition of districts was more than just an exercise in fine-tuning. For some people in the health service this admission effectively demolished the argument for not examining health board boundaries which the government, in its 1979 consultative paper, had decided was not on the agenda for discussion.

Concern over the size of area health boards arose because of what was happening in England at the time. Most of the 194 English DHAs cover populations of about 200,000 with large authorities, i.e. 500,000 and over, being the exception. In Scotland, Greater Glasgow Health Board covers a population of over one million and Lothian a population of three quarter million. On the basis of figures produced in Parliament on the size of English DHAs, Rees⁽¹⁷⁾ contrasted the position with what was happening in Scotland. Only 6% of DHAs have populations over 400,000 compared with 50% of health boards (excluding the three island boards); 70% of DHAs fall within the population band 100,000 to 300,000 compared with only 26% of Scottish boards; 75% of the districts in Scotland covered populations of between 100,000 and 300,000. On the basis of these figures it was thought that the Scottish *districts* or, in some cases, amalgamations of districts should form the basis of new authorities.

Of course an increase in the number of health boards would probably have brought forth calls for a regional tier in order to achieve complete parity with England and to return Scotland to a pre-1974 type of structure comprising regional boards and boards of management. Between 1948 and 1974, the NHS across the UK was more uniform than it became after 1974.

Apart from the merits or demerits of focussing attention on districts, there were two central weaknesses in the government's case for reorganising the NHS in Scotland. First, whereas in England savings in management costs were a major factor in the desire to simplify the structure this was not the case in Scotland. Even if one were sceptical of the claims being made in England that management costs might be reduced by up to 10%, it at least provided a firm political rationale for the upheaval that did not depend exclusively on unsubstantiated theoretical organisational gains

from shedding a tier. As administrators in Scotland argued, why proceed with major reform if no savings were likely to be realised and if the other benefits were uncertain to say the least. The effect upon morale and the disruption of services could hardly be justified. Even allowing for an element of safeguarding jobs, this view cannot be dismissed lightly given the inevitable distraction from arguably more important matters that any reorganisation brings in its train.

But the chief cause for dismay in Scotland over restructuring was the admission by the then Health and Social Work Minister, Sir Russell Fairgrieve, that 'with England having to do it we felt on balance we should do it'.⁽¹⁸⁾ Sir Russell went on record saying that 'while we don't like in Scotland necessarily to trail in England's coat tails the fact is that England was having a look at the thing after six years. It was really felt on balance that we ought to look at the structure in Scotland as well because we were quite convinced there could be some improvement'. The Minister hypothesised that if Scotland enjoyed independence he would probably not have gone ahead with reorganisation.

The above account of events in Scotland between 1979 and the present time is an endorsement of Keating and Midwinter's⁽¹⁹⁾ argument about policy-making generally in Scotland that 'if an issue comes up through the UK network or arises simultaneously in England and Scotland, (the Secretary of State's) discretion will be more limited'. The role of the Scottish Office becomes largely reactive responding to initiatives from the 'lead' department (DHSS) in London rather than grasping initiatives itself. Creativity in the Scottish Office seems confined to administrative means rather than to policy ends.⁽²⁰⁾ The restructuring of the Scottish Health Service is a good illustration of this management style. It appears, too, as if the changes about to occur in the management of the NHS in Scotland may provide a further illustration. Before describing events in this area, and by way of concluding this subsection, a brief review of the current structural position in the Scottish Health Service is in order.

By the middle of 1984, all health boards had their units of management in place; while doubtless scars remain the wounds caused by the reorganisation itself, and more especially by the way it was handled, have practically healed. Units present opportunities for improved management but they also open up the possibility of conflict within boards. In most boards some of the former districts have merely been relabelled units (e.g. Grampian and Tayside have done this in the case of two of the three former districts in each board). In devising units, services that were combined under the former districts have been divided. For example in Dundee with a

population of just under 200,000 three units have been created to replace the district: psychiatry, general hospitals, geriatrics and community services. This division of activities is probably no worse than any other (with the possible exception of organising services on a client group basis which may aid planning across services) but it could create difficulties in achieving co-ordinated care for groups like the elderly who straddle all three units. It means that professionals will in future have to deal with three sets of unit management groups, and four officers within each unit, instead of just one district management group as before.

It is, of course, far too early to assess, or pass judgement upon, the new arrangements but there are grounds for concern that they may not achieve their aim of improved decision-making. Significantly, both circulars sought to impress upon health boards that the principle of the integration of hospital and community based services – a primary objective of the 1974 reorganisation – be maintained. Proper co-ordination between units in respect of these services was to be ensured. The very fact that the government deemed it necessary to insert a statement to this effect suggests that it foresaw potential problems at this interface through the creation of units. As the Appendix shows, the boundaries of the old districts in some health board areas matched the corresponding local government districts. Some units (e.g. re-labelled districts) will continue to share these under the new arrangements. But in many cases, in part because units are not all based on geographical criteria, the mismatch in boundaries is now more apparent. For instance, the former South District of Grampian Health Board has been replaced by five units in contrast to two local government districts. In Dundee, where the health district and local government district shared common boundaries, there are now three units. Of course most local government community services are the responsibility of the regional tier the boundaries of which, with the exception of Strathclyde, are coterminous with health board boundaries. But housing is a district responsibility and social work divisions often match district boundaries. Since most contact between health and local authorities occurs between boards and regions the absence of common boundaries below this level is unlikely to make a great deal of practical difference. What it may do, however, is set back attempts to promote closer links at levels below health boards and local authority regions.

Another issue is the extent to which units will be granted the devolution ostensibly sought by Ministers in terms of controlling budgets and decision-making. The issue of devolved decision-making was a key one in the former area/district structure, especially in the smaller boards, and it remains to be seen how prepared boards will be to stand back and allow

units to manage. This has become a major issue in England because the original philosophy of local discretion has undergone a quiet revolution. While vestiges of the old rhetoric remain in Ministerial speeches the catchwords are no longer 'flexibility' and 'local discretion' but 'efficiency' and 'accountability'. They signal a fundamental shift in the running of the NHS in England. An interventionist stance has been assumed by the central department which has replaced the former *laissez-faire* stance. The reasons for this shift cannot be considered here but have been set out by the author elsewhere.⁽²¹⁾ Its implications for the new districts and units seems to be that regions are reluctant to allow districts too much freedom and, in turn, that districts are reluctant to let go of units. Span of control problems make it very difficult for regions to control districts and for districts to control units but it is precisely because of a concern over loss of control that regions and districts may be reluctant to devolve responsibility. However if units are not granted freedom to manage they will cease to be credible, authoritative bodies and run the risk of being bypassed in favour of districts in England and health boards in Scotland.⁽²²⁾

The *volte face* that took place in England is not apparent to such a degree in Scotland where initiatives to strengthen the centre's grip on the Service have not been replicated. Nevertheless it remains to be seen whether units of management will function as intended. Unless they do the case for reform will not have been met.

Managerial Reform

Not content with merely trying to get the structure right, the government has more recently directed its energies to the internal management of the NHS. Once again events in Scotland are inextricably bound up with events in England and, as with structural reform, have lagged some way behind.

In February 1983, the Secretary of State for Social Services appointed Roy Griffiths, Chief Executive of Sainsbury's, to lead a small team with the remit 'to give advice on the effective use and management of manpower and related resources in the NHS'. The NHS Management Inquiry took about six months and a twenty-four page typescript, the Griffiths Report, was published in October 1983.⁽²³⁾ The Inquiry was confined to England although the team visited the central departments and health authorities in Scotland and Wales. In a Parliamentary statement, the Secretary of State for Scotland made it clear that he would be seeking to apply Griffiths to Scotland and that the first stage would involve publishing a discussion document. As mentioned already, the Minister claimed that one reason for

finally instructing all boards to abolish districts was to pave the way for implementing Griffiths' proposals for strong unit management. After almost six months delay the discussion document⁽²⁴⁾ was published in June 1984 with comments to be submitted by the end of September. The reasons for the delay are not known. One possibility is that the SHHD decided to wait upon events in England before making its move. Such caution probably reflected the DHSS's own reluctance to move too swiftly on Griffiths after an initial burst of enthusiasm on the part of the Secretary of State for Social Services. Once again, the SHHD took its 'lead' from the DHSS.

Although confined to England, clearly what Griffiths has to say is of relevance across the UK especially if it is being acted upon beyond England. The report combines diagnosis with prescription. The thrust of its argument is that the NHS suffers from 'institutionalised stagnation', the result of a labyrinthine consultation process and a system of consensus management teams which gives the right of veto to each team member. Apart from the Secretary of State there is no manager, or managers, within the Service who can at the end of the day say 'the buck stops here'. There is a notable 'lack of a clearly-defined general management function throughout the NHS'.⁽²⁵⁾ Consequently in the Inquiry team's eyes 'the NHS is so structured as to resemble a "mobile": designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction'.⁽²⁶⁾ Griffiths' observations are divided between the central department and the health authorities at region and district. He also comments on unit management. He does not mince his words when considering the role of the central department. There is 'a danger of over-organisation' with the centre 'too much involved in too many of the wrong things and too little involved in some that really matter'. Authorities 'are being swamped with directives without being given direction'⁽²⁷⁾ which makes it difficult to implement major initiatives or achieve change.

Not surprisingly Griffiths brought a business perspective to bear on the NHS and was intent upon emphasising the similarities between NHS management and business management, a view that is very much in keeping with the spirit of the times. But his diagnosis is broadly shared by many both inside and outside the Service even if differences of opinion exist over parts of it. For instance, consensus management has given rise to considerable comment and to sharp differences of opinion. Whereas Hunter⁽²⁸⁾ in a study of management practices in two Scottish health boards in the mid-1970s did not find any great enthusiasm for consensus management, Schulz and Harrison⁽²⁹⁾ in their survey of management teams in England found 'widespread support for the practice of consensus

decision-making'. But although Griffiths was firmly of the opinion that consensus management 'can lead to 'lowest common denominator decisions' and to long delays in the management process' he did not wish to replace consensus management *in toto*. Without detailing precisely what might be involved, a general manager was 'to harness the best of the consensus management approach and avoid the worst of the problems it can present'.⁽³⁰⁾

The House of Commons Social Services Committee conducted a brief inquiry into the Griffiths Report and concluded that 'the general critique contained within the Report commands general assent'.⁽³¹⁾ But the Committee was less happy with some of the prescriptions to deal with the condition diagnosed. Four of the proposals merit comment. They are, first, to establish a Supervisory Board within the DHSS, chaired by the Secretary of State and charged with the oversight of the NHS; second, to set up an NHS Management Board under the direction of the Supervisory Board to 'give leadership to the management of the NHS'⁽³²⁾ and to cover 'all existing NHS management responsibilities in DHSS',⁽³³⁾ third, to introduce a general manager at all levels – region, district and unit – to be drawn from any of the four disciplines currently represented on consensus management teams – administration, finance, medicine and nursing – and to be appointed from within each authority; and, fourth, to involve clinicians closely in management by, *inter alia*, developing management budgets.

Rare in government, the Secretary of State for Social Services moved quickly on Griffiths particularly in respect of the reforms at the centre. If the issue of general management took longer to resolve than was at first thought desirable this was partly because of the need to consult opinion in the Service and because of strong opposition to the idea from powerful interests like the British Medical Association. Consequently conclusions on the Griffiths Report were not announced in England until early June. These were published in guidance to health authorities.⁽³⁴⁾

The government has opted for the appointment of general managers at all levels while allowing health authorities some flexibility over the precise details and timing of implementation. But they will not be able to deviate from the principle. General managers will for the most part be full-time. Combining the general management function with other duties is not thought to be desirable although it may be permitted at unit level to encourage clinicians to apply for posts provided other duties take second place. In England, general managers, drawn from inside and possibly from outside the NHS, are to be introduced at regional and district health authority levels as soon as possible, and at hospital and unit level by the end

of 1985. Ministers are at pains to point out that there is 'no question of throwing consensus management out of the window. Consensus is vital to the management of any organisation ... but this should not mean that decisions are ducked or avoided'.⁽³⁵⁾ General managers will be on fixed-term contracts – 3-5 years in the first instance and annually thereafter. Further management training for clinicians is to be given a high priority.

In a Parliamentary debate⁽³⁶⁾ on the Griffiths Report in early May 1984 Norman Fowler, Secretary of State for Social Services, reported that the Supervisory Board had already been established. Under his chairmanship, it brings together key people both in and beyond the DHSS, including the Permanent Secretary, Chief Medical Officer, Chief Nursing Officer (an omission from the Griffiths Report, and Roy Griffiths himself. A Management Board is being established with a full-time Chairman recruited by open competition and acting as a fourth Permanent Secretary at the DHSS accountable for hospital and community services expenditure. Under its Chairman, the Board will be responsible for all the DHSS's work in relation to the management of the NHS – finance, personnel, service planning and so on. A personnel director is to be appointed to the Management Board. Pending the emergence of the Board, an NHS management group has been active in the Department 'to provide a better focus within the existing structure'.⁽³⁷⁾ To overcome fears that these new Boards might interfere with, or dilute, Ministers' accountability to Parliament, Norman Fowler has sought to assure MPs that the two Boards do not have separate corporate status and that their arrival does not herald increased involvement by the Department in the affairs of the Service. The Chairman of the Management Board, like the other Permanent Secretaries, will be directly accountable to the Secretary of State. He will not, as some would have wished, enjoy even the degree of independence and departmental detachment enjoyed by the chairmen of nationalised industries.

In the Scottish consultative paper, the Secretary of State accepts the principles underlying the analysis in the Griffiths Report and believes they apply to the Scottish Health Service. He wishes to see the identification of general managers at both health board and unit levels. The timetable for the changes is considerably lengthier than the English one. It is divided into three phases: phase 1, the appointment of general managers at board level, to be completed before the end of 1985; phase 2, the examination of unit structures, management information and budgeting systems prior to the introduction of the general management function at unit level, to be completed by the end of 1986; and phase 3, the strengthening of the management function at unit level, with no time limit given.

The bulk of the Scottish consultative document is taken up with a detailed description of the functions of general managers at board level. It is considerably more thorough than the English circular which in any case, and as mentioned already, places much more emphasis upon the general management function at unit level. The Scottish document lists thirteen different responsibilities which would be part of the post. The Secretary of State also goes to great lengths to ensure that the general manager's overriding responsibility for the sound management of public monies allotted to the board should be clearly established. The Secretary of the SHHD, as Accounting Officer for the health vote, would delegate part of his authority to the general manager who would be required to appear before the Public Accounts Committee (PAC) to answer questions on matters arising from the financial performance of his board. Indeed, the general manager would be directly accountable to the PAC since he would be required to sign the board's annual accounts. It is not clear if general managers in England are to shoulder similar responsibilities. Either way it seems curious that the Scottish document should go into such fine detail on this point. Whatever the reasons, the implications for the ability of units to operate freely are potentially profound. If the general manager at board level is faced with the prospect of appearing before the PAC, which has taken a tough and uncompromising line on variations in performance in the NHS, insisting on the need for tighter central control (see next section), it is hard to imagine unit general managers flourishing in such an environment. This could be one reason why the Secretary of State for Scotland is lukewarm about the general management function at unit level.

In contrast to the plans for England, the introduction of general managers at unit level in Scotland seems less than clear. The vigorous policy being pursued south of the border has given way to a vaguer, more cautious and more relaxed approach. Although a general commitment to general managers at unit level is contained in the discussion document, 'at this stage the Secretary of State does not propose a specific timetable for the complete introduction of the general management function at this level' since he '... is not committed to this particular approach in every case.'⁽³⁸⁾ The document goes to great lengths to pacify the professions, particularly the medical profession: 'while the introduction of the general management function at unit level will affect the roles of individual professional managers, it is not (the) intention to weaken the existing involvement of professional staff in management.'⁽³⁹⁾ In England the importance of general managers at unit level as being vital to the success of the whole reform strategy is stressed in the circular. 'The primary objective for health authorities in implementing the (Griffiths)

Report's recommendations must therefore be to achieve changes at unit level and below. If there were no observable improvement in services at that level, in the eyes of patients and the community, within three to five years, then there would have been no point in making changes at DHA level or above'.⁽⁴⁰⁾ There appears to be a significant difference of emphasis on this point between Scotland and England although it is possible that the Scottish circular which will follow the discussion period will adopt a tougher approach. Another, albeit slight, difference in emphasis can be detected over the fixed terms for general managers. Appointments should be for five years and should be renewable which is in contrast to the English arrangements.

At the centre in Scotland the changes being implemented (i.e. not open to discussion as happened in England some seven months or so earlier) are fairly limited and do not greatly disturb the status quo. A Supervisory Board has been set up with the Minister for Health and Social Work as the Chairman with a membership including the Secretary, the Chief Medical Officer and the Chief Nursing Officer of the SHHD, the Chairman of the Planning Council, individuals with relevant experience of private sector management, and the holder of a new post for NHS Management and Finance. No Management Board as such is being established but a new Under-Secretary post (Management and Finance) has been created and filled. The equivalent of the role which in England has been given to the chairman of the NHS Management Board (not yet appointed), the occupant of the post is in charge of a reorganised and strengthened group of divisions in SHHD concerned with NHS management, planning, finance and performance monitoring. This group was formerly the Planning Group (see Diagram). Unlike England, the Scottish equivalent of the Management Board is not being led by a chief executive, or general manager, appointed from outside the civil service.

In sum, the changes proposed for Scotland are in line with the plans now being implemented in England. In keeping with previous reorganisations, there are subtle variations and shifts in emphasis reflecting different circumstances and interests. But the overall thrust of what is likely to happen is virtually the same.

It is, therefore, almost certain that in Scotland the government will broadly follow England in the move to appoint general managers whatever the consultation process may reveal on the subject. It is hard to see how Scotland could for long remain out of step if general managers are to become the norm in the NHS in England. While fairly marginal variations in administrative arrangements are tolerated in

different parts of the UK,⁽⁴¹⁾ differences of this magnitude would be unlikely to exist for long. So it can be fairly safely assumed that general managers will be appointed in health boards and, over a longer period, in units.

The general management function will have the most profound implications for health care management if it succeeds. It is a little ironic that Scotland waited upon events in England before issuing proposals because in fact the arguments in favour of chief executives for the NHS were originally ventilated in Scotland some eighteen years ago⁽⁴²⁾ and it is possible that the Griffiths team had the benefit of access to this work. The Farquharson-Lang Report was concerned with improving the administrative practice of hospital boards in Scotland and much of the managerial philosophy and quest for greater efficiency and effectiveness which emerged forcefully as central themes in 1974 can be found in this Report. It called for increased standards of management ability from officers and recommended the establishment of a chief executive post at each type of board to be filled either by a professional or medically qualified administrator, the determining factor in selection being ability and not professional qualifications. Like Griffiths, the Farquharson-Lang Committee had industrial organisations in mind when considering the relevance of a chief executive for the NHS. 'We see no fundamental difference in principle between the hospital service and other forms of organisation within which highly skilled experts exercise a considerable degree of independent judgement, subject to direction on broad policy determined by a board and interpreted for them through a general manager'.⁽⁴³⁾ For Farquharson-Lang the choice was a clear one which is echoed in the Griffiths Report. 'The advantages of a single channel of management and administration seem ... clearly to outweigh the possible disadvantages'.⁽⁴⁴⁾ Just as the Griffiths Report said much that was true also of Scotland, so Farquharson-Lang said much that applied to England and Wales. But in the mid-1960s the proposal for a chief executive 'was quickly seen to have fallen on fallow ground even in Scotland'.⁽⁴⁵⁾ Since then all official statements on the management of the NHS have consistently either rejected the case for a chief executive, as in England, or have avoided any mention of the subject, as in Scotland.

The implications of Griffiths for the medical profession will be equally profound if they materialise. The intention is to make doctors more aware of the costs they incur every time they decide upon a course of treatment. Without actually confronting clinical freedom head on, Griffiths (and now the government) wants doctors to participate more closely in the preparation of management budgets. Some

commentators⁽⁴⁶⁾ do not think Griffiths makes sufficient inroads into clinical freedom and believe it will survive largely intact as a result. They see it as a 'fatal flaw' in the Report which will severely limit its impact upon practice.

An Assessment

As the title of this chapter attempts to convey, the NHS has been subjected to numerous organisational fixes since its inception. The rapidity with which these have been applied has increased since 1974 although England has borne the brunt of the battery of new initiatives. The pace of change has been considerably slower in Scotland and, indeed, many of the non-structural reforms that have taken root in England over the past few years, like privatisation and contracting out 'hotel' services, performance indicators, annual review meetings between Ministers and regional health authority chairmen and Rayner-type scrutinies of particular areas of administration, to name just a few, have not been reproduced in Scotland either in any guise or pursued with the same vigour. It is not clear why this should be so; there does not appear to have been a previous period in the NHS's history when there was such a marked divergence in policy style between Scotland and England despite a general tendency for Scotland to follow England's lead on major developments.

While the major developments described earlier have been applied in both countries, the enthusiasm for them in the SHHD is far less evident than in the DHSS. Moreover whereas all the initiatives launched in England combine to form a reasonably coherent strategy with fairly clear philosophical underpinnings, developments in Scotland have been less obviously coherent or ideological. They have occurred more haphazardly and cannot really be seen as components of a blueprint or grand design. The George Younger/John Mackay ministerial team at the Scottish Office shows little of the reforming zest and zeal regularly displayed by Norman Fowler and Kenneth Clarke at the DHSS where scarcely a week passes without at least one major policy announcement, whether it be the activities of general practitioners, links between the public and private health care sectors, or whatever. This is not necessarily a desirable way of proceeding, especially if the pronouncements are contradictory, but it is of interest to note the rather different policy and managerial styles evident in the two countries.

It remains to be seen whether all this hectic activity does more than merely heat up the system and offer a costly distraction from arguably more important concerns but it is of some significance that the initiatives

launched in England have a more explicit and full-blooded ideological basis than the more faint-hearted approach evident in Scotland where notions of 'paying lip service' and 'going through the motions' spring readily to mind. There may be other factors at work, however, which are less immediately obvious in England and practically invisible in Scotland. All the initiatives being pursued have as their common theme the drive for efficiency and improved control over resource use. If little or no new money is to be made available to the NHS, then the only alternative is to use existing resources more efficiently in order to create the means for new developments or simply to stand still. As Day and Klein⁽⁴⁷⁾ have said, it is 'the vision of a NHS that could stretch scarce resources by improving the quality of management'.

The Treasury and Public Accounts Committee (PAC) are keeping a wary eye on health spending and unless the DHSS can be seen to be doing all it can to improve the husbandry of resources then they will draw the conclusion they have drawn before, i.e. that there is too much slack (and fat) in the Service, and act accordingly. It was the wrath of the PAC⁽⁴⁸⁾ in 1981 which triggered the *volte face* on reorganisation in England mentioned earlier although this was not the only factor. A Green Paper⁽⁴⁹⁾ published by the Treasury in March 1984 states clearly that 'the Health Service needs to achieve continuing efficiency improvements, from higher productivity and *better management*, following the example of private industry in recent years'. Elsewhere the paper states that while demands for additional spending in some policy fields will be no more than special pleading there will be genuine demands for increased spending which must be financed by reductions in programmes of lower priority, or by further efficiency savings. The NHS is in the frontline of increasing demands because of an ageing population, increasing affluence and rising expectations, the switch from institutional to community care and medical advances. It seems that the Treasury's unswerving gaze upon the DHSS has deflected attention from the situation in Scotland although almost one-third of expenditure within the Scottish Secretary's responsibility goes on health and personal social services. This, coupled with a healthier resource base and higher per capita spending on health, has probably sheltered Scotland from the full brunt of the cold winds blowing between the Treasury in Whitehall and the DHSS at the Elephant and Castle. Another factor disguising the situation may be the way in which the block grant for Scotland is assembled which may make it less easy for the Treasury to monitor closely what is happening within the individual spending programmes that go to make up the block grant.⁽⁵⁰⁾

At a broader level, deeper environmental influences are at work. The

'Business Society' ethic is presently in vogue and manifestations of it in the health field are the Griffiths Report and numerous other initiatives designed to reinvigorate public sector management. The Business Society favours the private sector and self-help and is suspicious of public sector activities. The NHS is caught up in a wider debate about the future of the welfare state and public provision. Although not immune from this debate, the Scottish Health Service seems less central to it than the Service in England. From a geopolitical perspective, distance may have its virtues and may have the effect of reducing the potency of the rhetoric that fills the Whitehall/Westminster arena.

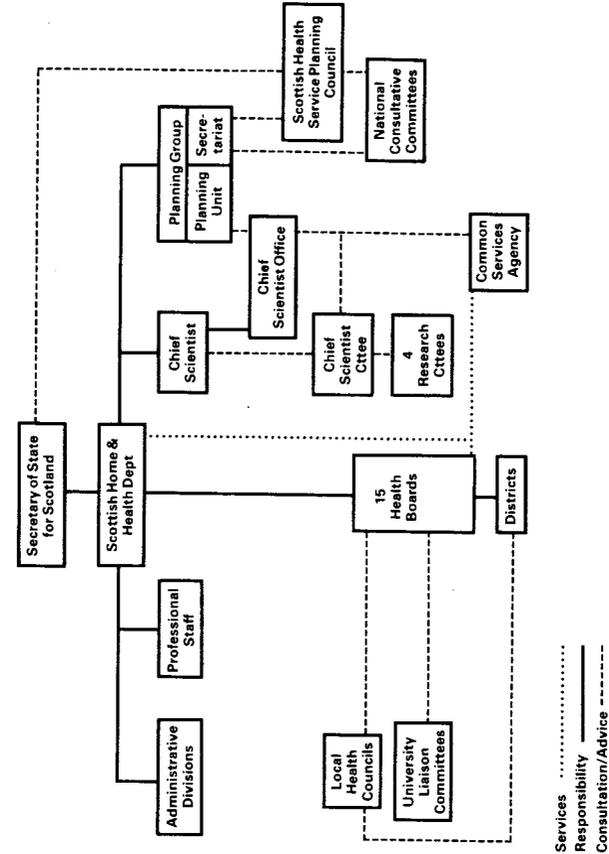
Of the two sets of changes that have either taken or will be taking place in Scotland the Griffiths Report and its proposal for general managers is potentially the most significant development. It will only be so, however, if it impinges directly upon the *process* of management. If it is no more than a role change or a minor structural modification then the chances are that nothing of real substance will change. It has been argued that Griffiths 'wants to change the culture. He is trying to do a very much bigger task than just appointing a general manager'.⁽⁵¹⁾ If he succeeds then the way may be open to tackle some of the deep-seated and pervasive problems in the NHS which have remained resistant to the ministrations of successive governments. Among these is the oft-repeated aim of giving greater priority to certain client groups than they have received in the past and to shift the balance of care away from hospital, or institutional, care to community care.⁽⁵²⁾ It is here that another of Griffiths' proposals becomes crucial, namely, the involvement of clinicians in management.

As has been mentioned, doctors' daily decisions commit resources and often the sums involved are not negligible. Whatever other changes take place, whether at unit level or above, will be rendered irrelevant unless the actual process of incurring expenditure at the sharp end of the Service is disturbed and modified. Doctors cannot be dictated to but they can be guided and required to justify explicitly their commitment of resources. At present they tend to make decisions in an implicit manner with no apparent consideration of alternative uses. Again, because of the historically healthy resource base in Scotland, including health care manpower, the pressures for improved clinical management are less acute. But they are there nevertheless and can be expected to intensify. A note of caution must be sounded. Just as structural or managerial reforms have been deemed panaceas for the ills of running a complex organisation so there is a danger of clinical budgeting and costing being included in the same category. Making doctors more cost-conscious and ultimately more efficient and cost-effective are laudable aims but while these approaches have merit in

some situations they can, if not handled with sensitivity, have major shortcomings. Care of the elderly is one area where the sensitive application of economic techniques is required otherwise one quickly reaches a position expressed vividly by Woody Allen: 'death is a great way to cut down on expenses'.⁽⁵³⁾ Economic and costing techniques have their uses but they do not provide the final 'single bullet' solutions to clinical priorities that some of their proponents envision.

If Griffiths, and government initiatives based on his Report, can help alter the climate in which managers and doctors operate and raise consciousness then he will have succeeded in an area which has defeated many before him. And if management *is* about to take a new direction then what was advocated for Scotland in 1966 by Farquharson-Lang may finally be about to be put to the test. But if Griffiths does not succeed then the well-worn cliché about the NHS being over-administered and under-managed will remain in 'good currency' as a valid judgement on the condition of health care management not only in Scotland but throughout the UK. At the same time the *limits* of administration should not be overlooked: perfect administration like perfect competition is an illusion. Misguidedly, general management could be regarded as the latest panacea to a range of deep-seated problems. Health care management is on trial. In the midst of all the activity could it be that this further round of reorganisation will be nothing less than yet another cruel diversion from the central policy issues confronting the NHS and health care? Although the lure of the organisational fix is forever present it is to be hoped not.

HEALTH SERVICE ORGANISATION: SCOTLAND 1974-1984



Note: Below Districts, until 1984, were units and/or sectors for day-to-day operational purposes. After June 1984 all Health Boards replaced Districts with Unit Management Groups (UMGs). Some UMGs retain the same boundaries as former Districts; others are closer in type and size to former units and sectors.

APPENDIX

HEALTH BOARD DISTRICTS

Board	HB District	Local Government District
Argyll & Clyde (Population: 452.4)*	Argyll & Bute Dumbarton Inverclyde Renfrew	Argyll & Bute Dumbarton Inverclyde Renfrew
Ayrshire & Arran (Population: 374.1)	North Ayrshire & Arran South Ayrshire	Cunningham Kilmarnock & Loudoun Cumnock & Doon Valley Kyle & Carrick
Borders (Population: 100.5)	(Single district)	Tweeddale Ettrick & Lauderdale Roxburgh Berwickshire
Dumfries & Galloway (Population: 144.2)	(Single district)	Wigtown Stewartry Nithsdale Annandale & Eskdale
Fife (Population: 340.2)	East Fife West fife	North East Fife Kirkcaldy Dunfermline
Forth Valley (Population: 273.0)	Falkirk Stirling	Falkirk Stirling Clackmannan
Grampian (Population: 483.0)	North South West	Banff & Buchan Gordon City of Aberdeen Kincardine & Deeside Moray
Greater Glasgow (Population: 1001.8)	Western Eastern Northern	Part of City of Glasgow Bearsden & Milngavie Clydebank Part of City of Glasgow Part of City of Glasgow Strathkelvin

Board	HB District	Local Government District
	South Eastern	Part of City of Glasgow Eastwood
	South Western	Part of City of Glasgow
Highland (Population: 192.0)	North South	Caithness Sutherland Badenoch & Strathspey Inverness Lochaber Nairn Ross & Cromarty Skye & Lochalsh
Lanarkshire (Population: 570.1)	Monklands/Cumbernauld Hamilton/East Kilbride Motherwell/Lanark	Cumbernauld Monklands Hamilton East Kilbride Lanark Motherwell
Lothian (Population: 746.1)	North Lothian South Lothian West Lothian	Part of City of Edinburgh East Lothian Part of City of Edinburgh Midlothian West Lothian
Orkney (Population: 18.9)	(Single district)	(Single district)
Shetland (Population: 25.9)	(Single district)	(Single district)
Tayside (Population: 396.8)	Dundee Angus Perth & Kinross	Dundee Angus Perth & Kinross
Western Isles (Population: 30.6)	(Single district)	(Single district)

* Population figures at June 1981 (in thousands).

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