A SYSTEMS APPROACH TO PUBLIC SECTOR BUDGETING: THE CASE OF THE PLANNING, PROGRAMMING, BUDGETING SYSTEM FOR THE HEALTH AND PERSONAL SOCIAL SERVICES

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SUMMARY

The aim of this thesis is to examine the specific contextual factors affecting the applicability and development of the planning, programming, budgeting system (P.P.B.S.) as a systems approach to public sector budgeting. The concept of P.P.B.S. as a systems approach to public sector budgeting will first be developed and the preliminary hypothesis that general contextual factors may be classified under political, structural and cognitive headings will be put forward. This preliminary hypothesis will be developed and refined using American and early British experience. The refined hypothesis will then be tested in detail in the case of the English health and personal social services (H.P.S.S.). The reasons for this focus are that it is the most recent, the sole remaining, and the most significant example in British central government outside of defence, and is fairly representative of non-defence government programme areas. The method of data collection relies on the examination of unpublished and difficult to obtain central government, health and local authority documents, and interviews with senior civil servants and public officials. The conclusion will be that the political constraints on, or factors affecting, P.P.B.S. vary with product characteristics and cultural imperatives on pluralistic decision-making; that structural constraints vary with the degree of coincidence of programme and organisation structure and with the degree of controllability of the organisation; and finally, that cognitive constraints vary according to product characteristics, organisational responsibilities, and analytical effort.

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P.P.B.S.
Health
Systems Approach.

LIST OF CONTENTS

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CHAPTER 1

CONCEPTUAL FOUNDATION

CHAPTER 1

LIST OF CONTENTS

1.1 INTRODUCTION AND SUMMARY OF ARGUMENT OF THESIS

The aim of this thesis is to examine the contextual factors influencing the applicability and development of the planning, programming, budgeting system (P.P.B.S.) so as to put forward a general model relevant to the various contextual backgrounds. A contextual hypothesis will be discussed in this chapter and developed with reference to American and early British experience. This elaborated hypothesis will then be tested in detail in the case of the English health and personal social services (H.P.S.S.)

This chapter will define P.P.B.S. as a systems approach to public sector budgeting and contrast it with traditional incremental budgeting. A preliminary hypothesis relating to the general prescriptions of P.P.B.S. and incremental budgeting will be advanced. Chapters 2 and 3 will examine the application of the system in the cultural contexts of America and Britain and the product contexts of defence, health, education, the police service, and general local government services. The preliminary hypothesis will be developed to take account of these contextual experiences. Chapters 4 through to 6 on the English H.P.S.S. will comprise the bulk and main emphasis of the thesis. The reasons for this emphasis are four in number:

1) it is the "most recent"[1] development of P.P.B.S. in Britain;
2) it is the sole remaining example in British central government outside of Defence;
3) it was considered to be probably the "most significant"[2] British example, involving a department having wide responsibilities for health and welfare;
4) it is fairly representative of non-defence programmes and the problems they face.

Chapter 7 will be a general conclusion to the thesis.

1.2 BACKGROUND

On 25 August 1965, U.S. President L.B.Johnson announced that:

> "This morning I have just concluded a breakfast meeting with the Cabinet and with the heads of federal agencies and I am asking each of them to immediately begin to introduce a very new and very revolutionary system of planning and programming and budgeting throughout the vast federal government, so that through the tools of modern management the full promise of a finer life can be brought to every American at the lowest possible cost."[3]

According to the Bulletin of 12 October 1965 of the Bureau of the Budget (B.O.B.) (responsible to the President for scrutinizing executive agencies' budgetary requests), the budget was to become the "financial expression of a program plan", and "setting goals, defining objectives, and developing planned programs for achieving those objectives are important integral parts of preparing and justifying a budget submission".[4] The emphasis was on the budgetary process since this was the "only recurring administrative process through which all major decisions must pass" and was the government's "formal resource allocation process and decision-forcing mechanism".[5] The aim was "to convert the annual routine of preparing a budget into a conscious appraisal and formulation of future goals and policies".[6] The new system would provide more effective information and analysis to assist line managers, the agency head, and the President in judging needs and in deciding on the use of resources and their allocation among competing claims" and its results would be "especially brought into focus in connection with the

spring Preview" leading to "more informed and co-ordinated budget recommendations".[7]

The 1965 American system was based upon three "concepts"[8]:

1) "The existence in each agency of an Analytic capability which carries out continuing in-depth analyses by permanent specialised staffs of the agency's objectives and its various programs to meet these objectives" and "of possible alternative objectives of the agency and of alternative programs for meeting these objectives", through the use of "broad systems analyses in which alternative programs will be compared with respect to both their costs and their benefits."

2) "The existence of a multi-year Planning and Programming process which incorporates and uses an information system to present data in meaningful categories essential to the making of major decisions by agency heads and by the President". The system would require adherence to "a time cycle within which well-considered information and recommendations will be produced at the time needed for decision-making and for the development of the President's budget and legislative program".

3) "The existence of a Budgeting process which can take broad program decisions, translate them into more defined decisions in a budget context, and present the appropriate program and financial data for Presidential and Congressional action".

The "products" of the system would be:

1) "A comprehensive multi-year Program and Financial Plan systematically updated", in the form of a program structure, and

2) "Analyses, including Program Memoranda, prepared annually and used in the budget Preview, Special Studies in depth from time to time, and other information which will contribute tothe annual budget process".

President Johnson said[9] that P.P.B.S. would enable public decision makers to:

a) "Identify our national goals with precision and on a continuing basis,

b) "Choose among those goals the ones that are most urgent,

c) "Search for alternative means of reaching those goals most effectively at least cost,

d) "Inform ourselves not merely on next year's costs, but on the second, third, and subsequent years' costs of our programs,

e) "Measure the performance of our programs to insure a dollar's worth of service for each dollar spent".

The entire system was to operate within the framework of overall policy guidance from the President through to line managers. Furthermore, P.P.B.S. was to be an executive instrument since it did not require any alteration in the format of appropriation requests as sent to Congress[10].

1.3 THE CONCEPT OF A PLANNING, PROGRAMMING, BUDGETING SYSTEM (P.P.B.S.)

The major tenet of P.P.B.S. is that planning should logically precede budgeting, with programming providing the necessary integration. This principle has been admirably set out by one of the founding fathers of P.P.B.S., F. C. Mosher[11]:

> "If we say a man plans a trip, we mean something a little different from the statement that he budgets a trip. The former expression signifies that he projects going somewhere at some future time by some means of transportation. The latter suggests that he is projecting how he is going to raise and allocate his available funds for the trip ... we usually think of the planning of the trip as coming before its budgeting. There is apparently some presumption that before we enter upon the process of budgeting we must have some kind of objective and programme already in mind".

P.P.B.S. views budgeting "as one element or aspect of the total planning process". Planning involves

> "first the conceiving of goals and the development of alternative courses of future action to achieve the goals. Second, it involves the reduction of these alternatives from a very large number to a small number and finally to one approved course of action, the program. Budgeting probably plays a slight part in the first phase but an increasingly important and decisive part in the second".

The concept of "programming" provides the "bridge"[12] between planning and budgeting. The distinction between planning and

programming is important. Planning "is the production of a range of meaningful potentials for the selection of courses of action through a systematic consideration of alternatives". Programming, on the other hand, "is the more specific determination of the manpower, materiel, and facilities necessary for accomplishing a program"[13]. In the planning stage,

> "one seeks a continual review of objectives and the means for their attainment. The preferred alternative remains preferred only as long as no additional knowledge of program prospects in relation to other competitive systems dictates another choice ... In the cost-effectiveness analyses used in planning, detailed cost estimates ... are not required."

In the programming stage,

> "one moves closer to actuality and acquires a greater respect for stability. Objectives are not challenged as frequently as in planning, instead, attention is concentrated on translating preferred alternatives to reality. More precise costing is now in order, because one must be able to anticipate the budgetary consequences of approved programs."[14]

The planning process leads to the selection of the "most promising" alternatives. Programming refers to the "analysis" of these short-listed candidates "in a less aggregative but still not completely detailed form". In this process

> "activities are identified and feasibility established in terms of capability, resource requirements, and timing of each one of the alternatives. The data used for programming are still not as detailed as next year's budget. The budget is an operating and financial document and must give great detail for inputs like personnel, supplies and equipment, and the assignment of such resources to administrative units ... choice ... between available and feasible alternatives ... takes place at the conclusion of programming."[15]

P.P.B.S. thus attempts to link output planning with input budgeting, with programming providing the necessary integration. Government activities are seen as giant conversion processes.

Inputs of resources at one end are transformed into valued outputs or objectives at the other. Hence budgeting should have an output planning dimension. This view of an organisation as a set of inter-related elements contributing to the functioning of the whole is generally known as the "systems approach": "Systems are made up of sets of components that work together for the overall objective of the whole. The systems approach is simply a way of thinking about these total systems and their components."[16]

1.4 THE SYSTEMS CONCEPT

A system is nothing more nor less than a number of inter-related elements or variables. The environment of a system is the set of elements and their properties which are not part of the system but which influence its state. A "closed" system is defined as having no environment, i.e. no inter-action with any external elements.[17] The closed systems of physics and physical chemistry are subject to the second law of thermodynamics and increase in "entropy" (i.e. disorderliness, lack of productive potential) over time. However, it has been increasingly recognised that the closed systems view is too narrow, even for the physical sciences.[18] Closure and openness are thus relative terms. Seven basic characteristics of open systems will be briefly discussed:[19]

1) Continuous input-output process.

By definition, open systems are open to influences from their environments. Typically they import some form of energy which is transformed and then exported into the environment; e.g. in the human body, oxygen, starch and sugar are converted into heat and action, and in the

enterprise, land, capital and labour are combined to produce goods and services. The process is continuous and cyclical in that the system output becomes the environmental input, and so on. In budgetary terms the allocation of funds to resource inputs leads to the production of goods and services which are valued and demanded by society. For a private business, the regulatory mechanism between the firm and its environment is the market which determines demand, supply, and price. As we will see later, no such automatic regulator is available to government.[20]

2) Negative entropy

Closed systems are subject to entropy, i.e. random distribution of their elements. But in open systems, entropy may be indefinitely prevented through the storage of energy or the continuous import of materials, energy, information, etc. from the environment. This is the case with complex social organisations which outlive their individual members. Biological systems, on the other hand, attain negative entropy for a fixed period, then positive entropy takes over and they die. The budgetary rule here is that an organisation will maintain its supply of resource inputs from society if it achieves its objectives of providing valued goods and services.

3) Steady state/Dynamic homeostasis

To the extent that the relevant properties of a system are maintained through the negative entropy or

"negentropy"[21] process of resource intake, then the system is said to be in steady state, or homeostatic equilibrium. Biological and social systems, however, are not static. Negentropy implies the preservation of the properties of the system through growth and expension. Dynamic homeostasis, then, refers to the preservation of the properties of the system through the quantitative and qualitative changes of its growth. It is not the simple reactive mechanism of the thermostat, but is also anticipatory of environmental disturbances[22]. Through it, the system attempts to maximise its potential energy or the capacity for work.[23] The long-term planning and forecasting of resources, needs, demands and goals is thus essential for organisational stability.

4) Feedback

The concept of feedback refers to the information input which indicates that the system is deviating from its course. The informational inputs are selected, or "coded". Without feedback of information from the environment about the functioning of the system then steady state will not be achieved.[24] The evaluation of systems performance is thus an essential prerequisite to the planning process.

5) Differentiation

Negentropy implies growth through increasing differentiation, specialisation, and elaboration.[25] This growth, as mentioned above, may be both quantitative

and qualitative: growth may alter the internal relationships between the elements, or may require supportive subsystems.[26] This process highlights the potential conflict between "integrality" and "complexity".[27] Open systems have within them a tendency towards integrality or the maintenance of a static equilibrium with respect to their environments. The environment, however, will force the system to adapt if it is to survive. It must therefore become more complex and develop adaptive mechanisms. As mentioned above, these adaptive mechanisms will both react and anticipate, e.g. anticipatory adaptiveness in the business enterprise may lead to mergers, diversification, product innovation, etc. Both "adaptive" and "maintenance" mechanisms are required for survival.[28] In order to maintain equilibrium, systems must ensure that their various subsystems are in balance. Maintenance forces tend to be conservative and prevent the rapid change which might disturb internal balance. This is akin to Simon's "conservation objective" of an organisation.[29] Similarly, if we regard Vickers' "balancing function" of budgeting[30] as a behavioural or "psycho-social"[31] one then we have an excellent description of the "conservative" and conflict-avoiding tendency of traditional budgeting.[32] P.P.B.S. aims to be the adaptive mechanism dealing with the "organisation goal"[33] and "optimising" function[34] of the public organisation in so far as it is concerned with the optimal allocation of scarce resources between

competing claims for the attempt at maximisation of valued output.

6) Equifinality

Closed systems have a direct cause and effect relationship between initial conditions and final state. Bertalanffy's concept of equifinality shows that the same outcome can be achieved from different initial conditions and by different behaviours. An organisation can therefore achieve its objectives with varying inputs and internal activities.[35] This concept highlights the problem of choice amongst alternatives in public and private organisations.

7) Purposefulness[36]

The highest form of system is the "purposeful" system. In addition to its being capable of producing the same outcome in different ways (equifinality), it is able to change its goals or outcome in the same and different states. It has the "will" to choose both means and ends. Under P.P.B.S., the choice of objectives would logically precede and determine the choice of means. The typical example of a purposeful system is a human being. Using this concept we can distinguish between an "organisation" and an "organism". There are four characteristics of the former according to Ackoff:[37]

1) It is a purposeful system containing at least two purposeful elements with a common purpose.
2) It has a functional division of labour for attaining the common purpose.

3) Functional subsystems can respond to each other through observation or communication.

4) At least one subsystem has a system-control function (e.g. an executive body responding to feedback information).

Organisms are "variety increasing" in that the behaviour of the whole is more varied and at a higher level than the behaviour of the system elements. An organisation can be either variety increasing or "decreasing" (e.g. an ineffective committee). The systems approach then focuses on the essential conditions for organisational equilibrium or steady state. The organisation must "maintain a favourable balance of incoming contributions over outgoing incentives in two ways: first by modifying the organisation objective in response to customer demand; and second by employing the resources, monetary contributions, and employees' time and effort in such a manner as to attain a maximum of inducement to employees, and a maximum of attainment of organisation objectives with these resources."[38] It is important, however, not to confuse facts with values. An organisation transforms inputs of e.g. materials, energy, and information[39] into outputs of products, services, etc. This is a purely "factual" process, recognized in the economist's notion of a production function. In these physical terms, output cannot exceed input (the law of conservation of energy), and the organisation must continually import resources to replace those lost through the transformation process. As mentioned above, it is the market mechanism

which regulates this process, in the case of business enterprises. The firm will be financially stable if total revenue (value input) is at least as great as total cost (value output). Customers will continue buying goods for as long as the utility of the last good exceeds market value, or price (again, value input exceeding value output). Assuming there are no resource constraints, then maximisation will occur at the point of equality of marginal revenue with marginal cost for the firm and marginal utility with price for the consumer. Thus mutual benefit between system and environment is the essential condition for sustaining the transformation process, both for private and for public organisations. But whereas the economic system is regulated by the market, the political system has no such mechanism.

The concepts of equifinality and purposefulness highlight the importance of decision-making to systems. The overall efficiency of an action system will be dependent upon the decision system used. As Simon has pointed out,

> "At each moment the behaving subject, or the organisation composed of numbers of such individuals, is confronted with a large number of alternative behaviors some of which are present in consciousness and some of which are not. Decision, or choice ... is the process by which one of these alternatives for each moment's behavior is selected to be carried out"[40]

The systems approach is an aid to choosing that alternative which has the preferred set of consequences relevant to the goal.

1.5 THE SYSTEMS APPROACH TO MANAGEMENT

The systems approach contrasts with the partial approaches of much of traditional organisation theory. These approaches may be referred to as the "structural", the "behavioural", and the "technical". Structural approaches have concerned themselves with such topics as the degree of specialisation, the design of authority structures, the optimum "span of control", the development of skills, work rationalisation, etc. Behavioural theories have dealt with human motivation, group loyalties, "informal organisation" and values. The technical approaches have concentrated mainly on the technological, economic or financial aspects of organisational tasks.[41] Each has focused primarily on one aspect of an organisation, to the detriment of the other aspects. Structural theories focus on the organisation's ability to expand the range of possibilities open to it. Behavioural theories concentrate on the integration of goals within an organisation. Finally technical approaches focus on the application of knowledge and information technologies to the decision process. The systems approach attempts the "integration"[42] of these three organisational "profiles"[43] at the highest, the "institutional"[44] level. It is an attempt to move from a "Cartesian" to a "configuration" view of the organisation[45]:

> "Managers must never permit their attention to be exclusively focused on any one aspect of the organisational system, for such tunneling of vision results ultimately in a loss of control over the destiny of the organisation."[46]

Above all, the systems approach emphasises decision-making. Traditional approaches emphasised "principles" for "getting things done" and for securing "concerted action from groups of men". The systems approach focuses on "the determining of what

is to be done rather than to the actual doing"; it is concerned with "the processes of decision as well as with the processes of action."[47] The organisation is seen as a "decision-making and goal-attaining system."[48] The aim, however, is not to reject the partial and more detailed approaches of traditional management theory but to "complement"[49] them and precede them since decision-making "prefaces all action"[50] P.P.B.S., as a systems approach,

> "is not designed to increase efficiency in the performance of day-to-day tasks, nor is it designed to improve administrative control over the expenditure of funds. It is instead a recognition of the fact that more money is wasted by doing the wrong thing efficiently than can be wasted by doing the right thing inefficiently."

P.P.B.S. aims at "the top-level determination of what to do, rather than deciding on how to carry on day-to-day operations, decisions which are best made by those who are closest to the activity."[51] The systems approach thus attempts to integrate the behavioural, structural and technical profiles at the institutional level. These profiles may be seen to mirror the three "premises" of decision-making, viz: "values", abilities" and"knowledge".[52] The behavioural aspect is concerned with values and their determination. The structural aspect is concerned with abilities and alternatives possibilities. Finally, the technical aspect is concerned with the consequences of alternative courses of action and requires the application of knowledge. At the highest level of a government organisation, behavioural profiles are best regarded as "political". That aspect of decision-making dealing with the technical consequences of alternative courses of action may also best be regarded as "cognitive" since it requires the application of knowledge and

information. Thus the three elements of the decision-making process dealing with the three aspects of an organisational system at the highest level will henceforth be referred to as the political, the structural, and the cognitive.

1.6 THE NATURE OF BUDGETING WITHIN A POLITICAL SYSTEM

According to Easton[53] politics is defined as the "authoritative allocation of values for a society". The political system is a complex set of processes and interactions through which demands and support from "politically relevant members" are converted into authoritative policies, decisions, and implementing actions. Thus all persisting political systems must be successfully fulfilling two functions; they must be able to allocate values for a society, and they must induce most members to accept these allocations as binding most of the time. Thus the necessary and sufficient condition for maintenance and adaptation is that the value to society of those decisions and actions is at least as great as their cost, as reflected in taxes, etc. This is the guiding principle of P.P.B.S. as a systems approach to public sector budgeting. Budgeting may be defined as the estimation and authorisation of revenue and expenditure for a future period.[54] In a business organisation, revenue refers to the market valuation or price of a commodity multiplied by total output marketed, and this can be directly related and compared with expenditure or costs as an indicator of financial stability. Government budgeting, however, has no such indicator of value and very often has no precise measurement of public output. A government is "a non-profit monopoly that provides services to its members at zero price, is financed by

lump-sum charges, and makes it budget decisions on the basis of information about the cash disbursements and anticipated vote of the members"[55]

In the public sector, "price does not interact with demand at the point of choice".[56] In the market, decisions on costs and benefits are made by individuals and households. Cost is compared with benefit directly by the consumer. In the public sector, decisions are made by various different institutions and at different levels on behalf of other people.[57] Demands are ambiguous and the absence of a regulatory price mechanism means that inefficiency can persist for long periods of time.[58] For the individual consumer, decisions on costs and benefits of public goods and services are usually separate, and at best the consumer can only make an aggregate comparison of taxes, etc. against total government activities at infrequent intervals, e.g. at elections.[59]

Furthermore, at government level, decisions on revenue and expenditure have traditionally been separate, revenue being "a general resource"[60] with no tie to programmes. For a profit-making organisation expenditure provides the means to sales revenue. But for a government tax revenue is a relatively fixed resource used to finance activities and which does not reflect the benefits derived from those activities. Benefits must be estimated by the Government itself from e.g. surveys, research programmes, and from political feedback.

In 1954, Novick pointed out the drawbacks of traditional budgeting through a comparison with business budgeting. These latter:[61]

1) included several demand forecasts, together with an evaluation of results in revenue terms of alternative resource employment;

2) assisted management in co-ordination the implementation of the chosen plan;

3) allowed the control of performance through a comparison of budget data with operations.

Business budgets therefore comprised planning, management, and control functions.[62] Government budgets on the other hand limited themselves to an estimate of expenditure and their financing for the coming year, with little or no output orientation. Novick said that government should use the budget:

a) to give details of costs and benefits of the proposed plan of action;

b) to prepare alternative plans and alternative methods for achieving any one plan;

c) to co-ordinate and integrate all the activities for a plan of action;

d) to control the implementation of the chosen plan.

This was the basis of what was later to become known as P.P.B.S.

1.7 THE INCREMENTAL MODEL OF BUDGETING AND THE NEED FOR A SYSTEMS APPROACH

The 1965 Bureau of the Budget Bulletin listed the shortcomings of traditional budgeting as:

" - program review for decision-making has frequently been concentrated within too short a period,

- objectives of agency programs and activities have too often not been specified with enough clarity and concreteness,

- accomplishments have not always been specified concretely,
- alternatives have been insufficiently presented for consideration by top management,
- in a number of cases the future year costs of present decisions have not been laid out systematically enough, and
- formalised planning and systems analysis have had too little effect on budget decisions"[63]

P.P.B.S., on the other hand, as President Johnson's quote at the beginning of the chapter showed, would identify and rank national goals, evaluate alternatives in terms of costs and benefits, measure performance etc.[64]

The comprehensive rational, or utility maximisation model, implied in President Johnson's pronouncements would require:

- the possession of a complete, consistent and intertemporal utility function for the formulation of objectives and criteria for the evaluation of alternatives;
- knowledge of all the possible alternate ways of achieving objectives;
- knowledge of every single consequence that would follow from the choice of each alternative.[65]

The political incrementalists[66] criticised this model. Reclassifying in terms of the 3 organisational profiles identified earlier, they argued as follows:

Political

Values are multiple, inconsistent, imperfectly known, impossible to rank and change through time. Their prescription is that administrators must decide on policies without first clarifying all the relevant values. Any ignored values will be taken up by their own "watchdogs", thereby securing a useful

division of labour, since "every interest is represented in the American system."[67]

The practical choice is between policies which offer different marginal combinations of objectives. Absolute values cannot be ranked or fully appreciated. Decision-making thus focuses on increments rather than the base, and on policies rather than ultimate objectives. Policies should be reviewed continuously since values change through time.

In cases of disagreement, then the test of a good policy is agreement on the policy itself rather than on its ultimate merits.

Structural

Public organisations are often unable to implement alternatives suggested by analysis. Legally and morally prescribed functions and other constraints limit their attention to incremental changes only.

Cognitive

Knowledge of cause and effect relationships surrounding social programmes is limited and in dispute. Past experience of small changes should therefore be used to judge between marginal differences. Successive comparison and approximation will remedy any errors.

These problems will be magnified in the case of an output-oriented approach to budgeting:

> "Since every governmental program is only as extensive as the money put into it, the place where decisions - whether rational or not - concerning the division of the national effort are most apparent, is in the federal budget"[68]

> "If politics is regarded as, in part, the conflict over whose preferences shall prevail in the determination of national policy, then the budget records the outcomes of this struggle"[69]

The budget therefore, "lies at the heart of the political process".[70] Wildavsky described budgeting in America as

> "an incremental process, proceeding from an historical base, guided by accepted notions of fair shares, in which decisions are fragmented, made in sequence by specialised bodies, and co-ordinated through repeated attacks on problems and through multiple feedback mechanisms"[71]

This process aided "in securing agreement and reducing the burden of calculation"[72] It is easier to agree when the matter in dispute can be treated as a difference in money rather than a difference in abstract goals or even in policies.[73] Conflict is reduced by focusing on increments since the area open to dispute is reduced. Existing programmes are not scrutinized and bargaining focuses upon incremental change and new programmes. Established programmes develop clientele with vested interests, making it easier to reject new programmes rather than old ones.[74] The burden of calculation is reduced because scrutiny is focused upon increments and new policies, and is carried out sequentially and in small segments. This situation was also compounded by the fact that government activities were traditionally regarded as fixed, necessary and limited, so there was just the need to concentrate on cost minimisation and financial and accountability.[75] In the American context, Wildavsky[76] has produced "a set of simple decision rules" or "heuristic rules of thumb" which "can explain or represent the behaviour of participants in the federal budgetary process in their efforts to reach decisions in complex situations": the agency tries to maintain a constant % increase

in its actual appropriations, whilst the legislature allows only a constant fraction of the request,

i.e. Executive Agency Xt = BoYt - I

Congressional Committee Yt = AIXt

where X is the requested appropriation, Y is the actual, Bo is a constant greater than one, and AI is less than one. Substituting the first equation into the second, and we get: Yt = AIBoYt - I, i.e. this year's budget will be a constant multiple of last year's budget (apart from stochastic disturbances).

This prediction will also be true of component programmes within an agency's budget.[77]

Participant roles or behavioural expectations make these rules relatively stable and consistent (although Supplementals have a more complex explanation[78]). Agencies advocate increased expenditure, the budget office follows presidential preferences and usually advocates cuts, the House Committee acts as "guardian" of the Treasury, and the Senate committee acts as a "court of appeal".[79]

The prescriptions of incrementalism are however valid in terms of system stability only in certain societal contexts. The two main prescriptions of incrementalism are incremental change; and agreement on policy, etc. as the criterion of a policy's quality.[80] The rationale behind incremental change is one of maximising security in making change. This is sensible when the results of existing policies are generally regarded as being satisfactory and there is a high degree of continuity in the nature of problems and the means for dealing with them. In such stable situations, and because change is slow, then routine and incremental change are often best. But where the results of past

policies are unsatisfactory then it may be better to take risks. Where there are no past policies, e.g. during the New Deal, then the results of the past cannot be incremented into the future.

Also changes in technology and in knowledge may force non-incremental change. Thus the level of "aspirations", the nature of the "issues", and the available "means of action" are the three main variables determining the applicability of incremental change.[81]

Similarly, agreement on policy would be rational in the sense of involving little risk only in relatively stable societal contexts. Under conditions of high-rate change, "ignorance can produce agreement on a catastrophic policy"[82] and it may be easier to agree on ultimate or operational goals than on policies because of the lack of previous experience. Agreement would also be rational in pluralist, non-interventionist societies and where the potential for conflict is great (as in budgeting) and its resolution of over-riding priority. The lack of a central authority would necessitate agreement before action could be taken. Political activity is initiated when there is a need for a common policy and mutually exclusive policies are put forward,[83] for "conflicts over demands constitute the flesh and blood of all political systems."[84] In this case, bargaining would seek the highest common factor of agreement. In wealthy societies, where politics is regarded as a "giant positive sum game"[85] allowing Pareto improvements among groups then agreement is easier. "It is only at the point of crisis that satisfying is no longer good enough and governments are compelled to re-examine what they are doing and where they are heading."[86]

None of these conditions pertained to the "Great Society"

epoch of the American mid-sixties.

Together with a spate of "human services" programmes came a "new demand for 'accountability', for demonstrable 'outputs' and measurable results of government spending". It was this "basic idea" which "spawned" P.P.B.S.[87]

1.8 CONCLUSION

The prescriptions of incrementalism have been shown to be potentially destabilizing, but could P.P.B.S. take its place? The prescriptions of the comprehensive rational model are clearly unattainable for complex open system problems involving value conflict. Furthermore, the attempt to integrate planning for system output with budgeting for system inputs creates additional difficulties. Since budgeting deals comprehensively with organisational inputs, then planning must also be comprehensive and objectives must be ranked. Budgeting is also an annual requirement in government which means that planning must fit into that cycle.

Finally, the attempt to link the process of allocating financial resource to real resource inputs with the process of deciding system objectives and strategies for their attainment requires a detailed examination of social production functions, or cause-and-effect relationships.

Thus the full incremental budgeting model is inappropriate and the full, comprehensive rational model of P.P.B.S. is impossible. Both fail to take account of the "contexts" of the budgetary process:

> "Purposes" and "principles" of budgeting" are generalised ... abstract ... and ... impersonal. They are meaningful and useful only to the extent that they are applied to organisations and institutions which are themselves

"understood. Budgeting, like other social processes, is a human undertaking, carried out by people who are subject to a wide variety of influences and motivations. The process itself can be examined, evaluated, and improved only to a minor degree unless there is an appreciation of the totality of situations and environment within which it is carried on ..."[88]

The incremental model of budgeting aims at "maximising security in making change", but is valid only where there is a "high degree of social stability".[89] Incrementalism is thus not universally dysfunctional. But can the same be said of P.P.B.S.? The aim of this thesis is to examine the specific contextual factors which influence the applicability and development of P.P.B.S. and any development of the concept as a consequence of these factors. A model of P.P.B.S. relevant to various systemic contexts will then be attempted. The analysis throughout will be in terms of the political process of value resolution, the structural variables affecting the implementation of alternative courses of action, and the cognitive requirements for the calculation of the consequences of government activities.

Chapters 2 and 3 will examine the American and early British contexts. These will provide the background to the main emphasis of the thesis, P.P.B.S. in the English health and personal social services, which will occupy Chapters 4 through to 6. Chapter 7 will be a general conclusion.

CHAPTER 2

THE AMERICAN EXPERIENCE

CHAPTER 2

LIST OF CONTENTS

2.1 INTRODUCTION

Chapter 1 has shown that P.P.B.S. is a systems approach to public sector budgeting since it reorients the allocation of resources towards the determination of objectives, the consideration of alternative activities, and the performance of the organisation, i.e. the political, structural and cognitive aspects at the highest level. However, the intention was to apply the comprehensive rational, or maximising, decision model to these relationships through the comprehensive analysis of all the political, structural and cognitive factors involved. President Johnson said[1] that P.P.B.S. would help identify and rank national (not merely federal[2]) goals "with precision and on a continuing basis", search for the most effective and least costly means for achieving those goals, determine multi-year costs, and measure performance "to insure a dollar's worth of service for each dollar spent". This approach to systems decision-making assumes an omniscience beyond human capabilities, and was indeed "revolutionary"[3] compared with the traditional, incremental process. The proponents of incremental budgeting thus had an easy target to attack. Comprehensive rationality, or utility maximisation, is impossible for complex open system problems involving value conflict. Decision-making in these conditions must of necessity be suboptimal. Rationality will be a matter of degree, of the identification of the "bounds"[4] or limits to maximisation and the attempt to push back those bounds. The incremental model, on the other hand, exaggerates human limitations and "justifies a policy of 'no effort'"[5]. Such an approach, however, is appropriate only in a type of societal context deemed no longer to exist, if it ever existed at all. Perfect rationality and perfect incrementalism

are thus extremes of system behaviour, the one impossible and the other potentially destabilizing.

The experience of the impact of the attempted comprehensive rational model of P.P.B.S. on the "inertia"[6] of incremental budgeting in the U.S.A. will now be examined. The analysis will be in terms of the political factors concerned with the determination of objectives and courses of action, the structural factors concerned with the ability of the organisation to act in different ways, and the cognitive factors concerned with the analysis of alternatives and the measurement of performance. The aim will be to discover the specific contextual factors influencing the success of P.P.B.S. and any development of the concept as a consequence.

2.2 DEVELOPMENTS IN EXECUTIVE BUDGETING[7]

The stages of executive budgetary reform in the United States federal government comprise the financial control orientation, the management orientation, and finally the planning orientation.

a) The Financial Control Stage

From around 1920 to 1935, the main emphasis was placed on the development of a realistic system of expenditure accounts for the purpose of expenditure control. Decentralisation of control responsibilities was not possible because of the lack of adequate internal control systems, which meant that central authorities had to be selective in the short time available to them. The control orientation also required different skills and information. The budget "came to mirror the appropriations act", and this act

"has a single purpose - that of putting a limitation on the amount of obligations which may be incurred and the amount of vouchers which may be drawn to pay for personal services, supplies, etc. The only significant classification of appropriation items, therefore, is according to persons to whom drawing accounts are given and the classes of things to be bought."[8]

The main priority, then, was the prevention of administrative improprieties and the strengthening of financial accountability[9].

b) The Management Stage

This stage began during the New Deal and led to developments in "performance budgeting" a decade later. The main reforms were in the appropriations structure, in the development of work measurement, and the reorientation of budget preparation towards the work and activities of agencies.

By this time, many administrative abuses had been reduced through legislation and a general upgrading of the public services, and more reliable accounting, personnel, and purchasing control systems had been introduced, thereby allowing a little more flexibility into the budgetary process. With the large increase in government activities and expenditure during this period, detailed financial control became in any case almost impossible at the centre, and the need became greater for central management and co-ordination of a huge bureaucracy. This was accomplished by a new perception of government. While government was considered a "necessary evil" and its output of limited and fixed value then the budget was used as an instrument of financial control. During the New Deal, however, government activities came to be regarded as benefits, and budgeting

became the means through which resources were allocated for effective management and co-ordination of activities. The President's Committee on Administrative Management in 1937 recommended that the budget be used to co-ordinate federal activities under presidential direction. In 1939 the Bureau of the Budget was transferred to the Executive Office and given a ten-fold increase in staff mainly of administrators rather than accountants. The bureau was directed

> "to keep the President informed of the progress of activities by agencies of the Government with respect to work proposed, work actually initiated, and work completed, together with the relative timing of work between the several agencies of the Government; all to the end that the work programs of the several agencies of the executive branch of the Government may be co-ordinated and that the monies appropriated by the Congress may be expended in the most economical manner possible to prevent overlapping and duplication of effort."[10]

Accompanying these developments were the introduction of management cost accounting, performance standards, work measurement, and grading systems. Yet it was not until after the end of the second world war that the classification of expenditure in the budget was altered. In 1949 the Hoover Commission recommended a budget classification based on functions, activities and projects, to be called a "performance budget" (or, misleadingly, a "program budget").[11]

Performance budgeting is management-oriented and is used to measure the work-efficiency of operating units by (1) reclassifying budget categories into functional terms, and (2) providing work-cost measurement to assist in the efficient performance of activities. These activities and functions generally correspond to organisational lines and are most relevant to the administrator or manager rather

than the budget maker. Performance budgeting is concerned with the "process of work" i.e. "what methods should be used" whereas P.P.B.S. is concerned with the "purpose of work" i.e. "what activities should be authorised". Performance budgeting is "retrospective" or "evaluative" in the sense of measuring what was done, whereas P.P.B.S. is "prospective" and "connotes planning"[12]. Implementation of performance budgeting was, however, "slow and only partial".[13]

c) The Strategic Planning Stage

"P.P.B. is predicated on the primacy of the planning function" where planning "involves the determination of objectives, the evaluation of alternative courses of action, and the authorisation of select programs".[14] The move from a management to a planning orientation was influenced, according to Schick, by three developments: the use of economic analysis in fiscal and budgetary policy; the development of informational and decisional techniques; and the gradual convergence of the planning and budgeting processes.

On the macroeconomic side, the use of tax rate changes for the management of the economy led to the consideration of using expenditures in a similar way. However, the transference of the budget bureau's fiscal analysis function to the Council of Economic Advisers in 1946 and the incremental nature of budgeting hindered this development. In the absence of central planning guidelines and constraints agencies' spending pressures limited the budget bureau's and the President's control.

On the microeconomic side, P.P.B.S. has roots in the attempt by welfare economists to use the marginal utility concept for the optimal allocation of resources between competing claims. This concept can be traced back to Pigou[15]

> "As regards the distribution, as distinct from the aggregate cost, of optional government expenditure, it is clear that just an individual will get more satisfaction out of his income by maintaining a certain balance between different sorts of expenditure, so also will a community through its government. The principle of balance in both cases is provided by the postulate that resources should be so distributed among different uses that the marginal return of satisfaction is the same for all of them ... Expenditure should be distributed between battleships and poor relief in such ways that the last shilling devoted to each of them yields the same real return. We have here, so far as theory goes, a test by means of which the distribution of expenditure along different lines can be settled."

Schick regards this approach as having been a failure for practical budgetary decision-making because of the political and cognitive difficulties involves. A useful bridge between theory and practice, however, is given as Smithies' budget rule that "expenditure proposals should be considered in the light of the objectives they are intended to further, and in general final expenditure decisions should not be made until all claims on the budget can be considered."[16] The second major influence on P.P.B.S. was the development of new informational and decisional techniques, particularly cost-benefit and systems analyses. These have enabled the consideration of a much wider number of alternatives and their effectiveness in reaching a particular objective. The success of analytical techniques in the Department of Defense was a major stimulus for their general adoption.

The third influence has been the gradual coming together of planning and budgeting. Traditionally these activities have been separate and centralised planning of any kind has always been avoided because of its association with socialist economic management. Nevertheless there have been forces for reform: the long lead time for developing and procuring major investments (which led to the introduction of multi-year expenditure projections in the early 1960s); the need to co-ordinate diverse and often overlapping agency functions; and the tremendous growth of federal activities and expenditures and the need for a better system of resource allocation.

2.3 P.P.B.S. IN THE DEPARTMENT OF DEFENSE

P.P.B.S. is generally regarded as having made its debut in Defense, although some of its roots can be traced back further.[17]

The National Security Act of 1947 brought together the Department of the Army, Navy and Air Force into a new department headed by a Secretary of Defense. In further legislation of 1949, 1953 and 1958 the powers of the Secretary were increased and the Office of the Secretary gained greater control over service roles, missions, and budget requests. These powers were increased yet again, though de facto not de jure, when McNamara served as Secretary from 1961 to 1968.[18] But "how much this is due to McNamara himself,to his insistence on quantitative estimates, or to the analytic advantages of a program budget cannot be determined".[19] Prior to 1961, defense planning and budgeting had been separate and distinct activities, the responsibility of the Joint Chiefs of Staff (JCS) and individual services, and the

Office of the Secretary of Defense (OSD), respectively.

Financial targets were issued to the individual services in similar proportions each year and the Services were left to prepare their own programme and policies. The system after 1961 reversed this procedure, requiring first of all a definition of objectives, then a statement of the alternative chosen to achieve this objective, together with its cost-effectiveness justification, and finally the preparation of a detailed budget.[20]

It was Charles Hitch[21] who recommended an alteration of the "budget ceiling approach" whereby service budget requests were made to fit an initial overall limitation established by the Bureau of the Budget. Hitch found that:

"1. Each service tended to exercise its own priorities:

   (a) Favouring its own unique missions to the detriment of joint missions;

   (b) Striving to lay the groundwork for an increased share of the budget in future years by concentrating on alluring new weapon systems; and

   (c) Protecting the overall size of its own forces even at the cost of readiness ...

2. Because attention was focused on only the next fiscal year, the services had every incentive to propose large numbers of 'new starts' the full cost dimensions of which would only become apparent in subsequent years ...

3. Almost complete separation between budgeting and military planning.

   (a) These critically important functions were performed by two different groups of people ...

   (b) Budget control was exercised by the Secretary of Defense, but planning remains essentially in the service ...

   (c) Whereas the planning horizon extended four or more years into the future the budget was projected only one year ahead ...

   (d) Planning was done in terms of ... outputs; budgeting ... in terms of inputs ...

   (e) Budgeting, however crudely, faced up to fiscal realities, the planning was fiscally unrealistic, and therefore of little help to the decision-maker

(f) Military requirements tended to be stated in absolute terms, without reference to their costs."

The budget ceiling approach was abandoned by Kennedy in 1961 for defense budgeting, and McNamara was given two general instructions: develop the force structure necessary to support foreign policy without regard to arbitrary budget ceilings; and procure and operate this force at the lowest possible cost. Hitch became Assistant Secretary of Defense (Comptroller). This was tantamount to saying that defense policy should be developed without reference to cost, and it is true that the United States was trying to increase, or at least maintain, its military commitments throughout the world at this time.[22] This, together with McNamara's supreme control over the defense establishment and the suitability of systems analysis for major procurement decisions, comprised a most favourable environment for the growth of P.P.B.S.[23]

The procedures have changed somewhat over the years, but the elements of the system, planning, programming, and budgeting, remain the same. The first phase, that of planning and requirements determination, is a year-round process initiated by the Joint Strategic Objectives Plan (JSOP) proposed by the Joint Chiefs of Staff.[24] It consists of military economic studies which compare alternative methods of accomplishing national security objectives in terms of cost-effectiveness. The second phase comprises the programming system. This integrates combinations of men, equipment and installations into program elements enabling the measurement of effectiveness as a whole in relation to national security objectives. The B52 bomber force, together with its resources, comprises a program element, for example.

These elements are then aggregated into the major missions of Defense. The system included a mechanism for continuous review and change, and data were projected for eight years in the case of military forces and for five years for all others. The budgetary phase initially remained structured in terms of object classes and it was necessary to translate the program into budget categories by means of a conversion matrix or crosswalk.

The first step in the budgetary process began (before the Budget and Impoundment Control Act of 1974, which, amongst other things, altered the start of the fiscal year to October 1) in June with the issue of the JSOP to the Secretary of Defence.[25] In October the OSD issued their Policy and Planning Guidance Memoranda. The second volume of the JSOP, which constitutes the preliminary budget request of the JCS, was then released in December. During McNamara's time the JSOPs were overshadowed by Draft Presidential Memoranda (DPMs) which were prepared by the OSD and signed by the Secretary. In 1969, however, Nixon recommended that they should be abolished and that the initiative in requirements-setting should once again revert to the JCS. The DPMs were comparable to the Program Memoranda required by the budget bureau, except that the DPMs were sent direct to the President, whereas the Program Memoranda (PMs) went to the budget bureau.[26]

After reviewing the second JSOP the OSD give out Planning and Programming Guidance Memoranda in February, an important innovation made under the Nixon Administration. These contain up-to-date policy guidance and spending constraints for each service and spending agency for the next five years. These spending constraints enable the services to plan more realistically, as

opposed to the early sixties when ceilings were almost non-existent and domestic agency expenditure was determined only after Defense had settled on a figure. These constraints also reduced the influence of the Secretary in setting overall ceilings and reflected the new Administration's belief that the country could no longer afford such massive defense expenditure.[27]

The next step in the process was the submission by the JCS of their initial programming document, the Joint Forces Memorandum, to the Secretary in early May. This will include assessments of the risks associated with particular spending constraints and is structured in terms of program categories.

In 1961, there were nine programs:

- strategic offensive forces
- continental air and missile defence forces
- general purpose forces
- airlift/sealift forces
- reserve and guard forces
- research and development
- general support
- retired pay
- military assistance

In 1965 these were changed to:

- strategic forces
- general purpose forces
- specialised activities
- airlift and sealift
- guard and reserve forces
- research and development
- logistics

- personnel support
- administration

These categories were framed for the purposes of Project PRIME, an attempt to "achieve a correspondence in terms of operating costs among program, budget, accounting system, and reporting system".[28] The aim was to integrate the planning, programming categories with the requirements for performance budgeting and financial control. But as Schick points out[29], under PRIME the concept of "mission within the program structure almost disappeared.

In 1974[30] there were ten major programs and four support programs

- Major Mission Forces - strategic forces
  - general purpose forces
  - land forces
  - tactical air forces
  - naval forces
  - mobility forces
- Other missions - intelligence and security
  - communications
  - research and development
  - support of other nations
- General Support - base and individual support
  - training
  - command
  - logistics

As can be seen from all these categories, very few of the programs refer to end purposes or objectives. Strategic offensice and continental air and missile defense of the original classification are perhaps the best examples.[31]

Soon after receiving the Joint Forces Memorandum, the OSD also gets Program Objectives Memoranda. (POMs) from the civilian secretaries of the services departments. These program requirement documents provide the justifications for divergencies from the existing Five Year Defense Program and the proposals of the JCS in the Joint Forces Memorandum. The Secretary then has before him by the end of May two sets of program requests, thereby increasing the range of options open to him and building greater competition into the system between the services.

During the preparation of these documents and after receipt, the Secretary, the OSD's Office of Program Analysis and Evaluation (formerly the Office of Systems Analysis), and the systems analysis sections of each of the services conduct studies to clarify issues, and on receipt of the documents the Secretary and his staff review their proposals and prepare Issue Papers. While all this is going on the OSD works closely with the National Security Programs Division of the budget office.

After a review of the Issue Papers in July, decisions are made in the form of tentative Program Decision Memoranda (PDMs). Service departments are allowed to appeal against these decisions by issuing "reclama". The PDMs are reissued in August as the final program guidance and represent the Department's approved program. The services then have until October to submit their final Budget Estimates. The Defense Comptroller and individual service comptrollers review these program requests and translate them into six appropriation accounts:

- military personnel
- operations and maintenance
- procurement

- research, development, test and evaluation
- military construction
- other

These are presented in budget "bluebooks" for the budget year, the current year, and previous years. A certain amount of "slippage" occurs, however, because any budget cutting at the costing stage is unrelated to program effectiveness. The completed bluebooks then go to the Secretary late in October and are reviewed by the OSD and the budget office. In November, the OSD issues Program Budget Decisions which translate budget review decisions back into program categories, thereby enabling adjustments to the Five Year Defense Programs. Also in November the budget is sent to the White House for review by National Security Council officials, economic advisers, and the President. Late in December the budget then goes back to the budget office, is combined with other departmental requests, and is presented to Congress early in January.

Congress must grant authority to carry out the activities of the Department of Defense through the annual Defense Authorisation Bill and must appropriate funds to pay for them through the Defense Appropriations Bill. Most of the work is carried out in committees, and while appropriations originate in the House, authorisation usually begins in the Senate. During this process congressmen, very often pressed by the military, try to add funds for programs rejected in the executive phase. These are called "end runs". Burt[32] has pointed out that "it is Congress that makes the American budgetary process more decentralised than the British model". A service which has lost out in the executive phase can always find a sympathetic ear in Congress, and this

relationship also adds to its bargaining power at earlier stages.

After both houses have approved the amended requests, a joint session is often required to iron out any differences between House and Senate versions. The legislation then goes to the President to be signed. The President can veto the bills if he feels that they diverge significantly from his original intentions.

2.4 P.P.B.S. IN THE NON-DEFENSE DEPARTMENTS AND AGENCIES

With the success of P.P.B.S. in the Department of Defense, the President decided to extend the system to the rest of the federal government (although the Department of Agriculture introduced a system of "zero-base budgeting" in 1962[33]).

(a) The 1965 System

The 1965 Bureau of the Budget Bulletin[34] described the essential elements of the system: the program structure, the multi-year program and financial plan, analysis, the program memorandum, the relationship to the budget process, the annual cycle, and responsibility and staffing.

(i) The Program Structure

This was defined as:

> "a series of output-oriented categories which, together, cover the total work of the agency. These will serve as a basic framework for the planning, programming, and budgeting processes (including work on systems analysis, reporting, evaluation of accomplishments, and other aspects of management) and for relating these processes to each other."

The program structure comprised program categories, sub-categories and elements:

Program categories "are groupings of agency programs (or activities or operations) which serve the same broad objective (or mission) or which have generally similar objectives ... each program category will contain programs which are complementary or are close substitutes in relation to the objectives to be attained."

Program Sub-categories "are sub-divisions which should be established within each program category, combining agency programs ... on the basis of narrower objectives contributing directly to the broad objectives for the program category as a whole."

Program elements "are usually sub-divisions of program sub-categories and comprise the specific products (i.e. the goods and services) that contribute to the agency's objective. Each program element is an integrated activity which combines personnel, other services, equipment and facilities."

It was recognised that the program structure would not necessarily reflect the organisation structure:

"It will be appropriate and desirable in many cases to have the basic program categories cut across bureau lines to facilitate comparisons and suggest possible trade-offs among elements which are close substitutes. It is also desirable to develop program formats which facilitate comparisons across agency lines ..."

Research activities "may not be and frequently are not mission- or output-oriented". For this reason, "such activities should be identified as a separate program category or sub-category as appropriate.

To facilitate top level decision-making, it was recommended that "the number of program categories should be limited" to a maximum of "fifteen" for a Cabinet Department.

Program categories and sub-categories "should not be restricted by the present appropriation pattern or budget activity structure" although it may eventually "be necessary and desirable for the 'Program by

Activity' portion of the schedules in the Budget Appendix to be brought into line with the program structure ..."

(ii) The Multi-Year Programme and Financial Plan

This document will be a "principal product" of P.P.B.S. The whole process

"is concerned with developing for agency head review, and ... for Bureau of the Budget and Presidential review (as summarized in Program Memoranda ..) a translation of concretely specified agency objectives into combinations of agency activities and operations designed to reach such objectives in each of the stated time periods."

The Program and Financial Plan (PFP) will:

" - Be set forth on the basis of the program structure ...

- Cover a period of years, usually five ... The multi-year feature is not to be compromised by the expiration of legislation ... since extension or renewal ... of the legislation should be reflected in the plan.

- Include activities under contemplated or possible new legislation as well as those presently authorised ...

- Show the program levels which the agency head thinks will be appropriate over the entire period covered by the multi-year plan.

- Express objectives and planned accomplishments, wherever possible, in quantitative non-financial terms. For example ... the additional capacity ... of recreational facilities ... the number of youths to be trained ... the number of hours of Spanish language broadcasts ... the number of children to receive pre-school training, and the number of patients in federally-supported mental hospitals ...

- Where relevant, relate the physical description of federal programs to the entire universe to be served ...

- Associate financial data with the physical data to show the cost of carrying out the activity described ... in systems terms. That is, all costs - such as capital outlay, research and development, grants and subsidies, and current costs ...

- Translate the costs and receipts used for analytic purposes ... into the financial terms used in federal budget preparation, presentation, and reporting ... "

The PFP must be submitted "to the Bureau of the Budget" who must also "be kept abreast of significant revisions and updatings ..."

The PFP "will form the basis for the agency's budget requests", and "provision will be made for a thorough reappraisal and updating ... annually."

(iii) Analysis

The purpose of analysis is

"to examine deeply program objectives and criteria of accomplishments. Whenever applicable, this effort will utilise systems analysis, operations research, and other pertinent techniques. The analysis should raise important questions, compare the benefits and costs of alternative programs and explore future needs in relationship to planned programs. The sources of data will be many, including most importantly, the Program and Financial Plan, special studies ..., and budget, accounting and operating data ..."

Special studies on specific topics

"should be carried out in response to requests by the agency top management, the Budget Bureau, or at the initiative of the analytic staff itself. Suggestions should also be made by line operating managers. The special studies may involve intensive examination of a narrow subject or broad review of a wide field ..."

Questions "should be posed by the analytic staffs to other elements of the Agency on program objectives, measures of performance, costs and the like".

A Program Memorandum (PM) "should be prepared annually on each of the program categories of the agency". The PM will "summarize" the PFP for that category and present "a succinct evaluation and justification". Thus the PM should:

" 1) Spell out the specific programs recommended by the agency head for the multi-year time period being considered, show how these programs meet the needs of the American people in this area, show the total costs of recommended programs, and show the specific ways in which they differ from current programs and those of the past several years.

2) Describe program objectives and expected concrete accomplishments and costs for several years into the future.

3) Describe program objectives insofar as possible in quantitative physical terms.

4) Compare the effectiveness and the cost of alternative objectives, of alternative types of programs designed to meet the same or comparable objectives, and of different levels within any given program category ...

5) Make explicit the assumptions and criteria which support recommended programs.

6) Identify and analyse the main uncertainties in the assumptions and in estimated program effectiveness of costs ... "

The analytical effort is designed to:

(1) Help define major objectives and sub-objectives;

(2) Develop criteria to measure and judge performance;

(3) Compare alternative programs, old and new, in terms of effectiveness and costs;

(4) Develop reliable estimates of total systems costs of alternatives over the time period;

(5) Analyse the validity of cost data;

(6) Identify and analyse program uncertainties;

(7) Carry out systems analyses to help in making program decisions.

(iv) Relationship to the Budget Process

The PM and Special Studies are to be used in the spring Budget Preview. All annual budget requests in the autumn are based on the first year of the current PFP. P.P.B.S. will not, however, require any changes in the form in which budget appropriation requests are sent to Congress. Operating budgets used to allocate resources and control the day-to-day operations and performance reports should be consistent with the PFP.

(v) The Annual Cycle

Program review "is a year-round process of re-evaluating and updating program objectives, performance, and costs." An illustrative cycle was given:

- January - the agency makes changes to the previous PFP according to Presidential decisions as reflected in the budget sent to Congress.
- March - bureaus submit to the agency head their appraisals of program objectives and multi-year plans and proposals for modifications and extension of the plan for an added year. The Director of the Bureau of the Budget (BOB) will advise on any overall policies and objectives.
- April - bureaus develop specific program plans on the basis of agency head instructions.
- May - analytic staffs complete PMs. The Agency Head reviews program plans and approves PMs for submission to BOB.

- May/June - BOB budget preview, based on PMs, Special Studies, and on any Presidential guidance.
- July/August - program plan changes are made on the basis of guidance received and of congressional legislation and appropriations. Budget estimates are made up on the basis of the first year of the PFP.
- September - budget estimates and legislative programs are submitted to BOB.
- October/December - BOB reviews estimates, consults agencies, and makes recommendations to the President. Presidential decisions are transmitted to agencies, the budget is prepared for Congress, and the legislative program is prepared.
- January - changes are again made by the Agency to the multi-year program plan to conform to the Presidential budget sent to Congress.

(vi) Responsibility and Staffing

Responsibility rests with the head of each agency. Each agency must establish an adequate central staff for analysis, planning and programming.

(b) Development of the System

On February 21, 1966, a Supplement to this bulletin was issued.[35] This provided further details on the PFP and the PMs. It pointed out that "No explicit financial guidelines or constraints are provided" but as federal budgets cannot provide unlimited resources, "choices will have to be made". For PMs, "Certain exceptions" could be made to the requirements

to submit one for each program category. PMs need not be submitted for a residual category, where no major program choices appear to be open, or where a joint analysis appears preferable. PMs should include a copy of the PFP for the program category, and their total length should be between 20 to 50 pages. They need not be comprehensive, but should focus on the "central questions".

On July 18, 1967, a new bulletin replaced the previous two.[36] No major changes were made, however. The principal objective of P.P.B.S. was "to improve the basis for major program decisions, both in the operating agencies and in the Executive Office of the President".

The "elements" or "documents" of the system were given as PMs, a PFP which provided a "comprehensive" summary of agency programs, and Special Studies (SS). An agency was recommended to have between five and ten major program categories. BOB would try to fit agency program structures into a government-wide structure. For the PFP, the years beyond the budget year show the future implications of current (past and present) decisions and are not designed to predict comprehensively future budget totals. It will include a reconciliation or "crosswalk" between program costs and appropriations, though it is not necessary to go below the level of sub-categories. It must be submitted to BOB annually. A further illustrative annual cycle was given.

- September - agency submits PMs, PFPs, the annual budget and legislative program to BOB.
- October/December - BOB reviews and recommends to the

President. Presidential decisions are communicated to the agency.

- January - Executive budget is presented to Congress. Major elements in the legislative program are indicated in the State of the Union message, the budget message, the economic report, etc.
- January - the agency reviews special study program and submits proposed list for the year to BOB.
- January - the agency updates the PFP to conform to the executive budget.
- February - BOB indicates to the agency its request for Special Studies and issues to be covered in PMs.
- February/July - the agency completes Special Studies and prepares draft PMs.
- April/August - BOB responds to Special Studies and draft PMs.
- July/September - the agency head makes final decisions on program recommendations; draft PMs are revised and PFP updated to conform to agency head recommendations.
- Year Round - Special Studies are begun, carried out and completed as necessary.

The length of the PM was shortened to a maximum of 20 pages, and since it was considered "impossible to provide full treatment of alternatives and their analysis" then "selectivity"was introduced by concentrating on"major program decisions". For the PFP, "Outputs will not necessarily measure the achievement of a program objective, nor the benefits of the program". These should be "given full consideration in the Program Memoranda and Special Studies".

The PFP should focus on "what is produced as a result of the program effort". The costs in the PFP "are defined in a more limited sense than the costs which may - and usually should - be utilised in the Program Memoranda or in Special Studies". Analysis "should include the consideration of economic opportunity costs, marginal costs, and systems costs". Where existing accounts fail to provide cost data for the base year then

> "Cost distribution practices should be so developed as to provide a suitable basis for program decisions and to provide to the managers concerned reliable information that will permit them to evaluate results actually obtained in relation to the resource allocation decisions made under PPB."

This highlights the triple nature of the "control" function of budgeting: program, function, appropriation[37]. Special Studies provide

> "the analytic basis for decisions on program issues in the PM" and "will review in terms of costs and benefits the effectiveness of prior efforts, compare alternative mixes of programs, balance increments in costs against increments in effectiveness at various program levels with attention to diminishing returns and limitations of physical resources, and assess the incidence of benefits and costs as well as their totals."

Each agency should establish a specialised analytic staff "reporting directly to the agency head or to his deputy".

In 1968, guidance on P.P.B.S. was revised once more.[38] P.P.B.S. was said to provide for "the identification of program issues and the consideration of such issues in the framework of program structure". The three "basic elements" were given as PMs, "Special Analytic Studies" (SASs), and PFPs. The SASs provide the "analytic groundwork for

decisions reflected in PMs". They are of two types: those undertaken "to better resolve an issue in the budget year ..." and those "which continue beyond the budget year ..." While the PMs "deal primarily with the resolution of specified program issues", the PFPs on the other hand "provide a continuing record from year to year of the outputs, costs and financing of all agency programs" for a seven year period: the past, current, and budget years and four future years.

The major change from previous bulletins was the emphasis on "Major Program Issues" and the selective approach. Major Program Issues were defined as questions requiring decision in the current budget year which have major implications in terms of present or future costs, the direction of a program or group of programs, or policy choice. As regards the program structure, agency activities which contribute directly to the output of a particular agency should be included in a program element even though they may be conducted within different organisations or from different appropriations. Arbitrary allocations for distributing all costs should be avoided and separate classifications used. Furthermore, "absolute uniformity and consistency will ... be counter-productive in some instances ... "

PMs "are oriented to major program issues". Draft PMs should be submitted before final versions. PFPs are "not intended as a projection of requirements" but of "commitments". A separate "commitment classification" is required to "group financial data for programs according to

the degree of control that can be exercised by the executive in the allocation of resources in the budget and future years". This constraint however, does not apply to PMs and SASs. In addition, agency reporting systems "should provide timely data on outputs and costs in budget execution, so that programs may be effectively carried out according to the approved plans and related operating budgets". The planning and budgeting cycle was as follows[39]:

- November/February - identification of major policy issues; Issue Letters sent from BOB to each agency head.
- May/June - results of issue analysis reported to agency heads and then to BOB. Commitments projected 5 years ahead together with proposed new expenditure and low priority expenditure.
- June / July - BOB holds spring preview of major policy issues, new and low priority programs. Implications projected 5 years ahead.
- August - BOB releases tentative guidance to agencies for development of final budget requests.
- September/October - final budget and PFP submitted by agencies to BOB.
- October/November - BOB holds final agency hearings and budget review.
- November/December - President decides on major budget issues.
- January - Presidential budget message transmitted to Congress.
- February/June - hearings on the budget by Congressional committees.

- March/July - Congressional approval.

Thus we can see that in certain major respects the P.P.B.S. concept had undergone some fundamental changes since the first BOB bulletin. In particular, P.P.B.S. was now to focus on selective major program issues, and the PFP became restricted to commitments only.

The end came in June 1971 in a message from the Office of Management and Budget (the new name for BOB)[40]:

> "Agencies are no longer required to submit with their budget submissions the multi-year program and financing plans, program memoranda and special analytical studies as formally specified in Bulletin No. 68-9; or the schedules (previously required under Circular No. A-11) that reconcile information classified according to their program and appropriation structures".

However, multi-year costing was required for new legislation and analysis would be required for new proposals[41].

Of the civil departments, Health, Education and Welfare was considered to have been one of the most successful in implementing P.P.B.S. (partly because of support from the top).[42] An examination will now be made of their experience, with particular reference to Health.

2.5 P.P.B.S. IN THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (HEW)

HEW was one of the largest spenders in the American federal government (and by 1973 had become the largest[43]). It comprised seven (more recently eight with the addition of the Office for Civil Rights[44]) major agencies[45]: the National Institutes of Health; the Health Services and Mental Health Administration; the Food and Drug Administration; the Office of Education; the Social Security Administration; the Social and Rehabilitation Service;

and the Office of Child Development. In the case of national security, the federal government has total responsibility and controls most of the resources. But in health, federal responsibility and finance extends to only 16% of the total[46]. And of total federal expenditures, HEW accounts for only half[47]. In addition to HEW, there are 12 agencies, 6 departments, and a trust funds agency all with health responsibilities. Within HEW funds are distributed amongst many different agencies, e.g. approximately a third go to welfare services[48]. Furthermore, most funds are expended in the form of grants-in-aid to State and local governments, universities, school districts, hospitals, and non-profit agencies. Approximately 94% are in this form[49], with HEW being directly responsible for the Indian Health Program, the Food and Drug Administration, and a small number of intramural research programs. HEW is thus "a federation of very largely autonomous agencies" and because of traditional American suspicion of collective action its programs are narrow, heterogeneous, controlled by many different agencies with overlapping responsibilities, and are part only of total provision[50]. Together with the vast increase in social legislation of the Great Society period, the need was great for a better system of co-ordination.

(a) The Traditional Budgetary Process in HEW

Budgets in HEW were traditionally formed "from the bottom up"[51]:

1) The process began with a call for a preliminary budget from the Office of the Secretary, with no guidelines on scale or priority.

2) Agency heads then requested budgets from their bureaus, who in turn passed the request to divisions, etc.

3) The existing budgetary base was considered "inviolate", needing no re-examination.

4) The process thus focused on upward changes.

5) The impact of proposed legislation was not considered, but instead left to a separate legislative process with little interaction with the budgetary process.

6) The planning horizon was the coming budget year only.

7) Appropriations categories related to administrative lines only.

8) Little attention was given to competing or complementary programs.[52]

(b) The New System

Responsibility for implementing P.P.B.S. was given to an Assistant Secretary who headed an Office for Program Co-ordination (later called Planning and Evaluation)[53].

Their mission was to help the Secretary make better decisions about resource allocation for the purposes of budget making and legislative proposals.

There were three main elements of the HEW system: the Program Budget and Information System; Analytical Studies; and the Planning and Budgeting Cycle[54].

i) The Program Budget and Information System

The first step was to obtain information about the current allocation of resources e.g. to health, to the poor, the elderly, or to research. The conventional budget was useless for these purposes, hence the need

for what was termed the "program budget". This was basically a program structure with financial data included, or a PFP without the "planning" or future-orientation. The appropriations structure of HEW never included line-items for such things as motor pools, quartermaster, etc. as in Defense because funds are expended mainly in the form of grants to provide specific services. But what was lacking was a grouping of these appropriations subsections into a program structure of objectives[55].

The first attempt at a program structure gave three major objectives: Human Investment; Providing Income and Other Benefits; and Institutional and Community Development. However, this classification made it difficult to, e.g. look at education as a whole.

The next attempt looked at more conventional objectives: Improving Health; Improving Education; Income Maintenance; and Social and Rehabilitation Services. This was the classification finally arrived at.

The "program structure" was defined as "a set of program categories, arrayed in a hierarchy, which express the purposes of programs" and is "distinguished from those parts of the PFP classification system which express program attributes other than purpose, e.g. activities, target groups, output measures..."[56]

The information system permitted the classification of information on the program budget (or PFP framework) in terms of program category, appropriation, activity,

organisation, legislative authority, source of funding, mode of obligation, output, target group, disease data, and manpower data.

The major category of Health was defined as comprising "programs concerned with promoting normal physical and mental development and well-being and with repairing or containing the effects of injuries and disease". The structure below Health consisted of a six level hierarchy of categories with operating programs assigned to one or more categories at the sixth or most detailed level. The sub-categories of Health were:

1) Development of Health Resources:
   - increasing knowledge
   - providing facilities and equipment
   - increasing and improving the health manpower pool
   - improving the organisation and delivery of health services
2) Prevention and Control of Health Problems:
   - disease prevention and control
   - physical environment control
   - consumer protection
   - social factors affecting health
3) Provision of Health Services:
   - health services for the aged
   - health services for the poor
   - health services for Indians
   - health services for children and mothers
   - other health services
4) General Support:
   - scientific and health information
   - program direction and management

Levels four to six comprise details on e.g. specific diseases, services,etc. and operating programs. The "Progr am Element" is the most detailed level and is defined as "part of an operating program which relates to only one program category at each level in the program structure and is thus described by a single 6-digit program category code ..."

The next classification of the PFP was in terms of "Activities" which "indicate the ways in which ... purposes are accomplished". There are seven major activities:

- research and development;
- demonstration and testing;
- training of personnel;
- provision of services;
- standards and regulation;
- facilities and equipment;
- other (specified).

These were further sub-divided, so that activities would be represented by a 2-digit code.

The third dimension was in terms of "Organisation". A 3-digit code indicated the organisational reporting unit: the first digit identified the agency; the second digit identified the bureau; the third identified the division.

"Legislation" was represented by a 1-digit code which indicated whether a program was authorised by current legislation, would require new legislation, or was proposed for authorisation at a future time.

The "Finance" classification indicated the source of funds for a program and the mode of funding obligation as a 2-digit code. The first 2-digit code related to "Source of Funds", sub-divided into General Funds, Trust Funds, etc. The second code related to "Mode of Obligation" in terms of Direct Operations, Formula Grants, etc.

One of the most important classifications was in terms of "Output". This was in the form of "data, usually expressed in non-financial terms, which indicates the impact, outcome, or results of investment in the program". However, "attempts to specify exact measures that would be useful have not proved very fruitful".

Two classes of output indicators were required, "operations indicators" and "program impact indicators". Operations indicators are "usually directly relatable to outputs of activities in the program structure. They are the immediate translations into non-financial terms of what is produced for the money or effort expended". Examples are the number of people in training, the numbers of people served, treated, rehabilitated, supported by payments, counselled or participating in a program, or the number of beds, etc. However, "these outputs are supported because they should bring about desired changes in the well-being of our people. They are inputs into the social system. So we are also asking programs to report on their effects in terms that go beyond the resources generated or the persons

and institutions affected". Program impact indicators "would reflect data related to the impact of the total program element", e.g. morbidity or mortality data for particular health problems, changes in the percentage of defective consumer products, reductions in air pollution, and the availability of health services for specific groups of people.

In addition, "social indicators should be included in the narratives accompanying PFP data submissions" because there were "many significant impacts of social developments which result from combinations of programs, and from the combined effects of HEW programs with other actions by other government agencies and the private sector". Examples are changes in life expectancy, infant mortality rates and morbidity indicators such as the number of work-days lost due to illness.

Output measures "are critical to an effectively working PPB system" yet those developed were "virtually useless" and occasionally "ridiculous"[57]. For example, the output measures submitted for medical services under Medicaid were the "number of potential recipients". These were the same for each service category and turned out to be the number of people enrolled in the Medicaid program. "Not only had the effort sunk so low as to count bodies, but potential bodies at that".[58]

The next classification was "Target Groups", that is "Groups in the population at which programs are aimed or on which they impact significantly". Programs were

identified by target group "when they are either (a) specifically aimed at groups within the population, or (b) when they are programs for the "Provision of Services" and are reported for that activity".

A 4-digit code identified:

- age class;
- income class;
- problem or need class;
- location.

The "Disease Annex" provided information on the impact of programs on specific health problems, as contained in the International Classification of Diseases. A 3-digit code described the set of health problem categories: the first digit summarises the health problem and the last two gave further details.

The "Manpower Annex" required "occupational data showing dollars for training activities by occupation together with selected output measures" in terms of numbers trained, etc. The final classification was the "Program Budget Code" or "Crosswalk" which was the "technical vehicle" for the "translation of multi-year PFPs into annual budgets". "No matter how useful the program budget proves as a way of organising information and as a planning tool, final decisions on the budget must be made in appropriations terms" which, amongst other things, determines the allocation of responsibilities for operating programs [59].

The five year PFP "shows how assumed budget totals would be allocated by objectives and sub-objectives in

the future in order to reflect presently conceived priorities ..."[60] Some elements "are only projections". In income maintenance e.g. the plan "is not a plan at all. It is simply a projection of the future costs of present income maintenance programs". "Only a few segments ... are real plans in the sense that they show how specific objectives could be reached over a multi-year period ..." e.g. in the Work Incentive Program the objective is one of "removing a specific number of people from the welfare rolls by 1975".

ii) Analysis

Analysis of alternatives was regarded in HEW as "the heart and soul of PPB"[61]. However it was "a long tough job, and it is going to take many years to develop the kind of output measures we need to understand what we are getting for our money"[62]. HEW

> "have not attempted any grandiose cost-benefit analyses designed to reveal whether the total benefits from an additional million dollars spent on health programs would be higher or lower than that from an additional million spent on education or welfare ... the benefits of health, education and welfare programs are diverse and often intangible. They affect different age groups and different regions of the population over different periods of time ... the 'grand decisions'- how much health ... education ... welfare, and which groups in the population shall benefit - are questions of value judgements and politics. The analyst cannot make much contribution to their resolution ... The less grand decisions, those among alternative programs with the same or similar objectives within health - can be substantially illuminated by good analysis. It is this type of analysis which we have undertaken at the Department of Health, Education and Welfare"[63]

In the health field, studies were carried out on e.g. selected disease control programs (tuberculosis, syphilis, cancer, arthritis and motor vehicle accidents) and alternative ways of improving the health of children.[64] For disease control programs, "very little is known about the effectiveness" and "guesswork and the opinions of knowledgeable experts had to be substituted for hard data in many cases"[65]. For child health, "We simply do not know whether children who receive medical check-ups and continuous medical attention are healthier than those who do not"[66]. Analysis was hampered by a lack of staff and a lack of information.[67] A related aspect of analysis is the evaluation of performance, which provides the essential feedback for planning purposes.[68] "In the absence of knowledge of the effects of past programs, analytical studies will often fail to influence Federal decision-making ..."[69] There was a serious lack of evaluation throughout the federal government, in addition to HEW[70]. However HEW did succeed in obtaining legislative approval for spending 1% of funds on program evaluation, a development which outlived P.P.B.S.[71]

iii) The Planning and Budgeting Cycle

This brought together funding decisions on existing programs with decisions on proposals for new legislation, and established a five year planning and programming process as the basis for current budget decisions.[72] The procedure was as follows:-

(a) Very early in the calendar year a list of signifi-

cant issues for the coming budget and legislative program was drawn up and discussed within the Office of the Secretary and with operating agencies and BOB. A decision was made on issues to be analysed and studies were initiated.

(b) The next step was the development of a set of tentative departmental objectives for five years ahead. Agencies were asked to formulate these objectives on the basis of high and low resource assumptions.

(c) Agency objectives and programs were reviewed and revised by the Secretary and his staff and tentative departmental objectives were formed. These were transmitted back to agencies as guidance for formulating budget and PFP submissions. These were then reviewed by the Secretary and his staff.[73]

There were, however, difficulties with this cycle. Delays were caused by the reluctance of the Secretary to take decisions early in the year, the initiation of much new legislation from the White House, and the slow response of agencies.[74] Furthermore, almost all new programs in HEW require new legislation, as opposed to, e.g. Defense. Yet the legislative cycle was generally out of phase with the budgetary cycle, and it was the bureaus which initiated much legislation.[75]

2.6 LESSONS FROM EXPERIENCE

Some lessons from the experience of P.P.B.S. in the U.S. federal government can be given:

(a) The Program Structure

This raised many philosophical problems of "What is government for?" and of the complex means-ends or cause-and-effect relationships of social production functions.[76] "There are as many ways to classify information as there are analytical perspectives"[77] and much valuable time which could have been given over to issue analysis was wasted on this aspect.[78] However, its "utility ... seems clear ... It raises many questions about the rationale for this particular configuration of Federal expenditures and opens up productive lines of inquiry"[79].

(b) Issue Letters

These "presented greater problems" : BOB "has had difficulty in sending letters to agencies early enough in the planning and budgeting cycle, in defining issues with sufficient specificity, and in limiting the number of issues posed in relation to scarce analytic capability"[80].

(c) Program Memoranda

These "have been of uneven quality"[81]. In 1969 "only about 25% could be judged as adequate-to-excellent", whereas after that date the percentage increased to "about 50%". " Many ... tend to be descriptive, verbose, non-analytic accounts of existing and proposed programs, together with an impassioned plea for funding at the full request ..."

(d) Special Analytical Studies

SASs have been the "successful part of the PPB innovation ... In some cases, public policy bargaining has been sharpened and needless friction avoided because of revealing

analysis. The preferences and judgements of decision-makers have been applied more knowingly than would otherwise have been the case"[82]. But there were difficulties : analysis was "constrained by the fact that several tiers of Government ... are involved ... each with a de facto veto over change ..." ; "some agencies tend to concentrate ... upon fairly minor issues ... sometimes major issues are left to rather superficial treatment. There is inadequate incentive ..."; and "studies do not usually encompass the full breadth of program problems when these are related to activities of several different agencies ..." The percentage of analyses which could be judged "useful" up to 1968 ranged from 16% in human resource programs to nearly 90% in community and economic development programs. The number of "adequate-to-excellent and useful analyses" increased by "about 200%" up to 1968/69. After that date it was reported that there had been a "four-fold rise in relevant analyses ... from five to twenty on a scale of a hundred", and the quantity of adequate-to-excellent increased "several fold".[83]

(e) The Program and Financial Plan

There were "difficulties" with the PFPs[84]. They were "a series of lengthy wishlists of what agencies would like to spend on their programs if no fiscal contraints were imposed". The definition then changed "to include only those future appropriations to which the Government is committed by legal and moral obligations resulting from past decisions or required by present decisions." However, the definition of "commitment" was "amorphous". Nevertheless the PFP "has been useful to a few agencies and to the Bureau

of the Budget. It has helped to provide some perspective on the level of committed public funds in the future".

2.7 CONCLUSION

The causes of the failure of P.P.B.S. will be classified under the 3 heads: political, structural and cognitive.

Political

On the political front, the main reason was that P.P.B.S. "did not penetrate the vital routines of putting together and justifying a budget."[85]

Budgets, particularly in the American pluralist system, are "political things"[86], not only between branches of government, but within them too. Budgeting in the federal government is "anti-analytic"[87]. It is a "tribute to the art of conflict-management"[88]. This is because of "budgeting's abhorrence of protracted or intensive conflict. Budgetary warfare brings challenges to those interests which are advantaged in the budget; it invites political and administrative disruption; and it may mean payless paydays, program cuts, reduction-in-force, and even agency terminations". Hence the need for "many devices and strategies for regulating and containing discord" such as "the stretching of time allowed for completing action on appropriations, continuing resolutions, informal understandings between congressional committees and agencies, and the widening of the gap between authorisations and appropriations"[89]. The budget view is "insular", and this separation from outside happenings "is one means of limiting conflict". Budgeting relies on "routine" and "routine drives out analysis"[90].

Secondly, P.P.B.S. was looked upon as affecting the political power structure. P.P.B.S. "contains an extreme centralising bias. Power is to be centralised in the Presidency (through the Budget Bureau) at the national level, in super-departments rather than bureaus within the executive branch, and in the federal government as a whole instead of state or local governments."[91] This whole argument must not, however, be taken too far: "It is possible to visualise, on the one hand, a decisive and powerful department head (or Bureau of the Budget) without program budgeting, or, on the other hand, a decentralised system in which officials are motivated to make use of the information generated by a program budget."[92] P.P.B.S. "is not a reorganisation plan nor does it seek or require changes in the organisation to fit the program structure."[93] But the important point is participant perceptions. BOB placed the responsibility for P.P.B.S. squarely on the agencies. But the agencies saw it as a system for increasing presidential and BOB control over the executive branch, particularly with the requirements concerning Issue Letters, review of PMs, etc.[94] Furthermore, P.P.B.S. "was conceived almost exclusively from an executive perspective, as if Congress does not exist."[95] Congress regarded the new system with suspicion and maintained the traditional accounts for fear of losing power to the executive.[96]

Finally, P.P.B.S. introduced an unwelcome "economic" approach to political decision-making. At best, the system let in "partisan efficiency advocates"[97]. This often led to the advocacy of "otherwise unrepresented interests"[98]. At worst the requirement for clarity and consistency of objectives and performance criteria meant that analysis attempted to replace the political benefit

weighting process with economic criteria: "to decide what the policy maker should want to do".[99] Analysts (and P.P.B.S. itself) often came from Defense and integrated badly with domestic administrators. There was no body of competent analysts or analytical knowledge available to domestic agencies as there was to Defense in the form of RAND. Agency heads reacted by "divorcing P.P.B.S. from budgeting."[100] Domestic agencies generally had less autonomy from their environment[101] making objective analysis more difficult for participants to accept. As commentators have pointed out, "We have no adequate understanding of the impact of knowledge on policy "[102]; "One objective may be not to reveal objectives"[103]; and "Truth is only one of a number of conflicting objectives."[104]

Structural

The structural problems associated with P.P.B.S. related to:-

(i) the lack of coincidence of the objective-oriented programme structure with the organisation structure; and

(ii) the constraints on alternatives due to legal and moral commitments and situational factors.

The first set of factors led to difficulties of:-[105]

(i) costing existing programmes and future proposals and allocating resources, necessitating a reconciliation through the system of "crosswalks"; and

(ii) the management of allocated resources. Agencies were often in the position of having "an array of programmes, all justified by analysis, all projected as five-year plans, all endorsed by the central budget department and all funded by

the legislature", but then finding that "very few of its managers can be held accountable for programme results."[106] The concept of a "lead agency" to manage these programmes was found to be politically unacceptable and co-ordination was difficult to achieve.[107]

Secondly, alternatives were constrained by relatively uncontrollable legal and moral commitments and situational problems. Of all departments only Defense had a controllable budget. The relatively controllable portion of some of the more important federal budgets for the fiscal year 1969 was as follows:[108]

Defense (Military)	74%
HEW	6%
President	5%
Agriculture	3%
Housing and Urban Development	3%
Transport	2%

The greatest situational problem was that of the lack of resources. Defense traditionally had a very large budget and P.P.B.S. was introduced in a favourable economic climate. However, Vietnam, the cost of "Great Society" programmes, inflation, tax cuts and economic recession after 1965 all gave little scope for programme developments.[109]

Cognitive

The cognitive requirements of P.P.B.S. are formidable. P.P.B.S. "always fails for lack of knowledge"[110] for "no one can do P.P.B.S."[111]. It requires good "planning and planners"[112] and there were few planners and precious little analytic knowledge outside of Defense. The "national security" objective of Defense

is reasonably well defined and understood and analysis is more suitable to weapon systems, whereas most civil agencies have more undefined, varied and multi-dimensional objectives.[113] Furthermore, defence is an example of a "pure public good" which must be provided equally to all or none. This avoids the analytic problem of calculating distributional effects (although marginal utilities will differ and defence industries will benefit disproportionately). The situation is compounded by the failure of much legislation to clearly state objectives (an aspect of the American "public philosophy" of "interest group liberalism"[114]), and the restrictions on the analysis of alternatives due to uncontrollable legal and moral commitments.[115]

Development of the Concept

These difficulties associated with the political, structural and cognitive context led to a development of the context. In particular, analysis, instead of trying to be comprehensive, focused on selected major programme issues, and the PFP was restricted to showing commitments only. Yet even this proved too much for the system, and P.P.B.S. was effectively abandoned in 1971.

The root of the problem was the attempted application of the Defense model of P.P.B.S. to civil agencies. Comprehensive rationality can be approximated only with respect to "relatively small-scale problem-solving where the total number of variables to be considered is small and value problems restricted."[116] The application of the rational prescriptions of P.P.B.S. to civil problems led analysts to substitute their own values in place of the conflicting and ill-defined values of budgetary

participants, consider infeasible options, and use "metric"[117] rather than "behavioural" evaluation. Defense was better-suited to this approach where major decisions "revolved around the choice of hugely expensive weapons systems designed to accomplish the military missions of the nuclear era."[118] Furthermore, Defense had a powerful Secretary, a centralised organisation, greater autonomy from the political environment, no distributional problems, fewer and more easily specified goals, a sophisticated analytical capability, and a very large budget.[119] When transferred to the civil agencies, Defense proved to be a "bad model".[120]

CHAPTER 3

THE EARLY BRITISH EXPERIENCE

CHAPTER 3

LIST OF CONTENTS

3.1 INTRODUCTION

Chapter 2 classified the problems affecting the applicability of the Defense model of PPBS in the context of U.S. civil agencies as political, structural and cognitive. The requirement for clarify and consistency of objectives led to the artificial reconciliation of conflicting and poorly-defined values by agency heads and their analytical staffs instead of through bargaining and "mutual adjustment".[1] The open search for alternatives led to the consideration of politically and structurally infeasible courses of action. Finally, the requirement for the calculation of the full consequences of alternatives led to an emphasis on those consequences which were readily quantifiable. The application of the Defense model, often by Defense analysts themselves, sometimes created greater problems than those PPBS was designed to solve. The development of the model to a more selective orientation eased some of the burdens of analysis but relieved none of the political and structural problems. This "modified" rational approach of the Defense model, shorn as it was of major subjective elements of social decisions, was applicable only to relatively low level, primarily factual (i.e. cognitive and structural) problems. For "macro-system" problems involving complex cause-and-effect relationships, structural rigidities and major political and behavioural inputs, the model was inappropriate. But could the model be applied with greater success in this country? Cognitive problems associated with the consequences of public programmes are of course universal and do not vary between countries. The specific characteristics of the product will also have comparable effects on organisational arrangements and the degree of pluralism. However, outside of these common factors, political culture,

structural arrangements, responsibilities and analytical effort clearly do vary between the U.S.A. and the U.K. These differences in the context of budgeting between the two countries were as follows:

(1) Political Institutions and Cultures

The United States is politically more pluralistic and decentralised than Britain and this is reflected in the circumscribed role of the Federal government. The separation of powers, the loose structure of the main political parties, the federal structure, the multiplicity and relative autonomy of administrative agencies, and the influence of interest groups all ensure the maintenance of advocacy and bargaining in the political decision-making process. Federal programmes tend to be narrow, specific, and partial, are the responsibility of many and often overlapping jurisdictions, and are usually only a small part of national provision.[2] British social legislation, on the other hand, tends to be wide-ranging and therefore the primary responsibility of a single central department. Furthermore, the influence of the federal government over States and local communities is much less than that of the British central government over local authorities.

This heterogeneity and multiplicity of programmes in America was an incentive to administrative reform. Major structural reorganisation being out of the question, P.P.B.S. provided at least programme co-ordination. The primary emphasis, therefore, was on rationalising the budget structure.[3] In Britain, on the other hand, the problem of multiple and overlapping jurisdictions did not arise to this extent.[4] Furthermore, budgeting could operate with fewer political constraints.

(2) Economic Environments

The introduction of P.P.B.S. in the Department of Defense in the early 1960s took place in a very favourable economic environment. McNamara was instructed to develop a military capability to fulfil American foreign policy objectives regardless of arbitrary budget ceilings, and as Wildavsky has pointed out[5] P.P.B.S. is facilitated when budgets are large and are likely to increase. When the system was generalised in 1965 the expectation was that there would be enough revenue to finance programme extensions. But the situation changed with the Vietnam war, the rising costs of the Great Society programmes, inflation, tax cuts, and the poor prospects for the American economy[6]. Scarcity necessitated hard choices of trade-offs between new and old programmes.

In Britain the introduction of P.P.B.S. coincided with a period of economic crisis and uncertainty and the system was looked on as an extension of the public expenditure survey system particularly as central responsibilities for finance are much greater. Hence greater attention emphasis was placed in this country on the determinants of expenditure, such as unit costs and relative prices[7], as will be seen.

(3) Motives

P.P.B.S. was perceived as an essential instrument in the "strongly interventionist strategy" of the Johnson administration[8]. The "centralising bias" of the hierarchical programme structure[9], together with the support of central analytical staffs, aided the co-ordination of the vast bureaucracy of the Federal government towards the achievement of the policy objectives of the Great

Society. Similarly in Defense, where McNamara's supreme control was facilitated by the greater co-ordination of the three services which P.P.B.S. provided. Both introductions were accompanied by "publicity" and "political bally-hoo".[10]

In Britain, the main motive was financial[11] with the impetus coming mainly from the Treasury. P.P.B.S. as will be shown would complement the public expenditure survey by providing information on objectives. Administrative co-ordination of programmes was not a central issue (although some local authorities feared greater intervention in local affairs[12]).

(4) Expenditure Decision-Making Contexts

The United States had no formal system of expenditure planning (apart from the five-year "previews") because of congressional hostility to such a system[13]. Since 1961, Britain has had a well-developed public expenditure survey system. Furthermore, Britain could profit from the American experience, particularly the developments towards a more selective approach.

This chapter will examine P.P.B.S. in the context of developments in budgetary decision-making procedures and techniques in Britain since the late 1950s. The presentation will be roughly in chronological order. The chapter will begin with a discussion of the public expenditure survey system. It will then go on to look at the first attempts at introducing P.P.B.S. in the Ministry of Defence, the police service, local authorities, the Department of Education and Science, and other departments. The main innovations of the Heath Government, Programme Analysis and Review and the Central Policy Review Staff, will then be analysed. The main topic of the thesis, P.P.B.S. in the health

and personal social services, will be left to later chapters.

3.2 THE PUBLIC EXPENDITURE SURVEY SYSTEM (P.E.S.S.)

Background

The search for a more rational, output-oriented approach to budgetary decision-making in the 1960s had its immediate origins in the development of P.P.B.S. in America, but fitted in well with post-war innovations in the control, management, and planning of public expenditure. Post-war social, political and economic changes had posed severe problems - public expenditure increased at a tremendous rate;

- expenditure decisions became more complex and involved contractual and moral commitments several years ahead;
- Keynesian economics stressed the relationship of government fiscal policy with the national economy;
- public demands and expectations increased.[14]

Treasury emphasis moved to economic management and the maintenance of full employment, and spending became "popular" as the promoter of public welfare[15]. But the relative divorce of expenditure from revenue that this policy entailed meant that resources were often not available to maintain the chosen expenditure rate, leading to flat percentage rate cuts. Parliamentary dissatisfaction with the system of public expenditure control led to the recommendations of the Select Committee on Estimates in "Treasury Control of Expenditure" (6th Report, Session 1957/58, HC254, July 1958). These were that:-

- expenditure and policy should be related;
- the Treasury should be involved from an early stage in the formation and implementation of expenditure policies;

- existing policies should be reviewed regularly;
- forward looks, or cost projections (already established in Defence) should be introduced;
- needs should be determined and measured in advance.[16]

The government's response was to set up a committee of inquiry under Lord Plowden, which led to the Report on the "Control of Public Expenditure", Cmnd. 1432, July 1961. Plowden proposed a corporate approach: " ... in place of single Departments dealing with individual problems in comparative isolation the public interest requires a team pursuing its common objectives with a single purpose ..."[17] Apart from certain areas of Defence, the nationalised industries, schools, hospitals, pensions and roads, where long-term cost projections were beginning to be developed[18], the committee were critical. They recommended that:-

- public expenditure decisions should be made in relation to total public expenditure over a number of years ahead and in relation to prospective resources. This was the "core" of the proposals;
- decisions should be consistent and stable over periods of time;
- measurement and analysis should be improved;
- collective ministerial decision-making should be improved.[19]

Development of the System

P.E.S.S. was the outcome of Plowden and the first annual exercise began in 1961. The first and second White Papers (Cmnd. 2235, 1963; and Cmnd. 2915, 1966, "Public Expenditure: Planning and Control") however, were highly "political" documents designed more to maximise short-term support than long-term

expenditure control[20]. The projected growth rate of public expenditure was linked to over-optimistic and subsequently unattainable long-term forecasts for the growth of the economy. As a result, the public expenditure growth rate overtook the growth in Gross National Product. The balance of payments crisis and devaluation in 1967 led to what might be called the P.E.S.S. Mark II of 1968/69):-

- costs, under functional headings, were projected for years 2, 3 and 4, in addition to years 1 and 5;
- the "focal year" concept was introduced for year 3 to permit a wider consideration of alternatives;
- further developments were made in running tallies, the contingency reserve, the relative price effect, and the resource impact effect;
- the results were published in the form of an annual White Paper[21].

Improvements have been made to P.E.S.S. each year. In the financial year 1974/75 a revision was made in the form of the Supply Estimates to bring them into line with the functional classification of the survey.[22]

The Current System

P.E.S.S. covers all expenditure which is financed from taxation, National Insurance contributions or government borrowing.[23] It includes current and capital expenditures by the central government and local authorities, and loans and grants made by the government to nationalised industries and public corporations. The aim of P.E.S.S. is to decide what total of expenditure should be planned for the public sector, and how this

total should be allocated between programmes and sectors.

Each year the government reviews its plans for future expenditure. These reviews are based on surveys of existing plans and prospects which are prepared by officials early in the year. The results of the reviews are published towards the end of the year in the form of an annual White Paper. The surveys deal comprehensively with all public expenditure and are in constant price terms. They cover the current year and the four succeeding years, these later years being increasingly provisional.

The White Paper classifies expenditure into 15 functional headings:

(1) Defence;

(2) Overseas aid and other overseas services;

(3) Agriculture, fisheries, food and forestry;

(4) Trade, industry and employment;

(5) Government lending to nationalised industries;

(6) Roads and transport;

(7) Housing;

(8) Other environmental services;

(9) Law and order and protective services;

(10) Education and libraries, science and the arts;

(11) Health and personal social services;

(12) Social security;

(13) Other public services;

(14) Common services;

(15) Northern Ireland.

Provision is also made for Debt Interest and a Contingency Reserve of unallocated expenditure.

The Survey Process

The first stage is the preparation by departmental offocials of a detailed analysis of expenditure plans for each programme and of any scope for changes. The work is carried out jointly by the Treasury and departments on a basis agreed by Ministers at the beginning of the year, and is co-ordinated by the Public Expenditure Survey Committee (P.E.S.C.), which is a committee of departmental finance officers chaired by a Treasury Deputy Secretary.

The official analysis provides Ministers with the following sets of information:

- the existing state of the expenditure plans;
- any amendments or additions to the existing plans proposed by departments, together with reasons;
- the scope for reductions in existing plans based on departmental programme priorities.

This basic analytical material is usually completed by the end of June. It is at this stage that Ministers discuss the plans and make decisions on the total of public expenditure and its allocation between programmes and sectors. This process takes place between July and October. Decisions on the expenditure total must take account of the prospects for the economy, and decisions on its allocation between programmes are made collectively. The results are published in a White Paper around the end of the year.

Developments in the published White Papers have been mirrored in the progress of select committees of the House of Commons. The Government White Paper of October 1970, "The Select

Committees of the House of Commons", Cmnd. 4507, in accepting the idea of an Expenditure Committee to replace the Estimates Committee, declared that "the new committee unlike the Estimates Committee would not be barred from considering the policy behind the figures".[24] This new committee was set up in 1971 with the authority "to consider any papers on public expenditure presented to this House and such of the estimates as may seem fit to the Committee and in particular to consider how, if at all, the policies implied in the figures of expenditure and in the estimates may be carried out more economically, and to examine the form of the papers and of the estimates presented to this House". It comprised a General Sub-Committee and five other sub-committees which dealt with particular functional areas of public expenditure. It has now, however, been replaced by a set of departmental committees.[25]

P.E.S.S. : An Evaluation

Defining the official survey as a "cost projection of existing policies", Heclo and Wildavsky[26] maintain that what would appear at first sight to be a purely "technical" calculation in fact turns out to be a complex political bargaining process between the Treasury and departments on the exact nature of "cost", "projection" and "existing policy". It is "incrementalism to the nth power"[27]: existing policies are projected from an historical base, thereby giving security to old departmental programmes (although recognised by Plowden as a positive benefit)[28]. Each department is "more conscious of its own fair share of the total and more aware of other departments' departures from the expected rate of increase".[29] P.E.S.S. now makes it "much harder

than it used to be to sneak in small items with large future spending implications ..." and makes it "correspondingly more difficult for old items to be taken out."[30] The incremental bias of the whole P.E.S.S. exercise is recognised in official literature[31] : the "incremental approach" of P.E.S.S. is "of necessity concerned primarily with proposals for changes at the margin of expenditure".

The emphasis on a constant price survey also meant that detailed "real" price accountability through the Supply Estimates would be overshadowed.[32] This situation has, however, been partly remedied in recent years through the introduction of cash limits - "simply a return to annual estimates"[33] - the use of the contingency reserve as a limit within which new expenditure decisions during the year must be contained, and the new financial information system for monitoring expenditure during the year.[34] There are also proposals to assimilate cash limits with the Supply Estimates.[35]

Heclo and Wildavsky have written that "No nation in the world can match the sophistication or thoroughness found in the British process of expenditure projection".[36] Yet this very broad functional costing system lacks the output-orientation of P.P.B.S. In 1970, the White Paper on "The Reorganisation of Central Government" declared that P.E.S.S.

> "does not call for explicit statements of the objectives of expenditure in a way that would enable a Minister's plans to be tested against general government strategy: nor can it regularly embody detailed analysis of existing programmes and of major policy options on them."[37]

The Conservative solution to these problems at the interdepartmental level would be Programme Analysis and Review, and the Central Policy Review Staff. But first an examination will be

made of the attempts to introduce comprehensive P.P.B. systems at departmental level.

3.3 P.P.B.S. IN BRITISH CENTRAL GOVERNMENT DEPARTMENTS AND LOCAL AUTHORITIES

3.3.1 Introduction

It was during the latter half of the 1960s that, mainly because of the need to manage public expenditure more effectively, the American P.P.B. system was considered as a complement to existing systems of expenditure planning and control (although the Treasury thought there was "less urgency" in Britain since the Americans had had "no system of forward expenditure planning" and "a multiplicity of agencies operating in one field"[38]). Various different names were given to this approach: Planning, Programming, Budgeting; Programme Budgeting; and Output Budgeting. They were all "broadly comparable" though the term Planning, Programming, Budgeting System or just Planning, Programming, Budgeting was eventually chosen in preference to Output Budgeting mainly because of the difficulty of measuring output.[39]

The first feasibility study, outside of Defence, was carried out by the Home Office and applied to the police service.[40] The second study was undertaken by the Department of Education and Science in conjunction with the Treasury Management Accounting Unit, and was published in 1970.[41] Until fairly recently, the D.E.S. system was "ahead ... of anything else in government".[42] Other studies have been of external affairs, carried out by the

Foreign and Commonwealth Office, the Ministry of Overseas Development, and the Treasury, and of aspects of the work in the departments of Transport and Environment.[43] Local authorities have also been interested in the system.

In contrast with the American introduction work has proceeded in 3 stages: "feasibility studies", "development work", and finally "operational systems".[44] Departments have been encouraged by the Treasury's Management Accounting Unit to "adopt the technique which suits them best".[45] Yet the concept remains the same throughout. The function of P.P.B.S. is "to improve the basis on which decisions are taken about the allocation of resources available for achieving a group of policy objectives".[46] The British approach appears to be based on the H.E.W. experience in America since the system is based on the same assumptions and components. The assumptions are that decisions will be better if:

> "(1) you know what you are trying to do. This means formulating and defining objectives.
>
> (2) information is available on how resources are being used now in relation to the objectives they are intended to attain.
>
> (3) information is available on how effective programmes are in meeting their declared objectives.
>
> (4) alternative ways of achieving the same objectives are considered and evaluated.
>
> (5) plans are made which relate the consequences of present decisions to future needs.
>
> (6) there is a systematic procedure for reviewing plans and programmes in the light of new situations, new evaluations, new analysis.
>
> It will also help if there is also an established framework for translating decisions into budgetary and legislative action."[47]

These are exactly the same assumptions that Alice Rivlin made at H.E.W.[48]

There are 3 "main components" or "elements" to the system:[49]

(1) The Programme Budget, or "management accounting base";

(2) Programme Review, or the "procedural base", sometimes called Systematic Review;[50]

(3) Special Studies, or the "analytical base", sometimes referred to as Programme Analysis.[51]

These three elements are the same as those used at H.E.W., namely the Programme Budget and Information System, Analytical Studies, and the Planning and Budgeting Cycle.[52] It is also interesting to note a possible down-grading of analysis throughout the development of P.P.B.S. In the 1965 B.O.B. Bulletin, analysis was at the head of the list. H.E.W. placed it second and British developments place it last.[53]

The Programme Budget

In the programme budget, "expenditure is classified by programmes which are as closely identified as is practicable with objectives".[54] But because of multiple objectives, its structure would need "to strike a balance between being related as closely as possible to objectives and the need to have programmes to which it is practicable to assign costs, and wherever possible some measures or indicators of performance. The fundamental criterion ... is what classification will be of most assistance to decision-making: there is no ideal structure."

The Programme Budget "would normally be expected to show expenditure for a number of years"; it might also display the effects of alternative policies on which decisions had still to be taken." It would "include wherever possible some measures of what has been achieved ... and what it is intended to achieve with future expenditure", though these would usually relate to "intermediate output ... e.g. nuclear submarines in operation rather than the degree of deterrence achieved, or the number of school places provided rather than the effect of education on the children in those places".

As can be seen, the British Programme Budget is rather more flexible and selective than the American Programme and Financial Plan.

The Programme Budget is the one part of P.P.B.S. which "attracts most attention" because it is the single most novel aspect of the concept and on which most preliminary examination is focused because of the difficulties associated with output. Yet it is no more than the "foundation" and product of the system. It is the purpose of the Programme Review procedure to "ensure that it is effectively used".

Programme Review

There is "no standard pattern" for this procedure because "it must fit both the nature of the organisation itself and the political structure within which it works". However, these reviews would generally be "annual, just because each year future plans have to be translated into

detailed budgets for the coming year, information about out-turn of expenditure and its results becomes available in many cases annually, and it is convenient to 'roll forward' the Programme Budget as a whole". The review would include "the questioning of the continued validity of objectives, and their relative importance, the consideration of alternative ways of achieving those objectives, and the assessment of progress so far made".

Special Studies

The "depth and form" of analysis will "vary considerably from area to area, depending on the suitability of the area for quantitative assessment". In some cases "a review of objectives, the identification of costs and an enumeration and qualitative analysis of the different benefits may be all that is realistically possible". However, "in the case of major issues it will be well worth carrying out studies using all the modern techniques of analysis which may be appropriate". These special atudies would require more time than is routinely available in the annual review cycle and separate provision would be made for them.

The analytical techniques which are said to be comparable with the American concept of "systems analysis" are operational research, cost-benefit analysis, and cost-effectiveness analysis.

The selective approach was chosen:

> "It is clearly neither possible, nor desirable, to apply systems analysis in its fullest sense to all programmes or policy alternatives. The programme review procedure can play an important part

> "by identifying issues for analysis sufficiently in advance for analysis to be carried out properly and in time for the results to be taken into account in the ultimate decision - possibly in some future programme review. The procedure can also provide an ordering of priorities between different candidates for analysis in relation to the analytical resources available".

As regards the relationship of P.P.B.S. to the parliamentary accounts,

> "it can assist the legislature in its consideration of proposed expenditure if it has figures available to it on the same basis as were available to the executive when it took its decisions. On the other hand a programme structure most suitable for planning and the making of policy decisions may involve the apportionment of expenditure in a way which is sufficiently accurate for that purpose, but which is not sufficiently accurate for the purpose of appropriation and audit".

The programme structure also needs to be "flexible" since "it can be expected to change frequently as experience is gained ..." It would be neither practicable nor desirable to change the form of the Estimates so often. It is only in Canada since 1970/1 that the Federal Estimates have been changed to a "programme basis", though this classification is not identical to the "departmental programme" basis used by the Treasury Board for P.P.B.S.[55] Similarly for the purposes of management: there must be some arrangement for translating programmes into organisational action, but "this does not necessarily mean that it is appropriate to have the same structure for the two".

A detailed analysis will now be made of the P.P.B. systems for defence, the police service, local government and education.

3.3.2 P.P.B.S. In the Ministry of Defence

Introduction

A system of "planning, programming, budgeting", or "programme budgeting" was developed in the Ministry of Defence between 1963 and 1965.[56] Its introduction accompanied the creation of a unified Ministry (as in the USA), a structural reorganisation often being a precondition for its successful implementation (cf. Canada[57]). The objective of the new system was to "assist in planning and co-ordinating the Defence Budget" by giving decision-makers "much more information than in the past about the relative costs of planned forces and weapon systems."[58] The 1963 reforms "were directed, like the McNamara reforms of the same period, towards eliminating the waste and duplication arising from tri-service competition", but "after 1964 the overwhelming priority was to find a means of controlling defence expenditure in response to the severe restraints imposed by the economy" and "to reduce British defence spending progressively in real terms".[59]

The three main elements of the system will now be discussed.

The Functional Costing

The department had previously used programming and long-term forecasting in certain areas of its work but before 1958 the only comprehensive financial statement was the annual Estimates in input form. Because of the long-term nature of much of defence planning, cost projections were introduced first for 5 year periods and later on for

10 year periods. Both were again in traditional input form. In 1964 these 10 year forecasts were translated into functional categories.[60]

Functional costing for defence has been defined as "the allocation of the costs associated with achieving a given objective, fulfilling a specified purpose or mission".[61] The major programmes used, however, are

> "a peculiar mixture of outputs and inputs arranged partly by individual service, partly by geography and partly by weapons. Only the first six major programmes are related to the combat activities of the defence forces, the rest simply show the various support activities which are now allocated to the front line units".[62]

The ultimate objectives of Defence have been given officially as:

- the maintenance of the security of Britain;
- the protection of British interests abroad;
- the fulfilment of our treaty obligations;
- the avoidance of a general war;
- the contribution to the defence of the free world.[63]

These objectives are however unsuitable for use by defence planners since military units contribute to a mixture of them, cost allocation would thereby be rendered difficult, and measurement of effectiveness would be almost impossible.[64] Furthermore, it is "quite sensible to regard a national Defence Department here as 'producing' maritime, land and air offensive and defensive capabilities - these are intermediate outputs ..."[65]

There were originally 6 Combat Force Programmes (now reduced to 5 with the omission of Air Mobility) and these were, together with their associated objectives:

(1) Nuclear Strategic Foreces - to provide a strategic nuclear retaliatory capability;

(2) Navy General Purpose Combat Forces - to provide a capacity to conduct a varied range of operations at or from the sea;

(3) European Theatre Ground Forces - to provide a land force contribution to the collective defence of Western Europe;

(4) Other Army Combat Forces - to enable the UK to meet certain continuing obligations to allies and alliances, and dependencies;

(5) Air Force General Purpose Combat Forces - to furnish the means for the air defence of the UK and of any territory where UK forces may be based or operating;

(6) Air Mobility - to provide a capacity for moving troops and equipment rapidly.

There were originally 8 General Support Programmes (now reduced to 7 with the omission of Special Materials):

(1) Reserve and Auxiliary Formations;

(2) Research and Development;

(3) Training;

(4) Production, Repair and Associated Facilities in the UK;

(5) War and Contingency Stocks;

(6) Other Support Functions;

(7) Miscellaneous Expenditure and Receipts;

(8) Special Materials.[66]

These major programmes are then subdivided into some six to seven hundred "elements" (e.g. a ship or squadron), although the published version contains only 50-55[67] (and

is on an annual basis). These programme elements "are in the same 'language' as that used by military planners. They therefore help to forge a link between military planning and budgeting processes ..."[68]

The functional analysis of defence expenditure is useful in that it shows

> "the possibilities for, and the implications of, substitution both within and between each of the major programmes ... the programme budget provides information on the costs of maintaining a nuclear deterrent, the 'mix' of nuclear and conventional forces, the geographical distribution of land forces and the weapons composition of sea and air forces: information which is required for any assessment of resource-use in defence".[69]

The traditional input budget however is preferred for the purposes of expenditure control.[70] But whilst the functional and element costing serves as "an important internal planning document for the ministry"[71], the published version gives no information on output indicators[72], is restricted to a one year time horizon, and gives only limited information on programme elements.[73]

The Annual Planning and Budgeting Cycle

Decisions on the allocation of financial resources to defence are supposed "to reflect the needs of defence policy as a whole and not simply a balance between the claims of each service".[74] To ensure this, a central policy and programming group of staffs within the department is provided; which has direct access to the Chief of Defence Staff and the Permanent Under Secretary, the Secretary of State's principal advisers. The central organisation includes the Defence Policy Staff (a mainly

military organisation under the Chiefs of Staff), the Policy, Programmes and Budget divisions (a civilian organisation), and the Scientific Staff, which includes the Defence Operational Analysis Establishment. The central organisation also has links with the Foreign and Commonwealth Office and the Treasury.[75]

The system of resource allocation in defence, as in civilian departments, is integrated with P.E.S.S. The cycle begins in January when the Policy, Programmes and Budget Divisions give "policy assumptions" and "costing instructions" which take into account any agreed policy changes over the past year and include financial guidance for the coming years (based on Treasury instructions for the conduct of the coming year's survey). Between January and May, the Service Departments and Procurement Executive, together with the Department of the Environment (for works and buildings) formulate their plans for the coming 10 years, which are then costed in two ways. The first is the Long Term Costing which gives expenditure under Vote headings. This is then translated into the Functional Costing. The Long Term Costing is forwarded to the Treasury in May and used as the basis of the Defence input to P.E.S.S. The Functional Costing, on the other hand, is used primarily for internal planning purposes. The P.E.S.S. target for the coming financial year sets a limit to the Supply Estimates which are prepared within the department between September and November. The Estimates are discussed and finalised with the Treasury and the Civil Service Department in December and published

in February together with the Annual Statement on the Defence Estimates (the "Defence White Paper").[76]

Defence reviews have also taken place outside of P.E.S.S. and have been "regular" and "frequent" since 1951.[77] The "continuing defence review" of the late 1960s was provoked by the need to cut back on defence expenditure and re-order the structure of national priorities.[78] Perhaps even more than civilian departments, "key defence decisions of recent years have been made within (and are hence intelligible only in terms of) the overall appraisal of Government spending".[79]

Special Studies

The main function of the Defence Policy Staff is "to formulate and carry out military studies concerned with defence policy, including the size, shape and deployment of the armed forces and the distribution of resources within the defence programmes".[80] The Policy, Programmes and Budget Divisions also have responsibilities for "long-term studies in defence policy and with maintaining contact with academic work in the strategic field". The Scientific Staff "are engaged in studies of defence strategy and weapons systems". The programme budget

> "provides the background against which these studies are developed but does not usually contain all the cost information in the form required for the study. The work necessary to produce the programme budget leads however to the development of costing methods and provides cost data which enables costs, and information about manpower and timescales, required for studies to be provided more easily than was possible before the programme budget was prepared."[81]

The Defence Operational Analysis Establishment "makes use of models to study a wide variety of problems".[82] These "usually take the form of mathematical procedures for synthesising a collection of input information to give an estimate of the outcome of a military operation or process". Many are specific to particular problems "but two major techniques of wider application have been employed and developed in support of studies ... - linear programming and gaming ..." This Establishment also undertakes many cost-effectiveness analyses (i.e. the search for least-cost (fixed utility) or greatest utility (fixed-cost) alternatives to achieve defence objectives).[83]

Programme Analysis and Review (discussed in greater detail later on) is also carried out in Defence, though details of the topics studied have not been released. Examples of the subjects of studies are reserve forces, support stocks, and reinforcement capabilities, yet "None of these studies has yet had a major impact on budgetary decisions".[84] Furthermore, "There is no attempt to make all studies part of the annual review cycle".[85]

Concluding Comments

The annual functional analysis of defence expenditure, the public expenditure and other reviews, and the various special studies, are said to be "counterparts" of the three basic elements of P.P.B.S., i.e. the "programme budget", "regular programme reviews", and "special studies".[86] However, "not all the concepts of P.P.B. fit the realities of defence planning". Firstly, the programme budget can

never be directly related to the ultimate objectives of defence. Secondly, the programme budget provides only a very general and incomplete background against which analyses and reviews can be compared and initiated: "the programme budget, or functional costing, is not the chief instrument in allocating resources and reviewing programmes". Finally, planning is said to be the function of the whole of the administrative structure and not just of the central staff. Studies and reviews also need not arise from the annual planning cycle.[87] The "balance" of the defence programme is maintained "by objective, comprehensive study of key issues and the application of a defence viewpoint to the main problems of resource allocation",[88] though key decisions will often still be the result of political bargaining and compromise between the three services, the central organisation, and external pressures.[89]

3.3.3 P.P.B.S. for the Police Service

P.P.B.S. for the police service was the result of a feasibility study within the Home Office during the late 1960s. The responsibilities of the Home Office were, however, considered too varied and unrelated for P.P.B.S. to have illuminated decisions regarding the allocation of resources between e.g. the police and fire services. Hence it was decided to develop the system for just one of its principal responsibilities, the police service.[90] The police service was chosen because the increase in the scale and complexity of police operations, particularly

since the amalgamation of police forces, had focused greater attention on the problems of resource allocation. However, the system "is primarily directed to meeting the needs of individual forces rather than to enhancing the planning capacity of the central Government".[91] This is because direct responsibility for the allocation of resources lies with individual police authorities and not with the central government. The majority of resource allocation decisions are taken by chief constables in relation to local needs.

The Programme Budget

The Home Office drew up a programme structure for the police service which was based upon the "objectives of police activities".[92] There are 9 major programmes, divided into about 80 programme elements:

(1) Operational - Ground Cover;
- Crime Investigation and Control;
- Traffic Control;
- Additional Services.

(2) Support - Management;
- Training;
- Support Services.

(3) Overhead - Pensions;
- Accommodation

Only the first three of these programmes can be said to reflect objectives, the rest being a mixture of activities and inputs. The Home Office preferred this structure to one emphasising the ultimate objectives of policing, i.e.

"the maintenance of law and order, the protection of persons and property, the prevention and detection of crime, the control of road traffic and the giving of help and friendship to those in need", for three main reasons. Firstly, such a programme budget would account for only two thirds of total expenditure, the rest being very difficult to allocate between objectives. Secondly, there would be the obvious difficulty in measuring effectiveness. Thirdly, the programmes would cut across organisational boundaries. Cost data would be difficult to obtain and assign, and control over programme operations would be partial.

The programme elements "are units of identifiable police activity or activities which can readily be arranged in different ways and can be further broken down into territorial or other organisational groupings". Since the programme structure is closely related to the organisational structure P.P.B.S. "can serve the needs of Management by Objectives and Accountable Management". Payments to each policeman, civilian employee, etc. are coded to correspond with the programme to which they contribute. Home Office officials do the initial codings, draw up the programme structure to suit local conditions and generally help with implementation.

Output Measurement and Analysis

Primary emphasis is laid upon the costing side of P.P.B.S. because of the difficulty of measuring output and identifying "significant relationships between expenditure

and environmental factors". Several areas of police work, particularly in the Support programme, are amenable to measurement and analysis, e.g. "routine office work, catering, and vehicle fleet management".[93] But for the overall aims of police work, i.e. those associated with the Operational programme, "there are major problems in discovering and applying objective criteria". For this reason, "the police must set themselves more limited tasks or objectives, such as that of answering calls for help as quickly as possible". These "intermediate" outputs must be recognised as being only part of "total" output. They must be supplemented with qualitative judgments which take into account "the interplay between local needs and national priorities and, in particular, between the police and the other parts of the criminal justice system". The relationship between police work and local authority functions such as traffic and transportation planning must also be taken into consideration.

Review

The review process will obviously vary between police authorities and no general guidance has been given. Small teams of Home Office officials "assist in designing and implementing procedures" which should take around three months. Help is then provided for a further four or five months to deal with any problems which may arise. The first authorities to use the system did not require any additional staff. The only requirements for the system are the "necessary computer facilities" and co-operation

between the force and the police authority treasurer's department.

The information for the programme budget "is available regularly, if necessary on a monthly basis, so that it can be used in the day-to-day management of the service".

Concluding Comments

The system is said to have 3 main benefits. Firstly,

> "It will provide police authorities, Chief Constables and the Home Secretary with more and better information about the policy options by enabling them to look for the first time at expenditure in terms of programmes as well as inputs ... In this way, it will provide a formal mechanism for relating expenditure more closely to recognised social needs so that resources can be applied and seen to be applied where they are most required."

Secondly,

> "Because it organizes expenditure by programme, P.P.B. can improve the planning and forecasting of the expenditure both locally and nationally by relating it more clearly to information about the environment in which the police operates ..."

Thirdly,

> "Because the programme structure is closely aligned to the management structure of a force, P.P.B. can provide the kind of information most appropriate for those concerned with day-to-day management."

The aim of the system is primarily "to help police managers at all levels in a force in taking decisions about resources".[94] It is "much more management-orientated than 'classical' P.P.B., replacing its initial emphasis upon the establishment of a base of much-improved manage-

ment information".[95] As Schick has pointed out,[96] in the context of project PRIME, the attempt to integrate the budgetary functions of planning, management and control means that "planning often loses out".[97]

3.3.4 P.P.B.S. in Local Government

The development of P.P.B.S. in English local government during the late 1960s was closely integrated with parallel developments in corporate planning. Prior to the Maud and Bains Reports[98] of 1967 and 1972 respectively, "local government tended to be seen as a process of administering a collection of services imposed or permitted by statute, and having little or no connection with each other except that they were largely financed from a common source".[99] Maud laid emphasis on a "unified decision making structure"[100] and recommended a "systematic approach" to management which comprised the following elements[101]:

- the periodic review of long-term objectives;
- the periodic review of short-term objectives;
- regular review of the performance of various Services;
- the feedback of information for planning purposes;
- the whole process to be 'cyclical' and following a time-table.[102]

The Bains Report emphasised the "corporate approach" to planning and management, which it defined as "a realistic attempt to plan ahead on an authority-wide basis, to formulate objectives, evaluate alternative methods of achieving those objectives and measure the effectiveness

of ultimate performance against these objectives."[103]

These corporate approaches stemmed mainly from industrial experience with corporate planning and from the American experience with P.P.B.S. The effect of their introduction was a reinterpretation of the local authority's role into the "primary arm of government in a particular area".

The "corporate" aspect of corporate planning "represents an attempt to secure unity of purpose in the affairs of a local authority" as opposed to its previous "federal" nature. The authority would be viewed as a complex system interrelated with its environment. The "planning" aspect "emphasises the adjustment of activities to changing needs and problems". Rational decision-making models would be required to ensure this "responsiveness".[104] Corporate planning can thus be regarded as a systems approach to planning with the primary focus on the level of the local authority as a whole (just as the American system of P.P.B. initially focused on the level of the Federal government as a whole). It differs from P.P.B.S. in that it largely ignores budgeting (the emphasis being on planning), and is authority-wide (whereas P.P.B.S. can operate at any level of budgeting).

Apart from corporate planning, there were other "less publicised" forces leading to P.P.B.S. The greater emphasis on "rolling programmes" in, e.g. road construction, together with concern about rising debt charges led to the search for "methods of forward financial planning and control". And the development of P.P.B.S. by the central

government "focused attention on the approach, partly because in some quarters there is a fear that it will increase central control over local government activities".[105] The Department of the Environment has encouraged the use of P.P.B.S. in local government[106] and other departments, notably the Department of Education and Science and the Department of Health and Social Security, have promoted the system for certain areas of the work of local authorities.[107]

Official definitions of P.P.B.S. in local government have emphasised the corporate planning dimension:

> "It is not a technique but a comprehensive system of corporate planning and controls which harness analytical techniques to the needs and process of management"[108]

> "Programme Budgeting is primarily a system associated with corporate management which identifies alternative policies, presents the implications of their adoption and provides for the efficient control of those policies chosen. It embraces several established concepts and analytical techniques within the framework of a systematic approach to decision-making, planning, management and control. The principal features of Programme Budgeting are that it relates to objectives, it relates to output, it deals comprehensively with all relevant data, it emphasises the future and it emphasises choice."[109]

Many local authorities, before and after reorganisation (structural changes once again facilitating the implementation of P.P.B.S.) have used the system, including the Greater London Council, Coventry, Gloucestershire, Teeside, Liverpool, Islington and Derbyshire, although the "degree of formality" and the "breadth of the approach" have varied enormously.[110]

3.3.5 P.P.B.S. in the Department of Education and Science

Introduction

The feasibility study on P.P.B.S. for the Department of Education and Science was carried out jointly by the Department and the Treasury Management Accounting Unit between November 1967 and January 1969.[111] The reasons for its consideration were basically economic. The 1970 feasibility study quoted the Joint Permanent Secretary to the Treasury who highlighted the basic principle of economics that scarcity necessitates choice:

> "When governments took less of the country's resources than now, the main question was whether they should do more. As they have taken more and more resources, that question has been changing into one of making choices, rejecting one thing in order to be able to do another."[112]

As Plowden pointed out,[113] the original purpose of public expenditure control was one of "propriety"; now it is one of "efficiency". P.P.B.S. would "help in the planning, management and control of public expenditure and of the resources used by the public sector" and "enable the Department both to allocate more effectively the resources made available to it, and to argue more cogently for its share of public expenditure."[114]

The feasibility study initially used the term "output budgeting" but "programme budgeting" or "planning, programming, budgeting" has since been preferred both by the DES and by the Commons Expenditure Committee because of the difficulty in measuring output.[115] P.P.B. was defined as a system for determining:-

(1) Departmental objectives;

(2) The activities contributing to these objectives;

(3) The resources or inputs devoted to these activities;

(4) The achievement or outputs of these activities.[116]

P.P.B. is said to be a way of "carrying further the ideas implicit in the annual work of P.E.S.C. ... by relating expenditure to objectives, rather than simply to functions, by looking at what is being achieved and by taking into account, where appropriate, costs other than public expenditure costs" (though ignoring "second and third order effects")[117]

There are 3 "essential elements" to the system:-

(1) "the allocation of expenditure to programmes which are as closely identified as is practicable with objectives. This is the programme budget which shows, for each programme, expenditure-proposed, forecast or actual - and whatever quantitative measures of output can be meaningfully constructed and used on a regular basis";

(2) "the systematic review of programmes on a regular basis ... this involves the questioning of the continued validity of objectives as well as the consideration of alternative ways of achieving them and of progress made so far";

(3) "special studies, either to establish the value for money of alternative ways of achieving given objectives, or to evaluate the progress made towards achieving particular objectives if this information is not available on a regular basis".[118]

Because of the difficulty of measuring final output, most work would be concentrated on the first element, the programme budget. This would be similar to "functional costing" except that functions would be related to objectives rather than to institutions as in the public

expenditure survey. The assessment of final output "poses severe problems", but even without this, its advantages are that:-

(1) "by directing attention to final objectives, even where success in achieving them cannot be measured, it can suggest improved methods of assessing the success of a programme of expenditure";

(2) "it provides a framework for assessing systematically how resources are being used";

(3) "it crosses institutional boundaries, so illuminating policy choices which might otherwise have been obscured".[119]

P.P.B. for Education

The DES is responsible for:

- all education in England and post-school education in Wales;
- Government policy for universities in England, Wales and Scotland;
- Government support for civil science, and for policy for the arts, libraries and museums.[120]

The feasibility study identified 3 "main objectives" to which their existing activities were contributing:-

(1) To meet the needs of the community for education and the requirements of the community for educated manpower ("Education");

(2) "to increase human knowledge" ("Research");

(3) "to enrich the quality of people's cultural and recreational activities".[121]

However, P.P.B. was applied only to the "education" block of objectives,[122] mainly because there was insufficient information on cost allocation and outputs for research

and cultural and recreational activities. Education tends to be "more homogeneous and is, on the whole, fairly predictable".[123] According to G.Fowler, Minister of State in the DES from 1969 to 1970, the education service is "self-contained", has "objectives not directly related to those of other public services", is "more isolated from the government machine than many other departments", and "has not of late been subject to sudden crises at national level"[124] (although more recently education has been subject to a "good deal of controversy" and the need for "self-examination"[125]) Education is more "predictable" because so much of educational expenditure is determined by demographic factors. It is more "homogeneous", "self-contained", and "isolated" because its effects on other public activities are not so direct or so evident. The relative absence of "sudden crises" is due to the fact that education is a commonly-held value. Planning is facilitated when the consequences of an activity are fairly predictable and self-contained, and are commonly valued. The difficulty, as far as P.P.B. is concerned, arises in measuring and ranking the full set of consequences.

Further reasons given for choosing education were:-

- the assumption of responsibility in 1964 for universities, civil science, and government support for the arts;
- the increase in central and local government spending on education from 4.4% of GNP in 1960/61 to 6.2% in 1969/70.[126]

The Programme Budget

The structure of the programme budget had to take account of the nature of the educational system in England and Wales. The organising principle of the education system is one of "decentralisation" since it operates on the basis of a "distribution of power" or "partnership" between the central government, local education authorities, and the teaching profession. It is a "national system locally administered". The 1944 Education Act, and subsequent legislation, gives the Secretary of State overall responsibility for all education in England, post-school education in Wales, and for government policy and support for British universities. His role is to "promote the education of the people of England and Wales", and to watch over "the progressive development of institutions devoted to that purpose". He is also ultimately responsible for the maintenance of minimum educational standards. The day-to-day operation of the service is however left to local authorities. The choice of text books and timetables is the responsibility of the headmaster, and the content and method of daily teaching is left to the individual teacher. Universities have complete academic freedom, and receive grants from the University Grants Committee.[127]

In exercising its responsibilities for education, the DES carried out the following functions:

- the broad allocation of resources for education;
- the rate and distribution of educational building;
- the supply, training and superannuation of teachers;
- the commissioning of research related to policy requirements and assisting in the development of

school curriculum and examinations through, e.g. the Schools Council;

- maintains basic national educational standards with the assistance of Her Majesty's Inspectorate;
- more long-term, less direct influence over, e.g. the elimination of all-age schools, secondary reorganisation, polytechnics, etc.[128]

The DES is a small department, "being almost entirely concerned with the formation of national policies for education rather than with executive functions". It exercises its influence primarily through "the broad allocation of resources and by influencing its partners in the system."[129] DES planning is "resource-oriented, being concerned primarily with options of scale, organisation and cost rather than educational content", content being the "preserve of the local authority and individual institution". The DES "does not plan education itself - curricula, pedagogical and professional matters are, by long tradition in this country, matters which the central government does not control".[130] About 85% of total expenditure on education is incurred by local education authorities and financed through local revenue and the Rate Support Grant (which the DES can influence but not control), and about three quarters of this is predetermined by demographic factors.[131] These factors led to 3 main conclusions for the use of P.P.B.S. in education:-

(1) "because the Department's influence is on the whole long-term rather than short-term, general rather than detailed, the system for education should be conceived of essentially as an instrument of planning rather than of detailed control";

(2) "the duties laid upon the Secretary of Stage by ... the 1944 Education Act imply that the Department needs to be aware of developments in the education system, and in particular of policy choices that may arise";

(3) P.P.B.S. may, "by the way in which it indicates alternative means of obtaining the same end, itself raise questions about the structure of decision-taking ..."[132]

(a) The Objectives of Education

The ultimate objectives of education were given as:-

- "educational", i.e. the learning of basic skills and the promotion of individual talents;
- "economic", i.e. the provision of a skilled, flexible and motivated labour force;
- "cultural", i.e. teaching a sensitivity to the arts; the transmission of "standards of citizenship" etc;
- "social", i.e. preparing young people for the society in which they live.[133]

These benefits would be both individual and social, and of an investment and consumption nature. However, most educational activities contribute to most of these objectives, thereby making a programme structure on these lines almost impossible to construct. Educational activities could be structured according to subject, institution, or to the groups at which education is aimed. P.E.S.S. structures education according to institutions. The division into major programmes by groups, or the levels of education, was however chosen because it had the advantage of being more related to the objectives of the system and to a "flow model" of the education process. Eight major programmes were chosen:

(1) Compulsory education (primary and secondary); Objective: highest possible educational standard;

(2) Nursery education; Objective: child's development and social adjustment; the release of mothers for work;

(3) Education for the 15 year old (a transitional programme later replaced by a subdivision of the compulsory programme into primary and secondary); Objective: highest possible educational standard;

(4) Education for the 16-19 year old; Objective: to meet the demand from those who would profit by it educationally or economically;

(5) Higher education (not degree or equivalent); Objective: for individual benefit or social manpower requirements;

(6) Higher education (degree or equivalent); Objective: for individual benefit or social manpower requirements;

(7) Postgraduate education; Objective: to meet the requirements of society for highly qualified manpower;

(8) Educational infrastructure (e.g. administration, inspection, research).

(b) The Sub-Programme Structure

The major programmes are structured according to the groups for whom education is provided (and related to age at the lower end and educational level at the higher end). The sub-programme structure, or second dimension,

distinguishes the main factors affecting educational expenditure:-[134]

(1) Existing Pattern and Scale of Provision

- existing numbers and standards;
- population growth;
- population shift

(2) Cost Reduction

- reduction in the cost of provision to existing standards.

(3) Improvements

- change in the proportion of age groups in public education;
- change in the proportion in different establishments;
- improvements in building;
- improvements in staffing;
- other improvements.

This structure was chosen because the DES is concerned mainly with planning the total expenditure on the educational system:

> " ... changes in the allocation of resources are taking place, not as the result of particular objectives of the Department, but as the result of numerous decisions in individual local authorities and institutions and in some cases as the result of pressures of 'demand' rather than as the result of changes in policy ... Moreover, the main calls on total resources devoted to education are the maintenance of existing standards and provision for increases in the child population."

Output Measurement and Analysis

The feasibility study wrote that there were "as yet no complete and reliable measures of final output."[135]

Some measures of the "consumption" benefits of education "might be possible", e.g. the standard of educational buildings. Investment benefits are of two types: extra-educational (economic, social and cultural); and intra-educational (the performance of pupils and students inside the educational system). The measurement of extra-educational benefits should include both the benefits to society as well as to the individual, though it is much more difficult to do the former.

A lot of work has been carried out in the United States to determine the economic return to education. In 1970, the DES was said to be "currently collecting information on the relationship between earnings and qualifications in England and Wales and it hoped that this will provide some indication of the economic return to different types of higher education in this country". This could be supplemented by employers' assessments of the quality of school leavers. The main difficulty with these economic assessments is the long time lag between education and benefits, and the fact that returns to compulsory education cannot be evaluated because there exists no group of children who have not received this type of education.[136]

There has been less work done on the non-economic returns to education. Progress here would be "fairly slow". Some form of "social adjustment indicator" was said to be needed, e.g. the "rate of juvenile delinquency ... to appraise the Educational Priority Area programme". Measurement of the cultural returns to education is

"likely to be even more difficult".

The intra-educational benefits will arise after a much shorter time lag than the extra-educational benefits. Progress will involve the development of "existing means of assessment", e.g. tests of reading ability, mathematics, languages and creativity. Assessment here is "essentially a matter for educationalists, whereas extra-educational output falls to be assessed by people less immediately concerned with the educational system, such as employers, sociologists, economists".

Because of all these difficulties, it was decided to make "considerable use of intermediate measures of output" such as staff ratios, and the numbers of people staying on after school. These must, however, be judged against final outputs, e.g. "the relationship between improving staff ratios ... and ... improvements in pupils' achievements".[137]

A more recent innovation has been the Assessment of Performance Unit which was announced in the 1974 White Paper on Educational Disadvantage (Cmnd. 5720) and set up in 1975 within Schools Branch III (which deals with the curriculum and examinations).[138] Its terms of reference are:

> "to promote the development of methods of assessing and monitoring the achievement of children at school, and to seek to identify the incidence of under-achievement".

Monitoring performance in mathematics has begun and test materials are being developed in both languages and science. The feasibility of monitoring personal and social development, aesthetic and physical development, is being

investigated. These developments have taken place outside of P.P.B.S. but the overall aim "will be to contribute to the background against which decisions about resources are taken and to provide the basis for a genuine debate about educational performance".

Mention must also be made of Programme Analysis and Review. There is evidence that the White Paper, "Education: A Framework for Expansion" (Cmnd. 5174) of December 1972 may have been at least partly based on "special studies" or P.A.R.s associated with the "Department's programme budget"[139]. Since 1972 there have been two major P.A.R.s on higher education (internal) and on the 16-19 year old group "entering the world of work" (interdepartmental). Other P.A.R.s have been more ad hoc, e.g. on the education of foreign students, an area involving little public expenditure.[140]

The Review Process

(a) The Departmental Planning Organisation (DPO)

The DPO was established in February 1971.[141] For education, it comprises two policy groups, A and B for higher, further and adult education, and for schools and the 16-19 year old group in further education, respectively. Each represents several policy branches, and both are accountable to the Policy Steering Group under the chairmanship of the Permanent Secretary. The Planning and Programmes Branch services the DPO. The DPO is not, however, a separate organisation, but "simply the officials of the Department with their thinking caps on".[142] Indeed

the number of additional staff employed for the introduction of P.P.B.S. in the DES (as also in other British cases) was very small compared with the U.S. (and also France).[143] The Planning and Programmes Branch has been criticised for being merely a "secretariat", composed mainly of "traditional 'administrative' civil servants."[144]

The DPO has two main functions: "to establish what is going on"; and to "help Ministers to decide what they would like to have going on". The department's "programme budget" is used as a 'tool' to help determine "what is going on now under present policies and trends, and where these policies and trends will take the education service if no deliberate changes are made". It's functions are:-

> "to show the determinants of educational expenditure - how much of it is needed to maintain standards in the face of population increases, how much is needed to cater for the growth in the numbers choosing to participate in education, how much is needed to accomplish planned improvements in the service, etc. Other analyses within the programme budget show the relative importance of various institutions at each level of education, and the share of expenditure attributable to various resource inputs (teachers, other staff, buildings, etc.). It thus serves as a useful guide to relative magnitudes in the educational expenditure field."[145]

The DPO has, however, been criticised particularly by the CECD and the Commons Expenditure Committee and witnesses for the "secrecy" and "passivity" of much of its planning.[146]

(b) Development of the Review Process

Since the feasibility study indicated that P.P.B.S. could provide an improved framework for educational policy-making, work began towards producing a "fully operational system" in 1969.[147] The figures in the study being only a

"very rough reallocation of P.E.S.C. data into P.P.B. categories", "more detailed calculations" were needed for a "real test of the practicability of the new system". The 1969 programme budget however took too long to prepare for use as a policy-making instrument and was incomplete in that too little detail was given on "improvement" programmes, i.e. those subject to departmental influence. A second trial exercise was carried out in 1970. It took 8 months to complete and gave more information on improvement programmes, but was still outside of the P.E.S.S. timetable. A third exercise was begun in 1971 and included improvements such as an extension of expenditure programmes to 10 years ahead instead of 5 years, and comparisons of past forecasts with actual out-turns. Up to 1974 programme budgets were produced twice yearly.[148]

Concluding Comments

A senior DES official told the Commons Expenditure Committee that "output budgeting" is possibly a "misnomer" and that what the DES were working on was merely an "input budgeting system" or a "reordering of our financial information."[149] However, the system was said to have helped the department to obtain

> "a much clearer picture of where our expenditure is going and is planned to go over the period to which our programme budget relates in terms of the stages of education which the expenditure supports, the change in the number of participants in each stage, whether school children or students, and changes in the standard of provisions being offered at each stage, whether improvements in premises, staffing or otherwise."[150]

However, the system was not a "durable" one. Early in 1977 an informal internal DES memorandum was circulated with the instruction to phase out the preparation of the programme budget.[151] The most enthusiastic period had been between 1972 and 1974, but the series of economic crises between 1974 and 1976 necessitating frequent budgets and expenditure cutbacks, and the time consuming nature of programming, all conspired against the system. A senior DES official listed ten reasons for its failure:-

(1) It was "always behind the game". The programme budget was either never ready in time for P.E.S.S. or not sufficiently up-to-date.

(2) It was considered not useful to the Policy Steering Group for the kind of decisions that had to be made.

(3) It was highly manpower intensive.

(4) It was too complicated to produce and understand.

(5) It was not sufficiently flexible.

(6) The DES is organised on an institutional basis and it was felt that budgeting had to be on the same basis. For example, there was no departmental structure for the 16-19 age group.

(7) The assumptions fed into the system were those of "planners and backgroom boys" and not of policy-makers. The feasibility study was carried out at the time when the department had a Planning Branch, separate from day-to-day administration. The DES now has a Planning and Programmes Branch which supports the Policy Steering Group and the Policy Groups A and B rather than plans on its own.

Planning is now a dispersed responsibility and this is felt to be more effective than having a planning organisation divorced from the day-to-day work of the department. If planning and P.P.B.S. are the responsibility of everyone, they end up being nobody's responsibility!

(8) There were difficulties with the reclassification of expenditures and with the allocation of costs.

(9) The system was not useful for policy-making since the "practice" (not the "theory") was that decisions for P.E.S.S., the Rate Support Grant, the University Grants Committee, and Parliament, etc. had to be made regularly and not on a fixed P.P.B. timetable.

(10) "People don't like it!" The system produced "considerable" amounts of "paper" which no-one wanted to read or could meaningfully interpret. The whole system was "not worth the effort". It was also found to be "very difficult to involve Ministers in planning".

3.4 PROGRAMME ANALYSIS AND REVIEW AND THE CENTRAL POLICY REVIEW STAFF

3.4.1 Introduction

The aims of the "new style of government" announced in the White Paper of October 1970, "The Reorganisation of Central Government"[152] were:-

" (i) To improve the quality of policy formation and decision-taking in government by presenting Ministers, collectively in Cabinet and individually within their departments, with well-defined options, costed where possible, and relating the choice between options to

the contribution they can make to meeting national needs. This is not confined to new decisions, but implies also the continuing examination, on a systematic and critical basis, of the existing activities of government.

(ii) To improve the framework within which public policy is formulated by matching the field of responsibility of government departments to coherent fields of policy and administration.

(iii) To ensure that the government machine responds and adapts itself to new policies and programmes as these emerge, within the broad framework of the main departmental fields of responsibility."

Apart from the "functional" reorganisation of departments, these aims were implemented through Programme Analysis and Review (P.A.R.) and the Central Policy Review Staff (C.P.R.S.)

3.4.2 Programme Analysis and Review

(a) Origins

PAR was born of the conjunction of viewpoints of the Conservative Opposition during 1964 to 1970, and of top civil servants (often a necessary precondition for success)[153] These were years of great enthusiasm for the new "rational" budgeting technique in America called P.P.B.S. and the Conservatives assembled a team of 18 businessmen from such firms as Shell International, Marks and Spencers, RTZ and Hambros to try to introduce a similar system in Britain when they were next in power.[154] The Treasury also wanted to extend the P.E.S. system into an examination of existing programmes, but favoured a more cautious approach than that attempted in the United States.[155] Both were cognizant

of the problems encountered in America and the move to a more selective analytical approach, and of the need to integrate any new system with P.E.S.S. The P.A.R. system was introduced on January 14th 1971, and co-ordinated by the Treasury Management Accounting Unit (now by Central Expenditure Policy Division 3).[156]

(b) P.A.R. : The Intention

P.A.R. was not intended as a revolutionary new technique. Some departments had already developed work on cost-benefit and cost-effectiveness analyses.[157] These previous studies and analyses had considered "objectives", measured "resource inputs" and "outputs obtained", and presented "alternative courses for decision with full supporting information about the effects of each of those courses."[158] But what was different about P.A.R., according to the Treasury, was that these features would be applied "systematically and regularly to a wide choice of programmes from across the whole field of government". There would also be "closer consideration" of objectives, "more attention" to the relationship between inputs and outputs, and a "wider review" of alternatives.[159] The aim of P.A.R. is "to get better value for public money and to achieve a more selective approach to the use of public expenditure". The system would be a "complement and reinforcement" to the P.E.S. system, supporting departmental submissions.[160]

According to J.B.B.Hunt, Treasury Deputy Secretary and chairman of P.E.S.S,[161] the public expenditure survey

is a "systematic and comprehensive operation" which enables Ministers to "settle broad allocations to the public sector and priorities within it". What it does not do, and what P.A.R. is intended to supply, is a "penetrating analysis of the purposes intended to be served by programmes, the effectiveness of existing policies in serving them and alternative policies". P.A.R. is supposed:

(1) "to contribute to the Government's overall strategy by focussing issues for collective ministerial consideration";

(2) to be the "instrument" of that strategy by "testing departmental objectives against it", and

(3) "to bring under regular review the major ongoing programmes" because of the "risk of ... inertia".

P.A.R. would "supplement" P.E.S.S. by "widening the margin of choice for Ministers through a more radical analysis of programme objectives and the means used to achieve them". It would have "relevance to the centre and in particular to Government strategy, to the work of the C.P.R.S. and so on", and to the department in "improved management information and planning". The function of P.E.S.S. is "essentially to aggregate" whilst the function of P.A.R. is "selective rather than comprehensive". Selection, though, would not be on an ad hoc basis, but taken only "after review of the whole field" with the "main criteria" being the "relevance of programmes to the general strategy of the Government, their relevance to the main objectives of Departments and their importance in the field of public

expenditure". Ministers would "approve the selection of topics", "be responsible individually for each review by their own Department", and would "consider results collectively" (hence the emphasis on "Review" in Programme Analysis and Review.[162]

P.A.R. was not, however, to consist solely of annual programme reviews, but was to include work on the "development of programme structures" for departments and on improving the "information base for decision-taking". It would have a "pervasive", "self-questioning" effect, since it is not a "technique" but a "systematic approach to general management."[163] But although P.A.R. is "intended to encourage a more systematic comparison of options and alternatives" it would be "no substitute for judgment or imagination"[164] : "there is at the moment no technique in the cost-benefit field which will enable you to compare the cost-benefit results of a mile of motorway with a hospital."[165]

According to R.J.East, one of the businessmen brought into the civil service under the Conservative government,[166] P.A.R. would be an essential element in the introduction of "corporate planning" from the private to the public sector. His implicit definition of corporate planning was "comparison between major programmes both within and across the boundaries of major departments" for the strategic functions of resource allocation between competing demands". The corporate concept, however, is a misleading one and often appears to embrace two different ideas. Its original American definition was that of strategic or long-

term planning for a business corporation.[167] In this country the concept has been taken by the public sector to mean a systems approach to planning aimed at the government-wide level.

P.A.R. would be a "selective process in which issues are systematically identified for further study" from a "broad, essentially overall strategic look across the whole area of policy in a way which facilitates the clear identification of major emerging issues which justify thorough depth programme analysis". Examples of analytical techniques used would be "cost-benefit analysis, cost-effectiveness analysis, operational research, and so on."[168] P.A.R. has a "cousin relationship" to American P.P.B.S., but is "very much a native version and is different in a number of respects." It corresponds to the "second or third stage" of "classical" P.P.B.S.[169] P.A.R. topic selection correspond with the Issue Letter sequence in the U.S. and the subsequent P.A.R. report is similar to a Program Memorandum.[170] P.A.R. has "affinities" with the French system of Rationalisation des Choix Budgétaires[171] and a "history" in "corporate planning". It would not be a "substitute for political judgment" and would not provide "figures and information for their own sake" : "This is the trap into which some of our Transatlantic friends have fallen".

The P.A.R. process would be as follows:-

(1) "defining objectives";

(2) "bringing together all activities which contribute to an objective or group of objectives and a record

of the resources being devoted to those activities";

(3) a search for the "main determinants ... of the use of resources" in order to consider "to what extent those determinants could be influenced by policy or not" and including a "wide range of possibilities for influencing the determinants."

(4) "Next we want to do our best to see what we are getting for the resources in terms of outputs", but "very often it is necessary in the public sector to settle for intermediate measures of output" such as the "numbers of people who have been adequately housed, or reduced accident rates, or reduced congestion on the roads."

The studies would take into account the "resources being devoted in the private sector to the same objectives." They would not necessarily exclude concentration on immediate or short-term problems.[172]

(c) P.A.R. : The Experience

A Treasury official has said that "P.A.R. is like programme budgeting without a programme budget."[173] The original idea for comprehensive programme structure for all departments proved overambitious[174] which effectively must have rendered P.A.R. topic selection unsystematic. The incoming business advisers also had to accommodate themselves to the fact that British central government is a "federation of departments" relying on "community relationships" largely and traditionally monopolised by the Treasury, and that private sector ideas of centralised,

hierarchical authority structures simply do not work in Whitehall.[175] This is one of the main drawbacks of the P.A.R. system as currently operated. P.A.R.s are perceived as benefitting the Treasury alone (cf. Bureau of the Budget/Agency relationships under the Programme Memorandum system), despite the intentions.[176] As for ministerial review, very often Ministers do not know of the existence of P.A.R. activity within their departments until a report is presented.[177]

The content of P.A.R. studies is also far from comprehensive. Two approaches have evolved: "Objective" P.A.R.s and "Instrument" P.A.R.s.[178] Objective P.A.R.s are "for topics of fairly clear definition and available options generally not too difficult to find". Instrument P.A.R.s are "concerned with activities, organisations, or institutions which exist to achieve certain ends, are not the only means of doing so, but are sufficiently important to be studied in their own right." They study "the way of doing something where the objective is relatively clear."[179]

But it is in procedure and not in content that P.A.R. differs from previous analyses.[180] Topics are usually initiated within departments in consultation with the Treasury and the C.P.R.S. and approved by Cabinet committee. The Treasury process is co-ordinated by the Programme Analysis and Review Committee (P.A.R.C.) which is composed of departmental representatives (half of whom are the same finance officers sitting on the Public Expenditure Survey Committee) and Treasury Under Secretaries, and chaired by the head of P.E.S.C.[181] When the P.A.R. study has been

completed, the report is sent by the Minister to the Cabinet. All aspects of the process, however, are subject to political bargaining rather than objective calculation based on a comprehensive programme structure.[182] Departments, as advocates, use P.A.R.s as part of their overall strategy for gaining a greater share of public money. They will push for the selection of topics in growth areas and avoid the analysis of programmes which are liable to be cut. It is perhaps an exaggeration to say that P.E.S.S. and P.A.R. are potentially in conflict,[183] but if the former sets ceilings and the latter is used to try to get out of these ceilings, then the two are far from complementary.

Finally, P.A.R. studies do not appear to have been very effective. Lord Diamond[184] has concluded that "no P.A.R. study has resulted in a change of policy". Another ex-Minister, with experience of the P.A.R. process, has declared that studies have been so uninformative and generally "low-grade" that action on them is often precluded.[185] The number of studies has dwindled over the years, and currently each department normally submits no more than one per annum. Some departments have never submitted any![186]

3.4.3 The Central Policy Review Staff

The C.P.R.S. was originally meant to be a "Central Capability Department" with a "corporate management" function.[187] It was to be composed of the public expenditure side of the Treasury, the managerial functions of the Civil Service Department, and the secretarial services of

the Cabinet Office.[188] However, the ensuing political opposition to this functional division was aimed mainly at the Treasury's loss of expenditure control and the additional hierarchy above ministerial level.[189] The C.P.R.S. was the watered-down result of these deliberations and was assigned to the Cabinet Office.

According to the White Paper,[190] the C.P.R.S. "will be at the disposal of the Government as a whole. Under the supervision of the Prime Minister, it will work for Ministers collectively". It would assist Ministers:-

(1) To relate specific programmes to the government's overall strategy;

(2) To establish priorities between programmes;

(3) To identify alternative policies and objectives;

(4) To analyse the consequences of alternatives.

The C.P.R.S., however, is an addition to existing central institutions and a competitor to them in the sense of creating an additional and overlapping decision-making function rather than the original intention of a reorganised centre.[191] It is "insulated from the public expenditure process and that is not a good idea, because it makes it hard to get into things."[192] It must also depend on the departments for much of its analytical responsibilities:[193]

> "The new staff will not duplicate or replace the analytical work done by departments in their own areas of responsibility. But it will seek to enlist their co-operation in its task of relating individual departmental policies to the Government's strategy as a whole. It will therefore play an important part in the extended public expenditure survey process ... and it will also be available to promote studies in depth of

interdepartmental issues which are of particular importance in relation to the control and development of the Government's strategic objectives"[194]

These "higher level"[195] issues which are its concern run "across the frontiers of normal departmental responsibility" or raise "what is regarded as a basic issue of government strategy" or are "thought to require a second opinion to test against an entrenched departmental view."[196] Examples have been Concorde, regional policy, population growth, the computer industry, research and development, shipbuilding, coal, public expenditure, nuclear reactors, energy conservation, race relations, worker participation, electric cars, and most recently, the Review of Overseas Representation.[197] Each report ends with "precise recommendations for action."[198] Half of the "Think Tank's" team were recruited from outside the Civil Service, and the team have authority to consult outside interests. This often results in its advice being of a "political" nature.[199]

An evaluation of the C.P.R.S. can best be reflected in the "precise", "comprehensible" and "accurate" summary of the team's functions as reported by Lord Rothschild:

"- sabotaging the over-smooth functioning of the machinery of Government;

- providing a central department which has no departmental axe to grind but does have overt policy status and which can attempt a synoptic view of policy;

- provide a central reinforcement for those civil servants in Whitehall who are trying to retain their creativity and not be totally submerged in the bureaucracy;

- try to devise a more rational system of decision-making between competing programmes;

"- advise the Cabinet collectively, and the Prime Minister, on major issues of policy relating to the Government's strategy;

- focus the attention of ministers on the right questions to ask about their own colleagues' business;

- bring in ideas from the outside world."[200]

3.5 CONCLUSIONS

The British innovations described in this chapter can be divided broadly into two groups:

(1) Integrated P.P.B. systems;

(2) Output analysis extensions to P.E.S.S.

The systems in Defence, the Police Service, local authorities, and Education were attempts to introduce the whole concept of P.P.B.S. They were initiated under Labour governments and were primarily designed for intradepartmental use. The second group of innovations were Conservative. P.A.R. (and the C.P.R.S.) were put forward as Conservative solutions to public expenditure problems conceived as having originated under the previous Labour administration. They were primarily designed for interdepartmental, government-wide use, a reflection of the business-minded Conservatives' concern with "corporate" planning. The problems of P.P.B.S. will again be shown in terms of political, structural and cognitive constraints.

Political

Defence and police services are examples of pure public goods and as such have no distributional problems. The number of objectives is less than in the case of social programmes, and much of decision-making is secret. These factors, common to both Britain and America, ensure a smaller political input to the decision-

making process. Education, as a quasi-public good, has a greater number of objectives, distributional effects (although the intensity of any disagreement need not be as great as that in defence - equal provisions does not necessarily mean equal marginal utility), and a more open decision-making process. These factors ensure a greater political input to the decision-making process. The nature of responsibilities towards the product is similar in the case of, e.g. defence, but in the social field, e.g. education responsibilities in this country are considerably more centralised and local authorities are creatures of Parliament. Political constraints are therefore not so great.

Structural

Structural problems are again not so great in this country because of the greater centralisation of decision-making and integration of activities. However, even in a completely centralised function like defence, organisational structures rarely coincide with programme structures, thereby creating difficulties for costing, resource allocation and management. Greater centralisation also aids the implementation of change, but a problem common to both Britain and America is the short-term fixedness of resources and the lack of finance.

Cognitive

Defence activities, as has already been explained in the last chapter, are more amenable to scientific analysis than, e.g. education (although ultimate problems of "deterrence" and "security" are more intractable). Problems are thus common to both countries. However, the nature of the responsibilities towards the product and the degree of analytical effort applied

to problems vary between Britain and America. The DES has overall responsibility for education, particularly resource planning, whereas HEW is more concerned with selective support to disadvantaged groups. Local authorities, though statutorily independent, have limited responsibilities and the nature of their services has traditionally rendered them relatively free from political controversy.

Development of the Concept

The British approach was more cautious and selective than in the U.S., reflecting both the development of the concept in America and a particular cultural orientation.[201] The emphasis in this country was primarily on budgeting within a department rather than budgeting to a department, one of the aims being to avoid any unnecessary Treasury intervention in departmental affairs. Even with the interdepartmental innovations of P.A.R. and the C.P.R.S., the Treasury was "willing to give up a good deal of formal sophistication in return for winning departments' co-operation",[202] exemplifying the British "elite culture's" "absorption" of conflict through "mutual trust".[203] Furthermore, to ensure viability, procedural arrangements were de-emphasised. Departments were encouraged to choose those elements of the system which were of most use to their decision-making responsibilities. Outside the P.A.R., there were no requirements for formal submissions to the Treasury comparable with the American system of Program Memoranda.

The rest, and main emphasis, of the thesis will now focus upon an examination of the P.P.B. system in the health and personal social services, "the most recent, and probably most significant" of the attempts made so far.[204]

CHAPTER 4

THE PLANNING, PROGRAMMING, BUDGETING SYSTEM FOR THE HEALTH AND PERSONAL SOCIAL SERVICES : INTRODUCTION

CHAPTER 4

LIST OF CONTENTS

4.1 INTRODUCTION

Chapters 1-3 have shown that there are 3 basic arguments against the general application of the Defense model of P.P.B.S. These are:

(1) Political

Budgeting is a highly political activity and therefore anti-analytic,[1] and P.P.B.S. is undemocratic since it forces the centralisation of decision-making and the objective calculation of interpersonal utility as opposed to "polycentric" bargaining and partisan mutual adjustment.[2] American political culture stresses the political "rationality" of incremental budgeting[3] whereby differing "conceptions of purpose"[4] are resolved through accepted "decision structures".[5] This political view, however, fails to take account of differing contextual factors. Political constraints have been shown to be far less in this country. Furthermore, the number and intensity of political inputs has been shown to vary according to the specific characteristics of the product or service, e.g. the degree of "publicness" and distributional effects, the number of objectives, the degree of expertise required, and the nature of delivery, and to the nature of the organisation's responsibilities towards the product, e.g. limited local functions.

(2) Structural

There are severe limits to organisational adaptability and change. Organisational structures have been shown rarely to coincide with an objective-oriented programme structure but the degree of coincidence varies with the nature of the technology and the number of objectives. For the two to coincide, "the

technology of the activity must be such that the work of the agency can be broken into distinct portions, each contributing primarily toward one, and only one, of the subsidiary objectives."[6] Problems will also be magnified when combined with programmes having multiple objectives, as in the social field. The consequent difficulties of costing, allocation and management have thus often been alleviated by using a programme structure closer to the organisation structure, e.g. in the police services. Problems in this respect have also varied between cultures. They are much greater in America where responsibilities are decentralised and often overlap or conflict. A second set of problems relates to the fact that resources are often relatively fixed or unavailable in the short-term and activities often become committed over time, particularly as the supply of services which are provided free at the point of use creates a demand which is often difficult to extinguish. These problems will be greater with respect to services requiring specialised equipment and highly trained manpower. They will also be magnified in the U.S. context where the pluralistic and decentralised decision-making structure promotes rigidities.

(3) Cognitive

"No one can do P.P.B.S."[7] This cognitive view exaggerates the lack of knowledge and information which would enable the calculation of the consequences of alternative courses of action. The lack of knowledge on social production functions in the U.S.A. forced a concentration on those benefits which were quantifiable, e.g. economic. Problems were shown to vary according to the nature of the product and responsibilities, e.g. the DES focused

on the "scale, organisation and cost"[8] of services. Cognitive problems, though great, were not however considered as important as the political. P.P.B.S. "always fails for lack of knowledge, when and if it is allowed to get that far".[9]

The critics of P.P.B.S. failed to relate general statements to particular contexts of budgeting just as the proponents of P.P.B.S. failed to appreciate the difficulties of applying the defense model to civil agencies. The aim of the rest of this thesis, therefore, is to test this hypothesis of political, structural and cognitive contextual factors in the case of the English health and personal social services.

This and the next two chapters will be set out in terms of the stages of the P.P.B. process. This sequence of stages for setting up and operating a P.P.B. system can be listed as follows:

(1) Planning -

(a) a feasibility study to determine the applicability of the system to the needs of the organisation. This is the "Research and Development" stage of P.P.B.S., a stage which was noticeably absent in America. Apart from general reappraisals of the system from time to time, this phase occurs in Year 1 only.

(b) the design of a programme structure of objectives, together with criteria for the evaluation of performance, which can be modified in future years as and when necessary.

(c) an analysis of the base-case in terms of the programme structure, and the identification of trends and future resource assumptions. This description of the existing

situation in terms of objectives will set the stage for the next phase.

(d) the analysis and comparison of base-case and alternatives in terms of the structure of objectives, leading to the selection of one or more preferred options, together with their associated objectives.

(2) Programming -

the more detailed analysis and costing of the chosen alternatives, leading to the preparation of the programme budget after programme choice. The programming phase, however, closely interacts with planning "by bringing together programs and costs by major program and program element ..."[10]

(3) Budgeting -

financial authorisation usually through a detailed line-item format for the purposes of expenditure control. Appropriation categories and expenditure totals must be consistent with the priorities and resource assumptions of the programme budget. This aspect of the system for the H.P.S.S. will be discussed in greater detail in Chapter 6, where it will be shown that detailed and definitive budgets, in the Defence sense, are not always applicable.

(4) Monitoring Performance -

the feedback of information to decision-makers during and after implementation concerning the success of programmes. This information will be fed into the planning phase of the following P.P.B. cycle.

This chapter will focus upon feasibility issues, i.e. stage 1(a), and will examine the origin and early development of the P.P.B.S. concept within the Department of Health and Social Security (D.H.S.S.). It will also look at the organisational context of the H.P.S.S. as an essential background to the rest of the thesis. Chapter 5 will concentrate upon the design of the basis and main product of the whole system, the Programme Budget (i.e. stage 1(b)). Chapter 6 will examine the system in operation, from stage 1(c) to stage 4. Chapter 7 will be a general conclusion.

4.2 THE ORGANISATIONAL CONTEXT OF THE H.P.S.S. : STRUCTURE AND FUNCTIONS

4.2.1 Introduction

The organisation for the H.P.S.S. comprises the health side of the D.H.S.S., the National Health Service (N.H.S.) and local authority personal social services. The structure for local authorities is decentralised, i.e. in the control of locally elected representatives, whereas that for the N.H.S. is better described by the French term "déconcentré", i.e. delegated authority to an agent of the Secretary of State. This relatively pluralistic structure, as mentioned earlier, is common to both Britain and America and is the result of the nature of the product, compared with such pure public goods as defence. In this respect, the H.P.S.S. would come somewhere between defence and education in the number of objectives and possibly also in the degree of (potential) central influence over periphery.[11] An important cultural

consequence of this pluralism in the health field is the considerable autonomy given to the medical and other health professions on treatment issues.[12] This is comparable in kind (though not degree) to the influence exercised by social workers in the personal social services and by teachers in education.

The English health organisation is however considerably more centralised than the American. Glennerster[13] has attempted to quantify the degree of centralisation between the two countries, as the following figures indicate:

Year 1971	Centrally Administered		Centrally Financed	
	U.S.	U.K.	U.S.	U.K.
Health	16%	92%	16%	96%

(The figures for the personal social services show little difference between the two countries, being 0%, 0% for administration and 73%, 57% for finance, respectively. The figures for education are 0%, 0% and 12%, 60% respectively). This greater degree of pluralism both between centre and periphery and within the centre in America is due to the cultural factors mentioned in Chapters 2 and 3.

4.2.2 The National Health Service

The National Health Service Act of November 6, 1946 came into operation on July 5, 1948. It became the duty of the Minister of Health "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental

health of the people of England and Wales and the prevention, diagnosis and treatment of illness". The reorganised N.H.S. began on April 1, 1974 and gave the Secretary of State the power:

> "(a) to provide such services as he considers appropriate for the purpose of discharging any duty imposed on him by the Health Service Acts; and
>
> (b) to do any other thing whatsoever which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty."

The services brought together were:

(1) the hospital and specialist services administered by Regional Hospital Boards, Hospital Management Committees and Boards of Governors of undergraduate teaching hospitals;

(2) the Family Practitioner Services administered by the Executive Councils;

(3) the personal health services administered by local health authorities;

(4) the school health service administered by local education authorities.[14]

These authorities were functionally and territorially organised.[15] Their functions were interdependent yet:

- each had different local populations;
- they were separately financed and planned;
- there were different assessments of priorities;
- there was no single authority responsible for providing a population of a given area with the right combination of comprehensive health services.[16]

Reorganisation enabled such an authority, the Area Health Authority, to operate.[17] One of the general aims of reorganisation was to set up a fully integrated health service in which maximum delegation of decision-making and the need for national and regional strategic direction were to be "balanced" by means of a planning system,[18] the "kernel" of which is the programme budget.[19]

Health authority members are, constitutionally, agents of the Secretary of State. Their officers work under a system of "team management".

Because of the doctrine of clinical autonomy and the necessary interrelationship between professionals, it was not felt appropriate to have a single hierarchical authority structure with a chief executive on top. There would instead be a senior management team of equals within each authority. The consensus approach would inevitably lead to slower decision-making but would on the other hand increase the acceptability of decisions taken. Members take joint responsibility but are individually accountable for their specific functions.[20] Furthermore, there is an elaborate system of consultation before decisions can be taken. Authorities must consult with Community Health Councils (representing the views of the consumer), local authorities, advisory committees, Family Practitioner Committees (see below), and others.

(a) The Area Health Authority (A.H.A.)

There are 90 A.H.A.s in England whose boundaries are coincident with those of the non-metropolitan counties and

the metropolitan districts of local government. The A.H.A. is the operational N.H.S. authority and is responsible for providing a comprehensive health service in its area according to need, taking into account national and regional guidelines and consultation with local authorities through the Joint Consultative Committees (see below). In this context the A.H.A.:

- sets policies and standards for its area;
- allocates resources to Districts;
- plans the services provided in Districts;
- plans Area-level services;
- collaborates with local authorities in planning.[21]

The Chairman is appointed by the Secretary of State, and of the total membership of between 18 and 33, one third or more are from local government and the others represent doctors, nurses, universities, etc.

Each A.H.A. must also set up a Family Practitioner Committee to administer contracts with general medical practitioners, dentists, ophthalmic medical practitioners, opticians and pharmacists (the Family Practitioner Services).[22]

Each A.H.A. must appoint an Area Team of Officers (ATO) who co-ordinate the work delegated by the A.H.A. The Team comprises:

- Area Medical Officer;
- Area Nursing Officer;
- Area Treasurer;
- Area Administrator.

The services to be managed on an Area-wide basis are:

- ambulance service;
- capital works delegated by the R.H.A. and specialised maintenance work;
- financial services;
- some management services;
- some personnel services;
- some preventive health services;
- some supply functions.[23]

For planning purposes, A.H.A.s have set up Health Care Planning Teams normally of second-in-line officers.[24]

(b) The Health District

The day-to-day running of the services is carried out on a District basis, of which there are 205 in England.[25] The work of Districts delegated by the A.H.A. is co-ordinated by the following officers:

- District Community Physician;
- District Nursing Officer;
- District Finance Officer;
- District Administrator.

These officers, together with a representative consultant and a representative general practitioner from the District Medical Committee (a professional executive and advisory body), form the District Management Team.

For planning of operational services, each District should have a District Planning Team[26] (formerly called a Health Care Planning Team[27]). It was originally assumed that Districts would constitute the basic units for strategic planning, but as will be seen later when the planning

system is discussed, they are responsible only for operational planning.[28] Nevertheless, the original intentions are relevant in that they make explicit the functions of a planning team which can then be applied to any level. They are of two types:

- Permanent teams having responsibility for certain groups of needs which require combinations of hospital and community care, e.g. elderly, children, maternity, mentally ill and handicapped;
- Ad hoc teams for other groups of needs, e.g. review of primary care services, introduction of day surgery, reorganisation of an outpatients' department, review of services for people with epilepsy.

The "role" of the teams is "to assess needs in order to effect changes in services". This involves the following activities:[29]

- "Continuously reviewing needs of particular groups and the services being provided to meet these needs";
- "Contributing to policy recommendations and to development of the annual District Plan";
- "Carrying out special studies to establish ways of bringing about beneficial change";
- "Assisting the DMT to monitor and co-ordinate the implementation of projects and assess results".

(c) The Regional Health Authority (R.H.A.)

The R.H.A. is the "link" between the A.H.A.s and the Secretary of State and the D.H.S.S., and there are 14 in England.[30] The R.H.A. has three main functions:

(1) Planning

- developing strategic plans and priorities based on

a review of needs identified by Areas and on a judgment of the balance between Areas;

- identifying services which need a regional rather than an area approach and arranging for their provision;[31]
- developing an overall plan for specialist services.[32]

(2) Co-ordination and Supervision

- reviewing Area plans;
- allocating resources between them and monitoring performance.

(3) Executive

- designing and constructing new building and works.

The R.H.A. generally delegates to A.H.A.s authority for

- projects approved by the D.H.S.S. and delegated according to type (e.g. Health centres);
- small schemes (costing between £50,000 and £350,000) delegated on an ad hoc basis;
- minor schemes (costing between £10,000 and £50,000) financed through population-determined block allocations and managed by the A.H.A.[33]

R.H.A.s are responsible for major schemes (costing over £350,000), non-delegated small schemes, and regionally-managed services (e.g. medical and scientific equipment). The D.H.S.S. is responsible for "those projects which display special features of type or design of major significance for service development"[34] ("starred" projects).

The Chairman and members are appointed by the

Secretary of State. The membership composition is as for the A.H.A.s except that two members should be drawn from those working in the N.H.S. in addition to the doctors and nurses who are already members.[35] Each R.H.A. must appoint a Regional Team of Officers to co-ordinate delegated work, as follows:

- Regional Medical Officer;
- Regional Nursing Officer;
- Regional Works Officer;
- Regional Treasurer;
- Regional Administrator.

The R.T.O. is "jointly responsible for the review of A.H.A.s' plans and performances and for the formulation of plans for Regionally managed services", the latter including:

- advisory services not provided by the D.H.S.S.;
- ambulance services in metropolitan counties;
- major capital building projects;
- more highly specialised management services;
- some personnel functions including consultants' and senior registrars' contracts in non-teaching Areas;
- some supply functions.[36]

A regional organisation, in addition to the A.H.A.s, was deemed to be required because

- the D.H.S.S. could not effectively supervise 90 A.H.A.s;
- few A.H.A.s are entirely self-sufficient;

- many planning and some executive functions are better carried out at the regional level.[37]

As in the Areas, R.H.A.s have set up Health Care Planning Teams comprising second-in-line officers.[38]

4.2.3 The Local Authority Personal Social Services

The personal social services were brought together under the Local Authority Social Services Act 1970 which became effective from January 1, 1971.[39] The services are provided by metropolitan districts, non-metropolitan county councils, the London Boroughs and the Common Council of the City of London. They comprise services to meet the social needs of young children, deprived and delinquent children, the elderly, the physically handicapped, and other vulnerable groups, particularly the mentally ill and mentally handicapped. The services include residential and day care accommodation, domiciliary services, and social work.

The Secretary of State has no general power of direction over local authority personal social services but according to section 7(1) of the 1970 Act "Local Authorities shall, in the exercise of their social services functions, including the exercise of any direction conferred by any relevant enactment, act under the general guidance of the Secretary of State". The D.H.S.S. exercises its influence by means of circulars but in effect local authorities are allowed a great deal of flexibility. Implementation is monitored through statistical returns and by the Regional Social Work Service of the D.H.S.S. In addition, three

quarters of the social service capital budget comes from key sector borrowing for which loan consent is required from the Secretary of State. The Rate Support Grant, on the other hand, is a block grant for all local authority services and it is for individual authorities to determine their priorities. The D.H.S.S. "takes the initiative" in planning but does not control expenditure.[40] Since 1974, however, an important source of central influence and local finance has been the introduction of Joint Planning and Joint Finance.

4.2.4 Joint Planning and Finance

A D.H.S.S. circular in May 1977[41] stated that "inter-dependence makes it essential to have effective arrangements for joint planning to secure the best balance of services and to make the most effective use of the resources available for the elderly, the disabled, the mentally handicapped, the mentally ill, children and families, and for socially handicapped groups such as alcoholics and drug addicts. Effective joint planning is vital to the Government's overall strategy of developing community-based services so that wherever possible people are kept out of hospitals and other institutions and supported within the community".

Section 10 of the National Health Service Reorganisation Act of 1973 required health and local authorities to "co-operate in the exercise of their respective functions" and to establish Joint Consultative Committees (JCCs) "to advise Area Health Authorities and their matching local authorities on their performance in co-operative activities

and on the planning and operation of services of common concern". JCCs should consist "mainly of members of the two sets of authorities",[42] preferably senior members including chairmen, although it is for the authorities themselves to determine their representation and non-members may be appointed. Because of the lack of formal consultation between R.H.A.s and local authorities, one of the members ought preferably to represent the R.H.A.

For the purpose of developing joint planning, each A.H.A. and local authority, together with advice from the JCC, should set up a Joint Care Planning Team (JCPT) to work under the "general guidance" of the JCC or one of its subcommittees.[43] JCPTs are "advisory" and not "executive". Their role is "to advise health and local authorities on the development of strategic plans and guidelines covering priority services identified by JCCs as requiring a joint approach to planning". They must "consider the health and social needs of particular groups in the community, and produce proposals for the future development of local authority and A.H.A. services relevant to these needs ..." Their membership comprises, on the N.H.S. side, officers working at A.H.A. level and in Health Districts with a major responsibility for planning, and on the local authority side, officers having a continuing interest in the planning of relevant services, particularly social services and housing. In addition, officers of the Family Practitioners' Committees should have representation. Further temporary members should be encouraged when the plans for specific services are being discussed.

Joint Finance is designed "to allow the limited and controlled use of the resources available to health authorities for the purpose of supporting selected personal social services spending by local authorities".[44] These projects must be "in the interests of the N.H.S. as well as the local authority, and can be expected to make a better contribution in terms of total care than if directly applied to health services ..." Joint Finance is, as one senior D.H.S.S. official puts it, "a specific grant to local authorities for limited purposes."[45]

There are three "general conditions" applicable to joint finance:[46]

- "support from N.H.S. resources for capital projects is to be provided to a defined and predetermined extent ... and in the case of revenue support, for a limited period ...";
- the local authority must accept "as a firm commitment all continuing financial responsibility on the cessation of the interim support given by the health authority so long as the activity to be jointly funded is continued by the local authority" ; and
- "any land or property leased to local authorities under joint financing arrangements would revert to the Secretary of State for Social Services whenever its use for personal social services purposes ceased."

Joint finance allocations are made to A.H.A.s by R.H.A.s mainly on the basis of population weighted for the 75+ age group, the mentally ill and the mentally handicapped, though a degree of discretion is allowed according to local circumstances.

4.2.5 The Department of Health and Social Security (Health Side)

The Secretary of State for Social Services is responsible for promoting a comprehensive health service in

England and Wales for the prevention, diagnosis and treatment of illness.[47] As such, he is responsible to Parliament for the N.H.S. and determines national policy. The D.H.S.S. assists him in:

(1) establishing national policies and priorities which will determine the kind, scale and balance of services to be provided in Regions and Areas (cf. education - the DES is responsible for the scale, organisation and cost of services[48]);

(2) guiding, supporting and, where desirable, controlling Regions. The Department helps authorities to understand the guidelines and the reasoning behind them, and allocates to the Regions the necessary resources;

(3) obtaining or developing resources which strongly influence the adequacy, efficiency and economy of services, e.g. personnel, finance, property and building, and supply;

(4) carrying out other functions which are best organised centrally, e.g. research, standardisation, national statistics, superannuation;

(5) supporting the Secretary of State in his parliamentary and public duties.[49]

Secondly, the D.H.S.S. under the direction of the Secretary of State, is responsible for securing the provision, under his general guidance, by local authorities and voluntary agencies in England of personal social services.[50] The Department assists in setting priorities and in determining the allocation of resources to the personal social services. But as mentioned earlier, the

Secretary of State has no power of general direction; local authorities are statutorily independent. The Department's responsibilities vis-a-vis the personal social services are similar to those of other Departments of State with central responsibility for services provided wholly or mainly by local authorities, e.g. education.[51]

Lastly, the D.H.S.S., under the Secretary of State's direction, is responsible for certain services which do not fall into the above categories, e.g. the administration of the Medicines Act, the control of private nursing homes under the Abortion Act, the direct administration of the Special Hospitals at Broadmoor, Rampton and Moss Side, and under the Ministry of Health Act of 1919 the development of national policy on health matters in general, including preventive health.[52]

As can be seen from these three sets of responsibilities, the influence of the D.H.S.S. on the H.P.S.S. varies according to function. The entirely central functions are of minor significance in terms of resources. The local authority personal social services are the least subject to central control. The Secretary of State however is accountable to Parliament "not only for the broad development of health services in England but also for their detailed functioning."[53] But in practice,

> "the differences in need for health services over the country and in the existing level of provision call for local variety and flexibility in their management, and a degree of local knowledge which a central Government Department could not possess. Responsibility for managing health services is delegated therefore as much as possible to local bodies but in such a way that the Secretary of State remains fully accountable to Parliament for their operation ..."

Health authorities, "while constitutionally agents of the Secretary of State, are bodies, run by able and experienced men and women who give their time very freely, which have been intended by successive Governments to have a certain independence of view and freedom of action."[54] This ambiguity between central direction and local flexibility is exacerbated by the considerable autonomy given to the caring professions, as mentioned at the beginning of the chapter:

> "choices are made at many different levels, most frequently at the level of the individual professional worker providing care. Central action may encourage or constrain actions at this level, but it should very rarely seek to do more, since then care would be much less responsive to individual need, and working conditions would be intolerable to professional workers."[55]

This view is aimed mainly at the health professions, but it is also true to a lesser extent of social workers. Thus, whilst central responsibility is greater in the health than in the social services, central control over the detailed use of resources by the caring professions is perhaps greater in the personal social services.[56]

In 1972 the D.H.S.S. was reorganised into 6 main groups for carrying out the three sets of functions mentioned above: Top of the Office; Services Development; Regional; N.H.S. Personnel; Administration; Finance.[57] The reasons for reconsidering the Department's role were three in number:[58]

- the amalgamation of hospitals, general practice and community health into unitary authorities.
- the integration of the local administration of the

personal social services and the need to prevent the administrative separation of these services from the health services;

- the enlargement of the Department due to the merger with social security.

The review of the organisation and method of operation of the D.H.S.S. was begun late in 1970 under a team comprising officers of the D.H.S.S., one official from the Civil Service Department, and consultants from McKinsey and Co. The review confined itself "to relatively senior staff and their responsibilities."[59] Their main recommendation was the reorganisation of the Department into 6 groups, although

> "Separate organisational hierarchies are preserved for the different disciplines (professional and administrative) but each hierarchy is related as closely as possible to the common work structure so that the disciplines can most easily work in partnership ..."[60]

This principle of "Separate but Co-ordinated Hierarchies" is a hybrid which takes account of the nature of the delivery of health and social care. The Fulton idea of "multidisciplinary working, and full participation by professional officers in decisions", necessitating "single, integrated organisational structures with managerial posts held by officers of any discipline", was not felt appropriate in its entirety:

> "for certain purposes the principal disciplines must preserve their own organisational structures long term and ... while a more limited form of integration, which we have called joint working, may offer advantages, these remain to be proved by experiment."[61]

The separate professional hierarchies are headed by the Chief Medical Officer, the Chief Scientist, the Solicitor, the Director of the Social Work Services, the Chief Architect, the Chief Dental Officer, the Chief Engineer, the Chief Nursing Officer, the Chief Pharmacist, the Chief Surveyor and the Chief Works Officer.[62]

The Top of the Office gives "support to the Secretary of State in his task of overall central leadership of the health and social services, of ultimate decision ..., and in the management of the Department."[63] It is "unlike other organisational groups in that its composition is not constant, having a varying composition of senior Departmental officers depending on the matter in hand."[64] Its task is to:

- help the Secretary of State provide central leadership;
- advise him on the major choices concerning the nature and scale of the N.H.S. and on national objectives and priorities;
- advise him on matters of major public concern;
- manage the Department's resources.[65]

The two major innovations are the Services Development and Regional Groups.[66] The Services Development Group is responsible for that part of the D.H.S.S.'s functions concerned with the determination of national objectives, priorities and standards, taking into account people's needs and ways of meeting them.[67] It is headed by a Deputy Secretary who works with two deputy chief medical officers and a deputy chief nursing officer. This group

develops policy on the scale and functions of the N.H.S. and the personal social services, and on the services to be provided to particularly vulnerable groups and to the whole population. It determines national objectives, priorities and standards for the N.H.S. and the personal social services, and has responsibilities for food safety, environmental health, and such matters as smoking, abortion and drug addiction.[68] It is a very important group in the planning process, as will be seen later, since it "represents" and "advises" the Ministers.[69] There are 6 Divisions:

Health Services

(1) - abortion, family planning, smoking;
health education and prevention;
general public health issues; food hygiene;

Health Services

(2) - scientific and support;
medical and surgical services; planning;

Health Services Organisation and Administration;

Local Authority Social Services

- general; planning and training;
services for the elderly and the physically handicapped;

Services for Mental Health

- services for the mentally ill and handicapped;
special hospitals; services for the homeless, alcoholics and drug addicts;

Children's Division

- delinquency; community homes and youth treatment

centres; children at risk; child health; adoption.[70]

The Regional Group has the task of guiding, supporting and where applicable and desirable, controlling health and local authorities,[71] (although communications are mainly effected through Services Development Group). It is the main link with R.H.A.s and local authorities and its detailed responsibilities are:

- to guide authorities on national objectives and priorities;
- to support and, where feasible and desirable, control them in the planning and running of services;
- to provide specialist support to them in building and supply;
- to support the Secretary of State in relation to allocated subjects.[72]

The Group is headed by a Deputy Secretary who is assisted by a deputy chief medical officer and a deputy chief nursing officer. It has 4 Divisions:

- Regional and Central Planning (resource allocations and programme management; regional planning and information; central planning);
- Regional Liaison (individual Regions; organisation, management and communications, industrial relations, etc.);
- Supply (disablement; health service supply; scientific and technical; mobility of physically handicapped);

- Industries and Export (home industries; exports; prices).[73]

The next two Groups, N.H.S. Personnel and Finance (together with the Supply functions of Regional Group) are responsible for the D.H.S.S. function of obtaining or developing resources that influence the adequacy, efficiency and economy of services.[74]

The N.H.S. Personnel Group is headed by a Deputy Secretary, assisted by a deputy chief medical officer and a deputy chief nursing officer. It is concerned with pay and conditions of service, training and recruitment, and has 5 Divisions.[75] The Finance Group serves the whole Department and is headed by a Deputy Secretary.[76] Its functions are:

- to represent the Department with the Treasury and other Departments on financial matters;
- to provide financial advice to the Top of the Office;
- to provide financial advice to the Department and to review the financial implications of policies;
- to exercise financial control over the Department, the N.H.S. and other agencies under D.H.S.S. supervision;
- to support the Secretary of State in relation to allocated subjects.[77]

There are 3 Divisions:

- Planning and Programming (HPSS) - PESS and the Programme Budget; personal social services; NHS personnel and family practitioner services;

- Financial Control (HPSS) - estimates and accounts; health authority expenditure; accountancy services; audit and expenditure review;
- Finance Control and Planning (Social Security).[78]

The Administration Group also serves the whole Department and enables the various functions and parts of the D.H.S.S. to run smoothly.[79] It is headed by a Deputy Secretary and its responsibilities are:

- to support the Top of the Office on departmental manpower, organisation and efficiency matters and to negotiate with the Civil Service Department and Treasury;
- to support line managers in the Department in organisation, staffing, and efficient resource use;
- to provide specialist support as needed;
- to support the Secretary of State in relation to allocated subjects.[80]

The Group has 8 Divisions.[81]

The function of supporting the Secretary of State in his governmental, parliamentary and public duties is given by all parts of the organisation, co-ordinated by the Secretary's Private Office, and as such does not have a separate work structure.[82]

In addition to the formal structure and the planning carried out by Divisions, there is a more flexible planning organisation. For planning purposes, the Top of the Office reconstitutes itself into a Strategy Committee, chaired by the Permanent Secretary.[83] Immediately below this, there

is a Planning Steering Committee composed of senior administrative and professional staff and chaired by the Deputy Secretaries of the Services Development and Regional Groups.[84] Its responsibilities are (a) the oversight of the planning process, and (b) the preparation and presentation of major planning issues.[85] The two planning committees are serviced by the Policy Planning Unit (until recently called Regional and Central Planning Branch 3 of Regional Group) which is formally accountable to both Services Development and Regional Groups.[86]

Having discussed the organisational context of the HPSS, the remainder of this chapter will look at the origin and early development of the P.P.B.S. concept within the D.H.S.S.

4.3 THE ORIGINS OF THE P.P.B.S. CONCEPT IN THE D.H.S.S.

4.3.1 Introduction

In 1970 a Project Team was set up with the terms of reference "to introduce a PPB system (sometimes known as output budgeting) for the health and personal social services".[87] Despite these terms of reference, the work was regarded as a "feasibility study".[88] The chairman of the Team was an Assistant Secretary with the Accountant General's Division, and the other members were a Treasury Principal from the Management Accounting Unit, an economist from the Economic Adviser's Office, a doctor from the medical hierarchy, and two more officials from the Accountant General's Division, one of whom acted as

Secretary to the Team.[89] The Team produced its First Report in April 1971.[90]

As mentioned early in this chapter, P.P.B.S. for the H.P.S.S. is very much a home grown version. The initial impetus was provided by the Department's Finance Division after consultations with the Treasury.[91] There were two main motives behind its introduction: the need "to reconcile policy advice with the resources planned through PESC"; and the fear "that other Departments might use the new Output Budgeting technique to establish their cases more effectively in PESC than the D.H.S.S."[92] There was, however, a "considerable fight" involved in getting PPBS under way in the first place.[93] There was very little top initiative apart from the suggestion to have a feasibility study.

The Team could learn from American experience and in particular from what were seen as the three main problems associated with their approach:

- P.P.B.S. was introduced too quickly and without adequate research;
- the information requirement produced large quantities of paper which no-one read;
- the cost of obtaining the information was extremely high.[94]

Their approach to the problem of introducing P.P.B.S. was as follows:

> " (i) to examine the purposes which a system could serve, the kind of decisions with which it would help, the administrative levels at which it could be used and how it would operate, and the best basis for a programme budget;

" (ii) to consider the information which would be needed to establish a useful system;

"(iii) to explore the availability of such information, the need for additional information and how it could be obtained;

" (iv) to consider the implications of PPB for financial and budgeting practice."[95]

The feasibility study had to take place in an atmosphere of uncertainty as to the details of the future organisation of the N.H.S., and it was the purpose of the report "to seek views on our main assumptions as to the purposes of the system and how it might work, and broad agreement on the lines on which we are working."[96] It was recognised, however, that

> "PPB is essentially an approach within which each organisation must construct its own system. Only by carefully tailoring this system to the organisation's needs is it possible to avoid the pitfalls of over-elaboration and irrelevance to real decisions which have been a feature of some PPB systems."[97]

4.3.2 The Nature and Aims of P.P.B.S. for the H.P.S.S.

The PPB Project Team contrasted P.P.B.S. with "traditional" budgeting.[98] These latter budgets "categorised expenditure mainly by the type of resource on which it is to be spent - staff, goods, buildings, equipment and so on - rather than by the purpose for which it is to be spent." It must be pointed out at this stage, however, that this description of budgeting is only partially relevant to the H.P.S.S. As will be shown in greater detail in later chapters, the D.H.S.S. does not budget for inputs apart from the small number of directly administered services. Previously, rough estimates were presented to Parliament

for each Region in input form. The present system is to give block allocations to health authorities. Nevertheless, a block allocation is an example of extreme incrementalism focusing on the lowest common denominator in the social production process, viz. money. As mentioned in Chapter 2, HEW faced the same problem, although its budget did provide greater information on institutions and services. There is still, however, the problem of relating services, etc., to objectives:

> "In so far as purposes have been built into the categories it has usually been because resources are allocated to institutions or services, some of which are identified with specific purposes, but the picture is necessarily incomplete because some institutions serve several purposes and different types of institutions may serve the same or similar purposes."

As opposed to traditional budgeting, P.P.B.S. is said "to analyse the use of resources according to the purposes which they are intended to serve and to relate the resources used to the results achieved." The system will establish:

> " (i) what an organisation is seeking to achieve - its AIMS and OBJECTIVES;
>
> (ii) what ACTIVITIES contribute to those objectives;
>
> (iii) what resources, or INPUTS, are being and should be devoted to the different objectives;
>
> (iv) what is being and is expected to be achieved, or what the OUTPUTS are."

This information "is presented in a PROGRAMME BUDGET (alias output budget)."[99] No mention is made at this stage of a strategic document to accompany the programme budget similar to the Program Memorandum in the U.S. The American PFP was never intended to display all the information on social costs and benefits.

The word "programme" in programme budget is taken to mean "a grouping together of all the activities, inputs and outputs contributing to a common aim or objective or to a group of similar aims and objectives."[100] Sub-programmes were not considered a necessity but "may be introduced where the usefulness of the programme budget is increased by grouping activities together below main programme level" for example in the case of "activities undertaken by particular types of agency or institution". Also, "the sub-programme structure can be designed to allow reclassification of information into ... alternative groupings" where this would be "useful". The programmes would be drawn up "on a multi-year basis so as to provide a historical and current record and a plan of the future."[101]

The programme budget "forms the basis for any PPB system, but it is of itself no more than an information document. Some organisations do not go beyond the stage of a programme budget, i.e. they have no more than an objective or functional costing system. "This, they maintained, is of itself very useful, but

> "a full PPB SYSTEM also aims to establish arrangements for systematically linking the planning of policy and priorities with resource allocation and the financial planning system, for relating individual decisions to an overall strategic framework and for considering the effectiveness with which resources are deployed."

This would require:

> " (i) regular reviews of the plans expressed in the programme budget, including the overall strategy;
>
> (ii) a formal link with the normal budget processes;
>
> (iii) special studies of particular areas where the programme budget information suggests that the

" deployment or utilisation of resources might be improved, or where a review in greater depth than the programme provides seems desirable for any other reason. The Programme Analysis and Review (PAR) Studies are an example of the kind of special study which might be carried out within a PPB system, but many other types of study will also be appropriate, e.g. statistical analyses, cost benefit and cost effectiveness studies, some operational research studies."

It was pointed out, however, that:

"This report concerns itself primarily with the design of the programme budget and the working of the PPB system. Little attention is given to special studies ... This is not because we regard the special studies as unimportant: indeed we consider them to be potentially one of the most valuable aspects of the system. It is because they are not critical to the purposes of this particular report."[102]

Analysis is not a new concept; the programme budget is. And as regards the review system, the Team were in the dark as to the detailed functioning of the reorganised N.H.S.

The Team pointed out the dangers of over-reliance on analysis, and emphasised that

"a PPB system does not seek to replace human judgement, but only to help that judgement to be directed to the most significant questions and to present the decision taker with relevant information. Nor does the system seek to establish either economic or financial factors as the chief factor in the decision process. Indeed it is inevitable and proper in the health and personal services that other factors should play a major part in many, perhaps most, decisions. The aim of a PPB system is that all factors including economic and financial ones should be assessed and given due weight in policy and planning decisions."[103]

After expounding these general properties of P.P.B.S., and arguing that the system must be relevant to organisational needs and decision-making, the Team went on to

examine the purposes which such a system would serve for the HPSS at a national level. The examination was based on four crucial assumptions:

" (i) that the National Health Service will continue to provide for the bulk of the country's health needs, and will be mainly financed by public expenditure;

(ii) that the first priority is a programme budget and PPB system for use at national level ...;

(iii) that in the reorganised N.H.S. the D.H.S.S. will ... play an active role in deciding and checking on how resources are used, and will not be concerned solely with obtaining funds and allocating them to regions or other organisations;

(iv) that the PPB system will be a vehicle for forward planning and not simply a new form of costing system."[104]

The Team assumed that the basic task of P.P.B.S. "is to assist in planning", particularly as this is the "more significant function at national and probably also regional level."[105] The management function "clearly involves both planning and resource allocation and also running the organisation, supervising those who are carrying out the day to day work, and accounting for what is done". Some organisations, however, notably Local Authorities, were "seeking to use PPB simultaneously for planning and as a means of detailed management and operational control and management accounting." This was not regarded as practicable in the N.H.S. "since a budget for operational control, etc. must be based on organisational units, whereas forecasting and planning will frequently cut across such units."

P.P.B.S. would be useful to the D.H.S.S. and health authorities for forecasting and planning purposes in the

following ways:[106]

" (i) by showing more clearly (a) how resources are being used and what outputs are being produced under existing policies, and who is benefiting, and (b) the resource implications of different policies and developments, the programme budget could help in the consideration of priorities for the future. In particular it might suggest areas of need not being adequately met, and existing activities which no longer meet important needs; there should thus be a move away from "incremental" to "zero base" budgeting.

(ii) by bringing together different activities, perhaps undertaken by separate parts of the health service, which serve similar needs, the programme budget could suggest areas where cost effectiveness comparisons would be useful and could also provide a context in which to judge the results of such comparisons.

(iii) by showing how trends in different factors contribute to total demands for resources - e.g. demographic factors, participation rates, and unit costs - the programme budget might improve the forecasting of expenditure under existing policies. In the longer term it might be possible to show how these factors are influenced by underlying trends in social conditions, medical treatment, etc.

(iv) by helping to show the reasons behind growing demands on the health service and what could be achieved by further expenditure, including benefits to the economy as a whole, the programme budget might help D.H.S.S. in competing for resources with other major programmes such as education and transport."

It was also considered that programme budgeting information might "assist Parliamentary control of health expenditure ..."

The Project Team considered that "precedence should be given to priorities and cost effectiveness."[107], i.e. numbers (i) and (ii) in the above list. This is because

"Expenditure on health is, and is likely to continue to be, controlled mainly by restraints on the total resources available and decisions on priorities and methods within this total. Demand trends are not the major determinant of total expenditure, and

> even where demand for a particular service increases, it need not necessarily be met in full, or by existing methods. Furthermore one of the Department's prime responsibilities is to secure the optimum use of available resources."

However, of number (iii) in the list, the Team said "the planning of future expenditure will clearly have to take account of such factors as demographic trends, changes in population and age structure, migration, changes in social habits, developments in health care and so on."[108] For this purpose,

> "The programme budget should itself show some information relevant to these factors, e.g. trends in numbers of cases and unit costs, but it will inevitably show much information in summary form. More detailed information will need to be obtained, either routinely or through special studies, as part of the wider PPB system."

The potential use of P.P.B.S. in the public expenditure survey, as pointed out in number (iv) above, was not forgotten:

> "... a system geared to priorities and cost effectiveness might be better able to make a case for additional resources by demonstrating that gaps remained between aims and likely achievement even when optimum use of resources had been secured."[109]

The Team next considered the use of P.P.B.S. by the reorganised health authorities and by local authorities, and the relationship of the system to the decision-making process.

4.3.3 P.P.B.S. and the N.H.S.

Discussions were held with Regional Hospital Board and Hospital Management Committee Secretaries and Treasurers on the proposed introduction of P.P.B.S.[110] The

Secretaries "had some reservations about it because of the work which they thought would be involved in providing information, and doubts about how it would be received by medical staff", but the "remaining groups" (presumably the Treasurers) "all welcomed the move and considered that PPB would be of value for their authorities", particularly "because of their greater range of responsibilities", within the reorganised N.H.S. However, such a system would only be useful "at a level where significant decisions on priorities and deployment of resources are to be taken", i.e. at "Regional and Area level, but not District"[111]. It was recommended that a PPB system should be ready for use by the "shadow" N.H.S. authorities on 1 April 1973. However, it was felt that Area authorities might consider that "operational control is more important to them than resource allocation, and that they will not have the resources to introduce systems for both purposes from the outset."[112]

It was intended that there should be "a single programme structure for both Regional and Area level which would conform as closely as possible to the national structure, though excluding the personal social services and any other inappropriate elements."[113] Health and local authorities could, however, co-operate to produce a joint programme budget. The programme budget at each level would be "a summary of the budgets for the next lower level (amplified as necessary)". An advantage of having compatible budgets at each level is that "some of the difficulties of obtaining information for the national budget ... would thus

be overcome ..."[114]

4.3.4 P.P.B.S. and Local Authority Personal Social Services

The Project Team took account of the increasing use by local authorities of PPB systems for the whole range of their activities, a factor then being studied by the Treasury Management Accounting Unit.[115] However, it was considered unlikely that agreement could be reached on a common programme structure for the personal social services. It was also thought that compatibility with the national structure could not be obtained "since Local Authorities must relate these services to others, particularly housing, which are outside the D.H.S.S. field." Information might therefore have to be specially obtained for the D.H.S.S. budget.

This first report by the Project Team concentrated mainly on the health services, "because services run by Local Authorities are not so susceptible to planning and decision-taking at Departmental level ..." and "there is no immediate prospect of incorporating them in an integrated planning system covering all administrative levels ..."[116] However, the Team thought it "essential that the PPB system at national level should cover the personal social services since there are many possible options between these and the health services". This aspect was to be given closer attention in the Second Report (see Chapter 5).

4.3.5 P.P.B.S. and the Decision-Making Process

The Team looked at five aspects of this problem:

timescale, financial and budgeting practice, links with the budgetary cycle, relationships between different levels, and procedure within the D.H.S.S.

(a) Timescale

The programme budget was seen as "a multi-year plan which would be used to express the resource implications of developments in care and changes in policy and priorities."[117] At Area level, it could be used for relatively short-term decision-making, but at the national level, "it would be directed primarily to medium term planning and long-term strategy. "For these purposes, it was decided that the timescale "should be about ten years":

> "This seems to be the kind of timescale which would be involved in any major re-orientation of policy and resource deployment, e.g. a major shift from institutional to community care. It is roughly the time which would be needed to achieve any major shift in the balance of medical manpower. It would also roughly match the capital programme and, if the system is to extend below national level, would greatly assist in the joint planning of capital and revenue ..."[118]

(b) Financial and Budgeting Practice

The main need here was that the Department should be given "agreed planning allocations (possibly on a high/low basis) beyond the current PESC period", and that health authorities should be given forward allocations.[119]

(c) Budgetary Links

P.P.B.S. "must be linked with the budgetary cycle" so that it can "function as a system".[120] The "most appropriate link at national level seems to be with the

Public Expenditure Survey, any changes resulting from the PPB system being geared into the later years of the PESC period". For the N.H.S., "there would be a sufficient link with the normal estimating procedure to ensure that the estimates were consistent with the programme budget but we do not envisage a detailed translation of the programme budget into estimates."

(d) Relationship between Administrative Levels

In view of the uncertainty surrounding reorganisation, firm recommendations could not be made on this aspect.[121] One possibility, "that matters would remain much as they are now in relation to hospital authorities", was considered. A major complaint of these authorities was that "the Department does not relate the advice and exhortations which it issues on policy and priorities to the resources available."[122] The consequence is that authorities are "subjected to competing pressures from the Department" and that "expectations of the community at large" are "built up to a level which cannot in practice be met". Two approaches were considered. The first approach was as follows:

> "The PPB system could bring together for the consideration of top management in the Department information on existing resource utilisation and on the resource implications of competing new developments. This total 'demand' for resources could be set against the total resources available, and the Department could then judge what the highest priorities were, how far it was realistic to hope to develop different parts of the service, and what resources could be devoted to them. This could greatly assist the effort to give authorities better guidance on priorities. The authorities could otherwise be left to develop

their own priorities, subject to any ad hoc supervision by their superior authority. They would not necessarily need to adopt the PPB system for this purpose."[123]

In addition, the programme budget could be used to monitor "not only the pattern of expenditure and the level of unit costs but also achievement", and would provide "a better basis for discussions between the Department and the different authorities than expenditure estimates arranged on traditional patterns."[124]

An alternative system to this, giving greater formal supervision, would be "an integrated PPB system for all administrative levels."[125] Following the Departmental review process, the D.H.S.S. could set objectives for authorities generally or specifically. Regions and Areas would then be given planning allocations and asked to produce programme budgets for the achievement of those objectives. There would have to be, however, "considerable scope for local decisions on the emphasis to be placed on different services in the short term, on different aspects of particular services, or on matters not covered by set objectives". Such a system "might form a basis for broad supervision and monitoring of the more important aspects of the service without detailed interference". As will be seen in later chapters, a compromise between these two alternatives was chosen.

(e) Departmental Procedure

For the system described above, a procedure would be needed to enable the Department to take decisions on either priorities (in the first alternative) or objectives

(in the second).[126] The Team suggested "an annual policy review timed to conclude just before the PESC exercise begins (in order to obtain the link (suggested above))". This review process "would aim to review the main lines of existing policy and priorities and cover the major options. It would incorporate consideration of the results of PAR exercises and other special analyses". The review would not, however, be rigid, since it would "clearly not be practicable only to consider major policy and priority questions once a year."[127] Proposals arising outside of the review timetable "would need to be 'screened' for consistency with the agreed programme budget and objectives (if appropriate) and, where there was inconsistency, top management would have to decide whether to adjust the programme budget and/or objectives."

The First Report of the Project Team went on to discuss the kind of framework for a programme budget (the programme structure) which would best provide the structured information for the sort of decisions which had to be made. This aspect of P.P.B.S. will be examined in the next chapter because of its central significance.

4.4 CONCLUSIONS

The feasibility issues discussed by the PPB Project Team can again be classified in terms of political, structural and cognitive variables.

Political

For complex social problems involving stress to system functioning, the major difficulty in the political context is that of value conflict, the central problem of non-economic decision-making.[130] Incrementalists fear that P.P.B.S. will be used by some central authority, backed by an analytical staff, to replace bargaining with a centralised, analytical calculation of interpersonal utility and the substitution of existing, incremental value change for the more radical (the "root" method)[131] values of a central authority. The problems were greater in the American context because of the pluralistic decision-making structure which constrained the effective implementation of plans made by part of the system, and specifically because of the use of the Program Memorandum concept which forced agency heads, etc. to give analytical justifications for what were in effect political decisions. In Britain, on the other hand, the degree of central, executive control over the H.P.S.S. is far greater, politicisation of the upper levels of the administration is less, and the PPB system was designed specifically to suit the needs of the constituent organisations, there being no analytical requirements imposed by the Treasury outside of PESS and PAR. Nevertheless, the consensual decision-making and delegated planning and budgeting philosophy of the N.H.S. and the decentralised personal social services means that even in Britain centralised decision-

making is inapplicable. The feasibility study emphasised that the PPB system would replace neither human judgement nor political bargaining.[132]

Structural

Alternative courses of action to solve major social problems are subject to severe legal and moral constraints, quite apart from situational rigidities and lack of coincidence between programme and organisation structure. The incrementalists fear that P.P.B.S. would threaten the existing state of affairs with radical reorganisation and cutbacks. But P.P.B.S. need not involve radical change; indeed change can, and often will of necessity, be incremental. The PPB Project Team said that:

> "... planning will be done 'incrementally', in terms of modifying the existing pattern of expenditure. This reflects the fact that the Department cannot alter, create or eliminate parts of the system abruptly. It does not imply 'incremental budgeting' in the bad sense that activities must always expand at about the same rate, having their share of increased resources; some increments could very well be negative."[133]

P.P.B.S. for the H.P.S.S. would focus on feasible options and propose incremental change. The philosophy behind incrementalism was discussed in Chapter 1. The small magnitude of changes within (the "prosperity change" concept[134]) and/or between major programmes are the products or consequences of the incrementalist philosophy. But incremental change does not have to be direction-less. P.P.B.S. illuminates the choice process by distinguishing between the relatively controllable and uncontrollable activities and items of expenditure. Hence the need for a feasibility study prior to implementation of P.P.B.S., as distinct from the American introduction. The system for the H.P.S.S. was also geared around

the use of existing sources of information, as will be shown later, and had to fit into the timetable for the public expenditure review, though its introduction was greatly aided by the reorganisation of the N.H.S. (and of the local authority personal social services earlier).

Cognitive

The incrementalists emphasise the impossibility (in addition to the political undesirability) of calculating the full social costs and benefits of alternative courses of action. This difficulty has been noted earlier and has been shown to vary with the nature of the product or service. Weapon systems (though not such ultimate objectives as "deterrence" and "security") are much more amenable to analysis than are the effects of "human investment" programmes such as health and education. This analytical problem ofP.P.B.S. was fully recognised by the D.H.S.S., as will be shown in greater detail in the next chapter, just as it was through experience in HEW. But this problem did not deter the D.H.S.S. The Project Team took the view that the applicability of P.P.B.S. did not rest entirely on the ability of analysis to calculate the full impact of a programme. Too much was expected of analysis in the U.S., a reflection perhaps of the American scientific culture. The D.H.S.S., on the other hand, left analytical questions out of the feasibility studies and concentrated on the programme budget and the planning and budgeting cycle, and specifically excluded the possibility of calculating ultimate benefits (as will be shown in the next chapter). Special studies would be conducted where relevant and when necessary. They would not be tied to a constraining budgeting cycle. As

analytical skills developed, they would be fed into the PPB system. But the primary emphasis of the system would be on the costing of intermediate outputs and their allocation to broad programmes, as will be shown in the next chapter. The fundamental aspect of P.P.B.S. is to focus on the objectives and full social impact of a programme, even if they cannot be evaluated objectively. Judgement and narrative description would be used where analysis was inapplicable.

Chapter 5 will now examine the design and development of the basis and most significant product of P.P.B.S., the programme budget.

CHAPTER 5

THE PROGRAMME STRUCTURE FOR THE HEALTH AND PERSONAL SOCIAL SERVICES

CHAPTER 5

LIST OF CONTENTS

LIST OF CONTENTS (Continued) Page No.

5.1 GENERAL INTRODUCTION

According to the First Report of the PPB Project Team, the primary aim of P.P.B.S. would be to assist in determining priorities and in achieving the cost-effective use of resources. Secondary aims were to improve the forecasting of expenditure and to help the D.H.S.S. in the competition for resources with programmes having more measurable and tangible outputs. It was recognised that

> "PPB is essentially an approach within which each organisation must construct its own system. Only by carefully tailoring this system to the organisation's needs is it possible to avoid the pitfalls of over-elaboration and irrelevance to real decisions which have been a feature of some PPB systems."[1]

For this reason, the D.H.S.S., in common with other British developments, began with a feasibility to determine the kind of decisions which would best be illuminated by the system. The Americans, on the other hand, imposed a uniform, Defense-oriented system on unwilling agencies.

After the feasibility issues, the next stage in the process of setting up and operating P.P.B.S. is to design a programme structure of objectives together with criteria for the evaluation of performance within each programme (i.e. stage 1(b) in terms of the model set out in the last chapter). The programme budget, the British equivalent to the Program and Financial Plan, would present information on:

> " (i) what an organisation is seeking to achieve - its AIMS and OBJECTIVES;
>
> (ii) what ACTIVITIES contribute to those objectives;
>
> (iii) what resources, or INPUTS, are being and should be devoted to the different objectives;
>
> (iv) what is being and is expected to be achieved, or what the OUTPUTS are."[2]

This information would be arranged into "programmes" which group together "all the activities, inputs and outputs contributing to a common aim or objective or to a group of similar aims and objectives".[3] Complex cause-and-effect relationships would be eschewed, and sub-programmes would be developed only "where the usefulness of the programme budget is increased."[4] Recalling HEW experience, their program structure comprised a six level hierarchy of categories, and additional information was provided in the PFP on appropriation, activity, organisation, legislative authority, source of funding, mode of obligation, output, target group, disease and manpower. The programme budget for the H.P.S.S. would be drawn up "on a multi-year basis so as to provide a historical and current record and a plan of the future".[5]

Chapter 4 dealt primarily with the feasibility aspect of the PPB process. It described the nature and aims of the system as seen by the D.H.S.S. and its likely role in the decision-making process of the reorganised H.P.S.S.

This chapter will concentrate on the next stage of the system, the programme budget structure and its development. The chapter will be divided into 3 main sections, dealing with the development of the structure from the First Report of the Project Team, through the Second Report, and finally to the operational structure.

5.2 THE PROGRAMME STRUCTURE OF THE FIRST REPORT

5.2.1 Introduction

The First Report of the PPB Project Team considered that the most important factor in designing a programme structure was that "expenditure should be grouped in a way that is useful for the kinds of decisions to be made."[6] Having regard to the priorities and cost-effectiveness decisions which were considered in the last chapter as the relevant concern of P.P.B.S., this meant that "expenditure should be grouped in relation to the objectives it is achieving." The broad aims of the N.H.S. are specified in the National Health Service Act of 1946 as: " ... to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness."[7] The White Paper of 1944[8] specified the "social" objectives of the service:

> "The Government have announced that they intend to establish a comprehensive health service for everybody in this country. They want to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend upon whether they can pay for them, or on any other factor irrelevant to the real need - the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens."

The N.H.S. is thus paternalistic and egalitarian in the pursuit of its broad aims.[9] However, "a much more comprehensive and detailed statement both of broad aims and of specific objectives would be necessary if the

programmes within the programme budget were to be based on them."[10] As a senior D.H.S.S. official has pointed out,[11] the concept of "equal treatment for equal need" implies "unequal treatment for unequal need", and does not help "in clarifying value of - say - treatment for the acutely ill and care for the mentally handicapped." With regards to the definition of detailed objectives, the Team considered that "The difficulties of securing such a statement would be formidable. Even if there was a likelihood of general agreement the process would take a very long time."[12] This is a reflection of the delegated structure, the concept of clinical autonomy, the nature of social objectives, and a democratic culture, as mentioned in the last chapter.

There are two main problems associated with the valuation of output:[13] "First, valuations within the services may not be consistent. Secondly, the valuations within the services may not be consistent with those of consumers." How is the decision made? It is useful first of all to draw a distinction between the "need for health care", the "demand for health care", and the "demand for health".[14] The need for health care "is defined by reference to some third party's view as to what a particular individual or class of individuals ought to receive." The demand for health care "is indicated by the individuals themselves in making claims upon health care resources." "The demand for health care derives from the demand for health, itself an investment good which provides direct benefits of feeling well and indirect benefits of increased

productivity, leisure time, etc. The third party views relevant to need determination are of two main types: political and cognitive. The Secretary of State is ultimately responsible for the determination of priorities, but any such valuation, whether by politicians or consumers, must be based upon some knowledge of the medical and other consequences of various treatment options. Lay opinion is severely restricted by the technical nature of treatment issues:

> "Consumers might find it easier to choose between 'intermediate outputs' where care was concerned (hospital food, for example) than where prevention, cure and perhaps palliation were concerned. These would require knowledge of technical possibilities and judgements of risk better left to 'experts'."[15]

Because of the difficulties associated with objectives, the Project Team "considered it more realistic initially to tackle the design of the programme budget by considering the kinds of question which, in practice, seem likely to call for decision and the groupings of information which would best assist the decisions".[16] This did not mean that objectives were to be ignored:

> "... one of the advantages of a PPB system is likely to be that it stimulates examination of what objectives are and should be. But it seems better that this should be a process of natural development and that the objectives should be identified and refined as individual programmes and their problems are considered in depth."[17]

The programme structure provides a framework for the choice of operational objectives (as will be shown in the next chapter), and should be flexible enough to accommodate major policy changes such as might occur on a change of

Government. Chapter 6 will analyse the D.H.S.S. Planning System which is "an attempt towards a more explicit concensus on priorities ..."[18]

5.2.2 The Programme Structure

The Project Team considered 5 main bases for the programme structure:[19]

(a) Target Groups

This refers to "particular groups of the population defined by such criteria as age, sex, income level or social group, geographical area, rural/urban location, irrespective of type of health needs if any."

(b) Client Groups

Client groups are "those making demands on the health services in respect of some particular type of problem". They are thus "problem" groups[20] and differ from, e.g. the Haldane concept.[21]

(c) Degree of Dependency

Under this classification, "people are grouped according to the extent to which they need or are receiving medical, nursing or social support irrespective of cause."

(d) Type of Function

This refers to the nature of the activities carried out, "e.g. prevention, treatment and long-term support".

(e) Institutions or Agencies

This is a straightforward classification according to the organisations "providing the service".

The Project Team considered that there was "no 'right' way of dividing up the N.H.S. into programmes."[22] Each method would have its "disadvantages" and would leave "overlaps". Hence the selection of one main basis "does not preclude the inclusion in the structure of others, e.g. if (ii) were chosen for the main breakdown it would be possible to include (i) and/or (v) at a lower level. Nor is it necessary to use the same basis throughout. We do in fact recommend a mixed structure." Special studies would be undertaken "to examine issues spreading over a number of programmes."

The Team thought that Client and Target Groups were most relevant to the decisions on priorities and cost-effectiveness. This classification "would ensure that cost-effectiveness analysis took place within main programmes and that choice of priorities (i.e. judgement) operated primarily between programmes".[23] For example,

> "the choice between expenditure on prevention and on treatment needs to be made in relation to particular conditions and will probably include an analysis of the cost effectiveness of the preventive measures. For this purpose one needs information on prevention and treatment grouped according to the condition involved and it would not help to have all information on prevention grouped together in one programme and that on treatment in another. Conversely one is unlikely to determine the relative merits of expenditure on the mentally ill and on 'cold' surgery by a process of cost effectiveness analysis. This is ultimately a matter of judgement. It would not assist this judgement to have the facts relevant to it scattered between many different programmes."

Thus the programme structure is strongly influenced by the relevance of analysis. Those choices which could be illuminated by analysis would take place <u>within</u> a programme,

whereas those which could not, given the present state of analytical skills, would operate between programmes.

The other bases for the programme structure were considered "inappropriate" for the following reasons:[24]

(c) Degree of Dependency - this was considered "important" and "a total picture may eventually be built up", but "it does not seem a practicable basis for a programme structure initially".

(d) Type of Function - this method would split up the various treatment and prevention options between the programmes, and, as mentioned above, would render the analysis of these options for a particular condition more difficult.

(e) Institutions or Agencies - these are "critical for operational purposes" but "represent means rather than ends and, for planning purposes, a structure based on them would conceal rather than illuminate options".

Of the two preferred methods of classification, the Team considered that

> "for most decisions on priorities and cost effectiveness comparisons it is the kind of health problem which matters rather than the section of population to which the client belongs; for instance if an elderly person has appendicitis, the most relevant factor to the health service is that he has appendicitis".[25]

The Project Team thus recommended that "the main classification should be on a client group basis", but since "age is sometimes more important than specific problem from a medical or social work point of view" the Team suggested "main programmes for the special problems of

children and the elderly." It was considered, however, that target group classifications, in particular age groupings, "might be highly relevant to forecasting."[26] This is because

> "incidence of disease varies with age, location and in some cases socio-economic group. Costs per case are likely to be higher for old people. The cost effectiveness of different types of treatment and of prevention as against treatment might vary with circumstances, and priorities might vary between regions because of different incidence of disease".

It was therefore proposed that "within the client orientated programmes information should be presented on age, possibly on a broad basis of pre-school children, school children (to sixteen), adults and elderly (65 plus)".

The following were the main programmes recommended:[27]

A - Primary Care Services

B - Maternity

C - Children's services, including paediatrics, chronic sick children, appropriate social services, school health services, child psychiatry and child guidance services, but excluding G - K below.

D - Services specifically for the elderly, including geriatrics, elderly chronic sick and elderly mentally inform, together with appropriate social services, but excluding F - K below.

E - Homelessness and other general support for socially dependent groups.

F - Mental illness (excluding child psychiatry, child guidance and elderly mentally infirm).

G - Mental Handicap

H - Physically handicap, subdivided between deaf, blind, disabled and other chronic sick (but excluding those in C and D).

I - Dental (including hospital dental surgery).

J - Ophthalmic (including hospital eye surgery).

K - Infectious diseases (including VD).

L - Accident, emergency and casualty.

M - Other specific clinical groupings.

N - Services not otherwise allocated.

There were two main problems of allocation within this structure, relating to primary care services on the one hand, and accident, emergency and casualty on the other.[28]

Primary Care

This comprises, in the main, the General Medical Service and the pharmaceutical service. However, the General Practitioner (G.P.) has two main functions. He "contributes to treatment of various specific disorders and to long-term support in the community", and secondly, "he also has functions in respect of diagnosis, referral, treatment of minor ailments and general help to patients which seem to form an independent category". Strictly speaking, it is only the second function which one could regard as being primary care. The Team considered that the costs of the first services could eventually be analysed in greater detail to allow allocation to other programmes. However,

> "the considerable flexibility in the way in which G.P.s can use their time, plus the severe limits on the total of G.P.s' time available, must make

existing costs and work patterns a highly unreliable guide to what would happen if there were a major change in the balance of G.P.s' work."

Further study of this problem was recommended, "with particular reference to the role of supporting staff (nurses, health visitors, etc.) whose time might more usefully be allocated out to other programmes".

Accident and Emergency and Casualty

This classification usually refers only to a small part of actual emergency work, i.e. "to those cases (of a more or less urgent nature) seen as hospital outpatients without having been referred by a general practitioner". However, if they are admitted to hospital, "the classification may be changed to e.g. 'traumatic and orthopaedic surgery'." Urgent cases "can alternatively be admitted direct by arrangement and are not then classified at any stage as A and E or casualty though they may be otherwise identical". The Team considered that since the "policy and practice of emergency services are still evolving" then "a distinct specialty may emerge, possibly for inpatients too". If information became routinely available it was hoped "to include in this programme the unplanned hospital work generally (except for the maternity flying squads which are grouped with other maternity services)". The casualty functions of referral, diagnosis and treatment of minor ailments would eventually be allocated to the Primary Care programme.

Programme M, "Other specific clinical groupings", is a very large group and covers most of the non-psychiatric hospital services. Because of this, the Project Team

suggested subdivision.[29] Two classifications were considered: by specialty; and by disease or broad groupings of disease, e.g. gastro-intestinal. The latter, however, "does not seem relevant to priority and planning decisions at national and regional level, since once resources are allocated to a specialty the doctor has clinical freedom in deciding how to use them". Furthermore, "present information is on a specialty basis". Thus the Team suggested the following classification of specialties as in the Hospital Reference Book:

- general medicine (including general practice units and beds);
- diseases of the chest (including TB);
- physical medicine, rehabilitation and rheumatology;
- other medicine (excluding VD), i.e. dermatology, neurology and cardiology;
- general surgery;
- ear, nose and throat;
- traumatic and orthopaedic surgery;
- other surgery (excluding eye and dental), i.e. plastic surgery, thoracic surgery, neurosurgery, urology and radiotherapy;
- gynaecology;
- other
  - intermittent haemodialysis,
  - pre-convalescent,
  - convalescent,
  - staff wards,
  - all other specialist units and unclassified.

The information required for this classification could be obtained from existing sources,[30] and would give

"a clearer picture of the pattern of expenditure and which areas have rapidly rising costs for one reason or another, which will help to identify areas for further analysis". However, cost-effectiveness comparisons of different forms of prevention and treatment would need to be related to specific diseases, hence the need for "more detailed information". But such information "would be impracticable and wasteful to produce ... routinely in the programme budget".

As regards the former Executive Council and local authority health services, the Team thought that "It does not seem worth providing a comparable breakdown routinely ... and we therefore propose restricting it to hospitals", although further consideration would be given to the implications of an integrated N.H.S.[31]

5.2.3 The Sub-Programme Structure

For the second level of the structure of objectives or means - ends hierarchy,[32] the Team proposed "to divide expenditure by function" as follows:[33]

(i) Prevention;

(ii) Treatment and long-term support: inpatient;

(iii) Treatment and long-term support: other residential;

(iv) Treatment and long-term support: domiciliary;

(v) Research;

(vi) Manpower training;

(vii) Administration and general support.

Treatment and long-term support are classified together "because the medical boundary between a chronic condition

and a series of acute, treatable episodes changes over time".

The next consideration in designing the programme structure was to examine the kind and availability of input and output information to be presented.

5.2.4 Information on Inputs

The Project Team looked at the two main inputs to services: finance and manpower. Since P.P.B.S. would be used "for planning and monitoring the direction and performance of the Service in broad terms" and not "for short-term budgeting and operational control purposes" then it was not considered necessary that the breakdown of information should be 100% accurate, except for input totals.[34] A margin of error of 10% was deemed acceptable, and perhaps more for small items.

(a) Financial Information

(i) The Concept of Cost

Costs may be defined as e.g. costs to central government, total public expenditure, costs to Gross National Product, and other community costs.[35] But since the "prime purpose" of P.P.B.S. "is to secure optimum deployment of the resources available for the N.H.S." the Team suggested that the programme budget should show "public expenditure on the health and personal social services as defined for P.E.S.C. purposes". Other advantages of this approach were that[36] "public expenditure is of major interest to Ministers in presenting Government policy to the public, and that the P.E.S.C. programme and

other financial information is also on a public expenditure basis". Of course social opportunity costs will differ considerably in many cases from monetary costs, e.g. the unrestricted market price of land, the social and economic costs of patients' time, etc. Cost-benefit and cost-effectiveness studies would have to take account of these wider social costs.

(ii) Capital

The major problem relating to capital expenditure was "whether capital costs should be annuitized or counted at the date when they are incurred."[37] Since, however, the programme budget would be "concerned primarily with public expenditure and resource allocation within budgetary constraints" it was suggested that capital costs "should be counted in the year in which they are incurred. This also reflects the point at which demands are made on national resources". Capital costs would also be shown separately from revenue.

For analytical studies, however, account must be taken of opportunity costs.[38] It would be necessary, therefore, to "annuitize capital costs at the test discount rate" for purpose-built accommodation, and to use imputed market rent for office accommodation.

(iii) Joint and Overhead Costs

This first attempt at a programme structure was based mainly on the use of existing information wherever possible. However,

> "there will still be many problems in allocating costs between programmes, for instance the home

> helps and ambulances on the local authority side, the work of general practitioners and many hospital departments, e.g. X-ray and administrative costs generally."[39]

Such methods as multiple regression could apportion all costs but

> "cost information collected routinely will include general items; it will have to be decided how far these should remain unallocated, how far accountants' methods of allocation are considered adequate, and whether in some cases special studies should be carried out to get a better allocation."

However, the Team considered that it might not always be worth the time and effort allocating expenditure in any great detail since it would not be "of significance for policy choice." As opposed to the original American concept, "the test in every case should be relevance to the decision process".

On the subject of overhead costs,[40] it was considered that since P.P.B.S. is concerned with long-term planning "it is probably true to say that most overheads are attributable to particular services and that marginal and average costs are therefore about equal". But for short-term decisions, special studies would be needed to determine short-term marginal costs. A further major problem is the lack of adequate recorded information on these costs.

(iv) Charges and Exemptions

The Team regarded the P.E.S.S. method of showing expenditure net of charges as unsatisfactory "because charges might have other objectives besides reducing public expenditure. Charges and exemptions together also

influence the distributional effect of the National Health Service". It was decided, therefore, that charges should be regarded as negative programmes and that the programme budget should present information on gross expenditure, charges, exemptions and net expenditure.[41] This, however, was not agreed to, as will be seen later on. P.E.S.S. figures are net of charges such as prescription and local authority charges which amount to 8-10% of total expenditure. Income from pay beds, etc., which amounts to less than 1% of total spending, is however not deducted. The Programme Budget figures are now net of all income.

(v) Private Expenditure

It was decided that expenditure by the private sector should be excluded, there being in any case little information available.[42] Small amounts of expenditure are, however, made to e.g. voluntary bodies for the purpose of increasing private expenditure, thereby making it difficult to estimate the proportion of output attributable to public expenditure. Special studies might be needed here.

Finally, the Team recognised certain other problems relating "to transfer payments and to Civil Servants' superannuation", but it was considered that "these do not raise major points of principle."[43]

(b) Manpower Inputs

The Team pointed out[44] that the N.H.S. has traditionally experienced difficulty in recruiting and

training staff, and that in some cases the long time-lags involved in increasing the supply of highly skilled manpower had the effect of making supply relatively inelastic. Thus manpower involved constraints additional to those of finance. Furthermore, highly skilled manpower has additional expenditure consequences in the form of general support services. It was therefore recommended that manpower as well as public expenditure costs should be recorded in the programme budget, though the degree of detail was left to further examination.

5.2.5 Information on Outputs

The Team considered that "output" "does not necessarily mean a tangible product" but "is an expression of an organisation's success in achieving its aims and objectives".[45] Measures of output should ideally be derived from "an agreed statement of aims and objectives", but as mentioned earlier, it is very difficult to get agreement on these objectives. Quite apart from these "value" problems, there are serious cognitive difficulties.[46] Outputs should be "final" and should reflect the ultimate objectives of the services. The main outputs, or "consequences", of the N.H.S. are, e.g. the restoration of health, the prevention of illness, the reduction of morbidity, the alleviation of disability or the relief from pain. Yet there are at present "no generally agreed objective indicators or measures of many of these final outputs, nor are there likely to be in the near future". In addition to these outputs, the health services are concerned "with population questions, with certain cosmetic

aims (in much of dentistry), with custodial care (for example, of insane criminals), with health education and with certain types of manpower training."[47] The personal social services are concerned "with certain problems of social interaction (particularly in the family) and with the care of some members of vulnerable groups (such as the elderly)".

As regards the "production" of health, the Team recognised the "additional difficulty that there is little knowledge of how the final outputs of the health etc. services are affected by non-health service factors such as housing, climate, income levels and occupational environment". A.J.Culyer[48] has pointed out that an individual "owns" a "stock" of health which is subject to depreciation through time, and which could fall so low as to result in death. This stock of health can be increased through "investment", which is determined by such things as diet, exercise, housing, consumption, environmental factors, education, etc. in addition to medical care. This makes it very difficult to ascertain the proportion of health output attributable to the N.H.S., which is an essential element in the evaluation of performance.

Despite these difficulties, the Team thought that "success can still be usefully assessed (and resource costs calculated) in terms of 'intermediate' outputs". These were defined as "the things which are done in order to achieve the final outputs". However, intermediate outputs "may necessitate assumptions about the standard of care given or, where the cost comparisons are to be

made, may need to be supplemented by qualitative judgements". Examples of these outputs were given as the number of cases treated, the numbers of diagnostic investigations carried out or, for chronic disorders, the number of patients cared for. These measures are more readily obtainable and are more likely to be meaningful to decision-makers.[49]

In considering the kind of intermediate outputs to use, it was decided that they should meet the following criteria:[50]

(a) "There should be widespread agreement among potential users of the system that the outputs were relevant to measuring the success of the service, though without making any precise value judgements". In other words, there must be agreement on the measurement, as distinct from the valuation, of outputs.

(b) "In the short term ... the information should be available or reasonably easy to obtain". There would be no additional information requirements.

(c) "In the longer term ... the usefulness of the information should be commensurate with the effort which would be needed to obtain it". That is, the benefit/cost ratio of information should be greater than one.

The problem, however, with the intermediate outputs of numbers of patients, etc. is that these measures give little or no indication of the effectiveness of treatment given. They are "relevant to monitoring, to consideration

of cost effectiveness and to some extent also to forecasting, but they do not directly assist in planning for the future or in judgements on priorities."[51] For planning purposes, "some means is required of identifying the marginal outputs which chould be achieved or would be lost with an increase or decrease of resources". Output assessment and priority determination would require a study of "currently unmet need".[52] But it is very difficult in practice to distinguish between "need" and "demand", since

> "apart from work load data the information usually available shows only the demand for services - and demand is in part influenced by the availability of resources to meet it and is in any case an unsatisfactory basis for planning. Waiting lists are a well-known example of these difficulties."

It is possible in a few cases to calculate need fairly precisely, e.g. the need to vaccinate a high risk group or to give ante-natal care to expectant mothers. In such cases, participation rates would be a good indicator of need. Participation rates could also be used to compare regional differences in morbidity, although "measuring morbidity is itself difficult". The use of special studies of need would also have to be extended, e.g. "the sampling of the needs of old people in their homes, measuring different degrees of immobility among the disabled, studying the health care needs of those in long stay institutions, studying the relative urgency of cases on waiting lists for different specialties and in different areas". These studies would, however, have to rely on "professional judgements" but "they would fit well into

the P.P.B. framework and should help both with priority decisions and with uncovering priority needs which are not at present translated into demand". Apart from the specific areas mentioned above, the Team considered that it is 'unlikely that any comprehensive assessment of health etc. needs could be obtained".

An approach which had been used in the past was that of "norms of provision"[53]. But the difficulty was "that the norms tend to be norms of inputs and unless they were based on an assessment of health care needs or some other measure of desired output, this approach could very easily lose sight of outputs". Some means would have to be found of setting norms "in terms of quantity or quality of output", or at the very least, of relating input norms to expected output.

The possibility of measuring some of the wider benefits of health care, such as "reductions in absence from work through sickness", was also explored.[54] Special studies could provide further information on "economic" benefits in some areas, but this was not possible "across the board". The Team thought that these extra benefits could be shown in the programme budget, but not at the expense of the more direct benefits: "because these can be measured and valued whereas the other benefits of the health service cannot, this must not lead to relative over-weighting of those benefits which happen to be measurable".

The development of output indicators was left to further consultation and special study, but it was

recognised that in the short term, "the lack of readily available output information in many fields will be a significant drawback."[55]

5.3 THE PROGRAMME STRUCTURE OF THE SECOND REPORT

5.3.1 Introduction

The Second Report of the P.P.B. Project Team, "Planning Programming Budgeting System For The Health and Personal Social Services", was completed in January 1972.[56] The main recommendations of the First Report, "that a programme budget for health and personal social services should be developed mainly on the basis of client groups", and that "its prime aims should be to assist with determining priorities and with achieving the most cost effective use of resources", together with the subsidiary recommendations, were "accepted" by senior officials "as the basis for further work".[57]

The Second Report concentrated mainly upon the design of a programme budget, and because of the continuing uncertainty regarding the detailed decision processes of the reorganised N.H.S., the Team "were instructed in June to give priority to the development of a programme budget for use at departmental level." The relevance of the national programme structure to the new health authorities would be considered in greater detail at a later date.[58]

The Team were given the following work programme:[59]

(1) "examination of the particular problems of the per-

sonal social services (which had not so far been adequately covered)". The First Report had concentrated almost entirely upon the health services, but it was now recognised that the programme budget should cover both health and social services.

(2) "the detailed design of a programme budget (for national use)".

(3) "the development of input information to fit the budget, with initial emphasis on finance".

(4) "development of intermediate output indicators".

To aid consideration of the first of these tasks, the Team was enlarged to include two officials from the Social Work Service in July 1971, and another Economic Adviser joined the Team in September 1971.[60]

During consideration of the programme structure in this second study, the Project Team modified its approach. Work began initially on the design of a programme structure for the Maternity client group "in consultation with the interested administrative and professional divisions".[61] A list of broad aims and possible output measures was agreed, and a detailed programme structure drawn up, as shown below.

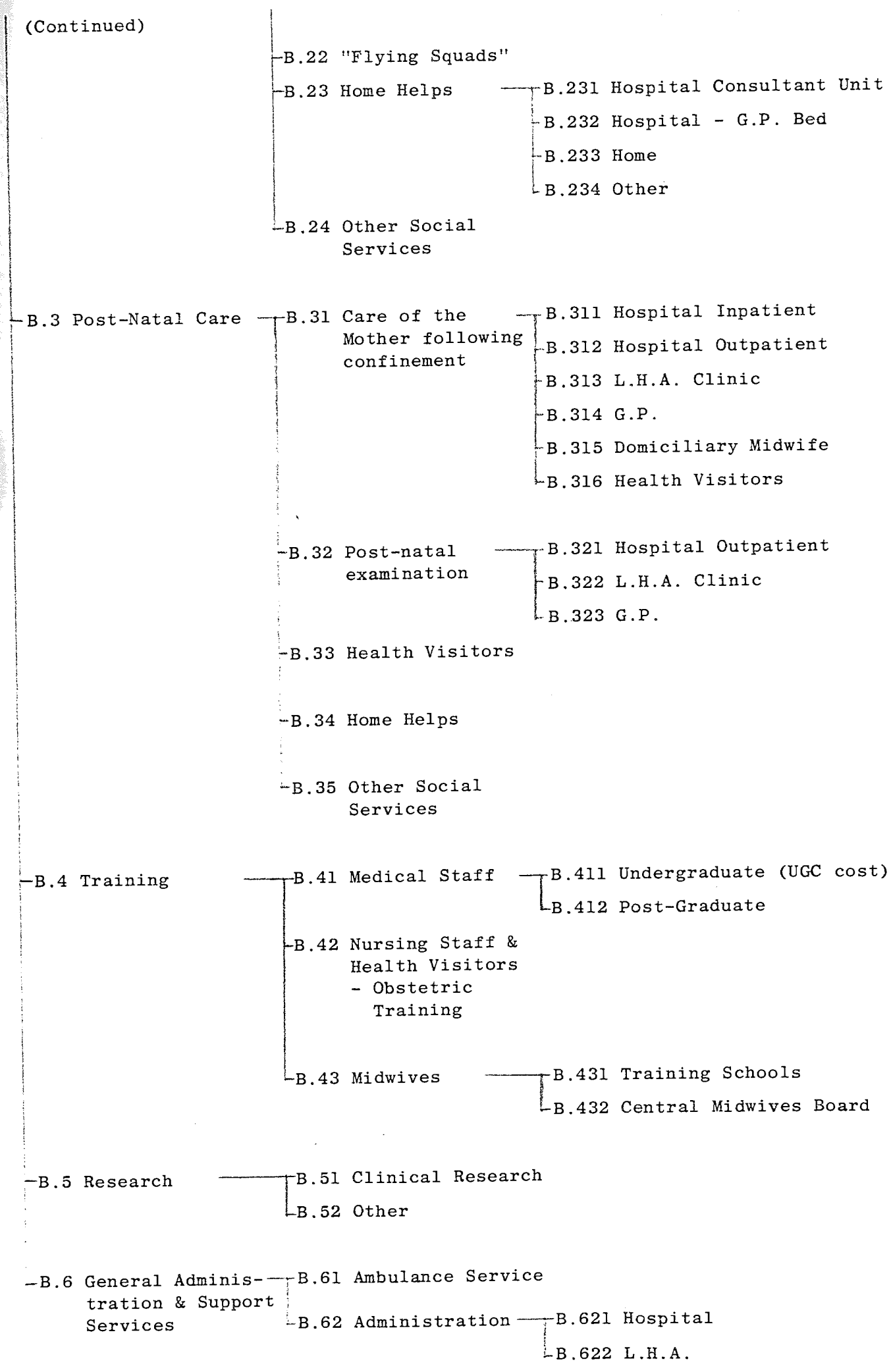
Programme Structure for Maternity

(Pregnancy, Delivery and Post-Natal Care of the Mother)

B - Maternity

- B.1 Ante-Natal Care
  - B.11 Confirmation of Pregnancy
    - B.111 Hospital
    - B.112 L.H.A. Clinic
    - B.113 G.P.
  - B.12 Ante-natal Examinations, Tests, etc.
    - B.121 Hospital
    - B.122 L.H.A. Clinic
    - B.123 G.P.
    - B.124 Domiciliary midwife
    - B.125 Health Visitor/ Home Nurse
  - B.13 Mothercraft and Relaxation Classes
    - B.131 Hospital-Midwives
    - B.132 L.H.A.Centre
    - B.133 G.P.Premises
    - B.134 Home

    (B.132, B.133, B.134 — Domiciliary Midwives and Health Visitors)
  - B.14 Dental treatment (charges foregone)
    - B.141 L.H.A. Clinic
    - B.142 General Dental Services
  - B.15 Pharmaceutical Services (charges foregone)
  - B.16 Welfare Foods
    - B.161 Free Milk
    - B.162 Vitamin Supplements
  - B.17 Abnormal cases - Hospital inpatient
  - B.18 Social Services — (Home Helps, Child Minders, Day Nurseries, etc.)
- B.2 Confinement
  - B.21 Delivery
    - B.211 Hospital-Consultant Unit
    - B.212 Hospital-G.P. Bed
    - B.213 Home
    - B.214 Other


(Continued)
B.22 "Flying Squads"
B.23 Home Helps
B.231 Hospital Consultant Unit
B.232 Hospital - G.P. Bed
B.233 Home
B.234 Other
B.24 Other Social Services
B.3 Post-Natal Care
B.31 Care of the Mother following confinement
B.311 Hospital Inpatient
B.312 Hospital Outpatient
B.313 L.H.A. Clinic
B.314 G.P.
B.315 Domiciliary Midwife
B.316 Health Visitors
B.32 Post-natal examination
B.321 Hospital Outpatient
B.322 L.H.A. Clinic
B.323 G.P.
B.33 Health Visitors
B.34 Home Helps
B.35 Other Social Services
B.4 Training
B.41 Medical Staff
B.411 Undergraduate (UGC cost)
B.412 Post-Graduate
B.42 Nursing Staff & Health Visitors - Obstetric Training
B.43 Midwives
B.431 Training Schools
B.432 Central Midwives Board
B.5 Research
B.51 Clinical Research
B.52 Other
B.6 General Administration & Support Services
B.61 Ambulance Service
B.62 Administration
B.621 Hospital
B.622 L.H.A.

Work also began on the Children's, Dental, Mental Illness and Mental Handicap programmes. However, it was considered that the information requirements to produce these budgets would be "very expensive" and in the short term "impracticable". The structures "would be invaluable for special analyses and major policy decisions in relation to individual programmes, e.g. to decisions between methods of delivery of care", but they were not considered of great relevance "for the more regular processes of planning and resource allocation". A "simpler" programme budget was needed for these latter purposes, and its "most essential function" would be to provide "a link between, on the one hand, policy formulation and planning of individual programmes at Divisional level and, on the other, resource planning and 'top of the office' decisions about overall strategy".

Because of these two separate, but related, aspects, the Team divided its work into two areas:[62]

(1) "Continued exploration of particular programmes in detail with the policy divisions concerned, with a view to devising a framework appropriate for special studies and major policy analyses, to defining aims and objectives and to considering possible output measures."

(2) "The design of a programme budget for the health and personal social services as a whole which
   (i) could be used at national level for overall planning and resource allocation;
   (ii) could be clad at least with financial information which was available or could be obtained in the short and medium term, and
   (iii) could therefore be got off the ground by April 1973."

Of the first of these activities, the Team was not yet ready to report further. Indeed, this aspect of its

work proved over-ambitious: "it was soon found that idealised structures could not be costed, nor final output measurements found".[63] The second of the two areas of work was carried out by a sub-group of the Team comprising the doctor, the Social Work Service official, the Treasury Principal, and the second Economic Adviser.[64]

5.3.2 The Functions of the National Programme Budget

The Team reiterated and re-emphasised the aims and objectives of the programme budget within the wider PPB system as follows:[65]

(1) The national programme budget "should help the Department, both immediately and within the planning system proposed for the reorganised Department, to consider major strategic and priority issues. It should provide a framework of essential information about the past and present situation and about future possibilities, so that competing claims on resources, and eventually detailed divisional plans for particular programmes, can be reconciled with P.E.S.C. and other expected resource constraints. It should also enable the impact of possible changes in one part of the system on other parts to be seen and the benefits which might be derived from alternative developments to be compared."

(2) The programme structure would be "based on client groups and should bring together different services included in the care of each client group, in particular hospitals, community health services and the personal social services", thereby aiding the planning process which would take place "in both client group and service teams, with the first emphasis on the former."

(3) The programme budget would show the "demands made by individual client group programmes on constrained resources other than finance" in such a way as to "facilitate identification of potential shortages which call for special action (e.g. an expanded training programme or the transfer of work to other types of staff) if the available resources are not to be overstretched."

(4) The programme budget "should enable trends in provision, utilisation and unit costs to be analysed so as to assist forecasting."

(5) The programme budget "should help to monitor the general development of the health and personal social services and to indicate areas where objectives are not being achieved and where special studies may be useful."

(6) The programme budget "should form a focal point for bringing together all the different aspects of departmental policy into a single forward plan which is coherent and realistic in that it takes account of the existing situation, the rate at which the Department is likely to be able to alter current trends, and overall resource constraints."[66]

(7) The programme budget "could also be used as a framework for exploring alternative developments compatible with resource constraints or which could be achieved with additional resources. Since the need for more services is open ended it is difficult to consider whether more provision 'ought' to be made in one programme unless it can be shown what would have to be given up elsewhere to make this possible. Questions of priorities become more meaningful if all programmes can from time to time be considered together and the programme budget could be useful in this way. The budget should also help to identify areas suitable for special study and to decide priorities for such studies."[67]

The Second Report, as mentioned earlier, concentrated on the programme budget aspect of P.P.B.S. This is not because the Team regarded the other aspects as unimportant. As in the case of Education, the design of a programme structure came first since it provides the basic framework for the whole sequence of planning, programming, budgeting and monitoring stages. It is also the most original and complex aspect of P.P.B.S., therefore requiring much preliminary consideration. Furthermore, in the case of the H.P.S.S., the procedural aspects had to be left until the detailed decision processes were known for the

reorganised system. The future planning system for the D.H.S.S. was the responsibility of a different team (the D.H.S.S. Review Team mentioned in the previous chapter in connection with the organisational context). This allowed a certain division of labour but necessitated co-ordination. The PPB Team recognised that the programme budget "is essentially a planning tool"[68] and that it must be "designed to fit into the Department's future planning procedures". The work of both Teams developed "in parallel" and there was "close consultation".[69] The conclusions of the Review Team will be analysed in Chapter 6.

5.3.3 The Information Requirement

The Project Team were constrained by the "practical limitations on the information which is available or could reasonably be collected";[70] and in addition they "sometimes had to compromise between the information required for the different functions". However, they did have the advantage that with the reorganisation of the H.P.S.S., "new forms of accounts, costing returns and activity statistics are being worked out".[71] They regarded this as a "unique chance to get better information for the programme budget". Conversely,

> "one important function of the programme structure could be to define common categories for use across all financial and statistical returns unless there is special reason to diverge from them. This should make it much easier in future to bring together financial and activity returns and to relate activities of different services to each other."

For this purpose, the Team were keeping in contact with the groups responsible for these changes. But, as Schick has pointed out in the American context,[72] the information requirements for the three budgetary functions of strategic planning, operational management and financial control differ markedly. The Team recognised that "estimates and accounts are needed for financial control and management, for which a client group basis may not always be suitable." It was necessary, therefore,

> "to compromise between the advantage of lining up the programme structure with a classification acceptable for financial returns, thus ensuring reliable annual information at no extra cost, and the disadvantages of moving from a genuine client group classification to a more activity based programme structure, thus losing the links between different activities serving common client groups."

5.3.4 The Main Programme Structure

The First Report concentrated mainly upon the health services and the programme structure was designed "without regard to what information might be available in the short or medium term."[73] The Second Report rectified this imbalance by examining the particular problems of the personal social services and how they could be integrated with the health services in one programme structure.

The social services advisers first of all pointed out that the client group classification which was important for the personal social services was different from that which was appropriate for the health services: "the needs of clients were more determined by their age and the severity of their personal and social problems than by any

specific medical condition". But on the other hand, "there were areas where there was a close relationship between the activities of the health and social services". For this reason, and because the organisation of the H.P.S.S. "only came together at national level", the Team thought that "there would be great advantages in producing a common programme structure for both services which illuminated the areas of overlap". It was decided to work on the two services separately and then to see what modifications, if any, would be required for integration.

A - Hospital Services

For the hospital services, which account for over half of the total expenditure on the H.P.S.S., 5 possible bases for a programme structure were considered:[74]

(i) Diseases;

(ii) Diagnostic Groups;

(iii) Specialties;

(iv) Age Banding;

(v) Dependency.

The Team's job was to consider which of these forms of classification was most relevant to "a genuine client group approach, defined in terms of problems".

Diseases and Dependency were first examined as being most applicable to a problem group classification. In particular, cost effectiveness analyses of treatment and prevention "can only meaningfully be considered on the basis of particular diseases". But the problem here was that "the number of diseases runs into several thousand",

so this was considered an impracticable basis for a programme structure. As regards the degree of Dependency, the Team thought this "an interesting approach but also quite impracticable for the present."

The Team next looked at Specialties and Diagnostic Groups, since these appeared at first sight to be "fairly similar, so that specialties might be taken as a proxy for type of diagnosis".[75] However, the Hospital In-Patient Enquiry data shows that most diseases and diagnostic groups may be treated "in any of a number of specialties." Although diagnostic groups are closer to client groups than specialties, they "have very little significance for policy" because (a) "cost effectiveness comparisons are meaningless at diagnostic group level", and (b) "the allocation of resources is to specialties, not diagnostic groups". Specialty groupings were considered to have the following advantages:

(i) They are "the main basis of current activity analysis in the SH3 returns". This enables costs to be allocated to specialties by the use of regression analysis, "explaining variation in average costs per case for different hospitals by variation in case mix, and hence deriving average case costs for each specialty." Similar regressions for diagnostic groups "would have to be based on much less reliable information about case mix and would require a very major research programme."

(ii) It was hoped that eventually hospital accounts would be "based on groups of specialties corresponding to

responsibility centres for management, with common services allocated between them".

(iii) "Some output information is on a specialty basis, for instance waiting lists (although these must be used with great care)".

(iv) "Some resources are specific to specialties or groups of specialties, very few to diagnostic groups".

(v) Finally, the Team considered that "there are probably significant differences in trends in expenditure between different groups of specialties".

The diagnostic group approach was not, however, completely written off, but it was deferred to the "longer term".[76] Research had shown that 80% of the variation in average cost per case could be explained by using 41 diagnostic categories from the International Classification of Diseases (e.g. Infectious and Parasitic Diseases, Malignant Neoplasms, etc.) When aggregated into 10 diagnostic groups, diagnostic mix still explained 70% of the variation. Specialty mix could only explain 50% or less of the variation in average costs. Diagnostic groups would therefore appear to be more significant in determining expenditure. They were also considered more relevant "if trends in morbidity are eventually to be considered as well as demographic trends in forecasting future needs", though for the moment the information on morbidity was not available. Finally, they were also "one way of relating general practice and hospital workload".

As regards Age Banding, the Team considered that "age is not as important as medical condition from the health service point of view".[77] It was, however, considered important because (a) "incidence of different problems varies with age", and (b) "so probably does cost per case". For this reason, it was suggested that each main programme should be subdivided on an age basis with breaks at ages 16 and 65, and possibly at 5 and 75. This could be done from existing information, though allocations would not be so reliable as those between specialties. The information would come from the Hospital In-Patient Enquiry on length of stay with cost per case assumed as proportionate to length of stay. This method would, however, overstate the costs for the elderly since they stay in hospital longer, whereas in actual fact costs are not likely to increase at the same rate as length of stay.

Specialties were thus chosen as the basis for a programme structure for the acute hospital services, for use "now and in the medium term."[78] The problem was which and how many to choose, particularly as they related "almost entirely to the hospital field and it is doubtful how far other parts of the health and personal social services can be subdivided in this way". On the other hand, the specialties outside of the acute sector "bear a rather closer relationship to the client groups which we see as the main determinants of our programmes for other parts of the services". For example, the hospital psychiatry subdivisions of mental illness and mental

handicap, and geriatrics would be included in the main programmes for the mentally ill, the mentally handicapped, and the elderly. There are, however, problems of allocation. Firstly, the specialties of geriatrics and general medicine overlap, which means that some expenditure recorded as medical should really be classed as for the elderly, "and perhaps vice versa". The Team thought that this was due to "a genuine overlap of role between doctors in these two specialties". It was therefore decided to attribute all "medical" expenditure to the medical programme and "geriatric" expenditure to the programme for the elderly without making any adjustments. The second problem arose because "there are quite a number of patients in the care of psychiatrists who are not suffering from functional mental illness". They ought ideally, if the resources were available, to be in geriatric beds and so recorded. For the medium term, this misclassification problem would need further study.

For the acute sector, therefore, the Team looked to existing information on specialty classifications. But the group which was working on the new accounts for the reorganised N.H.S. had found that there was "considerable divergence between hospitals as to how different specialties are defined".[79] There was a need for an unambiguous grouping, so the Team decided on the distinction between "medical" and "surgical" specialties. This was thought to be "probably the most meaningful division" for such purposes as, e.g. medical manpower training. A more detailed breakdown would be considered at a later date

if the information became available.

There were still, however, problems of allocation and classification difficulties. These related to obstetrics, gynaecology, dental surgery, eye surgery, accident and emergency, paediatrics and chronic sick. These will be discussed in turn below:

(a) Obstetrics

The Team considered that the hospital specialty of obstetrics ought to be classified with the domiciliary maternity services in a separate Maternity programme.[80]

(b) Gynaecology

This specialty, although for organisational purposes associated with obstetrics, was included in the surgery specialty.[81]

(c) Dental Surgery

Dental surgery and dental services for hospital patients are "closely related" to the community dental services, and for this reason were included in a Dental programme.[82]

(d) Eye Surgery

This was included with surgery since the community opthalmic services are principally concerned with refractive errors.[83]

(e) Accident and Emergency

There were two main reasons for a separate treatment of these services.[84] Firstly, they "cut across other specialties since patients may move from them into any acute specialty". Secondly, they "offer

an alternative to the general practitioner for dealing with minor problems where access to a G.P. may be difficult either geographically or because of the time of day". For these two reasons that G.P.s and accident and emergency departments have similar functions of "dealing with emergencies and giving access to the health service", it was recommended that accident and emergency should be included in a Primary Care programme.

(f) Paediatrics

The paediatric classification raised greater difficulties.[85] Children in hospital are in the clinical charge of many other specialist consultants including paediatricians, though the latter "is increasingly recognised as having an overall general interest in the care of all of them". In addition, there is a great deal of overlap between paediatrics and such other specialties as infectious diseases. Paediatrics thus resembles geriatrics, and could be classified in a Children's programme. However, the Team decided against this because outside the hospital there is little connection between paediatrics and the child care work of the personal social services, which in any case was to include the social care of whole families in need of support. It was decided, therefore, to include paediatrics in the medical specialties programme. This would be reconsidered if paediatrics developed as a community specialty related to the social problems of children and families.

(g) Chronic Sick

This specialty "includes very few people under 65", and was therefore included with geriatrics.[86] However, "units for the younger disabled" would be included in a programme for the Younger Disabled when the new SH3 returns became operational.

The final programme structure recommended for the hospital services was thus based on the following main categories:[87]

(1) Surgical Acute;

(2) Medical Acute;

(3) Geriatric and Chronic Sick;

(4) Mental Illness

(5) Mental Handicap;

(6) Younger Disabled;

(7) Obstetrics;

(8) Dental Surgery

(9) Accident and Emergency.

These divisions corresponded to the proposed structure for the new form of accounts "with the exceptions of dental surgery, units for the younger disabled, and an unresolved problem in relation to geriatrics". However, this proposed structure, essentially a form of specialty budgeting, did not materialise. The relative merits of the present functional versus the proposed specialty budgeting systems will be examined in the next chapter.

B - Community Health Services

As mentioned earlier, the Team regarded primary care

as a parallel specialty to the hospital acute services.[88] This would involve allocating out those aspects of a G.P.s work which correspond to the main programme outside the acute specialties:

> "general practitioners probably make little specific contribution to care of the physically and mentally handicapped in respect of their handicapping condition, but do make an important contribution to maternity, mental illness and also possibly children with behavioural problems ... and special care of the elderly. They also make a contribution to preventive work for which a separate programme is proposed ..."

For this general primary care part of general practice, the Team also recommended further subdivision according to age. Information on costs and age groups was to be obtained from the Royal College of General Practitioners' morbidity survey and information on special payments for prevention and maternity work. As regards drugs, these could be allocated "on the same basis as general practice costs, but this would introduce considerable errors, and there is little information available about the relationship between client groups and drug use".

The dental and ophthalmic services were classified as main programmes.[89] The ophthalmic services could have been included in the programme for physical handicap, but as this only covers children and adults it was decided to have a separate programme for the ophthalmic services covering all ages.

The (now former) local health services were regarded as being concerned mainly with "prevention and screening" for which a separate programme was recommended.[90] Health visiting and home nursing, on the other hand, "contribute

to support of various groups with long-term problems and also to early discharge from acute hospital specialties, and costs should be allocated out". The emergency ambulance services provide access to the health service in emergencies and were thus allocated to primary care. Non-emergency ambulance services are related to hospital specialties which the Team thought should be allocated out if possible.

C - The Personal Social Services

These services are concerned with "ongoing problems of those suffering from mental illness or handicap, physical handicap or social problems".[91] The need for services was thought to depend more on "age", "severity" and "type of problem", than on specific medical conditions. The following main structure of client groups was recommended, subdivided for children, adults, and elderly where appropriate:

(i) "Children and families needing help for reasons other than physical or mental handicap or ill health". This includes children "with behavioural problems, or who are delinquent or maladjusted", and problems associated with "inadequacy, illness or absense of one or both parents, homelessness and divorce".

(ii) "The mentally handicapped (all ages)".

(iii) "The mentally ill". Mental illness refers to "functional mental illness in all ages, but in practice including very few children". This programme was also to include "people with senile dementia, alcoholics and drug addicts", mainly

because of the lack of information on these groups which might suggest separate classification.

(iv) "The younger physically handicapped, including children and adults but not the elderly, since there is no clear distinction between the elderly physically handicapped and elderly people needing assistance in general".

(v) "The elderly, including those with physically handicap but excluding those with functional mental illness, senile dementia or mental handicap".

The Team thought that there should also be a programme for "socially dependent adults", but this was omitted because "there is at present no statutory obligation on local authorities to provide for adults who are neither ill nor handicapped, and no expenditure has as yet been identified ..."

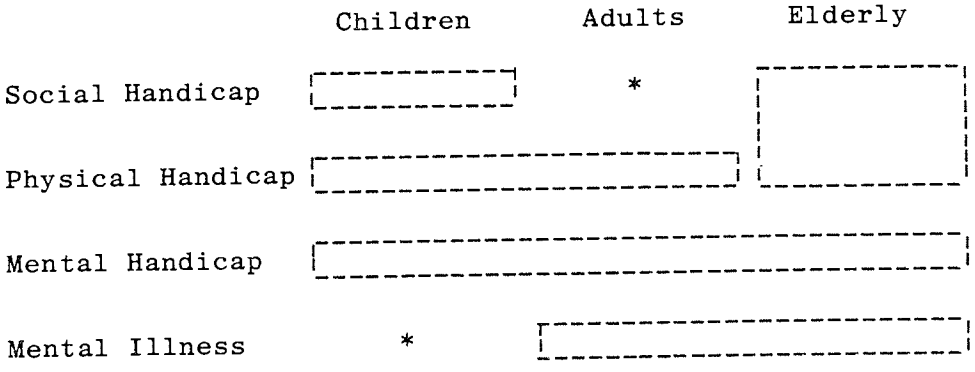
These categories could not, however, be regarded as mutually exclusive and there would "inevitably be difficult cases where people have multiple problems."[92] For example, the elderly with senile dementia were usually included with elderly mentally handicapped and mentally ill people as the "elderly mentally infirm". For this reason senile dementia was included with mental illness, though further research would be needed because hospital geriatric care might be more appropriate than psychiatric care for these people. For the "large majority of cases", however, the above classifications would "provide a useful basis for general planning and resource allocation".

The services for children and families "are almost

purely social in content apart from child guidance and child psychiatry".[93] But since a child under stress "may produce symptoms of delinquency, behavioural disturbance or educational under-attainment", it was decided that all these services should be grouped together rather than allocating child guidance and child psychiatry to mental illness.

Non-specific activities, such as field work, would need "to be allocated from analysis of who the clients are, either from regular statistical returns or from sample surveys".[94]

The programme structure for the personal social services can thus be shown as having two main dimensions: age and type of problem[95] :-



*Negligible expenditure

D - Prevention, Screening and Health Education

In the First Report, preventive services were allocated out on a "diagnostic" basis, e.g. mental illness, infectious diseases, diseases of the chest, ear, nose and throat, etc., because of "the trade-off between prevention and treatment".[96] This is possible, however, only "on the basis of individual diseases". The Team considered that

prevention and screening "must therefore either remain unallocated or be shown as part of a special programme for the promotion of health". The latter was preferred because "prevention of illness is an important objective in its own right". However, where prevention or screening could be allocated, the Team suggested that it be shown in square brackets as well as being included in the main general health programme. Health education, and possibly also family planning were to be included in the general health category. Abortion was thought to have some similarity with family planning, but for the time being was included under gynaecology. It was also suggested that general social development work by the personal social services might be included if the information was available. The programme would then have to be altered to "promotion of health and social development".

E - Research

Health research, like prevention, may be related to diseases or diagnostic groups, or may cut across client groups, e.g. research on methods of health care delivery.[97] Most public expenditure on health research is attributable to the Medical Research Council. The Team did not have time to consider this expenditure. Another important source of research lies in teaching hospitals, but it would be very difficult to identify since their higher unit costs are due to "a mixture of training, research, more difficult cases, and traditionally higher level of

expenditure ..." In the short term, the extra costs of the teaching hospitals would be shown as unallocated and there would be no separate programme for research.

Social services research may be related to client groups, age groups or services.[98] It may also cross boundaries, e.g. "visiting services for the elderly, or day services for the physically, mentally and socially handicapped children". Most research is sponsored by the D.H.S.S., but many local authorities are beginning to undertake research.

F-Common Programme Structure

The Project Team considered that it was possible to produce a common programme structure for both the health and personal social services "both in principle by using a common client group approach, and in practice with available information, provided slight modifications and a few untidy edges are accepted."[99] The hospital specialties of mental illness, mental handicap and geriatrics (including chronic sick) provide "comparable groupings" to the mentally ill, mentally handicapped and elderly groupings of the personal social services. In these areas both the health and the personal social services "provide for analogous groups and, to some extent complement and provide alternatives to each other's service". There is also some overlap with the younger disabled for such things as the provision of aids. On the other hand, social services for children and families and health services for children "are not providing for analogous groups".

There were still, however, problems of allocation relating mainly to the hospital services:

> "the allocation of expenditure will ... be improved and put onto the same basis as the allocation of social service expenditure if the psychiatric and geriatric programmes can be distinguished on a diagnostic rather than a bed classification basis."

A common programme for the H.P.S.S. naturally involves some compromise on both sides. For the social services the main programmes would be based on client groups rather than age "except for the elderly who are physically or socially handicapped."[100] However, age banding would be shown for the physically and mentally handicapped and the mentally ill. The common programme structure would therefore be based on

> "the use of a specialty basis for the acute hospital services, the development of a common programme structure based on client groups defined by problem and age for the non-acute hospital and personal social services, and broad age banding across all programmes."[101]

The main programme structure is as follows:[102]

(a) General Health

Health education, prevention and screening, health visiting and clinics for young children, welfare foods, family planning, school health services (from the DES) and possibly school meals and milk (from the DES). (The latter remained, however, the responsibility of the DES). Community development work by the social services would be included if the information became available.

(b) Primary Care

GP services (unless otherwise allocated out to other

main programmes) drugs, accident and emergency departments.

(c) Maternity

This programme includes the immediate post natal care of the mother and child.

(d) Children and Families

Personal social services for children and families who need help because of delinquency or maladjustment of the child, inadequacy, illness, absence of one or both parents, poverty or homelessness. The programme also includes child guidance and child psychiatry. Age group 0-18.

(e) Elderly

Special care of the elderly (aged 65 and over), including geriatric and chronic sick specialties, and community services for the elderly, including the elderly physically handicapped. General health care of the elderly by the G.P., acute hospital services, services for the elderly mentally ill and mentally handicapped, are all excluded.

(f) Younger Disabled

Hospital and community services for the younger physically handicapped (i.e. children and adults up to age 65).

(g) Mentally Handicapped

Hospital and community services for the mentally handicapped of all ages.

(h) Mentally Ill

Hospital and community services for those with

functional mental illness or senile dementia, including drug addicts and alcoholics, but excluding maladjusted children.

(i) Surgical

Hospital surgical specialties, excluding dental surgery.

(j) Medical

Hospital medical specialties, including paediatrics.

(k) Dental

Community and hospital services, including school dental services (from the DES).

(l) Ophthalmic

Ophthalmic services for the correction of refractive errors, with the possible inclusion of part of the school health service, but excluding treatment of diseases of the eye (which is included with primary care and the hospital acute services).

Before going on to look at the sub-programme structure, the Project Team considered the special problems associated with two major inputs, capital expenditure and training.

5.3.5 Capital Expenditure and Training

These two items are in the nature of "investments" which involve costs now but which yield a stream of benefits in the future. For this reason, they present special problems:[103]

(i) "how to handle the costs of capital and training";

(ii) "how to allocate such expenditure between programmes";

(iii) "how to divide such expenditure between replacement, extra provision and raised standards".

(a) Capital

Two alternatives were considered: using a separate capital budget; and putting capital expenditure in a current budget. Of the first, the Team thought that there was "a lot to be said for this".[104] It would enable cash expenditure on capital "to be shown programme by programme as they are incurred" and it would facilitate "reconciliation between total demands on capital and total available resources". It would also be "the most useful vehicle for dividing expenditure between replacement, extra provision and raised standards".

The second alternative was considered more problematic.[105] Three options were open:

(1) "It can be entered in a current Programme Budget as costs when it is incurred - that is in lumps";

(2) "It can be spread over its lifetime by annuitisation";

(3) "It can be omitted altogether".

As regards the first option, it was considered that in this way "all the actual cash expenditure in any one year in a programme is shown".[106] Financial constraints would be clarified and priority decisions facilitated. This method would be "by far the easiest and hence most practicable way of handling capital-short, of course, of complete exclusion".

The advantage of annuitisation was thought to be "much stronger on theoretical grounds than that for lump-sum treatment".[107] On the other hand, its practical

difficulties were greater. The main argument against the first option is that it imposes the financial cost of capital on the years when it makes little or no contribution to output.[108] The annuitisation method, however, would require a more detailed examination of the long-run costs of capital facilities.[109]

Even when these problems had been solved, there would still be the problem of allocating capital to the programmes.[110] This difficulty would be greatest in the hospital sector since "much capital is multipurpose and the pattern of programme use for a hospital may change over time". In such cases rough allocations based on the original purposes of the capital would have to be made, with adjustments whenever necessary. Re-allocation of capital annuities between programmes, if such a course were chosen, would bring the treatment of capital expenditure into line with that of current expenditure. Some capital expenditure might, however, have to be left unallocated.

The Team came to no firm conclusion on the treatment of capital. The First Report had recommended entering capital within a current programme budget as costs when incurred, but it was realised that "there are arguments for and against each of these procedures", and a decision was deferred pending further examination.[111]

(b) Training

Training was regarded as a form of investment since "it involves the imparting of skills to individuals over a short period of time who yield services corresponding to

these skills over a longer future".[112] However, a separate training budget would not be as relevant as a separate capital budget since "costs are not separately budgeted for or even accurately accounted for and they are thus not subject to the same kind of budgetary constraints". Training costs are also "more stable from year to year, so that the averaging of investment costs is less necessary". But the Team did consider that a "manpower budget" might eventually be developed, which would "relate programme plans, training and investment in a co-ordinated way".

Having considered the main programme structure, the Second Report went on to the design of a sub-programme structure.

5.3.6 The Sub-Programme Structure

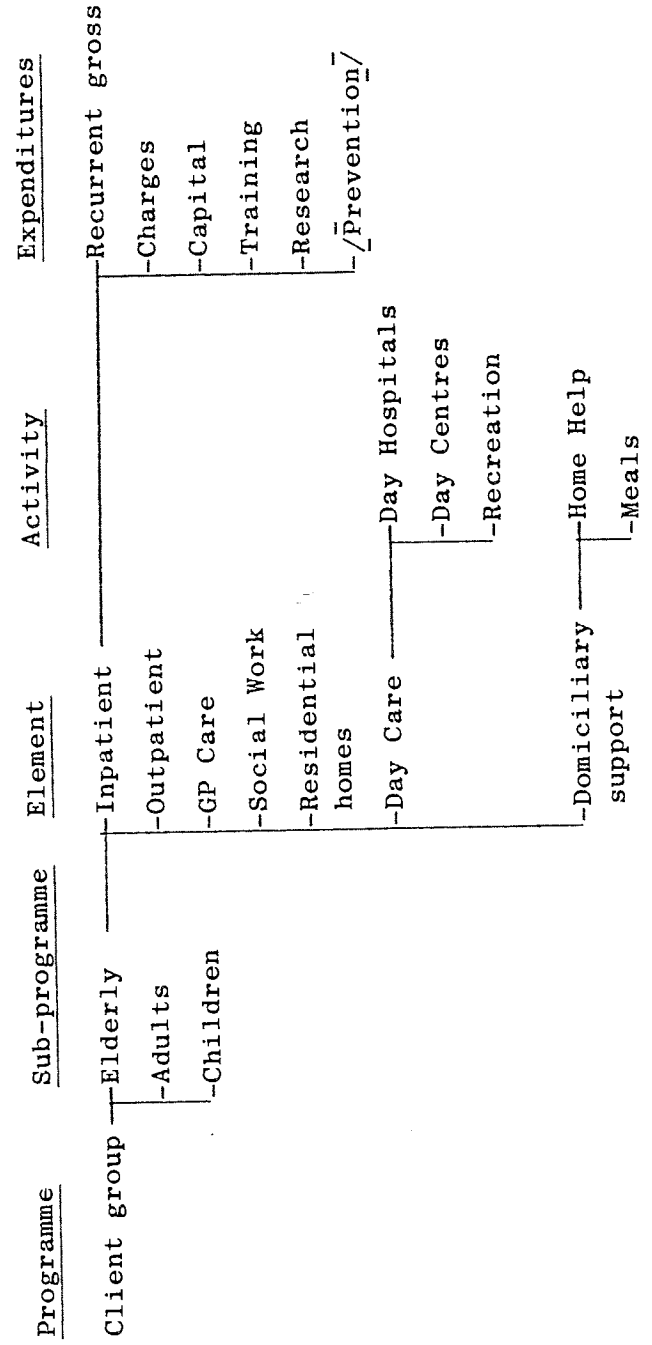
The First Report suggested that different types of care should be distinguished below each main programme, i.e. prevention, treatment, long term support, etc. were to represent "packages" of care for such groups as the mentally ill, the elderly, etc. The Second Report, however, did not regard this as a useful approach for the H.P.S.S.[113] The Team pointed out that the H.P.S.S. were different from such services as education, "where large numbers of people receive fairly homogeneous services determined by their age and what they are studying where". The service packages delivered to the clients of the H.P.S.S., on the other hand, "vary almost infinitely with the client's particular problem, the

locally available facilities and the decision of the doctor or social worker". For example, a mentally ill patient may receive a series of treatments in hospital as an in-patient together with community support in between hospital treatment. This hospital/community proportion will also vary according to the individual case. Community services for the elderly will also vary in their domiciliary support and day care elements. Even if these alternative packages could be identified the average costs over all clients "would have no meaning at all". For the analysis of alternatives "it is essential to identify those clients for whom there is a genuine choice, for instance between hospital and residential care, or residential and home care, and examine in detail the particular requirements of this marginal group". For all these reasons, this approach was rejected for a sub-programme structure. The Team suggested instead that

> "we should examine the possibility of developing rough indicators of what is going on within main programmes in terms of balance of care and standards of provision as well as intermediate or final output. These indicators would help the Department to monitor how different services for client groups were developing and might suggest areas where analysis was desirable; a single indicator at any point in time would not be very meaningful, but movement over time and perhaps also comparison between areas might be significant."

The Team considered, however, that it might be "convenient to group activities within programmes, for instance the different forms of domiciliary support could be grouped together."[114] Capital expenditure would be separated from current, and research and training costs

would be identified wherever possible. Administration was either unallocable or associated with specific activities. Prevention was to be shown in square brackets where it could be allocated. The revised sub-structure, "common to most programmes", was to be as follows:



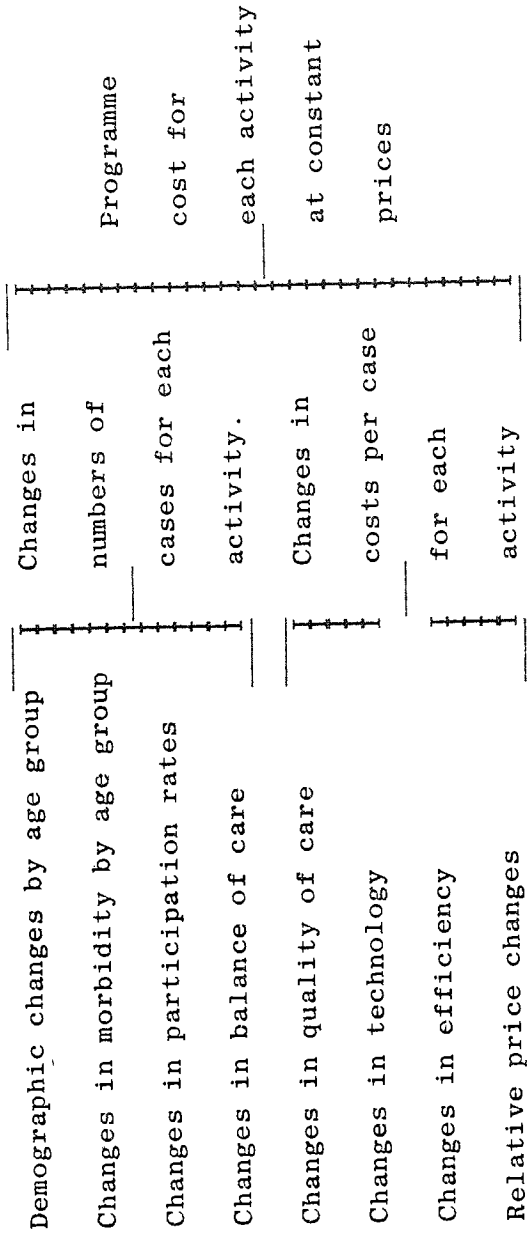
The Team admitted that this programme structure was "simplified".[115] As the Second Report had already pointed out at the beginning, in connection with the detailed programme structures for such programmes as maternity, these latter would be invaluable for special studies but not for routine planning work.[116] The simplified structure "would not in any way preclude more detailed analysis of any individual programme using a special sub-structure to illuminate the particular objectives and options for the client group concerned". The simplified structure "should provide a good starting point for such further work".

Having designed the basic framework of the programme structure, the Team went on to examine the more detailed information required for forecasting, planning and monitoring.

5.3.7 Forecasting and Forward Planning

The principle that forecasting, forward planning and monitoring should be based on the same measures was put forward since "the forward plan must be based on targets for provision of services for different groups" and "the Department will wish to know how far these policies are being implemented, and information about how services have developed in the past in turn forms the basis for the next round of forecasting and policy review".[117]

For the purpose of analysing trends and forecasting, the following "ideal" disaggregation was recommended.[118]



It was realised, however, that this degree of detail was not possible in the short term, particularly since "morbidity figures are not available, and unit costs for each activity will have to be taken as a single measure reflecting changes in standards of care and changes in technology and efficiency". For these reasons, activity disaggregations would be based on:[119]

(a) Number of cases;

(b) Unit costs per case;

(c) Size of client group (specific where possible, e.g. maternity or mentally handicapped; otherwise general population disaggregated by age);

(d) Participation rate ((a) divided by (c)).

An examination of past trends in these figures would "provide a basis for producing a forward programme budget".[120] This process of forecasting would include the use of "Independent demographic forecasts" and "exports in each programme ... should be consulted about probable future developments".

The whole process so far would constitute a base-case analysis. The next stage would be to consider Departmental policy for each client group, in particular:[121]

(1) Policy on levels of provision which would affect participation rates;

(2) Policy on balance of care which might alter the participation rates for different activities and sets of activities;

(3) Policy on standards of care which will directly affect unit costs.

Exogenous trends plus Departmental policy would "form the basis for producing future numbers and unit costs for each activity, and hence total costs". Other matters which would have to be taken into account would be inflation, relative prices and pay awards. These would require discussions with the Treasury and the Central Statistical Office.

The Team also recommended a second approach to forecasting which could be used as a "check" on the first method.[122] They considered that in some cases "total expenditure may be more closely related to manpower (e.g. consultants, G.P.s or social workers) or to capital units (e.g. wards, clinics) than to the number of clients using these resources". These forecasts should be compared with the main forecasts, and any divergences used for revising underlying assumptions and for suggesting "probable bottlenecks".

It was recognised that in the early years of P.P.B.S. the forward programme budget would "inevitably be crude".[123] This would be primarily due to lack of relevant data. But as the system developed it might "be possible to develop alternative forward plans providing a range within which lower level authorities could operate".

Having discussed the determinants of expenditure, the Team went on to consider in greater detail their relationship to Departmental objectives and output monitoring.

5.3.8 Objectives, Outputs and Monitoring

The Team considered that there were three main areas that the D.H.S.S. might want to monitor from a client group perspective:[124]

(1) "generally what is happening in the system, what resources are being used by what groups, and what trends are present". This would give a "general picture of how services are developing".

(2) "the extent to which Departmental policies and objectives are being implemented and specific targets met".

(3) "how successful the system is in achieving more underlying aims such as preventing and curing ill health and ameliorating handicapping conditions". This refers to the measurement of final output.

On the third area, it was recognised that "there is very little information available on final outputs which measure success in achieving the aims of the health and personal social services."[125] There were some exceptions, e.g. "in the maternity and general health programmes, where the level of infant and maternal deaths and handicapping conditions arising at birth, and the incidence of certain diseases subject to preventive programmes can be measured". Performance and unmet need might also be measured by "recurrence of problems and length of waiting time (if very carefully analysed)". But in general it would only be possible to measure "intermediate outputs, which are concerned with what is being done for people rather than what effect it has on them". There are three main groups of intermediate output:

(1) Number of cases;

(2) Standards of provision, e.g. various measures of quality of accommodation, staff/client ratios, etc.;

(3) Balance of care, "including range as well as average mix of services being delivered to different client groups".

D.H.S.S. policies and targets are generally in terms

of these types of output, "because final output cannot be measured."[126] Thus in the short term these measures would have to be used for the programme budget. But in the longer term "it is obviously desirable ... to get better measures of final output, to see how these correlate with intermediate outputs, and thus to assess the effectiveness of different policies". In the main, this would "require years if not decades of research", so that "for most programmes the immediate need for PPB purposes is to develop intermediate outputs". Even this would be "a very complex task".[127] Simple measures such as number of cases often mask important distinctions. For example, there is no information on whether different inpatient events refer to the same or different people. Outpatient returns do distinguish between first and subsequent appointments, but these cannot be related to inpatient care. The Royal College of General Practitioners (RCGP) morbidity survey links consultations and referrals to patients, but the survey is not based on a random sample of doctors. As regards the personal social services, there is little information to relate the people who receive, e.g. domestic help and meals on wheels. For a "meaningful measure", "events need to be linked to people". This would require special study, but for the analysis of alternatives and balance of care it would be essential. Standards of provision, on the other hand, are "extremely difficult to measure", e.g. the quality of buildings, and this would also require further examination.

Monitoring standards of provision and balance of care

would require "special sampling" probably every few years.[128] But information on the number of client events and unit costs would be needed annually for the purpose of forecasting and rolling the programme budget forward. This information would satisfy the "general picture" monitoring requirement referred to earlier, and would help to identify emerging problems and the need for special studies. Information on the success of specific policies would have to be obtained outside of the routine PPB cycle. The third area of monitoring, the measurement of final output, would in "most areas ... be impossible ... for many years to come".

The Team next considered the applicability of the national programme structure to the "lower level" authorities.[129]

5.3.9 The National Programme Structure and Health and Local Authorities

The Team thought that the national programme structure could also be used at health and local authority level, but this did not imply "translating the national plan into corresponding programme budgets at lower levels, nor ... controlling lower level authorities in programme budget terms."[130] On the other hand

> "if the Department's policies are brought together into a single plan which is considered capable of fulfilment with available resources rather than a statement of the ideal, and if whatever decisions the Department does control are made in accordance with this plan, this in itself may well increase the influence of the Department on the development of the different services for which it is responsible."

This was regarded as applying both to the personal social services, "where there is no possibility of imposing a uniform programme structure or controlling allocation of resources from the centre", and the health services. However, some decisions will always be taken by the D.H.S.S., some by lower levels, so that the programme budget would inevitably be "in part a forecast and in part a plan".

Thus a national programme budget would be very useful to the D.H.S.S. "without lower level authorities planning or being controlled in programme budget terms."[131] It would however, be advantageous "if programme budget information could be produced at regional and perhaps area health authority level, using boundaries as similar as possible to those incorporated in the national programme budget". A programme budget at the AHA level would also contribute to joint planning. But the main problem related to the information requirement. The Team hoped that specialty groupings would be incorporated in the estimates, accounts and costing returns,[132] but this was not to be. Even with speciality budgeting, there would still have been the problem of allocating such items as G.P.s, drugs, social work, ambulances, home nursing, domestic help, etc. between the various client groups. Special samples and assumptions which might be reasonably valid at national level for a national programme budget might be totally inapplicable at local level.

Irrespective of whether health authorities use a programme budget, there would still be the problem of

relating their plans to the national programme budget.[133] If health authorities used the national programme structure, this would make it "much easier to identify any incompatibility at the planning stage." An alternative was that

> "national programmes could be translated into targets for the development of different services and lower level plans considered on this basis, leaving to one side the question of how authorities intended or hoped to deploy services used by several client groups".

In the event of any inconsistencies between national and health authority plans, the question of D.H.S.S. control arises.[134] The Team pointed out that in general, "both the Department and the regions have more control over the creation of resources than their deployment". Many services are "general purpose" and their use "is determined at ground level by doctors, social workers and so on". This meant that health authorities could not ensure that client group plans were carried out, except where a service is specific to a client group, e.g. midwives and psychiatric wards. Policy-making must therefore take into account the way in which general purpose resources are deployed at the ground level, e.g. "it is no good having a policy for domiciliary support of a particular client group which depends critically on home help if social workers use home helps almost entirely for some other client group". The Team thought that in such cases, "either the policy must be abandoned, a new resource created or those controlling the existing services persuaded to adopt Departmental policy". But it was still

considered "useful to monitor the way in which services are developing and being used in cases where the Department is not in control as well as where it is".

Finally, the Team considered the allocation of resources to health authorities.[135] The present system of resource allocation will be examined in detail in the next chapter, but it is important to record here the fundamental problem encountered by the Team relating to definitive budgeting.

> "It seems very doubtful whether funds could be allocated first to client groups on a national basis and then to regions and areas within each client group, because so many services serve many client groups, the way in which some of these general purpose resources are deployed is controlled at lower levels and can only be measured on a sample basis from time to time, and it is therefore impossible to make firm allocations and control expenditure in detail on programme budget lines".

It was, however, considered desirable that regional allocations should be compatible with national client group policies. The problem still remains of how to secure this.

5.4 RECENT DEVELOPMENT OF THE PROGRAMME STRUCTURE

5.4.1 The 1976 National Programme Budget

The first National Programme Budget to be issued for field planning, was published in "Priorities for Health and Personal Social Services in England: A Consultative Document", March 1976,[136] (hereinafter referred to as the Consultative Document). The programme budget was regarded as a "crude method of costing policies

based on past expenditure" rather than "a complex technical tool". Its "central purpose" was to enable the D.H.S.S. "to cost policies for service development across the board, so that priorities can be considered within realistic financial constraints". It was to be neither a "forecast" nor a "plan" but "a way of exploring possible future strategies for development". The programme budget covered all the health and personal social services in England as defined for P.E.S.S. at a national aggregate level. Some "closely related expenditure" was, however, excluded because it did not fall within this definition, e.g. sheltered housing, sheltered employment, and the blind home workers' schemes.

The programme orientation of the budget was said to be "more meaningful in considering options and priorities" than the P.E.S.S. breakdown and the traditional estimates and accounts. However, a complete breakdown by objectives, e.g. the treatment of specific medical conditions, "would be extremely detailed and complex, and far too cumbersome for an across-the-board review; the necessary data is not in any case available". Thus the information required for "evaluating options in detail" was not provided. There were, however, "certain major groups of services cutting across administrative boundaries, which provide complementary and alternative forms of care for certain important groups of users, in particular the elderly, the physically and mentally handicapped, the mentally ill and children". These "client groups" were also "the subject of special policies and priorities, and

their numbers are changing in very different ways with the changing age structure of the population". For these reasons, it was also thought useful to distinguish maternity services.

It was considered possible to carry out "a fairly detailed allocation of expenditure to these 'client groups'", but to "facilitate comparison" with health and local authority planning, the programmes presented were "simply a grouping of services by major user". This "watered down" version was regarded as "very inadequate" but "at least it did group together some services which have strong complementary or substitute relationships."[137] Primary care and hospital services used by the whole population, including the elderly and children, were shown as two separate "whole population" programmes, with maternity services separately identified within the hospital programme. Because there was so much "overlap" between the services for the elderly and the physically handicapped these were grouped together. The concept of "major user" does not always refer to sole user, e.g. all home nursing and geriatric medicine are included in the "elderly" programme, and health visiting (though not paediatrics, since this cannot be costed separately) in the programme for "children". The "whole population" programmes have been variously referred to as "residual", "locational",[138] or "service"[139] groupings, which reflect the ambiguity surrounding these two classifications. They have been described as a "compromise" between client groups and the information available.

The Consultative Document listed 7 programmes comprising 42 services, as follows:

(i) Primary Care

- general medical service;
- general dental service;
- general ophthalmic service;
- pharmaceutical service;
- health centres;
- prevention;
- family planning.

(ii) General and Acute Hospital and Maternity Services

- acute inpatient and outpatient; (including Accident and Emergency previously under Primary Care);
- ambulance; (previously under Primary Care);
- miscellaneous hospital; (includes teaching costs, mass radiography, blood transfusion service, income and accounting adjustments);
- obstetric inpatient and outpatient;
- midwives.

(iii) Services Mainly for the Elderly and Physically Handicapped

- geriatric inpatient and outpatient (including units for the younger disabled);
- non-psychiatric day patient; (covers geriatric patients and also units for younger disabled and intermittent dialysis);
- home nursing;
- chiropody;
- residential care;
- home help;
- meals-
- day care

- aids, adaptations, phones, etc.;

- services for the disabled.

(iv) Services for the Mentally Handicapped

- mentally handicapped inpatient and outpatient;

- residential care;

- day care.

(v) Services for the Mentally Ill

- mentally ill inpatient and outpatient;

- psychiatric day patient;

- residential care;

- day care;

- special hospitals.

(vi) Services Mainly for Children

- clinics;

- health visiting;

- school health;

- welfare food;

- residential care;

- boarding out;

- day nurseries;

- central grants and Youth Treatment Centres.

(vii) Other Services

- social work;

- additional social services training;

- other local authority services;

- miscellaneous centrally financed services (including other health expenditure, Departmental administration and research)

In addition to this programme classification, the same services were grouped according to "sector" as follows:

Hospital and Community Health

- acute inpatient and outpatient;
- ambulances;
- miscellaneous hospital;
- obstetric inpatient and outpatient;
- geriatric inpatient and outpatient;
- non-psychiatric day patient;
- mentally handicapped inpatient and outpatient;
- mentally ill inpatient and outpatient;
- psychiatric day patient;
- health visiting;
- home nursing;
- midwives;
- prevention;
- chiropody;
- family planning;
- school health;
- health centres;
- clinics.

Family Practitioner Services

- general medical service;
- general dental service;
- generalophthalmic service;
- pharmaceutical service.

Local Authority Personal Social Services

- residential - elderly and disabled;
  - mentally handicapped;
  - mentally ill;
  - children;

- boarding out;
- home help;
- meals;
- day care - elderly and disabled;
  - mentally handicapped;
  - mentally ill;
- day nurseries;
- aids, adaptations, phones, etc;
- social work;
- additional social services training;
- other local authority services.

(N.B. Joint finance, recorded under Hospital and Community Health for P.E.S.S. purposes, is here included in Local Authority Personal Social Services)

Centrally Financed Services

- welfare food;
- services for the disabled;
- special hospitals;
- central grants and Youth Treatment Centres;
- miscellaneous centrally financed services.

Expenditure on these services was analysed in terms of:

Average Current Growth per annum 1970/71 to 1973/74:

1973/74 Outturn, Capital and Current;

1975/76 Provisional Estimate, Capital and Current;

1979/80 Illustrative Projection, Capital and Current;

Illustrative Average Current Growth per annum 1975/76 to 1979/80 (as a percentage).

For internal D.H.S.S. purposes, further analyses of

age banding, levels of provision, and unit costs were made.[140] The information in the Consultative Document was "simplified" for two reasons:

(a) "we wanted to present something which regions and areas could themselves use if they wanted to ... whereas some of our age banding was based on material from the General Household Survey and National Morbidity Survey which could only be used at a national level";

(b) "if one is going to consider past trends and future proposals against a baseline year it is much easier to do this if one uses a single dimension of analysis, leaving the other for changes over time".

The second reason is perhaps valid in presenting an across-the-board analysis for the purposes of a consultative document, but for the purposes of health and local authority planning, a much greater degree of detail, particularly on output, is required.

For its own planning work, the D.H.S.S. classified their information as follows:

Services	Expenditure				Output (i.e. levels of provision)	Unit Costs
	Recent Growth %	Base Year	Illustrative Projection	Implied Growth %	As for expenditure	As for expenditure

The detailed methodology of the programme budget will be discussed in the next chapter. Here the emphasis is on the programme structure. It is important, however, to point out the timescale of this first programme budget.

The expenditure trends over the 4 years from 1970/71 to 1973/74 were essential for costing future policy. The latest available accounting information was for 1973/74 and since the H.P.S.S. were "moving from a period of substantial growth into one of lower growth", it was necessary to make an estimate for 1975/76.[141] Projections could then be made to 1979/80 on the basis of information in the Public Expenditure White Paper. The programme budget was thus a 4 year forward programme, but for the purposes of health authority planning, as will be seen in the next chapter, it was essentially a 3 year programme based on the final 3 years of the White Paper.

Soon after the Consultative Document came the first of the annual Planning Guidelines for health authorities (HC(76)29) in May 1976.[142] These set out for the first time "Implied Average Levels of Provision and Current Expenditure per Head" in programme budget form. There were 14 hospital and community health services selected to indicate priorities, but without any client grouping:

- acute inpatient;
- obstetric inpatient;
- geriatric inpatient;
- younger disabled inpatient;
- non-psychiatric day patient;
- mentally handicapped inpatient;
- mentally ill inpatient;
- psychiatric day patient;
- clinics;
- health visiting;

- home nursing;

- chiropody;

- family planning;

- school health.

The output indicators for these services were given as:

(1) Estimated (1975/76) and Implied (1979/80)

Levels of Provision in terms of:

- beds per 1000 assumed population (for acute, geriatric, disabled, mentally handicapped and mentally ill inpatients);

- beds per 1000 births (for obstetric inpatients);

- places per 1000 assumed population (for day patients);

- staff per 1000 assumed population (for health visitors and home nurses).

The "assumed" populations were based on the following age groupings:

(i) 0-4 years (for clinics);

(ii) 5-14/5-15 years (for school health);

(iii) 15-64 years (for disabled inpatients and family planning);

(iv) 65+ years (for geriatric inpatients, non-psychiatric day patients and chiropody);

(v) All births (for obstetric inpatients);

(vi) Total (for the remaining services).

The years 1975/76 to 1979/80 refer to the previous, current and 3 forward years as in the Public Expenditure White Paper.

(2) Throughput, for the same years, in terms of

- cases per bed (for acute and obstetric inpatients);

or - occupancy rate.

(3) Estimated (1975/76) and Illustrated (1979/80) Cost

per - case;

- occupied bed;

- place; or

- staff.

(4) Estimated Expenditure per Head of assumed population (1975/76) and Illustrative Expenditure (1979/80).

(5) Departmental Guideline on Level of Provision. These "guidelines" differ in kind, status and timescale and are taken from various official publications:

5.4.2 The 1977 National Programme Budget

In September 1977, the D.H.S.S. published "The Way Forward"[143] as a strategic follow-up to the Consultative Document (as distinct from the annual operational guidelines). The programme budget projections were said to represent "broad national objectives" and "are not specific targets to be achieved by declared dates, even at a national aggregate level".[144] They "illustrate what might be achieved given provisional resource constraints", but "are not based on any detailed information about the intentions of authorities ..." Average Levels of Provision and Current Expenditure per Head were given this time for Hospital and Community Health Services, and for the Local Authority Personal Social Services. The former comprised 26 services:[145]

- acute inpatient;
- acute outpatient;
- obstetric inpatient;
- obstetric outpatient;
- geriatric inpatient;

- geriatric outpatient;
- younger disabled inpatient;
- mental handicap inpatient;
- mental handicap outpatient;
- mental illness inpatient;
- elderly severely mentally infirm inpatient;
- mental illness outpatient;
- non-psychiatric day patient;
- mental illness day patient;
- elderly severely mentally infirm day patient;
- ambulances;
- other hospital;
- health visiting;
- district nursing;
- midwifery;
- prevention;
- chiropody;
- family planning;
- school health;
- other community health;
- administration.

Output indicators for these services were given as:

(1) Level of Provision (including Departmental Guidelines) in terms of

- available beds;
- places; or
- staff

per 1000 "appropriate" population:

0- 4 years (prevention);

5-15 years (school health);

15-64 years (younger disabled inpatients and family planning);

65+ years (geriatric inpatients and outpatients, elderly severely mentally infirm inpatients and day patients, non-psychiatric day patients and chiropody);

All births (obstetric inpatients and outpatients);

Total (all remaining services)

for the years 1975/76 (Outturn) and 1979/80 (Illustrative Projection).

(2) Throughput (Outturn and Illustrative Projection) for the same years, in terms of

- cases per bed (for acute, obstetric and geriatric inpatients);
- occupancy rate (for disabled, mentally handicapped, mentally ill and elderly severely mentally infirm inpatients).

(3) Cost per Unit of Provision (Outturn and Illustrative Projection) for the same years in terms of

- cases;
- occupied beds;
- places; or
- staff (whole time equivalent).

(4) Expenditure per Head of Population (Outturn and Illustrative Projection) for the same years.

The personal social services comprised 19 services grouped into 3 broad categories:[146]

(1) Residential

- elderly
- younger disabled;

- mental handicap - adults;

- mental handicap - children;

- mental illness;

- children.

(2) Day Care

- elderly;

- younger disabled;

- mental handicap;

- mental illness;

- day nurseries.

(3) Other Services

- home helps;

- social workers;

- meals;

- boarding out;

- aids, adaptations, etc;

- intermediate treatment;

- other local authority services;

- administration.

Output indicators for these services are:

(1) Level of Provision (including Departmental Guidelines) for 1975/76 (Outturn) and 1979/80 (Illustrative Projection), per 1000 "appropriate" population:

0- 4 years (day nurseries);

0-15 years (residential mentally handicapped children);

0-17 years (residential children and boarding out);

5-17 years (intermediate treatment);

16+ years (residential mentally handicapped adults);

15-64 years (younger disabled residential and day care);

65+ years (elderly residential and day care, home helps and meals);

Total (all remaining services)

in terms of:

- available places;
- staff (WTE); or
- meals per week.

(2) Occupancy Rate (%)

(3) Cost per Occupied Place, Available Place, Meal or Staff for 1975/76 and 1979/80.

(4) Expenditure per Head of Population for 1975/76 and 1979/80.

Figures were also given in separate tables of Current Expenditure Per Head by Programme and Region (for hospital and community health services for 1975/76) and of Programme Expenditure as a percentage of total expenditure (capital and current), for the years 1975/76 (Consultative Document provisional estimate, and Outturn) and 1979/80 Illustrative Projection.

The Way Forward also notified some minor changes in the programme structure:[147]

(a) N.H.S. administrative costs are separately identified under Other Services instead of being included in expenditure on particular services. This change was necessitated by the information requirement of the new N.H.S. accounting returns.

(b) Similarly, administrative costs are separately identified for the personal social services.

(c) There is no separate provision for "training" in the social services.

(d) Intermediate treatment is separately identified instead of being included in "Other Local Authority Services".

(e) "Clinics" are moved from children's services to primary care and included with "other community health".

5.4.3 The 1978 National Programme Budget

The 1977 National Programme Budget, described above, was not included in the D.H.S.S. Planning Guidelines for 1977/78 (HC(77)19), May 1977 because of the financial uncertainty associated with the later years of the Public Expenditure White Paper (Cmnd. 6721).[148] The Way Forward itself confined itself to a re-evaluation of the Consultative Document figures. The 1978 National Programme Budget, however, was included in the D.H.S.S. guidelines for 1978/79 (HC(78)12) (LAC(78)6), March 1978.[149]

The 1978 guidelines explained the purpose of the illustrative projections in the programme budget.[150] These projections "show an overall national package of services that could be provided with the money available", and are included:

"(a) to illustrate the modest shift in resources required by the guidelines,

(b) to show how the figures add up,

(c) to demonstrate the assumptions implied, e.g. about growth in unit costs and level of provision,

(d) to indicate the national long-term pace and direction of service development."

Their relevance to local planning was explained:

> "The figures can aid local planning by providing an indication of potential areas for change and assisting a quantitative approach. But they must be considered and applied in the light of local circumstances. National projections are not specific local targets; they are not maxima or minima to be achieved in any particular place. They are national averages and as such reflect what in practice will be a wide variation between areas in the requirement for and development of services"

and again: projections illustrate

> "a possible national distribution of expenditure and level of service provision in 1981/82 consistent with ... financial assumptions and compatible with Ministers' priorities. These illustrative projections are not targets, but signposts indicating the direction of change to be pursued through the strategic planning decade. They are not specific targets for national developments, still less local targets to be aimed at by particular authorities regardless of local circumstances or of the baselines from which they start. The projections illustrate national averages which may reflect wide local variations in patterns of expenditure and provision of services."[151]

In addition to levels of activity and expenditure in 1976/77 and the Public Expenditure White Paper, Cmnd. 7049, the 1978 programme budget took account for the first time of "recent information from regional health authorities and local authorities".[152] These sources of information will be examined in the next chapter. Furthermore, tables analysing both expenditure, as in the Consultative Document, and level of provision, as in The Way Forward, were given.[153] The first sets of tables analysed expenditure by programme and by sector, indicating "rates of growth in expenditure which at a national level broadly reflect the priorities set out in these guidelines". The second set of tables "show what levels of activity might be achieved within the

projected expenditure given the assumptions about growth in costs per unit of provision indicated in the Tables". Departmental "guidelines" were again included "for ease of reference", but these had to be "treated with caution since they differ in kind, quality or status from one to another".[154]

As regards the allocation of expenditure to services, the 1978 guidelines re-emphasised the following points:[155]

(i) Expenditure on maternity is allocated to obstetric services whereas expenditure on the newborn is allocated within the acute services. This "reflects the different nature of the consultant cover for the two services - obstetric for maternity services and paediatric for babies - which in turn is reflected in the statistical data available to the Department."

(ii) Expenditure on health visiting is allocated to "Services mainly for Children" and expenditure on home nursing to "Services mainly for the Elderly". It was pointed out, however, that this "is not to imply that these staff work only with these client groups, but in the absence of a detailed breakdown of activity, expenditure has been assigned to the groups to which it is thought staff devote the substantial proportion of their time".

(iii) Expenditure on the elderly severely mentally infirm is included under mental illness.

The Summary Table by Programme listed 7 programmes as in the Consultative Document and comprised 40 services (no subdivision of the Family Practitioner Services, hence 39 services plus 2 services for health and local authority administration plus intermediate treatment minus additional social services training minus clinics). Expenditure on these services was given in terms of:[156]

- 1976/77 Outturn (Revenue and Capital);
- 1981/82 Illustrative Projection (Revenue and Capital);
- Illustrative Annual Growth Rate per annum on Revenue Account.

The Summary Table by Sector also listed 40 services and gave the same expenditure analysis. The Average Levels of Provision and Current Expenditure per Head Tables listed the same 26 services for the hospital and community health services and 19 services for the local authority personal social services as in The Way Forward. Output indicators were also the same, but for the years 1976/77 and 1981/82 (i.e. the two previous years and the next four years).[157]

5.4.4 The Programme Structure for the Health Authorities

In June 1976[158] the D.H.S.S. proposed a programme structure for RHAs and AHAs "in a form which enables a comparison to be made with analyses prepared in the Department for strategic planning purposes". The programme structure was not obligatory, but was recommended for the purpose of providing a "strategic planning information base."[159] There were 8 programmes comprising 27

services. The structure corresponded roughly to the health side of the national programme structure, except that there was a separate programme for Maternity Services, accident and emergency was separately identified instead of being included in Acute Outpatients, information on mental handicap day patients was requested, school health was subdivided, general administration was separate from community health councils and day cases are allocated between programmes instead of being allocated entirely to Acute Outpatients:[160]

(i) General and Acute Hospital Services

- acute inpatients, outpatients and day cases;
- accident and emergency;
- ambulance services;
- other hospital services not covered elsewhere.

(ii) Primary Care Services

- general medical service;
- general dental service;
- general ophthalmic service;
- pharmaceutical service;
- prevention (other than health visiting);
- family planning;
- other community care services not covered elsewhere.

(iii) Services Mainly for the Elderly and Physically Handicapped

- geriatric and younger disabled inpatients, outpatients and day cases;
- non-psychiatric day patients;
- home nursing;
- chiropody.

(iv) Services for the Mentally Ill

- mental illness inpatients, outpatients and day cases;
- psychiatric day patients (excluding mentally handicapped day patients if possible);

(v) Services for the Mentally Handicapped

- mental handicap inpatients and outpatients;
- mental handicap day patients (if possible);

(vi) Services Mainly for Children

- health visiting;
- school health - medical;
  - nursing;
  - dental;

(vii) Maternity Services

- obstetric inpatients, outpatients and day cases;
- community midwives (if possible);

(viii) Other

- general administration (administration, financial services, management services, education and training);
- Community Health Councils.

N.B. Day cases are separately specified in acute, geriatric, mental illness and obstetric, instead of being included in Acute Outpatients.

In January 1978, the Standing Group on N.H.S. Planning (set up the year before to improve communication between the D.H.S.S. and the N.H.S. on planning[161]) recommended the introduction of a series of tables for the Summary Analysis of Strategic Plans (SASP) which would provide "a minimum core of quantified information".[162] The 1977 regional strategic plans (to be discussed in

greater detail in the next chapter) were "tentative and incomplete"[163] and failed "to link service objectives to financial, capital and manpower resources",[164] hence the need to append SASP tables to the next regional strategic plans. The SASP tables provide a "format" for the "quantification of the pattern of service provision set as the strategic objective and the changes in resources identified as essential to its attainment",[165] and were designed so that the baseline "can be derived from present statistical and financial information".[166]

The D.H.S.S. considered that long-term planning requires a method of estimating costs which is "quick and simple" and which is related to levels of service provision or "output" rather than to resources used. Hence the SASP tables included a programme budget for revenue. But because of the difficulties of output costing and measurement, a choice could be made from 3 approaches to the revenue programme budget SASP table no. 3:[167]

(1) an analysis of level of provision, current expenditure, throughput, cases and unit costs;

(2) a shorter version looking at level of provision and current expenditure only;

(3) an alternative table giving details of changes in expenditure from changes in resources only.

These 3 approaches have been described as the "Rolls Royce", the "Cortina" and the "Mini" versions, respectively.[168]

SASP table 3 examines Current Expenditure - Changes Resulting From Planned Changes In Service Provision And

Output. The "Service Groups" and Services are:[169]

(i) General and Acute Hospital Services

- acute inpatient (regional specialties, subregional specialties, other specialties);
- day case;
- acute outpatient;
- accident and emergency;
- ambulance;
- other hospital service.

(ii) Community Health Services

- family planning;
- prevention;
- other community care.

(iii) Services Mainly for the Elderly

- geriatric inpatient (short-term; continuing care);
- geriatric outpatient;
- non-psychiatric day patient;
- district nursing;
- chiropody.

(iv) Services for the Younger Physically Disabled

- units for the younger disabled.

(v) Services for the Mentally Ill

- mental illness inpatient;
- mental illness outpatient;
- mental illness day patient.

(vi) Services for the Mentally Handicapped

- mental handicap inpatient;
- mental handicap outpatient;
- mental handicap day patient;

(vii) Services Mainly for Children

- health visiting;
- school health service - medical;
  - dental;
  - nursing.

(viii) Maternity Services

- obstetric inpatient;
- obstetric outpatient;
- community midwives.

(ix) Administration

There are thus 9 main programmes or "service groups" comprising 27 services, 29 if the school health subdivisions are counted. The main difference from the previous format is that services for the younger physically disabled have been separated from services mainly for the elderly into a new programme. Information is requested on inpatients, outpatients and day patients separately; the family practitioner services are excluded; day cases are excluded from mental illness and handicap and maternity and allocated to General and Acute Hospital; and Community Health Councils are not separately identified.

The "service groups" of SASP Table 3 are "a compromise between those required to facilitate study of the service outputs to the community, and those groups for which quantified information can be obtained."[170] For example, the use of general and acute hospital services by children and the elderly (excluding the elderly in "designated" geriatric beds), is included in General and Acute Hospital Services "since there would be considerable

estimation difficulties in separating costs of general and acute hospital services into patient age groups". Other "imperfections" are that District Nursing is included under Services Mainly for the Elderly and Health Visiting under Services Mainly for Children. Both services are used by other groups "but to divide them formally between each group and then to project that division into the future would not justify the time involved". The grouping is thus "very rough; it brings together certain of the services which need to be looked at together, but does not provide a precise analysis by client or health care group". Each service is recorded once only, and the family practicitioner services are excluded "since they are not financed out of the allocations to health authorities, within which priorities have to be selected". The Family Practitioner Services "are funded centrally and not through direct allocations to health authorities".

The output indicators for the services were given as[171]:

(1) Level of Provision for 1976, 1981 and 1988 in terms of:-

- available beds,
- clinic sessions,
- places, or
- WTE staff.

The baseline year of 1976 is the latest for which information is available. 1988 refers to the tenth year ahead, making this the first attempt at a 10 year programme budget. Since "relatively firm and detailed plans will already have

been drawn up for the operational planning period, and possibly a year or so beyond", the table also requested a projection to 1981 "which provides the true starting point for considering strategic options".[172]

Information was not required on relevant populations.

(2) Current Expenditure for 1976/77, 1981/82 and 1988/89.

N.B. Activity statistics relate to the calendar year, expenditure to the financial year.

These first two sections are all that is required for the shorter version of Table 3. The full version also requires the completion of the following three sections.

(3) Throughput for 1976, 1981 and 1988 in terms of

- cases per bed, or
- occupancy rate.

(4) Cases for 1976, 1981 and 1988 in terms of

- discharges and deaths
- attendances, or
- patients carried.

(5) Unit costs for 1976/77, 1981/82 and 1988/89

- per case,
- per attendance,
- per patient carried, or
- per occupied bed.

The minimum version looks at Current Expenditure: Changes Resulting from Planned Changes in Capital and Manpower Resources.[173] This examines:

- net effects of the capital programme, closures and changes of use;

- other changes in hospital provision - staffing
- other.
- family planning;
- prevention;
- district nursing;
- chiropody;
- health visiting;
- school health;
- other community care;
- contingency allowance.

Changes in these items are looked at in terms of Change in Expenditure from 1976/77 to 1981/82 and from 1976/77 to 1988/89. These changes are then roughly apportioned to 10 Service Groups:[174]

- general and acute hospital services;
- primary health services;
- services mainly for the elderly;
- services for the younger physically disabled;
- services for the elderly severely mentally infirm;
- services for the mentally ill;
- services for the mentally handicapped;
- services mainly for children;
- maternity services;
- other.

N.B. New schemes for the elderly severely mentally infirm have been separately identified, in order to comply with Table 6B on Capital.[175]

For Capital, Table 6B asks for Planned N.H.S. Capital Spending by Service Group (10 in number as above) for the

years 1979/80 to 1981/82 and 1982/83 to 1988/89.[176]

The main purposes of revenue costing are:[177]

(i) to test the financial feasibility of plans. This was regarded as the most important function.

(ii) to demonstrate to interested groups the cost of options and targets.

(iii) to provide a basis for examining manpower changes.

(iv) to provide a framework for considering priorities subject to available resources.

(v) to assess the implications of demographic changes.

(vi) to provide a better understanding of resource use and the achievement of priorities.

The minimum version would satisfy the requirements of (i) and (ii). The shorter version of Table 3 would also give some information on (iii) to (v). The full version would give more information on (i) to (v) and would also help with (vi).

The purpose of SASP Table 3 is "to give the proposed strategy's impact on service levels and current expenditure using unit costs based on examination of historical data and probable changes stemming from underlying trends and planned service changes."[178] Full completion was recommended since "cases are a much better measure of services to patients than beds, and costs are more closely related to cases than beds".[179] The minimum version was regarded as "obviously a less adequate means of examining the impact of a strategy as it is not related to the base-line position and is primarily resource rather than service orientated".[180] Unit costs for output measures,

e.g. cost per case, as in the full version are preferable to unit costs of provision, e.g. cost per bed, as in the shorter version since they are a better indication of service output.[181] Costs per bed could be misleading, e.g.

> "as throughput rises so does cost per bed, but that cost figure does not in itself reflect the increased activity. Some policies, e.g. 5-day wards, may have opposite effects on costs per bed and costs per case. Hence a service which is becoming more efficient in terms of cost per case may have a rising cost per bed or vice versa".

On the other hand, unit costs per case must be evaluated with respect to final output, for "it is possible for a service which appears to be efficient (perhaps with relatively high throughput and lower unit costs) to be ineffective in meeting the needs of patients".[182] Unit costs "reflect both quality and efficiency, and these are often impossible to disentangle".

5.4.5 The Programme Structure for the Local Authority Personal Social Services

In June 1977 the D.H.S.S. asked local social services authorities "to prepare and submit information about social services provision for the period 1976/77 to 1979/80"[183] by 1 October 1977, i.e. information was requested for the previous, the current and the next two years. The purpose of these "Summary Plans" was

> "to provide an indication of the direction in which authorities propose to plan their services and to assist the Secretary of State in the formulation of future guidance for the personal social services and for the health service."[184]

The Plans were to comprise Forms LAPS 1 and 2, and

"Covering Narratives".[185] Forms LAPS 1 and 2 provide "a statistical analysis of the information about local authorities' plans".[186] LAPS 1 is a "planning statement" and is in a form "similar to that used in the Programme Budget which was derived from regular statistics returned to the Department by local authorities."[187] Forms LAPS 2 deals with the population statistics used in preparing the planning statement.[188]

LAPS 1 grouped 22 services into 3 broad categories:[189]

(i) Residential Services

- elderly;
- younger physically handicapped;
- mentally handicapped - children
- mentally handicapped - adults;
- mentally ill;
- children.

(ii) Day Care Services

- elderly;
- younger physically handicapped;
- mentally ill;
- multi-purpose and mentally handicapped other;
- mentally handicapped - Adult Training Centres;
- children - day nurseries;
- children - pre-school playgroups;
- children - other.

(iii) Other Services

- children - boarded out;
- WTE staff - social work;
- WTE staff - home helps;

- meals (in thousands);
- intermediate treatment;
- aids, adaptations, telephones, holidays;
- administration;
- other services.

In addition, information on expenditure was requested in "Memorandum items" on:

- grants and payments for services provided by voluntary organisations and other agencies;
- training;
- expenditure on local authority services under joint financing arrangements:
  - LA contribution - elderly;
    - younger physically handicapped;
    - mentally handicapped;
    - mentally ill;
    - other.
  - NHS contribution - elderly;
    - younger physically handicapped;
    - mentally handicapped;
    - mentally ill;
    - other.

Output indicators for these services (except the memorandum items) were in terms of levels of provision as follows:-

(i) Residential Services

- Level of Provision in terms of All Supported Residents for the years 1976/77 Outturn, 1977/78 Estimate, 1978/79 Forecast, and 1979/80 Forecast.

(ii) Day Care Services

- Level of Provision in terms of All Places in Centres for the same years as above.

(iii) Other Services

- Level of Provision in terms of numbers of children, staff and meals for the same years as above.

Net current and capital expenditure for each service was requested for the same years as above.

The same information was again requested the following year.[190] The programme structure was the same except for minor alterations of detail:

- "administration" in "Other Services" now became "administration and training";
- in "Memorandum items", information was requested on level of provision and expenditure for "Day care places in residential homes".

5.5 CONCLUSIONS

A programme structure is fundamentally a hierarchy of system objectives within which organisational output, activities and inputs are recorded. As such, it is an essential prerequisite for the planning stage and forms the basis of the programming, budgeting and monitoring stages.

The comprehensive rational model suggests the "clarification of values or objectives distinct from and usually prerequisite to empirical analysis of alternative policies".[191] This was the original American intention with respect to P.P.B.S.: a detailed programme structure of objectives, explicitly defined and universally agreed upon, was to precede the analysis of alternatives and form the basis of the whole PPB process. The incrementalists, on the other hand, point out that values are imperfectly known in

a pluralistic decision-making structure, and that "evaluation and empirical analysis are intertwined."[192] Values become meaningful only in the process of considering or experiencing particular political programmes or policies;[193] they are almost impossible to anticipate in any real sense.[194] Secondly, the incremental model suggests that in the case of value conflict, the normal case in politics, no attempt should be made to force agreement or consistency since this would be counter-productive.[195] Instead, agreement can be reached on the highest common factor between conflicting courses of action, and mutual adjustment will take care of any important values which may have been ignored. Yet the 1965 model of P.P.B.S. required the identification of national (not merely federal) goals "with precision and on a continuing basis" and the choice of the "most urgent".[196] Finally, the incrementalists point out that objectives, cause-and-effect relationships, and performance criteria are exceedingly difficult to specify because of the lack of knowledge on social production functions.

There are thus two fundamental problems associated with the preliminary definition of objectives in a programme structure: the "political" problem of defining and securing agreement on objectives; and the "cognitive" problem of specifying and measuring final output. The case of the H.P.S.S. illustrates these two points. The detailed specification of objectives was avoided because of the difficulty of securing agreement and the lack of information on final output and its production. It was therefore decided to use a structure which would stimulate the consideration of objectives and allow their definition after the examination of particular programmes. Detailed operational

objectives would develop iteratively throughout the planning stage.

The initial attempts to design detailed programme structures for each client group were soon abandoned, as were the more elaborate across-the-board formats. Information requirements were too great, knowledge was lacking, and agreement could not be reached on objectives. What was needed was a programme structure which grouped expenditure in a way which was useful for the kinds of decisions that had to be made and which could use existing sources of information. As a senior D.H.S.S. official put it, this was an "important departure" from the original concept of P.P.B.S., since the need was "to develop programmes related to policies, which are usually concerned with the provision of services, rather than to 'outputs' in the sense of actual benefits to patients."[197] D.H.S.S. policies and targets are in terms of intermediate outputs because there is no information on final output and because of the difficulty of specifying and measuring professional output centrally. For these reasons, the term "programme budgeting" was preferred to "output budgeting" so as to emphasise the absence of a final output orientation.[198] This did not mean, however, that final outputs were ignored. Research and analysis is carried out both within the D.H.S.S. and at sponsored universities on the benefits and costs of particular treatments and care, and PAR studies are sometimes related to major programme options.[199]

The two general problems associated with the programme structure led the D.H.S.S. to believe that the emphasis in the future would remain in terms of "services and who uses them".[200] Officials would tend to leave "output" to the clinicians.

Resource allocation and use are strongly influenced by professionals, as has already been pointed out. The programme budget would therefore focus on the "aggregate level" and on "social equity" rather than on "individual clinical diagnoses".[201] Hence the choice of client groups for main programmes and levels of provision, etc. as output indicators for these groups.

Even this "hybrid"[202] classification of client groups for both the health and the personal social services masks serious problems of a conceptual nature. Most of these problems are due to deficiences in existing financial returns and activity statistics, on which the programme budget was to be based. The reorganisation of the H.P.S.S. and the D.H.S.S. "were essential to the use of the new programme budget information,"[203] but hoped-for changes in the financial and activity returns did not materialise, particularly with respect to specialty costing and budgeting. Thus strong assumptions, "guesstimates" and regression techniques had to be used for allocating the non-acute hospital sector, as will be shown in the next chapter. But the remaining acute sector, which accounts for around 30% of total H.P.S.S. current costs and up to 60% of capital costs, cannot as yet be subdivided. Secondly, the programme structure "remains in something of a muddle".[204] It is based "partially on client groups and partially on services, and the client groups themselves are not defined in any very systematic fashion". For example, "the same patient with the same episode of illness (for example, an elderly person, seriously disabled with arthritis, being referred by a general practitioner to a consultant orthopaedic surgeon for a hip-replacement operation) might pass through three different programmes during one episode of illness. Although the

Programme Budget accounts systematically for all current public expenditure costs, it does not account systematically for all the morbidity, mortality and social problems with which the H.P.S.S. deal". Lastly, the problem of relating the health and personal social services led to "undue"[205] attention being given to certain client groups, viz. the elderly, the physically handicapped, the mentally ill and the mentally handicapped, at the expense of e.g. the acute sector.

Despite these "teething" problems, the programme structure "provides a relatively simple framework within which the recommendations emerging from policy reviews could be brought together and priorities considered in terms of the pace of implementation."[206] Having now described and analysed the feasibility and programme structure aspects of the PPB process, the next chapter will look at the system in operation, stages (1)(c) to (4) as defined in chapter 4.

CHAPTER 6

THE OPERATIONAL SYSTEMS OF PLANNING, PROGRAMMING AND BUDGETING IN THE HEALTH AND PERSONAL SOCIAL SERVICES

CHAPTER 6

LIST OF CONTENTS

6.1 GENERAL INTRODUCTION

Chapter 4 pointed out that the programmed budget "forms the basis for any PPB system, but it is of itself no more than an information document".[1] The National Programme Budget should provide

> "a framework of essential information about the past and present situation and about future possibilities, so that competing claims on resources, and eventually detailed divisional plans for particular programmes can be reconciled with P.E.S.C. and other expected resource constraints".[2]

The full P.P.B. system thus also aims

> "to establish arrangements for systematically linking the planning of policy and priorities with resource allocation and the financial planning system, for relating individual decisions to an overall strategic framework and for considering the effectiveness with which resources are deployed".[3]

In addition to the programme budget, this would require:

> " (i) regular reviews of the plans expressed in the programme budget, including the overall strategy;
>
> (ii) a formal link with the normal budget processes;
>
> (iii) special studies of particular areas."[4]

Chapter 5 was concerned with the initial design of the programme budget format, since this is the "basis" for the whole system. The feasibility and programme structure aspects, though essential for the setting up of the P.P.B. system, are predominant only in the first year. Experience of the system may lead to a reduction in aspiration levels, as was the case in America, and the programme structure should allow a degree of flexibility for changes in objectives. But during a normal operational run, the process will start at stage 1(c), as defined in Chapter 4, and work through to stage 4, i.e. performance monitoring.

The design of the D.H.S.S. planning system was the responsibility of a Review Team.[5] The programme budget, as a "planning tool", had to be "designed to fit into the Department's future planning procedures".[6] The work of both the P.P.B. and the Review Teams developed "in parallel" and there was "close consultation". Both came to "very similar conclusions about the essential features of Departmental planning".[7] These were:[8]

(i) "an approach to planning whose first emphasis is on client groups";

(ii) "the production and regular rolling forward of plans covering a period some way beyond the current P.E.S.C. period";

(iii) "an annual planning cycle incorporating a 'top of the office' review of priorities within expected resource constraints";

(iv) "monitoring of the extent to which Departmental policies are being implemented in the field, and of their effectiveness".

The planning system would be integrated with the preparation of the programme budget (i.e. programme budgeting) in the following way:[9]

(i) "An analysis should be made of what services are being provided to client groups and of existing trends, disaggregated as far as possible. This would involve "analysing a series of previous years, probably at least five."

(ii) "Forecasts should then be made for each main programme, taking account of the current situation and existing trends, demographic and other exogeneous factors and present departmental policies."

(iii) "Policies for each client group should also be reviewed, taking account of the extent to which existing policies are being implemented, their success so far as this can be measured, any special studies and any new priorities formulated during the year." In this way, "a revised programme should be prepared for each client group."

(iv) "These revised programmes, part of the preparation of which might be undertaken by the policy Branches concerned, should then be brought together into a

single plan, and the total implications for constrained resources including finance and some capital and manpower considered. Other departmental policies cutting across client groups should also be taken into account, e.g. policies on standards of provision of general purpose capital or manpower. If the sum of the separate policies proved incompatible with resource constraints, individual programmes would then have to be modified".

A detailed examination will now be made of the development of the planning, programming and budgeting systems for the health and personal social services. The chapter will begin with a section on P.P.B.S. in the D.H.S.S. Then follow sections on the planning, programming, budgeting and monitoring arrangements for the N.H.S. and the L.A.P.S.S. Greater emphasis is placed on the D.H.S.S. because of its national, strategic responsibilities both for the health and for the personal social services, and because of its role in the initiation and development of the system for the H.P.S.S. The N.H.S. and the L.A.P.S.S. are treated in general terms, with the emphasis placed on the inter-relationships between the various parts of the H.P.S.S. Comparatively little detail is given on the L.A.P.S.S. because of the nature of central/local relationships.

6.2 THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY

6.2.1 The D.H.S.S. Planning System

(a) Introduction

As has already been pointed out, the design of the Planning System for the D.H.S.S. was the responsibility of a Review Team.[10] This team recommended "an increased emphasis on research and planning.[11] The Department should only "seldom" direct the

H.P.S.S. but should seek "to assist it to move towards the innovation that field experience or research indicates is sensible..."[12] It was pointed out, however, that in the past the D.H.S.S. "has had no adequate way of helping the Secretary of State assess the range of options available, and choose objectives and priorities in the light of resource "constraints" and "... has too often sent guidance to the field in unspecific terms and without sufficiently considering the availability to field authorities of the resources to carry it out."[13] Hence the need for a planning system:

> "The Department now needs to develop a planning and analytic process for the health and social services in which it can
>
> (a) draw together its policy development work for the Secretary of State to make informed decisions on national objectives, and national priorities among these objectives, within the constraints imposed by the availability of resources, and
>
> (b) help health and local authorities plan their future actions in the light of local conditions and national objectives and priorities..."[14]

The Department was to move from the "selective regulation" and "limited intervention" activities in dealing with "largely autonomous" health authorities to the "strategic direction" of an integrated N.H.S.[15] Similarly for the L.A.P.S.S. where the Secretary of State is responsible for "general guidance".[16]

As pointed out in Chapter 4, one of the objectives of the reorganisation of the N.H.S. was to set

up a fully integrated health service in which maximum delegation of decision-making and the need for national and regional strategic direction were to be "balanced" by means of a planning system.[17] The reorganisation of the L.A.P.S.S. and their important client group interrelationships also provided an impetus towards planning them from the centre. The D.H.S.S. Planning System was to be the key to exercising leadership over the H.P.S.S.

Planning and control are problems which are common to all complex organisations, but the Review Team considered that business organisations primarily emphasise effective control processes. The D.H.S.S., on the other hand, should emphasise planning because of the nature of the H.P.S.S. system. These special characteristics are:

(i) The Multiplicity of Objectives

The goals of the H.P.S.S. are many, complex and varied, as has been pointed out in earlier chapters. Yet it is the responsibility of the Secretary of State to determine and rank them with the assistance of the D.H.S.S. Even when this is done, there is still the problem of resource allocation, since the supply of resources is largely fixed.

(ii) Supply and Demand

The principle that supply creates its own demand is particularly applicable in the H.P.S.S., and has been referred to in earlier

chapters. Health and welfare differ from, e.g. education where demand is mainly determined by demographic factors since most schooling is compulsory and homogeneous. Hence the distinction between "demand" and "need" must be made at the planning stage. Prior planning is thus all-important in determining optimal patterns of health care.

(iii) Output Measurement Difficulties

Need and performance in meeting need are extremely difficult to measure in the case of these "social" programmes, as has already been seen in earlier chapters. Business organisations, on the other hand, have much better indicators of financial success, such as profits and sales. Sales reflect the value of their goods to consumers through the price mechanism, there being no need to estimate the "ultimate" benefits of those goods to consumers. Lacking the price system, the D.H.S.S. must evaluate the benefits of the H.P.S.S. to clients and compare them with costs. The problem is compounded by the considerable freedom given to the caring professions in the utilisation of resources and the assessment of the effectiveness of treatment options.

(iv) Fewer Short-Term Variations

Business environments are often highly uncertain and subject to rapid change, thereby

making feedback and control at frequent intervals essential for survival. Apart from the availability of funds, this situation does not arise to the same extent in the social field. Thus the control of a plan does not have to be as frequent or detailed.

(v) Decentralised Decision-Making

The considerable autonomy afforded to field authorities and caring professions has been referred to before, and applies both to the N.H.S. and to the L.A.P.S.S. The de facto influence of the D.H.S.S. over treatment and care issues is difficult to compare in these two services. Whilst social workers do not, as yet, have the same personal responsibility over their clients as doctors (and, to a lesser extent, nurses and other health professionals), their local authorities are statutorily independent. The consequence of both sets of factors is that close monitoring of performance is neither possible nor desirable. Hence the remark by a senior official at the D.H.S.S. in the conclusion to the last chapter that planning and programme budgeting at the central level would concentrate primarily on client group services rather than individual treatment issues.

These five special characteristics of the H.P.S.S. led the Team to emphasise the planning

function by:- determining national goals, alternative strategies, and resource allocation in consultation with field authorities;

-introducing a planning system into the N.H.S. and encouraging a similar system for local authorities;

-improving the information system for monitoring purposes;

-confining controls to a minimum.

The emphasis here will be on the first of these, the determination of national objectives and priorities.

(b) National Objectives and Priorities

The Secretary of State, with the assistance of the D.H.S.S., is responsible for the determination of national priorities and goals for the H.P.S.S. since:

-these social services carry important externalities and are essential in promoting social welfare;

-the Secretary of State is publicly accountable for the availability of services;

-the H.P.S.S. depend heavily on central government funds.

On the other hand, policy making must not be a one-way process. Innovation most often arises in the field, and because of the nature of the H.P.S.S. new policies must be discussed with field authorities and professionals prior to implementation. Nevertheless, the D.H.S.S. provides an essential focus for this policy-making process and a national, overall,

aggregate perspective which no single authority or body or professionals could supply. Yet in the past the D.H.S.S. has found itself incapable of filling this "strategic" role. The consequences have been:

- an inability to relate individual policies to the overall development of the services;
- the lack of any emphasis on strategic options and their likely consequences;
- a failure to link overall strategies with resource availability, reflected in inconsistent and unachievable field guidance;
- the tendency for the H.P.S.S. to lose out in the competition for funds with other Departments.

To remedy these deficiencies, the Review Team recommended a Planning System with the following characteristics:

(i) Emphasis on "Needs"

Plans should be based on the needs of different sections of the population for services. These plans:

- should specify the services required to meet the needs;
- should focus on client groups or specialites;
- should cover both the health and personal social services.

(ii) Availability of Resources

Plans must be feasible in terms of services, capital and manpower and the availability of funds.

(iii) Use of Output Indicators

Departmental standards and targets must be relevant, comprehensible, realistic and measurable.

(iv) Participation

Departmental planning should involve all the relevant administrative and professional parts of the D.H.S.S.

(v) Consistency with Field Planning

Planning procedures and performance indicators should be compatible with those of field authorities.

(vi) Emphasis on the Longer Term

Planning must focus sufficiently far ahead to allow for genuine strategic policy options. For example, significant changes in the pattern of hospital services can only be made after eight to ten years.

(vii) Importance of Short-Term Action

Long-term changes require detailed planning of the steps to be taken. Hence the plan must specify what action is required now and in the short-term to realise these long-term ends.

The Review Team recommends a planning process comprising a three step sequence, viz. Planning Guidelines from the Top of the Office, the preparation of Planning Statements, and an Annual Planning Review.

1) Planning Guidelines

These are produced by the Top of the Office

centred around the Secretary of State, in the form of the Planning Steering Committee and since June 1978 of the Strategy Committee.[18] The Top of the Office reviews progress made so far, identifies policy changes required, and provides guidance to the specialist divisions (i.e. those policy Divisions within the Services Development and N.H.S. Personnel Groups, together with certain Building Divisions) on the coming year's planning work. This guidance may relate to a reordering of priorities, the reallocation of available resources, strategies for dealing with major systemic disturbances, or a revision of Departmental targets. In some cases, specialist divisions may request guidance on specific aspects of their work. They may also challenge any guidance given, although final responsibility rests with the Secretary of State.

The detailed work on the preparation of guidelines is coordinated by the Strategy and Planning Steering Committees with staff assistance from the Policy Planning Unit (P.P.U.) and Branch F.A.I. of Finance Group. Branch F.A.I. is responsible for the public expenditure survey (P.E.S.S.) and the Programme Budget. It has four Units: F.A.I.A. deals with P.E.S.S.: F.A.I.B. deals with the statistical basis of P.E.S.S.; F.A.I.C. deals with the Programme

Budget; and F.A.I.D. deals with the Commons' Expenditure Committee.[19] P.P.U. works "closely" with Branch F.A.I. (particularly Unit F.A.I.C.) in its deliberations on planning with Services Development Divisions, etc. and Regional Liaison Division, with F.A.I.C. "co-ordinating" the work on the Programme Budget.[20]

It is the responsibility of P.P.U. to make sure that the Planning Committees have the basic planning information, e.g. population statistics, in front of them, together with:

- an overall analysis of resource use, including a Programme Budget supplied by F.A.I.C. giving details of the current situation and existing trends;
- any studies of long-range objectives and strategies carried out during the year, including P.A.R.s;
- the results of major research projects;
- recent planning information from the field;
- any special studies and analyses of issues and options which were requested by the Planning Committees.

Branch F.A.I. is primarily responsible for the Programme Budget and supporting financial submissions, and will advise on the financial feasibility of the Guidelines.

The Guidelines, when completed, are approved by the Secretary of State and are communicated

via a memorandum to the specialist divisions, where they are broken down into more detailed guidance for individual branches.

2) Planning Statements

The next stage is for the Services Development and N.H.S. Personnel Divisions to prepare new planning proposals for the national development of their parts of the H.P.S.S., together with their resource requirements. These plans will be based on the current objectives and priorities of the Secretary of State, adjusted to take account of the planning guidelines and any policy changes made in principle since the last review.

There are four different types of Planning Statements which correspond to the type of specialist branches involved:-

(a) Client Group Statements

These are prepared by each of the client branches of the Services Development Division. The Statements cover both the health and the personal social services needs of the client groups. Their contents and arrangements are as follows:

(i) Introduction

- key facts about the client group;
- major developments over the past years. In 1978 the Statements looked for the first time at the previous

five years.[21] Hitherto they had examined only the previous year.

(ii) Summary of Major Planning Proposals for the Next Ten Years

- changes in client group needs;
- new policies and priorities introduced this year:- justification
  - main consequences;
- alternatives presented to the Top of the Office for decision.

(iii) Quantitative Statement of the New Planning Proposals

- projections of client group needs;
- planned service levels to meet these needs, including:
  standard of service, e.g. places per head;
  use of resources, e.g. throughput per place;
- summary of resource implications:
  revenue;
  capital;
  key manpower.

(iv) D.H.S.S. Action Programmes

- the action the D.H.S.S. will have to take during the coming year in order to secure the implementation of the plan.

(b) Specialty Statements

These are prepared by the specialty branches of the Health Services Divisions in Services Development Group, and are set out in a similar manner to the Client Group Statements. The reason for the different emphasis is, as mentioned in the last chapter, that some client groups are best defined in terms of their need for specialist care, e.g. accident services, general surgery, cardiology, etc.

(c) Service Statements

Service Statements are prepared by the relevant branches within the Local Authority Social Services and Health Services Divisions, together with the Building Divisions. They differ in that they focus on the overall development of the hospital, primary care and local authority services to meet the needs identified by the Client and Specialty Statements. Planning takes place first on a client group basis, and, apart from any service objectives, e.g. on community hospitals, Service Statements will concentrate upon the service and resource requirements of the Client and Specialty Statements.

(d) Manpower Statements

These are prepared by the N.H.S. Personnel

Divisions and are similar to the Service Statements in that their role is to plan the supply of the key manpower required to meet the needs of the Client, Specialty and Service plans and to make provision for the necessary recruitment and training. Some of the Planning Statements are quite long, up to 50 pages.[22] Their quality, however, is variable and they are frequently in a form which makes programme costing difficult.[23] They are mainly in a "narrative" form, though they are usually accompanied by sets of tables and figures.[24] Like the American experience with Program Memoranda, some have been largely verbose unanalytical criticisms of existing provision as recorded on the Programme Budget and pleas for extra provision and funding.[25] The timescale of the plans is ten years, though for years five to ten the projections and forecasts can be little more than "guesstimates". Furthermore, objectives are expressed in terms of standards and levels of provision because of the difficulty in measuring final output. Recent Statements, however, are concentrating more on "key indicators" of health and welfare, e.g. perinatal mortality rates.[26] The Planning Statements are of two main types: those connected with specific

sections of the population, i.e. the Client and Specialty Statements; and those concerning the provision of services and resources to those groups, i.e. the Service and Manpower Statements. This close interdependence between the two sets of plans and with overall revenue and capital constraints as set out in the Guidelines necessitates careful co-ordination. This co-ordination is the responsibility of the senior officials of the specialist divisions, notably Deputy Secretaries, Under Secretaries, and their professional equivalents. This co-ordination is achieved in three main ways:

- senior officials of the specialist divisions break down the Top of the Office Guidelines into more detailed and specific guidelines for their branches, assisted where necessary by P.P.U.:
- informal consultations between branches is encouraged to ensure consistency between Client, Specialty, Service and Manpower plans and Branch F.A.I. advises all other branches on the financial aspects of their work;
- finally, a more formal co-ordinating mechanism is provided between the senior officials of the various branches, allowing

for modifications of guidelines when necessary.

3) The Annual Planning Review

In this stage, the Top of the Office reviews the Planning Statements in relation to the latest estimate of resource availability, decides between alternatives, and specifies priorities and targets for field authorities. Decisions are also taken at this stage on work to be undertaken within the Department, such as research programmes, special studies, etc. The Planning Committees are responsible for this review and determination of objectives and strategies and make recommendations to Ministers prior to the communication of these priorities to the field in the form of D.H.S.S. Planning Guidelines. The Committees will again be assisted by Branch F.A.I. and P.P.U. Branch F.A.I. will be responsible for advising on the financial aspects and feasibility of the Planning Statements and for the preparation of the Programme Budget. The Statements are in effect "bids" for extra funding for the client groups and are therefore likely to exceed the total resources available to the H.P.S.S. Branch F.A.I. will thus be responsible for suggesting financial options, e.g. if £xm. is spent on the elderly for services "y", this will mean a reduction in services "z" for the mentally handicapped. The detailed methodology for

programming will be analysed in the next section.

P.P.U. is responsible for ensuring that the Planning Statements are submitted on time and contain the necessary information. The Unit will also be responsible for presenting programme budget submissions and for co-ordinating work on any special analyses required by the Committees during the Review. P.P.U.'s job, however, involves more than the clerical functions of receipt and delivery of information. Its job is to "digest" and "summarize" the Statements for the Top of the Office so that they are in a form suitable for the taking of major strategic decisions.[27]

(c) The Planning Timetable

The timetable for the D.H.S.S. Planning System has been modified over the years. The Review Team originally proposed that the process should take place between January and July, with the rest of the financial year being taken up by field planning. On this basis, the Top of the Office's Planning Guidelines would have been ready by the end of February, the specialist divisions would have had the three months of March, April and May to prepare their Planning Statements, and the Annual Review would have been completed by the end of June so that guidance to the field could be issued in July. This proved to be a very crowded schedule, particularly

for the health authorities, and was chosen mainly to fit in with P.E.S.S. and to allow the submission of Regional plans prior to the start of the D.H.S.S. Planning System (a proposal which failed to materialise). As will be seen later in this chapter, health authority planning now extends over almost a full year, and local authorities have around six months. The D.H.S.S. Planning System now begins around September when the provisional allocations for the H.P.S.S. are known through P.E.S.S.[28] Ministerial decisions are taken between January (after the publication of the Public Expenditure White Paper) and March (prior to the issue of D.H.S.S. Planning Guidelines). This is still a very crowded schedule for the D.H.S.S., but is constrained on the one hand by P.E.S.S and the receipt of base year information from the field, and on the other by the need to get out guidelines to the field by March. A degree of flexibility is, however, allowed within the system. New initiatives on policies, special analyses, research projects, etc. continue throughout the year, but the results are gathered together and evaluated during the formal Planning System. This also applies to the Planning Statements and "thinking" on the Statements in 1979 began as early as April.[29] A consequence of the present Departmental timetable, however, as opposed to the original suggestion, is that there can be no formal planning input to P.E.S.S. until the following year. On the original model, the

preparation of the Department's P.E.S.S. submission would have influenced, and been influenced by, the formulation of the Planning Guidelines.

(d) Performance Indicators

D.H.S.S. planning is thus a continuous, cyclical process of guidelines, proposals and review, followed by field planning and implementation. Performance monitoring will then set the stage for the next round of planning. Planning and monitoring should therefore be in the same terms. The Review Team recommended the use of four types of performance indicator, as follows:

- basic information on needs;
- indicators of service provision;
- indicators of activity and throughput;
- indicators of demand pressure.

For the quantitative and financial purposes of the Programme Budget, as will be seen later, the information requirement is slightly different. The indicators used for the Planning Statements will, of course, be less rigorous because of the difficulty of measuring final output. The following are examples of basic indicators for all programmes and more specialised indicators for the maternity, mentally handicapped and elderly programmes:

Basic Planning Information

N.H.S.	L.A.P.S.S.
1) Total population;	1) As for N.H.S.

N.H.S.	L.A.P.S.S.
2) Age composition:- 0-4, 5-14, 15-64, 65-74, 75+;	2) As for N.H.S.
3) Social Composition;	3) ... do. ...
4) Housing conditions;	4) ... do. ...
5) Standardised Mortality Ratios (S.M.R.s);	5) ... do. ...
6) Sickness absence	6) ... do. ...

Maternity

N.H.S.	L.A.P.S.S.
1) Needs	
- No. of births;	- No. of births
- mortality rates -	- legitimate,
- infant	- illegitimate.
- perinatal,	
- maternal.	
2) Service provision	
- staffed beds - number	- mother and baby homes,
- ratio to births (or population)	- number,
- distribution between District General Hospital (D.G.H.) isolated G.P. units etc.	- ratio to illegitimate births.
- midwives (hospital or domiciliary)	

N.H.S.	L.A.P.S.S.
- number,	
- ratio to births (or population)	
- consultant obstetricians	
- number,	
- ratio.	
- health visitors	
- number,	
- ratio.	
- hospital nursing staff	
- number,	
- ratio to beds.	
3) Activity and Throughput	
- No. of births:	- admissions to mother and baby homes, and average occupancy.
- N.H.S. hospitals (%)	
- D.G.H.	
- isolated G.P. units, etc.	
- home (%)	
- other.	
- Throughput per bed:	
- average pre- and post-natal stay,	
- average occupancy.	
- Attendances at clinics etc.	
4) Pressure on Resources	
	- waiting list for mother & baby homes
	- size, waiting time

Mentally Handicapped

N.H.S.

1) Need

- estimated number of mentally handicapped persons by age,
- by category of handicap.

2) Service Provision

- hospital beds:
  - children-number
    - ratio to estimated no. in need
  - adults - number
    - ratio
  - hospital nursing staff:
    - number
    - ratio to beds
  - consultant psychiatrists:
    - number,
    - ratio
  - other staff
  - day places - number,
    - ratio

L.A.P.S.S.

- as for N.H.S.

- hostels:
  - children-number
    - ratio to estimated need,
    - staffing - ratio to places
    - % fully trained.
  - adults-number
    - staffing.
  - adult training centres (ATCs):
    - places,
    - ratio,
    - staffing - ratio to places
    - % fully trained.
  - day centres:
    - places, etc.
  - social work field staff:
    - number
    - ratio to estimated need,
    - % trained

N.H.S.	L.A.P.S.S.
3) Activity and Throughput	
- hospital inpatient:	- admissions to hostels (adults, children)-number,
- number,	- average occupancy.
- % occupancy of beds	
- day attendances	- attendances at training centres:
	- number
	- average occupancy.
	- attendances at day centres.
4) Pressure	
- waiting time/waiting list:	- waiting time/ waiting list:
- hospital inpatient	- hostels (children, adults),
- day centres	- ATCs.
Elderly	
1) Need	
- population-65-74,male/female,	- as for N.H.S.
- 75+, male/female	
- social indicators	- ... do ...
2) Service Provision	
- long-stay geriatric beds:	- old people's homes
- number,	- number,
- ratio to elderly - 65+	- ratio to elderly 65+
- 75+	-75+
	- staffing

N.H.S.

- nursing staff attached:
  - number,
  - ratio to beds
- consultant geriatricians:
  - number,
  - ratio to elderly
- geriatric day places:
  - number,
  - ratio

L.A.P.S.S.

- meals served:
  - number
  - ratio to elderly,
  - at home/in clubs,
  - etc/in residential homes.
- home helps (WTE)
  - number,
  - ratio to elderly.
- day centres, clubs, etc. -
  - no. of places,
  - ratio to elderly,
- other services provided:
  - sheltered housing,
  - laundry.
  - holidays,
  - etc.
- voluntary services.

3) Activity and Throughput

- home help visits
  - number (annually),
  - ratio to elderly,
- attendances at centres and clubs, - etc.

4) Pressure

- waiting time/waiting lists:
- waiting time/list:

N.H.S.

- long-stay hospital,
- day centres

L.A.P.S.S.

- old people's homes
- no. of applications for other services
- meals,
- laundry,
- etc.

(e) Development of the Planning System

The Departmental Planning System began with an experimental run from June 1973 to April 1974.[30] The Planning Statements submitted by the policy branches covered the following groups:

- primary care;
- prevention;
- acute services (three Statements);
- elderly;
- younger physically handicapped;
- mentally ill;
- mentally handicapped;
- children;
- maternity.

The first "live" cycle of the Planning System took place during 1974/75, and would have led to a Consultative Document on Priorities in the spring of 1975 but for the April budget cuts.[31] The Consultative Document had to wait until March 1976 to appear.[32] Two types of D.H.S.S. Planning Guidelines to field authorities have evolved:[33]

1. "Strategic" guidelines directed primarily at

R.H.A.s and local social services authorities. The Consultative Document and The Way Forward[34] are examples. As will be shown later these strategic guidelines will be issued every four years in connection with the N.H.S. Planning System. In the case of the local authorities, the system is of course less rigorous, and there is no strategic planning requirement.

2. "Operational" guidelines issued annually for the N.H.S. operational planning process (discussed later) and for the L.A.P.S.S. planning submissions. The burden of planning within the Department will obviously be that much less during an "operational" planning year than in a "strategic" planning year.[35]

The issue of the strategic guidelines in the Consultative Document coincided with the start of the N.H.S. Planning System. The D.H.S.S. considered the document at innovation in two main respects. It was the first time an attempt had been made "to establish rational and systematic priorities throughout the health and personal social services.[36]

Choices had to be made

> "in full knowledge of the facts facing the services as a whole: the likely changes in demand by different client groups; the areas where past neglect has led to serious deficiencies; the wyas in which the available resources can be used to get the best return; the vital importance of joint planning."[37]

Secondly, the document sought to turn planning into

> "a co-operative enterprise: a process in which the guidelines from the centre are related to - and influenced by - the experience of those who have to apply them in local circumstances."[38]

The result of consultations would be reflected in the "policy and planning guidelines" of the next planning cycle.[39]

The Consultative Document pointed out that the health and personal social services had been given a high priority compared with other public expenditure programmes. There was a need for "a continuing though reduced, growth ..."[40], mainly because of demographic changes, particularly the increasing numbers of elderly people, and rising medical costs. This relative growth element would allow the Secretary of State to redistribute resources to the deprived regions and encourage joint planning between health and local authorities.[41]

In order of priorities for the H.P.S.S. was as follows:[42]

1) Service standards would be maintained by cutting back on capital expenditure, thereby allowing current expenditure to rise.

2) L.A.P.S.S. capital expenditure would "level out" and be supplemented by joint finance capital. This would allow "some development" of the services for the elderly and younger physically handicapped, children, and the mentally ill and handicapped.

3) Primary care would be expanded to relieve

pressure on hospital and residential services.

4) An increasing emphasis would be placed on preventive services, training and manpower deployment.

5) The "unsatisfied need" in the provision of services for the mentally ill and handicapped, and the pressure on services from the increasing numbers of elderly people and children meant that services for these client groups had to be given priority over general and acute hospital services and particularly over maternity services.

6) Economies must be sought in prescribing, procurement and administration.

The timescale of the Consultative Document, as in the formal D.H.S.S. Planning System, was ten years. Relatively firm figures could be given for expenditure up to 1979/80, the period covered by the Public Expenditure White Paper, and more provisional information was given for the period 1980 to 1985.[43] (The Programme Budget, as a medium-term, comprehensive, quantitative summary of the plans, inevitably concentrated on the years covered by the White Paper.) For these years, objectives were specified:

(i) The H.P.S.S. as a Whole

The general aim of the H.P.S.S. is "to meet the community's need for health care and social support as fully as possible".[44]

(ii) Primary Care, Community Health and Prevention

The "main objectives" for these services for the "next few years" were:-

- to encourage the development of primary health care teams;
- to remedy personnel shortages;
- to prevent pharmaceutical costs from rising unduly; and
- to give priority to preventive measures and family planning services.[45]

(iii) General and Acute Hospital Services and Maternity Services

The "main needs" and "objectives" of these services were:[46]

- to reduce long waiting times;
- to reduce geographical disparities;
- to facilitate medical advances and improved patterns of care;
- to provide for the rising numbers of the elderly through an increase in resources to geriatric medicine and mental illness;
- to make further improvements in the rehabilitation services;
- to achieve these objectives with a lower rate of resource growth; and
- to reduce expenditure on maternity services.

(iv) Services Used Mainly by the Elderly

The "main objective" of these services for the elderly is "to help them remain in the community

for as long as possible".[47] "National targets" in terms of levels of provision of home nursing, chiropody, home helps and meals, residential places, and geriatric beds were also specified.

(v) Services for the Physically Handicapped

The "main objective" is "to enable the younger physically handicapped to lead as full and useful a life as possible, by providing appropriate support services ... and care within the community".[48]

(vi) Services for the Mentally Handicapped

The "long-term objectives" derived from the Command Paper "Better Services for the Mentally Handicapped" (Cmnd.4683) are:[49]

- to provide a satisfactory environment;
- to avoid unnecessary segregation;
- to provide education, training, and occupation to develop abilities;
- to support families and help them to cope.

(vii) Services for the Mentally Ill

These services "should be available locally in each district so that people can as far as possible receive treatment without losing touch with their usual life ... The "priorities suggested to 1979/80 were:[50]

- the continued development of community care;
- progress towards a District-based psychiatric health service;
- improving staff ratios and physical conditions

in existing hospital services;

- the provision of adequate secure accommodation in each region;
- the development of health and social services for alcoholics and drug misusers.

(viii) Services for Children and Families with Children

The health service "needs" of children "include expert care at the time of birth and screening and surveillance during pre-school and school years".[51] The "main objective" of personal social services for children is "to help families provide a satisfactory home for them, or where necessary to provide a substitute family or residential care". The "priorities" for 1979/80 were:

- improvements in special care for babies in hospitals;
- the expansion of health visiting services;
- the development of day care services, particularly for pre-school children;
- the development of services for the more effective implementation of the Children and Young Persons Act.

In addition to these client and service groups, the Consultative Document also devoted a section to the special problems of the personal social services. These latter services have the function of "meeting the needs of particular client groups" and "should be developed to identify and respond to the differing

needs of families and individuals in the community, irrespective of how they arose...".[52] Joint planning between health and local authorities would be aided by "a national joint approach to social policy".[53]

The Way Forward,[54] issued in September 1977, was a "further discussion" of "national strategy" and was "complementary" to, and "extended", the Consultative Document.[55] It reflected comments received, economic developments, and policy decisions and served as a further basis for the resubmission of R.H.A. Strategic Plans in January, 1979.[56] The three annual D.H.S.S. Planning Guidelines, HC(76)29, HC(77)19, and HC(78)12/LAC(78)6, contained more detailed advice to health and local authorities on resources and priorities for the purposes of operational planning and also strategic planning by health authorities, and for the annual L.A.P.S.S. planning returns.[57] In addition, "regional specific guidelines" were sent to individual R.H.A.s in 1978 covering points specific to their regions.[58] The first two Planning Guidelines were aimed specifically at health authorities, whilst the 1978 Guidelines were joint. Local authorities also recieved letters from the D.H.S.S., L.A.S.S.L.(77)13 and L.A.S.S.L. (78)14, in June of 1977 and 1978 regarding their planning returns.[59] L.A.S.S.L.(77)13 was in the nature of planning guidance, but with the issue of joint guidelines in 1978 L.A.S.S.L.(78)14 could

concentrate on methodological issues. All the strategic and operational guidelines, with the exception of HC(77)19, contained Programme Budgets, as the last chapter pointed out. All dealt with output in terms of the provision of services to client groups.

6.2.2 D.H.S.S. Programme Budgeting

The end product of strategic planning is a strategic plan, and the end product of programming is a medium-term physical and financial programme, or Programme Budget. The corresponding documents in the American context were the Program Memoranda and the Program and Financial Plan, respectively.[60] Programming is thus the essential linchpin between strategic planning and budgeting but at the same time highlights the problem associated with the measurement and costing of output. This section will deal with those problems, beginning with the information requirements of the Second Report programme structure.

A. The Programme Structure of the Second Report

As already pointed out in the last chapter, the programme structure of the First Report was designed without regard to the availability of information and tended to ignore the personal social services. The Second Report, however, produced an "illustrative" programme budget for 1969/70 in order to test their "simplified" structure with existing information.[61] An analysis of the problems raised is essential to an understanding of the present

system.

The Project Team recognised that there would be a degree of "arbitrariness" in trying "to reallocate items of expenditure from institutions and accounting units to the clients served by these units".[62] As such, the Team distinguished between "hard" and "softer" figures.[63]

"Hard" Figures

Total expenditure by institutions or accounting units which can be allocated directly to programmes is regarded as being fairly reliable. Examples at the time were:

- family practitioner services and drugs to Primary Care;
- the (formerly separate) child care services to Children and Families.

The figures for client numbers were derived from various statistical returns and were therefore also deemed to be fairly "hard".

"Softer" Figures

Average cost figures are "softer" because the accounting figures relate to institutions which do not coincide with the programme structure. Hence total and unit expenditure figures cannot be used directly, since they would either be "too narrow" (e.g. average costs per case in specialist maternity hospitals) or "too broad" (e.g. when the same cost per case is used for the mentally ill, the elderly mentally infirm and the mentally handicapped in

adult residential homes). In the latter case, the Second Report listed three methods of apportioning costs:

1) Costs per case may be assumed to be the same across all programmes,as in local authority residential homes.

2) Costs per case may be adjusted according to variables which affect cost. For example, outpatient attendances by specialty can be costed in inverse proportion to clinic session attendances.

3) Costs per case may be estimated through statistical regression techniques. The Team calculated acute hospital specialty costs this way. The assumption is that average costs per inpatient case will be proportional to specialty mix between hospitals.

Consideration of all these factors led to three different types of cost figures in the illustrative base year programme budget:

(a) Accounting figures which roughly coincide with programmes;

(b) Accounting figures which were modified:
- where the accounting base was too narrow,
- where the accounting base was too wide but assumed to be the same between programmes,
- where accounting figures were adjusted according to some relevant variable;

(c) Regression estimates.

The figures in (b) and (c) are less accurate than those of (a), but even accounting figures used directly may contain errors, e.g. in the arbitrary allocation of fixed costs, the failure to charge for the use of capital, etc. Below is a summary of the type of cost figures used:[64]

(a) Accounting figures which fit programmes:

- mental illness - cost per inpatient year.
- mental handicap - cost per inpatient year.
- general practitioners - total expenditure.
- pharmaceutical - total expenditure.
- community dental - total expenditure.
- ophthalmic - total expenditure.
- welfare foods - total expenditure.
- child care services - total expenditure.

(b) Modified accounting figures:

(i) Accounting base too narrow:

- maternity- inpatient cost per case.
- day patients - cost per day.

(ii) Accounting base too wide - no adjustment:

- most local authority expenditure except child care.

(iii) Accounting base too wide - pro rata adjustment:

- outpatient costs per attendance.

A further assumption was that costs in teaching hospitals were the same as in other hospitals.

(c) Regression estimates:

- geriatric and chronic sick - inpatient cost

per case.

- surgery - inpatient cost per case.
- medicine - inpatient cost per case.
- dentistry - inpatient cost per case.
- accident and emergency - cost per attendance.

The Team also found that 18% of total expenditure, including capital expenditure, could not be allocated and would be the subject of future research.[65]

Methodology of Allocation

(a) Hospitals

(i) Current Expenditure

The basic method for allocating hospital current expenditure to programmes is to take total expenditure from the Costing Returns and client numbers by programme from the SH3 activity forms and to find costs per case to distribute expenditure.[66] No adjustment was made for the different time periods of the Costing Returns and the SH3 statistics, the former relating to the financial year and the latter to the calendar year.[67]

Client numbers were derived as follows:[68]

Inpatients

The numbers of deaths and discharges or the numbers of inpatient years (whichever was appropriate) for each programme were obtained by adding the relevant specialties:

Programme	SH3 Specialty Nos. (1969 no. code)
Maternity	25+26+40
Elderly	11+12
Mental Handicap	29
Mental Illness	28+30+31
Surgery	13 to 21+23+24
Medicine	1 to 10+27+41
Dentistry	22+42

The residue of inpatients, such as convalescents were allocated to Medicine and Surgery in proportion to the number of patients.

Outpatients

Total attendances were allocated to programmes in a similar manner.

Accident and Emergency

Total attendances were allocated to Primary Care

Day Patients

Psychiatric day patients were divided between Mental Illness and Mental Handicap in proportion to expenditure on the two client groups. Geriatric and Chronic Sick were allocated to Elderly. Intermittent Haemodialysis and others were allocated to Medicine, even though some might be surgical patients.

Unit costs were derived as follows:[69]

Inpatients

Costs per case from the specialist hospitals were used for Maternity and costs per inpatient year from specialist hospitals for Mental Illness and Mental Handicap. Regression was used for the remaining specialties as follows:

Costs per Case

	Estimate	Standard Error	95% Confidence Interval
Medicine	£141.5	£ 7.3	± £14.7
Geriatric and Chronic	£426.4	£28.4	± £56.7
Surgery and Dentistry	£ 65.6	£ 9.9	± £19.8
Overall Cost per Case in 361 Hospitals	£ 96.9		

These estimates were deemed to be significant since they differ from the overall average by more than two standard errors in each case. However, when applied to client numbers the resulting total expenditure was slightly more than the actual total and the estimates were scaled down accordingly.

Outpatients/Accident and Emergency

The regression estimate of cost per attendance for Accident and Emergency patients was used to allocate expenditure to Primary Care. The estimated figure of £1.03 had a standard error of £0.11

and a 95% confidence interval of ± £0.22, differing significantly from the average outpatient/accident and emergency cost per attendance of £2.82. The remaining expenditure, less a deduction for day patients, was allocated in proportion to clinic sessions, on the assumption that clinic sessions in different specialties were equal in cost, as opposed to attendances.

Day Patients

Costs per day were obtained from the Costing Returns for psychiatric and for other day patients. However, total costs when multiplied by client numbers exceeded the figures in the Costing Returns. This was mainly due to the fact that only day patient costs in hospitals treating more than 5000 day patients annually are shown separately. This meant that the excess had to be subtracted from the total expenditure for outpatients, within which the rest of the day patients had been included.

In the case of teaching hospitals, the application of the same unit costs as derived by the above methods revealed a large surplus of recorded costs over calculated costs. This surplus is due to the costs of teaching, research, more

difficult cases and historically higher levels of expenditure.

The expenditure allocated by the methods above came to £742.1m as compared with £832.1m from the Annual Accounts.[70] The remainder was allocated as follows:

- mass radiography was allocated to General Health;
- Regional Hospital Board administration and other expenditure, and payments for maintaining patients in non-N.H.S. hospitals and allowances for patients, were left unallocated;
- the blood transfusion service was left unallocated until future research could determine blood usage by programme;
- S.E.T. was left unallocated;
- £29m., or 3.5% of total expenditure, could not be accounted for.

(ii) Capital Expenditure

The sum of £104.5m was left unallocated since the existing statistics at that time were inadequate.[71]

(b) Local Health and Personal Social Services

The activity statistics for 1969 allowed a rough allocation of costs, with the exception of home nursing and ambulance services, on the assumption that average costs per case,

etc. do not vary between client groups.[72] The methods used were as follows:

Health Centres

These were allocated to Primary Care.

Mothers and young children, clinics and centres.

Allocated in proportion to the number of sessions between Maternity and General Health (Form LHS 27/2).

Health Visitors

Allocated to General Health, Elderly, Mentally Ill, Surgical, Medical, and Younger Disabled in proportion to the number of cases. (Form LHS 27/3).

Chiropody

Allocated in proportion to cases (Form SBL 618).

Local Health - Other

Allocated to General Health.

Residential Homes

Allocated to client groups according to the number in each group, with the elderly mentally infirm being included in the mentally ill programme. A small unallocated group consisted of adults who are not mentally ill or mentally or physically handicapped and who could be put in a programme for socially handicapped adults at a later date. (Form H43). Capital was allocated in proportion to loan sanctions.

Temporary Accommodation, including social work

Allocated to Children and Families with Children.

Physically Handicapped

Services to those over 65 should be reallocated to Elderly if the information is available.

Elderly

Services for the mentally handicapped and mentally ill should be reallocated to those programmesif the information is available.

Day Nurseries

Allocated to Children and Families.

Mother and Baby Homes

Allocated to Children and Families.

Mothers and Young Children, Other.

Allocated with day nurseries and mother and baby homes.

Mental Health

Allocated between Mentally Ill and Mentally Handicapped in proportion to the number of cases in Form SBL 625. Capital was allocated in proportion to loan sanction figures for 1969/70.

Domestic Help

Allocated on the basis of cases per week and weekly visiting frequency in the Government Social Survey report on the home help service in 1967.

B. The 1976 National Programme Budget

During 1973/74 the Project Team completed their analyses of past trends, and retrospective Programme

Budgets were produced from 1966/67 for the hospital services and from 1968/69 for the remaining services.[73] A programming capability for the costing of Planning Statements was thus built up and ready for the first live planning cycle in 1974/75.[74] As already pointed out, this process would have led to a Consultative Document in the Spring of 1975, but the budget cuts delayed its appearance until March 1976. This document gave the first public description of the methodology of the National Programme Budget.[75] The programme structure was also simpler, as the last chapter showed. Even the "simplified" structure of the Second Report proved too demanding of information, and the Top of the Office, particularly on the Services Development side, regarded the provision of masses of data with considerable suspicion.[76] The absence of specialty costing also meant that regression analyses would have to continue for the acute sector. However, the standard errors became larger and unacceptable and regression was abandoned.[77]

An examination will now be made of the methodology for the calculation of the base year and the costing of future policies as described in the Consultative Document.[78].

(a) Base Year Analysis

The programme budgeting process began with an examination of past trends in expenditure for the four years 1970/71 to 1973/74. For the family practitioner, centrally financed and

former local H.P.S.S., expenditure figures were taken from the Appropriation and local authority accounts, converted to 1975 (November 1974) P.E.S.S. prices, and generally adjusted in accordance with P.E.S.S. costing methods. Administrative costs were allocated to services in the case of the personal social services.

For the hospital services, the allocation of current expenditure is effected through the use of the accounts, costing returns, and SH3 statistics. Adjustments had to be made, of course, to the pre-reorganisation accounts and costing returns. Expenditure in the costing returns was divided into Inpatients, Outpatients and Day patients (subdivided into psychiatric and non-psychiatric day patients). For inpatients and outpatients, unit costs were derived as follows:

- geriatric and younger disabled inpatient bed weeks and outpatient attendances:- R.H.B. Types 6 and 19(ii)(weighted average);
- mentally ill bed weeks and outpatient attendances:- RHB Type 12;
- mentally handicapped bed weeks and outpatient attendances:- RHB Type 13;
- maternity inpatient cases and outpatient attendances:- RHB Type 11,

These unit costs were then multiplied by the

number of bed weeks, cases or attendances in the SH3 forms to give total expenditure for each client group. A similar method was used for day patients. The remaining expenditure in RHB hospitals was then attributed to all other inpatient cases and outpatient attendances (mainly "acute"). These unit costs were then applied to Board of Governors hospitals to give a total for acute hospital services. This left a residual expenditure in the Board of Governors hospitals which was allocated to "miscellaneous" hospital expenditure. This latter item also included patients in other hospitals, the Blood Transfusion Service, mass radiograph, R.H.B. and family practitioner administration, income and various accounting adjustments. Hospital capital was allocated on the basis of special returns for geriatric, mental handicap and mental illness schemes.

The next step was to analyse trends in current expenditure. In particular, an examination was made of how far the trends were due to changes in activity levels, e.g. numbers of cases, and how far to unit cost changes. This showed that in all hospital services and in local authority residential and day care services unit costs accounted for a large proportion of the increase in expenditure. This was partly due to higher standards, medical advances, etc., partly to the increasing numbers

of elderly, and partly to the increasing costs of maintaining service levels through e.g. wage drift, the Health and Safety at Work Act, the junior doctors' contract, etc.[79] The latest financial information available to the Department was for 1973/74, but as the H.P.S.S. growth rate was slowing down it was necessary to estimate the likely outturn for 1975/76 as a basis for projectons. For the family practitioner and centrally financed services information could be obtained from the Estimates. For hospital and community health current expenditure trends in 1972/73 to 1973/74, which were similar to longer term trends, were extended to 1975/76 and adjusted to accord with P.E.S.S. totals. Capital estimates were based on P.E.S.S. totals and the latest returns for geriatric, psychiatric and health centre expenditure. Personal social services projections started from an estimate of the likely outturn in 1976/77 from Rate Support Grant negotiations.

(b) Projections

From the respective bases of 175/76 and 1976/77 estimates were made of the cost of policies for the development of client group services.

For the family practitioner services and welfare food, this is based on expected demand. For all the other services, estimates are based on,

inter alia:

- specific client group policies, e.g. on the provision of services for the mentally ill and handicapped and for children in care;
- demographic factors;
- recent legislation;
- general priorities, e.g. for community care.

Total costs are then compared with public expenditure constraints in the Public Expenditure White Paper. This leads to the reconsideration of priorities and an adjustment to the various estimates compatible with the resource constraint. An important part of this reassessment is "the minimum rate of development at which a policy remains viable, and the point at which a complete change of strategy may become necessary".[80]

An important assumption in the analysis of past expenditure is that geriatric, psychiatric and maternity patients in acute hospitals cost the same as in the specialist hospitals. This is a strong assumption, particularly as only one third of maternity cases are in Type II maternity hospitals. However, the Consultative Document pointed out that projections for future years were "not very sensitive in aggregate"[81] to allocation errors in the base year. The important thing was that all expenditure should be counted once only in the base year, and the

only effect of a misallocated sum would be the application of a different grwoth rate. HC(76)29 provided further information on the 1976 Programme Budget in a table of Implied Average Levels of Provision and Current Expenditure per Head. Information was given on the derivation of "Departmental Guidelines" as follows:[82]

(i) Acute Inpatient

- beds per 1000 population: DS 85/75.

(ii) Geriatric Inpatient

- beds per 1000 population over 65 years: DS 329/71.

(iii) Non-Psychiatric Day Patients

- places per 1000 population over 65 years: DS 329/71.

(iv) Mentally Handicapped Inpatient

- beds per 1000 population: White Paper, "Better Services for the Mentally Handicapped", 1971, Cmnd.4683.

(v) Mentally Ill Inpatient

- beds per 1000 population: White Paper, "Better Services for the Mentally Ill", 1975, Cmnd.6233, HM(71)97,HM(72)71.

(vi) Psychiatric Day Patient

- beds per 1000 population: HM(71)97.

(vii) Health Visiting

- qualified staff per 1000 population: Circular 13/72.

(viii) Home Nurses

- qualified staff per 1000 population: Circular 13/72.

C. The 1977 National Programme Budget

The methodology of the 1977 Programme Budget remained broadly the same as in the 1976 version.[83]

(a) The 1975/76 Base

Outturn figures from the accounts and costing returns for 1975/76 were adjusted according to P.E.S.S. costing conventions and analysed using the same method as in 1976. The main difference, however, was that the 1977 version was based on the new N.H.S. accounting returns and administrative costs were separately identified.

(b) The 1979/80 Projections

The projections to 1979/80 provided "a quantitative assessment of national priorities at a level of expenditure compatible with the plans set out in Cmnd.6721".[84] They were based on an analysis of outturn expenditure in 1975/76 and on estimates of future growth. In the case of some services, such as the family practitioner services, the projections were based on expected demand, as in the previous year. For the other services, estimates of the cost of service developments took account of:

- past trends in activity and unit costs;
- demographic changes, such as the increasing

numbers of elderly;

- specific client group policies;

- the effects of recent legislation;

- general priorities.

This expenditure total was then compared with the levels planned in the Public Expenditure White Paper, leading to the reassessment of priorities and the revision of projections.

In evidence to the Commons Expenditure Committee in May 1977[85] the D.H.S.S. gave information on the "basic method used in assessing the growth in expenditure needed to cope with changes in the population structure "[86] for the purposes of the Programme Budget as well as being "in aggregate a key element in P.E.S.C. negotiations".[87] Total annual net current expenditure on each service is broken down according to the utilisation of the services by various age groups (i.e. total population, all births, 0-4, 5-15, 16-64, 65-74, 75+ years). The figures for each age group are summed and the total divided by the mid-year estimate of the home population to give a figure of expenditure per head for each age group. These costs per age group are then multiplied by the population projections to give the projected expenditure for that age group.

The allocation of expenditure by age group was determined as follows:

1) Acute Inpatient - from the average number of beds used daily by age from the 1972 Hospital

In-Patient Enquiry.

2) Acute Outpatient - from the distribution of outpatient attendances by age from the 1972 General Household Survey.

3) Accident and Emergency Outpatients - Acute Day Patient - use assumed to be distributed by age in the same way as the whole population.

4) Ambulance and Miscellaneous Hospital - age distribution of all hospital expenditure was applied to expenditure on these activities.

5) Geriatric Inpatient - from the average number of beds used daily and returned as allocated to geriatrics from the 1972 Hospital In-Patient Enquiry.

6) Geriatric Outpatient and Day Patient - from the distribution of outpatient attendances by age from the 1972 General Household Survey.

7) Mental Handicap Inpatient ; Mental Illness Inpatient - from the distribution of residents in mental illness and handicap hospitals from the Mental Health Enquiry 1972.

8) Psychiatric Outpatient and Day Patient - age distribution assumed to be similar to mental illness hospitals.

9) Obstetric Inpatient and Outpatient - expenditure allocated to all births.

10) Health Centres - assumed to be the same as for the general medical service.

11) Clinics - divided between all births and the 0-4

group according to the number of sessions of ante-natal and post-natal clinics and the number of sessions of child health clinics from the Departmental statistical return LHS 27/2 on clinic sessions in 1973.

12) Health Visiting and Home Nursing-Departmental assessment used.

13) Midwives - allocated to all births.

14) Prevention - many activities cannot be age banded. Expenditure distributed on the basis of vaccinations.

15) Chiropody - distribution according to the number of people under 65 and over 65 treated in 1973 from the Departmental statistical return SBL 618.

16) Family Planning - allocated to the 16-64 age group.

17) School Health - allocated to the 5-15 age group.

18) General Medical Services - from the numbers of people consulting G.P.s by age and site from the General Medical Service and National Morbidity Survey.

19) General Dental Services - from the distribution of courses of treatment and cases of emergency treatment by age in 1973.

20) General Ophthalmic Services - from the enquiry into sight tests in one month in 1959 by age.

21) Pharmaceutical Services - from the special enquiry into the total cost to the Exchequer

by age.

22) Residential Elderly and Younger Disabled - from the distribution of residents by age from the Departmental Statistical return S.S.D.A. 101, 1974.

23) Residential Mentally Ill and Mentally Handicapped - from the distribution of residents by age, SSDA 107 1974.

24) Residential Children - some information obtained from SSDA 104 1974 on children in care. Estimates were then applied to residents on the form SSDA 903 for 1974.

25) Social Work - one third to the 65-74 group, two thirds to the 75+ group (Departmental assessment).

26) Home Help - from the form LHS 27/3 and the General Household Survey.

27) Day Care: Elderly and Younger Disabled - expenditure divided between the 16-64 and 65+ age groups on the basis of places in SSDA 502, 1974 and the General Household Survey.

28) Day Care: Mentally Handicapped and Mentally Ill - all expenditure allocated to the 16-64 age group.

29) Day Nurseries - all expenditure allocated to the 0-4 age group.

30) Aids, Adaptations, Etc. - 50% allocated to the 16-64 age group, 30% to the 65-74 age group, and 20% to the 75+ age group.

31) Other Local Authority Services - distribution

proportional to the total L.A.P.S.S.

32) Welfare Food - all expenditure allocated to the 0-4 age group.

33) Artificial Limb and Appliance Centres - Departmental assessment of a ratio of 80:20 for the 65-74 and 75+ age groups.

34) Special Hospitals - from Census publications and the 1972 Mental Health Enquiry.

35) Central Grants and Youth Treatment Centres - all expenditure allocated to the 5-15 age group.

D. The 1978 National Programme Budget

The methodology underlying the 1978 National Programme Budget is the definitive version.[88] No National Programme Budget was produced in 1979 because of the economic and political uncertainties produced by the failure of the Government's wages policy, inflation, the general election, etc.[89] This was not regarded as a failure in programme budgeting, but as a "temporary aberration". Planning work within the Department was carried out as usual and a base-year analysis was made, but the plans could not be translated into detailed programmes for the next four years.

(a) The 1976/77 Base

1. Hospital and Community Health Services

(i) Current Expenditure

Hospitals

The distribution of hospital expenditure

between specialties is calculated by multiplying the number of patient days in the relevant hospital specialties (mental illness, mental handicap, geriatric medicine, maternity) obtained from the 1976 SH3 returns, by the cost per patient day for the equivalent specialist hospitals derived from the 1976/77 costing returns. Expenditure on acute services is taken as the difference between total expenditure and the estimated expenditure on the four non-acute specialties. The assumption once more is that geriatric, psychiatric and maternity patient days in acute hospitals cost the same as in specialist hospitals.[91] This approach "gives the best national estimage possible in the absence of any method at present of obtaining specialty costings routinely at national level and has been supported by regression analysis". This assumption has to be treated with a certain amount of caution, particularly for geriatric inpatients where 30% of beds and 50% of cases are in acute (types 1, 2, 3) hospitals compared with 42% of beds and 26% of cases in type 19 (geriatric) hospitals. The average cost per day for all patients in type 1-3

hospitals in 1975 was £26 compared with £12 for a type 19 hospital, although cost per case does not vary so much. The first stage in the process is to obtain regional summaries from the costing returns for the following hospital types:

- 11 - maternity;
- 12 - mental illness;
- 13 - mental handicap;
- 19(1) - geriatric.

This process begins around September but usually only 60% of the costing returns are in by this date.[92] The Summarised Accounts should be submitted for Parliamentary scrutiny by the statutory date of 30 November, though accounts are often delayed. Late submissions mean that programme budgeting calculations have to take place on a "sample" basis.[93] The regional summaries record "net" expenditure, output and unit costs for the following types of cases:

1) Inpatients;
2) Outpatients;
3) Accident and Emergency;
4) Day Patients;
5) Day Cases;
6) Other Patients.

Unit costs are calculated for the first

five types of patients from the four specialist types of hospitals. The relevant units for costing purposes and the source of financial information are given below:

	Source	Row	Information
Inpatients[a]	Cost 1[a]	400	Net Expenditure[d]
		030	Patient Days
Outpatients[a]	Cost 2[a]	400	Net Expenditure[d]
		010	Attendances
A. and E. (included in Acute Outpatients)[b]	Cost 3[b]	400	Net Expenditure[d]
		010	Attendances
Day Cases (included in Acute Outpatients)[b]	Cost 5[b]	400	Net Expenditure[d]
		010	Attendances
Day Patients[c]	Cost 4	400	Net Expenditure[d]
		010	Attendances
Other Hospital	Cost 6	400	Net Expenditure[d]
	Summary of Accounts		
	Statement 5	Row 2	Blood Transfusion
		3	Mass Radiography
		4	Emergency Bed Services
		5	Contractual Hospitals and Homes
		7	Other
Income	Summary of Accounts		Income from Pay
	Statement 1	Row 3	Beds Total

All Hospital Expenditure | Summary of Accounts Statement 3 | Total Net Expenditure[d]

Notes: a. Information obtained separately for types 11, 12, 13, 19(i) and all other types.

b. All information included under acute outpatients.

c. Information obtained separately for psychiatric and non-psychiatric hospitals.

d. Net expenditure in the costing returns is the same as gross expenditure in P.E.S.S., for which net expenditure is derived by subtracting income from pay beds from acute and obstetric inpatients in proportion to the number of private patients and by subtracting other income from other hospital.

The unit costs as calculated above were then applied to the relevant measure of the number of patients in each of the four specialties in all types of hospitals taken from the SH3 activity returns for 1976, as shown overleaf

Service	Source	Remarks
Hospital	SH3 1976 Specialty	
Acute In-and Out-Patients, A.and E.Patients, Day Cases	(Total minus those below)	Estimates of private patients are deducted from SH3 figures for deaths and discharges but not from figures for beds.
Obstetric IP and OP	(26,27,34)	
Geriatric IP and OP	Part 2 (11.)	
Units for Younger Disabled IP	Part 2 (12)	
Mental Handicap IP and OP	(30)	
Mental Illness IP and OP	(29,31,32)	
Psychiatric Day Patients	Part 3 Sec.G (1)	Estimate of places is derived from assumption of 200 attendances/place.
Non-Psychiatric Day Patients	(Total minus 1 above)	

The method used to transform this information into estimates of net expenditure for the Programme Budget is shown in the table overleaf. Expenditure on acute inpatient days is the difference between the total cost of all inpatient days and total expenditure on the four non-acute specialties. Expenditure on acute outpatients, including accident and emergency attendances and day cases was calculated in a similar way. The current expenditure total in the Summarised Accounts for 1976/77 was then distributed pro rata between patient types according to the above estimates.

	Costing Returns			SH3		Reconciled to financial accounts
	Expend. £m.	Bed Days	Unit[a] Cost £	Bed Days	Expend.[b] £m	£m
	(Hospital Types)			(Patient Types)		
1	2	3	4	5	6	7
IP						
Obs	e_1	o_1	c_1	d_1	$c_1 d_1$	$c_1 d_1 q$
MH	e_2	o_2	c_2	d_2	$c_2 d_2$	$c_2 d_2 q$
MI	e_3	o_3	c_3	d_3	$c_3 d_3$	$c_3 d_3 q$
Ger.	e_4	o_4	c_4	d_4	$c_4 d_4$	$c_4 d_4 q$
Acute	e_5	o_5	na	na	x	xq
Total	$\sum_{i=1}^{5} e_i$	$\sum_{i=1}^{5} o_i$	c^1	d^{11}	$c^1 d^1$	na
OP						
Obs	e_6	o_6	c_6	d_6	$c_6 d_6$	$c_6 d_6 q$
MH	e_7	o_7	c_7	d_7	$c_7 d_7$	$c_7 d_7 q$
MI	e_8	o_8	c_8	d_8	$c_8 d_8$	$c_8 d_8 q$
Ger.	e_9	o_9	c_9	d_9	$c_9 d_9$	$c_9 d_9 q$
Other	e_{10}	o_{10}	na	na	y	yq
Total	$\sum_{i=6}^{10} e_i$	$\sum_{i=6}^{10} o_i$	c^{11}	d^{11}	$c^{11} d^{11}$	na
DP						
Non-Psych.	e_{11}	o_{11}	c_{11}	d_{11}	$c_{11} d_{11}$	$c_{11} d_{11} q_{11}$
Psych.	e_{12}	o_{12}	c_{12}	d_{12}	$c_{12} d_{12}$	$c_{12} d_{12} q$
Other Patients[c]	e_{13}	na	na	na	$e_{13} p$	$e_{13} p$
Total	$\sum_{i=13}^{13} e_i$	na	na	na	S	A

Notes: a - Unit costs c_i, c^1 and c^{11} are calculated by dividing e_i by o_i. These are not calculated for acute patients.

b - Expenditure for each patient group is then calculated by multiplying d_i, etc. by c_i, etc. Expenditure on acute patients is the difference between expenditure on all patients calculated on the basis of SH3 and expenditure on the non-acute specialties:

$$x = c^1 d^1 - \sum_{i=1}^{4} c_i d_i \quad ; \quad y = c^{11} d^{11} - \sum_{i=6}^{9} c_i d_i .$$

c - Expenditure on other patients is reconciled with the financial accounts through multiplication by the ratio, P, between total expenditure in the Financial Accounts and that in column 2.

d - Reconciliation between net current expenditure, S, and the figure shown in the accounts, A, is effected by calculating the ratio between these figures, excluding other patients:

$$q = \frac{A - e_{13} p}{S - e_{13} p} .$$

These calculations were carried out for each region and the results aggregated to give the figures for England. Income attributable to pay beds is deducted from acute inpatients, and other income is deducted from "other hospital".

Community Health Services

Expenditure on the community health services for the 1978 Programme Budget was derived directly from the costing returns, numbers 41-48:

Service	Source	Row	Information
School Health	Cost 41,41A	400	Net Expenditure: School Medical[c]
	42,42A	400	... do ... : School Dental[c]
District Nursing[a]	Cost 43	400	... do ... Total
		103	... do ... Nursing
Midwifery[a]		161	... do ... Administration
Chiropody[a]	Cost 43	400	... do ... Total
		152	... do ... Chiropody
		161	... do ... Administration
Prevention[b]	Cost 46	400	... do ... Total
			... do ... Health Visiting
Health Visiting[b]	Cost 45	400	... do ...
Family Planning	Cost 47	400	... do ...
Other Community Health[a]	Cost 43	400	... do ... Total
		103	... do ... Nursing
		152	... do ... Chiropody
		161	... do ... Administration
	Cost 47a	400	... do ... LA Services
Total	Summary of Financial Accounts Statement 4		Total Net Expenditure

Notes: a - Cost 43 is used to provide expenditure figures for three services and the remainder is allocated to other community health.

b - Expenditure on health visiting is deducted from total expenditure in Cost 46 to give expenditure on other preventive services.

c - Cost 41 and 42 include expenditure on nurses in the school health services.

The costing returns, as can be seen above, do not fully identify the costs of midwifery, district nursing, chiropody and other community health such as clinics and health centres. This led to the following assumptions:

- figures for midwifery, district nursing and chiropody include expenditure on these services provided in health centres or clinics;
- a pro rata allowance for administration is added to net expenditure in Cost 43 for community health nursing and chiropody services;
- expenditure on prevention equals total preventive services (cost 46) minus health visitors (Cost 45);
- as the reorganised expenditure statistics no longer distinguish between expenditure on district nurses and midwives, expenditure on community nursing is allocated according to the ratio of 3:1 for district nurses and midwives, based on past trends in unit costs and staff numbers in 1976.

The expenditure figures derived from the

costing returns were finally scaled in proportion to the figures in the Area and Regional Accounts.

Output Statistics for the community health services were derived as follows:

Service	Source	Remarks
Community Health		
Health Visiting)		(All health visiting staff + TB visitors,
)		(excluding those working in school health.
District Nursing)	SBH2(C)	(Home nurses, SRN and SEN + tutors
)		(
Community Midwives)		(Midwives

Ambulance Services and Administration. Net current expenditure on these items was taken straight from the Financial Accounts. Administration refers to Headquarters Administration from Statement 2, plus Community Health Councils from Statement 5, Row 6. Ambulance service expenditure is taken from Statement 5, Row 1.

Revaluation of Net Current Expenditure. Net current expenditure as calculated above for the hospital and community health services was finally revalued to November 1976 prices compatible with those given in the Public Expenditure White Paper, Cmnd. 7049/11.

(ii) Capital Expenditure

Capital expenditure for the health services.

was calculated by allocating total expenditure for 1976/77 in the Public Expenditure White Paper at Survey 1977 prices to each services in proportion to the distribution in the summary of Statement A in the Revised Capital Estimates, February 1977. This gave information on the following services:

Inpatients

- acute/obstetrics;
- geriatrics;
- mentally handicapped;
- mentally ill.

Community Health

- other community health.

(iii) Throughput

Projections of "available beds" and "occupied beds" were calculated from the following relationships:

$$\text{Occupied beds} = \frac{\text{Cases x length of stay}}{365}$$

$$\text{Available beds} = \frac{\text{Cases x (length of stay+turnover interval}}{365}$$

Throughput assumptions were:

Acute Services

- length of stay falls by 25% between 1975/76 and 1985/86 from 10.4 to 8.6 days.
- turnover interval falls from 4.3 days in 1975/76 to 3 days in 1985/86 (3.4 days in 1981/82)

Obstetric Services

- length of stay falls by 2% p.a. from 6.8 days in 1975/76 to 6.1 days in 1981/82.
- turnover interval was derived on the basis of the following assumptions
  - there would be 17,600 available beds in 1981/82 (on the basis of the likely rate of closures and long-term needs), and
  - the number of cases would equal:

    OPCS birth projections x 1.2 (i.e. 1.2 cases per birth reflecting periods of hospital admission prior to birth).

Geriatric Services

- length of stay falls by 2% p.a., i.e. a slower rate of decrease than in recent years.
- turnover interval was derived from the assumption that there would be 57,000 available beds in 1981/82 (based on information from the field).

2. Local Authority Personal Social Services

(i) Current Expenditure

Unit costs for the personal social services were calculated by dividing net expenditure, excluding debt charges, from the national summary Revenue Outturn for 1976/77 by

the corresponding figures for each service derived from the activity statistics. The sources of information on current expenditure and output were as follows:-

	Expenditure		Notes	Statistical Source			
	RO Forms	Row	Net Expend. =Col.12 minus Cols.(3&4)	Form	Table	Row	Column
Resid.Accom.							
-elderly & YPH	RO3 B	1-5	Common Unit Cost Calculated	RAIQ2		5	3,6
-MH adults	RO3 B	7		SSDA107	1	1.7	7 to 14
				SSDA107	2	2.7	7 to 14
				SSDA107	4	4.1	3,4,5
-MH children	RO3 B	6		SSDA107	1	1.7	5,6
				SSDA107	2	2.7	5,6
				SSDA107	4	4.2	3,4,5
-Mental Illness	RO3 B	8		SSDA107	6	6.7	15
				SSDA107	7	7.7	15
				SSDA107	9	9.1	3,4,5
-Children	RO3 A	1-9		SSDA903	item 8 codes 09 to 23		
					mixed centres Table 3 Row 3.44 Col.6 shared out pro rat. to Eld., YPH and MI.		
Day Care							
-Elderly & YPH -Mental Illness	RO4 A	5,7,8 9,10	Common Unit Cost Calculated	SSDA512	3	3.22	6
					3	3.33	6
					3	3.11	6
					4	4.1	4
-Mental Handicap	RO4 A	11		SSDA512		1.10	6
-Day Nurseries	RO4 A	3,4		SSDA503	1	1	2
Other Services							
-Boarding Out	RO4 B	3,4					
-Social Work	RO5	1		SSDS001		2.6	5

-Home Helps	RO4 B	1	SSDS001	4.3	5
-Meals	RO4 A	6	SSDA302	9	4
	RO4 B	6,7			
-Intermediate Treatment	RO4 A	2			
-Aids, Adaptations, Phones, Holidays	RO4 B	8,9,10 12			
-Other LA	RO3 B	9,11			
	RO4 B	2,5,11, 13,14			
	RO5	4,5			
-Administration	RO3 B	12			
	RO4 B	15			
	RO5	2			

Around 90% of the Revenue Outturn forms, on which the national summary is based, are submitted by August/September for the Rate Support Grant negotiations.[94]

In allocating expenditure, the following assumptions and adjustments were made:

- residential care for the elderly and younger physically handicapped

  Expenditure was allocated between these two groups in proportion to the number of residents over and under 65 years of age in the estimated activity statistics for March 1977.

- day care for the elderly, younger physically handicapped and mentally ill

  Expenditure on these groups was similarly

calculated, again assuming that unit costs are the same.

- At outturn prices, £3.2m was deducted from other local authority services to take account of the transfer of responsibility for bed and breakfast accommodation to Housing Departments. Capital recorded as revenue in the accounts was estimated at £4.9m. £1.6m of this was deducted from net expenditure on social work and the remainder was deducted in proportion to net expenditure on other services. The contribution to current expenditure from Joint Finance was estimated at £1.2m in 1976/77 and allocated in proportion to net expenditure on all services.
- expenditure on administration appears as a greater percentage of total expenditure than in the health services. This is because L.A.P.S.S. administration includes such costs as supervisors' salaries which also cover the costs of organising services.

Finally, after expenditure had been calculated for each of the services, it was revalued at Survey 1977 (i.e. November 1976) prices for consistency with the

Public Expenditure White Paper.

(ii) Capital Expenditure

Capital expenditure on specific services was calculated by allocating the total for 1976/77 in the White Paper at 1977 prices in proportion to the distribution in the Secretary of State's list of loan approvals in 1975/76. Information was derived for the following services:

Residential

- elderly;
- younger physically handicapped;
- mentally ill;
- mentally handicapped adults;
- mentally handicapped children;
- children.

Day Care

- elderly;
- younger physically handicapped;
- mentally ill;
- adult training centres (mentally handicapped);
- day nurseries.

Domiciliary

- other local authority services.

In addition, Joint Finance from health authorities for capital projects was added to these figures. Joint Finance appears under the hospital and community

health services for the purpose of P.E.S.S. but is recorded under the local authority personal social services for the purposes of the Programme Budget.

(b) Projections to 1981/82[95]

This was carried out in two stages: the "preliminary" projection and the "amended" projection.

1 The Preliminary Projection

This projection was based on the following assumptions about expenditure increases between 1976/77 and 1981/82:

(i) Hospital and Community Health Services - Current.

Projections for 1981/82 were calculated on the basis of the Public Expenditure White Paper, which stated that

> "current expenditure on the hospital and community health services will need to grow at around 1 per cent a year, merely to cover the effects of demographic change and make some allowance for the cost of constantly improving medical techniques."[96]

This 1% was broken down into 0.7% for demography and 0.3% for medical advances. This meant an additional £33m, for the latter. 50% was allocated to the acute sector (excluding mental handicap, mental illness, geriatrics and maternity) and the rest was distributed between specialties according to the number of consultants. Management expenditure was projected to

decrease following the management costs review. Allowance was not made, however, for other savings since these would be used to offset unplanned increases in unit costs. But £24m. was added for such service pressures as changes in nurse training, health and safety at work, and "transitional problems of rationalising resources and adopting new priorities."[97] .£2m of this was allocated in proportion to expenditure on community health services and the rest was distributed within the hospital services in proportion to expenditure. The total sum of £57m. was assumed to increase unit costs rather than activity.

(ii) Personal Social Services - Current

Residential care unit costs were increased by 3% as suggested by the Rate Support Grant personal social services forecasting subgroups. £3.7m. was also allocated for increases in all unit costs as a result of social work training, committees established under health and safety at work and employment protection legislation, etc.

(iii) Demography

The increased unit costs for the H.P.S.S. were then applied to the activity levels required through demographic changes. These increases or decreases in activity

levels were calculated on the basis of O.P.C.S. 1976-based population projections for 1981/82 for the age groups 0-4 years, 5-15, 16-64, 65-74, 75+, and all births, and of the current use of each service by each age group (as described for the 1977 Programme Budget). Each service was assumed to reach at least this level of activity, except for the mentally ill and mentally handicapped where the number of beds was projected to decrease.

(iv) Capital

Personal Social Services

For the purpose of calculating the capital expenditure required for the additional residential and day care places needed to cope with demographic change, it was assumed that all the places would come into commission during the years of the programme. The number of places was then multiplied by the relevant unit costs to give total expenditure on each service for 1981/82.

Hospital and Community Health Services

Capital expenditure for these services was based on the provision shown in the Consultative Document.

2 The Amended Projection

After taking account of these various factors,

total expenditure in the preliminary projection was less than that planned in the White Paper by £77m for the hospital and community health services and £43m for the personal social services. This preliminary projection was thus amended as follows:

- to provide for the expenditure growth rates implied in The Way Forward for:
  - prevention
  - family planning,
  - chiropody,
  - district nursing,
  - health visitors; and
- to provide for the level of provision growth rates implied in The Way Forward for:
  - home helps,
  - meals,
  - residential and day care for the mentally ill and mentally handicapped.

The total expenditure in the Programme Budget then equalled the England component of the public expenditure figures.

The Programme Budgeting Timetable

The timetable for the preparation of the Programme Budget is the same as that for the Planning System, i.e. September to March. This timetable, as mentioned

earlier, is constrained on the one hand by the timetable for the submission of information from the field, and, for the receipt of provisional P.E.S.S. planning figures for the H.P.S.S., and on the other hand, by the need to issue guidelines to the field. With such constraints, the timetable inevitably varies each year. Several Programme Budget submissions are made to various parts of the Department during this time, ranging from "rough draft" versions to "finalised" versions.[98] It usually reaches finalisation around the end of December and is completed in January for Top of the Office review after all the costing returns have been received. Ministerial decisions are made between the period of January, after publication of the Public Expenditure White Paper, and March, when the D.H.S.S. Planning Guidelines are issued.

6.2.3 The Allocation of Resources to Health Authorities

(a) Introduction

The allocation of resources to health authorities is guided by the recommendations of the Resource Allocation Working Party (RAWP)[99]. R.A.W.P. was appointed in May 1975 to establish a method of distributing capital and revenue to Regions, Areas and Districts

which would secure a pattern of distribution "responsive objectively, equitably and efficiently to relative need".

Traditional methods of distributing financial resources incremented and perpetuated historical imbalances and responded slowly and marginally to demographic and morbidity changes. In 1948 the N.H.S. comprised an unevenly distributed stock of hospitals with unequal shares of staff and funds. Some equalisation of revenue resources was achieved in the early years but progress was poor. Up to 1969 revenue allocations to Regional Hospital Boards were based mainly on their previous allocations.[100] In addition, R.H.B.s received extra revenue to cover the running costs of new hospitals, the Revenue Consequence of Capital Schemes (RCCS). Planning, such as it was, was primarily concerned with capital projects since their revenue consequences would be funded in full by the D.H.S.S. As a partial remedy to these problems, the "Crossman" formula was devised in 1969 and 1970 and applied in 1971/72 for making revenue allocations to R.H.B.s.[101] From 1969 the D.H.S.S. also phased out the R.C.C.S. system. Instead of bids from R.H.B.s, objective criteria were used: population, beds in use, and cases. The first criterion had a 50% weight, the others 25% each. Money was distributed according to these criteria and any surplus was given to the poorer regions. The system continued up to 1975, but it was soon realised that