THE NETWORK-ACTOR APPROACH TO POLICY NETWORKS:

Case Studies from Health and HIV/AIDS Policy Implementation in Britain

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It is justifiable to use policy networks analysis as a tool of explanation of the policy process, since this approach has become the "dominant paradigm" within political science, in Britain at least. However, since this approach has become increasingly under attack from within and without the discipline, the first task of this thesis is to defend - theoretically - the usefulness of the approach, with the second to demonstrate its continued usefulness. This is achieved by extending network considerations to arenas outwith policy formulation.

Discussions of the importance of implementation, as well as Parliament, allow some qualifications to a traditional network focus on policy formulation networks, and the development of a framework which outlines a network interpretation of the policy cycle. The case study of health care policy in Britain largely confirms the hypotheses contained within this framework, whilst a closer look at the specific health policy response to HIV and AIDS policy allows focus on the applicability of traditional network concerns - such as sector/ subsector and the importance of insider status - to implementation.

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CHAPTER 1 - INTRODUCTION

Policy networks analysis may be the "dominant paradigm" (Dowding, 1995) in political science, but in recent years there has been a burgeoning literature of criticisms of this approach from within and without the field. This thesis is concerned with the analysis of such criticisms. It presents a defence of policy networks analysis by reformulating the concepts at the formulation stage and extending this analysis to areas such as implementation and Parliament, since much criticism stems from its apparent inapplicability to stages other than policy formulation. This new theoretical focus is then applied to the problem of "chaotic" or "episodic" policy making - challenging the static nature of policy networks analysis which stresses stability and incrementalism. However, two questions follow: can another approach to policy networks be justified? and, how does such an approach relate to the empirical work?

Can Another Approach to Policy Networks be Justified?

The problem with the expansion of the literature is the threat to its coherence. At least four main approaches already exist and often each does not sit well with the other. This places the paradigmatic nature of policy networks analysis into doubt. Add this to the different meanings attached to sector/ subsector, macro-meso-micro and insider/ outsider and it becomes clear why so much intellectual energy is reserved for first principles discussion, to the detriment of empirical research. Finally, the relationship between approaches and empirical research is also undermined by the increasing sophistication of policy network accounts, often so abstract that it is difficult to relate the concepts to documents and interviewees with different approaches and languages of explanation.

It is thus difficult to justify yet another approach unless it simplifies matters, allowing the problems of internal conflict to be bypassed and the networks analysis' focus to be returned to the comparisons of case studies within a similar framework. This is the task of the network-actor approach which is fully introduced in chapter 2. Chapter 2 looks at the group interaction, personal interaction, formal networks analysis and dialectical approaches

(as defined by Marsh and Smith, 1995) and discusses criticisms of each, mainly from within the literature. This point is crucial and the review of the literature important, since it highlights the fact that the paradigmatic nature of policy networks analysis is threatened mainly by the theoretical conflict between different approaches. Consequently, the network-actor approach is identified and developed to address the problems which arise from such a critique of the literature.

The network-actor approach concerns the definition of networks as social actors - like state agencies or groups - constituted by the institutionalised relationships between a government agency and relevant groups. The approach is abstract, using Hindess' (1989) definition of a social actor as a locus of decision and action. Chapter 2 thus provides a critique of the four main approaches and attempts to address subsequent problems with the application of this fifth approach. However, this is not an exercise in replacement, but an attempt to address such puzzles so that they can be solved, and the coherency of the discipline can be maintained. This differs from the approaches of Dowding and Marsh and Smith, with the former favouring a different approach altogether and the latter using a critique and partial rejection of the literature. Such conclusions are unsatisfactory since they undermine the whole basis of the discipline. That is, if each hitherto approach is untenable, then where does this leave the status of policy networks research? How can it be built on? In contrast, the network-actor approach presents an abstract defence of the literature. Most criticisms of policy networks analysis come from within the discipline anyway, so a successful challenge to these criticisms would allow both the statement of legitimacy of the discipline as a whole, as well as a move from the first principles debates which hinder practical research.

Subsequently, chapter 2 argues for a return to the analysis of more practical problems within the literature:

(1) The Boundaries of Network Action

This discussion is needed to define the nature of the network-actor itself, since this requires identification of the decision making process, or at least the important elements of such a process. Some effort must thus be made to distinguish between, say, cosmetic consultation and negotiation or core versus peripheral insider status. Without such judgements, the exercise becomes futile, with network action resembling chaos theory and involving hundreds of groups and government actors with no real attribution of responsibility.

The boundary question is used to examine the *importance* of the distinction between types of consultation. We examine the question: does consultation matter? Does a privileged consultation position within the network imply power within the decision making process? Or, is all consultation cosmetic at some stage, depending on the strategy of government?

Each chapter considers this question to some extent, with the discussion in chapter 3 of Parliament revealing the most positive answer to the value of the distinction between types of insider status. For example, the distinction between oral and written evidence preceding a report has practical and demonstrable importance. However, chapters 2 and 4 question the *assumption* of the value of core insider status, especially when considering the effects of Thatcherism or the "Thatcher style". These concerns are applied to the discussion of health policy in chapter 6 and the implementation of HIV/ AIDS policy in chapters 7-9.

(2) Consultation and the Thatcher Style

The second enduring theme is the legacy of the Thatcher style, particularly since implementation analysis (the main focus of the case studies) may require the analysis of policy change, "over a decade or more" (Sabatier, 1993). Central to the argument of this thesis is the conclusion that one consequence of Thatcherism is the need to reformulate the boundaries between formulation, implementation and even parliamentary networks.

Chapter 2 provides an important qualification to the argument that the Thatcher governments rejected consultation with groups, with subsequent periods of the internalisation of policy. First, this does not negate the existence of network activity, since influential consultation may still take place at lower levels within the civil service. Consultation is *displaced* rather than *rejected.* Further, this has enduring consequences for the study of both Parliament and implementation, since parliamentary and departmental level implementation networks took on much of the characteristics of their formulation predecessors.

Such an argument requires three main discussions. First, to examine the importance of the parliamentary and implementation stages, in terms of the ability of actors to influence policy outwith the formulation network arena. Further, chapters 3 and 4 examine the increased importance of such arenas following the effects of the Thatcher style. Second, to extend networks analysis to identify similar characteristics within parliamentary and implementation networks. In chapter 3, this involves the examination of parliamentary select committees, whilst chapter 4 introduces four levels of implementation networks which are associated with each level of government - central, regional, district and unit. Finally, to bring such considerations together to present a more dynamic and less incremental description of the policy process (chapter 5).

(3) The Distinction Between Sector and Subsector

As chapter 2 argues, there is disagreement about the appropriate levels of analysis of networks, be it in terms of the size of a policy community, the grade of civil servant responsible, or the relationship between the authority associated with the highest, or sectoral level, and the specialist, or subsectoral, level. Is the sectoral level most important since it sets the agenda for subsequent action? Or, is sector less important since it either consists merely of the coordination of a number of influential subsectors, and/ or presents an agenda which is so broad and difficult to police?

This frames the main case study which examines whether or not it is fruitful

to extend such concerns to the arena of implementation. In particular, chapter 8 looks at whether or not the general UK example of HIV/ AIDS policy is mirrored in the particular areas of Scotland and Lothian. HIV/ AIDS policy provides an excellent example of the sector/ subsector dynamic and it is worthwhile exploring its generalisability, to all arenas of AIDS policy, if not similar policy areas. The origins of the network highlight the subsector argument, with policy made from the "bottom up" and coordinated by the Chief Medical Officer within the Department of Health (and Social Security) for at least 5 years before sectoral level involvement. Further, due to the unusual nature of AIDS policy, sectoral level involvement largely resulted from subsectoral activity in highlighting the issue to ministers and senior civil servants, and when the latter became involved they followed the existing policy agenda. Yet, still, sectoral attention to the issue was brief and the issue returned to the subsectoral arena within two years. On the other hand, sectoral level involvement was profound in that consultation relationships built up at subsectoral levels were replaced by more established sectoral level arrangements. Core insiders were preferred to specialist insiders (Maloney *et al*, 1994), and a new organisational agenda was set following higher level involvement. Further, crucial to the success of the network strategy was the strengthened policy position of harm reduction which only higher level legitimation could afford.

Subsequently, the question which dominates the main case study is whether or not similar results can be found when one moves from formulation to implementation. And, if not, what are the differences between these arenas which undermine such comparisons. These include:

(a) The identification of the sectoral level. If the focus of decision making may be situated at various levels of government (and their associated networks) over time, then the sectoral level may also change.

(b) The nature of the sectoral level. Is it based on policy or organisation? Can we talk of a sectoral level defined by the generality of the policy involved, or is this meaningless without discussion of the requirement of authority?

(c) The continuous threat of central government involvement. Whilst long periods of time may see no central government involvement, the indirect effects of central government policies, as well as brief interventions, often undermine the status of these networks, and hence one's ability to directly compare them with their formulation counterparts.

The Plan

As discussed in chapter 2, three main themes provide a focus throughout this thesis, which applies policy networks analysis to parliamentary and implementation arenas. This project is based on the premise that a sole focus on formulation networks underestimates the power of actors to influence policy at subsequent stages of the policy process. Each part can be outlined as follows.

Part 1 - The Framework

Since policy networks analysis largely rejects the importance of Parliament, chapter 3 is required to justify the argument that parliamentary networks have begun to resemble their formulation network counterparts. Rejections of the importance of Parliament misinterpret the fact that Parliament may not be observably involved in the deliberations of networks. Rather, second or even third face arguments are required to discern Parliament's importance. The exercise of power within networks requires the delegation of responsibility for such decisions from representative institutions, and the actions of networks reflect the anticipation of parliamentary reaction as policy is processed within the parliamentary arena.

Further, as chapter 3 discusses, the importance of Parliament *is* observable. For example, there has been a significant rise in parliamentary lobbying over the past 20 years, reflecting dual strategies of groups and well as the increased effectiveness of parliamentary procedures. As demonstrated when this chapter extends the network-actor approach to select committees, Parliament is not only important in terms of the "wider policy network", but it also has a pre-legislative role, often prompting rather than reacting to government policy.

A similar stage is set in chapter 4 for the discussion of implementation networks. This begins by examining the merits of top-down and bottom-up approaches when extending networks analysis to implementation. Marsh and Rhodes rightly explain the "failures" of top-down Thatcher government policies in terms of the managerial conditions of the top-down approach which were not met. This includes discussion of the "paradox of governing competence", which involves governments bypassing networks and internalising policy to present an image of strong government, yet subsequently undermined by those crucial to the policy's implementation success since their involvement was rejected at an earlier stage. In other words, "policy networks acted as the greatest constraint on the development and implementation of radical policy" (Marsh and Rhodes, 1992b: 185). Yet, whilst Marsh and Rhodes distinguish between the success of policies at formulation and implementation stages, they do not distinguish between networks at each stage. Further, given the constraints of their framework, their case studies do not go into detail to explain the development and evolution of policies.

Chapter 4 attempts to supplement such analysis by examining the scope for a bottom-up analysis of the role of implementation networks. It describes the differences and similarities of formulation and implementation networks before outlining the four main levels of government associated with these implementation networks. Subsequently, it explores questions such as the levels of discretion and fragmentation of policy associated with each level of government. These will vary according to the policy area and the importance attached to each policy by central and sub-government actors.

To complete the framework, chapter 5 draws together the preliminary conclusions from chapters 2-4 to present a dynamic account of the policy process. It restates the conditions in which network-actors are found in each of the three main policy making arenas and sets the scene for the systematic comparison of the influence of these actors. Such conclusions are used to discuss the appearance of "chaotic" or episodic policy making,

or the threat to the assumptions of stability, insulation and incrementalism from the increasingly observed problem of issues breaking out from networks, and policy communities breaking down. It argues that it is only the rigidity of these assumptions which undermines the continued utility of policy networks analysis, and that a more open assessment of a more open policy process can deal well with the existence of policy influence outside the formulation arena. Discussing the utility of policy cycles , chapter 5 argues that policy networks research can progress by incorporating a broader and more fluid account of the stages in which a policy progresses.

Part 2 - The Case Studies

Why were these particular areas of policy chosen?

Health policy is best placed to gauge the usefulness of the themes already set out. For example, the fact that doctors are considered to be the classic example of core insiders and that the network is "professionalised" provides a good test of the effect of Thatcherism on established networks, as well as the value of insider status. Second, UK HIV/ AIDS policy affords the analysis of the importance of sector and subsector from the very inception of the network to the present day. Third, the emphasis on implementation links well with the need for NHS studies to examine territorial dimensions to policy structures and delivery, whilst the medical response to HIV/ AIDS allows the focus on a manageable section of health policy. HIV/ AIDS policy also allows a discussion of the importance of bottom-up, or unit levels of government before and after central government involvement.

Chapter 6 uses the general framework derived from the conclusions of chapter 5 to analyse the development of UK health policy from 1979. This discussion highlights the openness of a policy area which is apparently a closed policy community dominated by the profession. It also discusses various reasons to challenge the assumption of the primacy of the profession even before the Thatcher years. Subsequently, detailed discussion of relatively radical health policy measures in the 1980s demonstrates that domination of the network in terms of consultation does not equate with dominance of policy.

Similarly, discussion of the role and influence of Parliament suggests that two of the most major health policies of the Thatcher era were prompted by parliamentary committees and/ or their involvement with the media and the medical profession. This followed discontent with the implications of the then existing policies. However, this is not to say that Parliament always works to the benefit of the profession, since, before the Griffiths Management Report, government policy to devolve decision making responsibility to medical committees conflicted with Parliament's requirement that the Secretary of State was responsible for all aspects of the NHS.

Chapter 6 concludes that a detailed discussion of health care implementation is required to assess whether or not the threat to professional dominance stops at the formulation and parliamentary stages. Preliminary analyses by authors such as Wistow (1992b) and Klein (1992) suggests that it does, but a longer period of analysis is required.

So, the stage is set for the discussion of the implementation of health policy with particular emphasis on the medical response to AIDS. However, first, Chapter 7 serves a dual function - of qualifying the importance of formulation networks in contact with a wider policy network of actor, such as Parliament, within a more specialised arena, whilst providing the UK context for the local study of AIDS policy.

Chapter 7 argues that in the case of AIDS policy influences external to the formulation network are subject to exaggeration. Government action was often associated with heightened periods of public, media and parliamentary concern. Thus, it may appear that the policy area was chaotic or episodic - the issue broke out of the hitherto insulated network arena and the government acted as a result. However, further examination suggests that since the main network strategy was to highlight the issue of AIDS, the usual rules do not apply. Media and parliamentary concern followed government action, and most actions they did take legitimated the

network policy. The exception of the issue of HIV infection through blood products highlights a general parliamentary effect, with Parliament's focus on one aspect of government policy allowing it a policy reversal to the expense of focus and influence on general policy.

Chapter 7 also introduces a discussion of power within a network, with a particular emphasis on its initial development, arguing that the "harm reduction" approach developed in early years was never effectively challenged even following government involvement. This ties in well with chapter 8's discussion of the relationship between sector and subsector.

Chapters 8 and 9 explore the usefulness of the extension of sector/ subsector distinctions to the study of implementation by first identifying the sectoral level within the Scottish Office, and second by considering its identification according to the policy area rather than an organisation. Chapter 8 analyses the relative influence of sector/ subsector and top down versus bottom up approaches to the study of implementation by looking at the development of HIV policy in Lothian. It begins with a focus on the bottom up development of policy at unit levels, with pioneering doctors and groups providing much of the impetus for policy initiation. However, it qualifies this discussion by arguing that in certain aspects of HIV policy the Scottish Office has always been active. Further, in areas where it had less involvement and merely provided financial support, it still had at least indirect influence due to the effects of legislation and organisational change within health care policy in general. This suggests that the legacy of radical policy formulation is more marked than predicted by earlier studies.

Chapter 9 provides similar conclusions. It examines the usefulness of equating the sectoral level with a policy area, arguing that HIV/ AIDS policy in general was left to regional level statutory authorities who came together to coordinate a regional level HIV policy network. However, this discussion stretches the usefulness of the sector/ subsector distinction and chapter 9 subsequently reverts to a more straightforward emphasis on the levels of government networks approach. Nevertheless, its conclusions still tie in

well with the question of the implementation (or not) of radical policies associated with the Thatcher era. Chapter 9 highlights the numerous direct and indirect effects of *Working For Patients* on groups and doctors working at unit levels of government, arguing that the results are surprising given the original emphasis on the nullifying effect of the implementation stage on radical policy formulation.

Finally, chapter 10 draws together these conclusions and considers the extent to which these can be found in other policy areas. It also considers the effects of such a thesis in terms of its original concerns. For example, does it defend well the concept of policy networks? Or does the fact that its arguments depend on the rejection of incrementalism and insulation actually distance it from the very literature it set out to defend?

CHAPTER 2 - FORMULATION:
THEORISING POLICY NETWORKS

Introduction

Policy networks analysis explains the dynamics of the policy process in terms of state and interest group interaction. However, most criticisms are directed at particular approaches and some redefinition of the nature, functions and characteristics of policy networks allows such criticisms to be bypassed. To simplify this, Marsh and Smith (table 2.1 below) provide an organising framework of four main approaches, arguing that disagreement revolves around factors such as: the levels and types of consultation involved; the (metaphoric) status of networks; normative conclusions; and the appropriate levels of analysis (in terms of macro-meso-micro and sector versus sub sector arguments).

Subsequently this chapter develops a fifth, "network-actor", approach to the study of policy networks, arguing that networks should be viewed at a more abstract level, to allow greater scope for generalisation. A policy network can be characterised as a social actor in the same way we talk about states and interest groups. The key is the identification of the means to formulate and act on decisions within the network, and this in turn is explained by the actions of states and groups. Such a characterisation allows the return of the networks analysis focus to themes which pervade the rest of this thesis - the boundaries of network action, the effects of Thatcherism, and the sector/ subsector debate.

TABLE 2.1: APPROACHES TO POLICY NETWORKS

	Personal Interaction Approach	Group Interaction Approach	Formal Approach	Dialectical Approach
Theory of Power	Pluralist	Pluralist	Pluralist/ Elitist	Elitist/ Statist/ Strategic Relational
Epistemology	Relativist	Positivist	Positivist/ Realist	Realist
Position on Structure versus Agency	Stresses Agency. Actors as Interpreters of Meaning.	Stresses Agency. Actions of Individuals or Groups as Key to Network.	Structuralist. Networks are Structures Which Constrain Agents.	Dialectical Relationship. Structures Constrain and Facilitate Actors Whose Actions Reconstitute Structure.
Methodology	Qualitative: Interviews, Documents and Case Studies.	Qualitative: Interviews, Documents and Case Studies.	Quantitative: Case Studies Based Upon Statistical Analysis of Linkages.	Qualitative and Quantitative: Interviews, Documents, Case Studies and Statistical Analysis of Linkages.

Source: Marsh and Smith (1995: 25).

(1) The Group Interaction Approach[1]

Richardson and Jordan (1979; 1987a; 1987b) describe the British policy style as an incremental process reflecting consensual arrangements between groups and government departments, characterised by the term "bureaucratic accommodation", in which policy decisions are facilitated by interactions between civil servants and, "civil service-like officers of interest groups" (Jordan and Richardson, 1987b: 29-30). Policy styles vary in terms of accommodation and policy sector - due to such pressures as, "increasingly resource stressed and densely populated policy environments".

This is summarised by Richardson (1993: 86-90) who argues that: (a)

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[1] This approach is discussed first to allow a preliminary discussion of the distinctiveness of networks analysis.

Britain is a unitary state with comparatively weak local government; (b) there is a fusion of Executive and Legislature, with very strong party discipline; (c) the electoral system produces exaggerated majorities for the ruling party in Parliament; and (d) Britain has unusually centralised media (assisting the centralisation of power in terms of agenda setting - 1993: 89).

Second, unless a strong ideological government is in office, ministers tend to rely heavily upon their civil servants for information and advice. Given their vast responsibilities and limited (time and cognition) capabilities for action, ministers must delegate the bulk of decision making to civil servants (Drewry and Butcher, 1988: 157). Senior civil servants have the advantage of more specialised knowledge and greater expertise in the running of the department. Therefore, while the departmental minister may be held to have great executive powers, these are situational - dependent on the constructed information and advice provided by civil servants at various levels.

Third, British civil servants themselves tend to be "generalists" rather than "specialists", and in turn depend on groups for specialist advice - on technical matters as well as advice on implementation effects (1988). As a result: (a) the important policy decisions are made within government departments; (b) these decisions are heavily dependent on civil service activity; and (c) interest groups are necessary parties in this process (Richardson, 1993: 86) . This key role forms part of a "standard operating procedure" of government. Policies are only formulated by governments when the "affected" interests have been consulted, and consultation lists of departments include those considered to be central to the successful implementation of policy. The incremental nature of the policy process is thus explained in terms of the stability of the memberships of those consulted.

Such an approach has criticisms. First, Judge (1993) argues that the sole emphasis on policy communities is incomplete, insular, and underestimates the importance of institutions such as Parliament (see chapter 3). Second,

Marsh and Smith (1995) criticise Jordan and Richardson's pluralist bent, arguing that this reflects and reinforces the methodological and theoretical weaknesses of their approach. Third, Dowding (1995: 137) argues that the term "policy community" fails to serve as the driving force of explanation, because:

> *The independent variables are not the network characteristics* per se *but rather characteristics of components within the networks.*

The term is metaphorical, implying a common culture, or consensual understanding about the problems and appropriate solutions in any policy sector. Consequently, Dowding (1995: 139) argues: (a) that, although the term is "heuristically useful", this approach is, "incapable of explaining transformation" of the network itself; and (b) that unless the characteristics of networks are developed, networks are unnecessary components of policy outcome explanations. He therefore advocates either the development of formal networks analysis, or the abandonment of the term to focus on individual bargaining frameworks.

(2) The Personal Interaction Approach

Associated with Heclo and Wildavsky (1974), this concentrates on explaining policy in terms of personal interactions between ministerial, civil service and interest group elites. Inclusion within the network depends on the gaining of personal trust, through the awareness of, following, and reproduction of "rules of the game". It involves a process of individual socialisation, in which new members learn to act according to their ascribed roles. The learning process involves immersion within a "common culture", or network in which there exists a great deal of agreement on the nature and solutions to policy problems. This is taken up by Wilks and Wright (1987: 302-3) who argue that this notion of a "united 'view of the world' based on common ideas, values and knowledge", sets the parameters and levels of integration of networks. Similarly, McPherson and Raab (1988: 55) argue that if individual agency explanations are to be taken seriously

then the "assumptive worlds", or "intermingled beliefs, perceptions, evaluations and intentions" of policy makers must be researched.

This approach identifies elements of agents' discursive construction of policy problems which may be lost in broader approaches. There is stress on the investigation, rather than the assumption, of interests and motives for individual action, and as Raab (1992: 79) argues, it "emphasises depth, and complements the more fully developed approach in the literature". However, there are a number of disadvantages if considered as a distinct approach. First, as Marsh and Smith (1995: 10) argue, it pays little attention to, "the outside world and how it affects departmental networks". Second, it overplays the importance of personal relations, suggesting that the only way to become a regular consultee is if one follows the rules and gains personal trust. However, much consultation is based on the state agency's *reliance* on certain groups for technical and implementational advice, as well as group members' representative legitimacy.

Third, this approach is insular in the identification of policy actors. Discussions of elite interaction in this context requires the inclusion of permanent secretaries because ministers rely on their civil servants for information and advice, given their limited time and cognition capabilities. However, the same argument applies to these permanent secretaries who are subject to similar constraints. As Grant (1995) argues, most representations by interest group members are directed at a relatively low level within the civil service hierarchy, given the specialised and time consuming nature of the process. Therefore, busy permanent secretaries will not usually contradict advice given to them by lower level civil servants who, "know much more about the issue under consideration". Thus, if the importance of elite civil servants is based on their expertise, and their ability to provide select, or constructed, information and advice to ministers, then the civil service as a whole should be considered in this way. Junior civil servants necessarily construct the information provided to their superiors. Therefore, if so much attention is to be paid to norms, ideology, common goals, and so on, then the construction of information and advice should be

placed centrally within any explanation. Therefore, to avoid insularity, more emphasis should be placed on the effects of action at lower levels.

Finally, its weakness is that it assumes that someone must be, "in control of the ship". Yet, "to a very substantial extent, government can be run on automatic pilot" (Rose, 1986: 304). Most existing public programmes were introduced by previous governments and are routinely delivered by existing organisations. The principal concern of elite policy makers, therefore, is with, the, "non-routine and exceptional". Thus, only by, "ignoring nine-tenths or more of what is being done in the name of government", can top decision makers find the time to introduce significant programmes of their own (1986: 305). The implication is that the personal interaction approach ignores nine-tenths or more of government activity.

(3) Formal Networks Analysis/ The Structural Approach

A network is defined as a specific type of relation linking a defined set of persons, objects or events (Knoke and Kuklinski, 1991: 175). Explanations of power are couched, not in terms of individuals, but these relational connections. By focusing on aggregate social structures, and structural properties of networks, one is able to detect features of social phenomena which do not exist at the level of the individual actor (1991). Networks, as structures, influence the actions of individuals and the patterns of linkages are held to account for aspects of behaviour. As Marsh and Smith (1995: 11) argue:

> *Networks ascribe roles, resources, and capabilities and those affect both the way that groups behave and the policy outcomes.*

The analysis of networks in this sense cannot be explained by individual action, because: (a) explanation is provided in terms of the structural mechanisms within which agents operate; and (b) the influence and impact of agents depends on their position within the network. Power according to Knoke (1993: 2) is inherently situational. The powers of individuals depend

on their (dynamic) relations, which in turn can be explained by external circumstances, or a changing set of social power relations outside the control of individuals.

The emphasis of this approach on broader contexts has a number of advantages. First, it avoids the insularity of the personal interaction approach, recognising that an emphasis on elite individuals ignores the mechanisms within which action takes place. Second, this approach is not metaphorical. Dowding (1995) himself argues that this type of analysis is required for network characteristics to be explanatory variables. Finally, this approach has dynamic elements, identifying the ongoing importance of situational effects on power relations.

However, a number of difficulties undermine it. First, as both Dowding (1995: 156) and Marsh and Smith (1995: 13) argue, for all the years of "hard data collection", formal networks analysis provides conclusions which are, "not particularly startling", and not worth the effort, unless one is interested more in the technique than the results. The lack of surprises does not invalidate the exercise, but it does at least raise the question of the economics of research. Second, the *effects* of network activity on policy outcomes and the *effects* of organisational activity within networks are apparently secondary to this analysis. All it seems to show is *levels* of activity, without the demonstration of exercises of power by organisations. As Marsh and Smith (1995: 14) argue:

> *Mapping networks solely using quantitative data tells us nothing about the quality of interaction and even less about ..influence.*

The primary research problem is to identify: (a) the *type* of consultation involved; and, (b) the *effects* of advice/ consultation, which is often based on representational legitimacy and the relaying of advice on technical and implementational aspects (there is no reason to believe that more consultation means more effective consultation). As Hogwood (1987: 49)

argues, although most consultation may be seen as negotiative, in which the government has some degree of policy goals, in many cases the government may act as a relatively disinterested referee, or the consultation may be merely "cosmetic" (1987: 49-53). Therefore, the mere quantification of consultations between organisations and state agencies does little to show their types and their effectiveness. Thus, as Hogwood (1987: 49) argues, if the term consultation is to mean anything, then it needs to be "unpacked", or disaggregated.

More importantly, there is the fundamental problem of relating policy network to policy outcomes. This is due to one of two problems. One inference is that network structures influence action in the same way that, say, objective class positions do. One's position determines one's interests and therefore one's actions. The problem, however, is that agents have numerous, often conflicting, interests, and therefore these interests alone cannot explain an agent's behaviour. There is no adequate demonstration of the indirect effects of structure on action, and hence no demonstrable relationship between networks and policy outcomes. Alternatively, one may view the network structure as a direct constraint upon, or facilitator of, action. This is favoured by Marsh and Smith and discussed below.

(4) The Dialectical Approach

This is as an attempt to overcome the insularity of personal interaction and the pluralism and methodological flaws of group interaction, whilst avoiding the sole use of quantitative measures, although retaining some hope for the usefulness of structural constraint. Marsh and Smith develop an alternative approach to networks, which is "dialectical", recognising:

> *...the complexity of the policy process, seeing agents as reflexive and interpretive, whilst at the same time recognising that agents operate within a structural context* (1995: 15).

They identify the need to contextualise the actions of decision makers, by

developing the notion that the structure of networks, "affects the way decisions are made and the nature of policy outcomes" (1995: 15), whilst these structures are often reconstructed by the agents concerned: "structures constrain and facilitate actors whose actions reconstitute structure". However, their conception is undermined by its description of structural effects. Marsh and Smith do not seem to view structures as ascribers of interests as above, but suggest that structures in some way exercise structural power[2] . In this sense, a structure (or perhaps structural relationship) may be considered as an actor and distinct from other actors such as state agencies, groups and individuals, exercising power to constrain and facilitate action. However, this notion of structural power suffers from a number of difficulties.

Stated briefly, any notion of power must demonstrate its exercise. The notion of power as a capacity, or potential for action, is only useful when considered in combination with the means available to an actor to exercise power. In turn, this requires some demonstration of an actor's ability to deliberate, formulate and act on decisions made. Otherwise, the power could not be exercised. The problem with Marsh and Smith's conception of policy networks as structures (which are distinct entities), is that these structures do not appear to have the means available to formulate and act on decisions, and hence to exercise power. It is therefore unclear as to how structures could constrain and facilitate action: there are no demonstrable means of action. We are thus left with a black box. This point is developed further below. I argue that policy networks should not be considered as distinct structural entities, but as actors - constituted by state agencies and interest groups, in turn constituted by individuals, and considered at different levels of abstraction. If policy networks are to be explanatory, then one must demonstrate that they act, or exercise power, to affect policy outcomes. Further, if structural relationships are considered to be the resources of individuals, then focussed attention to the importance of the language employed is necessary to overcome the problems in viewing this as structural 'power' viewed independently of the actors involved. That is,

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[2] Correspondence with David Marsh, 1995.

how do we describe or explain the importance of "structure" without separating this from the actions of individuals?

(5) The Network-Actor Approach

Some basis for the network-actor approach can be found in the discussion of Jordan and Richardson (1982: 84). Following Habermas, they argue that a "rationality deficit" has arisen from the general pattern of group-department relations:

> *Authorities with little informational and planning capacity...are dependent on the flow of information from their clients ... thus unable to preserve the distance from them necessary for independent decisions.*

As the scope of government has expanded and its departments have become more specialised (coinciding with the increase of "particularistic" groups), civil servants have taken on a, "larger and larger part of the policy making load" (1982: 86). Given civil servants' lack of political legitimacy, they are, "ill placed to impose and conflict avoidance is likely to result". Further, given civil servants' lack of specialised knowledge, they are often dependent upon groups for information and advice. Therefore, this process of specialised accommodation leads to a form of "clientelism", or civil service association with some groups. A bargaining relationship develops between groups and civil servants at various levels of government, based on an exchange of information for influence. This suggests that policy making is too complex to be readily reduced to individuals and it is difficult to attribute responsibility for the exercise of power to make policy to those individuals. Rather, as Rose (1987: 267-8) argues, their activities are not separate but interdependent, and public policy, "is the joint product of their interaction".

A further basis for the network-actor approach is found in a discussion of Hindess (1988) who provides a minimal concept of an actor, to critique rational choice accounts and identify actors other than individuals. An actor

is defined as:

> *A locus of decision and action, where the action is in some sense a consequence of the actor's decision. Actors do things as a result of their decisions. We call those things actions, and the actor's decisions play a part in their explanation* (1988: 44).

This concept is formal and abstract, positing that for an entity to be considered an actor it must have some means available to formulate and reach decisions, whilst being able to act on those decisions. It imposes no further restrictions, allowing identification of actors other than human individuals: "... capitalist enterprises, state agencies, political parties ..." and policy networks (1988: 46 - although not structures. Structures do not have the means available to either formulate or act on decisions. This may only be an analytic distinction, but is a crucial one nonetheless), whilst raising the question:

> *What means of formulating decisions (and other propositions) are available to that actor, and ... the conditions on which they depend* (1988: 48).

The means available to a policy network to formulate decisions are demonstrated in discussion of: (a) the consultation process; and, (b) the macro-meso-micro problem. Marsh (1995b), for example, places the state at the macro level, with civil society at the micro level, and policy networks at the meso level - as the process of intermediation between the state and civil society. However, these terms refer to different levels of abstraction, and if networks are treated as actors, then they exist at the highest, or macro, level of abstraction. State agencies and interest groups occupy the meso level, with individuals occupying the micro level. Nevertheless, as Dowding (1994: 60) argues, and as table 2.2 suggests, "the same model may be heuristically useful at all levels of analysis". The point of such a distinction is to consider action as the product of power exercised by each

actor, depending on the appropriate level of analysis:

TABLE 2.2: EXAMPLES OF TYPES OF NETWORK ACTION

LEVEL OF ABSTRACTION	POLICY ACTOR	POLICY ACTION
	Macro-level - the policy network	The policy network acts to: (a) place an issue on the agenda; (b) formulate a policy; and (c) pass legislation in Parliament.
	Meso level - state agencies & interest groups	The dominant interest group issues press release, and lobbies key number of MPs.The state agency & insider interest groups consult on policy options and agree on appropriate measures. The state agency places the issue solution before Cabinet and Parliament.
	Micro-level -ministers, CS, interest group heads	An interest group representative gives a timely press release, as well as giving numerous interviews on a topic of concern. Civil servants advise minister on necessity for action. Minister consults with group heads at latter stage of consultation process. Minister raises issue in Cabinet, and proposes bill in Parliament.

Policy outcomes are primarily attributed to policy networks, which operate at the highest level, since network action to exercise power must be explained in terms of network deliberation, or the means available to formulate and reach decisions by whatever specialised technique employed. The means available to the network involve the consultative process between state agencies and interest groups. Crucial to this explanation, then, are the levels and types of consultation involved (quality, effect, formal status, 'institutionalised' nature, etc.), as well as the actions of both the state agencies and interest groups. Additionally, this may force the distinction between formulation and implementation networks if, for example, a group is excluded but still plays an important part in the blocking of policy at the next stage.

The actions of state agencies and interest groups are explained in the same fashion - in terms of: (a) the hierarchical nature of the department, the processes of consultation between ministers, permanent secretaries, junior civil servants, etc; and (b) the processes of decision making (committees,

AGMs, etc) within interest groups. For example, Grant (1995: 135) discusses the decision making structures within pressure groups which, whilst taking account of different interests, must still , "develop effective policies" and respond to change. Thus, a typical structure in a large organisation is an executive committee making decisions based on information from the devolvement of research to working parties. Obviously, state and interest group action is mainly explained by the actions of individuals, but the point is that this action would not be fully explained without some conception of the processes through which this action takes place, the obstacles to such action, and the limits (in terms of possible outcomes) to any action. Further, attributing outcomes to elite individuals obscures the dependence on actions by others.

The point of this approach is that policy outcomes are more readily explained by actors other than individuals. For example, it is possible to explain policy making in terms of individual ministers as they have formal powers and considerable discretion in decision making. The task then is to explain their behaviour in terms of their interests, their discursive construction of policy problems and their anticipation of policy effects. However, for example, perceptions of policy problems generally depend on media reports (often influenced by group activity) and civil service mediated information and advice. Further, the anticipation of effects of policy generally depends on consultation between civil servants and groups, which eventually culminates in advice given to ministers. This combined with the fact that most administrative protocols are simply rubber stamped suggests that unless a strong, ideological government is in office, it rarely makes sense to talk of policy as produced by ministers (and even then most of the conditions still apply). It is in this sense that one refers to state agency action. Additionally, states are rarely autonomous - action rarely takes place without detailed consultation with affected interests, and therefore it makes more sense to attribute policy action and outcomes to higher level collectivities or actors such as networks.

The Advantages of the Network-Actor Approach

Problems arise when the exercise of power is viewed solely at the level of the individual. As Barnes (1993) argues, this emphasis is often insular, and power is generally considered as exploitative and unproductive[3]. Further, attempts to supplement such discussions with notions of structural power are problematic. Attributing power to collectivities avoids many of these problems. First, the network-actor approach avoids the metaphorical charge against the group interaction approach, since by viewing networks as actors, the policy network is crucial to the explanation. Networks are demonstrably responsible for policy outcomes, with the mechanics of their action in turn explained by their deliberations, or the consultation processes tying state agencies and interest groups. This point is rejected by Dowding (in correspondence, 4.98), who argues that the network actor:

> *Must be a metaphor since networks can only act through the acts of individuals comprising them, even if those actors act as they do because of the interests they have due to the structural relations that define them.*

However, this is to miss the point of the approach, since individual and network action here is one and the same thing, albeit through a more or less abstract perspective. Thus, in contrast with metaphors, B is not used and discussed to help describe A. Rather, A is a simpler version of events than A, which is a simplification of A^4.

Second, it avoids the insularity of the personal interaction approach by defining network constitution more broadly to include the effects of lower

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3 For example, consider Dahl's definition: " A has power over B to the extent that A can get B to do something which B would not otherwise do" (Dahl, 1957: 202-3).

4 Consider a simple football analogy and these 3 statements: (1) Jess scores; (2) Aberdeen (ie the team of 11 players) scores; (3) Aberdeen (the club) scores. All three statements explain or describe (explanation would require fuller discussion) the same phenomenon in 3 different ways, with the first the most specific and detailed and couched in terms of an individual, whilst the other 2 are less focussed or precise but yet more accurate, more 'holistic', providing the implicit notion of context (eg paying Jess' wages) and collective action, with the goal coming as the final culmination of a team effort which is implied in statements 2 and 3.

level consultation. In other words, it provides the operational context to the final actions of decision makers.

Third, it avoids the problems of viewing networks as structures, and this is the key to understanding the network actor approach - not as a departure from, but as a means to solve the problems of language which underpin more sophisticated network accounts. These are undermined by a flawed conception of the demonstration of structural power and constraint. Structures have no demonstrable means of formulating or acting on decisions. It is therefore difficult to describe structures as "constraining" and "facilitating" state and interest group action, as this implies some notion of action. There also exists the problem of structural determinism - how does one state that structures influence action without determining that action?

Such problems are conceptual puzzles which can in part be solved by reversing the conflation of several different types of "structural" effects. The first refers to the conditions, modes of action and limitations on possible outcomes specific to any situation - or "arenas of struggle" (Hindess, 1989: 28). Although outcomes are not *determined* by these conditions, "there are always definite limitations on what the outcome may be" (1989: 29). However, this does not demonstrate structural power. Political power must be exercised, but no means are available for structures to exercise power. Therefore it would be difficult to attribute outcomes to an entity which does not act. The second type may not directly attribute outcomes to structures, but action determined by those structures. However, any actor has numerous, conflicting interests, and their active construction can only be explained with reference to the modes of decision making associated with that actor. In both of these cases, the analysis could clearly benefit from analysis at a lower level of abstraction. As Hindess (1989: 7) argues:

> *To treat social conditions and events as resulting from the actions of collectivities that have no identifiable means of formulating decisions, let alone acting upon them, is thoroughly to obscure the social processes that bring about*

those conditions and events.

The key to explaining policy outcomes is to locate and assign responsibility, and this responsibility can only be attributed to actors who formulate decisions and act upon them. It is not enough to argue that an entity is in a structurally powerful position because policy outcomes favour its interests. Some actors may have been "lucky", or "systematically advantaged" (Dowding et al, 1995: 270). Further, it is just as likely that the favourable outcome is the byproduct of the actions of a powerful third party - like a government - acting in its own interests. In turn, given that the government has forms of discourse available to allow it to formulate a variety of distinct and often incompatible objectives, these objectives cannot themselves suffice to account for the action that it takes (see Hindess, 1989: 38). This depends on the discursive construction of the requirement for, and the likely effects of, policy. In turn, this may partly depend on the ideology of the government in office, or the levels and types of consultation involved in any policy's process. The point is that to focus on some structurally privileged position to explain a policy outcome is to divert analysis from the policy process itself.

According to the third conception, structurally privileged positions are seen as power resources held by certain strata of the population. Stone (1980: 978) argues that an element of power is neglected in discussions of anticipated reaction, potential power and non-decision making. This is termed "systemic power", manifest when:

> *Durable features of the socioeconomic system confer advantages and disadvantages on groups in ways that predispose public officials to favor some interests at the expense of others.*

The conditions for systemic power are situational. Decision makers rely on consultation with some groups, be it in terms of the need to discuss technical and/or implementational aspects, in part to develop anticipated

reactions. This is well covered in the power-dependency networks literature. However, Stone goes further, arguing that given the limited time and hence conflictory competition for consultation, some groups are excluded. Some are in a better position even if they do not seek this consultation and decision makers are "inescapably" predisposed to favour some interests at the expense of others, even though this does not result from direct exercises of power by those groups (1980: 982). Rather, they are favoured because of their economic and social positions. They occupy the top social strata, perceived by decision makers as "possessing a greater capacity to mobilize and sustain resources for goal attainment" (1980: 983), and hence more likely to be consulted, than lower level strata who are more numerous and are subject to collective action problems.

There are two problems with Stone's argument. First, Stone relies on "durable" power conditions both in terms of stratification and consultative practices. No aspect of systemic power, then, can readily explain changes or variations in consultative processes. Indeed, systemic power is only significantly manifest when the issue under consideration is in the "least visible phases of policy making" (1980: 989). Second, the power of groups is viewed in capacity terms. Power is conferred on some groups by way of their position. However, if two conflictory groups "have" power, then how do we explain outcomes? By focusing on the relative capacities, and quantifying structurally powerful positions? This could be inferred from Stone's emphasis on locating those who are powerful in society, according to particular specified attributes, such as economic, social and consultative powers. However, it is impossible to predict outcomes on this basis without consideration of means of action available to groups in any situation (see Hindess, 1996: 29-30). Powers in capacity terms can only be understood as resources to attempt to further interests, rather than to secure interests. However, as Stone argues that groups may not indeed even exercise power, then this action cannot be demonstrated.

Stone does however argue that systemic power is manifest in the decisions of public officials (1980: 984). So, these considerations could be easily

subsumed within the network-actor approach. Systemic power is demonstrably manifest when network action systematically favours the interests of certain groups, reflecting their dominance of the network. In turn, this dominance may be explained by the state's reliance on such groups for technical information, as well as advice on the ease of implementation.

This discussion thus calls for some reconstruction of the identification of apparent structural power effects in the study of policy networks. Alternatively, the network is viewed as an actor. In turn, network, state and individual actions are considered as (non-mutually exclusive) actions at different levels of abstraction, with each tool used according to the nature of the consultation process and the relative dominance of lower level actors within this process. Generally, the policy network's actions are the first to be identified, in turn explained if necessary by lower level action. Policy networks do not "constrain" individual action. Rather, the individual's action can be seen as a reflection of network activity, or merely as activity considered at a lower level of abstraction. The dialectical approach, for example, may argue:

> *Policy outputs do not derive from the behaviour and choices of individual actors but are the result of actors within structural locations making choices from a range of structurally determined options* (Smith, 1993: 73).

Alternatively, the network-actor approach would argue that indeed policy outputs do not merely derive from the behaviour and choices of individual actors. Rather, they are the result of exercises of power by actors at higher levels of abstraction, their action in turn being explained by the consultative nature of the interaction between lower level actors. Network action explains policy outcomes in the most abstract sense and this is a **full** explanation. It recognises the importance not only of, say, elite decision makers or groups, but also of lower level actors, as well as the conditions in which decisions take place. Further, the statement of these conditions does

not betray a notion of structural power as discussed above, since the mechanism of decisions is conflated with the decision making process itself. That is, for example, the implicit notion of "structural resource" as a mechanism of decision making is always qualified (within the same term) by a tandem discussion of the means by which a resource is used - network action on the basis of its means of making decisions.

However, it is not a **precise** answer, which is provided by greater attention to this decision making process, either in terms of the interactions between agencies and groups, or by the interactions between individuals, depending on the extent to which a fuller explanation is required. As suggested in discussions of formal network analysis, a balance is always sought between precision and necessity, or precision and cost.

But where does this leave us? The point is that if policy networks analysis is paradigmatic, then this raises the question of internal consistency. If policy network theory is defined as a recognised approach, then a certain level of coherency is implied, and one which is not borne out by the above discussion. Too much internal criticism undermines the coherency of the approach. However, if the subsequent problems with each approach can be adequately addressed by the network actor approach, this negates the purpose of constant debates over first principles. It thus does not replace other approaches, but lends them legitimacy at a more abstract level, as part of a broader approach. In other words, if a network is identified as above, then the subsequent application of each approach, or branch of the discipline, attempts to fill in the blanks left by the imprecision of the abstraction. It is a Wittgensteinian tool - a discussion which can be ignored or bypassed once it is carried through to its logical conclusion.

Such an approach solves problems surrounding the characterisations of policy networks and the resolution of conflict allows greater emphasis to be placed on more practical problems emanating from networks research.

3 Problems: (1) The Boundaries of Network Action

When explaining collective, network, action it is unwise to include all the groups which have been consulted by government, since much consultation is cosmetic or peripheral. The importance of information resulting from the consultation process is different from one group to another, and so some process of disaggregation is required to discern the relative status of groups.

One solution is the insider/ outsider distinction. As Grant (1995: 18) argues, this highlights the choices made by groups and government. Insider status is dependent upon groups pursuing an insider strategy, or following the "rules of the game" of consultation, and the granting of that status by government. However, as Maloney *et al* (1994: 36) argue, the securing of insider status is more likely to depend on the *resources* rather than the *strategy* of groups:

> *The group-government relationship is exchange based; government offers groups the opportunity to shape public policy, while groups provide government with certain resources (e.g. knowledge, technical advice or expertise, membership compliance or consent, credibility, information, implementation guarantees) which it needs to secure a workable policy.*

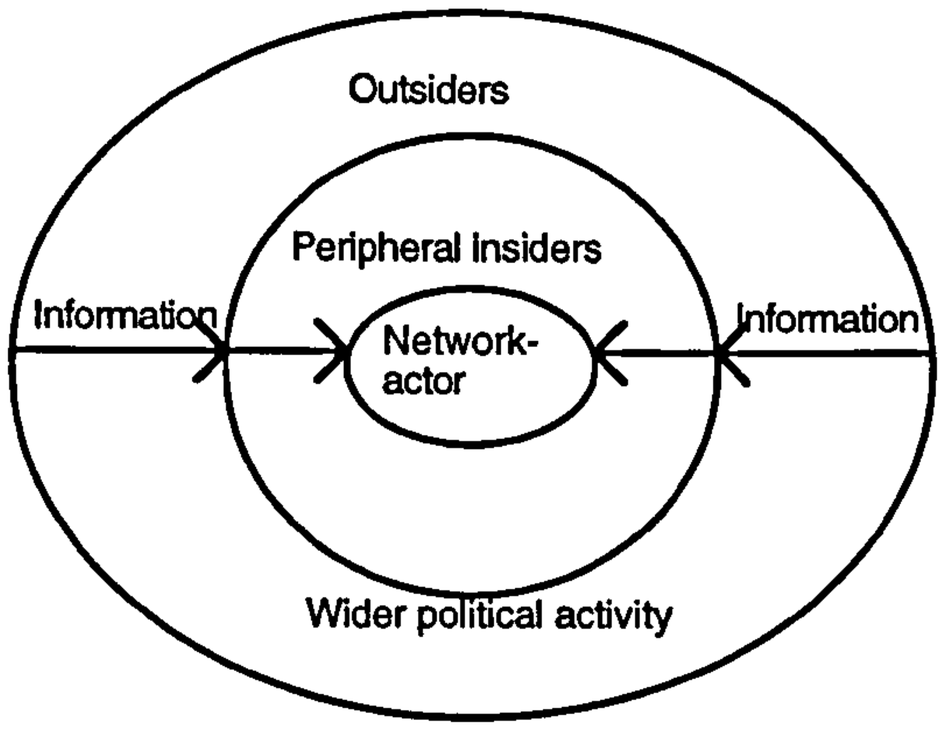
So it may be that the government cannot afford to ignore groups and some are consulted more than others even if both follow the rules. Second, this distinction fails to discern the quality of consultations. A vast number of groups (judging by consultation lists) are granted (insider) access as the threshold is low, yet few have significant influence and some distinction must be made between the process of privileged access and negotiation as opposed to mere access and consultation:

> *Consultation involving hundreds of groups is qualitatively different from that which involves a handful of groups in*

close regularised consultative relationship with decision makers (1994: 25).

Maloney *et al* (1994: 30) thus distinguish between core or specialised insider groups, depending on the variety of issues with which they achieve regularised participation, and peripheral insider groups, with access but little influence. These can be readily applied to the network-actor approach.

FIGURE 2.1 - NETWORK BOUNDARIES



The distinction between consultation and negotiation allows the distinction between those who provide information (peripheral insiders) and those who participate in and influence the process of decision making itself (core and specialist insiders). Thus, the network-actor is constituted by the state agency and core/ specialist groups. In turn, their interaction constitutes the decision making apparatus of the network-actor. This network acts on the basis of negotiation, the information it receives - partly through consultation - and in anticipation of the reactions of other groups and organisations. However, it is also important to clarify at what levels the negotiations and consultations take place (see below). Subsequent chapters on implementation also discuss whether or not core insider status is particularly important.

(2) Thatcherism and Consultation

Thatcherism is a favourite topic of networks research since in some instances there appears to have been no consultation at all (and hence no

network action) as an apparent consequence of the Thatcher style. Further, since a parallel discussion of implementation is necessary to gauge the long term effects of formulation network output, a historical approach is still essential to explain current policies.

As Marsh and Rhodes (1992: 8) argue, the Thatcher governments sought to: set the policy agenda and formulate policy quickly, unencumbered by interest group constraints. Thatcher was, "determined not to waste time on internal arguments over policy making", and so rather than consult, the aim was to force through policy, irrespective of the levels of opposition. However, the effect may be overstated. Jordan and Richardson (1987b: 30) were, "impressed with the sheer weight of consultation" in their own interviews with civil servants, whilst Maloney *et al* (1994: 23) argue that, "the practice of consultation has been *growing* in importance over the last decade". The difference can be explained by: (a) the effects of Thatcherism varying across policy sectors, or affecting some groups (e.g. trade unions) more than others; (b) consultation present after the initial presentation of policy, but before implementation, suggesting network activity has merely been displaced (necessitating discussion of implementation networks); or (c) the quality rather than the quantity of consultation which has suffered.

Whilst almost half of those groups Baggot (1995: 489) surveyed perceived, "no change in the frequency or effectiveness of contacts with ministers and civil servants during the 1980s", others were highly critical of the process. Many complained that consultative documents were statements of intent and this was reinforced by the limited time to consult. Therefore, it may be that Thatcher rejected *negotiation*, rather than consultation. However, the rejection of negotiation is largely a (prime) ministerial level effect and to concentrate on consultation at this level alone would be to ignore the vast majority of consultation taking place within lower grades of the civil service. Even in cases where the minister may attempt to "internalise" policy making, s/he will still depend on information and advice from civil servants, based on information obtained from consultation and, if the minister consults various grades within the service, s/he may find particular civil servants

defending the interests of their clients. Thus, influence (albeit indirect) will still be exerted by groups in this process. Further, ministerial consultation is less important in detailed policy issues in which the minister is not particularly involved.

Consequently, it is important to discern the departmental levels of consultation. As table 2.3 outlines, the absence of network activity in any form is scenario (5). This is highly unlikely, and even then the government is likely to know the views of those affected and act partly on that basis. More likely scenarios are 1-4. In (1), the government may have no clear policy and may be content merely to referee proceedings. In (2), sectoral level network activity is present in which a close relationship exists between groups and government. In (3), the relationship is less close and the minister may just be going through the motions of consultation. However, groups may still exert an indirect influence. As Baggot (1995: 491) argues, even when ministers were hostile, some groups maintained, "fairly cordial links with civil servants". Finally, (4) describes either the rejection of consultation completely, or that ministerial consultation at such a level is unnecessary. Thus, a subsectoral network may exist, in which the management of policy is delegated to lower grades within the civil service.

TABLE 2.3: TYPES/ LEVELS OF CONSULTATION

	(1)	(2)	(3)	(4)	(5)
Does government acquiesce with dominant group demands or act merely as referee?	YES	NO	NO	NO	NO
Does negotiation take place between government and groups at ministerial level?	YES	YES	NO	NO	NO
Does consultation take place at ministerial level?	YES	YES	YES	NO	NO
Does consultation exist at lower levels within the civil service?	YES	YES	YES	YES	NO
Are policies formulated in anticipation of stated or known group reactions?	YES	YES	YES	YES	YES

Ministerial rejections do not preclude the existence of consultation between groups and civil servants before and after the formulation of policy. The

policy formulation/ implementation network distinction may thus be required to discuss the latter. Internalised policy making is likely to lack the necessary detail to be directly implemented, and so the negotiation process at the implementation stage in many ways resembles traditional conceptions of policy networks. This is certainly the case in 1980s and early 1990s NHS reforms, with a shift in the negotiation of the details of policy from policy formulation to implementation networks (see chapters 6-9).

Additionally, for example, the case of the review which led to the formulation of *Working For Patients* demonstrates the need for caution in viewing Thatcherite policy formulation as "internalised" anyway. As Burch and Holliday (1996: 233) argue, Thatcher took personal charge of a small review team, which was a, "close knit group meeting largely in secret on a regular basis". However, even at an early stage, there is ample evidence of network influence. By the summer of 1988 the review had suffered from a loss of momentum because of the DHSS's difficulty in collating the necessary data:

> *The reason for this is just as likely to have been genuine problems in amassing detailed statistics as deliberate sabotage* (1996: 234).

This implies both a reliance on the DHSS for information and that consultation was taking place at lower levels within the service to at least gather that information. Moreover, following Kenneth Clarke's appointment as head of the newly formed Department of Health, the reforms were, "more clearly driven from the DH" (1996: 235). Clarke, "an able minister heading a well-resourced team, usually managed to maintain his department's line" (1996: 236). Thus, the formulation of NHS policy reverted back to the old system. Thatcher and her staff had initiated the review, set the terms of debate and developed ideas for discussion. However, because they lacked the resources and the information to formulate policy effectively and because the ideas from outside bodies were not feasible or practical,

Thatcher eventually passed the mantle onto Clarke, and the reform process then, "conformed more closely to normal British government procedures" (1996: 236-7).

This highlights the extent of network activity, or the standard activities of networks which characterise the British policy process, even despite attempts to internalise policy making. At the sectoral level, policy is developed within a department by the minister in charge, facilitated by a staff of civil servants in close contact with groups. The attempt to bypass the process was unsuccessful, undermining the idea that any policy measure can be considered as "internalised". To fully formulate any policy, some degree of civil service support and hence group activity is essential - an argument which can be lost with a sole focus on elite or group interaction. Subsequent chapters examine whether or not the same conclusions are found in implementation arenas.

(3) The Sector/ Subsector Distinction

Disagreement revolves around the appropriate levels of analysis of networks. Jordan and Richardson have been grappling with the problem of the size of a policy community since 1979, whilst Marsh and Rhodes' studies have a sectoral level emphasis. More recently, Jordan et al (1994: 524), reject the focus on closed policy communities at the sectoral level. Rather, the pervasiveness of internally fragmented bureaucracies necessitates viewing communities at the sub-departmental, or sub-sectoral level. In contrast, Cavanagh *et al* (1995) argue that subsectoral networks are likely to be constrained by decisions which are taken at the sectoral level, which set the agenda for the policy area. Subsectoral networks follow the rules of the game set out by sectoral networks.

However, one should not overestimate the disagreement. The constraints which Cavanagh *et al* specify, such as a tax-financed NHS, are so broad as to be of little importance in the day-to-day operations of sub-sectors, whilst Jordan *et al* do not reject the existence of activity at the sectoral level. Rather, they warn of the problems of considering the insularity of such

networks as a given, arguing that influence in regard to lower level negotiations may filter upwards, as clientele representatives within the service campaign at higher levels.

Maloney (1996) likens this to Putnam's (1988) two level game used to describe national government operations in international negotiations. Key players within sectoral level networks may follow strategies representing the views of the subsector which they head:

> *... responding to, and to a degree articulating, the interests of their 'home' constituencies of groups. Each player, therefore, has particular obligations (often statutory) and objectives, and can mobilise the support of its own network of groups and organisations* (Maloney, 1996: 964).

In terms of the network-actor approach, two distinct decision making processes may be discernible: that of the subsectoral level, in which group representatives negotiate with civil servants of, say, assistant or undersecretary level (Jordan and Richardson, 1982: 88); and, that of the sectoral level, in which the minister, permanent secretary and (civil service) subsector representatives negotiate. Core insider group representatives may also be present. The latter process, however, is likely to be restricted to decisions which are either subject to politicisation, conflict between subsectoral networks, or are the subject of major reform. Subsequent chapters discuss whether or not a similar situation is apparent in implementation arenas.

Conclusion

Four approaches were identified in this chapter, and each was undermined by a number of theoretical weaknesses. The group interaction approach is "metaphorical", with the concept of a network unnecessary to explain outcomes. The personal interaction approach is insular, both in terms of the ignorance of external context, as well as the importance of studying lower level civil servants. The focus on elite policy makers: exaggerates

the importance of personal relations; gives insufficient attention to a policy's environment; and underestimates the importance of lower level actors. Finally both formal networks analysis and the dialectical approach are undermined by their inability to demonstrate the exercise of structural power, either in terms of ascribing interests or constraining action.

This critique demonstrates the need for the "network-actor" approach, in which the policy network is seen as a social actor. This approach avoids the metaphorical charge of Dowding. It considers networks and their characteristics as central to the explanation of policy outcomes. It also gives due consideration to all levels of civil service activity, whilst the high level of abstraction allows greater emphasis on external influences. Finally, it avoids the problems of the demonstration of structural power, by characterising the policy network as an actor with identifiable means of decision making and hence demonstrating the means through which power is exercised.

The network-actor approach is not presented as yet another alternative but rather an abstract defence of the policy networks literature. It presents a critique of the literature to solve the problems within it. Such resolution of conflict allows greater emphasis to be placed on more practical problems emanating from networks research, such as the boundaries of network action, the effects of a Thatcherite style on the status of networks, and the sector/ subsector distinction. As chapters 4-10 highlight, these 3 areas are particularly relevant to the study of implementation and this initial discussion marks the beginning of a theme which runs through the rest of the thesis.

So, following the initial discussion of the effects of Thatcherism on networks, the basis for the importance of chapters 3 and 4 is in the displacement rather than rejection of consultation. A focus on policy formulation networks alone underestimates the power of all actors to influence policy at subsequent stages of the policy process. In particular, whilst the government may be able to reject consultation or negotiation at early - and

mostly sectoral level - formulation stages, this may be much more costly when it comes to implementing and even legislating that policy. Therefore, consultation and negotiation at top levels within the department may have been displaced rather than rejected, with departmental level implementation networks and even parliamentary networks taking on much of the characteristics of their formulation predecessors.

CHAPTER 3

LEGISLATION : PARLIAMENTARY NETWORKS AND "EPISODIC" POLICY MAKING

Introduction

The most influential early literature on policy communities in Britain was built on a critique of the study of formal institutions and as the study of policy networks became paradigmatic, subsequent studies followed this line in neglecting their study. It may therefore be tempting to follow most (although not all) of the networks literature and reject the empirical importance of Parliament. However, this ignores the fact that Parliament can act in a pre-legislative mode and not just as legitimator of government policy. Analysis of Parliament is also required to gauge the degree of displacement of consultation and group activity from formulation networks.

This chapter provides a brief discussion of existing considerations of Parliament within the networks literature, as well as a critique of this position which draws on the work of Judge. It argues that some middle ground can be found, with MPs considered as an important part of a wider policy network, as well as the dominant figures within parliamentary networks. The latter point is used to compare network actors in chapter 5, arguing that parliamentary networks form an important part of the network policy cycle.

Policy Networks and Parliament

The "group interaction" approach partly originated as a critique of formal institutions, characterising the British system of government as "post-parliamentary". Jordan and Richardson (1987a: 57) saw Parliament merely as a place to register votes, giving effect to decisions taken elsewhere. The argument goes as follows. First, power is concentrated in Whitehall, because there is a fusion of Executive and Legislative branches, with very strong party discipline on major issues. Dissent in Parliament is either symbolic, directed at minor policy areas, and/or rarely successful (Jordan and Richardson, 1987a: 68-9). The parliamentary majority of government allows it to "push through its legislation" (Richardson and Jordan,1979: 42;

Richardson, 1993: 89). However, this will not lead to great policy change with successive party governments anyway, since constant constraints to governments within policy communities force them into similar policy positions (Richardson and Jordan, 1979).

Second, many policy objectives are administrative - they can be achieved, "without direct recourse to Parliament" (Richardson and Jordan, 1987a: 59). Others can be pursued by using "delegated" or "subordinate" legislation, mostly in the form of statutory instruments which are subject to much less, if any, scrutiny; and, minor policy changes can be achieved by means such as departmental circulars to implementing agencies, and interest group "earstroking". As Rose (1990) argues, day-to-day departmental activity is concerned with the reinterpretation of legislative programmes which already exist, rather than the formulation of new legislation.

Third, whilst Parliament is active in areas of high political salience, it is unable to influence the "real", or central, political issues. Executive involvement is a symbolic gesture, "to satisfy the government's parliamentary majority who are effectively ignored in more central matters" of that policy (Richardson and Jordan, 1979: 41).

Fourth, group-government consultation processes supplement or replace parliament's scrutiny role on legislation. The expansion of governmental activity into more political areas means that Parliament is less able to scrutinise its activity. The details of policy are, "too specialised to require parliamentary attention" (1979: 48), in terms of both interest and ability.

Finally, most amendments at the committee and report stages are ministerial, with, "a negligible amount of opposition amendments accepted" (1979: 123). Indeed, a significant amount of amendments would place the whole bill in jeopardy, because the precise nature and wording of that bill is the result of extensive bargaining and negotiation at the formulation stage. (Jordan and Richardson, 1987b: 251).

So, whilst Parliament may legitimate government policy, it does not legislate. The government formulates policy in consultation with affected interests, the executive dominated parliamentary majority pushes the legislation through; there is little effective scrutiny, and few amendments are made at committee and report stages. Further, Midwinter *et al* (1991: 70) argue that Scottish politics commands *particularly* weak parliamentary control for three main reasons. First, party discipline is more likely, because the issue is marginal to English MPs who therefore have little to gain in rejecting government policy. Second, given the relatively small number of Scottish MPs, a Scottish backbench "revolt" is rarely effective. Third, the Scottish executive is less subject to scrutiny, given the wide range of Scottish Office activities and small number of Scottish MPs. The policy networks approach is thus particularly appropriate in the study of public policy in Scotland, and one basis for the importance of a Scottish Parliament (!).

The influence of these arguments explains the widespread ignorance of parliamentary influence in networks, but can they explain developments such as increased "dissent" in the House and an increase in the levels of parliamentary lobbying?

Parliamentary Lobbying

A survey conducted by Rush *et al* for the Study of Parliament Group into, "the means by which organisations outside government seek to influence policy through Parliament", (HC 518-iii: 27), highlights their contacts with Parliament:

> *74.7% ... said they had regular or frequent contact with MPs; ... 49% said they had presented oral evidence and 65.6% written evidence to a select committee ; 40.9% said they had had contact with party subject committees and 47.6% with all party groups.*

In addition, 83.4% of respondents expressed concern about a specific piece

of legislation through Parliament, of which 65.6% circulated a large number of MPs, and 31.3% asked an MP to arrange a meeting with the responsible minister (HC 518-iii). This reflects a belief within these organisations that policy can be influenced through Parliament (HC 518-iii: 28). It also contradicts Jordan and Richardson's (1987b: 251) argument that a testament to the minimal influence of Parliament is the lack of effort expended in that arena. However, they still downplay the significance of this evidence.

Jordan and Richardson (1987b: 251-2) argue that such activity consists mostly of mass letter writing and lobbies, where, "the link between 'noise' and influence is weak". The use of Parliament by groups is an "emergency technique", used either when all else has failed, when a group is slow in the uptake, or if some or all of a group's objectives have not been met in prior consultation (1987b: 270-2). They follow Ian Greer, arguing that by the time a bill reaches the parliamentary arena it is a "draft Act", and "anyone seriously interested should already have made it known". Second, they argue that group activity can be successful at the margins, or in small details of policy, provided they are not central to, or do not threaten, a previously bargained stance. Third, they point to the exchange relationship which ties MPs and groups, even if the MP is not in a good position to affect policy. MPs are dependent on outsiders for detailed information on most policy areas and invite groups to brief them on policy developments at the pre-legislative stage, to, "underscore the main issues and brief them with the central arguments" at the reading and committee stages of bills (1987b: 257). In turn, groups seek access to Parliament for one or more of the following reasons: (a) as an, "indirect method of influencing the real decision makers"; (b) to "win TV time" or put matters on the political agenda; (c) to establish a reputation as an expert source of information; or, (d) to gain access to the "glamorous" world of high politics (1987b: 253; 258; 268-9).

So, parliamentary lobbying is unimportant because Parliament is unimportant, a view widely supported by current and former MPs (see

Marquand and Wright, 1996; Mitchell, 1991; and Public Policy Consultants, 1987). As Jordan (1991: 180-1) argues, the time to apply pressure is in the drafting or pre-drafting stage, not when a bill reaches Parliament. Indeed, the indirect method of influencing government may even be unwelcome, if it encourages an "adversarial mood". Rather, confidential negotiation within the department is more effective, and by the time a bill reaches Parliament, the chance of any significant changes are remote (1991: 180).

However, this type of argument is insular and draws on false assumptions of the policy process. It assumes a rigid linearity in policy progression that at least requires demonstration. More recent literature on Parliament stresses its role in the drafting and pre-legislation stages of most major policies. Further, the role of Parliament should be viewed within broader considerations of the state and the policy process.

The Role of Parliament in Policy Making

No conception of policy making in Britain is complete without consideration of the activities of groups and state agencies within a, "broader framework of representative government" (Judge,1990a: 29). As Judge (1993: 2) argues, the importance of Parliament is not found in the observance of its "powers" as such, but in examination of, "the very process of representation and the legitimation of governmental outputs flowing from that process". The exercise of public power is dependent on the executive's relationship with Parliament, or the granting of consent or legitimacy by a representative institution - the effectiveness of executive policies depends upon the, "delegation of authority from representative institutions" (Judge, 1990a: 29). In other words, the determination of policies by groups and state agencies alone suffers from a legitimation gap - a gap necessarily filled by Parliament, to the extent that without this legitimising role, the policy system would be unable to operate (at least in a liberal democracy). As Judge (1990a: 30) argues:

> *Without this presumption of the ultimate authority of Parliament the outputs of ... [state agency and group*

interaction] ... would be far more difficult, if not impossible, to sustain as 'authoritative' and 'binding' policy.

This is supported by Norton (1990: 178), who argues that Parliament can be characterised as a "powerful institution in terms of Luke's third dimension of power", best demonstrated, "by contemplating what legitimacy would attach to executive or group-formulated 'legislation' if Parliament did not exist". If not from a representative parliament, where would the executive derive its authority to exercise public power? Accountability to a representative assembly is required to ensure "responsible government", essential, "in a system with a dominant executive and without legal checks provided by a constitutional court" (Woodhouse, 1994: 3).

Developments in developing and formerly communist countries towards the creation of parliaments as representative institutions suggest that such a system would not endure. This charge is difficult to level against Parliament, because: (a) it fulfils popular requirements in terms of the proper source from which public power should derive, as well as the ways in which this is exercised (Judge, 1993: 2); and (b) criticisms of the inadequacy of the (microcosmic) representative function of parliament generally point towards improvements, rather than the abolition of the system itself. Thus, the "parliamentary tradition" of the transmission of electoral opinion and consent to the executive via a representative institution, has persisted over time as the foundation of the British state (Judge, 1993: 5), by far outliving Corporatism and policy communities. And, as Judge (1993: 5) argues, following Haskins, "the most persistent phenomena ... are on the whole the most important".

So, the exercise of power by policy networks cannot be considered outwith the context or confines of representative government and the consequent relationship between the executive and Parliament. The workings of a policy community cannot be considered as "closed" to parliamentary participation (Judge, 1990b: 55). Its deliberations and actions within the community arena largely reflect an anticipation of the likely reactions to that

policy as it is processed and scrutinised within the parliamentary arena. Parliament is always in the back of the minds of ministers or civil servants acting on behalf of ministers, and the element of anticipation increases with the perceived effectiveness of Parliament (see discussion of "new" select committees). So, to ensure the legitimation of executive policies made within policy communities, the executive must follow a set of rules or conventions outwith the policy community arena. Such conventions not only shape the behaviour of network actors, but also the functions of the departments of state.

Individual Ministerial Responsibility

As Judge (1993) argues, Individual Ministerial Responsibility shapes the actions of decision makers, the operations of departments and Parliament itself. However, the concept requires disaggregation. As Woodhouse (1994: 28) outlines, there are five main types of IMR:

(1) Redirectory responsibility (expanded since the Next Steps initiative);
(2) Reporting/ information responsibility;
(3) Explanatory responsibility, suggesting a "more reasoned account" than (2);
(4) Ammendatory responsibility; and
(5) Sacrificial responsibility, (i.e. resignations, of which 10 occurred 1982-92).

The most significant types are (2) and (3). In such cases, following the conventions of IMR ensures that a minister submits to scrutiny and accounts for, "the work of his or her department in the sense of explaining and informing parliament of such activity" (Judge, 1993: 137). This has two effects. First, it, "constrains the 'normal' style of policy making", by requiring actors within networks to, "consider wider partisan/ parliamentary/ public concerns" (1990a: 32); and, second, it shapes the structure of government departments.

Judge (1993: 144-5) argues that so embedded is the convention of IMR,

"within the psyche of ministers and civil servants alike that abstract principle comes to affect actual behaviour". The Whitehall "culture" reinforces the doctrine that ministers exert executive control, whilst their civil servants remain "upward looking" towards ministers. In turn, this doctrine is based on the minister's responsibility to Parliament for all aspects of the government department's actions. Inherent in the deliberations of departmental officials is the anticipation of parliamentary reaction, and the actions of ministers and civil servants in negotiation with interest groups are partly explained by their understanding that any policies formulated will have to be processed or at least justified in Parliament. The anticipation of accountability is thus integral to the decision making process of networks, and network policies are formulated on the basis of representations from wider interests.

Parliament is therefore part of a, "wider policy community or network", playing its part in setting the policy agenda, "focussing attention on specific and detailed policy concerns, and feeding information and opinion into the policy networks" (Rush, 1990a: 145). In particular, the select committee system provides a specialist scrutinising role for MPs which is not available in other parliamentary business .

The "new" (1979), reformed, select committees possess a rationale based on the rise of policy community activity. As Walkland (1989: v) argues, enthusiasm for reform was based on the recognition that the increase in policy making by government negotiating with producer groups, "diminished the role of Parliament as the importance of primary legislation was reduced and the role of discretionary action enhanced". This was reinforced both by increasing party strength and the extension of the scale and extent of governmental activity (Baines, 1989: 14). Thus, as Baines (1989: 14) argues, the reforms were based on the need for MPs to, "become better informed", and thus be, "better placed to do their job of holding the executive to account", by scrutinising its activity outwith the confines of the adversary system of government. The new select committees were based on departmental arrangements, to provide "continuous and systematic"

scrutiny, and replaced the existing, "patchwork of Select Committees which had evolved piecemeal during the 1960s and 1970s" (Nixon and Nixon, 1983: 334; 331).

However, the question remains as to how effective such scrutinies can be. No select committee could scrutinise every detail of its department's policy (Drewry, 1989a: 349), whilst it is not the forum through which legislation passes (Rush, 1990a: 145). However, the power of the select committee resides in its ability to hold ministers (and hence the department) directly to account on any matter of departmental policy. As Giddings (1989: 373-6) argues, having to give evidence, "concentrates the minds of witnesses", and this in itself, "can result in a reappraisal of current attitudes or policies" (see also Hennessy, 1990). This can have a greater deterrent effect than other activities - if ministers or civil servants are aware that their behaviour can be called into question at any time - because the weaknesses of decisions are more likely to be exposed than if MPs relied on questions on the floor of the House (1989: 374). Indeed, the scale of this pursuit of accountability is recorded by Lock (1989: 327), who estimates that in the period of 1979-83, total committee activity called for 1779 official appearances, 117 cabinet and 113 other ministerial appearances, with approximately 100,000 questions asked, 5000 written submissions received and 12, 039 "man-days" spent by civil servants per year on preparation. A similar picture emerges even after the introduction of Executive Agencies, with the Liaison Committee (HC 323 - 1) reporting in 1997 that no problems have emerged in summoning the accounting officers of departments, Executive Agencies or other public bodies by name, whilst in 1995 the agencies alone attracted 3691 written parliamentary questions and approximately 18,000 letters from MPs to ministers and Agency Chief Executives (Judge, Hogwood and McVicar, 1997: 109-114).

However, it may be easy to exaggerate the effects of select committees, and committees do vary in effectiveness (see Drewry, 1989b: 426). This is based on:

(a) the extent to which unified reports can be produced over and above adversarial concerns - this may also influence the choice of topic;
(b) the strength of party influence, through the Whip system, and the governmental majority in the composition of committees (although see Nixon and Nixon, 1983);
(c) the style of working, "calibre of membership" and motivation of that committee;
(c) the amount of time for evidence as well as for subsequent debate in the floor of the house - for example, the committees lose about six months at the start of each session and, from 1979-85, only 5 of 275 reports debated on the floor of the House (Madgewick and Woodhouse, 1995: 182);
(d) more general time and work constraints - whilst the Liaison Committee (1997) argues that the value of select committee reports is that they are Member-driven, being a committee member can be more work than a junior minister's post, given constituency responsibilities and the lack of administrative support (Nixon and Nixon, 1983: 338);
(e) the willingness of ministers and civil servants to cooperate and disclose documents - e.g civil servants often hid behind the "Osmotherly rules" (updated in 1997) of non-disclosure of advice given by civil servants. However, a there is a recent (1997) trend towards the cessation of Permanent Secretaries marking papers "not for NAO eyes" (Liaison Committee, 1997);
(f) the timing of reports, the current government position on the issue under investigation and the centrality of this issue to government policy. That is, if a policy has been formulated and the government is committed to it, then committee influence will be considerably weaker than if the committee is innovatory in the scope of its investigation.

However, IMR also shapes the structure of government departments. As Judge (1993: 144-5) argues, departments are hierarchically structured in, "recognition of the constitutional preeminence of ministers", and decision making is centralised, "in tall, narrow pyramidical hierarchies with all major decisions funnelled upwards to the minister through his (sic) permanent secretary". The principle of IMR is so extensive that the Secretary of State is

legally responsible for all decisions made within the department. The actions of civil servants are made in, "the minister's name, not, as in the case of other countries, in their own name but on behalf of the state" (Madgewick and Woodhouse, 1995: 146).

The implications are most notable in the case of the Next Steps initiative. This involves devolving managerial responsibility to chief executives of newly formed government agencies. Yet, as Judge (1993: 146) argues, the major restraint upon this drive, "continues to be ministerial responsibility to Parliament" for all aspects of his or her department. The autonomy of each chief executive, and hence scope for decentralisation, is constrained by his or her accountability to the minister and hence to Parliament. As chapter 6 shows, this problem was manifest in the NHS a decade before Next Steps, when the DHSS failed to balance its drive towards decentralisation with the requirement of the Secretary of State to be responsible for all aspects of the NHS.

Collective Ministerial Responsibility

Collective Ministerial Responsibility (CMR) similarly shapes departmental action since the "ethos" of the central state is, "conditioned by the requirement for collective and coordinated action, stemming from the requirement of parliamentary accountability" (Judge, 1993: 142-3). Certainly, for the period under analysis, *Questions of Procedure for Ministers* stated that decisions should be made collectively and advises ministers: (a) that decisions reached in Cabinet or one of its committees is binding on all members of government; (b) that ministers should maintain a "united front" after such decisions have been reached; and (c) that ministers cannot speak publicly for themselves and that their statements are consistent with collective government policy (see Madgewick and Woodhouse, 1995: 122-3).

So, interdepartmental consultation is "institutionalised in Whitehall"[1] , and coordinated by civil service communication, the cabinet office and

[1] And the Scottish Office - see chapter 4.

interdepartmental committees, which exist to reinforce the requirement of a department to consult with all other affected departments on all major initiatives. This "network of interdepartmental relations" is coordinated by the Treasury and Cabinet Office, "which must clear any proposal requiring funding and Cabinet approval" (Madgewick and Woodhouse, 1995: 138).

In turn, collective decision making is predicated upon the formal requirement of the executive to answer collectively to Parliament. Policies are coordinated in Cabinet and Cabinet committees with some degree of anticipation of parliamentary scrutiny, and political expediency suggests that a show of unanimity is necessary to avoid, "unnecessary political embarrassment in the developing adversarial context of the House" (Judge, 1993: 141). Similarly, civil service negotiations with interest representatives are based on the knowledge that the results must be compatible with other departmental policies as well defendable, if necessary, by the minister in Parliament. Thus, although Parliament may not be, "actively involved in any policy discussions", it impinges in these ways upon the actions of network officials (Judge, 1990a: 31-2).

Both individual and collective ministerial responsibility are thus central to the context and a wider understanding of the operations of government, and derive, in turn, "from the requirement of parliamentary accountability" (Judge, 1993: 143). The practical effects of such accountability are likely to vary with levels of parliamentary attention, but the channels of accountability are no less apparent in so-called "insulated" areas of policy. For example, with regard to Executive Agencies, Judge, Hogwood and McVicar (1997: 105) point out that even the smallest and least politically contentious agencies remain accountable:

> *First, in that they are expected routinely to provide information and, second in that ultimately their every action can be subject to questioning and the need for explanation,* should MPs be so disposed.

Therefore, the "'depoliticisation' of operational matters ... is limited in practice by the overarching accountability of ministers to Parliament" (1997: 106). Further, at the other end of the scale, there is so much attention focussed on agencies such as the Prison Service that it affects the agency's ability to operate, with a consequent management style resembling the senior civil service "surrogates of ministers" approach (1997: 104). It is worth re-examining the significance of parliamentary lobbying on this basis.

The Lobbying of Parliament Reconsidered

Few groups think of public policy as solely determined by networks. Rather, groups act in the knowledge that support should be developed and maintained within both Westminster and Whitehall. They operate a dual strategy of, "simultaneously working with departments and maintaining channels of communication with Parliament" (Judge, 1990a: 35). Indeed, the Study of Parliament Group's figures reflect: a general increase in lobbying in all areas; the increase in independent MP actions; the "development of more extensive means of parliamentary scrutiny"; and, the perception that "government is less responsive to outside representations than in the past" (HC 518-iii: 26).

Groups have become more organised and the extent of state activity has increased. Additionally, many groups or organisations acting in political arenas are concerned with the details of policy and, as Rush (1990b: 6) argues, "choosing a particular channel of influence in no way precludes the use of others". Indeed, groups only interested in details may find it useful to seek parliamentary support if they fail to sustain that support within government. However, it would be incorrect to assume that groups take the parliamentary route solely because they are promotional and outsider, have "failed" in Whitehall, or are naïve in their operations. As Rush (1990a: 143-4) argues, if this were the case, why would insider groups be more active in virtually every form of parliamentary contact? Rather, insider and outsider groups "hedge their bets". They may be:

Well aware that ... government departments are generally

> *far more important than Parliament in policy-making, but that making use of a multiplicity of channels of influence makes both tactical and strategic sense.* (Rush *et al,* HC 518-iii, 1988: 28).

Parliamentary activity is often pre-legislative in that it plays a part in setting the agenda, influencing government decisions in terms of anticipated reactions, and directly affecting government policy by exercising pressure and relaying information to government as part of the wider policy network. Further, policy formulation does not end with legislation. As Hurd (1997: 2) argues, because there is too much legislation drafted too quickly, its quality is poor. Thus, a raft of amendments follow to correct mistakes and change policy. Further, group links - often the source of information for changes - are maintained throughout. Indeed, Brown (1996: 3) suggests that some "catch-all" bills mark the *beginning* of policy formulation since they represent opportunities for amendments within the very broadly titled scope of the bill. It is therefore worthwhile for insiders, as well as outsiders, to maintain links with Parliament as well as government.

Second, as Norton (1990: 208) argues, whilst Parliament remains a "reactive" body within the legislative cycle, "behavioural changes within the House" in tandem with the increase in MP assistance by groups, "have made it a relatively more vigorous body in reacting to government bills". Since 1970, MPs have exercised a relatively large degree of independence in parliamentary activities, resulting mostly in amendments to government bills and the occasional defeat. However, its importance lies in Parliament's demonstration that it is not solely a forum for automatic assent and legitimation. The "occasional willingness to say no to government" has the effect of forcing governments to take, "more heed of likely parliamentary reaction when formulating measures", and hence makes it, "more attractive to groups" (Norton, 1990: 179). Certainly, the 1997 Labour government's aim of negotiating with MPs to ensure their agreement is significant, and its breach in instances such as social security reforms demonstrated the scope of alternative action for groups.

Third, select committees are "obvious targets" for group activity if seen as a channel of influence, and, because they call for personal and written evidence, they provide, "clearly defined opportunities for pressure groups to put their point of view" (Rush, 1990c: 137).

Finally, the rise in group activity in Parliament can be explained by the perception that government is less responsive to outside interests. There are a great number of cases (see chapter 6), in which negotiations between groups and government have broken down, as the Thatcher government attempted to impose policy on networks (Judge, 1993; Marsh and Rhodes, 1992; Richardson, 1990). In turn, this has led to formulation network insiders to concentrate their political activities in wider political arenas - namely, the public/ media arena and the parliamentary arena. Thus, in part, parliamentary networks replace their formulation counterparts (see below).

Discussion of this effect in the areas of industry, pharmaceuticals, privatisation, water policy, agriculture, health and education allows Judge (1993: 131) to argue that any one sector's policies may be processed, "variously in either policy communities, or issue networks, or even in Parliament itself". Because policy communities change or even break down, the issue itself becomes politicised and hence Parliament has greater scope for influencing policy. Issues are then considered:

> *Sometimes simultaneously, sometimes serially or sometimes sequentially - in these different arenas of interconnected 'episodes' of policy development* (1993: 131).

However, the formulation of policy in other arenas should not be considered as a unique consequence of Thatcherism. As Rush (1990b: 7-8) argues, policies vary in their origin, formulation and implementation, and the policy process cannot be reduced to a simple unidirectional model. Further, most arguments on the insignificance of Parliament can be criticised on the

grounds that they rely on this conception of a linear policy process. Parliament is considered insignificant because it stands at the end of the line. When it comes to considering legislation, the policy is already a "draft Act", relatively insulated from amendment because it reflects a prenegotiated deal between groups and government. Such an argument is undermined if it ignores the fact that Parliament can act at each stage of the policy process (see chapters 6 and 7).

Further, such arguments point to the usurping of parliamentary scrutiny functions by policy communities, suggesting that groups and government have robbed Parliament of its traditional function. As Judge (1993: 110) argues, this is to ignore the initial pluralist literature on group government relations, which stresses the requirement of a representative institution to legitimate legislation, as well as the "satisfactory balance" which has developed between the executive and the legislature. In particular, Stewart (1958) argued that the balance was maintained *because* consultation mainly took place before bills were presented to Parliament. This was necessary: first, so that consultation could be processed in an administrative system capable of formulating such a wide variety of demands, and therefore that Parliament would not be presented with "unworkable bills" (Stewart, 1958 in Judge, 1993: 111); and, second, because the legislature could not act merely as a "vehicle for organised group demands", as this impinged on its wider representative role (Truman, 1951 in Judge, 1993: 108).

So, a system developed in which Parliament would, after consideration, legitimate the outcomes of detailed consultations between groups and government. There is no question, then, that the executive would be "insulated" to wider parliamentary concerns, because of the requirement for legitimation and because the functions and powers of the executive derive from Parliament's devolution of responsibility. In any case, this is not to say that Parliament would never become involved in the details of policy at such early stages, and in the past 20 years or so it has.

Parliament and the Network-Actor Approach

Given this discussion, what is the role of Parliament in explanations of network activity? This may vary across countries, policy areas, and time. Therefore, for any study of policy networks to have implications beyond its own national scope, it must situate the actions of networks within a wider political arena (Atkinson and Coleman, 1992; Judge, 1993; Pross, 1994; Wright, 1988). Further, even within Britain, policy sectors and subsectors require disaggregation, based on the perceived ability of Parliament to "hold the executive to account" (based on its past practices and reputation in specialist areas), the requirement of primary legislation, and the strength of the government's position (and majority).

It is likely that some sub-sectors may be so specialised and depoliticised that they are subject to no scrutiny, whilst others are continually monitored. As Judge, Hogwood and McVicar (1997: 96) argue, "issues of relative visibility and accountability" arise not only in departments and Executive Agencies, but also, "in the full range of bodies used by government to deliver policy". For example, in terms of Executive Agencies, whilst the Prison Service attracted 613 written parliamentary questions in 1995, more than two-thirds of existing agencies attracted less than 25, with half of those attracting less than ten (1997: 99). Further, even in relatively visible areas such as health care, the ability to politicise areas is restricted by time, the government's ability to set the political agenda, and the resources of Parliament and affected groups. Therefore, many subsectors within this policy area may operate in relative insulation from Parliamentary activity for long periods of time. In other words, successful parliamentary specialisation on one topic is offset by its consequent inattention to other areas. Therefore, as Judge (1990b) argues, "what needs to be examined is the activity of Parliament in specific policy areas", in specific time periods, in the absence of a standard policy style.

Nevertheless, it is possible to draw some broad conclusions on the relationship between Parliament and policy networks. Parliamentary effects on formulation networks are incorporated in three interrelated ways. First,

the anticipation element is manifest if the relevant MPs are considered a part of the wider policy network, providing information and advice to the executive on parliamentary and implementational matters. Second, most ministerial activity and some interest group activity in Parliament can be considered as a reflection of network action to attempt to explain and defend network policies. Examples of this network action are statements of policy by ministerial heads, as well as activity in which, as Judge (1990a: 35) argues (quoting Pross), groups act in agreement with state agencies to explain, defend and promote network policies. Third, it is possible to discern a parliamentary network-actor within the wider parliamentary arena; an actor whose importance is most notably highlighted - as in chapter 4 - by the *displacement* rather than rejection of consultation or network procedures.

Parliament and Wider Policy Networks

Most MPs specialise to some extent and *Dod's Parliamentary Companion* shows that MPs generally specialise in a handful of areas. However, as Judge (1981: 8) argues, whilst specialisation may be a necessary consequence of the increased scope of government, pressures exist to constrain the degree of specialisation which takes place. It is against the interests of ministers for MPs to specialise, since they themselves are generalists. IMR frustrates specialisation within departments and a necessarily hierarchical systems exists which requires a generalist approach. Similarly, elite civil servants, to coordinate such activity, must be generalists, and act as "quasi-politicians", or "instruments of control within departments" (Judge, 1981: 21). It is thus, "politically expedient to perpetuate generalist norms" in the House, because backbench specialisation would undermine ministerial authority which is based on a hierarchical position rather than knowledge (1981: 21) and action geared towards the attainment of executive office may ensure some backbench conformity. More importantly, the process of representation itself undermines specialisation. The organisational imperative to specialise conflicts with the need to be responsive to lay opinion over a wide variety of subjects. As Judge (1981: 25) argues:

> *The importance of knowledge, expertise and specialisation, on the one hand, does not fit entirely easily in a legislature with that of reflecting, on the other, the often non-specific views and prejudices of the electorate.*

Thus, it is no surprise then to find conflicting evidence on the extent of specialisation in the House. As Judge states, on the basis of a quantitative analysis of written records of parliamentary proceedings, subject specialisation is relatively low. However, on the basis of a questionnaire of MPs, the picture is different, with nearly 50% responding that they concentrated on 3 or fewer subjects, whilst 85% concentrated on 5 or fewer (Judge, 1981: 97). This effect is subject to interpretation, with one MP suggesting that interested is being confused with specialised in the questionnaire, whilst Judge (1981: 121) argues that it is more likely that MPs are unconsciously exaggerating their own degree of specialisation.

In the case of health, about 100 MPs, from 1979-1997 at least, rate this as their main interest (*Dod's Parliamentary Companion*), and presumably then spend a large proportion of their time in consultation with affected interests, in debate on health matters, and in tabling questions to the Secretary of State for Health and other health ministers on all aspects of health policy. This, then, mainly constitutes the "wider policy community" as described by Rush (1990a) or, as part of an issue network surrounding the formulation network-actor. However, contrary to the positions of Marsh and Rhodes, Laffin (1986: 2) argues that, "politicians with a special interest in the policy area" could be considered part of a policy network, and this seems logical since arguments about the insularity of networks from MPs depends on the untenable argument that Parliament merely legitimises policy at the end of the line. However, if an MP represented a particular group, or group of MPs, and the cooperation of that group was necessary to ensure the implementation or passage of policy, negotiation would be necessary to ensure this cooperation, and so the MP would constitute part of the decision making process. Chapters 6 and 7 provide such examples, but even

without recourse to evidence, why assume that only groups are consulted? Since MPS often have the resources - such as membership compliance or consent, credibility or implementation guarantees discussed by Maloney *et al* (1994:36) - attributed to groups, then it may be inappropriate to assume the primacy of insider groups in such discussions.

Parliamentary Network-Actors

The above discussion refers to general parliamentary activity as a wider policy network. This is distinguished from discussions of network-actors, since such general parliamentary activity is too loose or complex to attach a decision making centre as identified in previous chapters. That is, the identification of the means involved to formulate and act on decisions would be difficult to demonstrate when analysing such uncoordinated activity. However, the situation is different with select committees. The scope for specialisation and relatively detailed scrutiny of departmental policies means that select committees are central to the pursuit of accountability. Further, select committees can act in a pre-legislative, rather than reactive, manner and much activity is concerned with drawing attention to specific areas of policy with the intention of spurring on future government activity, and setting the agenda for future policy formulation (see chapter 6).

In addition, it is possible to discern a decision making process which is similar to that described in chapters 2 and 4 on formulation and implementation networks. Select committees have an explicit formulation and decision making process which is unique in its simplicity. Each committee has a maximum of 11 members (with a quorum of 3) who call individuals and organisations to provide evidence, study departmental policy, deliberate on the basis of that evidence, then provide a detailed written report. Compared with the other identified networks, this is a relatively straightforward and simple process, with a much clearer output (see chapter 5). Select committee activity therefore seems well suited to integration within the network-actor approach. However, further discussion is required to demonstrate parliamentary network activity, rather than merely select committee action.

First, each select committee has a recognisable "clientele". This is likely to be similar to the clientele associated with their respective formulation network counterparts. Further, select committees maintain, "extensive circulation lists for distributing information about their activities, including pending inquiries and calls for evidence" (Rush, 1990c: 142).

Second, just as the existence of network, as opposed to state agency, action is based on the blurred boundaries between government and interest groups, select committees are often so dependent on the specialist information and advice provided by groups, that the groups themselves are partially responsible for the outcomes of committee deliberations. There is and exchange based relationship which ties MPs and groups (Jordan and Richardson, 1987b). Yet this does not undermine the former as Jordan and Richardson suggest since the latter depends on them for access. Further, one can disaggregate this clientele into insider and outsider, or perhaps core insider versus peripheral insider and outsider groups, based on whether the group was invited to give evidence directly as opposed to merely submitting written evidence (which anyone can do). As a result, one can argue that those core insiders, invited to give (formal and informal) evidence and advice, are central to the decision making process found within committee networks.

A third similarity to formulation networks is found in the operations of select committee staff. As Rush (1990c: 142) argues:

> *Just as some groups have links with committee members ... so links between committee staffs and, to a lesser extent, the specialist advisers of committees has developed.*

A select committee has a range of staff to facilitate the provision of evidence and formulation of reports. The most important is the clerk, who usually serves five years under a particular committee and becomes, "familiar with most aspects of the policy areas within the committee's remit" (1990c).

Thus, as Rush (1990b: 142) argues, s/he and other committee staff:

> *Become known to group spokesmen* (sic) *and in many cases perform a valuable liaison role for their committee ... the clerks' knowledge of their 'clientele' is invaluable to the committees, especially in deciding who can most usefully give evidence, especially oral, for each inquiry.*

The time available for hearing evidence, as well as reading submitted evidence is heavily restricted. Therefore, the gatekeeping capacity of the committee staff should not be underestimated, and is comparable with that of the governmental civil service. Other analogies are also discernible. The clerk acts as the official voice of the committee in day-to-day dealings with groups, as well as a, "permanent presence for the Committee thereby ensuring continuity over different enquiries even though changes in membership may occur" (Nixon and Nixon, 1983: 342). The clerk and the specialist adviser are also jointly responsible for drafting questions and briefing reports, analysing the written evidence in detail, and drafting the chair's report. This is especially the case when in session with ministers. And, as Nixon and Nixon (1983: 344) argue, this reliance upon committee staff is, "essential if Committee reports and recommendations are to command credibility and are to make some impact".

A prime example of this process is the (then) Social Services Committee's analysis of AIDS and its subsequent conclusions which reinforced the existing consensus surrounding AIDS at this time. As discussed more fully in chapter 6, one can trace some parliamentary and governmental consistency in this regard to the similarity of clientele, as well as background of advisers. The advisers to the committee were doctors, the witnesses were chosen as a result of negotiations between the MPs on the committee, the advisors and the clerks, and the clerks drafted the report. Therefore, whilst the activities of the MPs themselves should not be discounted, the agenda and emphasis of the report was significantly influenced by a process parallel to that activity by advisors, clerks and the

clientele involved.

Therefore, it is possible to discern, or assert the existence of, a network actor within the parliamentary arena. This network has a clear decision making process, headed by a group of MPs, whose deliberations are facilitated by specialist advice provided by groups, which are mediated by a specialist body of committee staff. As suggested by the term network-actor there is a fusion of action and responsibility which is not easily disaggregated and hence such level of abstraction may be appropriate, especially to compare with network actors in other areas. Other comparisons with formulation and implementation networks are considered in chapter 5, and it is sufficient at this point to argue that, as the case studies in chapter 6 demonstrate, this actor is important not only in examination of the "reactionary" activities of Parliament, but also in the pre-legislative activities of Parliament. Network action within the parliamentary arena not only affects policy, but affects the context within which other networks operate.

Conclusion

Most early policy network accounts ignore parliamentary activity which is pre-legislative and part of the "wider policy network", reflecting its centrality in the process of representation and legitimation of governmental outputs. The exercise of public power based on group-government consultation depends on the delegation of authority from representative institutions. To ensure the legitimation of executive policies made within policy communities, the executive must follow a set of rules or conventions outwith the policy community arena and the deliberations and actions of networks thus reflect an anticipation of parliamentary reaction as policy is processed and scrutinised within the parliamentary arena. Accountability shapes the actions within, as well as structures of departments since group-government negotiations are made in the knowledge that resultant decisions will have to be justified by the minister in Parliament. Further, this requirement of the minister alone to account for the actions of the department means that the department is hierarchically structured, with each decision ultimately

answering to the minister, and civil servants "upward looking" in approach. Similarly, the formal position of Executive Agencies is still that the Minister is accountable through Parliament.

Such considerations justify concentration on the rise of parliamentary lobbying, reflecting the dual strategy of most groups, assertive behavioural changes in the House, the perception of closed government as a consequence of the Thatcher style, and the increased effectiveness of accountability procedures. This is best demonstrated in consideration of the extension of the network-actor approach to select committees. Parliamentary network actors act in similar ways to their formulation counterparts with MP deliberations facilitated by clerks, specialist advisors and the evidence submitted by groups. Further, their deliberations may be pre-legislative in nature, often spurring governments to redress policy stances or at least take their reports into account when formulating policy. Of course it would be unrealistic to suggest that this was always the case. However, the point of the discussion is that it is contributing to the development of a number of hypotheses involving policy networks viewed within a more dynamic framework, outlined in chapter 5.

CHAPTER 4

IMPLEMENTATION NETWORKS

Introduction

Few policy networks accounts adequately explore implementation because most conflate policy formulation and implementation issues. However, the displacement of consultation and negotiation from formulation to implementation networks necessitates the distinction. The rejection of negotiation at ministerial levels does not preclude the existence of consultation between groups and civil servants at more specialised levels before and after the formulation of policy. The policy formulation/ implementation-network distinction, then, highlights the importance of consultation and negotiation after the formulation of policy. Internalised policy making is likely to lack the necessary detail to be directly implemented, and so the negotiation process at the implementation stage in many ways resembles traditional conceptions of policy networks.

However, implementation policy networks are clearly distinguishable from their formulation counterparts. Even if they contain similar memberships, in all likelihood the roles of each actor will change and the balance of power may tilt in favour of the implementers or local level actors as a particular policy passes from national to devolved levels of government. Therefore, a "top-down" approach may be inappropriate because the main shaping of policy at this stage may come from implementation networks which are not dominated by central government departments. Rather, explanation would require the examination of the characteristics and actions of these devolved networks. So, there is clear scope for the study of national, regional, district and unit levels of policy implementation networks.

This chapter has 3 aims. First, to extend discussions of networks to the implementation arena. Marsh and Rhodes explicitly address the relationship between the top-down approach and networks, whilst the network-actor approach examines the usefulness of a bottom-up emphasis. Second, to define the parameters and types of implementation networks as a framework for subsequent case studies. Finally, to discuss the utility of

implementation network case studies in the examination of issues such as sector/ subsector, the levels and types of consultation, and boundaries of network action.

The Top Down Approach to Networks: *Implementing Thatcherite Policies*

The conditions for successful implementation from the top down are well covered in the existing literature (Hogwood and Gunn, 1984; Pressman and Wildavsky, 1984; Sabatier, 1986). This chapter focusses on the links between this approach and policy networks analysis. The best example is Marsh and Rhodes (1992) which draws on a body of case studies to argue that the literature on Thatcherism tends to overestimate the Thatcher effect because it concentrates on policy formulation. To demonstrate, they rightly use the top-down method of evaluation, since: (a) a systematic evaluation across most policy sectors requires a relatively high degree of aggregation; and, (b) as Marsh and Rhodes (1992: 8) argue, "the Conservative Government of the 1980s adopted the same model". The government operated within a model of policy making in which they sought to set the policy agenda and formulate policy quickly, unencumbered by interest groups; pass legislation in Parliament without amendment; and control the implementation process. Thatcher was, "determined not to waste time on internal arguments over policy", and so rather than consult, the aim was to force through policy, irrespective of the levels of opposition. Legislation was to be "pushed through with limited consultation before, during and after its passage", reflecting Thatcher's political style, to operate a "conviction government" and construct an image of governing competence (1992: 8).

Nevertheless Marsh and Rhodes (1992b: 9) argue that, however much a government tries to force policy implementation, most policies do fail to some extent. Further, this failure was more acute because, although the Thatcher government operated within a top down model, they chose to ignore the managerial conditions for successful implementation inherent in this approach. Analysis of these conditions, and the ways in which Thatcherite policies failed to meet these conditions, thus allows for

explanations of the relative "failure" of Thatcherite policies. One example of each, (as provided by Marsh and Rhodes) demonstrates the usefulness of this approach (although a combination of factors aids such explanations). The following policies were relatively unsuccessful because the fulfilment of the following objectives was not obtained:

(1) *That there is an understanding of, and agreement on, clear and consistent objectives* - Privatisation suffered because political objectives clashed with economic/ ideological objectives. The government's policy objective was to transfer public companies into the private sector. However, to ensure management cooperation, competition and efficiency suffered. This contrasts with housing policy, which was relatively successful because it contained clear and consistent objectives.

(2) *That a valid/ adequate causal theory exists, in which the relationship between cause and effect is direct (i.e. that the policy will work as intended when implemented)* - Economic policy suffered due to the wrong information on cause and effect. The link between inflation and the money supply, which formed the basis of monetarist policy, was suspect.

(3) *That subsequent tasks are fully specified and communicated (in correct sequence) to a team of skilful and compliant officials* - In local government, the instruments to implement control over local budgets were not available.

(4) *That the required time and resources are available, and fully committed, to the relevant programme* - With industrial relations, the government could only provide the legislative framework. Managers often chose not to take advantage of the legislation.

(5) *That dependency relationships are minimal and support from interest groups is maintained* - the paradox of governing competence is discussed below.

(6) *That external, or socioeconomic, conditions do not significantly constrain, or undermine, the process* - In social security, benefit expenditure cuts were undermined by rising unemployment. However, increasing unemployment did facilitate the effects of trade union restraint. In health care, demographic effects undermined the policy of financial stringency.

So, the lack of attention to these conditions undermined the success of these policies. Greater attention to interest group support, for example, may have facilitated greater success. Marsh and Rhodes (1992: 180) argue that after 1979, consultation in the policy areas they examined, "became a thing of the past", due to the government's "expressed desire to centralise power and authority and ... reduce the role of interest groups" (1992: 185). However, this rejection of consultation exacerbated the implementation gap. Those groups and agencies which were affected by policy, but not consulted, "failed to co-operate, or comply, with the administration of policy" (1992: 181). As Jordan and Richardson (1987: 242) show, there are four main advantages to consultation. First, it secures wider participation in the political system, and hence support for that system Second, it creates a sense of involvement, and thus ensures greater commitment to the success of a policy. Third, it allows the government to benefit from the practical experience of those consulted. Finally, it allows some portion of responsibility for that success to be transferred to other participants. Consultation allows a more informed government with fewer problems of agreement, or at least compliance (Marsh and Rhodes, 1992).

So, the rejection of consultation demonstrates an irony of the Thatcher term - the paradox of governing competence. In pursuit of an image of governing competence, the Thatcher government sought to exclude outside interests from the policy process. However, this only ensured implementation problems, and undermined that image, since:

> *It is the continued existence and power of policy networks which has acted as the greatest constraint on the development and implementation of radical policy* (Marsh and Rhodes, 1992b: 185).

Marsh and Rhodes rightly point to the primary importance of policy networks in the implementation of policy, and the level of aggregation allows a systematic evaluation of policy impact in most areas. Further, the use of the top-down model shows the utility of explaining the implementation gap in

terms of fulfilment of the conditions for successful implementation. However, one consequence of this is the conflation of policy formulation and implementation networks, and it is never made explicit just which one provided the main obstacle. Some disaggregation is thus required for detailed policy analysis, since displacement rather than rejection characterises the consultation process associated with Thatcher governments.

Second, this approach focusses more on why policy "failed", rather than the policy outcomes themselves and their main influences. As Barrett and Fudge (1981: 4) argue, to bypass the emphasis on success, policy cannot be regarded as a 'fix', "but more as a series of intentions around which bargaining takes place", modified as each actor, "attempts to negotiate to maximize its own interests and priorities". Central government may be the most influential actor, but to assume so would be to ignore the power of the implementation network. Rather, implementation involves the general operations of implementing agencies, with the constraints of hierarchical influence and legislation one of many factors in the deliberations and actions of any agency, which themselves may be limited or preempted by the actions of lower level actors. Hierarchical constraints contend with the interests and ground level activities of the actors concerned, lower level institutions and structures, and the lower level "environment", in which local demands and needs arise (1981: 25).

The notion of policy failure is criticised by Hjern (1981), who argues that inattention to the fact that: (a) departments are made up of more than one programme, and hence intra-departmental conflict may occur; and (b) few policies are fully implemented by one organization, causes the exaggeration of failure and lack of power to implement. Programmes are implemented through "multi-organizational clusters of organizations", or *implementation structures*, where, "parts of many public and private organizations cooperate in the implementation of a programme" and inattention to the complexity of these structures causes difficulties in the administration of policy (1981: 213-6). Hence, the exaggeration of policy

"failure", as difficulties lead to feelings of powerlessness since no one seems to be in charge. It is difficult to force decisions on actors within the implementation structure who are employed by other organizations, so it is unrealistic to think that a sole central actor could secure its own aims and objectives irrespective of the actions of the others involved. Although national governments create the overall framework of regulations and resources, and there are "administrative imperatives" behind the legislation authorising a programme (1981: 213), the main shaping of policy takes place at regional and local levels by implementation structures in which national considerations may play a small part. So, to understand the development of policy at this level, one must understand the characteristics of these structures.

Hjern and Porter (1981: 216) define an implementation structure as an entity:

> *Comprised of subsets of members within organizations which view a programme as their primary...interest. For these actors, an implementation structure is as much an administrative structure through which purposive actions are taken as the organizations in which they are employed.*

There is thus a clear similarity with a policy network, although a formulation network will differ from an implementation network. In the latter, Hjern (1981: 216) suggests:

(a) there is less formal structure and fewer authoritative relations;

(b) the social structures which exist are more dynamic and shifting;

(c) decisions to participate in a programme are 'fuzzy', based on consent and negotiation; and

(d)implementation structures are more likely to be *self-selected* than *designed* through authoritative relationships.

However, implementation structures *are* allocative and administrative entities, organised around specific programmes, suggesting some level of

commitment to that programme. Thus, objectives can be set and plans formulated, resources made available, services provided and performance evaluated (1981: 219).

Such distinctions are used to discuss network actors, bearing in mind that, contrary to Hjern's or Barret and Fudge's position, this is a complementary rather than a replacement discussion to a top-down approach to networks, especially since it is easy to exaggerate the autonomy enjoyed by implementation authorities, as well as groups' abilities to "self select", especially at departmental and regional levels of government.

Implementation Network-Actors

The network-actor approach broadly defines a policy network as an actor constituted by departmental interests and "core" or "specialist" insider groups (as defined by Maloney *et al*, 1994), since governmental action cannot be fully explained without reference to the procedures in which it consults and negotiates with groups before presenting final decisions. If sole responsibility cannot be attributed to government, the group-government decision making apparatus should be viewed as a single actor, with its actions explained with reference to those negotiating procedures. The network-actor represents the decision making apparatus of government. This actor is surrounded by "peripheral" insider groups, who consult but do not bargain with government, outsider groups and other institutions such as Parliament, which whilst not part of the network itself, influence that network's actions, since the network acts in anticipation of external reactions.

Implementation networks resemble former notions of formulation counterparts and therefore have similar constituents - the relevant governmental agency and insider interests. Networks can be situated at departmental, regional, district and unit levels of government (according to policy area - the basis for this discussion is NHS policy), and exhibit the following characteristics. First, whilst each level forms the part of a wider network or structure of implementation, each level of government can be

seen as a distinct network-actor. Each level of government has its own decision making procedures and has its own clientele or interests. This first point requires departure from Hjern, since there is more emphasis here on a dominant actor around which consultations and negotiations revolve. If a decision making centre or core or centre is not discernible, then this approach has less utility. However, Hjern and Porter are more likely to stress the proliferation of multiorganizational activity, with large differences in relative cohesiveness between structures. Second, formulation networks can reconstitute to some extent the structure of implementation networks as well as employ various regulatory techniques to affect the behaviour of implementation network-actors. However, the exercise of this power, rather than the capacity to act, requires demonstration.

TABLE 4.1 TYPES OF IMPLEMENTATION NETWORK

LEVEL	STRUCTURE OF NETWORK	RELATIONSHIP TO CENTRE
Government Department	**Stable/ Relatively Closed -** Consultation mainly between sub-sector of department and stable set of interests	Very Close - akin to a policy community relationship, in which acceptance of a broad policy facilitates the negotiation of details
Regional/ Scottish Office	**Stable -** Regional level often performs intermediary function. Therefore, consults mainly with dept and districts (although specific regional interests may be present).	Close - the department can coordinate activity to some degree, and ministers or their representatives frequently meet with regional chairs
District/ Local Authority	**Less stable -** participation within network less subject to control; incentives for implementers to cooperate relatively low	Regulatory - the department is unable to coordinate activity, given the number of fragmented authorities. It relies on broad regulation techniques.
Unit (e.g school, hospital)	**Relatively independent -** no departmental representatives within decision making process, although manager accountable to higher levels	Indirect - the day-to-day operations of units operate within a broad framework of regulation, but without direct intervention

As described in table 4.1, the ability of central departmental actors to

coordinate implementational activities in detail decreases as policy is devolved to each subsequent level. Therefore, at the level of the department or subsector within the department, consultation and negotiation revolves around the activities of civil servants interpreting a broad agenda within the department. It is civil servants who set the "rules of the game" and dominate the process. Similarly, at the regional level, the numbers of regional chairs or executives is small enough to maintain close links with each, and even hold regular strategy meetings with all regional representatives present. Thus, at the regional level, there may be clear boundaries to network action, based on meetings at the national level, and so the process of decision making may be relatively difficult to influence.

However, at district level, the proliferation of authorities and organisations undermines the possibility of close, centralised, coordination of policy. The formulation network is more reliant on legal regulations and the policing of these by regional authorities. Further, the participants within the district level network are more likely to be "self-selected", because the implementing agency is much more reliant on local implementers to further policy objectives. Similarly, at unit levels, the local network acts within a broad regulatory framework, in part policed by district and regional levels of government. Indeed, formulation network influence may be so indirect that it may not figure in the day to day actions of the unit level network, except insofar as to determine the broad scope and structure of that activity. Unit and departmental level consultations may be so infrequent that central department representatives are unlikely to be considered as part of the core decision making apparatus of such a localised level of government. Thus, again, significant discretion would exist, and the network would be more subject to external influence.

Thus, the process of implementation can be seen as a complex interaction between four network-actors associated with each level of government. As policy is devolved to each level, the levels of discretion increase and so the particular characteristics of local networks are identified as necessary to explain, first, their processes of decision making and hence, second, their

actions as part of the implementation process. Whilst the structure of government suggests a hierarchical arrangement ties each level, the levels of discretion associated with each level suggest that an imperative to follow guidelines and to further departmental policy forms only a part of the basis of the decision making process.

Of course, such a discussion marks only the beginning of the analysis, in two ways. First, it remains to be seen whether or not statutory regulations are as effective as constant day-to-day involvement in the influencing and directing of policy at each level, and indeed it may be the case that suitably detailed and stringent laws prohibits discretion just as effectively as personal contact. However, the initial point is that as one goes further down the line it is less and less valid to *assume* that a top-down policy will necessarily be followed without qualification, especially since central government is less and less able to constantly negotiate those details on a day-to-day basis.

Second, it remains to be seen whether or not the distinctions can be made between each level of government. However, as chapter 8 discusses more fully, the classifications are used not to reject the idea that networks are developed between levels of government, but that the location of <u>core</u> decision making shifts over time, in part according to policy area and policy priorities. Thus, to understand the outcomes of the networks, it is necessary to identify and examine the focal point of decision making, depending on the policy area under discussion. For example, chapter 8 situates the focus of drugs and prisons policy at the Scottish Office level, whilst chapter 9 argues that the decision making focus of at least the care and treatment element of HIV/ AIDS policy is situated at the level of Lothian Health. Each type of implementation network is discussed in greater detail below[1] .

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[1] Note, however, that since these are Scottish examples, their comparison to British policy as a whole requires the SO to be viewed as regional, and thus subordinate to, say, the DH, whilst LH would be the equivalent of an English district health authority.

The Departmental Level

The effect of Thatcherism on consultation may be overstated since Jordan and Richardson (1987: 30) and Maloney et al (1994: 23) report constant or increasing consultation over the period. As Baggot (1995: 489) suggests, it is the quality of interaction which suffered - negotiation, not consultation, was rejected. Further, given that this is a (prime) ministerial phenomenon, the question remains over the links maintained between groups and civil servants before and after the internalisation of policy. Internalisation produces very broad policy objectives since it relies on a relatively small body of information. So, the details are left to civil servants in the department, who in turn consult with implementing agencies and interested groups. In other words, negotiation has been displaced from formulation to implementation networks within the same department.

Richardson (1990: 14) argues that the Thatcher governments recognised this distinction and acted accordingly. Whilst major decisions took place at the sectoral level, the logic of bargaining and specialisation suggests that such decisions will eventually be translated through the normal, "manageable" channels. Thus, whilst the Thatcher governments may have excluded some groups from "high politics", they subsequently reverted back to, "the traditional style of bargaining, once the 'stuff' of high politics [got] down to the implementation level" (199): 14; see also Baggot, 1994: 492).

Thus, departmental implementation networks resemble their former formulation network counterparts. However, there are notable differences. First, negotiations within implementation networks are, "based upon the government's own proposals" (Richardson, 1994: 185). Or, as Cavanagh *et al* (1995) argue, sectoral level networks set the agenda for the policy area. Thus, the decision making process within implementation networks is influenced by the earlier decisions and actions taken by the formulation network. Second, there is an attitudinal shift in terms of the purpose of negotiations and the roles of the relevant civil servants which shifts from consulting with groups to provide information and advice to ministers on the formulation of policy, to negotiating the details with groups to ensure that an

already broadly formulated policy is acceptable. Third, subsectoral activity is much more likely at this stage. Sectoral level activity is mostly associated with periods of politicisation, conflict and/ or major reform or at least direct ministerial involvement. However, the shift to the implementation stage suggests at least a partial resolution of such disruptions and policies are devolved to more manageable units. Further, if a policy is multi-faceted, then some groups may only be interested in some parts, and therefore their activity revolves around a subsectoral network. Relations and interactions, then, are more likely to resemble those of policy communities since there is an accepted agenda and set of rules of discussion. Groups may not agree with the policy emphasis, but to gain access they must accept them and negotiate within such a framework. Finally, in many cases, the shift in a policy's development from formulation to implementation may be associated with a ministerial shift, or the type of minister.

For example one might expect to see a ministerial change from policy innovator to ambassador (Headey, 1974) to coincide with the stage of policy, especially if the group-government relationship must move from confrontational to conciliatory to ensure the implementation of policy. This was best exemplified by Kenneth Clarke's periods of office in Health, Education and the Home Office. As Baggot (1995: 491) argues, Clarke was often criticised for being openly dismissive of groups, and relations between Clarke and group heads were understandably strained. However, the same groups subsequently reported improved relations with some of his successors (see chapter 6).

The Regional/ Scottish Office Level

The Scottish Office - before the creation of the Scottish Parliament in 1999 - is a good test of the bottom-up critique, since we can ask the question- to what extent was the Scottish Office a policy *making* or implementing administration. Or, to what extent did scope exist for distinctly Scottish policies in the discretionary implementation of British policies?

The Scottish Office is a territorial department, and following the *Senior*

Management Review (1995), it had five main departments: Agriculture, Fisheries & Environment; Education and Industry; Home Affairs (& Scottish Courts Administration); Local government, Housing, Planning & Transport; and Health (NHS-ME and Public Health Policy Unit). However, as Midwinter *et al* (1991: 56) argue, this range of, "*responsibilities* should not be equated with the *powers* of the Scottish Office", since it was never designed to be a policy making body and generally does not initiate policy outwith the control of central government. Britain was a unitary state, with each government department accountable to Cabinet and Parliament. Also, central government departments were likely to be possessive of the responsibilities for national policy, and the devolution of decision making powers were generally discouraged. So, it was in the interests of both ministers and civil servants to minimise "policy divergence", especially if dealing with a salient issue (Keating and Midwinter, 1983: 22).

Thus, the scope for autonomous policy making was limited to areas in which the Scottish Office had, "the entire administrative responsibility and there is no overlap with the work of Whitehall departments" (Midwinter *et al*, 1991: 80). This rules out most activity. With areas like defence, foreign affairs, social security and transport, where there was no Scottish Office equivalent to a central department, the administration of policy was performed directly by departments. Indeed, the numbers of civil servants in Scotland working outwith the Scottish Office was 5 times greater (1991: 62). Second, the activities of Scottish Office departments must generally conform to those of their central department counterparts[2]. Third, even in cases where policy is formally made separately and there is scope for difference, this may not occur. The Secretary of State may be content to act merely as a policy administrator. The civil service in Scotland, with close - communication and employment - links to Whitehall, may even act as a steady influence. Also, different arrangements are most likely in specialised areas with low political saliency. In these cases, such as industry, health care and the social services, only professional bodies may be interested in influencing policy, and hence the policy may reflect UK wide professional

[2] The effect of the new Scottish Parliament is outwith he remit of this thesis.

values (1991: 80; Keating and Midwinter, 1983: 22-3). In effect one may reasonably expect policy autonomy only in areas such as administrative and local government reform.

However, still, the Scottish Office did have policy influence - as a consulted party within departmental networks as well as in the administration of policy. Midwinter *et al* (1991) see some utility in viewing the Scottish Office itself, (as the focus for Scottish interests), as Britain's largest pressure group. Whilst it may have little in the way of powers to innovate policy, it did have influence within existing policy networks. And, as such, the Scottish Office would go to great lengths to "secure an agreed line" with the affected Scottish interests to present a united front in negotiations with its Whitehall counterpart. So, it has traditionally, and relatively successfully, promoted close consultation and consensus building in Scotland, reflecting a "common interest among all actors in the Scottish network in promoting Scotland's material interests" (1991: 74). However, as Midwinter *et al* (1991: 74) argue, this lobbying tended to be discrete, allowing: (a) the public maintenance of the governmental line by Scottish Office ministers and the maintenance of neutrality by Scottish civil servants; and, (b) the continued existence of privileged access to central government, on the understanding that there is a "trade off between autonomy and access" (1991). In other words, the public commitment to the Union by members of the Scottish network allowed those members greater access, and hence influence, within that union[3].

However, Scottish Office influence is not only restricted to lobbying. As Keating and Midwinter (1983: 20) argue, although much Scottish activity is reactive, the Scottish Office generally maximises its impact by fully participating in the formulation of British policy. Further, in some cases, the Scottish Office may be given the role of policy leader, in which it coordinates the consultation process and convenes meetings with the other interested departments. Nevertheless, given the relative influence, expertise, research facilities and ranks of their Whitehall counterparts, and

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[3] The Scottish Parliament changes things now, but the argument remains within the scope of this thesis.

the fact that the Scottish office is often regarded merely as a territorial department, it is usually the larger department which leads, with the Scottish Office making a relatively small contribution (Midwinter *et al*, 1991: 79).

As a result, most Scottish Office influence can be found in the administration of policy. In most areas, the principles of policy may be the same, but there is scope for differential implementation by the Scottish Office, in the following ways. First, because Scotland has a separate legal system, many UK policies require separate Scottish legislation and there is scope for bargaining and Scottish Office discretionary influence even before a policy has reached the statute. Second, in cases such as health and education where separate structures and functions exist, the Scottish Office may negotiate exemptions from central policy or at least negotiate greater leeway in the implementation of specific proposals to suit Scottish arrangements. Third, in cases where a UK policy is vague, the Scottish office has wide discretion in its implementation. In certain cases, the Scottish Office has been able to pursue an innovative policy whilst presenting it as implementation. For example, Midwinter *et al* (1991: 83) argue that the development of New Towns in Scotland, designed to regenerate areas of high unemployment, was presented by the Scottish office as consistent with the government's policy on urban overspill. The Scottish Office may also be relatively free to pursue Scottish objectives within a very broad UK framework, if distinct priorities have been developed (as in health policy). Finally, the Scottish Office has some discretion in the timing of implementation.

So, discussion of the Scottish Office as an example of a discretionary implementation network shows that considerable scope does exist for regional actors to influence policy. Although the Scottish Office has little powers to initiate policy outwith central control, it exerts considerable influence in negotiating concessions for Scottish interests at the formulation stage, as well as in the detailed, discretionary implementation of policy.

The District Level

At district level, the proliferation of authorities and organisations undermines the close, centralised, coordination of policy. The formulation network is thus more reliant on legal regulations and the policing of these by regions. Further, as Rose (1985: 14) argues, the study of implementation in terms of a hierarchical centre-periphery relationship may be misguided, because in "nationwide government", the, "power that counts is the power to deliver programmes". Central government departments may state the conditions or parameters for services, but do not administer them (1985: 15). Rather, service delivery is devolved and implementation fragmented. Networks develop around these local decision making centres, and action results from the interaction and negotiations between core insider groups and the implementing agency. However, this process is itself subject to problems of coordination. For example, as Ham (1992: 166) argues, health authorities may have the same distribution of conflicting programmes; subsectors develop, and important decisions often require the acquiescence of individuals or interest groups.

Thus, district level decision making processes may be relatively independent of central control, and explanations for their actions are more readily explained by the characteristics of district level networks. Implementation is explained by the joint product of implementing agency and core insider groups' actions, on the basis of a discursive construction of the regulations and instructions laid down from the departmental level. This action may in turn require disaggregation with, for example, a sectoral level of district network activity influenced more by central departments, as well as subsectoral elements, in which implementational responsibility is relatively insulated (although the use of such terms may become confusing - see chapter 9).

Of course, much will depend on the type of policy involved, as well as the levels of commitment or involvement at each level of government. Levels of discretion and independent action of district actors may vary according to the detail and scope of central department regulations. For example, in

terms of NHS reform, DHAs were given very clear roles and their constitution restructured to ensure greater accountability to the centre. However, even then this coincided with a governmental wish to devolve decision making to this level, with DHAs given devolved responsibilities to serve its local population. A good example is a health target. Whilst the Department of Health sets accountable targets for the reduction of a health condition and allocates resources: (a) the indicators may be unreliable; (b) there may be no central protocols to determine how targets are met , and so (c) resources may not be earmarked for any particular projects. The extent of the condition may vary with locality, and so discretion must be present in the relative importance attached to that condition. Thus, the examination of decision making at local levels is essential to explain how resources are distributed.

A qualification to this argument is that: (a) such discretion often results from the direct devolution of responsibility, coupled with statutory and/ or financial constraint; and (b) discretion is defined here as a capacity. Further discussion of the exercise of that power capacity is thus required to assess its practical importance, since one should not necessarily equate discretion with opposition. In some cases implementing authorities may act to further the interests of central government in their dealings with groups and subordinate implementers (see chapter 9).

The Unit Level

At unit levels, the local implementation network acts within a broad regulatory framework, in part policed by district and regional levels of government, and formulation network influence may be so indirect that it may not figure in the day to day actions of the unit level network, except insofar as to determine the scope and structure of that activity. As Rose (1985: 19) argues, "From a service delivery perspective central government is now the peripheral institution of government", because the programme delivery itself, "must be done by people who work locally". While the central department may define the scope and constitution of unit level government organisations, as well as broadly regulate their activities, it

does not impinge on the day-to-day operations of these actors. Rather, responsibility must be devolved to local actors to account for the heterogeneous nature of service delivery.

The term unit-level can apply to a variety of organisations, from a school or hospital to a private company which has won a contract to deliver some public services. Each unit, however, must have some decision making apparatus to be considered a network-actor. Further, although responsibility for that unit's actions may be placed in the hands of an individual manager, still a process of negotiation with that individual and others may be apparent, based on the powerful position of "street level" implementers. As Lipsy (1980: 3) argues, the decisions made by street level actors constitutes the service delivered by government. Further, whilst their discretion is, "formally circumscribed by rules and relatively close supervision", their roles are often, "too complicated to reduce tasks to a programmed format", and they often face situations which, "require unique decisions" (1980: 13-15). Therefore, for a manager to ensure the delivery of unit or agency policy, s/he may have to negotiate with such discretionary actors on the details of that policy, and a distinct decision making process may develop at unit levels.

The types of decision making procedures which exist at this level will vary across policy area, programme and time. For example, greater discretion may be associated with doctors and teachers, as opposed to, say, council tax officers or cleaners in a contracted company. However, even in education and health, recent changes have resulted in an increase in the standardisation of activity. As in discussion of the district level, if discretion is coupled with legal and financial constraints, then the capacity for discretion may have little practical relevance.

More importantly, unit levels of analysis have two basic *a priori* problems which undermine one's ability to extend discussions of network implementation. First, such organisations are perhaps the most difficult to identify, and thus so is the location of the focus of decision making, since

there is such a proliferation of relevant agencies at this level. Multiple foci of decision making may thus be apparent. Second, the actors at unit levels may also be heavily involved in network activity at district, regional and even departmental levels, whilst such activity affects the subsequent context in which unit level agencies operate. Therefore, it may be difficult to distinguish between policy involvement in general from a distinct process at the unit level. However, as chapter 9 discusses, in practice these problems may be less serious.

Thatcherism, Boundaries and Sector/ Subsector

But how does such a discussion relate to the themes identified in chapters 1 and 2? First, with regards to Thatcherism, this chapter has discussed in detail the argument that implementation networks resemble their former formulation network counterparts following the displacement of consultation. Second, the issue of boundaries and insider/ outsider status has two main elements: (a) the effects of consultation and negotiation *following* policy formulation; and, (b) the possible existence of similar negotiating styles in lower levels of government. For example, as discussed in chapter 6, a common rejoinder to the argument that the medical profession was not included in central government policy deliberations in the 1980s is that it was still involved in the detailed implementation of policy. However, the question over how effective this involvement is or was still requires discussion. The exercise of clinical autonomy and medical dominance may be apparent at unit levels of government, but what about within health boards following the purchaser/ provider split? Further, does insider involvement really matter if implementing authorities are operating under strict financial constraints? Finally, the question remains as to the usefulness of extending sector/ subsector issues to case studies involving implementation and this is taken up in detail in chapters 8 and 9.

The focus on implementation comparisons allows theories and hypotheses concerning networks to be applied to a greater number of policy sectors with the possibility of greater variations in results. For example, chapter 9

argues that group (as opposed to government) strategies, are less important in determining insider access within the local arena in a cash strapped climate.

Why Focus on Implementation Networks

The focus on implementation allows greater scope for detailed qualitative research. Questions of access are less of a problem. There is no thirty year rule, the key players are arguably more accessible and the procedures are more apparent. Board meetings may even be held in public. Further, this is not a case of just looking for the key under the lamppost if it can be demonstrated that implementing authorities are the key decision makers in the development or at lest processing of a policy.

Much may depend on the personality of the head of the implementing body and/ or the political relationship between formulator and implementer. S/he may maintain an innovatory style by both pressing for policy concessions and altering policy at local levels, or s/he may be content merely to facilitate the administration of central policy. All that can be said - *a priori* - is that in policy areas where the government has no strong policy line, a very broad policy or relatively few policy instruments to ensure implementation, and hence considerable local discretion is discernible, power will be devolved to lower levels of government (and a group-government process results). There is thus great analytical potential for the discussion of implementation network actors.

Conclusion

A focus on policy formulation networks alone underestimates the power of all actors to influence policy at subsequent stages of the policy process. In particular, whilst the government may be able to reject consultation or negotiation at early - and mostly sectoral level - formulation stages, this may be much more costly when it comes to implementing that policy. Therefore, consultation and negotiation at top levels within the department may have been displaced rather than rejected, with implementation networks taking on much of the characteristics of their formulation predecessors.

This chapter also draws on the work of Hjern to supplement top down analyses of implementation networks. Top down analyses may begin and end with the evaluation of policy in terms of success or failure. It may therefore not be clear how the legislation was used, affected and developed at local levels. Analysis of implementation networks is necessary to allow analyses of the processes through which policy is affected and implemented. Thus, four distinct levels of group-government activity are identified, each of which may provide the main focus of decision making at any point in time following formulation. The distinctions allow a disaggregation of implementational effects, highlighting geographical and local level differences in administration as well as policy outcomes.

However, whilst four main levels of government are available to examine the implementation of network policy, the above examples demonstrate that: (a) Some are more important than others, depending on the policy area; and, (b) each subsequent level of government is subject to change from above. It is important not to go too far in arguing that once a policy has been passed from formulation to implementation it is automatically subject primarily to influence from implementation networks. Rather, this is dependent upon the importance attached to the policy by each actor and the respective means available to influence that policy at each stage.

CHAPTER 5 - THE POLICY CYCLE

Introduction

This chapter considers policy networks analysis and the literature on policy change as a means to link the three preceding chapters. One of the main criticisms of networks research is that it tends to be too static - the logic of negotiation and the stability of membership implies stability or incremental policy changes over time - and that it tends to ignore interactions outwith the network arena. Such conceptions of the policy process have come under increasing challenge, especially during the Thatcher period of office and subsequent changes to the British policy style. Maloney and Richardson capture this well by arguing that a new research agenda is required to explain the apparent chaotic or episodic nature of policy making, in which issues are considered by different actors at various stages of a policy's development.

The work of Maloney and Richardson (1995a; 1995b; Richardson *et al*, 1992) reflects increasing recognition that the policy networks literature ignores broader policy process considerations. Non-central government actors are often only considered important when they interact with central government within the policy network framework. In this context, the preceding three chapters should be seen as an attempt: (a) to formulate the existence of policy networks within a broader context; and, (b) to use the conclusions of chapter 2 on the nature and characteristics of network-actors to identify similar actors within implementational and parliamentary arenas.

The notion of actors other than individuals is a useful way of aggregating behaviour when it is difficult to assign responsibility to those individuals. So, the network-actor approach involves assigning responsibility for public policy to higher level actors, and explaining their actions in turn by examining the decision making, or consultation and negotiation, process over time. So, network-actors are present under the following conditions. One could identify: (a) a working relationship between a formal authority (such as an implementing agency or select committee of MPs), its staff or bureaucracy, and "core insider" interests, so close, or indeed closed, that

the assignment of responsibility solely to one of those actors would be inaccurate; (b) a decision making or negotiation process linking these actors (often to the exclusion of influence, at least formally, of all other actors); and, (c) subsequent action based on the decisions reached by this authority.

If the simplicity of such considerations are maintained, then these can be applied to areas other than formulation. That is, the project of applying policy networks analysis to all areas of the policy process involves identifying similar entities which mostly operate at each "stage" of policy making, rather than extending some idea of a network, or some policy making infrastructure, to all such levels. It thus avoids the charge that, "if networks are everything, then maybe they are nothing", and the utility of distinguishing such an approach from traditional concerns, as discussed in chapter 2, should now prove apparent. However, this is not enough. What we have is some notion of how networks act. What is required is some conception of how such actors *interact* - with each other and with their "environments".

Consequently, the task of this chapter is to locate such considerations within the framework of "policy cycles". This should enable the location of networks within a more fluid, as well as broad, process than that previously envisaged - after all, the whole point of the earliest studies was to show that things did not change! To this end, then, the plan of this chapter is as follows.

First, this chapter discusses the work of Maloney and Richardson, which typifies an increasing recognition that current conceptions of policy networks do not adapt well to change. Second, earlier conceptions of the policy cycle are outlined as a precursor to the integration of such concerns with the network-actor approach. Third, the network actor approach is expanded in terms of the interactions between such levels in three arenas of government.

"Chaotic" or "Episodic" Policy Making?

Richardson, Maloney and Rüdig first alluded to the"chaotic" style of policy making in 1992 when discussing water policy. This study produced surprising results for Maloney and Richardson who had previously stressed the constant and close policy making relationship which exists between central government departments and insider groups, based around the logic of negotiation, and causing incremental policy change (Jordan and Richardson, 1982; Jordan, Maloney and McLaughlin, 1992a). However, at different stages of water policy development they identified different policy styles. Policy community activity was followed by destabilisation and rejections of consultation, in which interest group activity was directed at Parliament, and finally a return to community decision making was identified, in which "technical" or implementational aspects of the policy were discussed. As a result, one model, "is insufficient, over time" to account for shifting patterns of policy making. Therefore, studies of the policy process require analysis of, "different manifestations of policy actor interrelationships", as a policy passes through, "various stages of its development" (1992: 159). In other words, a more flexible research agenda than that implied by the policy community approach.

This conclusion reflects the traditional insularity inherent in policy network approaches. As the term "chaotic" suggests, any deviation from the normal style and any substantial policy making outside the policy community arena is treated with alarm. However, Judge (1993) argues that such processes were merely indicative of an "episodic" policy process in which issues are considered:

> *Sometimes simultaneously, sometimes serially or sometimes sequentially - in these different arenas of interconnected 'episodes' of policy development*
> (1993: 131).

As discussed in chapter 3, groups operate a dual strategy of, "simultaneously working with departments and maintaining channels of

communication with Parliament" (Judge, 1990a: 35), and the effectiveness of such a strategy is best exemplified when, "disruptions occur to bureaucratic accommodation" (1990a: 33). Discussion of this effect allows Judge to argue that any one sector's policies may be processed, "variously in either policy communities, or issue networks, or even in Parliament itself" (Judge, 1993: 131). When policy communities change or even break down, Parliament has greater scope for influencing policy and group activity often reflects this changing emphasis. However, the effect is not "chaotic", but episodic, reflecting a process of change which is predictable and easily explained in terms of wider considerations of the policy process.

The term "episodic", if not the thrust of the argument, has been accepted by Maloney and Richardson (1995a; 1995b). In these studies, they attempt to expand the considerations of water policy to, "most areas of public policy in Britain", which have been, "subject to very considerable change in the 1980s and 1990s", and have tested, "the conventional model of British politics as dominated by policy networks ... to its limits", resulting in its exhibition of "intellectual fatigue" (1995b: 110-11; 1995a: x). Exogenous changes to existing policy networks such as: (a) growing economic pressures which force policy makers to reexamine policies and, "existing rules of the game"; (b) a new "ideological climate"; and, (c) the "Europeanisation" of public policy, have led to unstable periods of public policy in which actors within policy communities have been unable to maintain control of policy areas through processes of depoliticisation or professionalisation and close consultation (1995b). Rather, policy making in most areas has been opened up to a, "wider accommodation of interests" and, consequently, such areas have been subject to greater degrees of conflict (1995a: 174). They thus advocate the use of "multiple images", which take into account the dynamic and changing, or "episodic nature", of the policy process, the effects of a policy's environment on networks (policy networks as the "*product* of policy change rather than its *creator*") and, presumably, the significance of actors outside the traditional policy community arena.

But has this dynamic already been addressed? Certainly, the policy cycles approach has been around since the 1950s and this describes a dynamic policy process which is arguably more open and subject to influence at each stage than suggested by more static network accounts[1]. Put simply, the policy cycle approach establishes a framework for the study of public policy or policy problems, examining how a problem reaches the agenda of government, how it is acted upon, and what happens as a result of these actions (Jones, 1970: 1). This is done by disaggregating the political process into serviceable categories of action which, whilst guiding research, are not particularly strict or precise definitions or boundaries. Most policy cycle accounts (for example Jones, 1970; Anderson, 1975) involve the following steps or stages (in Hogwood and Peters, 1983: 7; Hogwood and Gunn, 1984:4), through which, "any policy must go through in order to become an operative policy":

> *(1) Agenda setting, in which problems existing in society are perceived as requiring some actions by government to correct them, and these problems are moved on to some sort of official agenda for resolution.*
>
> *(2) Policy formulation, in which the policy instruments which will be used to attempt to alleviate the difficulties perceived in the environment are designed.*
>
> *(3) Legitimation, in which the policy instruments are accorded the authority of the state, through some official action. This action may be legislative, regulatory or popular, e.g., initiatives or referenda.*
>
> *(4) Organization, in which some organizational structures are developed to administer the policy. This may, of course, simply involve assigning the policy to an existing organization rather than creating an entirely new structure.*

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1 The policy cycles, or "stages heuristic" approach has itself been criticised by Sabatier (1991a; 1991b; 1993), and Maloney's recent (1996) conclusions suggest the Advocacy Coalitions approach to be a fruitful alternative. However, time constraints force this issue to be discussed elsewhere (Cairney, 1997). It is sufficient to say at this point that: (a) Sabatier attacks a "strawman" version of cycles; and (b) his own approach is undermined by his own - "black box" - conclusions.

(5) Implementation, in which the administrative structures attempt to make the policy work in practice. This will involve linking legal authority, budgeted funds, and the organization to the environment in an attempt to produce a series of desired outputs.

(6) Evaluation, in which the outputs and consequences of the outputs are analysed and assessed according to some criteria. These criteria may arise from the original legitimation, or from the modifications of the original policy intentions made in the organizational structures and the implementation stage.

(7) Policy maintenance, succession or termination. Various procedures have been developed to make organisations and other policy making bodies consider termination of organisations and functions more often than they might otherwise.

The model is dynamic and relatively open, illuminating the, "numerous potential points of access within the cycle for those who seek to influence the nature of the policy" (Hogwood and Peters, 1983: 8-9). In addition:

(1) Its simplicity allows for systematic cross comparisons between countries, policy sectors and levels of government.

(2) The framework is easily adapted and reformulated for the purpose of individual study, with stages requiring prominence in some areas more than others, or distinct stages emerging through study.

(3) The fluid nature of the process is a welcome adjoinder to systemic or institutional approaches which are essentially static conceptions.

(4) The emphasis on recurring cycles perpetuates the importance of the insight that present policies are based on reformulations of past policies, rather than policy innovations (Lindblom, 1959; Hogwood and Peters, 1983). Thus, as Jones (1970: 135; 11) puts it, "the end is the beginning", because government action mostly results from the, "continuing application and evaluation of ongoing policies".

(5) Finally, as Anderson (1975: 26-7) argues, sometimes policy making actually does follow, chronologically, the sequence of activities listed above!

This type of analysis is well suited to the task of reformulating policy network concerns, since dynamic aspects of the policy process are absent within network accounts which necessarily stress the consistency of organisational structures, inertial policy styles and necessarily incremental policy outputs. Subsequent sections of this chapter therefore incorporate policy cycle considerations within the policy networks framework.

The Network Actor Approach

The network-actor approach uses the notion of cycles to discuss the interaction between three distinct network actors - formulation, parliamentary and implementation policy networks, at various stages in the policy process.

TABLE 5.1. CHARACTERISTICS OF NETWORK-ACTORS

Network	Dominant Actors	Stability of Membership	Arenas of Action
Formulation	**Sector** - Department and Core Insider Group(s) **Subsector** - Departmental subsector, Core Insider group(s) and/ or Specialist Insider Group(s)	**Relatively stable** - State agency negotiates with core insider or specialist insider, consults with peripheral insider, and acts in anticipation of other actors	**Primary:** National Level - Cabinet, Cabinet Committee, Departmental Committee **Secondary:** Local and Parliamentary arenas
Parliamentary	Relevant Select Committee members, Committee staff, groups providing oral evidence	**Relatively stable**- MPs and staff generally last the full Parliamentary Session, an identifiable "clientele" exists in the submission of oral evidence	**Primary:** Parliament - Select Committees, Committee and Report stages of Bill, etc. **Secondary:** Formulation and Local arenas
Implementation	Implementing agency, "street level" implementers, local affected interests	**Relatively unstable** - Subject to change from central government, some degree of self selection	**Primary:** Local policy, Implementation **Secondary:** Formulation and Parliamentary arenas

These are distinct because they are located at distinct arenas of

government and are dominated to a greater or lesser extent by central department actors. For example, whilst central department actors dominate proceedings within formulation networks, their power is diluted as one moves down the hierarchy of implementation networks. Additionally, while the government may at times dominate the legislative process, it does not dominate the parliamentary network-actor.

Each affects policy at subsequent stages in a policy's development and implementation and each main actor (especially central government) will generally participate to some extent at all stages of the policy process. However, this is not to deny the importance of the distinction between network actors and the importance of their internal decision making processes. Each may have similar memberships, but: (a) the balance of power in each differs, according to the stage of policy making and the formal responsibilities and jurisdictions of each lower level actor; (b) the means of action available to lower level actors varies in each network; and (c) the actions taken by each network take place in different arenas, reflecting the stage of policy making in which each distinct network generally acts to affect policy.

The mode of deliberation of each network-actor differs, reflecting the differing methods of decision making. In formulation networks, the "logic of negotiation" suggests that detailed consultation and negotiation will take place between the government and core insider or specialist insider groups at various levels within the department (Maloney *et al*, 1994). The membership of such networks is relatively stable, reflecting the strategies pursued by insider groups, the resources (technical and implementational knowledge, legitimate representation of membership interests) of groups, and the status granted to such groups which is stable over time. That is, departments and sub sectors within departments have a recognised clientele which are generally consulted on matters relevant to their interests. Finally, negotiation leads to policy, which is then applied in various arenas. For example, sub-sector policies may require assent by the minister at departmental level. Departmental policies may require formal

ratification within Cabinet or even Parliament in the case of major legislation. Further, most policies will involve some degree of direction from government at all stages of implementation.

The actions of parliamentary networks are similar in many ways. Their membership is - compared to implementation networks - relatively stable[2] , consisting of MPs and committee staff who generally last the full session of Parliament (although each MP may not be present at every meeting). The staff perform a gatekeeper role of selecting the relevant groups for the presentation of oral evidence, and thus each committee may be able to build up a stable clientele. Again, similar to formulation networks, some groups will be considered core insider, because they are consulted over a wide range of issues. For example, the proceedings of the SSC virtually always contained some input from the BMA and COHSE in matters of health care. The consultation of other groups may be more variable (as in formulation networks, when the consultation list is customised from policy to policy). Finally, whilst 'negotiation' does not typify the process, the committee is again dependent upon those groups for detailed information and advice, and this is reflected in the deliberations of the parliamentary network.

However, the arenas of parliamentary action differ. In the main, the select committee publishes a report which is circulated to governmental and private organisations, and also reports directly to the House. It is thus used as the basis for subsequent debates on the floor of the House if such a debate takes place. However, the committee also acts as part of the wider policy network of government by "holding the government to account" in its detailed questioning of departmental ministers. It also plays some role in the implementation of policy, evaluating and monitoring departmental policy by scrutinising its expenditure as well as questioning directly various implementing organisations.

Implementation networks are significantly different in terms of stability,

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2 Since 1979 at least. Previous committees could be disbanded by government.

membership and operation. First, given the complexity of organisation and the existence of a number of levels of implementation networks, there is less scope for coordinated action. Second, membership of implementation networks is subject to change from central government including, for example, the ability of government to designate the responsibility of implementation to another organisation. Third, given the vast scope of most policies, and the proliferation of organisations involved, the term "network" rather than structure may be appropriate, and some degree of self selection takes place. However, there is still a discernible decision making process, revolving around the agency given formal responsibility for implementation and the procedures which govern its operations. Therefore, discernible policy output and hence outcomes can be attributed to such actors, based on the local decision making process and the subsequent operationalisation of such policies by its constituents. Additionally, the representatives of implementers are likely to play some part in the deliberations of formulation and parliamentary networks, as they will represent core, specialist or peripheral insider interests within those networks.

The Thatcherite period of government presents one interesting modification to such a discussion. This marked a period in many policy sectors in which, whilst consultation procedures still took place, previous bargaining relationships suffered. This had the following consequences. The output of formulation networks was perhaps more radical, but was also less detailed. Because the bargaining relationship broke down and less time was given for consultation, less information was available and so the detailed formulation of policy and its implementation was replaced by more vague and restricted policy frameworks. This had the effect of increasing the importance of implementation, parliamentary and wider policy networks. Whilst there was little negotiation within formulation networks, its traditional role was taken by implementation networks at the departmental level. Because the policy would be so vague, detailed negotiations could still take place around how to put it into practice. Therefore, policy formulation was followed by a period of detailed consultation and negotiation before

implementation took place.

Vague policies also lead to uncertainty and so to the increased importance of Parliament and parliamentary networks. Increased attention was already directed at Parliament in this period, but its importance is also discernible in the evaluation of policy. Select committee activity particularly exemplifies this increased role, given its emphasis on the scrutiny of departmental expenditure[3] and policy, and continuous calls for the reformulation of policy. Developments in this period thus increase the importance of the understanding of the cyclical or "episodic" aspects of policy making, by integrating network-actor characteristics with a policy cycle approach.

The Network-Actor Approach and Policy Cycles

These considerations can now be applied to the policy cycles approach. However, cycles themselves are not without criticism and some discussion is needed to bypass these concerns. So, one apparent drawback to the notion of policy cycles is the assumption of linearity in policy development. Policy is successively formulated, legislated and implemented, and there is a clear demarcation between each stage. Such a conception suffers from the significant overlap which exists between stages, as well as the existence of policy initiation in implementational and parliamentary arenas.

However, this does not necessitate the rejection of the concept, for two main reasons. First, it is easy to exaggerate the importance of the overlap in network actor activities. As Hogwood and Gunn (1984: 207) argue, one should remember that while an overlap does exist, "there are also more substantial areas of relatively independent functioning". The Next Steps initiative attempts to formalise the distinction between policy and administration, whilst the executive is constrained in its ability to monitor and control implementation anyway. Similarly, while some MPs or Parliament may be considered as part of a broad policy network, the day-to-day activities of MPs is mainly centred on the floor of the House, constituency business and select committee investigations. And, whilst

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[3] Although chapter 6's discussion may exaggerate this capacity in other select committees.

implementers may be regularly consulted, most of their day-to-day activity is concerned with implementation. Indeed, with the exception of central-local relations, this may exaggerate the extent to which "street level" actors actually consult with government. Take, for example, the case of doctors and the BMA. The BMA is regularly consulted on all things medical in government. However, the process in the main is one of consultation between civil servants and professional officers of the BMA hierarchy. Therefore, those who are charged with implementation at local levels are not directly consulted, and hence are not considered to be "core insiders" within the policy formulation network. Rather, their views are mediated however effectively through the BMA. Hence, virtually all of their activity is concerned with implementation.

Second, whilst these actors may be found in each arena, participating in broadly defined network activity, qualitative differences exist in the operation of each within each network. Put simply, the outcomes of activity in each successive network are dependent on interactions between the *dominant* actors in those networks. And, in turn, the dominance of that network activity is dependent on the stage, or the arena, in which this activity takes place. So, the stage distinction is necessary: (a) to discern the dominance of, or at least the balance of power within, each network; and, (b) to consider the importance of action by each successive network in the stage which they act most and hence may have the most impact. For example, the domination of policy formulation by central government may or may not be offset by local actor dominance of the implementation network.

Therefore, explanation of a policy's development depends on a consideration of the extent to which a policy was affected at each stage by each actor. Specifically, the amount of time or attention given to each policy and the importance attached to that policy is crucial, given that every policy will pass through and be affected within each arena at some stage and to some extent. The most obvious example is a policy which is central to a formulation network's objectives, is not considered in any detail by Parliament, and is clear and easy to implement. In this case, formulation

network activity merits most attention. However, there are areas in which no clear central policy exists, there is fleeting parliamentary concern, and hence in which substantial local discretion exists. In this case, obviously the local policy arena merits most consideration. And, in some cases, parliamentary concern with issues lead to compliant government responses in areas not central to their objectives. However, as argued below, few policy areas are this simple, given the cyclical nature of the policy process, and hence a detailed examination of a policy's development at each stage is required.

A second drawback is the related problem of policy formulation in other networks, or the consideration of policy at the same time in different networks. For example, a policy may be formulated and implemented at a local level with little reference to central policy, or Parliament may consider a policy issue and set the agenda for subsequent policy prior to the identification of an issue as a policy problem by central government. However, neither case necessitates the rejection of the concept of stages or policy cycles. In the case of Parliament, an innovative examination of a policy problem will generally precede a more detailed consultation process within a formulation network, if the issue gains sufficient attention. And, in the case of local policies, again a major innovation may stimulate subsequent central government involvement, whilst a minor policy will still operate within the limits set by that government. This activity should then be seen in the context of prior policy formulation, as indeed most parliamentary activity is involved with the adequacy of current government policy. So, whilst in a small minority of cases the examination of a policy problem may not be initiated and may not even be solely considered by formulation networks, they may still nonetheless play the most important part in a policy's subsequent development. Chapters 8 and 9 provide numerous examples of this. The concept of a policy cycle is thus important in demonstrating: (a) that the policy formulating activities of other actors should not be seen in isolation; and (b) that a longer term perspective may suggest a much less significant formulation role for these other actors.

All that remains, then, is to briefly set out a general policy cycle, based on chapters 2-4. The characteristics of this cycle are:

(1) The formulation network initiates a policy. This is done under pressure, internally (but with anticipation of external reaction), or at least without due consideration of all factors. Since the details will be more subject to negotiation in the next stage of policy making, the proposed policy is likely to be vague and only presented in the loosest detail.

(2) The fact that the proposals are vague means that they are more subject to influence and reformulation as a result of their subsequent interpretation and execution by implementation networks.

(3) This in turn leads to: (a) general feedback from the monitoring operations of the formulation network; (b) pressure from implementation networks if or when the policy is found to be deficient in practice and/ or it causes unforeseen problems; and, (c) parliamentary involvement in the evaluation of policy leading to recommendations for change.

(4) Such activities lead to some reformulation of policy, on the basis of evaluations of the previous position. This may involve legislation, but more likely such a reformulation is likely to take the form of subordinate legislation, a departmental circular, or some other less formal means. However, any such reformulation implies a perpetuation of the cycle, or a policy's formulation, implementation, evaluation and reformulation or reinterpretation by distinct network actors in specific periods or stages of a policy's development.

This general set of hypotheses sets the agenda for the remaining chapters. Chapter 6 discusses British health care policy to analyse the utility of this "cycle" in highlighting the processes and arenas through which a policy progresses. It discusses the constitution and actions of formulation, implementation and parliamentary networks in the field of health policy, with the policy cycles approach used to demonstrate the dynamics involved. This should allow some qualification of the notion of 'chaotic' policy, in which diversions from the insular policy community style were seen to undermine the notions of communities themselves. Rather, the influence of

action other than that at the formulation stage reflects a policy cycle in which policy is "owned" by parliamentary and implementation networks at each stage of the policy cycle.

If the general framework is confirmed by the conclusions of chapter 6, then chapter 7-9 are able to focus of particularly important aspects of this cycle which require more specialist attention.

CHAPTER 6

HEALTH POLICY AND THE POLICY CYCLE

The previous chapter argued that the policy cycle involves a number of stages through which a policy must pass to become operationalised. In short, this involves policy formulation, which is vague and only presented as a broad policy framework, subject to influence and reformulation by implementation networks. This in turn leads to general feedback, pressure from implementation networks and parliamentary involvement in the evaluation of policy leading to recommendations for change. Finally, some reformulation of policy, on the basis of evaluations of the previous position, takes place, hence continuing the new policy cycle.

This chapter extends such a broad discussion by applying it to UK health policy from 1979. This serves a dual purpose. First, to test the accuracy or usefuleness of the framework. Analysis of policy formulation, legislation and implementation within health care allows the "fleshing out of the bones" of a relatively abstract framework. It still discusses the importance of the internal dynamics of formulation networks, but then situates its conclusions within discussions of broader conceptions of the policy process. Second, these still general conclusions are used as the basis for a more detailed and specialised discussion (chapters 7-9), by focussing on implementation in a more restricted geographical area.

This chapter is divided into three sections, according to periods of most significant policy change: health policy pre-Griffiths, the Griffiths management reforms, and Working For Patients. Major policy change marks the beginning of one policy cycle and the end of another.

Health Policy Pre-Griffiths

Agenda Setting

In the period before the Griffiths reforms, the issue of the NHS was not particularly pressing (see Hogwood, 1992a). As Bosanquet (1984: 77) argues, surveys in this period usually found a high level of satisfaction, "both with the NHS as a whole and with particular aspects of it". The

professions were relatively satisfied with the then present arrangements (based on consensus management) and the only significant source of pressure for change was the new Conservative party itself, which was committed in its manifesto to some degree of streamlining the NHS bureaucracy (Baggot, 1994: 120).

Policy Formulation - Policy and Network

Two documents published by the government - *Patients First* in 1979 and *Care in Action* in 1981 - marked the extent of policy formulation in this period. The former included plans to abolish Area Health Authorities in favour of District Health Authorities and to introduce greater devolved responsibilities to unit levels, without any increases in management accountability or monitoring. *Care in Action* continued the policy of devolved management by placing less stress on departmental priorities, in favour of local decision making. There was also a round of efficiency savings, or Rayner scrutinies, but no major change to the NHS took place in Thatcher's first term.

What about the nature of the formulation network up to this point? As chapter 2 argues, the key to power research is the assignment of responsibility for social actions - to policy networks which act to affect policy outcomes. This is demonstrated through the consultative, administrative and legislative procedures which constitute the deliberation and formulation of a network's decisions. In other words, what is the nature of the network?

Is it, according to Marsh and Rhodes' framework (table 6.1), a policy community dominated by the profession or government to the detriment of outside interests, or is it an issue network with a very open decision making process? Or some element of the two, with a decision making centre surrounded by an issue network? This is crucial to the discussion of the nature of the decision making process of such networks, since network action depends on constituent actor interaction - in terms of access and the size of membership, the type and frequency of interaction, the resources of actors, and power, or the domination of the network (see table 6.1).

TABLE 6.1: TYPES OF POLICY NETWORKS

Dimension	Policy Community	Issue Networks
1. Membership		
(a) Numbers of participants	Very limited number, some groups consciously excluded	Large
(b) Type of Interest	Economic and/ or professional interests dominate	Encompasses range of affected interests
2. Integration		
(a) Frequency of interaction	Frequent, high quality, interaction of all groups on all matters related to policy issue	Contacts fluctuate in frequency and intensity
(b) Continuity	Membership, values and outcomes persistent over time	Access fluctuates significantly
(c) Consensus	All participants share basic values and accept the legitimacy of the outcome	A measure of agreement exists but conflict is ever present
3. Resources		
(a) Distribution of resources (within network)	All participants have resources, basic relationship is an exchange-relationship	Some participants may have resources, but they are limited and basic relationship is consultative
(b) Distribution of resources (within participating organisations)	Hierarchical, leaders can deliver members	Varied and variable distribution and capacity to regulate members
4. Power	There is a balance of power between members. Although one group may dominate, it must be a positive sum game if community is to persist.	Unequal powers, reflects unequal resources and unequal access. It is a zero-sum game.

Source: Marsh and Rhodes (1992a: 251)

The health care network is one of the few described by Rhodes and Marsh (1992: 182-3) as "professionalised" - a policy community dominated by the profession. Professional interests and values determine policy outcomes in the following ways:

> *First, political/ managerial influences are subordinated to those located within the professionalised network; second, the values and interests embedded within that network determine the distributional outcomes of policy making; and, third, the needs of service recipients are filtered through professional values.* (Wistow, 1992a: 52)

Similarly, Ham (1993: 186) argues that medical professionals exercise the key influence on the, "definition of issues" and "allocation of resources" within networks. Both accredit this dominance to two factors. First, the "medical model" is the "dominant ... value system in the health field" (Ham, 1993: 186). Power is drawn from a, "wider social ... understanding of health

in terms which emphasise the centrality of medicine and hospital services" (Wistow, 1992a: 58). The second factor is clinical autonomy. As Wistow (1992a: 54) argues, a bargain struck on the introduction of the NHS was that clinicians were given the ability to use their sole discretion over "the place, nature, length and thus cost of treatment for individuals". So, the Treasury and Department of Health may control the budget, but doctors control spending within it.

However, this misrepresents the state's powerful position within this bargain. As Hoffenberg argues, the governmental control of cash limits to medicine "curtailed the freedom of doctors to prescribe, to operate" (1987: 6), whilst allowing political problems of funding to be converted into clinical problems of prioritisation (Klein, 1995: 78). As a result, the introduction of the NHS "brought about those conditions of restricted clinical and personal freedom that the BMA so vociferously warned about", including the work locations and disciplines available to doctors, reflecting the broad NHS objective to distribute doctors and specialties equitably throughout the country (Hoffenberg, 1987: 6-7). Further, there were no real negotiations with the BMA prior to the introduction of the NHS because the Labour government had a clear mandate, Bevan was hostile to the profession, and because it was clear that the BMA elite was against the legislation (Eckstein, 1960: 78; Smith, 1993: 170; Pelling, 1984: 102-3; Forsyth, 1973: 26). Rather, the influence of doctors returned at the implementation stage (Honigsbaum, 1989; Eatwell, 1979: 63; Pelling, 1984: 104). The most important concessions to the BMA were granted after the passage of the legislation and, as Eatwell (1979: 64) argues, the NHS Act marked the *beginning* of a, "long rearguard action". Based on a mandate of grass roots opposition to the scheme, the BMA leaders refused to cooperate in discussions of the implementation of the scheme. Thus, an impasse was reached, because whilst the legislation had been passed, the scheme essentially relied on professional, and especially GP, cooperation in joining up (1979: 108).

Such a discussion qualifies the historical power of the profession,

suggesting this was most manifest within implementation networks. Further, the argument that medical professionals, as a whole, exercise power to dominate health policy to the direct cost of the elected government, as well as interested users is misleading. This is demonstrated by discussing the basis of the power of the profession as a whole, as well as the explanatory power of individual clinical autonomy, before discussing more recent developments - such as Thatcherite reforms against the interests of the "profession" and the decrease in professional representation in government - in subsequent sections.

(1) The medical profession cannot be seen as a unified, or social, actor. The presence of competing interests within the profession necessitates the identification of distinct medical interests at a lower level of aggregation. As Elston (1997: 32) argues:

> *The medical profession is best described, like most occupational groups as, "loose amalgamations of segments pursuing different objectives in different matters and more or less delicately held together under a common name at a particular period of history".*

So, whose interests do we mean when we talk of the medical profession? Or, who can we exclude? Certainly, if managerial reforms (discussed below) go against the interests of the "profession", then we can instantly exclude NHS managers and administrators for now. But what about nurses? As Baggot (1994: 37) argues, much of the workload of nurses is routine (i.e. non-discretionary), nurses are less well organised politically, and hence nurses have far less control over the administration of health care than do doctors. Indeed, judging by the pay and working conditions offered to nurses within the NHS, it would be difficult to argue that their interests are served by the health policy network.

This leaves us with doctors. However, there are also competing and relatively excluded interests within the clinical profession, the most notable

of which are junior doctors. Most of the BMA's[1] activities centre around pay and conditions of work (Baggot, 1994: 44). However, as Jones (1983) and Elston (1977) argue, this rarely concerns the serious advancement of the conditions for junior doctors. Indeed, historically the objectives of junior doctors and consultants have conflicted. This was most manifest in 1966, when, "the existing consultants had no incentive to see a swelling of their ranks", and hence it was in their interests to stifle greater promotion prospects, thus "forcing" many out of the hospital service (1983: 91). Frustration with such difficulties led to the formation of the Junior Hospital Doctors' Association, "to directly lobby government on issues not actively pursued by the BMA" (1983: 92[2]). However, the current pay and working conditions for junior doctors are still unfavourable, and whilst the "New Deal" for junior doctors is now given serious consideration (see Health Trends, 1992: 3), this should be considered within the context of recent successful court and European Commission activity, rather than network activity (BMJ, 1995: 1088; Nottingham and O'Neill, 1996).

This leaves us with the relatively senior branches of medicine, perhaps confirming that network activity is essentially elitist rather than pluralistic activity (Wistow,1992a: 73; Marsh and Rhodes, 1992b) and that such a concentration of power supports Wistow's (and Marsh and Rhodes') argument. However, the rejection of a pluralistic system in this fashion is misplaced in that it attacks a caricature rather than the work of any author associated with pluralism (Judge, 1995). So, Wistow is able to argue that the health care arena is not pluralistic because of the existence of elites. However, the difference between the elitist/ pluralist positions is not in the identification of elites, but in their *numbers* (1995). That is, pluralists such as Dahl do not argue that individuals or groups possess equal political resources and access to power, but rather that, whilst power may be dispersed unequally, there is a plurality of powerful organisations, and hence a form of what Judge (1995) terms "competitive elitism" exists. This has obvious implications, since the dominance of the network by the

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1 British Medical Association - the main representative body for doctors.

2 See also Brazier *et al* (1993) for a discussion of the split between senior and junior members of the profession for control over the General Medical Council in 1978.

profession is undermined by competition within that profession, in a number of ways:

(a) Both Eckstein (1960) and Forsyth (1973) draw attention to the historical class divide in medicine between specialists and GPs, with the former enjoying higher status and drawn mainly from a male, white, middle class background. Specialists have traditionally tended to associate more with Royal Colleges, and these often perform a political role (Eckstein, 1960: 49). GPs, in contrast, were working class, considered to be an inferior if not illegitimate branch of the profession, and were excluded from representation within the Royal Colleges. Consequently, the BMA was formed and started off as a protest group, establishing itself by the end of the 19th century as a, "GP's trade union" (Forsyth, 1973: 6). Further, as Eatwell (1979: 63) argues, Bevan used such divisions to play the professions against each other when introducing the NHS.

Although such divisions are now less apparent and specialist representation is provided by the BMA, the formal distinction between general and specialist committees within the BMA, demonstrates their continued importance. Indeed, Eckstein (1960: 68) argues that a type of pressure group process developed within the BMA itself with the position of the BMA in negotiations with government reflecting a process of bargaining which has already taken place within its structure.

(b) Elston (1977: 32) outlines the competition between specialisms, providing the example of concern expressed within the profession over the distribution of merit or distinction awards to, "high-tech acute specialties, as against the lower prestige, less competitive geriatrics and psychiatry". Elston (1977: 32-7) traces this conflict back to historical gender, class and race divisions within hospital services. Medicine developed in the 19th century as a white, male, middle class profession, but by 1975 one-fifth of doctors employed were women and one-third were overseas born. However, women and overseas doctors are disproportionately employed in low status specialisms and low grade posts, thus both reflecting and

reinforcing their low status within the profession (1977). Indeed, even in the mid-1990s only 15% of consultant positions were occupied by women (Baggot, 1994: 40). This undermines the assumption that doctors would *necessarily* act collectively to promote a *general* medical interest.

(c) Professional power may be manifest, as Wistow (1992a) argues, in the actions of doctors who exercise autonomous clinical judgments at the level of the individual (although see below). However, not all resource allocation is determined by the "sum of the individualistic behaviour of individual doctors" (1992: 59). Rather, decisions on the allocation of the levels of resources for staff, technological equipment, premises and research take place at a higher level, leaving great scope for competition amongst specialisms for the relative shares of these health care resources. As Baggot (1994: 39) argues, "medicine itself is an arena for professional conflict and battles over status" as well as subsequent levels of resources, and their priorities, associated with this status[3] .

So, the difficulties of viewing the medical profession as a social actor undermine the argument that the policy network is professionalised, and the BMA elite does not possess the representational legitimacy, and hence influence (see table 6.1), as treating the "medical profession" as a unified actor would suggest. This has 2 implications. First, as Day and Klein (1992: 464) discuss, this has led to critical points in which the BMA elite has been at "cross-purposes" with the majority of the membership, and has failed to "deliver" its members (see, for example, DH, 1989; *Independent*, 11.5.89 and *Independent*, 13.4.89 for a similar discussion of Royal Colleges). Second, as discussed below, this lack of a united front may partly explain why the state led reforms of the 1980s were so difficult to obstruct at the formulation stage.

(2) Individual clinical autonomy as an explanation for policy outcomes is also problematic. This is defined by Hampton (1983: 1237) as the right of

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[3] This is well demonstrated by chapter 9's discussion of funding for HIV/ AIDS. Whilst HIV specialists opposed cuts to services in the 1990s, there was little support from other specialisms since AIDS was seen to enjoy a "Rolls Royce" service in the 1980s.

doctors to do whatever in their opinion is best for the patient, and, as Baggot (1994: 42) argues, "doctors are resistant to direction in clinical matters". Thus, the majority of the decisions on the allocation of health care resources are determined by the individual actions of autonomous clinicians (Wistow, 1992a). However, this requires qualification, since doctors, when exercising such "freedom" do so in the context of professional and financial constraint (Hoffenberg, 1987). First, membership of the medical profession implies that the member fulfils certain conditions and accepted codes of conduct which limit that freedom, in return for professional status (Fox, 1951 in Hoffenberg, 1987). So, the allocation of health resources is largely determined by the actions of individual, but professionally socialised, doctors. Hence, individual clinical autonomy may be subordinate to professional autonomy, and it is the profession which acts to control health policy.

Second, and more importantly, doctors may have autonomy in clinical matters, but this is increasingly subordinate to the financial context in which such decisions are made. That is, since doctors have so much discretion in what they take into account when exercising their clinical judgment, it is difficult to distinguish between strictly clinical and extraneous factors such as cost (Williams, 1988: 1184). As Williams (1988) argues, "despite their protestations to the contrary, doctors never have behaved without regard to the cost of their actions" (see also Owen, 1988: 17). Rather, these considerations have been subsumed within considerations of autonomy , implying a process made explicit by the BMA itself:

> *As the resources within the NHS are limited, the doctor has a general duty to advise on their equitable allocation and efficient utilisation* (Handbook of Medical Ethics in Hoffenberg, 1987: 26. See also Hampton, 1983: 1237).

As Hoffenberg (1987: 26-7) argues, rationing decisions are made by clinicians, in terms of the extent to which one patient would benefit relative to another, in cases when the availability of a treatment is limited. So, it

may be impossible in practice to identify purely clinical factors outwith the context in which these decisions are made, and clinical judgement may have more to do with assigning priorities to treatment within the context of financial constraint.

With this in mind, it is increasingly unlikely that such priorities are determined at the individual level. Increasingly, at district and regional levels, health care priorities are set by actors other than doctors. For example, whilst DHAs were originally charged with determining the levels and types of treatment to purchase on behalf of its population, there is also some evidence to suggest that some authorities are even beginning to impinge on the conditions of clinical operations. For example, the Times (23.9.96) highlighted one district health authority which would only fund cancer operations conducted by a specified list of surgeons, based on their agreement to follow surgical guidelines set down by that authority. The Department of Health has also established a Central Health Outcomes Unit, and there have been numerous instances (e.g. the striking of some procedures and prescriptions from the approved NHS list) in which the general principle of priority setting has been used at the national, or sectoral, level. These imposed restrictions, then, further constrain the autonomy of clinicians.

Such arguments undermine the assumption of privileged professional power within the health care policy network, and are extended in subsequent sections. However, whilst the above arguments are related, again the distinction between policy formulation and implementation networks may be required, since one's conclusions on the balance of power differs in each arena. For example, the importance of individual clinical autonomy may relate more implementation networks and are discussed in chapters 8 and 9, whilst this chapter continues to examine the nature of the formulation network at various stages of policy development.

Legitimation

See the discussion of evaluation below.

Organisation

In England, from 1974-82, the boundaries of Area Health Authorities (AHAs) and local authorities were harmonised to further coordination. AHAs were charged with service planning and priority setting in cooperation with local authorities and the new Family Practitioner Committees. The Regional Health Authority (RHA) tier was formed to prevent over centralisation and delay in direct accountability, given the existence of 90 AHAs, as well as to facilitate planning at a more aggregate level. Below the AHAs were District (or "consensual") Management Teams, composed of administrators, nurses and doctors, of which each contingent had the power of veto over any proposal (Klein,1995).

However, the AHA level appeared to be the weak link in the management chain, and the structure did not foster cooperation with local authorities, even when the DHSS provided incentives (1995: 117). So by 1982 *Patients First* replaced the 90 AHAs with 200 District Health Authorities (DHAs), which effectively corresponded to the old District Management Teams, and were justified on the grounds of the virtues of localism and small size authorities. It also suggested a greater role for directly accountable RHAs in planning and the setting of priorities (1995: 123).

Implementation

There were no regional difference in levels of implementation. All AHAs in England were abolished. Further, the new policy on devolved management was easy to implement. The department merely chose to issue less detailed management guidelines. Apart from some criticisms at the local level about central government attempting to off load political responsibility for the NHS, the policy was welcomed by those within the service responsible for implementation, because they, "relished the prospect of reduced political interference" (Baggot, 1994: 121).

However, a number of differences in Scotland merit discussion. First, NHS bodies in Scotland are accountable to the Scottish Office, rather than RHAs.

Second, after 1974, 15 Health Boards in Scotland took on the combined responsibilities of their AHA and FPC counterparts, and because they were more successful (in the government's view) and their abolition would have been a larger undertaking, these remained intact at the expense of districts after the 1982 reorganisation (Hunter, 1985: 233). Finally, the timing of these reforms varied. In England, the new DHAs assumed their responsibilities in April 1982. However, no similar timetable was set in Scotland, and the changes took years to implement (Hunter, 1985: 234). Indeed, the abolition of districts was eventually justified as adhering to the Griffiths Report's recommendation of strong unit management.

But what are the likely effects of such differences on service delivery? First, with the abolition of districts, many health board areas are larger than the average DHA and have greater management control problems (Hunter, 1985: 236). For example, 6% of DHAs had populations over 400,000 compared with 50% of health boards (1985: 236), with the Greater Glasgow Health Board covering 922,000 (The Scottish Office, 1994). Second, the lack of a regional tier means Scottish health boards assume more responsibilities than DHAs (Hunter, 1985). Third, in contrast to the late AHAs, Scottish health board and local government boundaries do not coincide, and as chapter 9 demonstrates, this has led to more difficulties in coordinating services.

On the plus side, the absence of separate FPCs in Scotland has facilitated closer professional relations between the primary and secondary sectors in Scotland (Hunter, 1982: 296), whilst the maintenance of health boards since 1974 ensured stability. Second, Hunter (1982: 294) argues that in terms of the 1982 structural arrangements, local discretion and subversion was much more likely under the English system. So, for example, the redressing of regional imbalances in health care delivery may have been more difficult, as the decentralised arrangements made it more difficult to monitor local decision processes. Third, because the Scottish Office has relatively high levels of discretion in the timing of implementation, as well as the extent to which and the ways in which implementation takes place,

some policy outcomes in Scotland differ. As Hunter and Wistow (1988: 83) argue, the means to achieve the effective implementation of community care policies have been developed much more slowly in Scotland, reflecting a relatively weak commitment to this policy against a strong commitment to hospital based care. Recent public health strategies have also been distinctive in that they focus almost solely on diet, reflecting Scotland's high incidence of heart disease (*The Scotsman* 26.7.96). Further, as Donnelly (1986: 185) argues, the private (and "privatised") sector in Scotland is much less developed, reflecting a traditionally greater political support for the voluntary sector and a corresponding hostility by trade unions to the private sector.

Evaluation/ Agenda Setting (Pre-Griffiths)

The evaluation stage of the policy cycle is the most important in this period. since parliamentary pressure spurred on the Griffiths reforms, in the following ways. First, both the Public Accounts Committee and the Social Services Committee (SSC) were instrumental in the development of accountable management and "strategic policy making" at a time when the DHSS was developing policy towards decentralisation. This was confirmed in the department's (DHSS, 1980) reply to an earlier committee report, which stressed that the future local health authorities would operate with, "considerable autonomy, free from the day-to-day intervention by the RHAs and the DHSS". This culminated in the replacement in 1982 of Area Health Authorities (AHAs) by District Health Authorities (DHAs), justified on the grounds of the virtues of small size authorities and localism. In addition, consensus management teams at the local level effectively held a veto over central direction, reflecting the desire of the minister at that time that, "local health authorities have greater freedom to determine the use of resources which they have available and they are freer to run their own shows" (HC 324-1, 1981: xv).

However, the SSC criticised the department on a number of these issues. Whilst it welcomed the proposed introduction of a "Management Advisory Service" to monitor DHAs, it was critical of the emphasis towards local

autonomy, as this would constrain the committee's ability to hold the minister accountable for developments at all levels of the NHS. In part, this was because the department would no longer set national priorities for local health authorities to follow, leading to two unresolved issues. First, the committee asked, how could Parliament judge the Government's policies on the distribution of public expenditure between different priorities if there were no guidelines? Second, it pointed to the unresolved difficulty of balancing the minister's accountability to Parliament with the devolution of decision making responsibility (1981: 14-5). This, it argued, was not to say that the committee disagreed with any notion of decentralisation. Rather, if any decentralisation were to occur, it had to be accompanied by better ways to gather information on the performance of individual DHAs, to assess whether or not they accorded with the "priorities and policies" of the Secretary of State. This was due to its concern that it find out, "how and how well public money is spent" - the key to parliamentary accountability. So, the only way to square accountability and decentralisation, it argued, was to better monitor the ways in which DHAs spent their money voted by Parliament, rather than effectively absolving all responsibility. As the SSC argued:

> *Effective monitoring at the centre is, we believe, a necessary precondition for greater day-to-day freedom at the periphery* (HC702-1, 1980: x).

Whilst the department dragged its heels on this issue (see DHSS, 1981 and HC 306-1, 1981-82), a more favourable response was given when Norman Fowler was appointed Secretary of State for Social Services. For example, in 1982 the department set up regional reviews to develop timetables for particular exercises. This implied a greater degree of departmental control over planning and monitoring in regions, since the regional chair was responsible for failure to meet the deadlines (HC 306-1, 1982: xxix). Further, these were set up as a direct result of the concerns expressed by the PAC on the absence of accountability in the NHS. As Norman Fowler stated:

> *What we are seeking to do is respond to the concern expressed by the Public Accounts Committee who have emphasised the importance of having formal responsibility and accountability upwards through the DHSS to Parliament* (1982: 208).

The PAC and Social Services Committee's concerns were also instrumental in the commissioning and acceptance of the Griffiths Report on managerial reform. Remember that the main concern of the SSC was that administrative decentralisation be met with effective monitoring. This is widely accepted in the Griffiths report, which attempts to establish a hierarchical, or line, relationship from centre to periphery. The responsibility for local actions is located in unit general managers, who in turn are accountable to their district, regional and central counterparts. It is no surprise, then, that the committee extended a, "general welcome to the spirit of the Report" (HC 209, 1984: vii). That is, they welcomed the devolution of management to unit level as long as it stayed committed to, "its proposed extension of accountability reviews".

However, the question of accountability did not rest there, and three aspects deserve comment. First, Norman Fowler was keen to reiterate that the reforms would in no way lead to the NHS or its new boards having corporate status, and that local management was to be encouraged, "within the framework of policy and accountability which I have set" (HC Debs, 1984: c648). Therefore, none of the changes would affect:

> *Either my existing accountability to Parliament for the Health Service nor Ministers' relationships with Health Authority Chairmen. I know that there has been some concern about this ... in the Select Committee ... [but all] ... the changes that I am setting in hand will be made within existing statutory arrangements .*

Second, however, there was still some concern by the committee on the proposal for less ministerial intervention in the day-to-day activities of the NHS, to concentrate solely on strategic issues. This, they argued, was unacceptable, "as long as Parliament votes the money which pays for it" (HC 209, 1984: xiv). Thus, ministers would still have to intervene at all levels of the service in, "matters of public concern", and used the assurances that the accountability arrangements were to be maintained to assert that the, "same range of Parliamentary Questions as hitherto will be answered" (1984: xiii). Third, the DHSS introduced annual meetings between ministers and regional health authority chairs, to negotiate long term expenditure and priority plans for regions, based on DHA/ RHA plans formulated within the confines of more explicit DHSS guidelines. These changes were attributed by Fowler to parliamentary concern. Finally, the Select Committee report on Griffiths even affected the timing of its implementation. The consultation period was initially six weeks in duration. However, the government's final plans eventually took six months to finalise after the committee decided to investigate.

So, the SSC and PAC reports were most influential in bringing NHS reform to the top of the health care agenda in this period. No public opinion or professional pressure existed for change, whilst the government were committed to devolved management until the end of 1982. However, by 1983 the government had commissioned the Griffiths management inquiry to address the concerns expressed within Parliament.

Policy Succession: *The Griffiths Management Reforms*

Whilst the new emphasis on strong management could be attributed to a newly elected Thatcher government attempting to construct and maintain an image of governing competence, it still reverses the previous Conservative policy of devolved management. Further, the emphasis on strong accountable management may not have seemed a particularly realistic strategy given that it involved reclaiming responsibility for actions largely outwith the direct control of central government. In other words if strong government depends on shuffling off the "low politics" aspects of

government, then this policy would be a dubious success.

Rather, the management reforms followed parliamentary pressure for a clarification of accountable management in the NHS. The *NHS Management Inquiry*, or Griffiths Management Report (DHSS, 1983) argued that the NHS lacked a general management function, or, "the responsibility drawn together in one person at different levels of the organisation, for planning, implementation and control of performance" (1983: 11). Hence, the NHS had a limited concern with strategic priorities in areas such as levels of service, cost improvement or productivity. Because management objectives were rarely set, the evaluation of NHS practice in terms of health output and the economic valuation of practices were rare (1983). Strong general management teams were thus recommended (and introduced) at all levels of the service.

Within the DHSS, Fowler set up a Health Services Supervisory Board (HSSB) and a full time NHS Management Board (NHSMB). The HSSB an elite group chaired by Fowler, would be concerned with overall policy/ strategic decisions, and the determination of objectives for the NHS (including budget and resource allocation), based on commissioned evaluations of performance from within the service. In turn, the NHSMB would be responsible for implementing those decisions by relaying them to Regional and District Health Authorities (RHAs/ DHAs).

The 1982 system was criticised because RHAs did not hold DHAs to account, and top-down management measures were undermined by the existence of the DHA veto. So general managers, charged with directly implementing policy from the centre, were introduced at regional (responsible for general objectives), district (budgets) and unit (day-to-day hospital decisions) levels, replacing consensus management teams, which included an administrator, treasurer, nurse and up to three doctors, with each member having the power of veto over any decision (Wistow, 1992b: 105). These were criticised because the management role could not be performed by an accountable, individual (DHSS, 1983: 12). Accountability

was thus to be ensured at each level by the centralisation of objectives, with: managers at each level having clearer responsibilities; each level of management monitoring the one above; salary incentives related to performance; and the reduction in the numbers and levels of staff involved in consultation and decision taking (1983: 8-9). The plan also effectively ruled out the clinical veto at most levels, "notwithstanding resistance by the BMA" (Wistow, 1992b: 107).

So what does this suggest about the nature of the network in this period? In terms of the immediate effects of this reform, many were against the general interests of the profession, challenging the state-profession "bargain". That is, the government attempted to introduce specific policy direction in terms of resource allocation, as well as accountability for this allocation of resources at all levels of the service. Additionally, as Baggot (1994: 132) argues, senior doctors and (particularly) nurses were in many ways the first to suffer the immediate impact, and the reforms were widely interpreted as, "an attack on NHS staff, as a threat to clinical freedom [and] a blow to nurse management" (HC 209, 1984: vii). In particular, they were seen as a direct assault on nurses', "hard won victories in the previous decade", which had included membership of the consensus management teams and the development of a line responsibility from ward level to district nursing officer which is cross cut by the general manager (Baggot, 1994). Few nurses were appointed as general managers (7% of Regional, 2% of District, and 12% of Unit managers were nurses from outset) and the role of nurses at senior levels diminished, since decisions on, for example, the levels of nursing staff required now come under the purview of managers. Similarly, the reforms ensured the mass removal of doctors from management structures at regional and district levels (Regional 7%, District 8%, Unit 18%). It even took extensive lobbying by both professions merely to secure that at least a nurse adviser and medical officer were present on each management board (Baggot, 1994: 127-33).

Legitimation

The management reform process was notable in this period for the lack of

legitimation sought by government within the network. The consultation period of 6 weeks was remarkably short, whilst the reforms were pushed through in spite of opposition within the profession (manifest in BMA and COHSE criticism). This may be partly explained by the anticipation of automatic legitimacy granted by Parliament. This could reasonably be presumed given that the measures mark a direct response to parliamentary criticism in the first place. The SSC welcomed the spirit of the report, and this opinion was largely reflected in parliamentary debates at the time.

Organisation

The management reforms entailed widespread organisational change. Consensus management teams were replaced by general managers at all levels in the face of opposition within the service itself.

Implementation

The implementation decisions of managers largely depended on cooperation from discretionary clinicians who would not accept the decisions of managers if they decided that such action was not in the interests of the patient (HC 209, 1984 - Minutes of Evidence, BMA). One could thus reasonably expect local variations in the degree of implementation of the new management style.

Another notable variation in levels of implementation could be found in Scotland. Although Griffiths focussed on England, the principles were found by the Secretary of State for Scotland to apply to Scotland (Hunter, 1985: 243). However, the timetable was much more flexible, with: (a) the appointment of health board managers to be completed by the end of 1985; (b) a study of Scotland's particular administrative structures to be completed by the end of 1986; and (c) the aim of strengthening the management function at unit level to be given no time limit, given a lack of commitment to this aspect (1985: 243-4).

Evaluation/ Agenda Setting - Working For Patients

Some of the issues subsequently covered in *Working For Patients* were

anticipated in the SSC's review of Griffiths. First, for example, they recommended that the government keep consultant contracts under review as they became more involved in management budgets. The departmental reply (HC 512, 1984: vi) concurred, and this was addressed 5 years later. Consultant contracts were placed much more within the purview of general managers and linked to consultant budgets. Second, the committee argued that the proposed "mechanistic management hierarchies" may not work at unit level. This was reconsidered in 1988.

However, the agenda for NHS reform was not particularly linked to evaluations of the Griffiths reforms. Parliamentary evaluation was favourable, whilst the opposition of medical professionals within implementation networks was diluted by their reduced role within the decision making process. Rather, SSC evaluations of the government's "chronic underfunding" contributed to the reconsideration of NHS funding and the 1988 review.

The origins of disquiet over public expenditure on the NHS can be traced to two main sources. First, in 1985, The Institute of Health Services Management (IHSM), the BMA and the RCN (Royal College of Nursing) commissioned a joint report on NHS expenditure which sparked media interest and, "led to an exchange of letters and memoranda between DHSS Ministers and the IHSM" (HC 387-1, 1986: viii). Second, detailed parliamentary interest can be traced to the SSC's reports in the mid 1980s, which questioned the government's claims to have maintained its financial commitment to the NHS.

The SSC paid particular attention to the government's claim that spending on the NHS rose by over 20% in real terms between 1978-9 and 1985-6. It argued that little of this increased spending included "new money", or spending which increased the volume of hospital care supplied because 37% of the increase went in pay settlements, while 36% went to family practitioner services which was demand led (HC 387-1, 1986: xii). More importantly, the committee jumped upon the Minister for Health Barney

Hayhoe's admission that a 2% rise in expenditure was required merely to cover demographic change, advances in technology, and the government's own priorities. With this figure, they calculated that the government only provided half of the required expenditure:

> *Resources for the Hospital and Community Health Services ... have actually grown by only 1% since 1980-1. The most telling way of representing the shortfall is to say that from 1980-1 to 1985-6 the cumulative underfunding ... was £1.325 billion at 1985-6 prices* (HC 387-1, 1986: xiii).

It estimated that this would rise to £1.9 billion by the end of 1987-8 (HC 264-1, 1988: v) and recommended that the government admit to and honour this shortfall by investing £1 billion over and above the planned expenditure, over a period of two years, to subvert the health authority practice of suspending services in order to balance the year's budget (HC 387-1,1986: xxiii; HC 264-1, 1988: v). In the departmental replies (DHSS, 1986; 1988), the government denied the validity of the 2% figure and the existing shortfall. £538 million, it argued, would be enough to cover increases in pay (1988: 1). However, this was to change after the Autumn statement, in which the Chancellor of the Exchequer, Nigel Lawson, announced that an extra £1.25 billion would be provided for 1989-90 as well as 1990-91 (HC Deb, 1.11.88, c822-3). Further, as the Secretary of State for Health, Kenneth Clarke, argued, this was on top of £300 million saved in employers' superannuation payments, £150 million in cost improvements and £25 million in income generation schemes. He thus announced an additional expenditure of £1.8 million in "new money ... immediately available for expenditure" that year (HC 713-i, 1988: 1).

Committee pressure was arguably an important resource used by the Department of Health in its annual negotiations with the Treasury in this regard. However, the committee was not involved at the formulation stage of *Working For Patients,* and more important pressures for funding and reform can be found in discussion of wider parliamentary and health service

activity. The SSC itself (HC 264-1, 1988) describes the activity which led up to health service reform. In the first 6 months of the new Parliament alone, 26 Early Day Motions were tabled, "drawing attention to cuts, ward closures and financial crises in health authorities"; there were 6 adjournment and 3 full scale debates; the subject dominated debate on the Health and Medicines Bill, as well as debate following the publication of the government's white paper on primary health care; it dominated the Prime Minister's Question Time; and:

> *A constant stream of Parliamentary Questions sought information from Ministers about the extent of the problem, and elicited disquieting statistics about ward and bed closures, waiting times and other events appearing to point to an accumulating crisis* (1988: v).

The NHS dominated the parliamentary agenda in terms of Early Day Motions tabled and parliamentary time, from 1986-92 (see Bosanquet, 1992: 209) and accompanied concern within the health service, which culminated, in December 1987, in a joint statement from Presidents of the Royal Colleges of Physicians, Surgeons, Obstetricians and Gynaecologists, demanding an overall review of the acute hospital service. This was supported by Sir George Godber, former Chief Medical Officer to the DHSS, and, "Since then", as the SSC argues, "parliamentary expressions of disquiet have continued". Before the announcement of the governmental review, there was time for 2 more full debates on the NHS, 4 more adjournment debates on particular areas, and 26 more Early Day Motions. This accompanied partial strikes by health workers.

So, Parliament was a focal point for the expression of disquiet over the future of the NHS, and parliamentary and media activity contributed to a sense of crisis within government. As Hogwood (1992a: 22) argues, the period of 1987-88 marked a massive increase in newspaper coverage of the NHS "crisis", whilst public opinion measures indicated a peak level of concern in February 1988, replacing unemployment as the most pressing

issue. Labour campaigned heavily in 1987 on the issue of NHS underfunding, cases of delayed treatment of patients leading to some deaths were highlighted in the media, serious consideration was given to industrial action by nursing unions, and the Royal Colleges issued a joint statement on the extent of the underfunding problem.

In addition, the detailed review of public expenditure by the Social Services Committee allowed it, as well as Parliament as a whole, to push strongly for specific increases. As Klein (1989: 179) argues, the figures were to, "reverberate throughout the entire debate, feeding alike the sense of grievance within the NHS and the indignation of the Opposition politicians".

Policy maintenance or succession: *Working For Patients*

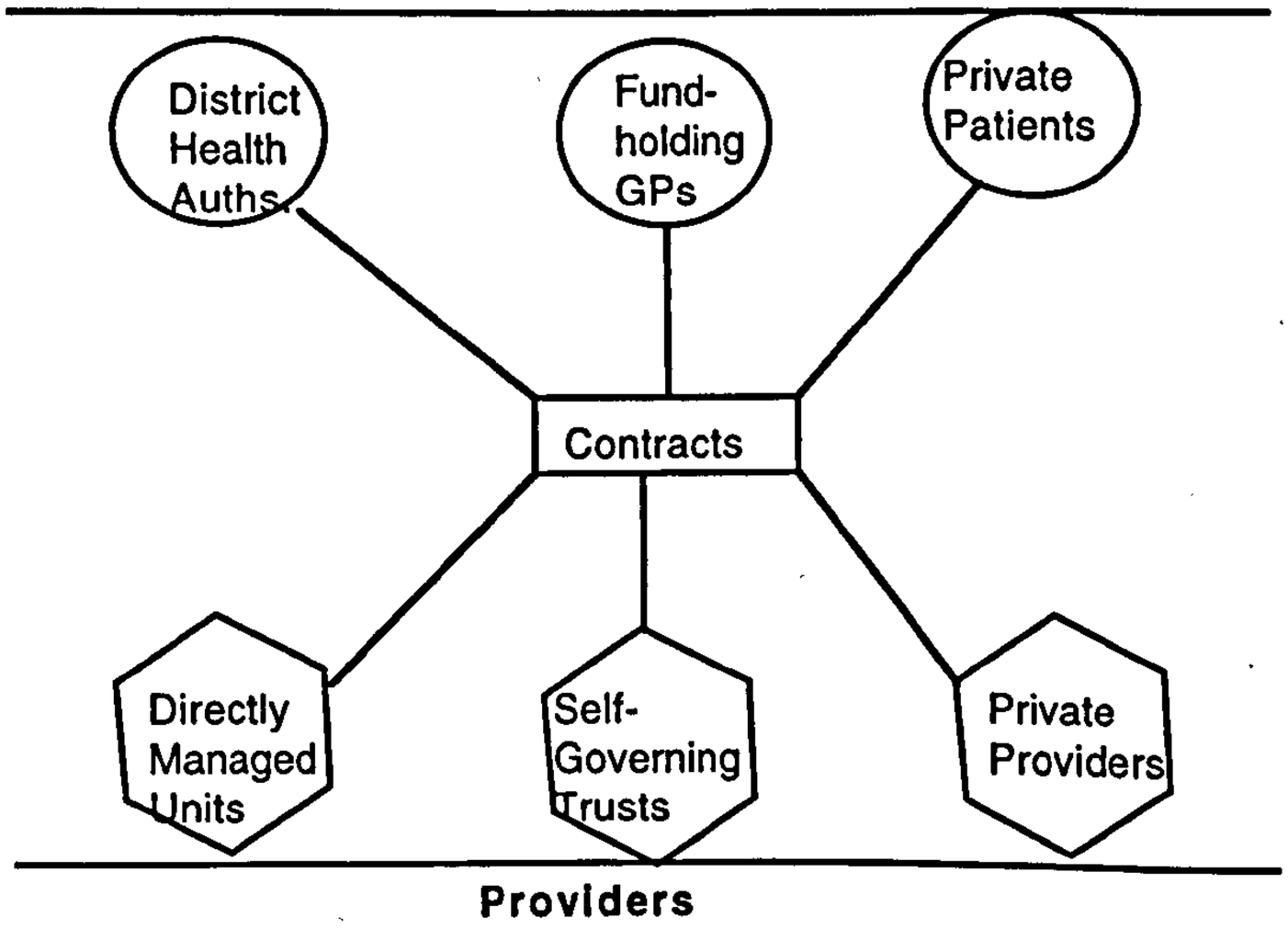
The DHSS bowed to public, group and parliamentary pressure by meeting the SSC's figures. However, the review's resultant policies were more than just responses to previous concern. There was policy maintenance in attempts to strengthen the links between the centre, regions and districts. The HSSB was replaced by an NHS Policy Board (NHSPB), whilst the NHSMB was replaced by the NHS Management Executive (NHSME). The NHSPB, determined, "strategy, objectives and finances of the NHS in light of government policy" and set, "objectives for the NHSME and monitor whether they are satisfactorily achieved" (DH, 1989a: 13). Further, the roles of regional and district authorities were reconstructed, and their membership determined by the centre, to ensure that their actions reflected government policy.

However, there was also policy succession. The centralisation of regional and district activity was accompanied by a greater emphasis on the delegation of authority to local levels and increasing competition. Both aims were to be achieved in two main ways. First, NHS Hospital Trusts were to be introduced. The government proposed to grant self governing status to hospitals if they fulfilled the requirements of good management skills and the involvement of senior professional staff in management. Trusts would be given full responsibility for employing staff and raising

revenue from contracts with health authorities, GP practices with their own budgets, private patients/ companies and other Trusts (1989a: 24). So, the delegation of responsibility would be accompanied by a "stimulus to better performance" (1989a), since cash strapped health authorities would have a strong incentive to secure value for money.

Second, the introduction of the purchaser/ provider split would ensure competition even if hospitals did not opt out. The government argued that health authorities should be funded for, "the population they serve, and not for the services they provide" (1989a: 30), and so RHAs are now funded on a (weighted for age) per capita basis. In turn, DHAs are charged to secure the most cost effective services they can for their patients, "irrespective of whether or not these are provided by the District's own hospitals" (1989a). Similarly, the government argued that NHS hospitals should be funded "more directly for the volume and quality of the services they provide", and so should be able to offer services to their own and other DHAs, as well as to the private sector. In effect, then, the providers of services now compete mainly to secure the contracts of cash strapped DHAs (see figure 6.1).

FIGURE 6.1 - THE INTERNAL MARKET



Source: Baggot (1994: 180).

There were also reform proposals on prescribing budgets, medical

practices and consultant contracts. First, the government proposed to tighten restrictions on prescriptions (DH, 1989c: 5), with RHAs monitoring the FPCs responsible for allocating indicative drug budgets (according to government policy) to GP practices in their area. FPCs were given the powers to monitor prescribing and take remedial action if necessary, "the final outcome of which may be withholding of renumeration from the doctors concerned" (1989c). Second, the White Paper announced that larger GP practices (with at least 11 000 patients) would be given the opportunity to manage their own budgets, subject to control by the FPC and statutory audit by the Audit Commission (this was extended to practices of over 5000 patients in 1994). The idea was to encourage local responsibility and accountability, whilst stimulating hospitals to be more responsive to the needs of GPs (1989b). Finally, the White Paper proposed to hold consultants more accountable - professionally and financially - by introducing arrangements which would, "more clearly define the scope and extent of each consultant's duties" (1989d). This was to be achieved by involving DHAs (in England) more in the defining of contracts, ensuring managerial membership on consultancy appointments panels, reforming the criteria for distinction awards, and introducing new procedures to deal with professional misconduct.

<u>But what do these measures suggest about the nature of the network?</u> The short answer is that it favours the government. First, the increased centralisation of objectives further strengthen the DH's role in the allocation of resources at regional and district levels. Second, the introduction of competition further constrains the autonomy of clinicians. That is, if hospitals compete in terms of costs and outcomes, then, "control over diagnostic and treatment procedures, lengths of stay, readmission rates and other outcomes" will, increasingly, be planned at the unit, rather than individual level (Wistow, 1992b: 110). Third, additional conflicts of interest within the profession may increase. For example, the management route is seen by many doctors at registrar level to be more fruitful than the traditional, hierarchical one (Hunter, 1994). The competition between specialisms for funds is also likely to increase. Fourth, the monitoring of

prescribing and spending further impinges on the autonomy of individual GPs. Finally, the increased monitoring of consultant activity challenges the profession's traditional emphasis of self governance.

Indeed, these reforms sparked off massive conflict and a concerted attempt by the BMA to block the proposals. This consisted not only in extreme opposition within the network, but also in the BMA's biggest ever press, television and parliamentary campaign against any Government plans (*Independent*, 28.9.89), with 11 million "SOS for the NHS" leaflets distributed through GP surgeries (*Independent*, 1.4.89) and extensive lobbying of MPs. The proposals were rejected by the Royal College of General Practitioners by 50 to 1 (*Independent*, 17.4.89), and the Association of the British Pharmaceutical Industry (*Independent*, 12.6.89). Nevertheless, notwithstanding the limited concessions made, most of the reform proposals were maintained at the formulation stage.

So, when one distinguishes between formulation and implementation networks, it is difficult to maintain that medical interests dominate the former. Medical groups still dominate *consultation* lists, often at the expense of other, mainly user, groups. So power *is* manifest. However, even then, this is more likely to be systemic power, with decision makers predisposed to favour some interests at the expense of others, even though this does not result from direct exercises of power by those groups (Stone, 1980: 982). They are favoured because of their relational position - as experts on technical, as well as implementational aspects of policy. This is not to say, then, that these groups necessarily act to exclude others from the process, nor that they could. Rather, consultation forms part of a standard network activity, manifest in most networks, in which state agencies and groups exchange influence for information, whilst imposed time pressures within the consultation process mean that some groups just cannot be consulted.

From Core to Specialist Insider?

There is also increasing evidence to suggest that even such dominance of the consultation process by the BMA (and/ or Royal Colleges) is also in

decline. This began in 1974 with the DHSS document *Democracy in the NHS.* As Elston (1977: 44) argues, the 1974 reorganisation attached greater importance to the representation of other health workers in national and local decision making bodies, thus ending the reign of the BMA as "sole partners" in consultation with the DHSS on all matters relating to the NHS. This reflected the realisation that doctors could not maintain a monopoly on either technical information or implementation on all issues in such a large organisation, and that some in issues, such as the conditions of work for auxiliary staff, the BMA had no legitimate reason to be consulted. Elston (1991: 70) traces this diminishing medical voice in policy making to the late 1980s, arguing that senior medical figures have, "appeared to be on the outside, trying to get in". This was best exemplified by the fact that when the Presidents of the Royal Colleges demanded an immediate review of NHS funding, they were "immediately rebuffed", and played no formal part in the review when it was established (1991: 70).

Changes within the DH have also arisen in the last decade as a result of the managerial reforms. For example, the government's own Chief Medical Officer was given no formal status within the NHS Policy Board, symbolising, "the displacement of the profession from the centre of health policy making" (1991: 70). Further, as Ham (1992: 158) argues, the status of groups within the DH vary according the issues on its agenda. Therefore, given the primacy attached to implementing the NHS reforms, as well as the effects of the 1991 Ministerial Review of the DH in which two-thirds of the senior posts were located in the Management Executive, the importance of the medical policy branch within the DH, and hence the BMA, has declined.

Given these changes, the BMA's status within the DH has moved from core to specialist insider. The existence of competing specialisms within the medical profession undermines viewing the power of the BMA at an aggregate level. Rather, the DH is divided into a multitude of divisions, or sub-sectoral policy networks, and the power of each branch of the BMA is likely to vary according to specialism. Further, in issues such as auxiliary and nursing labour relations and management issues, the BMA may not

even be routinely consulted. This suggests that the sectoral level policy network can no longer be considered as a closed policy community.

Legitimation - The Consultation Process within the DH(SS)

Further evidence to undermine the power of the profession can be found in examination of the consultation process surrounding major health reforms. The lack of importance attached to this process by governments prior to implementation is well demonstrated by the introduction of the NHS, as well as the process surrounding the 1974 NHS reorganisation. In the latter, as Forsyth (1973: 215) argues, although 600 organisations and individuals commented on the government's proposals, "the structure proposed for introduction in 1974 diferred hardly at all from that envisaged in the Consultation Document".

The Griffiths managerial reforms and Working *For Patients* also demonstrate the government's lack of regard for consultation both before and after the initial statements of intent. As discussed by the SSC, the Griffiths inquiry consultation period began on November 18, lasting for less than two months (including the Christmas period). Thus, it left little time for organisations to consult members and respond in detail, raising, "suspicions that it was less than whole-hearted" (HC 209, 1984: vi-vii). Indeed, COHSE argued that the short time reserved for consultation, the confinement of consultation to only two aspects of the report, the failure to consult all interested parties and the acceptance of the conclusions prior to consultation confirms the impression, "that it is a political exercise rather than a serious attempt to elicit considered responses from experts in the NHS field" (HC 209, 1984: 92). It concluded that the government was unwilling to consult because it was already aware of the opposition which would greet the proposals.

In the case of *Working For Patients,* the review conducted is perhaps the best example of "internalised" policy making in this policy area. Thatcher took personal charge of a small review team to consider NHS finance and reform, thus bypassing the regular departmental and cabinet channels

(Burch and Holliday, 1996: 232-7). The BMA was not consulted on matters relating to any of the proposals prior to publication, whilst the chair of the BMA Council was, "gravely concerned that the Government's timetable does not provide for proper and adequate consultation" (BMA, 1989: 3-4). Further, given the widespread opposition to the resultant proposals, few groups seemed to have much success from the limited consultation which did take place.

However, bearing in mind the discussion in chapter 2 this assessment can be qualified since, whilst medical involvement appeared to suffer during this period, departmental and civil service influence did not. Consultation procedures are apparent at lower levels within the department, and these are channelled upwards to inform higher level discussions, even if consultation is rejected at this level. There was a clear and heavy reliance by the team on DHSS involvement for processing the information required for the review and the information was in part obtained through consultation at lower levels within the civil service.

Moreover, the review's loss of momentum partly explains Thatcher's decision to split the DHSS and appoint Kenneth Clarke (a policy innovator) as health secretary, and from then on the reforms were, "more clearly driven from the DH" (1996: 235). In particular, the formulation of policy on GP fundholding which made the pursuit of internal markets much more feasible was said to be Clarke's "brainchild", whilst Clarke was the first to present and defend any detailed conclusions. Further, Clarke, "an able minister heading a well-resourced team, usually managed to maintain his department's line" (1996: 236). Thus, the formulation of NHS policy reverted back to the old system. As Burch and Holliday (236-7) argue, Thatcher and her staff initiated the review, set the terms of debate and developed ideas for discussion. However, because they lacked the resources and the information to formulate policy effectively and because the ideas from outside bodies were not feasible or practical, Thatcher eventually passed the mantle onto Clarke, and the reform process then, "conformed more closely to normal British government procedures".

Again, then this highlights the extent of network activity, or the standard activities of networks which characterise the British policy process, even despite attempts to internalise policy making. At the sectoral level at least, policy is developed within a department by the minister in charge, facilitated by a staff of civil servants in close contact with groups. Any attempt to bypass this process is problematic in that the resources for formulation are unavailable. As Burch and Holliday (1196: 237) argue in the case of the NHS review:

> *The initial mode of operation ... did not actually succeed in generating tenable proposals for health reform, and was partially abandoned ... In the end, it took a strong-willed minister drawing fully on the resources of his department to pull the review together.*

Thus, the above example undermines the idea that any policy measure can be considered as developed internally. To fully formulate any policy, some degree of civil service support and hence group activity is essential.

The Bill was passed and parliamentary network opinion reserved until further examination of the proposals in detail. However, implicit legitimacy is discernible from the focus of parliamentary attention, not on the framework of policy itself, but the detailed effects of its implementation.

Organisation

Working For Patients again involved widespread organisational change, given that for the fourth time in 20 years NHS reorganisation was the primary aim of the policy change. However, whilst the measures were opposed by the medical profession, a marked difference existed in the process of organisational change (compared with the Griffiths reforms), with widespread cooperation noticeable amongst the management profession. Additionally, because organisational change at the regional and departmental levels involved a streamlining of functions, rather than direct

replacement, there was no significant opposition or obstacles. With the introduction of fundholding, trust, purchaser and provider status, this policy has been effectively and successfully implemented. Even in Scotland, virtually all the eligible hospitals have now acquired trust status, whilst the lowering of GP fundholding criteria has expanded their scope further than anticipated. Indeed, the uniformity of policy structures is increasing. Legislation in force from April 1996 removed many of the differences between the Scottish and English systems. The RHAs in England were replaced by 8 regional offices of the NHS Executive, a ninth of which exists in Scotland, whilst DHAs and Family Health Service Authorities were replaced with single all-purpose health authorities, thus resembling Scottish Health Boards. This also coincides with the *Senior Management Review* in Scotland, which has resulted in the establishment of a separate Health Department. So, whilst it may be too early to speculate on the service delivery effects, the administrative differences between Scotland and England appear now to be much less significant.

Implementation

The policy formulation/ implementation-network distinction highlights the importance of consultation and negotiation after the formulation of policy. Internalised policy making lacks the necessary detail to be directly implemented, and so the negotiation process at the implementation stage in many ways resembles traditional conceptions of policy networks, albeit within an agenda already set in its broadest terms at the formulation stage (akin to the agenda set at the sectoral level). However, the analytical distinction between policy formulation and implementation is difficult to maintain, especially when a policy is still being handled mainly within the formulating department. Nevertheless, the then Secretary of State for Health, Kenneth Clarke's discussion of *Working For Patients* does demonstrate that such a distinction is followed in practice:

> *The discussion is passing into a new phase where I think we have moved on rather from the grand slam argument about whether or not it was a good idea into the stage*

> *where a great deal of detailed study is being done on the ground in the district health authorities by the people concerned as to how they might implement these reforms ... inside my department* (HC 148-i, 1990: 7).

Clarke describes three processes at work. First, there is at least an attitudinal change of emphasis from policy formulation to implementation and this affects the agenda of the network. Second, at such an early stage in the implementation and reform process, the department itself is still the main actor as a focus for coordination and evaluation. From this, then, it is valid to retain the analytical distinction between formulation and implementation networks at the departmental level. This is not to suggest that no policy making takes place at this stage, but that the type of policy activity is qualitatively different in that it involves the interpretation of a broad framework. This attitudinal emphasis is also reinforced by the internal organisation of the department. The NHS Policy Board (chaired by the Secretary of State) was responsible for the formulation of *Working For Patients*, whilst the NHS (Management) Executive, although subject to influence from the Secretary of State, is chaired by its chief executive who is responsible for the day-to-day operations of the implementation process. Indeed, this devolution of responsibility even extends to dealings with the Health Select Committee (HC 148-i, 1990: 7).

Third, Clarke suggests that the consultation and negotiation process is qualitatively different in this new stage. As already discussed, the health review was marked by a lack of negotiation. However, prior to implementation, the department could not consult enough on the details of the reforms: "the extent of joint working between the NHS and the centre ... is of a greater order than it has ever been" (Deputy Chief Executive of NHSME, HC 148-i). This difference is accentuated further by the type of minister at the head of the department. In terms of Headey's (1974) analysis, Kenneth Clark, a prime example of a policy innovator (or perhaps even an "agenda setter", intent on changing the "world view" of the department even after his departure - see Richards and Smith, 1997), was

replaced by an ambassador (Waldegrave) and then a legitimator (Bottomley).

The example of GP fundholding is an excellent example of the changing emphasis under Waldegrave. After rejection by the profession of the new GP contracts, Clarke announced that the contracts would be imposed. Waldegrave, in contrast, whilst emphasising that the *principles* of the new contract were non-negotiable, the *details* were not (Day and Klein, 1992: 475). Such an approach was continued with respect to the future of fundholding. In June 1991, the Department of Health announced the setting up of a joint NHS review committee with the General Medical Services Committee of the BMA, as a means for the profession to evaluate and develop the scheme (HC 614-i, 1991: xxiii). As Waldegrave explains:

> *Precisely because of its innovatory nature, the Government has always been ready to develop it in the light of experience and I am pleased that we now have a way of consulting the profession formally on this and hearing the collective views of both fundholding and non-fundholding GPs* (HC 614-i, 1991).

Such an emphasis was continued under Bottomley, a minimalist or ambassadorial minister (Headey, 1974: 76-7). Bottomley expresses the government's approach of setting up broad frameworks whilst leaving the important details to implementation groups (HC 902, 1993: 19).

Thus, departmental level implementation networks replace the concerns of former conceptions of formulation networks. As Smith (1993: 183) argues, conflict and the entering of new groups into the decision making process may have undermined the existence of a closed policy community. However, it has not now become a loose issue network: "Doctors are still important to the process of making and implementing policy, and the structures of institutionalised access still exist". Indeed, Day and Klein (1992: 475-6) argue that things returned to "business as usual" after the GP

contract wrangle, reflecting the compelling mutual dependence between state and profession if the NHS is to be maintained:

> *Following the confrontational crisis, it was in the self-interest of government to be conciliatory and to revert to administering policy through the medical profession.*

Therefore, whilst negotiation and access may have been rejected at the formulation stage, the requirement to administer the reforms compels widespread negotiation at the implementation stage. Such access has thus just shifted to a different type of network at a different stage of policy making. This is reflected in the number of sub-sectoral networks which were set up as a consequence of the proposals contained in *Working For Patients*, with approximately one network developing around each working paper published. For instance, the Information Management Group (IMG) was set up to oversee and facilitate the development of information technology within the NHS. The IMG (1990) describes the extensive consultation process which followed. The working paper derived from *Working For Patients* was sent out on January 1990 and sent to all RHAs, DHAs, FPCs, SHAs, as well as a large number of professional associations, colleges, information systems suppliers, and other branches of the DH. Two months were reserved for consultation, in which the IMG undertook a, "roadshow to Regions" (1990). As a result, over 200 written responses were received which were examined and incorporated into the decision making procedure prior to the detailed formulation of an implementation strategy.

Hence the importance as well as the occurrence of widespread consultation which takes place prior to implementation, which can be easily ignored with a sole focus on the effects of a Thatcherite rejection of negotiation at the formulation stage. Rather, negotiation has been displaced to implementation networks and sub-sectoral networks are much closer knit, because: (a) a necessary group strategy to attain insider status was to accept the broad framework produced by the formulation network, with negotiations focussed on the details; and, (b) the department's subdivisions

depended on a number of groups to ensure the implementation of that policy. It therefore could not afford to maintain a confrontational strategy.

Similar processes are apparent at district and unit levels of government, and according to Ham (1994a: 352) early developments were to a great extent being, "driven from the bottom up not from the top down" (Ham, 1994a: 352). As Ham (1994a: 351) argues, continuing uncertainty about the evolution of the NHS reforms existed, because *Working For Patients* was only "sketched in broad outline ... with many of the most important details missing". Due to the tight timetable and the partial formulation of policy from the outset, "there has therefore been no overall plan guiding the implementation of the reforms and little sense of where they will ultimately lead" (1994a). This has led a period of "learning by doing" on the part of managers and doctors, in which, "the importance of GP fundholding, NHS Trusts, and similar initiatives have been discovered in the process of making the reforms work" (1994a). In particular, Ham (1994b: 1032) argues that (bottom up) initiatives which include an increased advisory role for GPs in health authority decision making, locality purchasing, practice sensitive purchasing, fundholding consortiums, GP multifunds and total fundholding, have all emerged "spontaneously" as a result of the new collaborations between health authorities and GP fundholders.

In other words, district level policies have necessarily developed in the course of interpreting broad central policy objectives. Therefore, analysis at this level is necessary, because this is where NHS policy evolved. Two examples should demonstrate this point. First, the closeness of the relationship between purchasers and providers was relatively ignored at the formulation stage. Subsequently, DHA purchasers and GP fundholders found it necessary to, "set up stable relationships with providers" to avoid the transactions costs of the permanent renegotiation of contracts (Paton, 1996: 59). Whilst such a strategy has been encouraged at the departmental level, this may contradict the original imperative for purchasers to constantly seek more competitive provider arrangements. Second, Harrison (1995: 4) saw the potential for collaboration between nonfundholding GPs and DHAs

which reduce the need for fundholding, because it reduces the administrative burden of GPs whilst allowing DHAs to more fully coordinate health purchasing (although this turned out not to be a particularly popular strategy). However, this is not to discount the developing role of the DH in monitoring and influencing NHS reform at this stage. For example, early evaluations of fundholding, notably by the National Audit Office, were favourable, and therefore the DH sought to increase its effect by reducing the threshold for fundholding status (Harrison, 1995).

Further, it would be an exaggeration to argue that *all* policy is being developed at this level, given the necessary drive for centralisation. As Ham (1992: 165) argues, "to reduce the scope for local variation, RHAs maintain contact with DHAs through a variety of formal and informal channels" This includes regular meetings between RHA (now regional offices of Management Executive) and DHA chairs, general managers, as well as staff from the "same discipline", on the compliance of the DHA in furthering its plan derived from regional and national priorities. Therefore, whilst a strictly hierarchical relationship may not exist in practice, there are clear accountability and coordinating arrangements within the NHS which affect decision making at this level.

Evaluation/ Agenda setting

Evaluations of success and failure depend on the identified aims of a policy and the criteria for a policy's success. However, the aims may not be necessarily discernible from government discourse itself and indeed no system of monitoring or evaluation was set up in 1989 alongside the reforms (Le Grand, 1994: 243). Further, it is difficult enough to measure health gain even before linking this with health care, whilst some measures cut across others (1994: 248). Nevertheless, both Wistow (1992b) and Klein (1995) argue that, in the short term at least, 1980s/ early 1990s NHS reforms were a relative failure. For example, the challenge to clinical autonomy was "not particularly successful" (Wistow, 1992b: 107), whilst the dual aims of giving better health care and consumer choice, as well as greater satisfaction to responsive service providers, without a, "massive

infusion of extra funds", were not achieved (Klein, 1995: 236). The reasons for these failures can be further explained in terms of the (top-down) conditions for successful implementation:

(1) That there is an understanding of, and agreement on, clear and consistent objectives;

The best example here which faces all governments is the maintenance of a comprehensive service whilst containing costs. However, a number of particular inconsistencies faced the Thatcher government in this period. First, the *Working For Patients* reforms succeeded in reorganising the health care system and the "distribution of power within the NHS", but this was widely resented by the profession. In turn, NHS reform was widely viewed as being unsatisfactory because, "consumers tend to see the service through the eyes of providers" (Klein, 1995: 239-40). This undermined the political/ electoral aim.

(2) *That a valid/ adequate causal theory exists, in which the relationship between cause and effect is direct (i.e. that the policy will work as intended when implemented)*;

As Wistow (1992b: 103) argues, the, "mechanisms for reviewing performance and securing accountability for shortfalls against targets" have never been well developed, and thus the government could never be sure that a policy to increase centralism and accountability would not be undermined by hospital authorities. The DHSS did announce the introduction of performance indicators in 1986, but as Le Grand, Winter and Woolley (1990: 127) argue these generally refer to "throughputs", and are thus, "closer to measures of inputs than of outcomes".

Thatcher (1993: 616) herself was concerned about the transitional difficulties involved in the implementation of *Working For Patients*. She professed concern about the abilities of DHAs and hospitals to develop the technology and management expertise to adequately monitor the "flows of patients between districts" and the "costs of their treatment" (1993). Indeed, Winterton (HC 148-1, 1994: 11) suggests that from US experience and the

arguments of Enthoven, the technology required would take 3 years longer than necessary. Therefore, there was concern that the implemented reforms would not ensure competition, efficiency and reduced costs as intended.

Klein (1995: 238) also points to the problems inherent in *Working For Patients* method of inducing competition. Health authorities and GP fundholders, for example, have become proxy consumers. However, health authorities are monopolists, and therefore are under little pressure to demonstrate a responsiveness to their populations, whilst it is questionable whether or not patients have the knowledge or inclination to make "consumer like choices" when selecting their GPs. In addition, there is a trend towards surgery mergers, and even less competition, as successful GP fundholding seems to require an increase in size to accommodate the costs of information technology and expertise. So, an inadequate causal theory exists within the policies for NHS reform, because in many ways they do not ensure accountability and competition even if the measures described in *Working For Patients* were to be fully implemented.

(3) *That subsequent tasks are fully specified and communicated (in correct sequence) to a team of skilful and compliant officials* .

An initial aim of *Working For Patients* was to split the purchasing and providing roles, with providers responding competitively to the demands of centrally accountable purchasers. Subsequently, purchasers are required to publish an annual plan, in which they "set out what they propose to to buy and from whom ... on behalf of their populations" (Klein, 1995: 232). However, Klein (1995) argues that in practice purchasers do not explicitly prioritise and define those services which will be available. Rather, clinicians merely limit access to the existing services, of which virtually none have been restricted by the authority. Therefore, the adequacy of service provision is difficult to assess, and accountability is difficult to maintain.

(4) *That the required time and resources are available, and fully committed, to the relevant programme.*

This requirement met with mixed results. Although a significant expansion of resources accompanied the *Working For Patients* reforms, this was undermined by demographic factors as well as the costs of the reforms themselves. So, as Le Grand (1990) argues, to make the reforms work, the extra money provided for the NHS may be aimed at administrative and wages costs rather than the actual services themselves.

(5) *That dependency relationships are minimal and support from interest groups is maintained*;

Whilst the government was able to impose the legislation, the subsequent challenge to clinical autonomy was, "not particularly successful" (Wistow, 1992b: 107). Therefore, legislation alone was an inadequate measure, "in a context where street level providers possess significant discretion over resources", and where obvious opposition to government plans exist (1992b: 114).

(6) *That external, or socioeconomic, conditions do not significantly constrain, or undermine, the process*

According to Klein (1995: 240), spending on the NHS as a proportion of National Income rose from 6% in 1989 to 7.1% in 1992. However, a real growth rate in expenditure of 2% per annum is required to cover: the growth rate in the number of elderly people (1%); medical/ technological advance (0.5%); as well as the stated government objectives to improve services such as community care (0.5%). So, whilst expenditure increases, this is not necessarily translated into an increase in the treatments available per capita.

So, the top-down approach does point to areas of policy failure within NHS reform, and does provide particularly convincing explanations for this failure. However, much of this was based on an interim analysis, and the results of a longer and more specialised examination of the effects of *Working For Patients* on HIV/ AIDS policy in Lothian suggest that at least some of these problems became less apparent towards the late 1990s. For example, Wistow (1992b: 114) argues that the policy of tilting the balance of

power in favour of managers effectively failed. That is, in "policy outcome terms, there appears to have been significantly less progress in bringing clinical practice within the management process". However, managers now participate in the consultant selection process, they can set tight constraints on new consultant contracts, and have more responsibility for the financial implications of hospital spending, and hence have more leverage to call doctors to account (Hunter, 1994; Klein, 1995: 243). The point may be that the use of these powers will vary from locality to locality and from situation to situation, but certainly, as chapters 9 and 10 discuss, the new financial and managerial frameworks enabled funders rather than doctors to establish their centrality within the decision making process. Similarly, the ability of individual autonomous clinicians to determine the allocation of resources has been continuously undermined in recent years, to the point of the health board placing an embargo on the prescribing practices of doctors.

Policy termination?

The ensuing evaluations of the effects of *Working For Patients* in chapters 9 and 10 may be particularly important since the new Labour government signalled its intentions in December 1998 to abolish the internal market. This allows approximately a decade to analyse the legacy of *Working For Patients*.

Conclusion

Does chapter 6's analysis largely confirm the hypotheses contained in the broad policy cycle described in chapter 5? Certainly, a precursor to both the Griffiths reforms and *Working For Patients* was unfavourable parliamentary evaluation, and government action was particularly prompted in the case of the former. However, it should be noted that whilst the SSC became heavily involved in major policy change, this was admittedly at the expense of the analysis of policy in any great detail (HC 702-1, 1980: vi; HC 324-1, 1981: v; HC 306-1, 1982: x). This largely confirms the arguments of chapter 3, whilst chapter 7 similarly argues that successful parliamentary attention to the issue of compensation for those infected with blood products

was accompanied by inattention to or acceptance of most other aspects of AIDS policy.

The discussion of *Working For Patients* particularly supports the view that formulation policy is broad and subject to reinterpretation. Certainly this stage of policy making was dominated by government at the expense of medical representation, but consultation and negotiation was displaced rather than replaced, when the details of the policy were discussed in great detail prior to implementation (albeit within the broad framework of formulation decisions). Further, there is plenty of evidence to suggest that the direction of policy was only determined when putting such broad aims into practice. However, again, chapters 9 and 10 go some way to qualify such arguments. As chapter 4 argues, each subsequent level of government is subject to change from above. Further, it is important not to go too far in arguing that once a policy has been passed from formulation to implementation it is automatically subject primarily to influence from implementation networks. Rather, this is dependent upon the importance attached to the policy by each actor and the respective means available to influence that policy at each stage. As chapters 9 and 10 discuss, the scale of the longer term effects of *Working For Patients* are surprising.

CHAPTER 7 - HIV/ AIDS POLICY FORMULATION:
Policy Networks and Issue Attention Cycles
Introduction

Chapter 5 introduced the notion of policies "breaking out" from policy communities or networks, and discussed the idea that policy networks analysis has come under threat from the existence of "chaotic" or "episodic" phases of policy making (Richardson *et al*, 1993; Judge, 1993). Over time, the constitution of specific networks often changes, reflecting the effects of external pressure and the breaking out of issues to a wider and more political arena. At such times, external influences such as public opinion, media reports and parliamentary pressure appear to dictate the timing and content of public policies. As chapter 5 discusses, the policy style appears less chaotic if examined alongside wider considerations of the policy process. However, the present chapter goes one step further by arguing the contrary conclusion - that in the case of AIDS policy these wider concerns were actually *prompted* by the formulation network. Thus, the usual rules do not apply.

External influences *appear* to dictate public policy, but result largely from prior network activities. Such attention directly followed a governmental public education campaign which sought to highlight the issue. The ensuing public attention and apparent pressure for change was thus not responsible for that change. Rather, the campaign prompted much of the attention and the resultant timing and content of AIDS policy owes more to its network formulation beforehand. The network thus *appears* to be far more open than it is in practice. To demonstrate this, chapter 7 examines these levels of external attention, using Down's notion of "issue attention cycles" to highlight the concentrated yet infrequent and non-durable levels of concern. This allows us to examine the extent to which attention affects public policy, bearing in mind the direction of causation. That is, did the acute levels of attention *prompt* or *follow* governmental activity?

However, the nature or constitution of the British AIDS policy network <u>has</u> changed over time, suggesting that the requirements of insulation,

consistency of consultation, a consistent decision making centre and therefore incremental policy making have not been met. It is also apparent that in notable cases, members did not follow the usual "rules of the game" - a deviation from the "normal policy style". If external factors do not explain these changes, then what does? The issue of AIDS suggests that apparent "chaotic" periods of policy making are exaggerated by a focus on policy styles which took place when the issue was new and uncertainty caused instability. Apparent chaotic periods of policy making and network change can be confused with the origins and developments, or the pre- and post-ministerial legitimisation periods of those networks. Much of the confusion in this case rests in the use of the term "policy community" by Berridge (1996) within the AIDS literature to describe a relatively open and dynamic early local response which does not accord with the use of the term within the networks literature.

Finally, this chapter shows the extent to which network changes are mediated by networks themselves (Maloney and Richardson, 1995), as well as the role of the networks in influencing and even causing the sources of external pressure. That is, whilst policy networks operate most effectively when insulated from public, media and parliamentary attention, one cannot assume that this attention is necessarily detrimental to the network's interests. Rather, in some cases, it may be a direct result of the network's strategy. Thus, periods of apparent "episodic" policy making may not necessarily reflect periods of network instability or a "chaotic" process of policy making in which periods of politicisation of an issue disrupt the "normal" policy style. This is best demonstrated by dividing AIDS policy into 3 distinct periods. In the first, the degree of uncertainty and the temporary status of network relations suggests that a stable policy network was not formed and did not exist. The second followed a period of issue saliency caused by a previous collaboration, and hence still a stable network of relations did not exist, nor was envisaged. However, by the third stage, a period of "normalisation" followed in which the policy style reverted to reflect the existing balance of power within the Department of Health and the ministerial legitimisation of the consultation arrangements. Thus, out of

"chaos" comes "order". Further, whilst stable relations were not apparent throughout the whole period, a core insider network of officials acted to control and minimise policy change.

Is There an "Issue Attention Cycle" in HIV/ AIDS?

Downs (1972: 38) describes the cyclical nature of public attention to domestic political issues, arguing that it, "rarely remains sharply focussed ...even if it involves a continuing problem of crucial importance". There are other pressing domestic problems which "compete" for attention, since news is "consumed" as entertainment. Problems will thus not receive significant media attention unless exciting, and this excitement will be inversely proportional to the extent of media coverage. Therefore, public and media attention to an issue will at first peak and then slump, *irrespective of the continuing effects of the problem.* Downs divides the cycle into 5 stages:

> *(1) The pre-problem stage ... some highly undesirable social condition exists but has not yet captured much public attention ... some experts or interest groups may already be alarmed ...*
> *(2) Alarmed discovery and euphoric enthusiasm ... the public suddenly becomes aware of and alarmed about the evils of a particular problem ... accompanied by euphoric enthusiasm about society's ability to ... 'do something effective' within a relatively short time ...*
> *(3) Realizing the cost of significant progress ... gradually spreading realization that the cost of 'solving the problem' is very high ...*
> *(4) Gradual decline of intense public interest ... people realise how difficult and how costly ... a solution to a problem would be, three reactions set in ... discouraged ... threatened ... bored ... by this time, some other issue is usually entering Stage Two; so it exerts a more novel and thus more powerful claim upon public attention.*

> *(5) The post-problem stage ... an issue that has been replaced at the center of public concern moves into a prolonged limbo ... of lesser attention or spasmodic recurrences of interest* (Downs, 1970: 39-40; Hogwood, 1993: 1-2).

Whilst, as Hogwood (1993) argues, this cycle is not relevant to most policy areas, AIDS does satisfy Downs' broad criteria. First, a minority of the public is affected. Therefore, most need not be constantly reminded of the problem. A small minority of the population is directly affected, with under 22, 000 cases of HIV in the UK diagnosed from 1985-1995 (Berridge, 1996: 340). Further, the perception of risk may be relatively small for the majority. As Kitzinger and Miller (1992: 32) argue, early conceptions of those at risk were couched in terms of the 4 Hs - homosexuals, heroin addicts, haemophiliacs and Haitians, the latter category largely reflecting a widespread assumption that AIDS developed somewhere "over there", in Haiti and "black Africa" (1992: 33). Further, in the first Gallup poll (March 1985), those most at risk were perceived to be homosexuals (66%) and blood doners/ recipients (24%), with 30% believing that AIDS was spread through homosexual activities, rather than sexual intercourse in general (37%). Further, the risk from sharing intravenous needles was recognised by 91% (although only by 2% without the prompt). Those perceived to be relatively immune from HIV were women. As Treichler (1988) argues, women outwith the "risk groups" were, "almost invisible", or discussed as "incompetent" transmitters of HIV - although an interesting exception is lesbian women. Presumably because most respondents did not differentiate between male and female homosexuality, 60% of those polled by *British Social Attitudes* saw lesbians as "greatly" or "quite a lot" at risk, even though expert opinion puts their lifestyle in the "low risk" category (Brook, 1988: 75).

Opinion poll evidence does suggest that some beliefs have changed. Since the screening of blood for infection and the discouragement of "at risk" donors, haemophiliacs rarely feature in questionnaires. In the

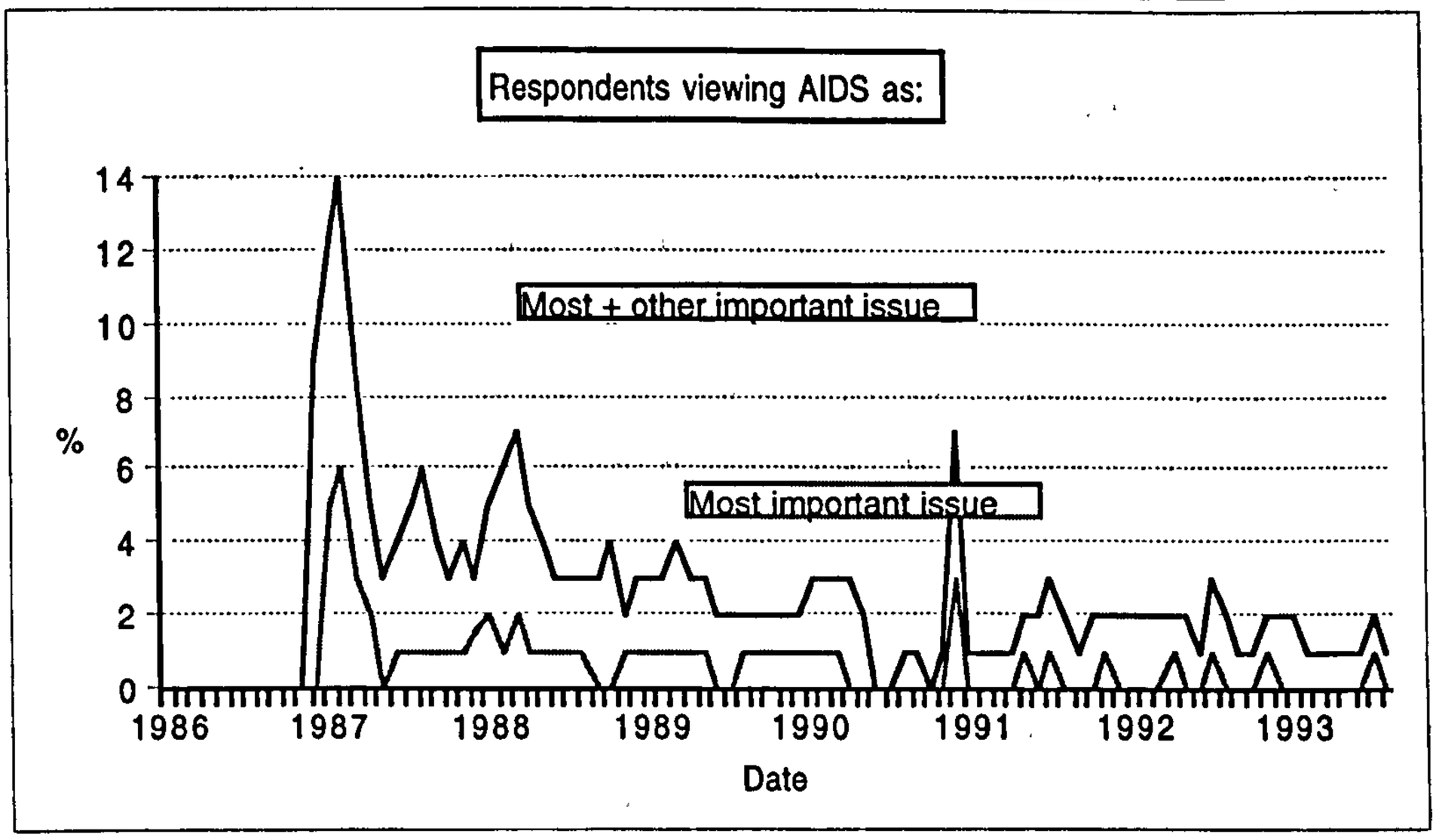
opposite direction, in the most recent survey in the Gallup Political Index (November 1990), 78% of respondents believed that AIDS was either a very or somewhat serious risk to women. However, the stigma attached to gay men (and heroin addicts) has stuck, even if it has declined. In the same survey, 37% (from 45% in July 1987) still agreed that the Government should introduce laws to restrict homosexual practice to tackle the problem of AIDS. This stigma attached to "risk groups" suggests that most feel relatively safe, with 76% of respondents feeling they, "Have no risk of getting AIDS" (and 86% feeling they did not need to change their behaviour).

Second, the problem is, "generated by social arrangements which provide benefits to a majority or powerful minority of the population", at the very least in terms of favourable tax levels through inaction (Downs, 1972: 40-2; Hogwood, 1993). Further, tackling the problem requires, "fundamental changes in social institutions and behaviour", which may threaten important groups. This may include the changing language of health education, or even the problem of direct intervention.

Finally, the problem is not intrinsically exciting to the public at large. Therefore, sustained media attention will, "soon bore a majority of the public", and when this is realised, the media will act accordingly. A problem must be exciting to maintain public interest because news is "consumed ... largely as a form of entertainment" (Downs, 1972: 40-2). The stigma or association attached to groups considered as high risk, such as gay men and heroin addicts therefore suggests that the topic may not even be *appetising* to a general public, far less exciting.

So, it is possible to discern a cyclical effect in public attention to HIV and AIDS from data derived from MORI's monthly British *Public Opinion Newsletter.* Each month, the following two questions are asked: (a) "What would you say is the most important issue facing Britain today?"; and (b) "What do you see as other important issues facing Britain today?".

FIGURE 7.1 - THE AIDS ISSUE ATTENTION CYCLE[1]



As figure 7.1 shows, there is an issue attention cycle in terms of the importance attached to the issue of AIDS over time. The period up to December 1986 represents the, "pre-problem stage", in which "some highly undesirable social condition exists but has not yet captured much public attention, even though some experts or interest groups may already be alarmed by it". Group and government activity did precede peaks in public attention - the Terrence Higgins Trust was formed in 1983, an Expert Advisory Group on AIDS met in January 1985, and the DHSS set up an internal AIDS unit at the end of this year.

Second, the rise in interest from December 1986 until a peak of attention in February 1987 represents stage 2 "alarmed discovery", in which, "the public suddenly becomes aware of and alarmed about ... a particular problem". As Michael Meacher MP argued , "In the past few months, as a nation we have gone from hardly talking about AIDS at all to scarcely talking about anything else" (*Hansard*, 21.11.86: vol 105, c808). Thus in February 1987, 6% of respondents saw AIDS as the most important contemporary issue, whilst 14% saw it as one of the most important. Further, the timing is not

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1 The sharp rise in response is genuine, since the questions relied on unprompted answers from respondents. A prompt was included after 1986. Since August 1993, (a) has had no significant response and (b) has remained at 1%.

surprising[2], considering that it coincided with intense government advertising, extensive editorial coverage and "insatiable" reporting of the campaign, when the most respected predictions suggested that the incidence of HIV would, "continue to grow exponentially" (Wellings and Wadsworth, 1990: 109). It was, as they argue:

> *An intensive publicly-funded campaign, unprecedented in the field of health education and designed to bring AIDS to the forefront of the public's consciousness.*

The campaign ran from December 1986 to February 1987 with the theme, "Don't die of ignorance", using the national press, then television advertisements, posters and leaflets (DHSS, 1987: 7; Greenaway *et al*, 1992: 74). Indeed, the surge in interest immediately followed the distribution by the DHSS of information leaflets on AIDS to all households in January 1987. Further, recall of the advertisements was amongst the highest for, "any social persuasion advertising campaign in Britain", and the campaign achieved its objectives of increasing knowledge and influencing the, "climate of opinion as a basis of behaviour modification" (DHSS, 1987: 15-6). However, official hype cannot account for all the concern or attention. Rather, predictions on the future incidence of AIDS, and the panicky beliefs of respondents as to the scale of the problem in the future surely fuelled this concern. For example, 60% of those polled by *British Social Attitudes* believed in 1987 that, "Within the next five years AIDS will cause more deaths in Britain than any other single disease" (Brook, 1988: 76).

Third, the levels of attention were not sustained for long and stages 3-5 of the issue attention cycle are represented from 1987. Thus, due to the realization of the costs of "significant progress" (including the cost of drugs), the downplaying of the problem within government, the government's response itself, and media debate undermining the belief in the probability of HIV affecting the whole population, there was a decline of interest, bar

2 Except that no significant levels of concern were recorded after the first campaign in March 1986.

some "spasmodic recurrences". Further, these smaller peaks of attention can be attributed to the dwindling effects of successive governmental campaigns and their associated coverage[3]. Thus:

(1) the upsurge of attention in March '88 followed the DHSS's anti-injecting message and the HEA campaign with the theme, "You know the risks; the decision is yours";
(2) the smaller surges of interest in October 1988 and March 1989 followed campaigns in the Summer of 1988 directed at holidaymakers, and in the national press from December 1988 to March 1989 with the theme, "You're as safe as you want to be";
(3) a small upturn from the end of 1989 to the beginning of 1990 followed the HEA "'Experts' campaign", HEA advertisements from December to March targeting young people, and newspaper advertisements and local initiatives on December 1, 1989 to commemorate World AIDS Day;
(4) the peak in December 1990 again follows the coverage of World AIDS Day, and two HEA campaigns on "Personal testimony" and "Condom Normalisation"; and
(5) the remaining two smaller peaks in mid 1991 and 1992 coincide with phase 2 of the "Personal testimony" and "Condom Normalisation" campaigns (Berridge, 1996: 193-6; Greenaway *et al*, 1992: 74).

However, there may be exceptions since (4) coincided with the government settlement of the haemophilia compensation case (see below) and (5) may reflect media coverage of the annual international conferences in June and July, news of the testing of Retrovir in 1991, and two news stories in 1992: of the French AIDS trials, and the case of a Birmingham man thought to be knowingly infecting women.

Since this final peak, AIDS has not commanded significant concern and has not featured in the published results of MORI polls since June 1991. Further, since August 1993, AIDS has never received over 1% for question

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3 With the exception of the August 1987 public debates on testing of patients without consent. This was exaggerated by the lack of attention beforehand due to the election campaign April to June.

(b). Similarly, the *British Social Attitudes* survey of 1989 reflects a, "calmer mood ... perhaps even to the point of near-complacency" (Wellings and Wadsworth, 1990: 109). So, it is possible to identify an issue attention cycle in terms of public concern about AIDS. However, the question remains as to the importance of these fluctuations of concern in terms of policy making. Acute levels of concern may encourage a government to do something, but such broad and uncertain concerns do not provide detailed instructions and are secondary sources on which governments draw when deciding how and when to act.

Additionally, there is strong evidence to suggest that government action sparked these levels of concern. Indeed, local government, interest group and central government activity was apparent at least 4 years before AIDS appeared as a major issue of concern within public opinion polls. Therefore, it is important to remember that: (a) acute levels of concern may spark government action, but do not necessarily guide that action; (b) governmental responses to a policy problem may precede and cause, rather than reflect and follow, acute public attention or concern; and, (c) therefore, other sources of advice and information, particularly interest group activity, are more likely to influence governmental action (see below).

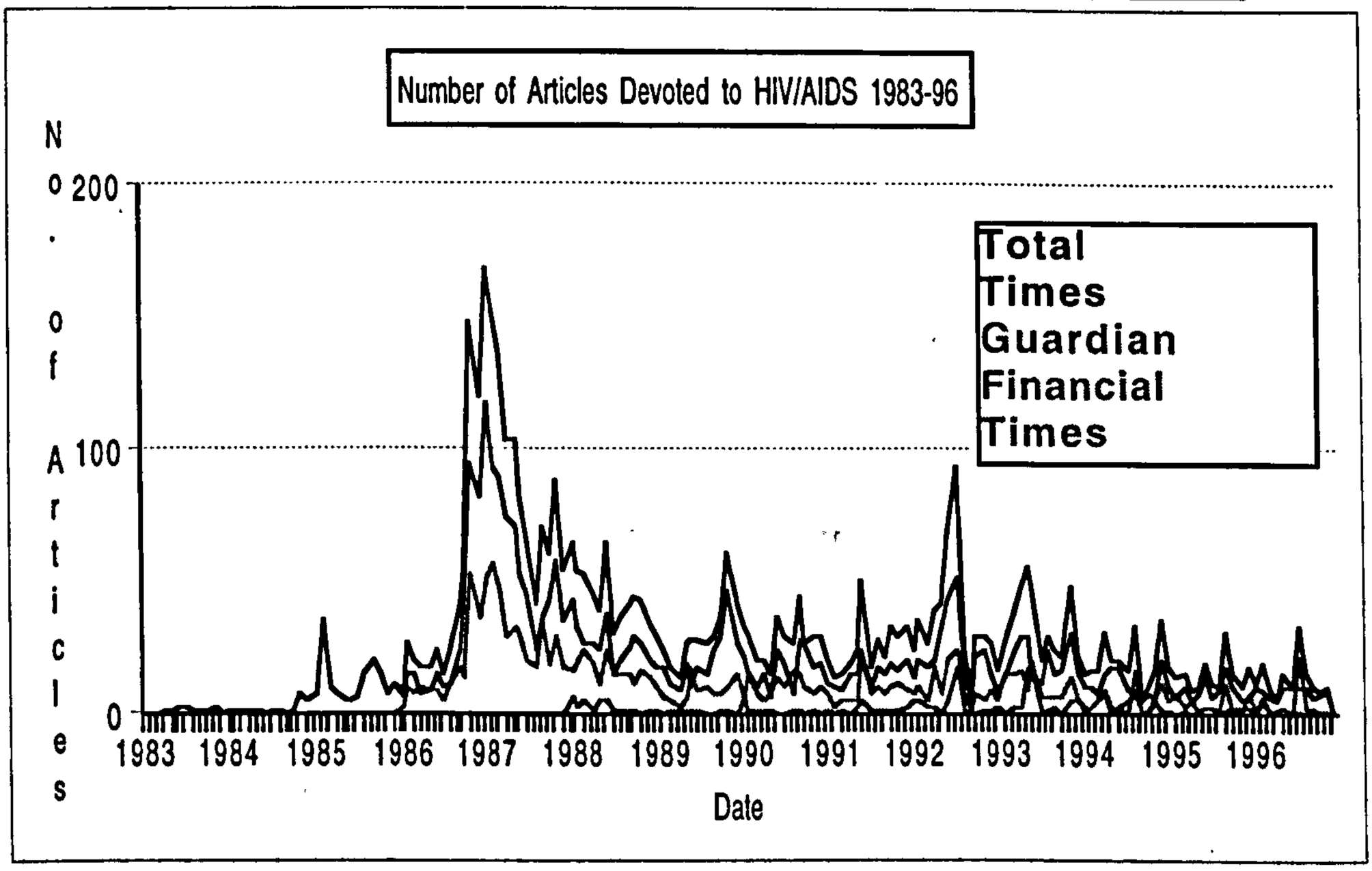
Further, public interest seems to have waned *despite* the efforts of health education to the contrary, with figure 7.1 ending at the same time as the last significant HEA campaign (see Berridge, 1996: 196). This leaves the policy effects of such a cycle in some doubt. Rather, the importance of the issue attention cycle is in the assessment of the success of the network's campaign, especially since the basic themes of successive campaigns often challenged media and public opinion. Thus, it is safe to argue that such external pressure did not damage or alter the existence and activities of the AIDS policy network. Rather, the levels of politicisation and attention to the activities of this network and AIDS policies in general *reflected* the strategy of the network itself. Since the policy of the AIDS network was to initiate an intensive publicly-funded campaign, the subsequent levels of interest in the subject would not undermine the operations of that network,

since policy community insulation was not required.

Is There a Media Issue-Attention-Cycle?

Figure 2 shows a discernible cyclical effect in terms of the number of newspaper articles devoted to the issue of HIV or AIDS since 1983:

FIGURE 7.2 - THE (PRINT) MEDIA ATTENTION CYCLE[4]



Newspaper attention is maintained for a greater period than in figure 7.1, and since figures 7.1 and 7.2 are remarkably similar, the quantity of media coverage is likely to be responsible for the levels of public attention. In turn, the bulk of newspaper coverage follows from governmental activity, since there is a massive increase in the total number of AIDS articles directly after the government's first major educational campaign. The variable influence of newspaper coverage therefore requires further attention.

Contrary to public concern, media attention did precede much of government policy on AIDS and acted in some ways to prompt

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4 From the Times, Guardian and Financial Times newspaper indexes. These are the only bound indexes available over the full period. For a chronologically restricted analysis of tabloids, see Beharrel (1993). The Guardian Index does not begin until 1986, while the lateness of AIDS reporting in the FT reflects a change in emphasis of the newspaper rather than the newsworthiness of the issue.

governmental activity. Whilst not involved in the formulation of policy itself, the media as well as parliamentary and interest group attention added to growing concern over a possible "backlash" as a result of government inactivity. As Strong and Berridge (1990: 247) argue, newspaper coverage acted to generate, "a growing sense of crisis", and focus on issues, "which ministers and their advisors had to deal". Further, in such a period of uncertainty, media sources provided an informative role not only to the public, but also to ministers who in notable cases acted directly as a result of some reports (1990: 247). It was also a favoured route by groups attempting to highlight the issue.

The bulk of the limited coverage in 1983 was directed at the reluctance of the medical profession to treat AIDS patients and the risks associated with blood products. Indeed, a story in the *Mail on Sunday* which reported the infection of two haemophiliacs after routine transfusions sparked off political and particular parliamentary interest in this issue (Berridge, 1996: 40). By 1984, there was greater emphasis on increasing reports of infection and sensationalism in the reporting of links to gay men and Africa. As Beharrel (1993: 214) argues, the subsequent education campaigns must be seen in part as a belated attempt to challenge established prejudices[5] . By 1985, there was a great leap in newspaper coverage which was mostly associated with human interest cases such as an infected Chaplain who worked in Chelmsford prison in February, and the detainment of a hospital patient in September. However, by the end of 1986 most newspaper coverage was associated with the government's advertising campaigns directly or with the agenda these set. Thus, if 1983-86 marked a period of media led concern, then subsequent years marked the regaining of the initiative by government.

[5] In turn, this may be indicative of the turnover of those responsible for government education messages. For example between 1983-5 all the advice the DHSS was giving out concerned "risk groups" both when discussing blood donations and when issuing guidelines for doctors ("look out for the symptoms in homosexual men, drug users, those with links to Central Africa, and female partners of bisexual men", etc - DHSS, 1985a). This changed when gay representation was more prominent on the education committees. Thus, the government both caused and challenged the risk-group approach.

This control of the agenda is most apparent in the subsequent cooperation which was granted by major television companies. As Norman Fowler, Secretary of State for Social Services, announced on the first full debate in the House on AIDS, he himself conducted negotiations with the chairs of the IBA and BBC about their role in the broadcasting of the campaign, securing their full cooperation in, "public service broadcasting" (Hansard, 21.11.86: vol 105, c802). Such was the cooperation that "AIDS Week" at the end of February 1987, "saw nineteen hours of 'public service' broadcasting across the channels devoted entirely to AIDS" (Berridge, 1996: 131) with broadcasters virtually giving up their editorial rights and, "more or less acting as mouthpieces for the government" (Strong and Berridge, 1990: 249).

Fowler also announced that the government had similar talks with the Newspaper Society and the Newspaper Publishers Association, and congratulated some newspapers for their factual articles. However, as Beharrel (1993: 211) argues, such reporting is not uniform, and "alternative" perspectives are often drawn upon by journalists, treating health education as propaganda, and favouring the targeting of "high risk groups" not only in terms of health education, but also screening and more repressive measures. Thus, some tabloid and broadsheet accounts continuously contested the view that people outside these groups were in danger, "often issuing hefty broadsides against the Government campaign" (Wellings and Wadsworth, 1990: 114).

So, the early history of newspaper reporting of AIDS marked a, "classic period of 'gay plague' presentation" (Berridge, 1992a: 16), which established , "an agenda of prejudice and ignorance which the education campaigns have had to confront" (Beharrel, 1993: 214). Whilst such "alternative" accounts are still pursued, the education campaigns were in most part successful, and by 1987 most media accounts either reported the government's campaign or drew upon the "dominant" perspective.

Alternative accounts had little apparent effect on public knowledge (Wellings and Wadsworth, 1990: 114-5). Indeed, in the period of greatest government activity and acute attention (1986-90), the "orthodox" campaigns were so successful they were in a sense *too* effective, with the dropping of the gay plague angle occurring, "almost at the expense of dropping AIDS and gays coverage altogether" (Berridge, 1992a: 17)[6].

Sporadic smaller peaks of attention reflected the dwindling amount of new angles, including the compensation trials in Britain and France, a Birmingham man knowingly infecting women (June 1992), an Irish woman likewise with men (September 1995), World AIDS days in December and annual international conferences mid summer, and the rocky progress of AZT trials (August 1993 and 1994).

Is There a Parliamentary Issue Attention Cycle?

Figure 7.3 shows a cyclical effect in terms of the number of parliamentary questions directed at the issue of HIV or AIDS since 1983, listed in Hansard's sessional index covering approximately two weeks of a parliamentary session. However, the coverage and dates vary, so a strict chronological reading is difficult. Still, the results do suggest the following conclusions. First, in contrast to figure 7.1, the peak of attention at the beginning of 1988 (31 questions) was preceded by 4 years of increasing interest. Nine adjournment debates and the passing of the AIDS Control Act 1987 preceded this peak (with 9 following). This reflects the fact that some MPs have been active in tracking and influencing government policy in this issue since the onset of government activity itself. Second, the decline in attention has been less marked, with as many as 6 questions still asked in one volume in May 1996, and sporadic peaks of attention since 1988 suggesting that the issue does not solely depend on government campaigns to maintain parliamentary interest. Constituency and group pressures may thus be apparent. Third, however, the bulk of parliamentary

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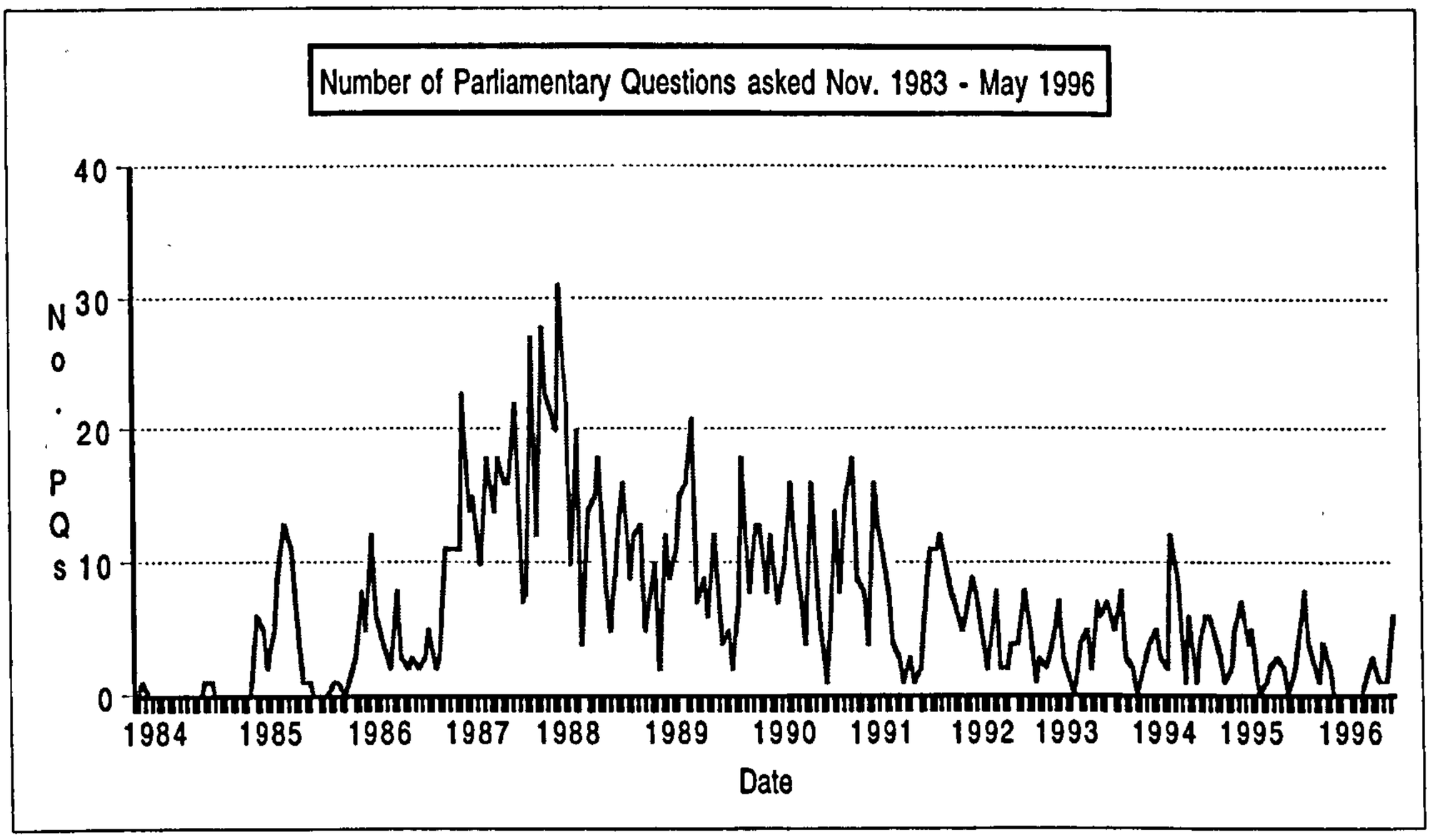
6 Leading almost a decade later to attempts promote the "regaying" of AIDS by gay campaigners attempting to ensure more funds and support for gay projects as well as the "anti-AIDS" alliance, questioning the government's entire approach (Simon Garfield, Guardian, 18.7.96; Berridge, 1996).

attention has followed successive government campaigns, with much attention a reaction to government activity itself and a marked decline in such interest after the "professionalisation" of the policy network.

FIGURE 7.3 -THE PARLIAMENTARY ISSUE ATTENTION CYCLE[7]



Thus, with notable exceptions, most parliamentary attention can be explained as a response to, rather than a cause of, network activity (Day and Klein, 1989: 352). The bulk of attention followed a period of politicisation of the issue of AIDS as a direct result of a network strategy to highlight the issue to ensure public knowledge of AIDS. Thus, the sustained and intense periods of parliamentary attention do not undermine the utility of networks analysis since in this case the creation of an issue

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7 (1) Early classifications may not have picked up on HIV/ AIDS. For example, the first question asked on the link between blood donation and AIDS (vol48, 11.11.83, c328w) was listed under blood, not AIDS. Others may have been missed. Additionally, some may broach the subject indirectly. A question on the control of arrangements for the donation of blood was asked as far back as 1982 (vol 21, 6.4.82, c295w). (2) These figures do not differentiate between a 3 line written answer and a 3 page debate, or between one question or a series of questions on the same subject by one or more MPs (although most listings do refer to short, written answers). (3) The figures also include questions which appear under the heading of HIV infection, introduced as a category in 1988/9. So some duplications or some listings overlooked may be a consequence of the styles of classification in Hansard. (5) Since May 1996, the index classifications have become broader, and both HIV and AIDS are no longer listed, even though there is still parliamentary interest. It is thus a, "rough and ready indicator" (Day and Klein, 1989: 352).

network did not undermine the strategy and operations of the core network itself. This is not to discount Parliament altogether, but to stress that its importance was to reinforce the "liberal consensus" which had developed within the network. Certainly, the SSC's report largely mirrored government policy and chose not to raise controversial issues like haemophiliac compensation (Berridge, 1996: 148). Further, this may be down to the consistency of advice and clientele, since the Committee's specialist staff shared the same background as those within the formulation network (Fox *et al* , 1989: 97) and the report was based on evidence from a clientele similar to that of government.

However, some exceptions do apply. First, a significant amount of parliamentary attention did precede the campaign, and Parliament has been active in this area from the onset. This, combined with group and media attention, contributed to the timing and the need for a concerted and significant policy stance to avoid a "backlash", or criticism of no significant government action. Second, the overall picture obscures Parliament's specialist or focussed influence and the issue of blood donation and haemophilia was a notable exception. As Berridge (1996: 37) notes, the, "possible contamination of the blood supply" and the, "particular danger to the haemophiliac population" was the first issue to arise on the AIDS agenda and this was well covered by the print media in 1983-4. This issue dominated the parliamentary AIDS agenda, as well as commanding sporadic, or even episodic, interest on a wider platform due in great part to that parliamentary interest and pressure.

Part of the distinctiveness of this issue stems from the distinctiveness of the haemophilia "lobby". As Berridge (1996: 233) argues, haemophiliacs had no "collective identity" comparable with "metropolitan-based gay organisations". The Haemophilia Society was not primarily a pressure group as such and, "AIDS was never, even through subsequent events, its only or indeed primary focus" (Berridge,1996: 44-5). Thus, it was never destined to play a key part in the AIDS policy network. It did, however, have government and parliamentary connections, whilst it followed the "rules of

the game" to ensure civil service accommodation - it was relatively discreet in its operations, presented modest claims, and did not criticise negotiated outcomes when it was clear that these were unacceptable (see below). Haemophiliacs also had the advantage of being regarded as innocent victims, and so the main beneficiaries of parliamentary and media sympathy (Berridge, 1996: 233; Kitzinger, 1993: 276). Further, as in chapter 6, parliamentary influence in this case was based on accountability - or the blocking of the devolution of NHS responsibility which was inconsistent with the parliamentary requirement for ministers to be accountable to Parliament for every decision taken by the DHSS.

Parliament had long been interested in Britain's lack of self-sufficiency in the provision of blood products, with John Marshall MP (*Hansard*, 15.12.90: vol 177, c1029) blaming the government for not keeping its promise - in 1975 - to achieve UK self sufficiency in the provision of blood products. Concern surrounding Britain's lack of self-sufficiency came to a head when evidence arose about possibly infected imported Factor VIII, with half of all the questions asked in the 1985-6 parliamentary session dealing with blood supplies (Berridge, 1996: 40). The first question on the subject came from Gwyneth Dunwoody MP (*Hansard*, 11.7.83: vol.45, c275w) who asked how many people had died from AIDS in the UK, and how many were haemophiliacs, with the reply revealing 5 male cases of which none were haemophiliacs. A similar line on the uncertain risk to haemophiliacs was maintained by Kenneth Clarke, Minister of State for Health, who replied to Edwina Currie MP's question on the current advice to hospitals on the use of imported Factor VIII:

> *There is no conclusive evidence that acquired immune deficiency syndrome is transmitted by blood products . The use of factor VIII concentrates is confined almost exclusively to designated haemophilia centres whose directors and staff are experts in this field* (*Hansard*, 11.11.83: vol.48, c328w).

Thus, at the time there was no government policy on the use of possibly infected blood products, with ministers keen to play down the risk and continue devolving policy to experts. AIDS was a medical, not governmental, problem. This was still the confirmed policy in 1984, when Clarke responded to MP Alfred Morris' question on the then current treatments available for treating AIDS: "treatment and therapy for a patient with AIDS is a matter of clinical judgement" (*Hansard*, 14.5.84: vol.60, c74w).

By 1985, this position had changed, with Kenneth Clarke reporting that 3 recipients of blood donations had developed AIDS in 1984, and that the government was considering applications for heat treatment licenses (*Hansard*, 4.2.85: vol.72, c450-1w). Two weeks later, Clarke announced the setting up of the expert advisory group, and discussed two main tenets of early government policy: to, "dissuade persons in the AIDS high-risk groups from donating blood" and to develop and coordinate the evaluation work for blood donation tests (*Hansard*, 20.2.85: vol 73, c498-500w). However, ministers still maintained that AIDS was a local problem. For example, in February John Mackay, Scottish Minister of Health, argued that, "existing resources should enable the appropriate authorities to deal adequately with this disease" (*Hansard*, 25.2.85: vol74, c42w), and the only government action was to ask regional health authorities to set aside the funding from existing budgets . Further, when extra money (£500 million in 1985-6) *was* made available, (presumably after pressure from RHAs since the announcement came a month later), Clarke still argued that it was up to individual health authorities to, "decide the allocation of funds in this area in the light of local needs and circumstances" (*Hansard*, 15.3.85: vol.75, c322-3w).

December 1985 thus marked a watershed in dealing with parliamentary questions on AIDS, since this was the first time that Norman Fowler himself answered questions in the House. Only then did Fowler signal the government's intention to centralise AIDS policy, with an extra £6.3 million allocated, of which £2.5 million was to be spent on advertising (*Hansard*,

2.12.85: vol. 88, c1-2w). The changing emphasis can be seen in part as a ministerial response to ensure parliamentary accountability, in a time when the government sought to avoid a backlash of criticism over inactivity.

There then ensued a period of parliamentary activity following the government's agenda on the promotion of AIDS awareness. However, still a significant amount of parliamentary questioning revolved around HIV infection through contaminated blood products, and this surfaced a number of times between 1987-1990. As well as constant questioning in the House, by March 1987 Tony Newton, the Minister for Health, noted that the DHSS had received 15 letters from MPs on compensation for haemophiliacs. Each question was met with the government line which was that no state compensation scheme existed or would be set up, since it was for the courts to deliberate on aspects of negligence.

The matter first came to a head in November 1987, when the government agreed to make a one-off £10 million donation to infected haemophiliacs through the newly established MacFarlane Trust (administered by the Haemophilia Society). The government had previously accepted the figure of approximately 1200 haemophiliacs infected before 1985 (*Hansard*, 27.10.87: vol.121, c159-60), and this was followed by representations from the Society to the government as well as to Parliament. Pressure from Parliament resulted in the announcement based on the "powerful case" from the Society that, even though there could be no question of "compensation", "the position of haemophiliacs is wholly exceptional and should be treated as such" (Tony Newton, *Hansard*, 16.11.87: vol.123, c767). As Berridge (1996: 233) notes, the compensation issue was a, "potentially explosive one", since its provision would set a dangerous precedent for other claims on the grounds of medical negligence. Thus, haemophiliacs were, "an exceptional and specific group who merited exceptional treatment" (Virginia Bottomley in *Hansard*, 20.12.91: vol 210, c626), and questions of negligence were a matter to be determined in the courts, since, "there is no state scheme of no-fault compensation for those injured by medical treatment" (Roger Freeman, Parliamentary Under

Secretary of State for Health, *Hansard*, 13.11.89: vol 160, c158).

Whilst a self-congratulatory period followed (*Hansard*, 16.11.87: vol. 123, c769), this was by no means the end of the matter, with Robin Cook MP (whilst welcoming the policy reversal) arguing that the sum (£8000 per head) was not enough, and Frank Field MP expressing surprise that the Haemophilia Society had accepted the amount [as Berridge (1996: 233) argues, there was no alternative but to accept, "for fear of bad publicity"]. Thus, parliamentary pressure continued for an increase in compensation, especially since by 1989 less than £3 million had been paid out due to the means tested nature of the payments. This resulted in a further injection of money into the MacFarlane Trust after an Adjournment Debate on 13.11.1989 (*Hansard*, vol 160 c153-60) which demonstrated a large all-party support, as well as an all-party coalition deputation to Downing Street that same month, and a series of articles appearing in the *Sunday Times* (Berridge, 1996: 234). Thus, on the 23rd of November, Clarke announced an additional £19 million ex-gratia payment, enabling £20, 000 payments to be made to each infected haemophiliac or their surviving family (*Hansard*, 23.11.89: vol 160, c12w). Still, this was not compensation:

> *It recognised the wholly exceptional circumstances which haemophiliacs and their families face, that their insurance, employment and mortgage prospects were already affected by their serious disability, and the hereditary nature of haemophilia can mean more than one member of a family may be affected ... Compensation is a matter for the courts.*
>
> (Virginia Bottomley, *Hansard*, 2.3.90: vol 168, c368w)

Whilst extra funds were welcomed, Parliament's attention was then focussed on settling out-of-court the 962 compensation claims pursued by infected blood product recipients within the week of the announcement, with numerous questions and adjournment debates following, expressing a virtually unanimous call for a policy adjustment. This issue was also well

covered in the press, with the High Court Judge, the BMA and the Chief Medical Officer all calling for the same outcome. However, it was not until the end of 1990 that the matter was settled after the Court of Appeal ruled that there was a case to answer, ordering the DH to release documents previously withheld on the basis of public-interest immunity (Berridge, 1996: 235). This was followed by rumours that RHAs were prepared to settle individually and of consultants refusing to testify on behalf of the government case. This coincided with Major replacing Thatcher and Waldegrave replacing Clarke (1996: 235). Thus, William Waldegrave announced a settlement in December, with a further £42 million to the MacFarlane Trust (*Hansard,* 11.12.90: vol 182, c365w). The details were agreed by most plaintiffs (who received between £20,500 and 60,500 depending on their circumstances) by June 1991 (10.6.91: vol 192, c446w).

The only remaining issue to be resolved, then, was compensation to non-haemophiliacs infected by blood products. Again, this was a matter of conflict, with the government's position in part based on its reluctance to set a precedent for no-fault compensation. In the case of haemophiliacs this had been achieved by describing their unique circumstances, a line which had been supported by most MPs and formed the basis for that compensation. Robin Cook MP, who pointed out that this could be the only stumbling block, since the payments themselves would be relatively insignificant to those already granted (*Hansard*, 6.3.90: vol 168, c848w). This was confirmed by Sir Michael McNair-Wilson MP, who reported a governmental statement that these cases were not different in principle from other injuries through medical accident (which the government had no policy on), making the point that this was, "almost the identical defence originally submitted by the Department of Health when it first refused to pay compensation to haemophiliacs" (*Hansard*, 12.12.91: vol 200, c1014). Indeed, this led Gavin Strang MP to argue in a subsequent debate that the only difference between haemophiliac and non-haemophiliac compensation was that the former, "were organised and had a society to campaign on their behalf" (*Hansard*, 20.12.91: vol 201, c622.

Despite such protests, the government line held through such debates. However, again, the pressure did not cease and the case of non-haemophiliac compensation received continuous support in the press (especially the *Observer* - see Berridge, 1996: 235), and in Parliament, including a succession of parliamentary questions and an early-day motion with 234 signatures tabled by Gavin Strang MP and with all-party support (*Hansard*, 20.12.91: vol 201, c622). This eventually led to Waldegrave's announcement that the special provision (including identical payments) for haemophiliacs was to be extended to non-haemophiliacs. After consultation and pressure, he argued, "I have concluded that ... this group ... is also a very special case" (*Hansard*, 17.2.92: vol 207, c12-13w).

So, haemophilia and AIDS provides one example of primary parliamentary influence. This and considerations of a parliamentary contribution to a backlash demonstrates to some extent the episodic nature of AIDS policy in which such issues are considered and influenced in areas other than within policy networks in successive episodes of policy development (Judge, 1993). However, generally, the AIDS policy agenda was dominated by the AIDS policy network, since most of this external attention can be attributed to a period of acute AIDS awareness derived from the public education strategy. So, the pervasiveness of episodic policy is uncertain. Judge may argue that the breaking out of policy in such a policy area demonstrates its episodic nature. However, the question of disaggregation remains. That is, the pervasiveness of episodic policy making is more apparent if the analysis of policy areas takes place at a high degree of policy aggregation - for example health policy, trade policy, etc. However, if further disaggregation takes place, the effect is less apparent. In this case, parliamentary influence was specialised and focused on the issue of blood and compensation, to the exclusion of focussed attention on other areas. Indeed, Parliament largely legitimised the government's "harm reduction" approach. Thus, to explain the changing nature of AIDS policy networks over this period, it is necessary to seek evidence from within the networks themselves.

The Formulation Network and AIDS Policy: 3 Stages

The term "chaotic" may not be appropriate to describe policy influencing activity outwith the formulation network, but there still exists the problem of explaining the changing nature of networks over time. From 1981 to 1997/98 (the period under analysis), the AIDS policy network has apparently changed from a subsectoral policy community to a sectoral issue network, to a professionalised subsectoral network. So too has the membership of that network changed over time, with an initial focus on gay/ activist groups, low status scientists and clinicians, to a ministerial-led network, and subsequently a professionalised network dominated by biomedical and public health specialties. Two points are thus discussed in this section. First, what is the status of this discussion? Does it concern the formative phases of a new policy network, with less parallels to the chaotic policy debate which describes changes to established networks, or the extent to which policy "broke out" from the existing health policy network?

Second, the instability which is implied here is almost certainly exaggerated, since there has always existed a core network consisting of and coordinated by the Chief Medical Officer, Sir Donald Acheson, and other public health civil servants. So, whilst the status of those groups consulted have differed over time, there may not necessarily have been a consequent destabilising effect on the network. Relatedly, the changing network involvement did not cause a change in, or destabilise the path of AIDS policy. Rather, a "liberal consensus" was formed around the issue in the first stage of network development and the consequence of one strand of this policy was the politicisation of AIDS policy. However, whilst the second stage marked changing network configurations and changing ministerial involvement, this served to reinforce and legitimise, rather than alter, the policies of that initial network. Thus, a constant, core influence is suggested by the consistency of AIDS policy since the early to mid 1980s. Further, it is striking that whilst the novelty and urgency of a policy issue can force ad hoc changes to networks in a short period of time, it also took little time for the issue to become "normalised".

Following Berridge (1996), then, three main policy emphases are associated with three periods of network characteristics.

(1) 1983-86

Government and ministerial involvement in this period was limited, restricted in most part to funding and the issue of infection through blood products. Policies were aimed at health and safety at work, the issuing of leaflets by the Health Education Council and the Terrence Higgins Trust (THT), the discouragement of "high-risk groups" from donating blood, the development of screening tests, and the consideration of licenses for heat treated Factor VIII (*Hansard*, 20.2.85: c498-500). Full ministerial and governmental responsibility was not accepted until December and Norman Fowler's announcement that £6.3 million was to be spent the next year, with £2.5 for a national information campaign, an extra £2.5 million to three Thames RHAs, £270, 000 for haemophiliac reference centres, £100, 000 for training counsellors, and £750,000 to the (once threatened with closure) Public Health Laboratory Service to continue testing blood (*Hansard,* 2.12.85: 1-2). Thus, there was no significant ministerial intervention until the end of 1985. The DHSS was active to some extent in the issuing of circulars and setting up committees, but as Day and Klein (1989: 346) argue, this was, "left very much to Sir Donald Acheson and his professional colleagues".

This uncertain period also saw the formation of what Berridge (1996) terms a loose "policy community", in which gay groups and some scientists and doctors from traditionally outsider specialties were considered experts in this field and treated as such by government. However, a national policy network was not fully formed since, whilst a partnership was developed by Acheson, no group was fully established within government circles. As Berridge (1996) notes, the policy machinery did not formally exist until at least 1985 when the Expert Advisory Group on AIDS (EAGA) was set up. Indeed, testament to the nature of the arrangement is the willingness of "AIDS experts" such as activists, doctors and scientists to, "use the media to be openly critical of lack of action" (Berridge, 1992a: 20), as well as the fact

that such an outsider strategy did not particularly affect subsequent access.

The importance of "policy community" activity in this period is more through "bottom-up" responses to AIDS. As Berridge (1992b: 304) discusses, early policy expertise was built up responding locally to AIDS issues, not only in the formation of the THT, but also in terms of early treatment of AIDS patients by GPs and hospital clinicians before the issuing of national guidelines, as well as the early funding of such activities by the most affected health authorities. Subsequently, these responses and the expertise developed through such activity allowed an exchange-based relationship - of information for access to the governmental machinery, both in terms of consultation with the CMO and the involvement in advisory bodies - to develop.

What is apparent, then, is that a "policy community" as described and accepted within the policy networks literature, did not exist. Indeed, very few of the criteria, discussed by Marsh and Rhodes in Table 6.1 (chapter 6) are met by such a network. Most notably at this stage, few groups were excluded, few actors followed the "rules of the game" and accepted the outcomes of negotiations, and in any case it is unlikely that those involved in negotiations could "deliver their members", considering the levels of anxiety at the time within the health profession, as well as an uncertainty about just who the membership was with regard to THT consultation. The continuity of membership, as well as a balance of power between members is also questionable.

This network displayed an unusual degree of openness, as well as the prodigious use of media and parliamentary channels of influence to further group interests. Indeed, unusually, "community" membership in the early years may in part have stemmed from this close group-media relationship. To use a parallel Scottish example, Derek Ogg as a co-founder of Scottish AIDS Monitor (SAM) was considered an expert by a broadcaster of Scottish Television (STV) and he was able to use their subsequent relationship as a bargaining tool in negotiations with the Scottish Office. At such a sensitive

time and if the talks did not go well, he had a direct line to the media to criticise the proceedings (interview, 9.1997). This does not follow Jordan and Richardson's (1982; 1987) "standard operating procedures" of policy communities in which the proceedings of the policy community are relatively insulated from other such institutions as a result of insider group strategies, in part because the AIDS policy network differs in terms of strategy - of politicisation rather than insulation. Further, "AIDS policy" and hence AIDS policy community is difficult to define in this period, since most measures were reactive and ad hoc and not always attributable to the formulation network.

However, the development of a "liberal consensus" surrounding AIDS did enable a number of significant early policy responses and the establishment of, "definitions of the issues around AIDS which were later adopted and expanded at a political level" (Berridge, 1992b: 305). Thus, even when the network was so loosely defined, the intervention in government by Acheson ensured that its participants had primary influence. This response can be defined as: (a) a promotion of the non-gender or sexuality specific nature of the virus; on high risk lifestyles rather than groups; (b) a response to the containment of AIDS in terms of public health education and prevention rather than punitive measures such as universal testing and screening, notification, incarceration, etc.; and, (c) a focus on harm reduction not prohibition, involving in the case of drugs the promotion of needle exchanges and counselling and, in the case of sex, promotion of the use of condoms and the reduction of partners. The importance, then, of the initial policy network response was in subsequent governmental strategies (as a response to network concerns) which drew on, reinforced and legitimated these policies.

The Expert Advisory Group on AIDS (EAGA) was particularly instrumental in establishing the network line between 1985 and 1986. As Berridge (1996: 70) argues:

In the absence of alternative departmental mechanisms

> *and of any political interest, it set the tone of policy and its substantial components ... which had the authority of science and which were then difficult to overturn when political interest supervened in 1986.*

Urgency and uncertainty forced an unusual reliance and quick acceptance of the recommendations of such committees (interview, Advisory Committee on the Misuse of Drugs member, 10.97) and the EAGA managed to deflect the introduction of notification and routine testing, as well as successfully promoting the use of counselling and some protection from discrimination for infected health care workers (Berridge, 1996: 72).

So at this stage, whilst the issue received some civil service attention and the building blocks of policy were being formed, it is apparent that a stable policy community as such had not been formed. No-one involved saw their relationships as durable, consultations took place sporadically on an ad hoc basis, and the groups involved, since seeking to highlight the issue to ministers and the public, chose not to follow the normal "rules of the game" concerning the insulation of that network from external attention. All groups concerned courted public and media attention, presumably because the highlighting of the issue was far more important than ensuring influence through insulation. Additionally, there were already signs that unusually privileged gay representation was coming to an end. Such marginalisation can be partly explained in policy network, as well as more political, terms.

First, whilst many representatives of each lobby were given places within a number of advisory bodies by 1985, there was a bias in the allocation of those places, with membership of the EAGA restricted to medical and scientific representatives, leaving activist roles to be conducted through the less influential working group on AIDS and health education (Berridge, 1992b: 310). This emphasis was partly down to the changing status of the value of gay and 'scientific' expertise on AIDS in favour of the latter within government circles. As Berridge (1996: 51-3) argues, scientific advances such as the discovery of the causative virus and the HIV test reestablished

the divisions between scientific and lay expertise; divisions less apparent when knowledge was uncertain. Thus, subsequent competition for funds and access left gay representation vulnerable, since there was less to exchange.

Second, gay groups concerned with HIV and AIDS would never attain "core insider" status in Maloney *et al's* (1994) terms. Rather, their involvement within the early policy network was specialist insider status within a sub-sectoral policy network. In contrast, medical (broadly defined) involvement at this time in AIDS policy reflected the BMA's (then) core insider status. Because the BMA was regularly consulted on all things medical within the DHSS, then its involvement is no surprise, especially since the main civil servant within the AIDS network was the Chief Medical Officer.

Thus activist marginalisation should come as no surprise. Because initial government involvement was limited, specialist insiders such as gay groups were unable to develop or maintain links with civil servants at higher levels. Therefore, when the issue of AIDS did come to dominate discussions at the sectoral level of the DHSS, and Norman Fowler took an active interest, the role of gay groups was demoted from specialist to peripheral insider. This is inadvertently confirmed by Fowler himself in the first debate on AIDS in 1986. Fowler talked personally with media executives, medical personnel and even church leaders. However, he implies a less direct involvement with voluntary organisations: "my Department is, *I hope*, in very close contact with the Terrence Higgins Trust" (*Hansard*, 21.11.86: vol105, c807 - emphasis added). Links were maintained within the civil service and consultations did take place, but now at less influential levels within government, especially since the initial basis for insider status - expertise - was also being eroded.

This demonstrates to some extent that gay groups and others were a "victim of their own success". AIDS was successfully promoted as a significant policy issue which warranted attention at the highest levels. However when

AIDS was discussed at these levels, specialist groups were in no position to be granted privileged access. Rather, elite civil servants and ministers relied on established (medical) experts within the DHSS (Day and Klein, 1989), who would be consulted as a matter of course anyway, given their core insider status.

A similar consequence of the network's educational strategy is also apparent. Since no gay activist representation was granted on the EAGA, this was restricted to working groups on AIDS and health education which met 1985-86. Whilst initially a "risk-group" focus was in place with separate working groups for educating the gay community, drug users and haemophiliacs, by early 1986 a general population focus was chosen (Berridge, 1996: 75-6). Further, as Berridge (1996: 76-7) argues, actors such as Tony Whitehead of the THT successfully maintained the "liberal stance" by ensuring a public education campaign which stressed heterosexual spread to avoid the stigmatisation of "high-risk" groups. However, this successful strategy also had its drawbacks, since it provided justification for gay based representation to be marginalised to peripheral insider status. If HIV is defined as an infectious but non-discriminatory virus, then why treat gay men's representatives as anything more than one of a number of clients, as opposed to experts or privileged representatives, and why provide privileged resources to gay groups? By so defining the range of HIV infection, the reasoning behind granting insider status based on representativeness, as well as some basis of expertise, was lost.

Subsequently, the THT in many ways became an implementing resource for government, and Street (1988: 505) argues that the government has always seen it, "as a conduit into the gay community, and as an adjunct of policy implementation, not formulation". However, the THT has only been able to maintain its position through the maintenance of a non-sexuality specific approach, thus redirecting funds and attention from gay projects. The history of AIDS policy has thus thrown up at least one trade off. Any campaign to challenge the stigma attached to gay men and AIDS and stress the possibility of heterosexual spread has the unfortunate

consequence of diminishing the role of gay representation in government as well as the need for specific projects and advertising (see Simon Garfield, "The Regaying of AIDS", The Guardian, 18.7.1996).

So what conclusions can be drawn from this phase of network development? Arguably for a period the issue "broke out" of the health policy network, with an emphasis on consulting those groups and hitherto not consulted doctors who had gained their limited expertise in the field of implementation. Further, those consulted did not have to follow the "rules of the game" to ensure access, with many maintaining parallel links with various media. The insulation associated with close networks and their decision making process was not apparent.

However, this is not to say that the effect or resultant policy style was chaotic, for the following reasons. First, whilst new actors were introduced, the subsequent relationships did not replace or force out existing network relationships within the DHSS. Rather, formerly outsider groups and doctors were consulted - temporarily as it turns out - because they could offer expertise for access, and, if anything, these actors filled a void left by government actors who sought to avoid the issue. Second, it should be noted that it took very little time for the policy area to be "medicalised" within government. The network was established by the CMO, whilst the EAGA quickly asserted its authority to decide on the details on AIDS policy within government. Third, as discussed in more detail below, the lack of insulation is not surprising in the case of AIDS policy, since insulation has never been a requirement of this network. Rather, the network has appeared to be far more open with its agenda since part of its aim was to highlight AIDS as a policy problem and invite as much involvement as possible. Finally, however, it is striking that despite this strategy, the policies of the AIDS policy network as discussed above have been insulated from change. The HIV/ AIDS policy network exhibits an unusual degree of openness, whilst its harm reduction approach has been successfully "sold", defended, or insulated from change, despite the highlighting of the issue in more public arenas associated with issue

networks. The key, then, is a core decision making process which is insulated from the effects of the issue it attempts to highlight.

(2) "Issue network" 1986-88

This period was marked by increased ministerial involvement, and saw the issue of AIDS brought to public attention through a series of government campaigns. The factors which prompted such action at such a time are numerous, and there is a danger of merely providing a shopping list to choose from. Fowler (1991: 260) himself argues that he was driven by his experience of overseas trips to the WHO, the USA, Amsterdam and Berlin. Further, AIDS came at a time when Fowler had apparently achieved all his aims in the department and otherwise had relatively little to do (1991: 255-6). Parliamentary and media-based pressures for action were also clearly influential, as were gay, medical, scientific and civil service lobbies within the DHSS. Fox *et al* (1989: 96) provide other stimuli, such as evidence to suggest a potential heterosexual spread, and Fowler's opportunist drive to ensure more money for his department, whilst Berridge (1996) identifies influences such as influential Foreign Office interest on the African links to heterosexual spread, and even the Queen's discussions with Margaret Thatcher. However, the initial policy network response was most influential in this policy shift, ensuring both ministerial and public attention to AIDS.

The AIDS issue network exhibits notable differences from most other areas. Much of the networks literature (rightly) assumes that a key characteristic is insulation. The logic of sub-sectoral devolution is to guard against politicisation and hence instability, and thus ensure continuity or incrementalism by treating an issue as technical and specialised, considered by like minded experts, implementers and civil servants. Thus, the specialised and technical nature of policy allows the insulation from political action due to either political disinterest or lack of lay knowledge.

AIDS differs markedly because the policy network strategy was to engage and encourage political action. The driving force for network change came from the network itself as each participant had an interest in highlighting the

issues to a wider public, and most network strategies since this period can be characterised as attempts to counter ministerial and political disinterest. Hence the concerted use of the media and Parliament by network members and the constant lobbying within government to ensure extra funds.

Most notable was the highlighting of the issue within government. The EAGA had already stated the need for political intervention. However, the key turning point was in the autumn of 1986 when Acheson secured the support of Sir Kenneth Stowe, the Permanent Secretary of the DHSS for the urgency of a public education campaign (Berridge, 1996: 103). Stowe approached Sir Robert Armstrong, Cabinet Secretary, who persuaded an ambivalent Prime Minister to approve the necessary policy measures, including the setting up of a Cabinet subcommittee (1996: 104). Further, whilst Thatcher's involvement was minimal, it did legitimate the policies which followed (1996: 104-5).

The process of legitimation was not just restricted to the Prime Minister, since much subsequent political action drew on policies which had been formulated by the earlier policy network. Total government expenditure on AIDS rose from less than £2 million in 1986 to over £200 million in 1991 and the services this money bought were developed according to the stated policy objectives of the initial network (Berridge, 1996: 167). Arguably, the government panicked and its financial intervention was not accompanied by a great degree of scrutiny over how the money was spent. Existing local arrangements and power relations dictated the provision of services, thus continuing the "harm reduction" emphasis inherent in early local responses.

The education campaigns also lacked the moral tone of the "New Right" government, stressing the reduction of risk rather than the cessation of behaviour. Needle exchange centres, whilst subject to extreme political pressures, were at first piloted and then accepted as government policy (see chapter 8) and more punitive measures such as incarcerating sufferers, widespread testing and screening, and so on, were resisted. Indeed, Fowler consistently advocated network policies - when interviewed

by the SSC - by promoting a harm reduction philosophy in drugs policy and the evaluation of needle exchange and methadone projects by doctors, rejecting mass screening, promoting the need to improve Genito-Urinary Medicine clinics, and stating on several occasions that his answers to questions would depend on the reports of the expert advisory committees (HC 182, 1987: 394-407).

There is no doubt that this policy area was marked by ministerial involvement, with the cabinet committee meeting weekly rather than monthly at the end of 1986. However, it is easy to exaggerate that ministerial involvement, since by 1987 the AIDS Unit had a staff of 34 and most policies were developed to a great extent by civil servants and "rubber stamped" by ministers. Ministers followed a bureaucratic "respectable out" strategy which aimed to shield ministers from adverse publicity surrounding their involvement in the nitty-gritty of this issue, "whilst at the same time giving the appearance of intense involvement in, and concern for the issue" (Berridge, 1996: 123). The result was the establishment of the Health Education Authority to take responsibility for the education campaigns and the National AIDS Trust to coordinate the voluntary sector, since explicit educational messages and AIDS activism were the two most sensitive issues for ministers.

This is not to say that there was little <u>departmental</u> involvement. The continuing sensitivity of the issue meant that governmental involvement was intense and each was still heavily monitored by the DHSS. This was especially the case with the HEA which was constituted as a DHSS outpost rather than an independent body after previous problems with the policies of the old Health Education Council (see Berridge, 1996: 125). The HEA was formed because the DHSS did not trust the HEC with money for AIDS campaigns, whilst subsequent clashes between the DHSS and the HEA over the AIDS agenda resulted in the requirement that every (not just AIDS related) HEA public or press announcement was to be cleared by ministers and, in effect, the DHSS. Indeed, such was the requirement that releases were sent to the DHSS for clearance before they were sent to the HEA

director (interview, former HEA worker, 5.97).

Civil service power is thus ever present here. DHSS civil servants, and the CMO in particular, ensured that the issue of AIDS gained prominence in the first place and when it did, ensured that the policies which had been formulated previously were maintained and legitimised by governmental activity. Further, when ministerial involvement was minimised, DHSS involvement was still intense, as its control over HEA information releases exemplifies. Thus, whilst this period was marked by the existence of an issue network of activity and attention surrounding network action, the main and constant policy determinant was a core body of civil servants and insider interests which successfully maintained its position over time. Although this period was marked by the involvement of ministers reacting to wider public concerns, it was also marked by ministers legitimating network policies against more punitive and reactionary responses.

So, does the existence of an issue network surrounding the issue suggest a more chaotic style? Certainly public, media, parliamentary, ministerial and even prime ministerial attention is high at this time, and the issue of AIDS at times dominated the sectoral level of the health policy network. However, whilst there was heightened policy debate, this was relatively fleeting and had surprisingly little effect on the established harm reduction policies established before this period. Thus, we reach a contrary conclusion - that even the existence of heightened activity surrounding the activities of core networks does not undermine their operations or policies, or the insulation of such policies from change (especially since such attention formed part of the network strategy in the first place). In turn, this is based on the expert status of such core networks as well as the unwillingness of ministers to interfere in such a sensitive area. Thus, Fowler ensured funds and made some organisational changes, but it was made clear that ministerial intervention was to ensure that the matter was dealt with by delegated authorities. The enduring legacy of ministerial involvement is legitimacy of existing network policies.

(3) The Professionalised Network?

Jordan and Maloney (1997: 578-9) argue that, despite the existence of politicisation, there is always a logic in the return to a less open system:

> *As policy moves toward resolution, there is once more a narrowing in the range of participants as only those with a strong interest have the persistence to invest attention.*

Whilst we may not return to a policy community set-up, "there still remains a pay-off for policy makers in establishing stable arrangements" and "borrowing ... policy community-type features", even if stability is difficult to maintain (1997: 579). Indeed, from 1988 onwards, it is possible to discern a shift from an issue to a professionalised network, since with the exception of sporadic peaks of interest and the politicisation of some issues, public and media interest in the issue has waned and has never again reached 1987 levels. As Miller and Williams (1993: 134) argue, this decline in interest cannot be solely attributed to an issue attention cycle, since one interviewee, a BMA press officer noted that AIDS had:

> *Become less fashionable because we've stopped parading it as an issue. It's become less fashionable because the Department of Health has deliberately run it down as an issue.*

This was helped by a series of reports which revised earlier figures and predictions downwards (Berridge, 1996: 209). Thus, 1988 onwards marks a shift in policy style since, in contrast to the shift from policy "community" to issue network, there were signs that interests in the BMA and DH did attempt to reduce external interest in AIDS in order to insulate the policy network.

However, the real difference between the "policy community" of 1981-6 and the professionalised network from 1988 onwards is legitimation. As Cavanagh *et al* (1995) argue, sectoral level networks set the agenda for

the policy area, and so the power relationships within and the decisions made by sub-sectoral networks often occur within the frameworks and agenda laid down at the sectoral level. However, until 1986 and onwards this agenda had not been laid down or even legitimated at the ministerial level. Therefore, insulation and stability was unlikely since ministerial intervention at any stage would most likely alter the course of that network, even if subsequent policies were legitimised, since the move from sub-sector to sector involved a different set of consultation arrangements, dominated by the profession.

So, the policy network surrounding AIDS was arguably not fully established until it was professionalised - manifest in issues such as the rights of infected health care workers which were successfully defended by the EAGA despite widespread public fears (see Berridge, 1996: 215). Further, ministerial activity following Fowler's departure continued to advance the interests of the medically dominated AIDS policy network. For example, the introduction of anonymous screening was give the go-ahead by Kenneth Clarke, whilst David Mellor as Home Office Minister ensured police cooperation over needle exchanges (1996: 213; 222). The legitimisation of existing policies thus ensured the eventual stability of the network. It can thus be concluded that the eventual professionalisation of the AIDS policy network was a predictable conclusion to its development, since whilst relatively open and apparently chaotic periods of change occurred around the issue of AIDS from the onset, the policies of the core network were insulated from such activity.

Professionalisation Revisited

However, these final conclusions do not sit well with those of chapter 6 which questioned the existence of a network dominated by the profession in health care. Perhaps this merely suggests that the profession may dominate some subsectoral policy networks which are well insulated from the sectoral level. However, significant ministerial interventions undermine this possibility. These were made by Virginia Bottomley as Secretary of State for Health and Dr Brian Mawhinney as Minister of State which often

went against and overruled advice given by civil servants sympathetic to medical interests within the AIDS Unit (1996: 254). This resulted in: greater marginalisation of the THT which was encouraged to seek funding elsewhere; the reorganisation of the EAGA to vary its membership (1996: 255); Bottomley's intervention in 1993 to revise the guidelines on health care workers in the face of opposition from the policy network (1996: 258); Mawhinney removing the HEA's automatic funding (1996: 258); Mawhinney's more punitive line on drugs advertising and enforcement; and, the removal of the care and treatment ring-fence from AIDS funding, marking an explicit downgrading of AIDS as a policy issue (1996: 261).

So one could reasonably wonder just what it is that doctors dominate within these networks, and whether such domination always subject to ministerial contradiction. However, the harm reduction line of the initial AIDS policy network still remains. So, as chapter 6 suggests, perhaps the power of the profession may be more apparent if one distinguishes between formulation and implementation, especially since so much responsibility for HIV/ AIDS policy was devolved to health authorities. This is the focus of the remainder of this thesis.

Conclusion

At first glance the existence of issue attention cycles coinciding with government activity would appear to undermine the operations of networks since most effective networks tend to operate in relative insulation from the public. However, the governmental response to HIV/ AIDS took place years before most public concern was apparent. Further, the most intense periods of concern can be *attributed* to governmental activity in producing advertising campaigns and funding projects, which were in turn the product of deliberations between groups and government. Thus, the peak periods of public concern did not undermine the activities of policy networks, since these came as a direct consequence of a network strategy to highlight the issue of AIDS.

Similar conclusions were reached on the influence of the media and

Parliament, with the bulk of attention following government activity. However, both were responsible in some part for the impetus for the government to act. In the case of the media, press campaigns from 1983-6 heightened a sense of crisis and some ministerial involvement was a direct response to tabloid stories. In the case of Parliament, there is some evidence that constant parliamentary questioning in the early years of AIDS forced the issue up the government agenda. In addition, the issue of compensation to haemophiliacs demonstrates that parliamentary influence is manifest in select areas where a degree of parliamentary specialisation allows a concentrated focus on one issue to the detriment of others. Thus, concentrated parliamentary attention on the issue of compensation to those infected through blood products, in conjunction with notable media coverage, seemed to force a series of governmental U-turns, first on compensation to haemophiliacs as a special case, and then to infected non-haemophiliacs. The existence of an episodic style of policy making is therefore apparent in this case. However, on the whole, parliamentary attention followed governmental action and most parliamentary activity reinforced the dominant or consensus approach and legitimated governmental action.

Thus, no "external" factor explains the timing or content of the network campaigns to any great degree. AIDS policy is less chaotic than it first appears and episodic policy making is restricted to "sub-issues", since the bulk of government activity over this period reflected a network strategy based on and reinforcing a pre-existing consensus, legitimated by government and Parliament and implemented often against signals from public and media opinion. It could be reasonably assumed that the operations of a policy network are undermined and hence the pervasiveness of policy networks analysis is undermined, if an issue is highlighted, since insulation from external attention is the key to the successful operations of such networks. However, in the case of AIDS policy making this is not the case since the lack of insulation resulted directly from a policy network driven, public education, campaign.

So, policy was not "chaotic" in this sense, but what about in terms of the changing nature of the formulation network itself? Again the answer is no, since a constant core decision making process and a policy line was maintained throughout much of the apparent turmoil in policy styles. The apparent chaotic style of policy making over time does not undermine the utility of policy networks analysis, since the events leading up to the formation of a stable, professionalised policy network exaggerate the instability of relations. In particular, the uncertainty surrounding AIDS in the period up to 1986 meant that policy making and consultation was conducted on the hoof, and services decided on the backs of envelopes. However, when the policy machinery was in place and the issue of AIDS considered at the highest levels, and subsequently legitimised, this chaotic period was replaced by the maintenance of a stable policy line by civil servants and ministers.

Thus, much of the difference in the stability of relations revolves around the degree of ministerial legitimation which has taken place. Before the issue received this top level attention, the "policy community" members did not follow the established rules of the game, since more important was the highlighting of the issue. Further, the instability of relations was clear since policy was conducted at a relatively low level on an ad hoc basis. However, following ministerial intervention, discussions at the sectoral level set down the agenda for policy, and consultative relations reflected the balance of power within the department at that time. That is, the Department of Health came to accept a medical definition of the AIDS problem, and hence such interests dominated the consultation process. So, the instability of policy making is often exaggerated by a focus on peripheral group-government relations, when the driving force behind policy may rest with a relatively constant body of civil servants and ministers.

But was this still the case following the establishment of a professionalised network? Ministerial interventions suggest not, and may reflect the general emphasis within health care policy of the marginalisation of the medical profession at the formulation stage. So, a detailed focus on implementation

is required to assess whether or not medical dominance, as well as the harm reduction approach more generally, is reasserted in the face of such interventions.

THE IMPLEMENTATION OF HIV/ AIDS POLICY: AN OVERVIEW

The preceeding chapters discuss a variety of interlinked themes which need to be "tested", or discussed in a more practical and concrete case study of policy and implementation in action. One must also justify the use of a particular area of policy or at least counter the charge that the case study is selected to fit the theory (or in some cases vice versa). This has already been discussed to some extent in the examination of health care policy and the structures for the delivery of health care in Scotland. The question which follows is: does the difference in the structure of the delivery of policy affect the policy itself?

A full and detailed examination of this question is beyond the immediate scope of this thesis. However, it should be possible to contribute to the discussion by examining the differences of policy delivery in a more specialised area. One of the themes of the discussion of health care policy, and public policy in general, was that central government influence may be most apparent in the *broader* areas of policy and the reorganisation of policy delivery *structures*. A narrower focus allows us to test the scope of government policy in more specialised areas, as well as examine the effects of generic public policies in specialised arenas (for example, what is the legacy of *Working for Patients*?; how does it affect the relationship between, say, health boards and hospitals with regard to HIV/ AIDS?). Further, the case study contributes to the themes already identified at the beginning of this thesis, and, in particular, examines the existence and scale of professionalisation at local levels of policy making.

Of course, some problems are discernible from the outset and some are easier to tackle than others. First, some network conceptions are more relevant to some policy areas than others. For example, Rhodes (1990) admits that his arguments are more suited to discussions of welfare policy rather than, say, defence, foreign or treasury policy. However, this may not be such a problem with a more abstract conception of networks itself. Rather, the usefulness of a similar framework for the discussion of both

formulation and implementation may be more problematic. Second, AIDS is an area in which policy boundaries are more likely to be crossed, and hence the conception of networks as discussed in this thesis may be undermined. Further, the identification of the sectoral level of the network may also be difficult. However, the practical investigation of these issues suggests that the centrality (or centralising influence) of the medical profession in the implementation of AIDS policy, as well as the use of the levels of network action, should address these issues. Finally, and perhaps most importantly in the case of AIDS policy, the differences in response and policy delivery may owe more to the distinct nature and timing of the problem in Scotland, rather than the delivery structures themselves. These issues are fully considered in the conclusion.

Overall, the discussion of HIV and AIDS has far more advantages. First, it allows the study of policy from its inception to the late 1990s without any loss of detail. Second, most of those involved at the time of the setting up of services are still involved and available for interview. Third, the legacy of the AIDS Control Act of 1987 is the necessary requirement of yearly detailed reports from health boards on the delivery of services. Finally, the study of the issue of AIDS allows us to extend previous discussions, such as the implementation of a policy which followed an issue attention cycle. the existence of episodic policy, clinical autonomy and the implementation gap.

Discussion of the following case study addresses the following themes:

(1) The need to distinguish between levels of government within networks and that these levels themselves constitute networks, or network actors. The point is that the main focus of decision making changes over a period of time - a change which is less recognisable without the distinctions between formulation and implementation networks, as well as levels of networks within the latter. The distinctions also make the boundary problems of network action more manageable - since we are discussing a number of networks, rather than one UK wide web of contact - whilst any

local discussion of insiders and outsiders require that one identifies which network they are inside. The alternative is the statement of insider status on a vertical basis. However, as the horizontal discussion of health care suggests, this is too simplistic since, for example, the medical profession as an insider group at all levels ignores the internal competition between specialisms which a disaggregation highlights.

(2) The levels and nature or types of consultation. Analysis of Thatcherism allows the argument that the importance of consultation is not restricted to the negotiation between senior ministers prior to policy formulation. Rather, a wide range of different types of consultations as discussed in table 2.3 may be considered as part of network action. Two avenues of discussion thus become apparent: (a) the effects of consultation and negotiation following policy formulation; and, (b) the possible existence of similar negotiating styles in lower levels of government. For example, a common rejoinder to the argument that the medical profession was not included in central government policy deliberations in the 1980s is that it was still involved in the implementation of policy. However, the question over how effective this involvement is or was still requires discussion. The exercise of clinical autonomy and medical dominance may be apparent at unit levels of government, but what about within health boards?

(3) Some discussion is also given to broader concerns discussed in chapter 7 such as the effects of "episodic" policy and the issue attention cycle on the implementation of policy. The former is discussed in terms of HIV and drugs policy, whilst the latter assesses the point that whilst public concern has waned since 1991, the structures for the delivery of AIDS related services are still in place. Downs suggests that implementation still takes place long after the issue has lost its appeal. However, it is important to analyse to what extent such service delivery still takes place and what effect a lack of attention has for a policy's continuation.

For example, the money available to maintain such services is often subject to cutbacks over time, in part reflecting trough periods on the cycle and a

statement on the future of some AIDS related voluntary organisations by Tom Sackville, then Parliamentary Under Secretary of State for Health reflects the importance of AIDS within government since 1993:

> *I appreciate that we have said that some of the largest single grants will be cut. However, we are talking about levels of central government funding for those organisations which some would say were out of proportion to other government funding for voluntary agencies. However that was a response in the early days to a new threat when it was very different to fund these organisations.* (Hansard, 22.7.93: vol229, 613-20)

Part of this is down to the fact that money was given in the past on the basis of anticipation of incidence. At the peak of the cycle, available government money seemed unlimited and was given relatively quickly and, subsequently, services were built up on this basis. Now, as one civil servant puts it, "HIV/AIDS care and treatment funding has in effect been normalised ie it is now paid for from health boards' general allocations" (interview, 10.1997). Subsequently, such services have suffered and in some cases have ceased to operate.

Second, there is some evidence of regional or district specific attention cycles in certain policy areas. In the case of Lothian AIDS policy, the 1980s peaks of attention were replaced by 1990s troughs and successive real decreases in the allocations for the care and treatment for HIV/ AIDS patients. However, the events surrounding the introduction of widespread use of combination therapies occupy much of this study since their effect was to force a significant redistribution of service provision and hence policy change to such a degree that it forced a parallel shift in this study's emphasis. The original conclusion to the discussion of issue attention cycles in this thesis was that no peak has occurred since the early 1990s, with the issue of AIDS trailing off not only at the national but also at the local level. The funds for HIV/ AIDS services were falling and the apparent non-

availability of combination therapy treatment for new patients did seem to mark the end of the importance of HIV policy for policy makers in Lothian. However, the events which followed and the widespread debate which this situation provoked has led to a need to re-evaluate the policy mechanisms which govern HIV policy. Specifically, when such levels of funding threatened to restrict the supply of combination therapies, attention to this issue peaked again, at least in terms of local media, (affected) public and group concern, and the consequent process of consultation arguably marked a change in the nature of the policy network at this level, moving from an initially closed network of participants to an apparently open process which is subject to much greater external influence.

(4) The relative importance of sector versus subsector and top-down or bottom-up. **This final discussion is the most important and chapters 8 and 9 both revolve around this main theme** by analysing the parallels between responses to AIDS in Lothian and the UK, as well as the ways in which each response is widely portrayed. Whilst the UK approach was initially criticised as taking action too late, the Lothian response, whilst also reactive, is widely lauded for its fast and effective response even though the former took place before the latter. Much of the difference can be traced to the initiative taken by Lothian. Whilst the UK's campaign and resource allocations were subject to delay and conflict over policy measures, Lothian's have their origin in a consensual, "bottom-up" response to a unique situation. That is, the Lothian approach is marked by a highly unusual degree of cooperation between the majority of the statutory services which resulted in a relatively quick and effective response.

As a result, it may be necessary to distinguish between two types of policy networks - or even policy sectors -which operated at this time. While the Scottish Office was heavily involved in AIDS policy, a different kind of network is apparent on examination of the consensual response between relatively senior members of the major statutory services which framed much of the response to AIDS in 1987. The resulting policies of the latter

are particularly important, since top-down funding decisions affected their continued existence a decade later.

Chapters 8 and 9: Sector/ Subsector

Chapters 8 and 9 revolve around the issue of sector/ subsector in most part because the emphasis on the implementation of policy allows an analysis of the status of the sectoral level which is not available to the student of formulation. In particular, it allows detailed focus on the basis of the identification of sectoral status. That is, chapters 8 and 9 ask the question: does the identification of sector derive from authority or from policy.

For example, let us return to health policy and ask these question at the formulation stage: Health policy is the sector, but is this because health is the logical umbrella term for all policy within its department (policy as sector), or because senior level decision makers in most part restrict their decisions to general policy (authority as sector)? Or is there some element of both in the explanation? It makes intuitive sense to argue that specialisms within health become specialist policy areas within health policy, but is this necessarily the case? The problem of course is that these issues are necessarily conflated at this stage since general policy equates with general decision making. But what if these could be distinguished and analysed separately?

This is possible at the implementation stage. Chapter 8 discusses equating authority with sector, with the Scottish Office identified as the authoritative member of the network even when it is not particularly involved with the implementation of policy. Chapter 8 asks the question: is authority enough to command the sectoral level? And, if so, what is the importance of sector in terms of policy outcomes? This discussion therefore links well with the UK discussion of the sector/ subsector dynamic as well as a more general assessment of top-down and bottom-up versions of implementation. It assesses to what extent a bottom-up policy response is tempered by the legal and financial framework imposed by authoritative institutions or levels of government. That is, it examines the policy influence of the Scottish

Office (and even the Department of Health) even at times when it is not particularly involved in the day-to-day implementation decisions of "bottom-up' actors.

Chapter 9 poses a different question, possible only afforded by the focus on implementation. It discusses equating the sectoral level with policy area by questioning the basis for seeing health policy as sectoral in the first place. In the UK example, the argument that AIDS policy was a subsector of health policy is more convincing, since there was a clear medical response from the DHSS. The DHSS took the lead in the response to AIDS in the UK and for at least two years a policy problem which occupied a subsectoral level within the DHSS was pushed up to be dealt with at a more senior and authoritative level. However, despite ministerial legitimation of policy, it was always clear that there was a much broader general health care policy remit at this level of decision making (for example, Fowler consulted on a wider scale, even including church leaders, and did not even meet activists, whilst Acheson mainly consulted with specialists and activists).

However, at the level of implementation there is a very strong case for viewing AIDS policy as sectoral and health care as subsectoral, since in Lothian the medical response to AIDS was one of many statutory authority responses - including education, social work and police - involved. Further, a network did develop which involved senior members of each authority. The medical response to AIDS was thus just one facet of the AIDS policy response in general. So, the policy which bonded these authorities was AIDS, not health, and AIDS policy commanded sectoral level attention, with the medical response occupying the subsectoral level, driven by the agenda set by the statutory collaboration around AIDS. As chapter 9 discusses, the Scottish Office was not particularly involved in this process, and so the decisions being made to determine the Lothian response to AIDS took place within this Lothian statutory network. The AIDS policy network was thus determining the response for each statutory authority, and there was no wider or more underlying agenda such as health policy in general which shaped these decisions. This may have occurred within

Lothian Health itself, but at a subsectoral level after the agenda had already been set. So, this example allows us to analyse the importance of the policy area determining the sectoral level, since the network was based on the imperative to collaborate according to the importance of the policy problem - not on authority.

The discussion of chapters 8 and 9 thus allows us to separately examine the importance of both authority and policy as the basis for the sectoral level and, without giving too much away, argues that it is authority which is more important since it is a lack of such authority which eventually undermined the AIDS policy network which developed in Lothian. The implication may thus be that while general policy sectors set the agenda for subsectors, the former may indeed be dominated by one or more of the latter. Paradoxically, this may undermine the authoritative basis for sectors. Such conclusions are returned to in chapters 9 and 10.

CHAPTER 8 - HIV/ AIDS POLICY IMPLEMENTATION - SECTOR AS AUTHORITY

Introduction

As the overview suggests, the case study of the implementation of AIDS policy addresses a number of questions arising throughout this thesis, including the professionalisation of networks and the importance of insider status within networks. However, chapters 8 and 9 highlight the particular importance of sector subsector since this is an area in which this case study can particularly contribute. Thus, this chapter revolves around the analysis of the relative influence of, and the relationships between, sectoral and sub-sectoral level networks at the implementation stage of policy. The case study of the formulation and implementation of AIDS policy demonstrates that direct parallels can be drawn between each arena, arguing that the distinction between four levels of implementation network actors is required to analyse the sector/subsector distinction at the implementation stage.

However, there are several initial problems, not the least of which concerns the levels of government themselves. As the discussion of HIV policy in Scotland demonstrates, a comparison of Scottish and, say, English policy is problematic, since the Scottish Office (at least pre-1999) can be considered to be both a central government department and a regional outpost of UK government. Similarly, Lothian Health is the equivalent of a district level network in England, in terms of size and proximity to unit levels at least, while classified as a regional level of government in government discourse. Further, as the concrete discussions below demonstrate, the operations of these levels of government are less distinct than table 4.1 (page 69), appears to suggest. Rather, networks appear to develop *between*, rather than *within*, these levels of government.

However, while these difficulties should be kept in mind, these are not unassailable, since they detract from the main point of the classification anyway. The discussion examines, over time, the devolution of decision making responsibility from central government to lower levels of government. This is extended to incorporate network theories on the

operations of these levels of government when that power is devolved. The classifications are used not to dismiss the idea that networks are developed between levels of government, but that the core decision making apparatus of these networks changes over time, and to understand the outcomes of the networks, it is necessary to identify and examine the focal point of decision making. While one huge network could be identified within a policy area, the concept would become meaningless without the distinctions maintained between insider and outsider (groups), or between consultation and negotiation. However, to attribute insider status to a group one must know what a group is inside. If a group is involved at one stage, or level of government, and not another, then disaggregation is required, since its insider status changes from stage to stage (or level of government).

Further, since chapter 6 suggests that implementers often have at best a peripheral involvement in the formulation of policy, the point of this chapter is to consider to what extent the reverse can be said to be true in the implementation of policy. So, following an identification of the core decision making network - see table 3.1 - one must consider the operations of this network: its decision making structure, the nature of its operations, and hence the nature of the consultations and negotiations in which it engages, including those with higher levels of government. The usefulness of this approach is thus in its agnostic evaluation of the influence of central government or the effects of its involvement in the deliberations of the implementation network actor, as well as its focus on consultation and negotiation with more local groups *after* the formulation of policy.

A useful parallel is the relationship between central government departments and Parliament (pre-1999). Chairs of health boards are directly accountable to the Secretary of State for Health just as the latter is accountable to Parliament. But the lack of attention to Parliament in network accounts suggests that this formal structure is not the primary determinant of network action. Similarly, one should *demonstrate*, not *assume* that the formality of central government inclusion in, say, the operations of district level networks necessarily affects their subsequent

action any more than Parliament impinges on the actions of formulation networks.

But how does this relate to the case study? The extensive emphasis on sector/ subsector is required not least because the case study identifies a similar development of policy between central government and health boards. AIDS policy initially developed in both central government and Lothian Health Board (as it was then known) at a subsectoral level, and the latter discussion ties in neatly with the emphasis on top-down versus bottom up explanations of implementation. As discussed in chapter 7, although the key figure in early AIDS policy was the Chief Medical Officer, Sir Donald Acheson, responsible for all aspects of health in the DHSS, he fostered early links with specialists outwith the existing sectoral net. Similarly, George Bath, although the LHB's Consultant in Community Medicine and public health as a whole, initially fostered links with pioneering specialist doctors and groups in Lothian. Both subsequently directed these subsectoral network efforts towards the aim of highlighting the issue within sectoral (and further) arenas.

However, a great deal of clarification of terms is required to make much sense of these comparisons within the implementation arena. For example, while it is relatively easy to identify subsectoral activity in these examples, the sectoral level is less apparent. With the UK case the hierarchy is clear. Policy is passed up to senior civil servants within the department. However, within implementation we have the choice of senior members within the same statutory authority, or contact with a more senior level authority (say, HEBS or the Scottish Office). In turn, this raises the question of what sector actually refers to and as the overview suggests, a discussion of, first, the Scottish Office and, second, the significant regional level statutory responses allows us to deduce their relative importance. The requirement of the levels of government approach should prove apparent in these discussions.

Sector/ Subsector Debates on Formulation Networks

As discussed in chapter 2, the size or level of a policy community is subject to debate. Does the pervasiveness of internally fragmented bureaucracies necessitate viewing communities at the sub-departmental, or sub-sectoral, level or are subsectoral networks constrained by decisions which are taken at the sectoral level which set the agenda and rules of the game for the policy area? Chapter 2 downplays the extent of the disagreement. The constraints which Cavanagh *et al* specify, such as a tax-financed NHS, may be so broad as to be of little importance in the day-to-day operations of sub-sectors, while Jordan *et al* do not reject the existence of activity at the sectoral level. Rather, they warn of the problems of considering the insularity of such networks as a given, arguing that influence in regard to lower level negotiations may filter upwards, as clientele representatives within the service campaign at higher levels.

It may be that subsectoral activity prompts the highlighting of the issue within government, and continues to exert primary influence at this higher level as a result of its expertise and established, recognised clientele. Nevertheless, the sectoral level is no less authoritative, since ministerial involvement allows the legitimation of subsequent policies, and this clearly sets, albeit broad, boundaries for subsequent action.

These issues are well demonstrated by chapter 7's discussion of UK AIDS policy. First, the move from apparent "policy community" (Berridge, 1996) in 1981 to issue network in 1986 resulted in large part from the actions of that initial network in highlighting the issue in government and in the media, and the policies initially formulated were largely legitimated by the government. Group influence was particularly clear in the destigmatisation of "risk groups".

Second, the move from a relatively open issue network to an apparently professionalised network resulted in part from the power of the medical profession. However, the real difference between the "policy community" of 1981-6 and the professionalised network from 1988 onwards is ministerial

intervention and legitimation. As Cavanagh *et al* argue, sectoral level networks set the agenda for the policy area. So the power relationships within, and the decisions made by, sub-sectoral networks often occur within the frameworks and agenda laid down at the sectoral level. However, until 1986 and onwards this agenda had not been laid down or even legitimated at the ministerial level. Therefore, insulation and stability was unlikely since ministerial intervention at any stage would most likely alter the course of that network. Further, since such intervention was indeed sought, there was no doubt that the initial policy network was a temporary alliance (Berridge, 1996). Following a period of top level and ministerial involvement, the nature of the network changed, with the role of groups demoted from specialist to peripheral insider.

So, the complex interaction between sector and subsector in the case of UK AIDS policy confirms our existing conclusions. The sectoral level was indeed subject to influence from its subsectoral counterpart, with early subsectoral policies mainly legitimised following ministerial involvement. However, the process of legitimisation in turn led to the reconfiguration of the subsector and the negotiation process itself, with activist groups further marginalised from the process as a consequence of the subsequent reliance on established sectoral level actors.

Sector/ Subsector in Implementation Networks

However, can a similar process be identified within implementation arenas, and how do their sectoral/ subsectoral levels of operation compare? First it is necessary to identify the sectoral and subsectoral levels in implementation networks. This is made difficult by the vague boundaries of the policy area and the amount of statutory agencies involved. However, it is not impossible. Specialisation forces the bulk of policy to be processed in subsectors rather than sectors, such as the medical treatment, social work treatment and criminal treatment of AIDS. In turn, a dominant actor - Lothian Health (formerly Lothian Health Board), Edinburgh City Council (Lothian Regional Council) and the Lothian and Borders Police Force respectively can be identified. while consultations and negotiations take

place, reasonably clear boundaries of action are identifiable (see next chapter).

The Sectoral Level

However, what about the sectoral level? In many ways this is more difficult to identify since sectoral level talks may be either non existent or less authoritative or binding than their formulation level counterparts. Further, does the sectoral level relate to a general coordinating body such as the Health Education Board for Scotland (HEBS) or the Scottish Office (based on authority), or a less formal set of arrangements fostered by each authority operating at subsectoral levels (based on policy area)? Finally, if sectoral refers to the policy area, which policy area constitutes the sectoral level? Is it health, social work or law and order, under the purview of a body such as the Scottish Office, or is it AIDS as a whole, constituted by the health, social work and policing, subsectoral aspects of AIDS policy?

Both approaches have their advantages and flaws. For example, the former approach may be unproblematic in areas with relatively clear boundaries, but AIDS policy is difficult to restrict to one department, and it may not be so high on the political agenda to justify its coordination at Secretary of State level. In the case of the latter approach, the main problem is that if AIDS policy is considered to be the sectoral level, then how do we describe more general policy areas such as health which both encompass and to some extent control AIDS policy from above? Further, can policy determined by a n AIDS policy implementation network be considered authoritative, especially since its coordination basis is in less formal relations between relatively independent statutory authorities? Both cases require extensive discussion. So, this chapter discusses authority and chapter 9 discusses policy as a basis for sectoral status.

Sector and Authority: HEBS

The Health Education Board for Scotland is perhaps the prime candidate as a coordinating authority, since its UK counterpart, the Health Education Authority was charged with much of the implementation of AIDS policy in

the late 1980s. Certainly its predecessor the Scottish Health Education Group developed courses and education packs to nurse educators in the field (Richardson and Gaskell, 1989: 75) when information was scarce, and Andrew Tannahill, as General Manager of HEBS, was a key figure in the two most recent Scottish Office task forces on HIV and HIV and Drugs[1]. However, by the late 1990s most of HEBS limited AIDS work was spent documenting and advertising local health education initiatives, rather than centralising policy. So what is the role of HEBS and Scottish HIV/ AIDS education?

Scotland has its own, albeit limited, arrangements (set up under an act of Parliament) for the provision of health education and some differences can be discerned in the actions of HEBS, and its national counterpart, the HEA (Health Education Authority)[2] . First, for example, the "Scottish identity" is important in most of the campaigns undertaken in HEBS advertising campaigns, even to the point of selecting a generic Scottish dialect in the narratives. Second, clear organisational differences exist and HEBS has greater discretion in the setting of Scottish health priorities. As opposed to the UK as a whole, in which the Department of Health (DH) sets health education priorities and the HEA subsequently bids for the contract to supply such education, in Scotland HEBS has responsibility for the setting, as well as the provision, of health education priorities. Third, the "memorandum of understanding" between HEBS and the Scottish Office differs from its national counterpart, with much less formal restrictions placed on the activities of HEBS in their day-to-day operations. Finally, however, the HEBS budget is much more restrictive, with approximately £2 million allocated per year for around 10 advertising campaigns.

The importance of these differences is highlighted in the process of obtaining clearance for health education campaigns and press releases in the case of HIV and AIDS. At the national level, Miller and Williams (1993)

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1 On the Ministerial Task Force (chaired by Michael Forsyth) which produced *HIV and AIDS in Scotland: Prevention the Key* in 1992 and the Ministerial Drugs Task Force (chaired by Lord Fraser) which produced *Drugs in Scotland: Meeting the Challenge* in 1994.

2 Information from Martin Raymond (HEBS press officer) in seminar, "Media, Gender and Health", at the Gender, Sexuality and Health Forum, Lothian Health, 5.3.1997.

describe a process in which the HEA/ DH relationship developed unfavourably around the issue of HIV/ AIDS information and the question of expertise. while the HEA was granted the main statutory responsibility for public education in this area, the DH was unwilling to give up its "expert" role and, "did not look favourably on the HEA trying to establish itself as the 'most useful source'" (1993: 129). Such concerns were "formalised" in the "memorandum of understanding" between the DH and the HEA, which, "circumscribes the conditions under which the HEA can put out public statements" (1993: 129). This includes the provision that while the HEA is responsible for public and private advice (where "appropriate") and may attempt to influence government policy, it must also operate within and accept that policy. It stipulates that Ministers, through the DH, must be informed in advance of any advice to be given in public (1993: 129). Thus, the autonomy of the HEA was heavily restricted by the need to obtain clearance from civil servants in the DH for any press release (on any subject), regardless of content. The political control of HEA information by the DH therefore had obvious effects on the content and timing of HIV/ AIDS education policies.

In Scotland, the HEBS/ Scottish Office relationship is much less restrictive, and the "memorandum of understanding" merely states that the Scottish Office expects "nothing surprising" to appear in public under the authority of HEBS. HEBS still operates within the context of government policy, but there is no formal or informal mechanism in place which requires Scottish Office clearance for HEBS literature or press statements. The influence of the Scottish Office is indirect or anticipatory. Thus, one would expect a greater degree of discretion to be apparent in the day-to-day operations of HEBS, as well as in its subsequent AIDS related output.

However, the evidence suggests otherwise, with a relatively small portion of the HEBS budget spent on HIV/ AIDS advertising which does not differ significantly in nature to its national counterpart. Thus, the significance of indirect influence should not be underestimated, especially in an area such as sexual health in which sexual images are still taboo. This, as well as the

financial constraint, explains why, as in the rest of Britain, the bulk of sexually explicit HIV and AIDS advertising is left to individual health boards and, more likely, contracted-out service delivery organisations.

When HEBS *is* involved, much of its work is spent in the development of existing initiatives by the most active Health Boards, rather than its own, original, projects. For example, HEBS plays a part in the coordination and advertising of existing initiatives, through the SHAIR project (The Scottish HIV and AIDS Initiatives Register - HEBS, 1995) and a database of initiatives. Further it contributes to the development, or nationalisation, of local advertising campaigns. Two examples in the case of Lothian Health are: (a) a campaign on drugs by Fast Forward for the Health Promotion department; and (b) the "Take care" campaign by the Health Promotion department, which were both developed and displayed nationally by HEBS (interview, Senior health promotions officer, 11.1996).

Thus, HIV and AIDS education initiatives still develop from the bottom up, because in the limited extent to which the HEBS participates, it is reliant for much of its work on the previous development of more local, health board, initiatives. The importance of HEBS may be more apparent with less innovatory health boards. However, still, it could not readily be considered as the sectoral level authority since its remit - health education - is more accurately described as subsectoral in nature, with no authority in, say, social work or policing arenas.

Sector and Authority: The Scottish Office (pre-1999)

The SO, as the hierarchically superior network, has some role to play in setting the agenda of AIDS policy and through its range of policy responsibilities under the Secretary of State for Scotland has the potential for centralising policy. It also authorises the AIDS budget to individual health boards, which are accountable through 6 monthly reports to the National Services Division. However, the involvement and influence of the SO has changed significantly over time. For example, it was involved heavily in the initial identification of HIV in Scotland. However, while it has

remained heavily involved in some areas of HIV, these have been as much to do with the key policy areas, such as drugs and prisons, with which HIV and AIDS have coincided. As exemplified by the cases of Care and Treatment, AIDS finance and combination therapy, SO involvement on the whole has waned as it has taken a back seat to individual health boards. Nevertheless, indirect top-down influences are still evident.

(i) The Identification of HIV in Lothian

In the early 1980s when HIV (or HTLVIII) was becoming an issue, the SO was well placed to act in a quick, effective and coordinated way, since reactions to drugs issues from the police, prisons, health and social work sectors all came under the responsibility of the minister of the then Scottish Home and Health Department. Subsequently, the Chief Scientists' Office within the SHHD was one of the first bodies to provide funds for HIV research. As a former civil servant argues (interview, 22.6.1997), in 1983/4 not much was known about HIV, and such was the level of urgency and anticipation that the CSO readily gave out "fairly soft money", or grants without going through the "rigours" of the Health Service Research Committee stages, to street-level practitioners who would not normally engage in such research. Indeed, he describes a prominent role for the CSO in the identification of the IV drug use incidence of HIV in Lothian, since one of its first grants in 1984 went to Dr Roy Robertson's Edinburgh Drug Addiction Study to look at the effects of intervention (and non intervention) in a group of IV drug users. In turn, Robertson initially set up testing for hepatitis and, "decided to test for this new thing, this HIV, at the same time" from stored samples.

The results of such tests are well documented, since the HIV epidemic was also identified by a group of doctors tracing its incidence in Scottish haemophiliacs as soon as the tests became available in mid-1984. As Brettle (1996: 5) discusses, Dr Chris Ludlam was still correct to arrange for the testing of his haemophiliac patients who, given the independent nature of the Scottish Blood Transfusion Service, had not been treated with imported blood products: "the results were positive, indicating that these

patients had been infected through Scottish blood donors"[3] . In turn, the exceptional incidence of HIV in Lothian was discovered almost by accident by Dr John Peutherer using stored sera (identified by George Bath's work) from intravenous drug users tested for hepatitis B as a control group when testing the efficacy of the new tests when continuing the work on haemophiliac infection. As Brettle (1996:5) discusses, Peutherer ran the tests three times before realising that the higher incidence in the control group was a "real effect and that there were a large number of drug users in Edinburgh infected with HIV".

Approximately 50% of those tested by 1985 were found to be infected with HIV and the retrospective testing of samples found that, "the AIDS virus was introduced into a community of drug users in or around August 1983" (Robertson, 1987: 81). Furthermore, the concentration of HIV incidence in Lothian was unparalleled in Britain, with 111 cases per 100 000 (0.11%) by June 1988, compared to the next highest, NW Thames, with 62 and Scotland as a whole with 27 (Lothian Health Board, 1988: 10). Indeed, further disaggregated estimates suggested that of men aged 15-44 in Edinburgh City this incidence could have been as much as 1% (1988: 12; see also Richardson and Gaskell, 1989).

While responsibility for the initial identification of HIV incidence is unclear, Scottish Office involvement is clear from the onset, since its funding of initial research and the subsequent results marked the beginning of HIV/ drugs policy in Scotland, prompting the creation of a ministerially headed group to look at HIV and drugs after the transmission rate was discovered, the funding of services and projects on an ad hoc and experimental basis - again through the CSO - as well as the setting up of committees associated with definitive policy guidelines, such as the McClelland and Tayler reports (see below).

Further, a six month research grant from the Scottish Office in 1985 allowed the establishment of the City Hospital's HIV clinic in Edinburgh, chiefly for

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[3] Although the source has never been identified and is "definitely different from the drug user epidemic".

the treatment of injecting drug users, at a time when Lothian Health Board did not have the money. As discussed above, the uncertainty surrounding the incidence of HIV allowed projects more chance of success without the usual "rigours" of the CSO committee stages, and a research grant was the quickest way to obtain funding. Still, some recipients of the early grants were surprised by the levels of available research funding for clinical services, especially since it was so difficult to obtain for research. In the case of George Bath, Brian McClelland (of the Scottish Blood Transfusion Service) and Ray Brettle's bid for the City HIV clinic, Bath was so pessimistic about its likely success that he left out mention of an outpatient's clinic, promising Brettle a share of the grant for this purpose from the little he expected to obtain. However, Brettle was insistent since he argued that any provision would be heavily monitored and earmarked. Subsequently, Bath agreed to include the extra demands, partly on the basis that he expected the bid to be rejected anyway. As it turned out, "they gave us every penny" (interview, Ray Brettle, 10.1997). Brettle argues in retrospect that this was not so surprising, since:

> *They had no choice originally but to spend it because they were jumping up about AIDS and how important it was and they couldn't exactly be seen to be being a bit stingy on the treatment and the setting up of the service.*

In addition, the new clinic fulfilled a newly identified central government need - to provide an alternative to blood donation centres as the means with which to test for HIV. When the DHSS announced the introduction of HIV (HTLVIII antibody) testing in transfusion centres across the country, it also stressed the need for synchronous provision of these arrangements in specialist (usually GUM) clinics and GP surgeries:

> *... to ensure that people who believe themselves at risk of infection do not donate blood in order to be tested. This is crucial because even a reliable test cannot detect very early infections to which an antibody response has not*

been generated. (DHSS, 1985b)

It was also consistent with the government's wish to deter those it considered at risk from donating blood anyway. So, while GUM clinics were generally seen as the alternative, the Infectious Diseases unit at the City Hospital was supported because it was already used to dealing with, and being able to attract, injecting drug users. The six month research grant was the quickest way of releasing the cash to set the service up, and after the six months Lothian Health Board agreed to take on subsequent funding (interview, Brettle, 10.1997), especially since the clinic's early testing results suggested that, "around 50% of the drug users attending were infected with HIV" (Brettle, 1996: 5).

Intense Scottish Office involvement continued in 1986 and 1987 with the McClelland and Tayler reports. The McClelland Report was commissioned by the SHHD and published in 1986, stating (before its parallel UK ACMD(1)[4] report) that the prevention of HIV spread should take precedence over the perceived risk of increased drug use. It thus recommended, immediately following its first meeting, that medical practitioners should be allowed to give out clean needles and syringes to their patients on a one-for-one basis provided that this was complemented by counselling and advice on drug use and HIV. Subsequently, it recommended substitute prescribing to reduce or stop injecting and to establish contact with injecting drug users to further the role of counselling. It also recommended organisational changes such as the establishment of an AIDS coordinator accountable directly to an SHHD counterpart, and the provision of extra expenditure for the increased workload of relevant agencies.

The report's effects were most notable in the identification of separate funding for AIDS services, from existing budgets and extra funding from the SHHD, and the establishment of an "AIDS team", consisting of an AIDS coordinator (George Bath), a health promotion officer, and administrator and a community outreach worker (Richardson and Gaskell, 1989: 74-5).

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[4] DHSS (1988) *AIDS and Drug Misuse Part 1* , Report by the Advisory Council on the Misuse of Drugs - hereafter ACMD(1).

Additionally, the institutionalisation of AIDS policy was furthered in 1987 following the Taylor report and Scottish Office sanctioning of three specialist "AIDS centres" in Scotland - Dundee, Glasgow and Edinburgh.

Thus, Scottish Office involvement in the identification of HIV and in policies directed towards the problem is clearly manifest, and the SHHD was well placed as a sectoral level body, covering health, social work and police policy at an authoritative level. Still, questions remain. For example, is the sectoral level the most important? and, is its primacy demonstrated by subsectors following the agenda and rules of the game set down by it? Unfortunately, the answer to both is yes and no.

The arrangements between Lothian and the Scottish Office mirrored, to some extent, those between the UK AIDS subsectoral and sectoral level networks as AIDS was highlighted within government. Much Scottish Office involvement resulted in part as a result from pressure within Lothian. Further, in many ways the McClelland report served to legitimate the policies of its Lothian subsectoral (health policy) counterpart and extend these to the rest of Scotland. As Richardson and Gaskell (1989: 73) note, Dr Ray Brettle had already initiated substitute prescribing for drug users attending the City Hospital's Infectious Diseases Unit, and Dr Roy Robertson (a GP) was already giving out needles and syringes and prescribing alternatives to heroin even before the identification of HIV in injecting drug users (Brettle, 1996: 6). Indeed, Bath, Brettle and Robertson were all prominent members of the committee which produced the McClelland report. Further, the Tayler report did not produce a new AIDS centre in Edinburgh. Rather, Edinburgh's centre was made possible by refurbishing the ward accommodation in the Infectious Diseases department at the City Hospital, so, "although it was an 'AIDS' unit it was an extension of the existing ID department with the same clinicians covering", and Ray Brettle as the Clinical Director (interview, Operational Manager HIV/AIDS and Drugs Services, LHB, 4.97).

So, on first inspection, rather than setting the policy agenda, initial SO

involvement served merely to legitimate existing policies operating in Lothian at the time. However, this is the first of many instances in which the discussion uses the levels of government networks, rather than sector/ subsector, terminology. In this case it may become confusing to count Lothian as a subsector without disaggregation, since the doctors (Brettle and Robertson) operated at a level below and above that of the Lothian Health Board. It was doctors in the field who were the first to act and respond rather than higher level actors in statutory authorities (interview, consultant clinical psychologist, 6.1997). In other words, the sub-sub-sectoral level or, less confusingly, unit level implementation networks were first to act. So, the McClelland Report reflected and legitimised existing arrangements and attitudes at unit levels, rather than setting down a new framework. Thus, chapter 4's framework is required to note that the sectoral level McClelland report did not simply legitimate the existing arrangements of its subsectoral level counterpart, Lothian Health Board. Rather, slightly less confusingly, the report mirrors activity at unit levels of government in the case of Brettle and Robertson, who in turn were involved in shaping the Scottish policy.

Much of the initiative at unit level can be explained by the novelty of the policy. The SO or the sectoral level was unable to set the agenda because it was faced with uncertainty and unfamiliarity with HIV and AIDS. Its main role, then, was to provide new money, without any particular knowledge about how it should specifically be spent. Practitioners at unit levels, on the other hand, had first-hand experience and knew where the service gaps were. However, while a specific sectoral level agenda was not apparent, more general conventions, structures and regulations had a bearing on the actions of implementing clinicians, and these were built upon over time.

First, unit level influence is highly and relatively dependent on its budgetary context, as provided by health board and central government levels. As discussed below, in terms of substitute prescribing, early "policy" in Lothian consisted of doctors Robertson and Brettle giving out needles and syringes and prescribing alternatives to heroin before this was officially sanctioned.

Both were able to act relatively independently because in many respects they were acting "ahead of the game", or before the appropriate new regulations or top down polices were in place. "Bottom-up" policy, then, consisted of reinterpreting current policy in the light of new evidence and circumstances. However, both were unable to prescribe without limit, since their budgets were restrictive and, in some cases, earmarked.

Second, discussion of Brettle's work at the City Hospital shows that the financial restrictions were tighter over time, in part because there was less money available, and in part because this was more tightly controlled. Indeed, Brettle was arguably more powerful as a relatively junior doctor, working to advise Lothian Health Board and the Scottish Office about what to fund and to what extent, at a time when the issue was urgent and high on the agenda and new money relatively widely available, than when he was the established clinical director of the service that he was instrumental in setting up. As Brettle (interview, 10.1997) argues, while he was not initially in charge of managing funds, his advice, along with that of George Bath was so relied upon in the early days that he was in effect, "managing it by remote control". Brettle and Bath were given so much responsibility and funding discretion because they were responsible for the patients and, "delivering the service ... and we were effectively getting the health board off the hook", since the health board with relatively little knowledge was seen to be acting. So, in earlier days it was much easier to get funding bids accepted. By 1998, while Brettle was more senior and ostensibly more in charge as consultant and clinical director, he argued that the process was more convoluted and that it is:

> *... very difficult to believe that you're ever in control of anything ... in one sense I have more control over the money, but there's less money, so actually most of the money I'm in control of is all tied up.*

Third, for example, the McClelland report may have legitimised existing ideas, but as in the case of needle exchanges which were delayed by a

year, they were not always sanctioned immediately. Finally, as the following two sections demonstrate, Scottish Office influence was manifest in areas such as prisons and drugs policy where an established position *is* apparent and which can be adapted and possibly reasserted to accommodate new, AIDS, policy.

(ii) Prison Policy and HIV

Scottish Office influence was apparent in prison policies regarding HIV and AIDS, both in terms of implementation and relations with UK policy, since it maintained a contrasting line to its Home Office counterpart over the issue of segregation versus integration. The Home Office at the time, on the basis of officer and inmate pressure, implemented its "viral infected regime", involving segregation of those prisoners who admitted their HIV status. However, the Scottish civil servants involved were critical of this approach, not only in terms of discrimination, but also since the extent of infection was unknown and the only way to gauge such incidence was to controvert prisoners' rights surrounding the confidentiality of their medical records (interview, former civil servant, 22.6.1997). Consequently, they developed an alternative, "total integration", policy which was piloted successfully in Edinburgh - targetted because of its high incidence of drug or ex-drug use and suspected HIV levels - albeit, "with great difficulty", using health education measures - posters, videos, talks - focussing on prevention, sharing needles, etc. to "sell" such an approach to the prison population (interview, 22.6.1997). Indeed, in many ways Scottish policy was "ahead of the game" since it was first to deal with drug related HIV as well as the first to adopt integration as a policy. While the success of the pilot enabled Scotland-wide adoption (see Lord James Douglas Hamilton, *Hansard*, 31.3.88: 642), it took several years for this to be accepted in England, in part due to the resistance of the English prison officers' association. Perhaps cynically, one commentator argues that such resistance worked in the favour of the Scottish policy, since the rivalry between Scottish and English prison officers' associations made it more likely that the former would accept a contrasting approach (interview, Social Work (prisons) officer, 6.1997).

At this point it is worth noting the difficulties in determining the focal point of networks when relying on oral evidence from actors across a wide range of professions and positions within hierarchies. For example, evidence from civil servants may highlight the role of the Scottish Office in policy making more than regional level actors and this is apparent in the discussion of the McClelland report and prison policy. As other commentators argue (e.g. interview, Operational Manager, 4.1997), the bulk of the resistance to punitive and segregation measures in Saughton Prison came from its governor, John Pierson, who was instrumental in setting up support services, "at a time when the rest of the prison service in the UK just didn't want to know". Pierson worked closely with representatives from the health board to introduce services such as pre-release counselling and support and foster links with community drugs projects, as well as, "putting dampers on mandatory testing which was a huge issue in prison services at the time".

However, Pierson was a "high flyer" and a "visions man", and so the implementation of the projects was down to the then Deputy Governor, Mike Duffy, the, "power behind the throne who put Mr Pierson's visions into operation ... [using] multi disciplinary management" (interview, Social Work (prisons) officer, 6.1997). Subsequently, the "ownership" of the initiatives is difficult to identify since the management style diffused responsibility for that implementation. In addition, the strength of disagreement surrounding the integration measures in Scotland may be overstated:

> *It was a heated debate to start with but ... at the end of the day we were all saying the same thing. Nobody up here believed in segregation. Apart from anything else, the numbers were too big* (interview, 6.1997).

At the time the HIV incidence of over 40 prisoners was considered to be the tip of the iceberg rather than the peak it turned out to be, and so aside from rights and welfare considerations, other measures would be impractical.

So, with diffuse responsibility for the implementation of the integration policy and support services, based on the "visions" of John Pierson, and apparent widespread agreement among staff and support from the Scottish prison officers' association, the role of the Scottish Office may be less apparent.

However, such arguments are less convincing in this case since, at this time (before agency status for prisons), the governor was also a civil servant within the SHHD. Pierson may have done a "superb job", but he was following SO policy of which he was a part (interview, former civil servant, 22.6.1997). Similarly, Pierson was instrumental in bringing together groups and experts such as Judy Greenwood and Graham Bird to inform that policy. However the point is that at the formulation stage the network was situated within the SO itself since the policy was to have Scotland-wide consequences, and had to be sold to the Secretary of State for Scotland who was ultimately responsible. Thus, the policy branch for the Scottish prison service, within the SHHD, was central to the formulation process since it would call the meetings, put together the papers on each issue, coordinate consultation and ultimately put proposals forward to ministers (former civil servant, 6.1997). If SO influence is less apparent to street level commentators this is because it stepped back from the <u>implementation</u> of its policy.

However, the general lack of SO involvement in the implementation of prison policy is also questionable, even after the granting of agency status and devolved budgets. For example, Michael Forsyth was particularly interested in prisons and so:

> *The last [SO] regime were into the minutiae of everything that happened in every prison and it meant that if you were going to do anything at all then the Scottish Office had to sanction it.*. (Social Work (prisons) officer, 6.1997)

This involved not only accountability measures but also the enforcement of

policy in the face of opposition from implementers. For example, the introduction of Mandatory Drug Testing in prisons in 1996 was heavily opposed but implemented nonetheless:

> *It was something that none of us wanted. Neither myself nor prison staff nor anyone else it seemed. But we got it anyway.* (Social Work (prisons) officer, 6.1997)

So, Scottish Office involvement with prisons policy remained consistently high and its influence was apparent. However, as discussed with regard to drugs policy below, this does not necessary mean that its involvement in *HIV policy* was quite as high.

(iii) Drugs Policy and HIV

A similar story becomes apparent with drugs and HIV policy, with the Scottish Office dominance of drugs policy disguising its gradually diminishing role in HIV policy over the years. This is despite the links between HIV and drugs, especially since the rise in salience of drugs policy in the early 1980s followed from the identification of intravenous drug related HIV. Not only did the incidence of drug related HIV prompt a reversal of government policy on harm reduction measures, but the identification saw a rise in the number and size of drugs groups on the back of HIV funding.

Put simply, in Lothian before the identification of HIV, government and public interest in drugs policy was comparatively low and the policy itself was punitive in nature. For example, the policing of heroin related offences in Lothian is regarded by Brettle (1996), Richardson and Gaskell (1989) and the McClelland Report (1986) as the primary cause of the spread of HIV through infected needles and syringes[5] . That is, it was an offence not only to possess heroin but also to possess the related equipment - needles and syringes. Thus, needles and syringes were confiscated and the offences used to coerce users into identifying their suppliers. However, heroin within

[5] Although the McClelland Report (1986: 7) also places importance on the lack of substitute prescribing and medical backup in Edinburgh.

the bloodstream was not an offence. Therefore, a system - based on the scarcity and illegality of IV equipment - developed in which users would inject at point of sale, often with the continuous use of a single (non-disposable) needle. So, if the needle was not properly sterilised between uses, the conditions for the spread of infection were "ideal". Further, the comparatively late introduction of HIV into Scotland ("in or around August 1983" - Robertson, 1987: 81) coincided with these conditions:

> *By bad luck it seems that HIV ... became established in Scotland's drug users, particularly those in East coast cities, at precisely the time when the conditions for spread of infection were ideal. The coincidence of these conditions ... has allowed a massive and rapid spread of infection* . (Lothian Health Board, 1988: 7-8)

In Lothian it took less than 3 years to infect approximately half of the IV drug using population and by Lothian Health Board's first report in response to the AIDS Control Act 1987, Lothian had the highest HIV prevalence in Britain, 58% of which was drugs related (1988: 9-10).

The identification of HIV incidence in Scotland prompted the McClelland committee to be convened and the report to argue that the prevention of HIV spread should take precedence over the perceived risk of increased drug use. This was followed and legitimised by its UK counterpart, the Advisory Council on the Misuse of Drugs (ACMD(1)) report, accepted by the UK government, stating that:

> *A change in professional and public attitudes to drug misuse is necessary ... The spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, we believe that services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans.* (DHSS, 1988: 75)

So, when accepted, harm reduction marked a change in governmental approach. However, as Berridge (1993: 140) argues in the UK case, the emergent harm reduction approach was not new as such. Rather, in Sabatier's terms, the harm reduction "advocacy coalition" was able to use the advent of HIV and AIDS to assert its dominance within the drugs policy network, on the basis of the McClelland and ACMD(1) reports in Scotland and Britain respectively.

This also happened relatively quickly and obstacles to implementation were readily highlighted. The McClelland Report took only five months to fully report, while the subsequent ACMD(1) report not only legitimised its predecessor's approach Britain-wide, it was also very critical of its lack of speedy and effective implementation. The ACMD(1) report argued that although the most urgent action was required in Scotland, "services in Scotland are particularly ill-equipped to combat the spread of the virus", despite the fact that the McClelland report published its, "sensible measures to combat the spread of the virus", more than a year before the ACMD(1)'s investigation:

> *We are deeply concerned that many of the report's recommendations have not been acted upon and we consider that valuable time has been lost in tackling the spread of HIV in Scotland.* (DHSS, 1988: 55)

In particular, the report was critical of the lack of, "easy, uncomplicated access to advice on safer practices and to sterile injecting equipment" for injecting drug users (1988: 58). The inference was clear - the harm reduction approach was not sufficiently manifest in the services available in Scotland, in three main ways. First, the then current **needle exchange schemes** were inadequate, "inaccessible and unattractive to the vast majority of drug misusers" (1988: 58). The then current practices were not only unattractive to the drug user, but also insufficiently helpful when the user was attracted. Second, the ACMD (1988: 59) reinforced the McClelland Report's emphasis on the value of **substitute prescribing**

and an, "increased willingness at all levels to prescribe", the lack of which led to a failure to foster links between drug users and the medical services. Third, **community based schemes** were either insufficiently funded or, "too strongly associated with abstinence" (1988: 55). Further, much of this argument follows the McClelland (1986:7) report's insistence that:

> *There has been a prevailing medical opposition to maintenance prescribing, and a generally low level of investment in provision of a medical drug-dependency service which may have led many drug users to sever contacts with hospital clinics or other medical agencies, or to avoid seeking professional assistance.*

Nevertheless, as Brettle (interview, 10.1997) argues, until the ACMD report, Lothian Health Board was, "dragging its feet as much as it could" and deflecting the advice from Brettle, Robertson and Bath about service delivery. However, following the report, proponents of harm reduction operated within a much more favourable context, since all three conclusions were largely accepted within government. These are discussed in turn. Needle exchanges and substitute prescribing are discussed in this chapter, since they demonstrate the relationships between the Scottish Office and unit levels of government. Discussion of the rise and fall of community based groups is discussed in the following chapter in terms of the relationship between drugs policy, HIV and group activity in Lothian.

Needle Exchanges

The criticism of needle exchange schemes, as well as the lack of substitute prescribing, provides the context for the introduction of the Community Drug Problem Service (CDPS) in Edinburgh. The McClelland report highlights the lack of general medical involvement in prescribing, and the ACMD(1) report highlights the inadequacy of the initial needle exchange programmes in Scotland. However, it is worthwhile to further detail medical provision before the introduction of the CDPS as a solution to these problems, especially since it is unlikely that its setup was the inevitable consequence

of these criticisms.

The availability of substitute prescribing before the effects of the McClelland Report is generally thought to be restricted to Roy Robertson's GP practice in Muirhouse and Ray Brettle's Infectious Diseases clinic at the City Hospital, reflecting in great part the importance of "bottom-up", individual initiative in early drug and HIV responses as an impetus for subsequent statutory responses. As Richardson and Gaskell (1989: 100) argue:

> *The issues surrounding harm reduction are difficult, but in Lothian they have generally been faced by individual professionals much earlier and tackled more effectively than by those in higher management. Initiatives, such as those at the City Hospital, in Muirhouse and in the establishment of the Community Drugs Problem Service, have been driven by specific individuals, rather than by government, regional, Health Board or social service policy.*

The point may be overstated, reflecting the authors' closeness to the issue and the frustration felt by those at the "street level" in facing the inertia of bureaucracy, rather than a belief that such policies could be sustained without some government support But certainly each initiative is correctly associated with a small number of (mainly) doctors involved at the time, operating under new conditions and uncertain constraints. The CDPS was not an inevitable result of either the McClelland or ACMD reports, but rather the product of the initiative of Judy Greenwood within the ensuing context. And neither would the lamentation of the lack of medical involvement in drugs lead to greater medical involvement, nor would the criticism of the lack of needle supplies by both reports necessarily have led to their reform, without the operations of the CDPS, as the following discussion demonstrates.

Early HIV/drug "policy" in Lothian consisted of Dr Roy Robertson giving out

needles and syringes and prescribing alternatives to heroin (even before the identification of HIV in injecting drug users), and Dr Ray Brettle initiating substitute prescribing for drug users attending the City Hospital's Infectious Diseases Unit, as well as supplying needles "on the side", influenced by evidence that their used and possibly infected supplies were frequently stolen (see Garfield, 1994: 93-5). Further, both were able to act relatively independently because in many respects they were acting "ahead of the game", or before the appropriate new regulations or top down polices were in place. "Bottom-up" policy, then, consisted of reinterpreting current policy in the light of new evidence and circumstances. Indeed, Brettle (1996: 7) notes that his early prescribing practices showed, "that NHS Consultants are quite powerful individuals". In the face of significant opposition, Brettle was confident that if he, "simply followed the regulations for prescribing very closely no one was able to fault what I was doing". Of course, it would be naive to assume that clinical autonomy knows no bounds. Rather, doctors work within regulatory and budgetary constraints which prevented both Brettle and Robertson treating as many patients as required. For example, (in correspondence, 1997) Robertson intimates that he thought his early HIV infected patients had every right to sue him as a health provider since he knew how and why to treat them, but was unable to do so. Similarly, Brettle (1996: 7) complains that the City Hospital prescribed a lot of methadone between 1986-7, but since the funding was not there he was, "told very forcibly to limit my prescribing to people who only had HIV" (possibly by the chief medical officer of the Lothian Health Board - see Greenwood, 1990: 587). This was an inconsistency heavily criticised by the ACMD as well as patients, some of which, "always felt that they were infected with HIV as a result of that silly restriction on methadone prescribing" (Brettle, 1996: 7).

Similar restrictions are apparent in the early needle exchanges in Edinburgh. Although the McClelland Report recommended the immediate introduction of needle exchanges in Scotland in 1986, pilot exchanges in Edinburgh, Glasgow and Dundee were not approved until April 1987, the delay reflecting, "just one manifestation of the ambivalence towards this

group of patients which has been prevalent within statutory services and at government level" (Richardson and Gaskell, 1989: 83). Certainly, the government had over a year to consider the issue of needles and syringes and this does seem excessive, given the urgency of the issue and the attention to which the government was giving to the issue of AIDS in 1986 and 1987. However, the delayed actions in government may also be seen as necessary in the context of uncertainty surrounding the effectiveness of exchanges, as well as the political opposition to them. For example, when the McClelland Committee first met in February 1986, and while it recommended immediate encouragement and license for doctors to give out needles and syringes to patients on a one-for-one basis, it also agreed that:

> *Not enough was yet understood about the relationship of sharing needles and syringes by intravenous drug misusers and the spread of HTLVIII infection for the Committee to make a recommendation for their wide distribution in Scotland* . (McClelland, 1986: 16)

It thus concluded at the time that more research was required to discern the precise relationship between sharing and infection, as well as sharing and the availability of needles and syringes (1986: 16). This initial uncertainty was also met with political opposition within Parliament, which reflected some public concern about the concentration of drug users in certain areas and the possible rise in needlestick injuries. In March, Sir Bernard Braine, then chair of the all-party committee on the misuse of drugs and leading an Adjournment debate on "Drug Misuse and AIDS" also questioned the logic of exchanges:

> *If dirty, reused needles are the principal means of spreading infection among drug users, would not a freer supply result in the means of infection being more widely available than now is the case?* (Hansard, 6.3.86: c561)

In the same debate, the then Minister for Health, Barney Hayhoe, also expressed the doubts within government surrounding the usefulness of exchanges:

> *I do not believe, according to the evidence as presented to me, that the greater availability of clean equipment if one could so describe it, would have the effect that many argue in reducing the use of contaminated needles* . (Hansard, 6.3.86: c564)

Further, the introduction of exchanges was beset by legal problems. The first was that at the time of this debate the government was also introducing an amendment to the Drug Trafficking Offences Bill to make it an offence to supply equipment for the purpose of administering illegal drugs (Hansard, 6.3.86: c564). The legal position in Scotland was also less conducive to the introduction of even politically sanctioned exchanges and neither the Scottish Secretary, Malcolm Rifkind nor the Scottish Health Minister, John Mackay, were particularly willing to sanction them anyway (see Garfield, 1994: 97).

So it may be no surprise that Norman Fowler waited for the lead of the full McClelland Report in September 1986, which stated that in cases where injecting drug users could or would not abstain, education and support was required to persuade them:

> *... to use clean equipment and never to share it. Clean equipment should therefore not be denied to those who cannot be dissuade from injection ... On balance, the prevention of spread [of HIV] should take priority over any perceived risk of increased drug misuse* . (1986: 12)[6]

Even then, both Fowler (1991: 261) and Edwina Currie (1989) expressed doubts over the adequacy of any exchange scheme without compulsory

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[6] A sub-group of the EAGA also expressed this view - see Garfield, 1994: 98.

counselling and education, and so delays were inevitable. Fowler, even when prompted by Gavin Strang in the first full parliamentary debate on AIDS in November 1986, would not respond that day since he was still apparently troubled over, "whether the free supply of needles may encourage drug misusers to inject" (Hansard, 12.11.86: c803). By December 1986, Fowler did acknowledge the recommendations of the McClelland Report, but chose to announce their introduction only as part of a wider project of reaching and counselling drug addicts, with the clear inference that the former would not occur without the latter (Hansard, 18.12.86: c701w). Further, the measures would not be implemented immediately, but following consultations, "with those most concerned locally - particularly the medical profession, the police and voluntary organisations" to decide on the location and number of schemes required (Hansard, 18.12.86: c701w), as well as the legality of their operations. As Stimson et al (1989: 192) discuss, the government sought to ensure police cooperation, as well as influence the prosecution of exchange related arrests, and in Scotland the Lord Advocate's permission was required and granted so long as participating staff followed closely the procedures approved for the schemes.

After receiving, "a wide measure of support" for the pilot schemes from that consultation, their set up was announced in April 1987 (Hansard, 2.4.87: c622w). In this and the December announcement, Fowler did admit that some exchanges had already been set up locally - for example in October 1986 in Liverpool by a drug training and information service and in June 1986 in Sheffield by pharmacists (see Stimson et al, 1989: 194-5) - before these announcements, and therefore that some pilot schemes merely legitimised their existing operations. However, this was far less likely in Scotland, where the law governing any drug related paraphernalia was more prohibitive. Indeed, a discussion of the early operations of the pilot scheme in Edinburgh demonstrates that the exchange policy in Scotland remained under a legally prohibitive cloud even when politically sanctioned.

Those who ran the needle exchange had very close contacts with local police even following dispensation from the Lord Advocate, not only because the police had to uphold the regulations, but also because those involved were obviously anxious to learn their boundaries. The problem of, "aiding and abetting ... was a huge issue for health care workers at the time", worried that anyone found supplying needles and syringes would end up in court (interview, Operational Manager HIV/AIDS and Drugs Services, LHB 4.1997; Brettle, 1996: 6).

So, it is worth painting the picture of early exchanges following political legitimation and the requirement of administration officers to register all users, a doctor to hand out the needles and syringes and qualified psychiatric support to ensure counselling. The ACMD (1) points out that Scottish pilot schemes were different to their English counterparts, since:

> *They are hospital-based, medically supervised, have limited opening hours and can only issue up to 3 syringes at a time. They could hardly be described as "user-friendly", and one is picketed by local residents. It is perhaps not surprising that they have failed to attract more than a tiny proportion of local injecting drug misusers.* (DHSS, 1988: 57)

Further, Edinburgh's official pilot scheme operated in an old annex to Leith Hospital:

> *... and we're talking about me sitting at reception, George Bath going down with some needles and some rubber gloves and [a psychiatric nurse] doing some counselling and that was it.* (interview, Operational Manager HIV/AIDS and Drugs Services, LHB, 4.1997)

So, the government guidelines only allowed for three needles to be given out in very limited time periods, subject to the recipient agreeing to

complete tracking questionnaires and counselling sessions. Further, the initial exchanges were undermined not only by their own conditions of operation, but also by the fact that alternatives developed to such exchanges. Initially, the alternative was an unofficial needle supply operated by Jacky Kerr which gave out needles with "no questions asked". And, following the rescinding of the pharmaceutical ban on the sale of injecting equipment, pharmaceutical needle exchange schemes, coordinated by the Harm Reduction Team and Lothian Health developed, of which 26 still remain in Lothian[7] . Last, but not least, the CDPS, as set up by Dr Judy Greenwood, run an exchange scheme from Spittal Street as part of its programme.

(2) Substitute Prescribing

Doctor Judy Greenwood (interview, 10.1997) recalls that while the government had taken on board the need to substitute prescribe and provide a needle exchange, the only GP prescribing was Roy Robertson; and, the exchanges themselves were not enough. Greenwood had worked one session per week at the Leith hospital as consultant cover for George Bath, "giving out needles and syringes and condoms to drug users who I'd never met before. I'd never even worked with drug users before". Thus, she concluded that it was wrong just to provide the equipment to prevent sharing, since, "we weren't really doing any work with their drug problems at all". In addition there was the problem of restricted prescribing at the City Hospital which saw only HIV positive drug users given methadone, to keep them returning to the hospital to chart their illness. So Greenwood proposed to act on the serious anomaly that if drug users were HIV negative they could only receive needles and syringes, but if positive could also receive methadone, leading to some, "trying to get positive to try to get methadone - which was a public health disaster".

Greenwood was convinced that methadone was required for HIV negative patients, and subsequently visited five UK drugs projects and searched the literature to back this up. By the end of 1987, Greenwood had written a

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7 Information from"Needle Exchanges" lecture by Liz Johnston (MELD) and Jim Shanley (Harm Reduction Team, 2nd George Bath Memorial Day, 1997.

proposal with George Bath to the Scottish Office to develop the subsequently titled Community Drug Problem Service (CDPS). Quickly, the then chair of LHB, Winston Taylor, was supportive and the then manager of the Royal Infirmary of Edinburgh "backed it as part of the mental health service", providing half of Greenwood's salary, as well as that of two nurses. Further, the urgency of the era is revealed by the fact that the plans were accepted within four weeks of their inception, "set up really on the back of an envelope", and based on the trust held in one well respected and enthusiastic consultant, ACMD backing and the government seizing on the idea of exchanges:

> *Because HIV was so new and because the government was so nervous about it, that Tory government was surprisingly quite with it with HIV ... and they put this money very early in a separate top sliced budget for HIV and it was very easy because of our big problems ... to actually persuade them that we needed to set up the service very quickly* .(interview, 10.1997)

Greenwood's role changed from community psychiatrist to drug consultant and in April 1988 the CDPS became the first specialist clinical drug service in Lothian (Greenwood, 1996a). Subsequently, it developed a "shared care" approach involving the fostering of collaboration between the CDPS and GPs, whereby:

> *... general practitioners were encouraged to offer physical care and substitute prescribing of oral opiates or benzodiazepines, or both, in doses negotiated by the CDPS which would support the GP and offer the drug user regular counselling, and random urinalysis to encourage beneficial changes in lifestyle and drug use.* (Greenwood, 1996b: 8)

This may appear straightforward, and ten years on this approach was

widely accepted by GPs in Lothian, but this was not the case when the service was founded. Indeed, at the time a drug service set up through GPs was unusual, and one which was fraught with difficulty since there was a great deal of medical ambivalence at the time about the suggested model of treatment:

> *... much of which stemmed from the GPs' emotional and attitudinal situation. GPs often feel untrained, confused, alienated, disgusted, anxious, de-skilled, disillusioned, angry, overwhelmed, concerned or indifferent to drug using patients and such emotions can interfere with their professional skills.* (Greenwood, 1996a: 20)

Indeed, a survey of GPs in 1988 suggested that 47% of those polled would not prescribe substitute drugs for drug users (Greenwood,1996a: 21). At the time it was not certain that GPs would cooperate, especially since it was also not certain if the prescribing of oral drugs would promote behavioural change through constant contact between medical service and drug user (Greenwood, 1996b: 8). So how were GPs persuaded to prescribe, given that the supporting government publications recommending greater GP involvement generally followed the introduction of the CDPS? As Greenwood (1996a) discusses, first they were initially sent an explanatory letter requesting their help to curb HIV by prescribing methadone as they would any other medication recommended by a hospital specialist. Second, following GP referral of a patient to the CDPS, a community psychiatric nurse would arrange a local assessment of the patient as a precursor to a management meeting to discuss the appropriate treatment, which would then be relayed to the GP, with a full explanatory letter advising on the patient's management, followed again by some encouragement for the GP to take part in the treatment programme. Third, and most importantly, following GP agreement the CDPS would decide whether or not the patient required to be put through the CDPS Methadone Clinic for three days:

> *... with methadone administered on site followed by 3 weeks central prescribing before the GP is asked to take over the now stabilised drug user ... with the CDPS key worker ... continuing to offer counselling to the drug user ... and support to the GP.* (Greenwood, 1996a: 20)

Stabilising the prospective patient obviously helped, and the offer of continuous support after releasing them had the desired effect:

> *Most GPs welcomed the weekly support, supervision and monitoring of the patient's drug taking behaviour that the team offered in exchange for the burden of weekly prescribing, and they recognised the value of shared care.* (Greenwood, 1990: 588)

Finally, the CDPS, harm reduction, approach "infiltrated" general medical training events on top of specialist drug training events, and CDPS workers visited individual and groups of surgeries, while a free local information sheet was developed by a group of local GPs and specialists (Greenwood, 1996a: 20) From this came Dr Judy Bury's post as Primary Care Facilitator, who in 1999 still visited individual practices, produces the information sheet and arranges specialist training events on HIV and drug treatment.

Subsequently, the CDPS became a "cause celèbre" since it was originally a highly innovative way to work with drug users, as well as a relatively cheap one, employing one consultant and two nurses from the onset. There was a, "real pioneering feeling" in the first four years of its introduction, and GPs - as well as specialists such as Doctors Alison Richardson, Ray Brettle and Roy Robertson - quickly came on board. Indeed, by 1993, the number of GPs who would prescribe rose to 73% (36% in 1988), with 15% willing if asked (17%), and only 12% unwilling to prescribe (47%). Similarly, 88% had referred patients to the CDPS and 69% felt positive or very positive about the CDPS (see Greenwood, 1996a: 21). Further, the rate of new referrals on the basis of GP acceptance rose

continuously, with almost 3000 referrals by 1993, of which 64% had attended the CDPS (Greenwood, 1996b: 9). This allowed a rapid increase in CDPS staff with new HIV money (Greenwood, 1997: 1). Finally, on the basis of evidence of the reductions of HIV transmission, injecting and death rates, the Scottish Office encouraged Greater Glasgow Health Board to adopt the same model (interview, Greenwood, 10.1997 - see below).

But, at this stage, how does this discussion relate to the question of sector/ subsector, or the relationship between departmental and unit levels of government? At first sight it appears to demonstrate the dominance or medicalisation of the drugs issue by a unit level of government. In an area of high governmental and local statutory interest, a formerly punitive policy of central government had been gradually replaced by a largely bottom-up, harm reduction approach with little basis in government policy bar its extension of the provision of needles and syringes. The CDPS was original and innovative, providing a specialist referral system for all drug users, irrespective of their HIV status, in an area with relatively few government guidelines. The CDPS was a powerful coordinating body, liaising with the majority of GPs in Lothian and, as in the discussion of Brettle and Robertson, Greenwood was founding a bottom-up policy which was "ahead of the game", acting relatively independently. The CDPS was funded by a government which was cash rich but knowledge poor, allowing its relatively autonomous development.

However, as noted above, this argument has to be qualified, both in terms of the challenges to the "ethos of shared care" caused by demographic change as well as central government inspired NHS reform. Further, the consistently high attention paid to drugs policy highlights the episodic nature of this policy area, suggesting the cyclical rather than incremental and insulated development of drugs policy.

First, there were changes within the service itself. From 1993 to 1995 the CDPS experienced a rapid turnover of staff at a time when the population it covered was still rising. This undermined the ethos of the CDPS since less

time was available to train the new and relatively inexperienced staff, while the new consultant recruits came from a more "traditional" background (Greenwood, 1997: 4).

Second, the CDPS was affected by government policy, and most notably the NHS trust and GP reforms which caused a:

> *... change in management and administrative style with a new emphasis on clinical directorates, clinical managers, business plans, productivity targets, efficiency savings, quality standards, and the need for throughput to meet and service the referral demands from GPs within a certain time frame.* (Greenwood, 1997: 4)

This affected the CDPS in two main ways. First, the "shared care" ethos of the service was undermined by the purchaser-provider split and GP fundholding roles. Second, the running of the service itself changed and Greenwood made way for a new manager, since it was felt that:

> *... the qualities needed for pioneering the service model and persuading GPs to work in shared care with drug users were not necessarily those needed to manage a large and flourishing drug service ... the art of shared care was being modified by the science of the market place.* (1997: 5)

The NHS reforms affected not only the type of manager required, but also their role and hence the ethos of the service, with more time taken up on audit, budget and administrative meetings, when before it had been "back of the envelope stuff" (interview, Greenwood, 10.1997), and less time to exchange ideas within weekly team meetings, which were considered, "time consuming and unnecessarily democratic" (1997: 5). In other words, more time was spent on scrutinising parts of the service to comply with audit demands, rather than more holistic issues like the changing CDPS/ GP

relationship and changes in drug use in the community (1997: 5). Similarly, the replacement of the multi-agency Lothian Strategic Planning Team for Drugs by the Scottish Office inspired Drug Action Teams[8] meant relatively less hands-on experience possessed by senior members than hitherto existed with the multi-agency format and therefore less sensitivity to, "emerging issues such as pharmaceutical drug leakage [i.e trading], pressure of referrals and changing patterns of care" (1997: 5). Further, Community Care proposals encouraged the Royal College of Psychiatrists to recommend that community psychiatric nurses worked closer with specialists rather than closely liaising with primary care services, "again somewhat at odds with the CDPS model" (1997: 5).

These factors <u>furthered</u> a changing CDPS focus from keeping patient contact with CDPS workers for as long as possible to discharging them back to the GP as soon as possible, "i.e. once they appeared to be stabilised on a substitute prescription and showing less signs of emotional or behavioural disturbance" (1997: 5), since this was increasingly necessary anyway, with so many referrals to the service - reaching over 1000 per annum by 1996 (1997: 6) - to allow for the minimisation of waiting lists for the methadone titration clinic. However, this has had 2 main effects. First, there is a cyclical effect when shared care is undermined. More (1500) patients are now in greater contact with GPs than with the CDPS (600), and so the monitoring of their progress is increasingly difficult, again undermining the idea of shared care, especially since the CDPS is likely to be in most contact with patients who are more chaotic and take up a disproportionate amount of its time (and money). Further, since CDPS workers are less familiar with the shared care model and have less time to liaise with GPs, this centralisation of prescribing is likely to continue (Greenwood, 1997: 6).

The second effect relates to increasing GP concerns regarding the changing nature of referrals. The original CDPS was dealing mainly with past injectors whose motivation to use the service was relief at the reduced

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8 See *Drugs in Scotland: Meeting the Challenge* .

likelihood of HIV infection, due to their use of street heroin and the restriction of needles and syringes. However, since 1994, past injectors only account for one third of the methadone receiving population, with the rest now down to non-injecting drug users including, perhaps most worryingly, those already using methadone bought from a street source (1997: 8). Further the evidence on methadone leakage and subsequent methadone related deaths suggest that patients are increasingly able to trick doctors into prescribing higher than necessary dosages. So, the changing nature of referrals combined with the changing emphasis on GP involvement has proved unpopular at the very least with a hard core of GPs who still either think prescribing is wrong or that it should not be done by GPs, and which is over represented in increasingly powerful local GP management committees (interview, Primary Care Facilitator, 7.1997).

The point of this discussion, then, is that a longer term analysis of this policy area allows the modification of the assertion that the policy area is dominated by a subsectoral, unit level of government, since least in the long run, the CDPS was subject to change from central government reforms. The purchaser-provider split undermined the shared care approach, the emphasis on GP fundholding increased the power of its "partners" and the changing roles of managers within the CDPS undermined its original ethos, focusing more and more on budgetary constraints and accounting procedures.

Further, GP concerns and the need to readdress the CDPS position on the provision of methadone to avoid leakage highlights the episodic nature of drugs policy, or the serial return of this issue to the attention of various decision makers at various stages. The longer term perspective here is crucial, because as recently as 1995, the CDPS would seem to have achieved unqualified success, with the methadone programme reducing injection related infections and deaths, and with the Scottish Office keen to effect policy transfer in Glasgow based on the CDPS shared care model. However, while methadone seemed to be the policy solution to HIV and injecting, and in effect the end of the line, it has raised the issue of

methadone leakage and death, and the whole issue of non-injecting addiction. Rather than being at the end of the line, the methadone policy began a new policy cycle both locally and nationally.

Nevertheless, the effects of this new cycle are debatable. Practitioners of harm reduction face criticism not only from those in favour of punitive policies, but also those who agree with the philosophy but not the method. However, this does not always weaken the philosophy, since the policy transfer involved in setting up Glasgow's service following Edinburgh's success involved changes which strengthened its position by addressing the existing drawbacks. As Greenwood (interview, 10.1997) argues, until the mid-1990s the Edinburgh set up and the CDPS was seen as the best example of how to manage drug users:

> *... because we'd cut the HIV problem, we'd cut the injecting rate and our death rate was quite low, so the Scottish Office was actually pushing Glasgow to adopt our model.*

However the Glasgow service was set up seven years after the initial service in Edinburgh, and so the policy transfer was set up with the benefit of hindsight. Those involved with the Glasgow service were able to witness the problems of "methadone leakage", or the sale or distribution of some part of a user's methadone prescription, "and so at the outset they went to supervised consumption for everybody". There was also far more money available for the initial service than there was for the CDPS because it was Scottish Office concern, reflecting public pressure to act on the rising drug related deaths in Glasgow, rather than "bottom up" initiative, which provided the driving force towards its quick set up. So the Greater Glasgow Health Board was able to fund its GPs (to ensure prescription cooperation) and pharmacists (to provide on-site oral consumption) from the outset to ensure that the service was set up to provide supervised consumption. Subsequently, drug related deaths "shot down" while methadone leakage was much less of a problem:

> *So suddenly Glasgow has now become the sort of 'in' service and we've now become the sort of 'bad news' because of our deaths.* (interview, Judy Greenwood, 10.1997)

The more recent and relatively successful Glasgow experience thus provided justification for Lothian to move towards supervised consumption, and the transfer of policy was not all one way, since the process of policy transfer itself allowed a reconsideration of the policy. However, again, this is not to say that Lothian's original policy - under far more difficult and urgent conditions - was unsuccessful, even if the constant changes in levels of patient prescription are labelled by some as a "flavour change" (interview, Social Work officer, 6.1997), since the spread of HIV and the injecting related deaths would have had a much worse impact on its population (Greenwood, 1993). Rather, it highlights the episodic nature of drugs policy.

Episodic Drugs Policy or Insulation for Harm Reduction?

Drugs policy is one of the best examples of the existence of episodic policy making. Yet, this does not necessarily lead to wholesale implementational change. That is, it is an area which is salient, revisited by government and by Parliament, as well as all media, and which shows promise for the politician ready to enact immediate change. As Judge (1993: 131) argues, such processes are indicative of an "episodic" policy process (see chapters 3 and 5). Yet, however much policy is revisited by whatever body, and however punitive this rhetoric may be, the policy of harm reduction has been comparatively unscathed since the introduction of AIDS into the policy mix. As discussed above, the problem of methadone leakage was dealt with by changes in the system of delivery rather than changes in the policy. So how does harm reduction remain so insulated from its surrounding, 'high politics' environment?

Three related dimensions may explain the dichotomy: the formulation/

implementation distinction, the distinction between criminal and health policy areas and the "twin-track" approach. First, then, the punitive agenda may dominate one level of government, but may not be so dominant when it reaches the operation of a lower level network. In particular, it may dominate debates within central government and Scottish Office levels, but only impact on the actions of implementers inasmuch as it is thought likely to affect their operations. The salience of the issue may also have different effects on each implementing authority. As discussed above, the concern over drug related deaths prompted action in Glasgow akin to that which took place in Lothian seven years before. In Edinburgh, the more established service was less likely to enact such wholesale change.

Similarly, the punitive agenda may refer more to criminal, rather than health policy, and so policy change may impinge only on factors such as sentences for possession. However, as discussed below, the distinction between penal and health measures is not <u>that</u> clear. Rather, the relative stability of harm reduction can be attributed to its political legitimacy afforded by AIDS, as well as the maintenance of this legitimacy not only by implementing agencies, but also by the civil service end of government in the face of episodic rhetoric.

Berridge (1998; 89) uses the term "twin-track" to describe the approaches of government departments responsible for penal control and medical reaction inherent in the history of drugs policy. Berridge traces modern drugs policy to the 1926 Rolleston Report which originated as a concern of the former, but was officiated by the latter which established the medical response to drug addiction, based on the "disease model of addiction", and affirming, "a doctor's clinical freedom to provide maintenance doses of opiate drugs as a form of treatment" (Berridge, 1998: 89). However, this operated within a "legal system based on penal sanctions and international controls", and so the balance between punitive and medical responses varied over time (1998: 89).

Berridge (1998: 98) argues that by the beginning of the 1980s, the balance

had swung towards a penal response, reflecting in part the retreat of medicine from involvement in that policy. Indeed, from a medical power perspective one could argue that penal responses fill the gaps left by medical retreat. This was manifest in the restriction of drug clinic services to short term treatments for motivated addicts, as well as the DHSS sanctioned medical withdrawal from prescribing (1998: 99). In turn, this change of approach reflects not only clinical discomfort with the role of "glorified shopkeepers", or the mere maintenance of the supply for drug users, but also an officially sanctioned change in the definition of drug use (1998: 99). That is, in the 1960s this had changed from a disease requiring specialist treatment to the WHO inspired concept of dependence (paralleling developments in alcohol treatment - 1998: 99), and by the early 1980s dependence was only deemed worthy of medical intervention if other subsequent problems were manifest.

As discussed by Cranfield and Dixon (1990: 5-7), until the impact from HIV was felt, drug specialist services, and drug dependence clinics in particular, were primarily concerned with "problem drug takers", defined by the ACMD in 1982 as:

> *any person who experiences social, psychological, physical or legal problems relating to intoxication and/ or regular excessive consumption and/ or dependence as a consequence of his [sic] own use of drugs or other chemical substances (excluding alcohol and tobacco).*

However, this change of approach was accompanied by DHSS encouragement of rising police, local authority and most importantly voluntary agency involvement, thus diluting medical involvement, especially in terms of the membership of the ACMD. Berridge argues that one consequence of this dilution was a shift in approach and the formation of a new and broad-based policy network, "involving revisionist doctors, the voluntary agencies, researchers and, most crucially, like minded civil servants within the Department of Health", who were keen to foster, "a more

bottom-up approach, to try and bring the voluntary agencies, drug and ex-drug users into a more active relationship with services" (1998: 91). Subsequently, the newly formed ACMD took harm reduction as its broad approach. However, the measures associated with such an approach were, not politically acceptable, and it took the advent of AIDS to change this.

AIDS allowed the ACMD to modify its position to include:

> *... an expansion of our definition of problem drug use to include any form of drug use which includes, or may lead to, the sharing of injecting equipment.*

Further, as Cranfield and Dixon (1990:7) discuss, this led to the requirement of drug agencies and services to make contact with, "as many of the hidden population of drug users as possible" to ensure their access to all the available advice and counselling on harm reduction and treatment services. The new definition thus fostered outreach work, added pressure for the use of needle exchanges and, most importantly, encouraged drug dependency clinics to, "adopt more flexible prescribing and treatment policies in order to attract drug users into treatment and to maintain longer term contact with them" (1990: 8).

Further, political legitimacy of the new approach was ensured by DHSS endorsement of the ACMD statement that:

> *A change in professional and public attitudes to drug misuse is necessary ... The spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, we believe that services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans.* (DHSS, 1988: 75)

So, while political or rhetorical concern over drugs policy follows an

episodic cycle, the continued statement of the primacy of the risk of HIV has ensured that this does not impinge on the implementation of policy and that more punitive measures are deflected (since we argued that penal responses fill the gaps left by medical retreat, which is now less apparent). However, what happens when the importance of AIDS itself diminishes? If public and governmental attention to AIDS resembles an issue attention cycle, what happens when AIDS slides down the agenda, but drugs returns to the top? Two Scottish Office examples highlight this effect.

(1) Insulation

At this stage, any such discussion of the Scottish Office requires disaggregation, and, in both examples, the political and administrative or ministerial and civil service distinctions highlight the often conflicting approaches to drugs policy. As discussed in chapter 7, civil servants in the DH(SS) were the initial force behind government legitimisation of harm reduction, and the same can be observed in the Scottish Office in terms of attempts to maintain this legitimacy. This is apparent as recently as the consultation process preceding the 1994 Ministerial Drugs Task Force report, *Drugs in Scotland: Meeting the Challenge*, which at the time was considered to be innovative, as well as distinct its English counterpart. It was "ahead of the game" at a time when Scottish circumstances were considered to be sufficient to allow an opt-out from the UK-wide approach (interview, Dave Liddel, Director, Scottish Drugs Forum, 6.1997).

The centrality of the civil service within the SO drugs network responsible for this report is apparent both in terms of its relationship with groups and the relevant minister. First, close involvement with particular groups suggests the broad approach of the network itself. In this case the Scottish Drugs Forum, a harm-reduction oriented group, was granted specialist insider status: "basically there was a very good group of civil servants around at that time that we worked closely with to produce that report" (interview, Dave Liddel, Director, Scottish Drugs Forum, 6.1997) which included the continued support for substitute prescribing, needle and syringe exchange schemes, non custodial programmes for drug users, and

the commissioning of information/ publicity materials from the SDF. Indeed, even before the production of the report, the SDF had weekly personal meetings in the Scottish Office, as well as regular phone contacts, as part of their exchange of expertise for access, and a partnership, "where we effectively had the same agenda" (interview, 6.1997). The relationship even worked both ways in the case of Liddel, who worked on at least one committee which the SO had an interest in lobbying. However, perhaps the best example of this close relationship is the process surrounding the inquiry of the Scottish Affairs Committee which preceded the Task Force report. Liddel had been invited to act as a specialist adviser to the committee, to provide a list of questions to ask Lord Fraser. As well as fulfilling this task, Liddel provided civil servants with some of these questions in advance, to ensure an effective and considered response.

So, the civil service and SDF approach was clear, but how was it furthered within the Task Force itself? The membership of the Task Force suggests that no radical policy change would be forthcoming anyway, and Lord Fraser, compared to Michael Forsyth, was considered to be relatively liberal. However, this would not by itself ensure the civil service line. Rather, this was maintained because the civil servants responsible for the report could manipulate both group consultees/ Task Force members and Fraser because they alone were responsible for the minutes of each report, the chairing of most meetings and the drafting of the report. Fraser attended few of the Task Force's meetings, and so relied mostly on the minutes of meetings he did not attend, as well as advice from civil servants on the attitudes of groups which he did not regularly meet. Similarly, while the attendance of Task Force membership was more frequent, the relaying of ideas and opinions of these members, as well as other groups, was dependent on their detailed inclusion within the minutes drafted by the civil servants, which was not always forthcoming. So, since the civil servants were central to the administration of the Task Force report, and provided the mediation between group interests and ministerial involvement, they were best placed to influence the direction of the report, which they duly did (interview, former civil servant, 7.1997). Such a process is indicative of the

centrality of the civil service in Scottish Office responses to AIDS and drugs. Civil servants successfully furthered governmental legitimation of the harm reduction line.

(2) Ministerial Intervention

However, the second example shows one way that the episodic nature of policy can have an effect on the balance between medical and penal responses to drugs policy. As discussed above, HIV/ AIDS is a good example of a set of external circumstances which force the balance to change. But now, since HIV is not high on the agenda, and drugs remains so, drugs policy is again subject to the original rhetoric, and again the balance has changed. The harm reduction measures initiated in Lothian on the basis of the threat of injecting related HIV were successful. Injecting fell. Injecting related HIV and injecting related deaths fell. However, now, since injecting related HIV is much less of a problem, and methadone leakage is more, the gains are less clear, especially if those on methadone have never injected. Further, as discussed below, the government funded Scotland Against Drugs (SAD) campaign has, often successfully in terms of media coverage, blamed harm reduction agencies for the general rise in drug related deaths, including those related to oral or "recreational" drugs like ecstasy. Subsequently:

> *The harm reduction approach has become a bad word .. I think it's a political hot potato to be seen as lenient with drug users... [the Tories] got round it with the HIV problem, but now the HIV problem is not as high on the agenda.*
> (interview, Greenwood, 10.1997)

However, until recently, harm reduction policies have been relatively insulated from such pressures. So, the changing SO emphasis must have relied on more than rhetoric. Rather, it was furthered by a ministerially driven policy unobstructed by civil servants. Since this runs counter to the chapter's previous arguments, it deserves further comment.

As discussed above, civil servants have advantages over ministers (and groups) because they coordinate, attend, and minute the meetings, draft the proposals, and provide the links between experts and the decision makers. They are better informed and more established than ministers, whose reign may be less than half of a parliamentary term. They are thus more involved in the policy area they are responsible for, and are justified in maintaining a consistent and established agenda or "departmental view" in the face of new and relatively inexperienced ministers who may have few clear policy objectives. However, while these factors explain the harm reduction line in the first example, they did not apply in the second. First, when Michael Forsyth replaced Ian Lang as Secretary of State for Scotland, drugs was high on his agenda, and he devoted a lot of time to an issue he had clear ideas about even before taking office. Further, ministerial turnover in the Scottish Office is relatively low, with only nine Secretaries of State in 36 years[9].

Second, civil servants may be, on the whole, relatively established in their departments. However, there is still some civil service turnover. Indeed, Liddel (interview, 6.1997) complains that the (on average) <u>two year turnover of civil servants</u> in this policy area forces groups such as the SDF to "start all over again", in terms of "befriending" civil servants, and regaining access to this otherwise "closed world". Since the new civil servants are less familiar with group members and their attitudes, the groups have to strike a "delicate balance" - which they would not otherwise have to do with a more established service - between courting insider status and being critical of proposed policies: "we're called in by the Scottish Office to make appropriate critical comments but at the same time we want to keep them broadly on our side". Further, Forsyth's SAD initiative, which encouraged the introduction of high profile campaigns promoting the complete abstention from drug use (a clear departure from the harm reduction

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9 See the ESRC's "The Organisation of Central Government Departments: A History 1964-1992" (http: ///www.open.gov.uk). This shows great variation in ministerial tenure, ranging from a 16 month average for Parliamentary Under Secretaries of State for Transport to 3 years for Chancellors of the Exchequer (and 5 years for Prime Ministers). Within the Scottish Office, the average tenure of both Parliamentary Under Secretaries of State and Ministers of State is over 3 years.

approach previously endorsed by the SO), coincided with such a major civil service turnover, with most of the senior grades involved in Scottish Office drugs policy, including the Under Secretary, leaving around this time:

> *So you had a whole new bunch of civil servants who didn't know their brief at all in terms of drugs. Forsyth came in with his idea and if there had been some of the previous civil servants they would have at least put up a fight and said this is going to be disastrous ... [but] there wasn't a lot of bottle in terms of opposition from the civil service.*
> (interview, Liddel, 6.1997)

The newly incumbent civil servants had no established group links, and hence no reference points for the discussion of the new approach, concerned with traditional Conservative concerns such as "turning back the tide" and the "balance of morality". Indeed, arguably because they had little knowledge of the drugs field and the history of drugs policy, they may have been supportive of the resurrection of an abstinence based campaign which had been replaced within the Scottish Office by a harm reduction approach in the 1980s because of the overriding importance of AIDS and the dubious practical value of former campaigns. Certainly, Liddel (interview, 6.1997) argues that in more recent times, the civil service has, "begun to believe that SAD was a sort of Frankenstein's monster that they assisted in creating".

So, the arrival of Forsyth changed not only the SO's attitude to drugs policy, but also the nature and membership of the policy network. For example, the SDF had no established links, and would find it difficult to make those links, given the difference in the emphasis of campaigns, as well as the way in which Forsyth ran his departments:

> *SAD came along and ... we were viewed with suspicion all of a sudden ... as an outsider ... Forsyth was a stickler for the authoritarian regime [and] all the civil servants were*

> *watching their backs, reluctant to speak to us for fear of being repeated.* (interview, Liddel, 6.1997)

Forsyth initiated the SAD campaign in January 1996 as a "crusade" against drugs. Since he placed so much emphasis on this policy issue, and the focus was so simplistic, it was difficult to oppose or even refuse to give support, and it soon received all party support in Scotland, as well as as attracting support from businesses, police chiefs, church leaders, councillors and so on, many of whom later formed the 35 member advisory council (*Scotland on Sunday (SoS)*, 6.7.1997: 10). Subsequently, the SAD advisory council replaced harm reduction groups within the network, and received an initial £1 million launch grant, leading to a sizeable budget of £2 million per year for advertising campaigns which marked a departure from the harm reduction message (*SoS*, 6.7.1997; *Scotsman*, 23.1.1998). Indeed, while the initial remit of SAD was *not* to attempt to scare people about the risks of drugs, its first major campaign in the autumn of 1996:

> *... used scenes of date rape, a comatose drug taker lying in a hospital bed and a corpse being dissected to drive home the message: drugs can be fatal - steer clear ... Such images were a throwback to the discredited "just say no" strategy.* (*SoS*, 6.7.1997)

Similarly, the second campaign was arguably to alarm parents about the likelihood of their children's drug use, asking the question: "what do you call kids who take drugs? the majority" (*SoS*, 6.7.1997). Further, SAD's media backed campaign was in danger of attacking the harm reduction measures which were still government policy, even though its original remit had included some elements of harm reduction to secure its funding. By June 1996 at the time of National Drug Awareness Week, SAD's campaign director, David Macauley, had begun to attack government funded harm reduction agencies, suggesting that the approach of "peddling the myth that drugs can be safe", was responsible for the spate of ecstasy related deaths at the time (*SoS*, 6.7.1997). Indeed, Campbell reports that Macauley was

influenced by Jack Irvine, its media based advisor, in exploiting the lack of cohesiveness in the drugs policy line of the SAD advisory committee, to abandon and attack the harm reduction philosophy, or the "'muesli-eating, happy-clappy, pro-drug' support network for drug takers" (*SoS*, 6.7.1997). However, since most government funded drugs agencies follow this philosophy, the result is that, "a campaign intended to play a key role has been left isolated from the very people it should have been leading (*SoS*, 6.7.1997). Indeed, as Liddel (interview, 6.1997) argues, "most agencies at that time were keeping their heads down". .

(3) A New Network?

So what do these examples say about the SO's drugs policy network? First, since the existence of HIV and AIDS, civil servants within the SO have provided the driving force towards harm reduction measures by funding and subsequently forging close links with like-minded agencies. As the first example demonstrates, civil servants manipulated their roles as mediator between groups and ministers and drafters of the minutes of meetings and the report's agenda to work closely with groups such as the SDF to produce the bulk of *Meeting the Challenge*. However, the episodic nature of drugs policy and the agenda of Forsyth undermined the stability of this relationship, causing, arguably, a period of "chaotic" policy making culminating in a government funded condemnation of the very services that the government funds! Previously close relationships between harm reduction agencies and civil servants were undermined by this agenda as well as the coinciding turnover of those civil servants.

The dubious success of this may partly explain the fact that Labour's first major reaction to SAD was to remove £1.5 million from its budget and slim its advisory committee to 6, returning the lead publicity role to the harm reduction oriented HEBS (*Scotsman*, 23.1.1998), which in turn may explain the resignation of Macauley, who as a parting shot attacked the political will of both Tony Blair - for consorting with known drug users - and Sam Galbraith - for uncritically accepting the practices of harm reduction agencies (*The Herald*, 31.8.1998). Further, Macauley's replacement,

Alistair Ramsey, as a former health education adviser to Glasgow City Council (see *Daily Mail*, 2.12.1998), marks a departure in personnel for SAD. Indeed his appointment was met with immediate criticism by representatives of groups such as Calton Athletic, and MediaHouse, the agency responsible for SAD's earlier advertising campaigns have also withdrawn their involvement.

Nevertheless, there is no evidence to suggest that the network has returned to its pre-Forsyth structure. Indeed, the legacy of the effect of civil service turnover on the policy network is that groups such as the SDF are reluctant to operate through civil servants - whose agenda still differs to some extent from harm reduction groups - if they can deliver briefs directly to Sam Galbraith, feeling that otherwise this gives the civil servants the chance to act as buffers and delay or dilute any recommendations (interview, Liddel, 6.1997; 12.1998). This may (although see above) be more possible following Galbraith's decision to chair the (previously civil service chaired) Scottish Advisory Committee on Drugs Misuse, but of course much depends on the development of Labour's future agenda which is still unclear. While Galbraith is the first Scottish minister to declare the link between unemployment, poverty and health, the latest campaign, "Drugs aren't glamorous or chic, just bad news" (*Guardian*, 17.11.1998) does not significantly detract from the paternalistic SAD campaigns which preceded it.

Insulation Revisited

Following the discussion of Forsyth it is difficult to maintain that networks are insulated from the wider political process, especially when ministerial intervention coincides with civil service turnover. A previously stable departmental level network was undermined by circumstances which are far from unique, whilst a return to a close policy community is not particularly close. So, this discussion in part qualifies chapter 7's conclusions on the existence of "chaotic" policy, since there were clear signs of the internalisation of policy and no civil service consultation was even apparent.

However, since implementation is multi-layered, it remains to be seen whether or not a changing emphasis on drugs messages had an effect on drug service delivery, since the new emphasis did not coincide with a completely new emphasis on the types of services which were funded. In any case, service delivery has more than one source of funds. So, while general governmental influences have affected service delivery at unit levels, this concerned more the effects of organisational change, rather than the political rhetoric surrounding drugs.

Conclusion

The UK AIDS case study demonstrates that policy began with bottom-up, subsectoral, activity which actually encouraged action at the sectoral level to achieve greater attention and funds for policy measures, as well as the necessary legitimacy the network required to operate in the long term. In the beginning, the importance of the sectoral level was not to set the agenda for subsectoral networks, but to legitimise the existing agenda of the initial network. However, this drive for legitimacy had its consequences for the subsequent development and agenda of the post-legitimation network. Specifically, because the subsectoral driven agenda entered the sectoral arena, the proponents of this agenda themselves were somewhat displaced, because the nature or set up of the network was different at that level. An established sectoral network with its own core insiders and senior members of government not only legitimised the existing policies, but also subsequently became responsible for the post legitimation agenda, and once prominent specialist insider roles of, activist groups was diluted or even marginalised when the specialist subsectoral level network was itself displaced.

But can this dynamic be observed in a parallel discussion of the implementation of policy? Discussion of the levels of government involved as well as the different nature of the policy problem in Scotland suggests yes and no. There is certainly evidence of similar effects, but confusion abounds without the disaggregation between levels of government networks, since the sector/ subsector distinction itself requires

disaggregation (to sub-sub sector), and sector/ subsector can be identified within these levels of government.

The work of Brettle and Robertson in the early phases of policy development, and Greenwood when policy was more established, demonstrates the bottom up nature of early drugs and AIDS policy. Further, the presence of such experts on the committees which produced the major SO reports - McClelland and Tayler - ensured in most part that early Scottish Office policy merely legitimised the existing harm reduction oriented practices which were established at unit levels in Edinburgh. This was confirmed in the almost uncritical government acceptance of the need to establish the relatively autonomous CDPS, responsible for the coordination of the shared care approach. Further, the most convincing justification for the detailed examination of early bottom up responses is that its legacy remains. The philosophy of harm reduction fostered in these early years, while subject to continuous pressure, is still the dominant approach at all levels of government, at least in terms of implementation.

This suggests that the policy drive came from unit and subsectoral level networks and that this effect could be generalised. However, this is undermined by the uneven balance of power between central government and unit levels in these examples. While the novelty of the issue allowed Brettle and Robertson greater policy freedom, financial constraints limited the extent to which they could implement. Similarly, while the needle exchange scheme legitimised the existing harm reduction philosophy, legal and political constraints delayed their introduction when it was clear that such a course of action was urgent. Further, in the case of the CDPS, the whole shared care ethos of the service was undermined by indirect central government measures, including the purchaser/ provider split, as well as measures to ensure greater financial accountability which redefined the requirements for the manager of the service. In other words, the bottom up conclusions to initial discussions have to be tempered by top down considerations of the political, legal and financial frameworks in which unit levels of government make their decisions.

Finally, as in the parallel UK example, the longer time scale allows the conclusion that the policy agenda was largely reasserted at the sectoral level following initial uncertainty and unquestioning funding. The Scottish Office has been unarguably prominent in the formulation of policies regarding prisons and drugs, and the constant supportive role of civil servants from the initial identification of HIV suggests that the legitimisation of harm reduction, in prisons and in the medical treatment of drug users, was crucial to its development.

But what about sector/ subsector? Does this demonstrate that the Scottish Office occupied the sectoral level of government? Unfortunately, the answer is yes and no. Of course, in terms of drugs and prisons policy, the clear implication is that it is, and the key to explaining network action at this level is in the discussion of the brokering of group activity in terms of the nature of the relationship between ministers and civil servants. For example, ministerial intervention has undermined harm reduction in recent years, at least in terms of health education if not service delivery. However, as chapter 9 suggests, general SO involvement in AIDS policy has diminished, suggesting an alternative conception of the sectoral level.

CHAPTER 9 - HIV/ AIDS POLICY IMPLEMENTATION - SECTOR AS POLICY

Introduction

This chapter follows chapter 8's focus on the sector/ subsector distinction, and the identification of the sectoral level in particular. It examines the utility of viewing the sectoral level as defined by the policy area, rather than authority, by stating that AIDS policy rather than health policy occupies a sectoral position. This is based on the following arguments:

(1) The Scottish Office was not the main actor in the decision making process surrrounding AIDS policy in Lothian;
(2) the main actors were statutory authorities who coordinated their approach, and formed an AIDS policy network in Lothian;
(3) the harm reduction approach adopted at such an early stage served as a blueprint for the subsequent actions of each authority; and,
(4) the policy area which binded each authority was AIDS policy.

In addition, there were no formal authoritative relations to bind each authority's actions. The agenda was set at the sectoral level by these authorities, but the implementation of that agenda depended upon cooperation on the basis of a policy driven imperative. This is an important discusion since it gives us the opportunity to assess whether policy or authority determines sectoral level status.

However, the lack of authority eventually undermined the network, and a sectoral level agenda based on policy soon proved to be temporary in this case, since statutory authorities eventually reverted to relatively independent action. So, whilst the initial discussion is important, it eventually serves to reinforce the link between sector and authority. As chapter 9 argues, the break up of the temporary network is itself based on indirect central government pressures and Scottish Office involvement, whilst one can discern a sector/ subsector distinction within Lothian Health (and other authorities) based on the formal positions of the actors within it, and with a broader health policy remit occupying sectoral status at this

regional level.

So, whilst Scottish Office influence is less apparent in this context it still fills the authoritative gap left by these fragmented regional authority arrangements, and this conclusion allows us to return to the focus of the operations of distinct levels of government action. Discussion of the reasons behind Lothian Health acting relatively independently allows us to answer the questions raised by the other themes which run throughout this thesis. It allows us to assess, over time, the existence and importance of the insider/ outsider status of medical professionals and groups, whilst continuing to address the importance of the power of professionalisation at lower levels of government. Finally, it shows us another important legacy of *Working For Patients* with regards to the changing consultative practices following its implementation, reinforcing the conclusion that broader health related sectoral issues impinge on AIDS policy within, rather than between, authorities.

Why is the Regional-Level Effect Important?

It may be analytically useful to make the distinction between policy and authority as the basis for sectoral discussions, but the centrality of regional and policy area-based activity must also be an accurate reflection of the policy area. Further, this is put into some doubt because, first, the policies derived from regional coordination (discussed below) did not mark a departure from the broad central government approach, and indeed the first regional policy document produced largely mirrorred a previous central government document (see below). Second, the case of AIDS policy is one of the best to demonstrate the enforced subsectorization which takes place within each disinct level of government.

The requirement of specialist knowledge is generally enough to insulate a specialist policy area from another. However, in addition to this, with AIDS policy the uncertainty with regard to the nature of HIV and the subsequent stigma attached to HIV by non-specialists also discouraged the "normalisation" or mainstream handling of the virus. Therefore, early AIDS

policy development was subsectoral within the Scottish Office and the then Lothian Health Board. Similalry, at unit levels, specialist centres were set up within hospitals and, less obviously, specialists were also manifest within general practice surgeries, with some GPs at first unwilling to treat AIDS patients or indeed, at times, intravenous drug users, and this had an effect on the development of the service.

As discussed in chapter 8, a small team headed by George Bath was charged with the initial implementation of HIV policy. The team favoured integrating HIV services into generic services whenever possible, but:

> *In a lot of cases that just wasn't possible ... primarily due to fear and ignorance ... when you asked generic services to take on the care of HIV infected people they all of a sudden asked for clinics to be cleaned after every consultation, masses of supplies of rubber gloves etc., and we thought hang on here, HIV is transmitted in the same way as Hep B and indeed other less serious infections ... weren't you doing this already. And of course that created a whole sort of political and financial element to the situation.* (interview, Operational Manager HIV/AIDS and Drugs Services, LHB, 4.1997)

The financial element was relatively easy to overcome, since often some of the initial HIV budget was distributed to the affected agencies, "although the policy for distributing money at the time did state that we shouldn't be giving the money out purely for health and safety purposes". This worked, at least initially (see below), with district nursing (DN) and health visiting (and physiotherapy) where, for example, instead of appointing a special team of DNs to deal with people who were HIV positive who needed DN services, money was given to the DN service to increase their overall size so that they could absorb the extra activity. However, the political resistance to integration was harder to overcome, often since health care workers were initially reluctant to treat HIV positive individuals:

And everywhere they go to have these routine health care issues seen to, you're going to meet a range of clinical admin staff all with their own prejudices, fears, budgetary constraints, ... anyway, for a lot of reasons there were, if you like, little sort of parallel health services set up here and there to deal with bits and pieces of health care that people with HIV had. (interview, Operational Manager, 4.1997)

Again, paediatric care was the most important example which was seen to warrant separate treatment because of the unique scale of babies and small children with possible HIV infections. So there were parallel paediatric services set up for HIV infected mums and their babies had to be monitored and checked, "and as it transpires that was a really successful one" (interview, Operational Manager, 4.1997).

Community psychiatric nursing also set up special teams to deal with the, "psychiatric and emotional fall-out from HIV infection". The specialist psychiatric team - later called CAST, the Community AIDS Support Team - was originally set up because the nature of work and clientele at Brettle's clinic at the City Hospital changed dramatically when HIV was identified. The clinic, "all of a sudden had tribes of infectious drug users who let's face it could be a pretty disruptive group", given the volatile behaviour associated with drug and poly-drug use, as well as HIV related dementia complications. So the clinic's physical nurses and clinicians were having to deal with emotional and psychiatric services, "and did their best but were really under fire":

... so a team of specialists were set up as a sort of crisis intervention, the reasonable intention was where a physical service needs a specialist backup on the psychiatric side they would call upon this team . (interview, Operational Manager, 4.1997)

So, in 1987, and often despite the best efforts of this initial team, specialisation was the norm, especially since the government's endorsement of the Tayler Report led to the granting of huge capital resources to three Scottish Boards with the main problems - Tayside with Dundee, Lothian with Edinburgh and Greater Glasgow - to build specialist AIDS units.

So, regional policy did not differ from government policy, whilst early activity was specialist. This would appear to suggest that the importance of activity within Lothian would be subsectoral and specialised and that a convincing demonstration of the existence and importance of regional/ sectoral level activity is required. This is achieved both in discussion of the role of the Scottish Office and the lobbying activities of individuals

The Scottish Office and HIV

The identification of SO influence in the areas of drugs and prisons policy may deflect from its involvement in HIV policy in general. As in the UK case, Scottish Office involvement in HIV and AIDS policy in general has waned over the years, following to some extent the issue attention cycles discussed in chapter 7. This is apparent not only in the decreasing real financial allocation, but also in the 1997 decision to devolve fully to Health Boards decisions over the allocation of care and treatment for HIV/ AIDS budgets. In other words, the devolution of financial responsibility fosters the "normalisation" of the issue, allowing HIV/ AIDS to be paid for from Health Boards' general allocations (correspondence, Scottish Office civil servant, 10.1997).

As chapter 6 argues, the devolution of financial responsibility is nothing new, and chapter 7 discusses that, whilst total UK government expenditure on AIDS rose from less than £2 million in 1986 to over £200 million in 1991, there was not a parallel increase in monitoring of service delivery (Berridge, 1996: 167). However, the difference in the late 1990s, as discussed below, may be that whilst initial funding was effectively devolved to unit levels of

government, with services developed "on the back of an envelope" or with "soft grants" , more recently the Health Boards themselves have become more financially responsible for service delivery, most likely because the devolvement of financial responsibility is a double edged sword. Whilst Health Boards have greater freedom in this regard, they also know that as part of the "rules of the game" they are not expected to invite Scottish Office involvement if for some reason the allocation is not enough to cover the problem. In other words, the SO is keen not to foster the approach that there is always "fall back money" to bail out Health Boards (interview, SO civil servant, 11.1997).

So, interactions between the Health Board and the Scottish Office do not necessarily set this former's agenda since, for example, the Health Board link with the SO is, "very formal, it isn't an active partnership in the same way as that which we try and get going with some other organisations" (interview, Director of Public Health, Lothian Health, 4.1997). Further, its involvement is not constant:

> *They're limited as it were in what they can do and the extent to which they can become engaged, unless they set up a specific working group on some particular topic ... HIV stimulated a lot of Scottish Office Working Groups in the 1980s, so obviously there was a more active partnership with the Scottish Office at that time than there is now* (interview, Director of Public Health, Lothian Health, 4.1997).

We can thus reasonably argue that to best understand the actions of Lothian Health we must analyse the decision making process at this level. Further, following chapter 4 we can postulate that there is a group-government relationship at this level which is akin to a policy network and that it is the nature of this relationship, or the interactions between groups and decision makers before the final implementation decisions are made which determines the development of relatively broad policies at this level.

The focus on Lothian Health thus allows us to investigate a number of network themes, including the professionalisation of networks and the existence and importance of insider/ outsider status (see below).

But this argument by itself only demonstrates the importance of independent regional authorities. So where does the importance of regional coordination originate? In most part it stems from the discussion of specialisation. Since the nature of the policy area facilitated a great deal of specialisation, and since the issue was so urgent, most of the policy actors involved were experts, or AIDS specialists who understood the need for quick and effective coordination to allow the speedy implementation of policy. So, in the event it took the coordinated attempts of key individuals to highlight the issue within government, and to maintain the status of the issue over time. Strong, vertical, subsectoral policy links based on expertise existed in each level of government, fostering close and personal working arrangements in Lothian.

Therefore, there are clear links to the UK example of the development of AIDS policy. In the UK case, as chapter 7 discusses, early DHSS activity was, "left very much to Sir Donald Acheson and his professional colleagues" (Day and Klein, 1989: 346). As the CMO, Acheson, in the absence of any formal policy machinery, coordinated and developed the formation of a loose "policy community" (in Berridge's terms), recruiting gay activist groups and some scientists and doctors from traditionally outsider specialties considered experts at the time. Acheson also ensured that AIDS was given senior level attention within government (see chapter 7). However, while Acheson secured his position as primary adviser to the Secretary of State when the issue was successfully politicised, as Street (1988: 504) argues, the creation of the AIDS Cabinet Committee usurped the power of the DHSS and the EAGA, presenting the paradox that, "while the Chief Medical Officer sought the present political commitment in order to obtain the necessary funds, the effects of the new arrangements has been to diminish his role and influence". It was increasingly difficult to "own" AIDS policy and its agenda as in the earlier years.

A similar scenario is apparent in Lothian, at least in terms of the medical response:

> *Unlike the other major areas in the UK, particularly London, we didn't have a slowly developed epidemic and because of the laboratory work, almost overnight Lothian realised that we had huge problems, so it was very much an emergency, urgent task force mentality at the time ... Prior to that the only person on the health side working on it was George Bath.* (interview, Operational Manager HIV/AIDS and Drugs Services, LHB, 4.1997)

As in the UK case, no policy machinery existed to deal with HIV, and so the gap was filled by a committed individual. Indeed, perhaps George Bath went further than his UK counterpart, involved as he was in the initial research which sparked concern, through to the collation over time of HIV incidence and the establishment of a confidential register (see Brettle, 1996). Bath was influential, partly through work on the McClelland report, in legitimising the practice of substitute prescribing and the use of needle exchanges. Bath's position itself as head of the "AIDS team" was indeed legitimised, or at least established, as a result of the McClelland report. Further, Bath was given the discretion by the then General Manager of LHB, Winston Tayler, to develop HIV related services on the, "back of an envelope" long before the new government allocation (interview, Operational Manager, 4.1997).

However, the importance of Bath was not only as an individual, but as someone keen to foster links at all levels and types of governments, as well as groups. Indeed, it was Bath who in 1986 arranged a Lothian and Fife Health Boards' "consultation day", inviting virtually every interested professional working in the field, and stressing the, "urgent need for coordination of policy on AIDS throughout the various levels of government" (LHB and FHB, 1986: 1). Bath was also the crucial conduit between key

medical practitioners and activist or community based groups. In contrast to the late 1990s which was marked by, often internal, conflict:

> *At that time there was no question of conflict ... George Bath had this reputation; he was very well respected by both [medics and activists];it was quite unusual because of tensions between the hospitals and money spent in the community, and really you can trace the downfall/ decline of official policy structures to his death a few years ago (1994). When he died the AIDS coordinator post was never really filled [effectively].* (interview, researcher, 3.1997)

The Regional-Sectoral Level?

So, whilst the Scottish Office operated a disengagement strategy, its decision making role was replaced by the coordination of agreements taking place between statutory sectors at the height of the Edinburgh crisis and (ironically) institutionalised by the NHS and Community Care Act 1990. That is, in Lothian at least, since statutory level authorities were responsible for so many policy decisions with regards to HIV, it became clear that a coordinating process was necessary at a regional level. This was partly because of the urgency of the issue. The need for immediate action prompted relatively swift, senior level attention on an unprecedented scale, comprising the Director of Public Health and the General Manager of the LHB, the Deputy Director of Social Work (Les McEwen), the Assistant Chief Constable of Lothian and Borders Police and the governor of Saughton Prison (interview, Operational Manager, 4.1997), building on work by George Bath and McEwen to highlight the issue on the basis of Brettle's early figures (interview, Principal Officer, 4.1997). Further, the conclusions reached set the agenda for each statutory authority. The best example here is the introduction of needle exchanges. Prior to the epidemic, injecting equipment was scarce partly due to police policy. The provision of injecting equipment by needle exchanges was still illegal in the early stages, and so police cooperation - and in effect a change of police policy as well as

special dispensation from the Lord Advocate - was required for the exchanges to work effectively:

> *So because we had pretty heavyweight senior people taking regular decisions on policy matters, that was fed down the line and if you like the police on the beat would be told to cooperate with needle exchanges, don't pick up people for possession right outside our gates for instance, the health issue is more important. And that was a big factor ... and I think a lot of our work would have been more frustrated if we hadn't had this support..* (interview, Operational Manager, 4.1997)

However, this is not to say that the decisions were reached outwith the context of early government policy, as the following discussion demonstrates.

The regularity of such regional level cooperation began in December 1986 when Graham Bowey, the Chief Executive of the Lothian Regional Council (LRC) formed the Regional AIDS Support Group (RAG), comprising senior people from the LRC, Health Board, district councils, the Director of Social Work, the Director of Education, the Director of Management and Information, George Bath representing Helen Zealley, the Director of Public Health, as well as David Taylor, the first Lothian Regional AIDS Coordinator, appointed by Lothian Regional Council (interview, Taylor, 11.1997). RAG was originally convened to examine the policy document required to outline the LRC's employment policy, which eventually recommended a "commonsense approach" to "prevent overreaction" based on "ill informed speculation" (LRC, Nov 1987). Subsequently, it followed its DHSS (July 1986) predecessor in producing a series of recommendations for the conduct of its staff, and its initial formation did not cause a significant break from UK or SO level policy. Interestingly, whilst the document would seem uncontroversial now, its context illuminates the urgent need for clarification of the nature of HIV and AIDS at the time. Additionally,

perceptions of the nature and likely scale of the problem should be remembered here, since, for example, initial projections suggested that four hospices like Milestone House would be required in Lothian itself.

Taylor and Roger Kent, the then Director of Social Work, visited health board agencies, hospitals and voluntary agencies in New York to examine the probable requirement for services. Further, they found that few HIV services existed, since most were "fire fighting", or structured to deal only with AIDS. So, Lothian's policies were likely to be innovative since they were planning for HIV. Further, in terms of policies for children, in 1985 Edinburgh was taking the lead since no other part of Britain thought this would be a major problem - given that no other part of Britain had such a spread among women. Subsequently, a large, empty, children's home was identified as an alternative site to hospitals to send the sizeable number of children expected to be affected as a result of high HIV related birth rates (interview, Taylor, 11.1997). It was assumed at the time that the majority of children born to women with HIV would themselves be infected and that their drug using mothers would either be in jail or unable to look after their babies. In fact, the infection rate in the 150 directly affected children was approximately 10%. Further, in the event, Social Work had an, "avant garde policy for recruiting foster carers for special needs children" (interview, Jacki Mok, Consultant Paediatrician, 10.1997). However, such reports were still necessary since there was a great deal of anxiety surrounding infection at this time[1] :

> *When people were dying , priests were coming with gloves on and wouldn't touch people with AIDS, people were having their food shoved under doors and when you think about it now it's shocking ... I'm not blaming professionals, I think they were gripped by the same fear* . (interview, formerly of Scottish AIDS Monitor 1, 10.1997)

There was a lot of public anxiety and hysteria, that you

[1] Indeed, as late as October 1990 the LRC still felt it necessary to issue a policy document arguing that infected children should be, "allowed to attend school freely".

> *could catch it sneezing, you could catch it from toilet seats ... every time a community heard about a child who* might *have HIV ... [we didn't have the sophisticated tests we have nowadays] ... you needed to scrape them off the wall.* (interview, Consultant Paediatrician, 10.1997)

So, a policy document and training were required to overcome concerns from children's centres and foster carers:

> *I helped with a lot of training sessions ... [and] once you gave them the time to voice their concerns and once they heard about how really with proper hygiene you don't catch HIV in normal settings people became much more comfortable.* (interview, Consultant Paediatrician, 10.1997)

The point about the centrality of children in these proceedings should also not be lost, since when compiling the report and policy recommendations for services, Taylor's thinking at the time was that it would be concern for the fate of children which would determine the extent to which services would be provided:

> *Drug users don't have a great deal of public sympathy, or gay men, so with it* [the report's recommendation] *going in on the back of kids people are more likely to be sympathetic and more likely to do something in terms of agreeing to finance ... services.* (interview, Taylor, 11.1997)

The subsequent policy document was the first regional document in Britain, and served as the blueprint for other authorities in England. Remember, however, that the LRC document was not wholly original. In fact a detailed analysis of guidance documents from the DHSS through to the SO and the LRC suggests that the UK network's well established harm reduction approach was followed to the letter by the LRC to the effect that it largely

reproduced, word-for-word, government advice to its employees as its own guidelines (see DHSS, July 1986; Lothian Regional Council, November, 1987). This includes central government guidelines on the identified means of transmission, the areas of non-risk (social contact, sharing eating utensils, washing facilities, coughing and sneezing, etc), the steps to be taken to minimise risk, and so on. In turn, the guidelines are traceable to the centre of the original formulation network - the Chief Medical Officer (CMO) and the Expert Advisory Group on AIDS (EAGA). So the product of early regional meetings was the direct implementation of central government guidelines.

So why study these early networks when disengagement strategies are <u>not</u> initially apparent? The point is that each regional level network may implement policy according to government guidelines, but since these guidelines are generally either vague or at least broad, then the analysis of local circumstances, rather than the systematic consultation with central government, often dictates the direction of implementation. As one SO civil servant put it, ministerial priorities exist, but their usefulness is another matter since they are likely to be broad and they are often not ranked in order of priority. There are no clear instructions if policies conflict or if there is competition for funds (interview, 11.1997). This is certainly true in the case of HIV/ AIDS policy in Lothian, since, as the previous chapter demonstrates, regional and unit levels of government were often reacting to the urgent policy problem before detailed central government guidelines were available, not least because the policy problem - based on drugs, or the first wave, rather than sexual spread, the second wave - was significantly different in Scotland and not dealt with by the preceding central government deliberations. Further, since responsibility for different aspects of AIDS is held by different statutory authorities, then the successful coordination of regional AIDS policy as a whole will not be achieved on the basis of central government guidelines alone, even if all the statutory authorities concerned are in agreement over the interpretation of those guidelines (see below for a discussion of the effects of disagreement). So, in the absence of continuous and detailed guidelines, regional level

authorities act according to local circumstances (and consultation with interested and affected groups and service delivery organisations).

Regional level actors also play a top-down role, as demonstrated in discussion of the implementation of regional policy at unit levels. This is well demonstrated below in discussion of Lothian Health, but a good example also comes from the implementation of social work HIV policy at the "street" level. As a senior planner in Social Work (interview, 1.1998) argues, practitioners are given a framework in which to act and are expected to know what the department's policy decisions and strategies are, and to apply these consistently. However, within this context, planning is subject to change and often decisions are made at the operational level, especially when the initial policy is broadly defined:

> *Decisions about practice are not made within Shrubhill [the department's headquarters]. Decisions about policy are, but within that each office might adopt different sub-policies as long as it's consistent with the department's approach. For example, take harm reduction. None of our officers would promote abstinence. That wouldn't be acceptable. This council has endorsed the harm reduction policy.*

Harm reduction is a good example of a broad policy which provided a lot of leeway in its implementation, and which in turn allows a practitioner to use her/ his analysis of local circumstances, and consult local groups and clients, rather than constantly look upwards for specific direction:

> *How a problem is solved in Wester Hailes may be quite different to how the same problem will be resolved in Craigmillar. That is, because practitioners use their networks to help people they will draw in people and make use of the resources within their communities. Only if there is a need will they refer up here ... if they need additional resources.*

So, there is a clear unit level network process which operates in this area within the context of, and which is subject to, the framework determined from above, as well as financial constraints. Nevertheless, the process of decision making at this level is important, since until this implementation takes place, the exact nature of the policy is indeterminate. This argument forms the basis of the need to analyse decision making processes at each level of government, as well as identify a parallel group government process at these levels.

RAG and LAF

Within Lothian a parallel system of consultation developed with the formation of the Lothian HIV/ AIDS Forum (LAF) as a result of the early work of RAG. RAG gave Taylor the job of "talking to as many people as possible about HIV" to compile a report which would inform its early decisions. So, Taylor spent his time talking to groups involved with HIV and thought that it was "sensible to get them all together". He thus wrote to them all and invited them to a meeting which was also attended by an HIV development worker from the Social Work department and George Bath as a representative of Lothian Health. Thus, LAF - at least in the first few years following its introduction (see below) - became an influential forum for groups in direct and regular contact with statutory authority representatives, who were themselves members of RAG. Further, LAF further fostered links and coordination between the statutory authority themselves, with Taylor from Social Work founding and Bath from LHB "taking the reins" (interview, Taylor, 11. 1997).

This type of coordination and action is often fostered by central government itself, since the Griffiths review recommended that social services departments should take the lead in planning, in consultation with health and voluntary authorities, and this was enshrined in the NHS and Community Care Act (1990), based on *Working For Patients* (see Baggot, 1994: 234). So, again, the formation of such procedures should not be seen as a detraction from the central government process.

However, contrary to what one might expect, this has not strengthened a policy-based sectoral level agenda, and the levels of agreement between statutory authorities in the early years were short lived. As discussed below, the loss of key individuals, the relative lack of urgency in later years, the financial and organisation effects of central government policy, the changing status of groups and the tension between local government and health authorities undermine the operation of a sectoral level arrangement based on coordination and a shared policy problem.

Why Were the Regional Arrangements Undermined?

(1) The Importance of Individuals

In the UK case the retirement of Acheson in 1991 is associated with the downgrading of AIDS as a policy area, showing perhaps that without a centralising and prominent figure to coordinate AIDS policy its development tends to suffer and be subsumed within more general sectoral level lines, especially when the issue itself loses its salience.

Similarly the death of Geaorge Bath coincided with: the loss of status of LAF (see below); less coordination between local government and the health board; and the loss of status of the issue within this level of government. Further, similar departures took place around this time. Maureen Moore left Scottish AIDS Monitor (see below) and Roger Kent (as Director of Social Work), David Taylor and John Chant (as Chief Executive of Lothian Regional Council) all retired , and this all happened in less than 18 months. Such "personal networks" are seen by some as crucial to the process of government (confirming to some extent the personal interaction approach described in chapter 2):

> *I think they had achieved a way of working which was highly collaborative, they were all powerful influential players in their different fields and I think that left a huge gap, ... certainly in terms of the culture of working collaboratively because once they were out of the picture it*

felt like it fragmented very quickly. (interview, Director, Waverley Care Trust, 10.1997)

I think that personal relationship ... is very helpful because what you could do was pick up the telephone immediately to the person before something gets out of hand ... there are less misunderstandings. (interview, former Scottish AIDS Monitor (SAM) executive, 10.1997)

However, as discussed below, one shouldn't go too far with this argument, since other factors such as the subsequent lack of urgency and the reorganisation of government structures and procedures may be more important. So what can we say for sure about the roles of Bath and Acheson with this in mind?

First, this was a policy area which required an influential official to coordinate policy in the absence of higher level political intervention, and to press the importance of such an issue to those politicians. Second, in the short term at least, the success of the latter strategy did not diminish the influence of the respective individuals. Acheson became primary adviser to Fowler, whilst Bath was given discretion by Tayler to set up and extend Lothian's medical response. Subsectoral dominance translated to sectoral level primary influence on the basis of expertise and representation of current policy practitioners. The broad "harm reduction" (as opposed to abstinence or prohibition) philosophy still dominates in the face of political opposition and conflicting campaigns such as Scotland Against Drugs. Further, at the local level at least, this operates relatively autonomously:

I think the Board is very good in the extent to which they have accepted the philosophy and concepts of harm reduction which is what we are about, and while some individuals may be uncomfortable with some of the details they do accept the necessity of it and they leave us to get on with it. (interview, Director of Public Health, Lothian

Health, 4.1997)

Of course, this is not to say that everyone in government now agrees with or is in favour of harm reduction in general, and the extent of the practice of harm reduction has to be qualified, since the suggested autonomy may only be granted within intimated boundaries:

> *I would say there isn't a shared view ... harm reduction always sits uncomfortably, certainly within the health board. If it's about direct services to drug users they can handle it, but if it's about harm reduction messages to general groups, young people especially, around the dance scene or anything like that they have difficulty with it. All funders do, because politically it's seen as condoning behaviour and it involves parents' anxieties and their own, so there is a tension there.* (interview, senior health promotions officer, 5.1997)

Third, in the long term and with the retirement or untimely demise of key figures, AIDS policy was subsumed within more general health or public health issues (hence undermining AIDS as a policy sector).

<u>However,</u> in many ways this policy area in Lothian is significant in that most of the personnel initially involved - like Drs Jacki Mok (Consultant Paediatrician), Roy Robertson (GP), Ray Brettle (Clinical Director), Alison Richardson and Judy Bury (Harm Reduction Team), Judy Greenwood (CDPS) and Helen Zealley (Director of Public Health) - have risen to the top of, and are still involved in the profession. Further, the new Director of Social Work, Les McEwen was involved from the beginning as Deputy Director, and Ray de Souza in Social Work and Roger Lewis from CHADS (Centre for HIV and AIDS Research) used to be a part of the legendary Friday night meetings at around the time of, and following the illness of, George Bath. So, arguably, personal relationships have endured remarkably. The point is that too much emphasis can be placed on the

personal over the institutional links here, since it is debatable, for example, whether or not the regular Friday night meetings between key individuals - mostly Bath, Moore, Taylor, de Souza, Richardson and Lewis - were political or merely social. Further, as a brief discussion below demonstrates, a preoccupation with these meetings could paint a false picture of the developing nature of the policy network.

One plausible description of the development of the network could be as follows. The identification of specialists is important since the early history of the network suggests that policy was made largely on the basis of very regular, informal meetings between these key individuals. The outcome of these meetings shaped the agenda of each major statutory and voluntary agency, since the key players were also senior members of these authorities. The network was closed and insulated from outside actors. Following the loss of a number of these key players, the nature of the network shifted, since the insularity and cohesiveness of the network was dependent on personal interaction which was subsequently undermined. The successful lobbying process and subsequent large-scale consultation exercise which surrounded the issue of funding for combination therapy, for example, highlights the new nature of the network. It is relatively open and subject to external and health board influence.

The alternative explanation, to be developed below, is as follows. The identification of specialists is important since the early history of the network suggests that policy was influenced by regular, informal meetings between these key individuals. The outcome of these meetings shaped the agenda of each major statutory and voluntary agency, since the key players were also senior members of these authorities. The network appeared to be closed given the types of meetings which took place and because the link was medical. Following the loss of a number of these key players, consultation and coordination suffered, but this coincided with a series of financial and organisational changes which also shifted the responsibility for decision making from service deliverers (providers) to purchasers. The lobbying process and consultation exercise which surrounded combination

therapy, for example, highlights this shift in the status of formerly key players. They are more likely to be consulted, but the financial basis of these consultations leaves little room for negotiation. The shift, then, refers to the balance of power from "AIDS team" and its mobilisation of medical practitioners and community based groups, to the Commissioning and Public Health branches of government. However, the network is no more open than it was under previous arrangements.

Such decision making shifts undermine the identification of an HIV/ AIDS policy sectoral level, with decisions more likely to be made independent of the original coordinated process described in the beginning of this chapter. This also suggests much about the stability of these original arrangements with regards to central government influence.

(2) The Financial and Organisation Effects of Central Government Policy

As discussed above, the heady mix of urgency, specialisation and key individuals fostered coordination perhaps on an unprecedented scale:

> *It certainly was unprecedented in my experience and I'm not aware of there being any other single issues, health issues, that either (a) had impacted on all the other statutory services to a significant degree or (b) had warranted the same regular senior level attention .* (interview, Operational Manager, 4.1997)

Indeed, one senior planner (interview, 1.1998) argues that the type of statutory level coordination which the NHS and Community Care Act 1990 was trying to foster was already being practised in the 1980s: "all that has become the rhetoric since then around joint commissioning and planning, all the sort of new MBA speak was practised in Edinburgh":

> *I call that the Lothian factor ... very close cooperation and networking between organisations in Lothian and at that*

> *point there was even more so than now. Now it's gone by the board a bit because organisations have changed and policy has changed, but at that point ... They stuck their necks out ... The voluntary sector, health board and local authorities got together and dealt with it and that was what distinguished Edinburgh to this day ... from any other part of the country.* (interview, Senior Planner, 4.1997)

However, he also suggests that this was not only unique to Edinburgh, but also to a specific combination of policy and time period within Edinburgh:

> *I'm not sure that would ever happen again in Social Work. You just have to compare the likes of mental health problems, ... the new drug problem, the recreational drug scene or alcohol to see how those days have gone ... people are much more political, ... partial, partisan, calculated in terms of defining social problems and how they are responded to.* (interview, Senior Planner, 4.1997)

In other words, without the special circumstances caused by the identification of HIV, one would not expect particulalry high degrees of cooperation, especially since tension has always existed between local government and health authorities, and this still has an effect on joint planning. As Baggot (1994: 226-7) argues, collaboration often fails because of professional rivalries and, "the contrasting organisational cultures and structures of the NHS and local authorities", leading to needs being defined in different ways and differing perspectives. This is manifest in some of the interviews conducted for this thesis, with at least two local government representatives reminding the author that health boards are merely "unelected quangos".

Nevertheless, in Lothian and in the AIDS field, the lack of coordination has been a relatively recent one. This may be partly down to agreements reached in earlier years - that is, since a harm reduction philosophy is

apparent in most statutory authorities, then less direct agreement may be necessary. Further, the perceived relative lack of urgency may also be a factor, since much early agreement was fuelled by anxiety. However, since the earlier figures or projections of the incidence of HIV did not materialise, urgency was no longer a motivational factor to overcome historical differences.

This notwithstanding, the following discussion demonstrates that, as in chapter 8, it is the indirect effects of central government policies which have undermined the usefulness of the networks which developed in the 1980s. Such a discussion demonstrates the relatively unstable nature of implementation networks, since central government inspired organisational change alters the nature of implementation networks even when this is not a direct aim.

As discussed in the previous chapter, the longer time scale of the study is useful, since AIDS policy networks 10 years on are often much different to those which developed as a reaction to an urgent problem. The examples already discussed suggest that the appearance of bottom-up, unit and subsectoral level dominance of policy in the cases of Robertson, Brettle and Greenwood have to be qualified by financial and legal constraints, as well as the often indirect effects of central government policies on their operations. Similar effects are apparent at regional levels, and are largely responsible for the subsequent shaping (or undermining) of the relationships within and between statutory authorities at the regional level in Scotland. In terms of AIDS policy, the two most important examples are local government reorganisation and the purchaser/ provider split within Lothian Health. These examples highlight the move from regional coordination to relatively independent decision making within statutory authorities.

Scottish Local Government Reorganisation

Following the local government reorganisation in 1997, Lothian Regional Council (LRC) was split into four - Edinburgh City, West, Mid and East

Lothian, with two relevant effects. First, joint planning is obviously more difficult with more, smaller authorities since subgroups proliferate beyond the means of senior staff:

> *Now, for Lothian Health, we used to work on a regional basis and have about 12 of these subgroups [drugs, HIV, alcohol, etc] for the whole of Lothian Region. We now have four local authorities, each of which is divided in different ways. I think Edinburgh has kept the 12 original groups, just for Edinburgh, West Lothian have divided it up between WWL, MWL and EWL for everything, East Lothian has done it different again and I don't know what is happening in Mid Lothian, so instead of having 12 subgroups we now have something like 27 and four different reporting-in structures and it all has only just started but it is fairly nightmarish in terms of working effectively together, because we've got relatively few people at a senior level to be contributing in this way.* (interview, Director of Public Health, 4.1997)

Further, HAMT, the regional level coordinatory body ceased to operate, and this undermined the regional level agreements which were due to be finalised before the reorganisations were implemented. Whilst HAMT remained until it completed a revised strategy, the new arrangements meant that this would command less authority anyway. This proliferation of policy is a general problem with statutory level coordination. Second, AIDS policy was a particular problem since in Lothian approximately 95% of those living with HIV do so in Edinburgh, and most services are concentrated within the new Edinburgh City area. However, surrounding areas appeared less willing to contribute, financially as well as politically - Edinburgh City received 78% and 80% of Lothian's budget for HIV and drugs respectively (interview, Senior Planner, 1.98). The biggest issue is thus to persuade the Lothians, "to pay their share, rather than planning" (interview, Director, Waverley Care Trust, 10.1997).

The Purchaser-Provider Split

The second example concerns changes which took place in Lothian Health which affected joint working relationships indirectly, but have at least as much significance for two reasons. First, as in the CDPS example, the purchaser-provider split redefined roles within Lothian Health (LH), as well as creating a power shift from those involved in service delivery to those involved in the commissioning of services. Thus, it is ironic that while most key players' positions within LH became more established with regular consultation and presences on committees, their power to negotiate decreased, since the focus and basis of decision making itself changed. A paradox has arisen in that the political status of key players has decreased as their professional status has risen, reflecting the decision making shift based on financial constraints rather than medical expertise.

As already discussed in terms of Brettle at the City Hospital and Greenwood at the CDPS, the power of doctors as a profession was most manifest when doctors were relatively knowledgeable about the nature of HIV and AIDS, and the urgency of the issue encouraged immediate funding for services. Doctors involved at the early stages were able to direct policy by "remote control", since a lot of funding or "soft money" was available - it was often described as the "Rolls Royce of the NHS" (interview, GUM Consultant, 10.1997) - and services were set up, "on the back of an envelope":

> *There was loads of money before. I mean loads of money. At one point almost any crackpot who came up with an idea about HIV in Edinburgh got funded.* (interview, Consultant Clinical Psychologist, 6.1997)

Further, since a less formal policy and finance apparatus existed, and services developed on the basis of existing (medical) expertise, the developing relationships between specialist doctors, Health Board and SO officials was of great significance. Early Health Board and SO policy merely legitimised existing "bottom up" practices within Lothian, not only because funding was given without detailed direction, but also because the same

doctors were members of the advisory groups which produced the main reports. Subsequently, the consultative positions of many of these doctors has been institutionalised, with Brettle, Richardson, Robertson, Greenwood and others playing a regular part in Lothian Health advisory committees.

However, the purchaser-provider split, as well as subsequent financial restrictions, changed the nature of consultation. Policy advice no longer equated with policy, since it was now one step removed from the final decision. Initially the main contact within Lothian Health was George Bath who eventually became Consultant in Public Health and reported directly to the Director of Public Health. Bath was both the central figure of AIDS within Lothian Health, as well as a direct contact for all the key players, and he and Roger Lewis, "advised the second tier senior manager who made the decisions then reported to the general manager" (interview, Roger Lewis, 10.1997).

However, after the health service was restructured, AIDS policy moved down a rung within Lothian Health. George Bath's role was not replaced in the same way, and indeed the AIDS coordinator post became half time in 1997, with the Director of Public Health subsuming ultimate responsibility within the full range of responsibilities at this level. Further, following the new emphasis, as well as the dwindling salience of AIDS as a policy issue, the people brought in under the Director of Public Health and Commissioning had health service planning, rather HIV or drugs specialist, backgrounds. So, specialist HIV/ AIDS influence was one step removed, since Lewis and colleagues now reported to the assistants to the Director of Planning, who in turn consulted with the Directors of Public Health and/ or Commissioning, depending on the nature of the policy at hand. Similar links still existed between practising doctors and like-minded specialists within Lothian Health, but this was like being a core insider to the wrong network, since any conclusions reached in discussions required the approval of Commissioning, which had its own, generalist, agenda:

With the way that funds are allocated and the way it's all

> *managed now, it's very difficult to do something that the Health Board doesn't want you to do, if it costs money.*
> (interview, Consultant Clinical Psychologist, 6.1997)

The need for formal approval for funding marked a shift of authority, and one which demoted the involvement of such specialists from negotiation to consultation. The example of combination therapy funding, below, illustrates this shift, but so does this Consultant's 1997 evaluation of the exercise of senior medical power. Whereas in the early days this was paramount, an outsider strategy now would not be particularly effective:

> *At one point we were just all going to march off into the sunset and say do it yourselves. We're not going to give you any advice because you're not heeding it.* Would that be enough? *No, it wouldn't make a lot of difference.*
> (interview, Consultant Clinical Psychologist, 6.1997)

Of course, the changing status of doctors is not surprising in the context of chapter 6's discussion, which outlined Elston's (1991: 70) argument that the medical voice in health policy making in general is diminishing. Senior medical officers have often, "appeared to be on the outside, trying to get in", and the government's own CMO was given no formal status within the NHS Policy Board, reflecting the, "displacement of the profession from the centre of health policy making". However, this was a discussion of formulation and the conclusion to that discussion was that medical power was often not negated, but displaced to implementation networks. However, the Lothian Health example suggests that this displacement is manifest even at regional/ district levels of government, while the CDPS example has already highlighted the beginnings of such problems (for doctors at least) at unit levels of government. These examples undermine the idea that medical dominance is necessarily reasserted at the implementation stage. They also confirm the argument that the usefulness of sector/ subsector is most manifest within rather than between organisations. Certainly, this discussion suggests that AIDS policy is no longer sectoral, since it is

subordinate to a more general health oriented agenda furthered by senior members of Lothian Health.

Second, the shift towards financial and managerial bases of power again undermined joint working arrangements between LH and other statutory authorities - and Social Work in particular - since as discussed above these had their basis in specialist, expert working relationships between like minded individuals at lower levels within these authorities. The move towards the generalist manager at the helm, who if nothing else has less opportunity to come into contact with similar staff in other authorities, thus affects the way each authority deals with each other, since joint planning groups may only facilitate the development of the broadest of guidelines.

Meetings may be geared more towards effective communication between statutory authorities and the incorporation of groups in an advisory capacity than the enforcement of priorities on those authorities. As discussed in chapter 4 (p65), consultation secures wider participation and support, a sense of involvement and hence commitment and dispersed responsibility, and allows a more informed government with fewer problems of compliance (Jordan and Richardson, 1987; Marsh and Rhodes, 1992), even if the resultant plans and guidelines are not followed to the letter. It may thus be a consensual process, "in the sense that it is advisory ... but not binding ... but not decision making ... These groups won't tell us how to spend our money" (interview, Senior Planner, 4.1997).

Agreements made between two statutory authorities are perhaps more important, but they are still subject to reinterpretation and contradictions: "We're only absolutely bound if we have signed undertakings with people to do certain things and even those we can go back and renegotiate" (interview, Director of Public Health, Lothian Health, 4.1997). More tacit agreements on, for example, the demarcations of investments and services are more likely between Health Boards and local governments, but, again, these are subject to unilateral change. For example, "they (Social Work) have pulled out the educational team that used to go into schools and they

didn't ask us they just did it" (interview, Director of Public Health, Lothian Health, 4.1997). Similar charges are made by local government officials with regards to the combination therapy issue (see below).

These examples highlight the inadequacies in viewing formal and informal relationships between regional statutory authorities as the sectoral level in this study. The viewing of regional AIDS policy as sectoral and each statutory level response as subsectoral is a useful exercise in terms of the examination of the basis - authority or policy - for the determination of the sectoral level, and this distinction is not easily maintained in discussions of policy formulation. However, over time, it becomes increasingly clear that this type of sectoral level activity does not provide an adequate long-term explanation of the activities of stautory authorities.

The AIDS policy agenda was a temporary one, fostered not by authority, but by an agreement that the urgency of the policy issue required a unique level of regional cooperation. However, this agenda was ultimately undermined by a lack of authority, partly since each statutory authority draws its authority from external, hierarchical, sources and has other, more important, influences to account for. Statutory authorities often act in light of external - most likely funding - changes and new evidence. In the education team example, Social Work had to cope with the financial effects of local government reorganisation. Similarly, the requirement for swift and decisive action may have prompted Lothian Health's decisions on the service effects of the provision of combination therapy (see below). Further, in the regional case there was no real incentive for each authority to look upwards for advice or assistance. Or, in other words, there was no reason to pursue an insider strategy within this sectoral level network. Rather, such authorities had more incentive to look towards the Scottish Office to pursue negotiated settlements. Therefore, as discussed above, it does not seem fruitful to pursue the idea that AIDS policy occupied a sectoral level. Rather, sector refers more to the (high) level and (central, generalist) authority of government.

The existence of relatively independent action by statutory authorities suggests that network activity is best viewed at each level of government, with networks developing around statutory authorities. Indeed, the combination therapy example highlights the existence of relatively clear boundaries between statutory authority action. As the following example suggests, it has become clear that most health-related decisions with regards to HIV and AIDS are taken at the regional level - by Lothian Health - following SO disengagement and the financially driven need to prioritise services. In turn, the lobbying or group-government process develops around such a decision making authority, and network activity (although perhaps not network action) is thus apparent. So, the traditional concerns of network theory, such as the existence and importance of the insider/ outsider status of groups, consultation versus negotiation, and professionalisation can be explored in examination of the implementation of policy.

Lothian Health, Combination Therapy and the Status of Groups

(1) Groups and Funding

One commentator argues that in the early days of HIV there was so much panic around that money was freely available for HIV projects. This explains the growth of voluntary organisations, who were traditionally much quicker at responding to needs and hence found it relatively easy to attract funding (interview, Director, Waverley Care Trust, 10.1997). Further, a lot of the money available was from charitable trusts such as the Monument and Paul Getty Trusts, and David Taylor in his continuing work with LAF helped to ensure groups such as Body Positive and SOLAS, as well as the Milestone House hospice received funding. Taylor met with representatives of the Monument Trust who wanted to give money to Lothian and asked him to compile a series of recommendations for the specific funding of services in this area. So, voluntary group submissions were studied by a LAF subcommittee which drew up recommendations for HAMT to agree and pass on to the Monument Trust. Subsequently, Monument agreed to provide approximately £1.5 million in 1987 on the understanding that in two or three years the LRC and LHB would pick this up themselves (interview,

Taylor, 11.1997).

Monument wanted to disperse its money through the regional statutory services, and so it was pooled with the ring-fenced HIV money already made available by statutory authorities. This also had an effect for early drugs groups:

> *It was never an issue of who was funded and who was not funded, the money was made available ... you could probably get a core grant of maybe £40k from LHB and then probably double that or the same from trusts who were willing to expand services.* (interview, researcher, 3.1997)

> *Lothian had never been involved in funding drug services in a big way, and there's quite a lot of political history to that, but all of a sudden HIV came along and because HIV in Lothian was linked to drugs use, suddenly the drugs agencies had a profile within the health sector and the funding streams started to be combined and new money was (given) to drugs.* (interview, Operational Manager HIV/ AIDS and Drug Services, 4.1997)

This timely rise in funding for groups masks their plight in the years before HIV. Many drug groups had been unsuccessfully warning authorities about the police policies based on abstention and the need for harm reduction measures long before HIV. So, as one former Scottish AIDS Monitor (SAM) executive (interview, 10.1997) comments, "a lot of the drugs projects were extremely angry because all of the work that they had been doing didn't count" until the, "explosion of HIV in Edinburgh because of the needle sharing". Relatively little money had been available for such groups and the discussion of the prevention and harm reduction policies they advocated, such as the supply of sterile injecting equipment, were not even entertained in government before HIV. Following the "explosion" of HIV,

however, policies changed. For example, the ACMD highlighted the need for community based schemes not "too strongly associated with abstinence" (DHSS, 1988: 55). Still, to obtain the money, "drugs projects that should have had money legitimately for their own work had to go in on the back of HIV to get that work". In turn, this had a significant effect on the types of services which began to develop:

> *They had to stretch and change their services to attract the money, so what happened through that process was ... a proliferation of services ... popping up all over the place ... In Lothian you actually got a distortion of services.*
> (interview, former SAM executive, 10.1997)

Inevitably, such services suffered when the time limited money from charitable trusts ran out. A lot of services were set up on one year grants on the expectation that statutory funding would maintain their service beyond that year. However, in many cases this did not happen and a "rationalisation" of services was apparent following trust money cutbacks. In retrospect it was arguably inevitable that there would be financial shrinkage following the worst of the panic and the fact that figures did not materialise. However, the shrinkage has not happened in any coordinated way. Rather, "agencies have sunk or swam". There has not been a rational or strategic approach to the decrease in funding, "despite having a strategy in place .. I don't think it has been used to inform what's on the ground" (interview, Director, Waverley Care Trust, 10.1997). Further, in part this was because of the urgency in which services were set up in Lothian. As discussed in the previous chapter, Glasgow for example had much more time in which to set up services to tackle HIV and drug use, and therefore, "it was a much more coherent attack on it ... Lothian was more 'bitty'" (interview, former SAM executive, 10.1997).

So, even prior to the funding cuts discussed below, groups had already been hit by the fact that trust money was disappearing whilst government money did not rise to meet inflation (interview, researcher, 3.1997).

However, if by 1994 drugs services were to be worst hit by early funding cuts, this was to change following funding cuts associated with combination therapy in 1997.

(2) Groups and Access

The need for community based schemes not "too strongly associated with abstinence" (DHSS, 1988: 55), suggested that formerly outsider groups would be granted insider status since their approach was consistent with the government's objectives. Certainly, the founding of LAF (Lothian AIDS Forum) as a means for groups to meet and jointly influence RAG - later HAMT - ensured such insider status. However, the fate of LAF and groups in general has largely mirrored the financial positions of those groups involved, and the increasing competition for funds has revealed the uneasy alliance between issues of drug policy and HIV policy and their associated groups.

The fate of LAF was partly decided by the development of HAMT (HIV and AIDS Management Team). HAMT developed from the work of RAG and initially had only statutory authority representation, mostly from the LRC and LHB. However, "as the years went on with negotiations between LAF and HAMT we got some representatives from LAF onto HAMT" (interview, Taylor, 11.1997). However, whilst this strengthened negotiations in the short term between voluntary and statutory sectors, it did little for LAF because the links between LAF and HAMT were less necessary, and LAF itself had become too big:

> *We had a large room and an enormous table with 30 odd folk sitting round that. So you can imagine how unwieldy it was.* (interview, Taylor, 11.1997)

Subsequently, the representatives agreed to divide into five "functional" groups, often used to provide direct feedback to HAMT since the heads of each group sat on HAMT. Still, LAF was increasingly considered as too large, "involving all and sundry" and too big for any coherent policy advice

to emanate. Rather, "you get lots of shroud waving and emotion" (interview, Roger Lewis, 4.1997), and so LAF became seen as, "a talking shop, no power whatsoever ... if you don't have someone there from [a statutory service] then you're just chatting" (interview, Consultant Clinical Psychologist, 4.1997), until it disbanded in 1994 in part because of the conflict which developed between groups and their representatives as a result of the purchaser/ provider split and the subsequent competition for contracts (interview, Taylor, 11.1997).

Of course, this did not mark the end of statutory and non-statutory cooperation, since HAMT had since evolved into a 50-50 partnership, with prisons and police representation as part of the statutory side. However, such a dilution of HAMT undermined its position as an authoritative coordinating body. HAMT became too inclusive, and each statutory authority was less able to control its agenda or conclusions. Therefore, not surprisingly it became less and less important to those authorities, who felt less and less bound by its decisions: "HAMT was OK but at the end of the day nobody will give up easily its power to disperse funds" (interview, Roger Lewis, 4.1997). HAMT only met about once a month anyway, and later became, like LAF

> *... a kind of discussion body where they talked about things, and a "moan shop" where people were moaning about the lack of support and lack of money and stuff like that ... So, the original intentions of it being an advisory body for the main process was never really realised because it never really had the support from all the key players ... HAMT was an advisory body but it wasn't a decision making body. The decisions were still kept hidden in an "inner cabinet"* .(interview, researcher, 3.1997)

In other words, when authorities such as Lothian Health were open to advice, they drew on more established relationships with key figures within

the medical profession, and this gave credence to arguments that policy making within it was insulated, from groups at least.

However, the shift from specialists to planners and commissioners at the centre of the network at Lothian Health increasingly undermines part of this description - that medical professionals had valuable, privileged access. As discussed below, the same key players were invited to discuss the effects of combination therapy before anyone else, but whether or not this is suggestive of an "inner cabinet" or merely an advisory process, calling first on those affected most, is another question.

Each discussion regards the insider/ outsider nature of groups and individuals and the practical effect this has on policy. For example, does the insider status of doctors have any practical policy effects? Similarly, if an insider strategy by such groups was increasingly unsuccessful with statutory authorities, would it be possible or worthwhile to pursue an outsider one?

The latter question highlights an important quandary for groups which is particularly pertinent for service deliverery organisations at the implementation stage. In general, depending on the willingness of government to grant insider status, groups may follow either an insider strategy, following the "rules of the game" to ensure access, or an outsider strategy to influence policy by highlighting the issue and criticising government behaviour. Further, groups which are excluded indefinitely may have nothing to lose or may be more likely to follow an outsider strategy. However, this may not be advisable in the Lothian case. Put simply, a large number of voluntary organisations receive funding from Lothian Health to provide HIV related services. Thus, one would assume that they maintained insider status. However, many decisions made in 1997 suggest that such involvement is peripheral at best, and most groups felt excluded from the process surrounding combination therapy, with attempts to pursue an insider strategy unsuccessful. Lothian Health engaged in a lengthy consultation process, but no negotiations followed.

Nevertheless, since organisations such as Waverley Care Trust, Body Positive and Scot-Pep depended on Lothian Health for funding they were constrained in their pursuit of an outsider strategy as well.

(3) Combination Therapy

The crisis surrounding the provision of combination therapies for people with HIV appeared to come to a head following the decision to suspend its provision for new patients, apparently without consultation. In January 1997, this provision was rejected for new patients on the grounds of cost. The drugs budget was apparently already overspent, and additional treatment is not cheap, with dual therapy costing £5, 000 per patient a year and triple therapy £8500 (*The Scotsman*, 29.1.1997). This was (relatively) well publicised following the organisation of a protest by groups and "clients" at the doorstep of Lothian Health. On the 28th January 1997, about 70 supporters of the immediate introduction of the therapies for new patients demonstrated outside the Health Board itself, encouraging much unwanted publicity, and culminating in the lifting of the ban, at least until the next financial year (*The Scotsman*, 29.1.1997). The protest was thus - on the face of it - successful. The policy area was sensitive, and Lothian Health had a history of panicking in the face of, or even the threat of, such adverse publicity (interview, researcher, 3.1997).

If this were the case, this would mark a departure from the characterisation of Lothian Health's AIDS policy network as relatively closed to relatively open - a "chaotic" issue network, sensitive and susceptible to external influences. However, this is doubtful, since further examination suggests that the "ban" was only in place long enough for Lothian Health to find the money from its existing AIDS budget, the real subsequent cause of conflict as well as the real indicator of power within the network: "the work had all been done beforehand", but not announced or heard of until its ratification from the Board of Directors following the lobby (interview, Director of Public Health, 4.1997).

The Financial Context

Medical specialists - as members of the HIV/ AIDS and Drugs Advisory Committee (HADSAC) - meet quarterly with LH officials to advise them on HIV/ AIDS patients' requirements, and some argue that it warned Lothian Health years in advance that money would eventually have to be found to fund the larger scale introduction of combination therapies.

Historically, the drugs budget for people with HIV was changeable since no one was certain how much would be required. Doctors were allocated approximately £0.5 million per year for drugs and treatment, but in the early days this was rarely spent fully, in part because of the unsuitability of the AZT regime for drug users. Subsequently, Lothian Health decided that instead of giving a block fund, they would reimburse prescribers as they prescribed, using the money saved to spend on other AIDS projects (interview, Clinical Director, 10.1997).

When the SO was informed of such an understanding, it decided to maintain control of the budget itself, with Lothian Health applying for the money at the end of the year. So, LH, "ran with a deficit ... until March 31st and then suddenly all this money would arrive for the drugs and the deficit would be wiped out" (interview, Clinical Director, 10.1997). However, things changed in 1996, both in terms of the scale of prescribing and the funding arrangements, and uncertainty - or at least a number of conflicting accounts - surrounds the identification of responsibility for the funding of drugs budgets.

First, then, Brettle, Richardson and others had been warning Lothian Health at least since 1995 that there would be an increase in costs for drugs in the years to come, since: (a) AIDS treatments are arguably the most thoroughly researched for clinical effectiveness; and, (b) it was becoming increasingly clear that dual and triple therapies (ie the combination of drugs such as AZT) were effective in the clinical treatment of HIV (interview, Clinical Director, 10.1997). Indeed, by 1996 the license and protocol to prescribe dual therapies was granted, and both the City Hospital and the Royal were

soon running up a substantial overspend which they expected to be refunded.

Second, the funding arrangements between the SO and LH had themselves changed, with the Care and Treatment budget now subsumed within LH's overall budget, and according to one civil servant (interview, 11.1997), LH members knew the "rules of the game". The SO was keen not to foster the approach that there was always fall back money to bail out health boards.

Nevertheless, interviews suggest a great deal of confusion surrounding the new arrangements, with some arguing that there was always an understanding both that Lothian Health would reimburse prescribers and that any shortfall would be met by the Scottish Office. However, this was clearly not the case in 1996, in part because a lot of the Lothian Health personnel had themselves changed and there was less of an understanding between each actor. So, when LH was informed of the overspend within Trusts responsible for the City Hospital and the Royal Infirmary of Edinburgh, they originally refused to meet the shortfall, and hence no doctor was able to prescribe for new patients (interview, Clinical Director, 10.1997).

The Medical Director of the RIE (interview, 10.1997) agreed with this strategy up to a point. Ray Brettle and Gordon Scott (GUM Consultant) had the view that they did not have a cash limit put on their service:

> *Every year they had spent more and every year the Scottish Office refunded the hospitals at the end of the year. So in terms of what happened in previous years I think they were correct.*

However, he argues that it was made clear to Trusts that this system would no longer operate, since the budget had been devolved back to Lothian Health. So when it became clear that they were spending way over budget

and that this would not be refunded, "we had to ask them to stop prescribing until Lothian Health came up with the money for these drugs" (interview, 10.1997). Further, it was important that the doctors and Lothian Health agreed a protocol, so that the doctors, "were clear about what they were doing", and Lothian Health as a purchaser, "was clear that the protocol was a sound evidence based model and there would be active support", especially since this issue would arise again when there were calls for triple therapy to be introduced: "you can't make a change like that without telling Lothian Health and getting their support for a change of policy because that has to be paid for" (interview, 10.1997).

This account is also supported by the Director of Public Health (interview, 4.1997). Just before Christmas, the RIE reported that they were running up a "huge overspend" on dual therapies:

> *... and since no one is actually meant to introduce new treatments without authorisation the medical director of the Royal phoned me and said that they can't sustain this growing increase in overspend, and since they shouldn't have started prescribing it anyway we had no difficulty agreeing that the clinicians concerned be asked to freeze what they were doing at that time until we sorted things out.*

This affected new patients only, despite calls by the then chief executive of the RIE to freeze prescribing for <u>all</u> patients to pull back the overspend. Further, both knew that this would have to be dealt with quickly, and so the subsequent protest merely increased the urgency (interview, 4.1997). So, Zealley and others attempted to "guesstimate" the amount required on the basis of who would be both eligible and willing to take the treatment, and came up with the figure of £1.2 million to take to the next Board meeting in January. Consequently, they decided on the basis of how they currently spent their allocation that they could find this, with difficulty, from their £8 million, and that therefore they could recommend lifting the freeze in January.

So what does this initial process say about the power of clinicians and groups? In short, that neither had much influence. Doctors in particular were constrained by LH's determination to freeze prescribing until the money was found, and "the Trust was willing to go to the stage of denying doctors prescribing privileges" by ordering the pharmacy to refuse any requests for prescriptions (interview, Clinical Director, 10.1997). Further, this presents two generalisable conclusions. First, this builds on increasing evidence that the notion of individual clinical autonomy is under threat even at the "street" level:

> *Yes it was an infringement on clinical autonomy in that we were told that we could not exercise our clinical judgement. We felt that someone should be on treatment, we were not allowed to give them the treatment that we thought they should get ... It was a joint decision taken between people higher up in the Trust and Lothian Health* . (interview, GUM Consultant, 10.1997)

> *It is a partnership. They are employees of the NHS, they can't just operate outside the rules ... autonomy does not equate with 100% freedom to do as you like because you are working in an NHS which is government funded and therefore government directed ... It is a cash limited service ... so clinical autonomy can only be given effect within that overall constraint.* (interview, Medical Director, 10.1997)

However, it is less clear, at least in this case, what this says about professional clinical autonomy - bar that it highlights the problem of seeing the profession as a whole (see chapter 6), or that is most apparent when its interests coincide with those of the government - since:

> *For all that it was a financial decision, the actual decision was made by doctors. It was really a combination of*

> *Charles Swainson and Helen Zealley who actually said you shall not prescribe.* (interview, GUM Consultant, 10.1997)

Similarly, no group was particularly involved in the initial process, and arguably the lobby only took place because of their reliance on second hand information. That is, a preliminary cost cutting and grading exercise preceded much of the resultant protests and on this basis a more closed network is apparent since the lack of knowledge of this process sparked the concern. Lothian Health did not communicate well with groups at this stage, and, for example, the rumours at the time were either that a general ban was being placed on all therapy provision, or that the freeze on new patients would remain until the next financial year. Such conclusions on the power of groups are supported by the following events.

Lothian Health and Consultation

Examination of the decision making process, surrounding the service delivery effects of the need to fund combination therapies from within the existing AIDS budget, tells us a great deal about the nature of the network. In this case, the network was relatively insulated from external influence, but whilst doctors dominated the available time for consultation, the network was by no means professionalised. Further, its status as a policy community is also debatable, since the only agreement surrounded Lothian Health's acceptance of the medical advice that combination therapy was effective and necessary. So, what does one call a network so dominated by government, and how did each actor fare within it?

First, the relationship between LH and the SO. This example suggests that both were fighting to pass the buck rather than control the decision making process. Further, one civil servant (interview, 11.1997) argues that the consultation process as it was did not serve groups and did not appear to influence the subsequent decisions, since this was not the point for Lothian Health. She argues that the Lothian Health strategy seemed to be successful in two ways. First, it successfully controlled the agenda of

consultation by forwarding the argument that the funding for combination therapies could only come from the AIDS budget. As mentioned above, the care and treatment element of AIDS funding became part of health boards' general allocation. Therefore, it could have - as Glasgow did - used its general allocation to pay for the drugs. In other words, this was a smokescreen for the fact that senior members of Lothian Health did not want AIDS to have additional funding which was not justified, since the drugs are expensive and in other areas the existence of a new drug does not necessitate its provision. Further, the drugs issue is a convenient one, since it allows Lothian Health to cut the funding decisions it inherited for groups which it does not approve of.

Second, the consultation process provided legitimacy in its subsequent negotiations with the Scottish Office. The SO was surprised at LH's approach - of not asking for more money, but asking that it be able to take money from both the care and treatment and the prevention budgets to pay for the drugs - but went along with it on a one off basis (so far) on the basis that LH claimed to have legitimacy for such a move because it found an apparent consensus through its extensive consultation exercise.

However, three factors undermine at least the first argument. First, Trevor Jones, LH's general manager did admit and reject the option of taking money from other services (*The Scotsman*, 31.3.1997), and so the agenda was set on this openly made decision. Second, at the public meeting in May 1997, the then Chief Executive of the board said that extensive, informal, lobbying had taken place to seek further funding.

Indeed, it is reasonable to argue that the government, should have provided extra money since the funding formula has historically been skewed against Scotland. Historically the funding formula was based on the amount of AIDS patients each authority had, until 1991 when Lothian actors argued that this skewed funds away from Scotland which had a high incidence of HIV but a relatively delayed incidence of AIDS (interview, Roger Lewis, 4.1997). However, at least according to some, the equity issue was not fully

addressed until 1996 when £14 million was taken from the English budget (interview, Director, Waverley Care Trust, 10.1997). This contrasts with the argument that this was taken to fund future combination therapy requirements, with the budget left in Scotland since this money was part of a general allocation. So, whilst the SO line may be that English funding came from original budgets, critics argue that this was additional money granted to England and not Scotland. Therefore, Lothian Health was wrong not to push harder for extra money and the SO was wrong not to give it, even without such formal requests (interview, Director, Waverley Care Trust, 10.1997). Third, HIV and AIDS, like cancer therapy, cardiac surgery, renal dialysis and others is a "rapid growth area" of medicine, in that it is new medical advances themselves which allow more treatment to take place. Therefore, arguably such areas of rapid growth and advance should be considered differently at the central government level, with the prospects for growth built into any subsequent funding decisions (interview, Medical Director, 11.1997). Otherwise, what is the incentive for medical advance? Some of these issues are considered in further detail below.

First, then, LH influence is apparent in the restriction of subsequent debates. A clear agenda (based on a sectoral or general health policy remit) was set in the discussion which stated that in deciding on service cuts to pay for combination therapy it would only come from within the existing AIDS budget, and not the overall one:

> *The facts were unaltered. We had a budget. The budget was not going to get any bigger and we had to take that out of the budget enough money to pay for ... combination therapies. That's not changed ... [everyone knows that] ... We were not given any more money ... [it therefore] had to be taken out of the existing budget.* (interview, LH commissioning, 10.1997)

In turn, this was based on a widespread feeling within the board itself that, over the years, HIV and AIDS has commanded a disproportionate amount

of LH's time and money to the detriment of other services:

> *We can't legitimately take it from mental health, heart disease or old people because they are actually all considerably worse off than the HIV/ AIDS patients at the minute, so it would be unfair and unreasonable to do that.* (interview, Dr Helen Zealley, Director of Public Health, 4.1997)

Further, historically, following the need for an urgent early response to AIDS and the effective lobbying by groups and health service specialists, "the services for people with HIV/ AIDS are, compared to other health services, very luxurious". For example:

> *There are virtually no psychologists and counsellors for people with cancer, all the cancers, all the neurological disorders like MS, Motor Neurone Disease ... but we have a whole team of psychologists for people with HIV/ AIDS.*

In addition, it should be noted that this recognition of good funding in the past is more widespread than members of Lothian Health:

> *HIV as an area was very well funded ... there were a lot of support services, ... full refurbishments of wards, and so on ... A lot of money went into HIV at a time when the rest of the NHS was really really strapped for cash and so there is a lot of resentment around which I think is justifiable ... HIV got too much cash in the past so that when the HIV budget came back for more there were people around who complained.* (interview, GUM Consultant, 10.1997)

So, the agenda for taking money from the general allocation was not entertained, especially since George Bath's position was not filled effectively, and so, "by the time the combination therapy issue arose ...

there hasn't been anyone from Lothian Health themselves to carry the HIV banner (interview, researcher, 3.1997).

LH did, however, successfully appeal to the SO to allow cuts to be made from the whole £8 million, rather than merely the Care and Treatment budget, allowing money to be taken from prevention work and this, combined with the nature of the consultation process which was to follow, highlights Lothian Health's dominance of the implementation network.

In its proposals to the Board, the Director of Commissioning (Lothian Health, 1997: 3-4) argued that extensive consultation took place, with: (a) a preliminary meeting with, "representation from the relevant Trusts, professional bodies, local authority and voluntary sector"; (b) a report noted from HADSAC; (c) a meeting with senior members of Social Work, "our major purchasing partner"; (d) individual meetings with the specialist HIV/AIDS service providers within the Trusts and voluntary organisations; culminating in (e) a public meeting with HIV service users. Further, from these meetings, the report concluded that there were clearly a number of areas which could be immediately targeted for cuts:

> *... these areas do appear to be widely acknowledged as the place to start in building up a package of cost reduction measures and they will, it is believed, achieve a wide measure of acceptance and support if the Board decides to activate them* (Lothian Health, 1997: 4).

However, different conclusions were drawn by those apparently consulted. First, there were concerns that some were consulted more than others, and it is clear that medical professionals and service providers were consulted quicker and in greater detail than groups which also provided services. However, the status of these professionals should not be too controversial, at least considering the development of the initial network and the fact that most of this consultation merely involved establishing the value of the therapies. More notable is the effect of such consultations, and most

commentators report that this was not sizeable, since the agenda - if dual drug therapies are to be provided, then the cost of the drugs must be met from the existing budget - was already set by Lothian Health. So in effect medical professionals were asked two questions: should the therapies be provided, and if so, which medical service budgets should be cut?

First, doctors were consulted since they sat on HADSAC. However, this only meets quarterly and the purpose of this was really just to make sure that the therapies to be introduced were so effective that it was justifiable to cut services to pay for them (interview, LH commissioner, 10.1997). Again this approach was not criticised by all of those involved in the medical side :

> *You can't say that I want money for drugs but they may not work so I want all the services as well ... I think if you really say we must have these drugs because they're effective you've got to accept that somewhere down the line there must be a saving somewhere else.* (interview, GUM Consultant, 10.1997)

Second, since most of the AIDS budget concerned goes to medical services, doctors were first consulted since they were most affected. However, to treat this as early insider negotiations and decision making would be wrong, since medical protests seemed to have little effect:

> *Many people thought we were making the decisions and deciding which services were funded. That's certainly not my impression. For example, they were saying shall we close the ward down and I was saying no, but in fact ... that's exactly what we did do ... it wasn't that we were making decisions, it was:*
> *"well what do you think about this service?" - "well it does this that and the other" - "well, how would you manage without it?" - "badly". But they said, "well we think you can do without it"* .(interview, Clinical Director, 10.1997)

So, as in chapter 6, doctors may dominate consultation in terms of the amount available, but not in terms of subsequent negotiations. But did they fare better in terms of the outcomes than other less consulted groups? Again, this is debatable. For example, as Ray Brettle (interview, 10.1997) argues, the yardstick often used is that there were redundancies with groups but not in hospitals. However, it may well be that redundancies were just managed differently. In the City Hospital, because this was due to be closed and moved to the Western, many nursing temporary contracts were due to expire. So 30 such redundancies were less apparent after the funding changes since, "it wasn't as though they were sacked because we just didn't reappoint them".

However, there is at least symbolic importance in the way that groups were treated in comparison. Activists are less likely to enjoy insider status since they are not considered to possess the resource of specialist knowledge or be as involved in the direct implementation of policy. As discussed above, early rumours fuelled public protests, and this is regarded by some as a strategy to ensure that service cuts were <u>seen</u> as a conciliatory measure. However, even this is dubious since the service cuts were announced to the media before the protesters (interview, Body Positive worker, 9.1997). Further, following the decision to take money from the budget for services, the consultation process was short and inadequate:

> *The consultation over this year's funding cuts was that they sat all the organisations down round the table and said this is how we're going to cut you ... what do you think?* (interview, Body Positive worker, 9.1997)

This may be an exaggeration, and the decisions themselves had to be made quickly, but voluntary groups have had a hard time influencing recent decisions - even though many are themselves funded to some extent by Lothian Health . If medical specialists have been displaced, or pushed down a rung, then most groups are one step further back since they often

rely on indirect access to funders through such doctors.

But is the Lothian Health process representative of funding decisions taken by statutory authorities? One commentator involved in both local government and health board decisions around this time argues that the former is far more open:

> *Social Work cut us as well but we were given opportunities to be heard; to go to Social Work committees, to lobby committees and to lobby individual councillors. You had the sense that at least you could get into dialogue. It was much harder to do that with health. What health did was to hold one 2 hour meeting involving about 30 agencies which they then called a "consultation", but it was not even the kind of setting where they encouraged speaking.* (interview, Director, Waverley Care Trust, 10.1997)

Further, Lothian Health apparently broke a promise to make sure it kept the Scottish Voluntary HIV/ AIDS Forum informed at each stage, and the representations it did make were "window dressing" - including a meeting at SOLAS with service users, which was, "late in the day and actually changed nothing" (interview, Roy Kilpatrick, Scottish Voluntary HIV/ AIDS Forum, 6.1997).

The appearance of consensus on the basis of consultations was necessary to give LH greater leeway in its negotiations with the SO and to make sure cuts could be made from (AIDS and drugs) prevention as well as (AIDS) care and treatment budgets. In turn, this touches on the interrelated nature of drugs and AIDS in Scotland since originally their budget and funding streams were combined, albeit with ring fences surrounding each element. So, when it came to finding the money from the £8 million, Lothian Health found that it could not touch the money devoted to treating drug use - in the

CDPS for example - since the SO had already ruled this out[2] . It was thus necessary that of the £4 million left, LH had full scope in which to consider its cuts. However, this does not necessarily explain why it was done so quickly, and perhaps so blatantly. Rather, it was likely that those making the decisions already knew what the individual reactions to their plans would be:

> *You can consult until you are blue in the face but it doesn't necessarily mean that you get agreements because each of them have ... reasons why their particular service shouldn't be taking any reductions.* (interview, Director of Public Health, 4.1997)

Like ministers, decision makers in Lothian Health are there to take a wider view and they will recognise that lobbies will be based on known self interest, and thus maintain a hands-off approach to maintain wider public considerations (interview, Scottish Office civil servant, 11.1997). Therefore, they may have looked like they were not listening simply because they did not have to. Further, the *type* of group consultative strategy may be important. The literature on policy networks suggests that the most effective group strategy is to follow the "rules of the game", most likely set by Lothian Health, as well as the wide agenda of consultation. The former is likely to include the need to be relatively discreet in its operations, to present modest claims, and not to criticise negotiated outcomes, whilst the latter revolves around recognising Lothian Health's view that HIV and AIDS has generous funding compared to other services. However, the evidence - particularly with regards to the initial lobby - suggests that such rules were not followed, and arguably the inflexible approach taken by some groups made relatively independent decisions by LH easier.

In any case, the point is that looking at the whole process it is clear that the

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[2] This in turn opened up wounds between the drugs and AIDS sectors involved, with some groups in the latter arguing that they were unfairly asked to take on most of the burden of cuts. Of course, the former could legitimately argue that since continuing opiate users are the least likely to be eligible for dual therapies, then they should be the least affected by cuts in direct service delivery.

majority of lobbying both by groups and by medical professionals was not effective. So, the explanatory power of the core/ peripheral/ specialist insider or outsider status of groups and implementers was not notable in this case. Further, the ability of Lothian Health to act so independently demonstrates the relatively clear boundaries between each implementation network, even when two statutory authorities generally conduct joint planning. Hierarchical and financial, as well as political, constraints undermine such cooperation. In this case, new financial demands forced "tough decisions" in the face of criticism throughout and beyond the consultation period.

So what does this say about the power within the Lothian Health network? That the case of Lothian Health largely mirrors the conclusions already reached in the discussions of the UK network, as well as the Scottish Office. Initial, bottom up, subsectoral activity as a reaction to the new policy eventually gave way to sectoral and generalist authority as the main determinant of subsequent networks and their policies, in part following central government reorganisations. Specifically in the case of Lothian Health, the purchaser/ provider split and subsequent emphasis on planning and contracting shifted the power to decide from specialists involved in the field to generalists involved in the general planning and commissioning end of policy. Further, the case of combination therapy and the continuing financial constraints demonstrate the marginalisation of both group and specialist medical involvement.

Conclusions

What conclusions, then, can we gather from chapters 8 and 9 on the relative influence of sectoral and subsectoral levels of governmental policy networks? Unfortunately, mixed ones. Certainly, following chapter 8's discussion of the Scottish Office, the argument that subsectoral networks must follow the agenda of their sectoral level counterparts has undeniable force. However, it does require disaggregation in terms of pre and post legitimation phases of direction, and this is where the ambiguity begins. Following ministerial or other authoritative legitimation there may be clear

directives for the subsequent operations of a subordinate network even if close accountability is not sought. Further, the UK AIDS policy case suggests that the agenda and membership of subsectoral networks largely mirrored the apparent consultative arrangements present at the sectoral level with, for example, activist representation being squeezed by the more established core insider medical representation.

However, the case is less clear pre-legitimation since it relies both on the notion of anticipated reactions and on the assumption that relevant guidelines are available. It is unclear why subsectors would *necessarily* act in accordance with their evaluation of sectoral level positions? This is further undermined, as in the AIDS policy case, when it becomes apparent that sectoral level actors, such as ministers, were reluctant to become involved. When this involvement became almost necessary, the initial action was to approve and extend the existing policies. Thus, the influence of sector and subsector varies over time, and in the case of AIDS policy it is perhaps cyclical. In addition, the fact that the transformation of the subsectoral network from pre to post legitimation in this case took approximately half of the current life span of AIDS policy suggests that the initial effect is anything but negligible.

Things get more confusing when we turn to the analysis of sector and subsector at lower levels of implementation, since the hierarchical nature of government affects the actions of networks at each level of government, and the importance of the authority of sectoral level networks is more pronounced. As discussed in the case of the SO and early unit, subsectoral level policies, the - subsequently legitimised - "bottom up" nature of early responses was tempered by financial and political constraint created by the SO. Further, even following the legitimation of policy, the example of the CDPS showed that such agreements were subject to major change at the formulation stage, often without regard to these arrangements.

The question of authority as a basis for sectoral activity is even more crucial to discussions of regional coordination. Successful statutory cooperation

was achieved with the continuous involvement of senior members as a response to HIV and AIDS. Further, because of the senior level involvement, the subsequent decisions reached at this level were followed through to the final implementation of policy of each statutory sector. However, three factors undermined this process and hence the status of such cooperation as authoritative, sectoral level activity. First, such cooperation was only temporary, based on the nature of the policy problem, its urgency, the financial ability to act, and the subsequent basic agreement with regards to harm reduction. Second, the authority of the network was based not on the authority of one or more of its members, but by mutual agreement between those members. Further, no member had the luxury of autonomy, and such agreements were often subject to the hierarchical relationships each authority operated within. Third, then, too many obstacles existed to undermine the authority of such a network, including the effects of central government policy, as well as subsequent statutory authority reaction. The effects of local government reorganisation and the purchaser/ provider split undermined joint planning. Further, financial burdens constrained the leeway of each authority and encouraged statutory authorities to act relatively independently.

However, whilst such discussions question the suitability of comparing sectoral and subsectoral conditions in formulation and implementation arenas - especially since the sector/ subsector distinction is best viewed within authorities - they consequently strengthen the levels of government approach outlined in chapter 4. Since relatively independent decision making takes place over time within more than one level of government, according to the policy area and stage of policy development, then network activity can be identified and examined as a result. The example discussed in this case was the consultation and decision making process surrounding the service effects of combination therapy funding, and the conclusions from this case study have consequences the other two main themes discussed in this thesis.

(1) Thatcherism - Chapters 2, 3 and 6 suggest that the effects of the

rejections of negotiation at formulation stages would be that more power for groups and professions to negotiate in the details of policy would be found later, at the implementation stages of policy. This would be increasingly manifest at each level of government (for example, professional influence should be most apparent at unit rather than central government levels). Clinical autonomy was described as the "best case" example of professional power associated with the implementation of policy.

However, chapters 8 and 9 undermine such arguments, since with the exception of the period of activity associated with pre-legitimation, each example at each level of government implementation showed the increasing constraints to professional power and clinical autonomy, as a direct result no less of the original formulations associated with *Working For Patients*. Further, as examples such as the limits to prescribing combination therapy, as well as the changes which have taken place within the CDPS demonstrate, this is no less so at unit levels of government.

The Lothian Health case suggests that a Thatcher style is not confined to the formulation of policy, and that at this stage consultation has nowhere to be displaced to. Thus, it is ironic that the focus on implementation networks was to debunk the idea that Thatcherism demonstrated a break with the past and a rejection of negotiation, since what it really showed was that a similar style was apparent at lower levels of government.

(2) The insider/ outsider distinctions and their subsequent effects on policy outcomes. This theme, introduced in chapter 2, was readdressed in chapter 6 with the argument that the domination of consultation need not necessarily equate with negotiation, or the dominance of the network itself. Indeed, this has largely been borne out with discussions of the lead up to and the decision making process surrounding the service effects of combination therapy. While medical professionals were most consulted about the effectiveness of therapies and the service effects of the need to fund them, their views were not particularly adhered to. So, one can identify types of insider and outsider status, but it is more difficult to demonstrate

their practical importance in these cases. This also presents problems for the maintenance of the network line, since if the decision making process is dominated so much by government, at all levels, then is this really network action, or merely government action informed by experts?

Rather, such is the particular nature of implementation network activity that consultation takes place not only to achieve some kind of consensus among those affected, but also/ rather to be used as a tool to achieve agreement from a hierarchical superior. Thus, the evidence forces a departure from chapter 4's argument that the influence of groups (over central government) would be more important the further down the hierarchical chain one moved and, if anything, the Lothian Health case suggests that it was only top down influences which were perceived as important by the main decision makers.

CHAPTER 10 - CONCLUSION

Part 1 - The Framework

Policy networks analysis is under challenge and the network-actor approach developed to address this challenge, in two main ways. First, numerous approaches exist, and their differences undermine the comparison of case studies, since often a discussion of the study is questioned on the basis of the underlying framework.

However, it is important not to overestimate the problem, since much of the criticisms of networks are based on "straw men", or the simultaneous simplification and assignment of coherency and purposive direction to a body of work, with the aim of simplifying a critique. This charge can certainly be directed at both Dowding (1995) and Marsh and Smith (1995). Rather, a more positive evaluation of the literature may attempt to harmonise the literature by extracting its main tenets - the difficulties of assigning responsibility to individuals; the difference between formal political responsibility and collective decision making; and, the blurred boundaries between decision makers and advisers:

(1) In all but the personal interaction approach, individual decision makers are not the main units of analysis. Rather we talk of governments, groups, departments, sub-departments, and we assign responsibility to them. In part, this is because we may not have the necessary information to arrive at detailed conclusions, but in most part it is because the policy process is too large and complex to assign responsibility to individuals. Rather, interdependence necessitates collective responsibility.

(2) In the case of policy networks we are talking about the interdependence between ministers, civil servants and groups. Senior ministers and officials have decision making responsibility, but they rely on less senior officials for information and advice to the extent that they could not make informed decisions without them. In turn, officials rely on the advice from experts who rely on officials for access to decision making. Again, this makes it very difficult to assign responsibility to those formally responsible for political

decision making and some language must be put forward to convey the interdependency context in which decisions are made. Formal decision making is the end-point (and beginning) of a lengthy and complex process of consultation.

(3) Therefore, as the scope of government increases, so too does the blurred distinction between decision maker and adviser. As Jordan and Richardson (1982: 84) argue, a "rationality deficit" has arisen, because:

Authorities, with little informational and planning capacity ... are dependent on the flow of information from their clients. They are thus unable to preserve the distance from them necessary for independent decisions.

Of course, there is also disagreement within this literature, and this surrounds the process of consultation itself. It may be agreed that the decision makers or their representatives influence the processes through which information and advice is obtained and used, but this is often where the agreement ends and the proliferation of approaches begins. However, if the main tenets are less controversial, then it seems unjustifiable to "throw the baby out with the bath water" as manifest in Dowding's discussion. Rather, a more positive approach would be to provide an abstract discussion of the interaction between ministers, civil servants and groups as a means of harmonising the literature's approach to it. This seems particularly necessary since often these different approaches tend to focus on different but not mutually exclusive means of explanation. For example, the personal interaction approach may focus on elite decision making, but this aids rather than contradicts a more formal approach. So, in this context, the aim of this thesis was to address these issues, by attempting to overcome the fragmentation of policy networks analysis with the construction of an inclusive, network-actor, approach.

Second, policy making appears - following Thatcherism and through the eyes of the networks approach - "chaotic" or episodic, and networks analysis does not adequately differentiate between formulation and

implementation, recognise the importance of the parliamentary function, or provide a dynamic model of the policy process. However, again, this may be because of the rigidity of the assumptions assigned to the bulk of networks analysis in order to criticise it. The subsequent aim, then, of the network-actor approach was to apply a previously "harmonised" literature to broader political arenas, to assess the network-actor approach's "flexibility" of explanation. Chapters 1 and 2 suggest that the abstraction and flexibility of this approach should aid the systematic study of implementation, Parliament and policy cycles.

Formulation Networks and the Network-Actor Approach

Chapter 2 began by studying theoretical issues in the study of policy networks. Four approaches were identified, and each was undermined by a number of theoretical deficiencies. First, the group interaction approach is "metaphorical", and there is no demonstration of the necessity of network characteristics to explain political behaviour. This led Dowding (1995) to recommend either the rejection of the term, to focus on individual bargaining frameworks, or its development along the lines of formal networks analysis. Second, the personal interaction approach is insular, both in terms of the ignoring its external context and the importance of the civil service at lower levels. The focus on elite policy makers exaggerates the importance of personal relations, gives insufficient attention to other determinants of policy, such as its environment; and, underestimates the importance of lower level actors. Finally, both formal networks analysis and the dialectical approach are undermined by an inadequate demonstration of the exercise of structural power, either in terms of ascribing interests or constraining action. Neither approach demonstrates adequately the existence of structural power.

Stemming from this critique a definition of the "network-actor" approach is offered, in which the policy network is seen as a social actor at the macro, or highest, level of abstraction. This approach draws on existing conceptions of the policy process, whilst circumventing the problems already identified. So, it avoids the metaphorical charge of Dowding (1995), with network

characteristics central to the explanation of policy outcomes. Consultative practices, as well as the actions of state agencies and interest groups, constitute the means of formulating and acting on decisions, and hence the means to exercise power. It also gives due consideration to all levels of bureaucratic activity, whilst the high level of abstraction allows greater emphasis on external influences. Finally, this approach avoids the problems of the demonstration of structural power, by characterising the policy network as an actor with identifiable means of decision making and hence demonstrating the means through which power is exercised.

But what does the network-actor approach say? First, that there is general agreement on the main tenets of networks research - there is a necessary interdependence between ministers, civil servants and groups. Second, that there is dispute about the nature of the process in which these actors operate, but that the differences in each approach does not make them mutually exclusive. Rather, if the main approach is to be truly paradigmatic, then a framework must be constructed to aid the coordination of such disparate "sub-approaches" to the same problem.

How is this achieved? The network-actor approach argues that a network is a social actor in the same way that we talk about governments, groups and individuals. In other words, it is a third way to describe the same phenomenon, and one which recognises the complexity of the process. Discourse which describes the actions of groups and governments is used because the process is too complex to attribute responsibility to a handful of formal decision makers. Rather the language is used to denote interdependence and group action on the basis of individuals' responses to rules within decision making arenas. So, the language of network action is required when a similar process is manifest in the actions of groups and governments. Further, this is not just a metaphor, since the status of a network-actor is as tangible as that of a group or government if its decision making process is manifest in the institutionalised relationships between them.

So, this broad approach ties together the studies of personal and group interaction, as well as formal networks analysis, since each may merely focus on one of three non-mutually exclusive means of interpreting network action - the interaction between individuals, the interaction between groups and government, or the formal processes between the two. So, all can be incorporated within the network actor approach which provides discussion of three complementary ways to analyse the same phenomenon with different levels of abstraction or simplification.

Such resolution of conflict allows a much greater emphasis to be placed on more practical problems emanating from networks research, such as the boundaries of network action, the effects of Thatcherism, and the sector/ subsector distinction. These areas are themes which run throughout the thesis.

Parliament

Certainly, the Thatcher style highlights the importance of Parliament, since chapter 2 concluded that a focus on policy formulation networks alone underestimates the power of actors to influence policy at subsequent stages of the process. While governments may be able to reject consultation or negotiation at early - and mostly sectoral level - formulation stages, this may be much more costly and unlikely when it comes to implementing and even legislating that policy. Therefore, consultation and negotiation at top levels within the department may have been displaced rather than rejected, with parliamentary and departmental level implementation networks taking on much of the characteristics of their formulation predecessors. But is Parliament important?

The role of Parliament in policy making has largely been ignored at least in the early policy networks literature, based on its marginal importance to the operations of those networks. As Richardson and Jordan (1979; 1987a; 1987b) argue, the expansion of state activity has led to the inability of Parliament to scrutinise that activity. This role has been taken over by groups and government. Parliament is also ignored in the central matters of

policy and, when it does debate, this is more symbolic than substantive, on issues which the government does not consider central to its objectives. Further, the increasing use of delegated legislation allows ministers and departments to bypass Parliament and, even if legislation is necessary, the party's majority ensures that a bill is passed with few significant amendments. Thus, Richardson and Jordan reject the significance of the rise in parliamentary lobbying. This is only important if Parliament is important, and the link between "noise" and influence is weak. Lobbying parliament is either naïve or misguided, or used as an emergency technique to affect policy at the margins,since by the time a policy reaches Parliament it is in the form of a "draft Act". The MP-group relationship merely reflects MPs' reliance on outsiders for information on the one hand, and group attempts to establish themselves within political circles, on the other.

However, such arguments are insular, drawing on a linear conception of the policy process, in which Parliament comes at the end of a long line. This ignores parliamentary activity which is pre-legislative and part of the "wider policy network". Further, as Judge (1993) argues, Parliament's importance lies not in its "powers", but in the process of representation and legitimation of governmental outputs. The exercise of public power depends on the delegation of authority from representative institutions, as policies determined by groups and government alone would be impossible to sustain as authoritative or binding, without some mechanism to channel a popular or electoral mandate. Therefore, to ensure the legitimation of executive policies made within policy networks, the executive must follow a set of rules or conventions outwith the policy network arena. Such conventions reflect wider popular conceptions of how a democratic political system should operate - including the monitoring of the executive by a representative institution. The deliberations and actions of networks thus reflect an anticipation of parliamentary reaction as policy is processed and scrutinised within the parliamentary arena. The deliberations of officials in consultation with groups reflect the knowledge that resultant decisions will have to be justified by the minister in Parliament.

Such arguments provide the context for evidence of the rise of parliamentary lobbying and Rush (1990a) argues that the maintenance of multiple links with political actors makes strategic sense in that groups "hedge their bets" in their activities. Similarly, Judge (1990a) argues that groups recognise the need for a dual strategy of maintaining links both with Whitehall and Westminster, and that the importance of the latter rises with the increasingly episodic style of government, in which network relations break down and groups seek to influence the process in other arenas.

Further, the role of select committees demonstrates that the importance of network activity in Parliament does not necessarily depend on activity in formulation networks. Parliamentary network-actors share some characteristics with their formulation counterparts. This network has a clear decision making process, headed by a group of MPs, whose deliberations are facilitated by specialist advice provided by groups, mediated by a specialist body of committee staff. As suggested by the term network-actor there is a fusion of action and responsibility which is not easily disaggregated and the level of abstraction allows comparison with network actors in other arenas. This actor often demonstrates the pre-legislative activities of Parliament. Network action within the parliamentary arena not only affects policy, but affects the context within which other, especially formulation, networks operate.

Implementation Networks

Similarly, in chapter 4, the discussion of implementation networks begins with the argument that consultation has been displaced rather than rejected. The policy formulation/ implementation-network distinction highlights the importance of consultation and negotiation *after* the formulation of policy, in part as a consequence of Thatcherism. However, the argument is not restricted to the Thatcher era. All internalised policy making or insufficient consultation periods are likely to suffer from a lack of the necessary detail to be directly implemented, and a focus on policy formulation activity alone underestimates the power of all actors to influence

policy at subsequent stages of the policy process. This links well with criticisms of the top-down approach, and the argument that negotiations over broad policy aims have shifted to implementation networks suggests that a bottom-up approach is necessary.

So, chapter 4 applies both top-down and bottom-up approaches to the study of policy networks. Marsh and Rhodes (1992b) rightly use the top-down approach to assess the impact of Thatcherism. This is useful since it allows a systematic evaluation of Thatcherism over a range of policy areas, in terms of the aims of the Thatcher government which itself used a top-down approach. Indeed, the non-fulfilment of implementation conditions do convincingly explain the wide gap between intention and implementation. Whilst policies were forced through the formulation stages, they were not successfully implemented. The Thatcher style of rejecting consultation led to problems in maintaining interest group support. The exclusion of affected interests at the formulation stage meant that their efforts were directed at blocking that policy at the next stage, and policy networks thus acted as the greatest constraint to implementation.

However, the advantages of discussing implementation networks are also apparent. Top down analyses may begin and end with the evaluation of policy in terms of success or failure. It may therefore be unclear how the legislation was used, affected and developed at local levels. Analysis of implementation networks is necessary to allow analyses of the processes through which policy is affected and implemented. Thus, four distinct levels of group-government activity are identified, each of which may provide the main focus of decision making at any point in time following formulation. The distinctions allow a disaggregation of implementational effects, highlighting geographical and local level differences in administration as well as policy outcomes.

This was demonstrated in discussion of the scope for distinctive Scottish policies, due to the levels of discretion available to the Scottish Office. While the Scottish Office has few policy formulation powers, it does (or at

least before the Scottish Parliament, did) maintain a privileged position within the UK policy network and has distinctive levels of discretion. The the existence of a separate legal system and unique administrative structures allows negotiations on Scottish exemptions before a policy has even reached the statute. Further a less constrained time scale and leeway to account for distinct Scottish problems does allow, to some extent, the administration of distinctive Scottish policies.

However, whilst four main levels of government (and their associated networks) are available to examine the implementation of policy, each level of government is subject to change from above. It is important not to go too far in arguing that once a policy has been passed from formulation to implementation it is automatically subject primarily to influence from implementation networks. Rather, this is dependent upon the importance attached to the policy by each actor and the respective means available to influence that policy at each stage. Similarly, one should not necessarily equate discretion with obstruction, and hence the inclusion of previously excluded groups as soon as the initial process ends. As discussed below, groups and professions may experience similar problems of access at each level of government.

The Policy Cycle

So, how do these three areas relate? Network actors can be identified within three distinct arenas - formulation, parliamentary and implementation. Each has a similar basis for study. First, the assignment of responsibility for the exercise of political power cannot be readily associated to one individual or organisation. Therefore, this power is attributed to higher level, network-actors, which consist of a formal decision maker, its staff and core and specialist insider groups. Second, a decision making process of these network-actors can be identified. Third, subsequent political decisions are made by these actors. Therefore network action is apparent in each case. However, each actor is differentiated in terms of the arena within which it operates, as well as the type and stability of membership.

Such considerations are applied to the policy cycle, and consequently a simplified account of their interaction within this process can be identified, to generate a series of broad hypotheses which frame the subsequent case studies. First, the formulation network formulates a policy, but because this was done under pressure, internally, without due consideration of all factors, with anticipation of reaction in mind, and because the details will be more subject to negotiation in the next stage of policy making, the proposed policy is likely to be broad or vague and only presented in the loosest detail. Second, the fact that the proposals are vague means that they are more subject to influence, as well as reformulation as a result of their subsequent interpretation and execution by implementation networks. Third, this leads to: (a) general feedback from the monitoring operations of the formulation network; (b) pressure from implementation networks if or when the policy is found to be deficient in practice and/ or it causes unforeseen problems; and, (c) parliamentary involvement in the evaluation of policy leading to recommendations for change. Finally, such activities lead to some reformulation of policy, on the basis of evaluations of the previous position. It was thus the task of the second part of this thesis to test the veracity of this account. A general focus on British health policy focusses on the full cycle, whilst analysis of AIDS policy at formulation and implementation stages allows a focus on particularly important aspects of this cycle and qualifications to the general arguments.

Part 2 - The Cases

How does this framework relate to the case studies? The answer entails a two step process, since whilst the theoretical element of this thesis is relatively abstract, the subsequent case study of HIV/ AIDS policy in Lothian is anything but. So, the decision was made to discuss health care policy broadly defined, in part to provide a buffer between the "theory" and the "practice". This seemed necessary especially in light of Chapter 1's identification of the divide between frameworks and case studies. More importantly, however, the broad discussion of health policy also illustrates the theoretical concerns in a concrete discussion. In turn, the more

concrete discussion of health policy serves to provide the frame of reference for subsequent HIV/AIDS policy discussions, providing the chance to examine more thoroughly broad areas such as the effect of Thatcherism on medical power both within networks and in the arena of implementation.

So, the initial task of the health policy case study was to illuminate the concerns of the theoretical framework, discussing in turn the make-up and actions of formulation, implementation and parliamentary networks in the field of health policy, with the policy cycles approach used to demonstrate the dynamics involved. Indeed, one conclusion drawn was that the framing of the policy cycle in terms of network actors allowed extensive qualification to the notion of 'chaotic' policy, in which diversions from the insular policy community style were seen to undermine the notions of communities themselves. Rather, the influence of action other than that at the formulation stage reflects a policy cycle in which policy is owned by parliamentary and implementation networks at each stage. This is a theme furthered in subsequent HIV/ AIDS case studies.

The Health Policy Cycle

The discussion of health policy formulation network in chapter 6 demonstrates that this network is no longer professionalised in the sense of being dominated by the profession. Whilst the medical profession, broadly defined, may dominate consultation within the network at a sectoral level, this does not translate into a power to decide, or in some cases even to negotiate. Professional or medical interests do not dominate the network in the way suggested by Wistow (1992a) or Marsh and Rhodes (1992c) in terms of the dominance of policy in favour of medical interests. This was shown in a discussion of: first, the difficulties of viewing the medical profession as a social actor and hence in even defining a medical interest in the first place; second, the unclear and contested nature of clinical autonomy, be it individual or professional; third, the series of reforms which contradicted medical interests and indeed flew in the face of medical objection; and finally, the changing levels of consultation within the

Department of Health. At the level of policy formulation, the latter two examples undermined the argument that doctors maintained a privileged policy position, with the legislation of such measures as the purchaser-provider split which often forced clinicians to be accountable to health authorities, and changing consultative arrangements which even saw less and less subsectoral health policy representation for doctors (to the benefit of financial and administrative interests). Rather, the dominance of the policy network in terms of the relative levels of consultation granted to the medical profession, reflects a standard operating procedure of networks in which those most likely to be consulted are those with expertise on the technical and implementational aspects of policy. Thus, as the agenda within the department of health changes, so does the consultation process, and a clear move towards the marginalisation of traditional professional interests took place.

However, a focus on policy formulation networks alone underestimates the power of the profession at subsequent stages of the policy process (and indeed much of Wistow's argument is that clinical autonomy was not challenged at the implementation stage). In particular, whilst the government may be able to reject consultation or negotiation at early formulation stages, this may be much more costly when it comes to implementing and even legislating that policy. Therefore, consultation and negotiation at top levels within the department may have been displaced rather than rejected, with departmental level implementation networks and even parliamentary networks taking on much of the characteristics of their formulation predecessors.

This was well demonstrated in the case studies of Parliament in the 1980s, and the Social Services Committee (SSC) in particular which provides a good example of select committee influence to affect a change in existing government policy. From 1979-83, the SSC examined the department's ability to monitor and report its own expenditure at local levels, and when the government embarked on a "disengagement strategy", or a policy to decentralise decision making in the NHS, the SSC pointed out that this

could not be achieved without an accompanying increase in methods to monitor and account for expenditure. This was necessary for the committee to judge whether or not local policies accorded with national priorities. This emphasis, as well as similar PAC reports and parliamentary questioning on health expenditure, facilitated a change of policy by the government, culminating in the drive towards the implementation of the Griffiths report, which stressed a much stronger centralisation and accountability arrangement not hitherto present in the government's policies.

Examples of such influence demonstrate that it is reasonable for groups to see Parliament as an important arena of redress for their marginalisation from formulation networks, with parliamentary networks providing the audience for medical information and advice which was hitherto rejected. This was most apparent with regards to the SSC's role in pressuring government to provide additional expenditure for the NHS in the mid 1980s, as well as to consider NHS reform. The SSC consistently insisted that the lack of expenditure on the NHS was having a cumulative underfunding effect. Subsequent reports were highlighted by groups and in Parliament, as well as the department itself in negotiations with the Treasury, and were instrumental to some extent in the provision of billions of pounds of extra expenditure. Further, the committee's activities, as well as those of health care organisations, the media and the wider parliamentary network, succeeded in portraying the state of the NHS as at crisis point, thus arguably obliging the government to undertake a wide ranging review on the future of acute hospital services - a review which formed the basis of *Working For Patients.* However, parliamentary influence in these areas was at the expense of the analysis of policy in any great detail, and Parliament tends to trade specialisation for widespread legitimation.

Finally, chapter 6's discussion of *Working For Patients* supports the argument that formulation policy is broad and subject to reinterpretation. This stage of policy making was dominated by government at the expense of medical representation, but consultation and negotiation was displaced rather than replaced, with the details of policy discussed in great detail prior

to implementation (albeit within the broad framework of formulation decisions). Further, there is plenty of evidence to suggest that the direction of policy was only determined when putting such broad aims into practice. However, chapter 6 anticipates the discussion of AIDS implementation by suggesting that it is important not to go too far in arguing that once a policy has been passed from formulation to implementation it is automatically subject to influence from implementation networks. Rather, this is dependent upon the importance attached to the policy by each actor and the respective means available to influence that policy at each stage.

The AIDS Policy Cycle

Themes regarding the role of actors such as Parliament in the policy process, or of policy "breaking out" of the community arena, were continued in the initial discussion of HIV and AIDS policy. There is some evidence that constant parliamentary questioning in the early years of AIDS forced the issue up the government agenda. Further, concentrated parliamentary attention on the issue of compensation to those infected through blood products in conjunction with notable media coverage, seemed to force a series of governmental U-turns, first on compensation to haemophiliacs as a special case, and then to infected non-haemophiliacs. The existence of an episodic style of policy making is therefore apparent in this case. The question of compensation was rejected by the government within the formulation network. The issue then received increased attention within Parliament, which forced the government to reconsider the issue. So, the issue "broke out" of the formulation arena after an unfavourable response, was considered outwith this arena, and subsequently broke back in again to be reconsidered.

However, this issue also highlights the limited extent to which such influence can be viewed across the full range of health and HIV/ AIDS issues. Parliamentary influence is most notable in select areas where a degree of specialisation allows a concentrated focus on one issue (the "innocent victims") often to the detriment of others. Thus, whilst notable cases "break out", the same cannot be said, at least to the same extent, of

all or even most policy issues, and, in the main, parliamentary attention followed governmental action and most parliamentary activity - including the Select Committee report - legitimated governmental action.

But can such "break outs" still denote a "chaotic" process? Certainly, peaks of levels of public, media and parliamentary concern coincided with periods of government activity and a relatively open period of policy making in which an issue network is identifiable. At first glance, this would appear to undermine the standard operations of networks, because most effective networks tend to operate in relative insulation from the public, media and Parliament. However, the most intense periods of public concern can be *attributed* to governmental activity, in the form of advertising campaigns and funding, which were in turn the product of deliberations between groups and government. Thus, the peak periods of public concern as a consequence can hardly be said to undermine the activities of policy networks, since these came as a direct consequence of network activities, or a clear network strategy to highlight the issue of AIDS as much as possible to enable a process of awareness, education and changing behaviour. Thus, policy didn't so much break out - the harm reduction agenda of the formulation network was sent out.

Thus, AIDS policy is less chaotic than it may appear and the existence of episodic policy making is restricted, since the bulk of government activity over this period reflected a network strategy based on and reinforcing a pre-existing consensus, legitimated by government and Parliament and implemented often against the apparent signals from public and media opinion surrounding the type of measures appropriate to deal with AIDS.

Similarly, it can be reasonably assumed that the operations of a policy network are undermined and hence the pervasiveness of policy networks analysis is undermined, if an issue is highlighted, since insulation from external attention is the key to the successful operations of networks. However, in the case of AIDS policy making this is not the case since, first, whilst an issue network surrounded the network actor between 1986 and

1988, the external attention associated with such an issue network resulted from the network strategy to highlight this issue with an aim to educate and change behaviour. Successive public education campaigns resulted in most part from internal policy community pressures to highlight the issue of AIDS within government to ensure funds and to publicly highlight the issue of AIDS to effect a change in risk-taking behaviour.

The resultant network changes, apparently from policy community to an issue network can thus hardly be said to undermine the operations of that network, especially considering that the effects of such attention did not undermine the pre-existing network strategy which was developed before any significant external attention, and that this attention itself was encouraged by the network, whose polices were subsequently legitimated in government and Parliament. The initial network response was a liberal rather than punitive one, and in the most part these measures were furthered even when the issue gained so much attention and when significant numbers of MPs, media reports and public survey responses suggested a disposition to act otherwise.

Hence in order to explain changes in networks over time, it is more appropriate to examine the internal politics and mechanisms of the networks themselves and chapter 7 found that the stability of network relations revolves around the degree of ministerial legitimation which has taken place. Before the issue received top level attention, the "policy community" members did not follow the established rules of the game, since more important was the highlighting of the issue. Further, the instability of relations was clear since policy was conducted at a relatively low level on an ad hoc basis. Activist representation was encouraged at this stage, resulting in notable successes such as the destigmatisation of "risk groups" in health education and the highlighting of the issue within senior levels of government. However, following ministerial intervention, discussions at the sectoral level set down the agenda for policy, and consultative relations reflected the balance of power within the department at that time. The Department of Health came to accept a medical definition of the AIDS

problem, and hence such interests dominated the consultation process.

However, chapter 7 concludes with the question of medical dominance. The apparent professionalisation of the AIDS formulation network does not sit well with the conclusions in chapter 6 about the marginalisation of the profession, or instances following that professionalisation which saw ministerial intervention go against the interests of the profession. It is unclear just what the profession dominates, and chapter 7 again suggests that a study of implementation is required to assess whether or not professional dominance is seen here as a result of the conflation of formulation and implementation issues. Disaggregation allows the question: if the government dominates formulation networks, is power reasserted by the profession at the implementation stage?

Health Policy Implementation

The importance of the question of health policy implementation is well demonstrated by the apparent failure of top-down NHS reform in Britain. Top-down commentators such as Wistow (1992b) and Klein (1995) view the NHS reforms' failure as a consequence of the political style, as well as the content of policy itself, which challenged professional dominance within health care, and thus caused widespread resentment. This resentment was channelled into blocking radical reforms at the implementation stage, using the power clinicians have to make autonomous decisions.

Accordingly, clinical autonomy acts as the yardstick with which to gauge the success of reforms enacted at the formulation stage, as well as the importance of professionalisation within implementation. Medical dominance was indeed challenged within the arena of formulation networks. However, the question remains as to the effects of this conclusion down the line. As a result, four crucial questions with regards to implementation warrant further attention and thus framed subsequent discussions of the main case study - the implementation of HIV/ AIDS policy.

(1) The effects of Thatcherism on medical power/ clinical autonomy;
(2) Insider/ outsider distinctions and the domination of consultation and negotiation with regards to implementation networks;
(3) The top-down or bottom-up nature of AIDS policy; and,
(4) The extension of sectoral/ subsectoral concerns when the formulation/ implementation distinction is maintained.

Sector/ Subsector and AIDS Policy

In terms of formulation networks, the AIDS case study demonstrates that policy began with bottom-up, subsectoral, activity which encouraged action at the sectoral level to achieve greater attention and funds for policy measures, as well as the necessary legitimacy the network required to operate in the long term. In the beginning, the importance of the sectoral level was not to set the agenda for subsectoral networks, but to legitimise the existing agenda of the initial network. However, this drive for legitimacy had its consequences for the subsequent development and agenda of the post-legitimation network. Because the subsectoral driven agenda entered the sectoral arena, the proponents of this agenda themselves were somewhat displaced, since the set up of the network was different at that level. In other words, an established sectoral network with its own core insiders and senior members of government not only legitimised the existing policies, but also subsequently became responsible for the post legitimation agenda, and the once prominent specialist insider role of, for example, gay groups was diluted or even marginalised when the specialist subsectoral level network was itself displaced. So, the argument that subsectoral networks must follow the broad agenda of their sectoral level counterparts requires disaggregation in terms of pre and post legitimation phases of direction.

Sector/ Subsector and Implementation

Sector/ subsector discussions have obvious relevance to the relative merits of top-down and bottom-up approaches. But can this dynamic be observed or such issues illuminated in a parallel discussion of the implementation of HIV/ AIDS policy? Chapters 8 and 9 concluded yes and no.

Top-Down or Bottom-Up?

Certainly, the early work of doctors Brettle and Robertson in the beginning, and Greenwood when policy was more established, demonstrates the bottom-up nature of early drugs and AIDS policy in Lothian. Further, the presence of such experts on the committees of the major SO reports - McClelland and Tayler - ensured in most part that early SO policy was to serve to legitimise the existing harm reduction oriented practices which were established at unit levels in Edinburgh in the face of pressures for the continuation of punitive approaches. This was confirmed in the almost uncritical government acceptance of the need to found the relatively autonomous CDPS. Finally, the most convincing justification for the detailed examination of early bottom-up responses is that its legacy remains. The philosophy of harm reduction fostered in these early years, whilst subject to continuous pressure, remained the dominant approach at all levels of implementation.

However, unlike the UK example, the sector/ subsector distinction often masks the uneven balance of power between central government and unit levels in these examples. Specifically, whilst the novelty of the issue allowed Brettle and Robertson greater policy freedom, it also provided financial constraints which limited the extent to which they could implement. Similarly, while the needle exchange scheme legitimised the existing harm reduction philosophy, legal and political constraints delayed their introduction when it was clear that such a course of action was urgent. Further, in the case of the CDPS, the whole shared care ethos of the service was undermined by indirect central government measures, including the purchaser/ provider split, as well as measures to ensure greater financial accountability which redefined the requirements for the manager of the service. In other words, the bottom-up conclusions to initial discussions have to be tempered by top-down considerations of the political, legal and financial frameworks in which unit levels of government make their decisions. Further, as in the parallel UK example, the longer time-scale allows the conclusion that the policy agenda was largely reasserted at the

sectoral level following the initial uncertainty and unquestioning funding. The Scottish Office was prominent in the formulation of policies regarding prisons and drugs, and the constant supportive role of civil servants from the initial identification of HIV suggests that the legitimisation of harm reduction, in prisons and in the medical treatment of drug users, was crucial to its development.

But where does this leave us? First, these conclusions suggest that sectoral level considerations are more important when it comes to implementation, since the balance of power is underpinned by the balance of power between central government and implementation authorities. So, even when the subsectoral level was acting relatively independently of its sectoral counterpart in the pre-legitimation stage, its actions were restricted to a far greater extent by the financial and organisation constraints which reflect the more formal arrangements between central and local authorities in general. Much of the power of subsectoral networks came from informality and the lack of detailed direction from its sectoral level counterpart. However, with regards to implementation, this discretion is undermined by more formal and detailed central-local relations.

The Applicability of Sector/ Subsector to Implementation

Second, such conclusions are in part undermined by the uncertain application of the notion of the sectoral level to implementation. As chapters 8 and 9 discuss, the assignment of the sectoral title to the Scottish Office is applicable to some extent, whilst the alternative was to assign the title to a less formal arrangement of organisations which lacked authority.

In terms of drugs and prisons policy (and their relationship with HIV/ AIDS), the clear implication is that the Scottish Office does occupy the sectoral level. Further, the key to explaining network action at this level is in the discussion of the brokering of group activity in terms of the nature of the relationship between ministers and civil servants. In other words, chapter 9 discussed the role of ministerial and civil service activity regarding drugs policy agenda and used two episodes to demonstrate that the sectoral level

agenda derived in each instance from civil service or ministerial activity. Civil servants were in the main responsible for maintaining the harm reduction philosophy within government and hence at the sectoral level. This was most notable in drugs policy - and especially the 1992 Task Force report - when key civil servants used their brokering position between ministers and groups to push the established harm reduction line. However, civil service turnover coinciding with a strong (Forsyth) ministerial agenda undermined this approach, and from 1994 to 1998 a more punitive approach was maintained at the sectoral level. Of course it remains to be seen what effect the latter agenda had at the unit level, but the point is that a sectoral level agenda can be clearly identified within the Scottish Office with regards to drugs (and prisons) policy and hence their relation to HIV and AIDS.

However, continued SO policy in the case of AIDS policy in general is less clear, with, for example, the devolvement of care and treatment budgets to health boards reflecting a general hands-off approach. This prompted chapter 9's discussion of the alternative identification of the sectoral level in terms of formal and informal agreements between regional statutory authorities - with the implication that policy, not authority, determined the nature of the sectoral level. Indeed, successful statutory cooperation was achieved with the continuous involvement of senior members as a response to HIV and AIDS. Further, because of the senior level involvement, the subsequent decisions reached at this level were followed through to the final implementation of policy of each statutory sector. An effective, sectoral agenda was thus clear and this high level coordination shaped the implementation of policy by each statutory authority (often in the absence of clear guidelines from government). This is well demonstrated by the cooperation between the health board and the police force in matters regarding the legality of needle exchange centres.

However, three factors undermined this process and hence the status of such regional cooperation as authoritative, sectoral level activity. First, such levels of cooperation proved to be temporary, based on the nature of the

policy problem, its urgency, the financial ability to act, and basic agreements with regards to harm reduction. Second, the effectiveness of the network was based not on the authority of one or more of its members, but mutual agreement by those members. Third, too many obstacles existed to undermine the authority of such a network, such as effects of local government reorganisation and the purchaser/ provider split which undermined joint planning. This combined with financial burdens which constrained the leeway of each authority and encouraged statutory authorities to act relatively independently. This was well demonstrated by complaints from Lothian Health members that too many unilateral decisions were taken by Social Work, and vice versa. This suggested both that the sectoral level was best viewed within organisations according to the hierarchical relations within it, and that Lothian Health as a relatively independent statutory authority with decision making powers, was an excellent organisation in which to assess network concerns in terms of the implementation of policy.

Relatively Independent Networks at Each Level of Government?

However, whilst such discussions question the suitability of comparing sectoral and subsectoral conditions in formulation and implementation arenas - especially since the sector/ subsector distinction may be best viewed within statutory authorities - they consequently strengthen the levels of government approach. That is, since relatively independent decision making takes place over time within more than one level of government, according to the policy area and stage of policy development, then network activity can be identified and examined as a result. The example discussed in chapter 9 was the consultation and decision making process surrounding the service effects of combination therapy funding, the point being that Lothian Health acted with little regard to the opinions of its local government "partners", groups and doctors. Subsequently, the conclusions from this discussion have consequences for discussions of Thatcherism as well as the practical importance of the insider/ outsider distinction.

The most obvious relevance is in terms of the effects of Thatcherism on

medical power at the implementation stage. Chapters 2 suggested that the effects of the rejections of negotiation at formulation stages would be that more power for groups and professions to negotiate in the details of policy would be found later, at the implementation stages of policy. Negotiation would be displaced and reasserted rather than totally rejected. Further, as discussed in chapter 3, this would be increasingly manifest at each level of government since the powers of central government coordination are diluted - from personal contact to representative contact to the reliance on regulations - as authorities proliferate(for example, professional influence should be most apparent at unit rather than central government levels). This theme continued in chapter 6, with discussion of Wistow's (1992b) argument that the maintenance of clinical autonomy acts as the yardstick for the evaluation of the failure of top-down policies. However, chapters 8 and 9 have gone a long way to undermine such arguments both in terms of representation as well as the autonomy of implementers, even at the point of prescription.

In terms of representation, groups fared no better at the regional level than they did in national politics. Interviews in chapter 9 suggested that groups were consulted very little and that when they were invited to give advice, this was en masse with a very limited agenda. Similarly, doctors were increasingly marginalised from financial decisions, and when they did receive relatively privileged access, there was no evidence to suggest that this translated to the negotiation of policy. This in part supported by the arguments in chapters 2 and 6 on the insider/ outsider distinctions and their subsequent effects on policy outcomes. That is, the domination of consultation need not necessarily equate with negotiation, or the dominance of the network itself. Whilst medical professionals were most consulted about the effectiveness of therapies and the service effects of the need to fund them, their views were not particularly adhered to. Rather, such is the particular nature of implementation network activity that consultation takes place not only to attempt to achieve some kind of consensus among those affected, but also/ rather to be used as a tool to achieve agreement from a hierarchical superior on this basis. In this case,

Lothian Health used the consultation exercise to argue that its decisions - which required approval - were arrived at after an extensive period of consensual consultation.

Further, each example at each level of government implementation - including the unit level - showed the increasing constraints to professional power and clinical autonomy, as a direct result no less of the original formulations associated with *Working For Patients* - as best demonstrated by the changes which have taken place within the CDPS. This ranged from general financial constraints to the bottom up provision of services, to extreme examples with regards to combination therapy where doctors were expressly forbidden to prescribe. Again, these examples give legitimacy to the use of the levels of government approach, since often one implementing authority at one level (Scottish Office or Health Board) acts both as a relatively independent implementing authority, whilst in other cases it acts as an extension of the top-down approach fostered by Thatcher governments. This was most starkly expressed by the latter example of Lothian Health and hospital chief executives physically constraining the ability of doctors to prescribe.

Conclusions

It is now worth returning to the original discussion regarding two of the main aims of this thesis - to qualify the importance of policy networks by situating their existence within broader theories of the policy process, and hence to qualify arguments surrounding the effects of Thatcherism on public policy more broadly defined. In other words, to address two challenges to the primacy of policy networks analysis in analysing public policy. So, chapters 2-5 extended the relatively abstract network-actor approach to the arenas of Parliament, implementation and hence the policy cycle as a whole, in part to extend the explanatory power of networks analysis, and in part to qualify the importance of discussions of policy formulation with particular regard to the Thatcher period.

Interestingly, however, many of the case study conclusions can be used to

undermine the often assumed importance of subsequent stages in the policy cycle. The qualifications discussed in the theoretical chapter talked about the capacity for influence outside the arena of formulation and hence the capacity of actors increasingly marginalised from the formulation process to influence policy at subsequent stages (especially implementation), since parliamentary and implementation networks often took on the characteristics of their formulation counterparts as consultation and negotiation was displaced rather than rejected. Yet most of the concrete discussions showed how such alternative influence was undermined by central government activity itself. For example, in terms of HIV/ AIDS policy, the formulation network agenda was largely maintained despite chapter 7's extensive discussions of chaotic and episodic policy, as well as the effects of external attention. However, more important conclusions were reached in discussion of implementation.

Following the initial identification of four main levels of implementation networks, the aim of chapters 8 and 9 was to identify the main focus of decision making in each case. So, with regards to drugs and prisons policy (and HIV), the main decision making process was located within the Scottish Office. With the care and treatment elements of HIV/ AIDS policy, decision making took place, on the whole within Lothian Health. And, the initial impetus for decision making came from the "bottom-up" or unit levels. However, a more striking conclusion to this analysis was that each stated example highlighted the often primary importance of central government direction even following the identification of discretion and the devolution of responsibility to these levels of government. So: chapters 4 and 8 discussed the limits to Scottish Office independence in drugs policy; chapter 8 discussed the effects of financial and legal constraints on early HIV/ AIDS policy, as well as the even indirect effects of *Working For Patients* on organisations such as the CDPS; and, chapter 9 attributed the increased health board control over doctors to both financial stringency and the purchaser/ provider roles prescribed by *Working For Patients*. Whilst chapter 4 found it appealing to postulate that discretion would increase with the devolution of policy responsibility to lower levels of government, this

was not particularly borne out by subsequent long-term case studies which if anything showed the primacy of formulation networks - the very thing this thesis set out to debunk.

These discussions also have implications for the usefulness of policy networks analysis in general. In part, the conclusion to chapter 2 was that the network-actor discussion was more of an abstract defence of the literature, rather than a blueprint or framework for the detailed exploration of network effects. Its discussion was taken to its logical conclusion in chapter 5, whilst the case studies analysed the details at a much more concrete level. However, it still deserves discussion. While the abstract network discussion allowed a broad explanation of policy cycles involving three main actors, its usefulness is stretched by discussions of internalisation and the bypassing or breaking up of networks. Part 1 used a discussion of the Thatcher style to argue that this effect can be overstated and that a discussion of displacement and implementation networks suggests that the network style of government is reasserted at the implementation stage - thus reasserting the value of networks research, as well as the network actor approach and its emphasis on departmental rather than elite interaction. However, ironically this argument is undermined by Part 2's discussion of the operations of implementation networks at regional, district and unit levels. That is, the argument that negotiation is merely displaced to another influential arena at a subsequent stage of the policy process is less convincing at this stage, since there is often nowhere for the consultation to be displaced to and the government agency can directly implement policy. Thus, again, a discussion which began as a defence of the network style with a discussion of implementation has ended with the conclusion that the internalisation of policy at this stage is less likely to be explained away. The network may still exist, but its explanatory power is stretched to the limit, especially in the discussion of cosmetic consultation prior to the service cuts associated with combination therapy funding. Contrary to the formulation discussion in which the details were returned to by the network at the stage of implementation, this example highlights the fact that such details can be imposed rather than deferred at such a stage of implementation.

However, the problems addressed in this thesis were extremely useful, in the following ways. First, it provides convincing reasons to return the network focus to case studies rather than first-principles discussions. Second, it integrates network concerns with more dynamic accounts of the policy process. Third, it uses implementation case studies to broaden the horizons of network concerns. This provides ample opportunity to supplement formulation-based case studies, as was particularly shown by the discussion of professionalisation of networks at lower levels of policy, as well as the legacy of *Working For Patients*. Finally, this thesis provides a particularly useful discussion of the sector/ subsector distinction by exploiting the unique position of implementation studies to analytically distinguish between policy or authority as the basis for sectoral status.

To What Extent are These Results Generalisable?

One of the main aims of this thesis was to aid the harmonisation of the policy networks literature to allow a return to the assessment of a large body of case study literature which it has produced. Further, if this has been achieved, then the results of the case studies should add to that body of results and aid the examination of a number of pressing questions within the politics literature. But are there any ways in which this generalisability has been constrained by the focus of analysis?

Certainly, chapter 6's focus on the need to concentrate more on geographical (and Scottish in particular) differences with regards to the delivery of health care policies has one undesirable side effect - if the service delivery differences are so significant that they warrant individual study then this undermines one's ability to generalise from such results to the whole of the UK. This is certainly the case to some extent since, for example, a clear Department of Health role is apparent with regards to controls of the budget for combination therapies, whilst the Scottish Office emphasis is more on disengagement. Further, as discussed in chapters 8 and 9, the development of policy in Lothian was also distinct from that of the rest of Scotland. Thus, for example, the discussion of the early

development of drugs services "on the back of an envelope" reflected the panic felt at the time after the identification of so much HIV in such a small population. Subsequently, the "task force" mentality observed at the time has less application to most policy areas or even to the same policy area in Lothian today.

Nevertheless, this should not necessarily be seen as a failing of the research, since it pinpoints the ways in policy areas may be influenced from the bottom up. That is, such a study may aid evaluations of generalisability which come from the opposite direction, asking the question: why do these policy areas differ? This may be appropriate in a study of, say, Thatcherism in which a similar policy style may be apparent, but with different policy effects according to area. If this is the case, a detailed examination such as the one contained within this thesis may aid the identification of a variety of means to examine the differences between those policy areas

Further, most of the case study conclusions do have a general application. Indeed, whilst Lothian's was an unusual situation, the parallels between the early roles of, say, medical (and to a lesser extent activist) expertise with regards to early policy in Lothian and within the UK AIDS policy network are unmistakable, whilst in each case one prominent figure acted as a central focus for the coordination of group-government relations (see chapters 7-9). In addition, Lothian's arguably unique situation refers perhaps more to the timing, the urgency and the lack of information available more than anything else. So, it has comparative relevance for similarly urgent, new policy issues. Further, the continued levels of attention still focussed on the Lothian situation from both Scottish and English health authorities, as well as the policy transfer, encouraged by the Scottish Office, which took place between Edinburgh and Glasgow suggests that the policy measures taken within Lothian had great relevance.

In terms of the more general theme of medical power, the Lothian case study provides ample evidence for the extension of a "challenge" to clinical autonomy from formulation to implementation, in part as a result of the

legislation and hence policy structures, such as the purchaser and provider split, associated with *Working For Patients.* At the formulation stage, even the domination of consultation by the profession was under threat from the increasingly administrative and financial agendas within the Department of Health, and there is clear evidence of a similar shift at the (Scottish) regional level, with Commissioning replacing Planning as the central focus of devolved decision making and hence displacing medical representation a further rung down the ladder.

Finally, such examples supplement the ever increasing literature on the ability as well as willingness of health authorities to influence the autonomy and self regulation of the profession. The willingness of chief executives of hospitals, as well as health boards to restrict the prescription capabilities of doctors - surely the most important yardstick of clinical autonomy - ties in well with examples as diverse as the non-funding of cancer operations for those doctors without a specialist qualification recognised by health authorities to threats by GPs to prescribe Viagra without authority, whilst the restriction of funding for new drugs to within the service budget of each health area has profound implications for the future of medical advances in areas such as Alzheimer's, arthritis, cancer and even emergency medicine.

So, questions of clinical autonomy inform more general discussions of the role of the implementers of policy, and hence the importance of implementation in general, whilst examination of the role of health authorities in the same time period adds to our knowledge not only on health care implementation, but the general question of top-down versus bottom-up. The discussion of prescribing provides a particularly good example of the importance not only of the role of non-central government in the implementation of policy at the final stages, but also the central governmental context in which these authorities operate.

The Generalisability of the Network-Actor Approach

However, did the network-actor approach aid the discovery of these findings and could it be used for other studies?

It is notable that the language of network action was not frequently used throughout the case study portion of the thesis. This is in part because of the conclusions of chapter 2 - that the discussion served to solve, or at least address, some problems within the network literature rather than to provide a blueprint or a new discourse for the interpretation of events. This would be to confuse matters and has been attempted by, for example, Wilks and Wright (1987) to no great success. Rather, the mechanics of network-action are relatively abstract and are not particularly required when we reach the sort of detail that the case studies presented.

However, this is not to say that the framework has no lasting value, since detailed and abstract accounts are not mutually exclusive. Indeed, the value of the abstraction is manifest in discussions of the relative importance of formulation and implementation networks, as well as the relative importance of the levels of implementation network.

Further, the broader conclusions of the AIDS implementation chapters largely derived from a previous discussion of the policy cycle which situated implementation networks within a broad framework describing the interaction between formulation, implementation and parliamentary networks. Chapter 6 followed this discussion, describing a general health policy cycle and this allowed a more detailed examination of one part of this cycle in chapters 8 and 9. So, the network-actor framework situated chapters 8 and 9 within a broader health policy process.

This is also a two-way process, with the detailed investigations generating research questions such as:

(1) The role of professionals at each stage of the policy process. The discussion of implementation suggested that the issue of the level of government cross-cut an assumption of the coherency of the medical profession. That is, vertical integration may be undermined by the consultative effects of medical specialisation and it is difficult to follow

Wistow or Klein's line that the dominance of the "medical profession" is reinforced at the implementation stage.

Such a discussion is less appropriate at the implementation stage since the case study evidence suggests that doctors engage more in discrete areas of policy and there are fewer signs of this broad agenda. It is also a difficult line to follow since, if anything, doctors seem to fare worse at this stage than the BMA does in the formulation arena.

(2) The coherency of government. The conclusions of chapter 4 on the value of discerning levels of networks at the implementation stage were largely supported by the discussions of chapters 8 and 9. At each major stage or level of implementation there developed a group-government process suggestive of significant policy discretion and a significant consultative relationship based on the trade of information for access. Yet, the discussion of the effects of *Working For Patients* highlighted the centralising effect a policy can have at all levels.

Therefore, discussions such as these could justifiably prompt investigation into different health care policy and general policy examples to assess whether or not these are general effects. Whilst one can assume that central government has the potential to so drastically alter the operations of implementers, and governmental implementers constrain negotiations with professionals, it is still worth pursuing the idea that the scope of government is so large that such detailed regulation and action is generally impossible. It remains to be seen, then, just how exceptional these results are.

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