STRUCTURE AND POLICY IN THE NHS:
THE CASE OF THE COMMUNITY HEALTH SERVICES

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1987

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Central-local relations in the NHS since 1974

Since 1974 the NHS has been characterised by turbulence in both structure and policy (Klein, 1983; Haywood and Alaszewski, 1980). Dissatisfaction with the outcome of the 1974 reorganisation soon made itself heard and by 1979, with the Report of the Royal Commission, it was well-established. It culminated first in the organisational changes of 1982 originally mooted in the policy document Patients First, and finally in the fundamental management changes introduced in 1984 as a result of the Griffiths Inquiry. During the same period, major shifts in policy relating to the balance of resources allocated between the acute and community and long term care sectors, between institutional and community care and between geographical regions were being recommended. Along with these developments, governmental pressure mounted to limit public expenditure on the NHS - through the introduction in 1976 of a cash-limited system of financing the service and later by imposing efficiency savings and introducing measures of privatisation. As a result of all these changes, by the mid-1980s the morale of the service and its workforce was low, its motivation enfeebled and its objectives increasingly opaque. It was just at this point that the new Griffiths-style general managers began to take up their posts, charged with a duty to set objectives and get the service moving towards them.

At the time of its imposition a decade earlier, the 1974 reorganisation had been seen as a means of introducing modern, rational planning and

management structures into the NHS. As Klein (1983, p 105) describes it, it was the 'apotheosis of paternalistic rationalisation'; the key themes of the reorganisation were:

> centralisation and managerial efficiency. The new hierarchical, integrated structure was designed to give central government more control over development in the NHS. Sophisticated management arrangements were prescribed by the architects of reorganisation (Alaszewski, Tether and Robinson, 1982, p 1).

It was an attempt to introduce control over a more even (some would argue a more equitable) distribution of resources throughout the service (through centralised monitoring and guidance) and to ensure health authorities' compliance with central governments's priorities. The spate of policy documents which came from the DHSS during the 1970s can be seen as examples of this attempt. Priorities for Health and Personal Social Services in England (DHSS, 1976), for example, was regarded as a first ever attempt at establishing 'rational and systematic priorities throughout the health and personal social services'. It reviewed current levels of service and expenditure and made suggestions about future levels (including in some cases reductions in current levels). It singled out certain areas of the service (notably those relating to what later came to be called the priority groups - the elderly, mentally ill and mentally handicapped groups) for priority, emphasising that others - notably the acute hospital services and maternity services - should either be cut back or at least held in check. The follow-up

document The Way Forward (DHSS, 1977) was even more explicit in its aim to achieve ' a national pattern based on national priorities' and built on the findings of RAWP, which set out a pattern for geographical redistribution to achieve a more equitable allocation of resources on a nationwide basis. During this period, then, the commonly stated view was that rational and consistent priorities could only be achieved by central monitoring and control.

But it would be glib to characterise the immediate post-1974 period as being wholly fixed in the mould of centralised planning and decision-making. Even those at the epicentre of power were aware that there were in-built conflicts and tensions in the model as laid down in the 1974 structure. Barbara Castle, the then Secretary of State at the DHSS stated in the foreword to the first 'Priorities' document:

> One of the biggest challenges to effective democratic government is how to reconcile two potentially conflicting aims: central government must be able to establish and promote certain essential national priorities, while the local agencies of government should have the maximum scope for making their own local choices in the light of their local needs (DHSS, 1976, p iii).

And, indeed, others have noted that whilst purporting, both in this document and The Way Forward in 1977, to lay down guide-lines for a national strategy which it expected all health authorities to abide by, the government did not in fact do more than suggest 'desired shifts' in

expenditure patterns. As Klein says, the 'language of norms and objectives turned out to be merely a vocabulary of exhortation'. Even in the case of the RAWP formula, whereby centrally arrived-at targets for redressing geographical imbalances in resource allocation were established, the length of time projected for reaching those targets was in some cases so distant as to be almost meaningless (500 years in the exceptional case of the East Anglian Region according to one source (Harrison and Gretton, 1984)). Thus the centralisation so often complained of was perhaps more to do with rhetoric and intention than with structure and practice.

Nevertheless, by the turn of the decade, the received wisdom was that 1974 had heralded a move towards centralisation and that the time was now ripe for reversing the flow. The tone was set in 1979 with the publication of Patients First (DHSS, 1979) and later with Care in Action (DHSS, 1981) in 1981. No longer was there talk of targets and norms; instead a broad statement was made to the effect that the Secretary of State 'expects authorities to give priority to the further development of services, both statutory and voluntary, for the needs, as locally assessed, of the priority groups' (emphasis added). Emphasis on 'localness' was seen to be the key to the future success of the health services. As Patrick Jenkin stated in the introduction to Patients First:

> We are determined to see that as many decisions as possible are taken at the local level - in the hospital and in the community. We are determined to have more local health

> authorities, whose members will be encouraged to manage the service with the minimum of interference by any central authority, whether at region or in central government departments. We ask that our proposals should be judged by whether they achieve these aims (1979, p 2).

This new rhetoric and intention found form in the reorganisation which followed in 1982 with the abolition of area health authorities and the formation of units of management within districts. Such units were to be constituted from a range of examples as laid out in the circular HC(80)8; thus they could be any of the following: institutional (based on a single large hospital, or group of smaller hospitals); community-based (community health services); client group-based (all the services for a particular client group gathered together in one unit);or geographical (to include small institutions and community health services within a defined geographical area).

These options matched the government view as expressed earlier in Patients First that decision-making power should be delegated down the structure as far as possible; decisions were to be taken at a point closest to the patients since 'the closer decisions are taken to the local community and to those who work directly with patients, the more likely it is that patients' needs will be their prime objective'. In the interests of speedy and effective decision-making, there was to be no tier between the units as envisaged and the health authority (which was to be at the district level). The structure was to be clear, simplified and, wherever possible, was to correspond with 'natural'

socio-geographical contours and local authority boundaries (although it was the Area Health Authorities, now dissolved, which had been most often co-terminous with Local Authorities).

Interestingly, in contrast to those who had sought to establish national priorities a decade earlier, the proponents of the new decentralisation saw little inherent tension in their plans. Whilst the 'centralisers' were only too conscious of the difficulty in balancing the needs of the periphery against those of the centre, the 'decentralisers' hardly addressed the question. Indeed, in so far as they did, they tended to minimise the issue. Patients First, for example, was wary that Regional Health Authorities might use their powers deriving from the Grey Book 'insensitively', thus allowing them (RHAs) to 'intervene in virtually any area or district matter'. This was a matter for concern, and the document drew the conclusion that whilst RHAs clearly had a role in reforming financial control and for monitoring the implementation of district plans (both seen as unproblematic), 'it is far less clear that it will be necessary for RHAs to have a broader monitoring responsibility (the exercise of which could undermine the delegation of responsibility to district level)'. And in the 1980 circular, this view was reasserted: the government would review 'the relationship between RHAs and DHAs ..... and the composition and functions of RHAs and the role of the Department in relation to them ..... with a view to enhancing local autonomy'.

Thus the complex set of oppositions relating to the centralist/decentralist debate, as descried by Klein (1983), of

responsiveness as opposed to efficiency, of differentiation as opposed to uniformity and of self-government as opposed to national equity was simply not considered. It was more the stuff of political disengagement than considered devolution.

The development of community focussed policies

At the same time as the rhetorical and structural shift from centralisation to decentralisation was taking place, there were parallel shifts being recommended in the organisation of service delivery. Such developments were related to the targeting of the priority groups in the 1976 and 1977 policy documents in which precedence was also given to the importance of developing community care policies - shifting the balance from institutional to community-based forms of care. This view was re-iterated in the documents published by the new Conservative government from 1979 onwards.

There have been many arguments about the origins of and motivations for such policies (Illsley, 1981); they are policies which have been validated by different interests within the health and personal social services for a variety of different reasons. Some have favoured them as a means of saving on the heavy expenditure costs of large-scale institutional care. Others have seen them as a means of transferring responsibility for professionally unattractive groups of patients to other areas of the service (or to other services: NHS $\longleftrightarrow$ Local Authorities $\longleftrightarrow$ voluntary sector). And yet others have seen them as giving confirmation to strongly-held professional and/or ideological

views about the rightness of one form of care over the other.

What they came to mean in practice - this variety of views notwithstanding - was that greater emphasis should be given to the primary care and community health services; that the large mental illness and geriatric institutions should be closed down; that the domiciliary services be greatly developed and that collaboration between the agencies providing long-term care of various sorts be promoted, especially with the help of such mechanisms as joint finance. Where in-patient care proved to be necessary, priority should be given to the establishment of small-scale, local provision - in the form of 'HEC' or 'EMI' units (for the confused elderly), hostels, half-way houses and group homes. Thus the decentralisation of power through reorganisation of both management and structures was to be parallelled by the 'decentralisation' of services; decentralisation, through de-institutionalisation, was to take on a 'geographical' perspective in terms of the increasing emphasis on community-based service provision.

In the light of the fact that the development of community care was already accepted as a major priority by 1979, it is ironic that Patients First was widely criticised on publication as being too 'hospital orientated'. The summary of comments received, published by the DHSS in 1980, indicates that almost half of all RHAs, along with many other bodies including CHCs and professional associations, felt this to be a regrettable feature of the document (DHSS, 1980). The commentary published by the Nuffield Centre for Health Service Studies

expressed the view clearly:

> The document appears to regard the hospital as the cornerstone of the health service and reinforces the view of the supremacy of the hospital when it talks about the management structure for 'each major hospital, group of hospitals and <u>associated</u> community services'. The community services according to this statement are an adjunct to these hospital services ..... The abolition of community services 'sectors' will reinforce this impression. This apparent switch in emphasis comes at a time when there is a growing awareness both within the country and internationally that, while not neglecting secondary care, increasing importance should be placed on primary care as the appropriate cornerstone of our health system (Nuffield Centre for Health Service Studies, 1980, p 7).

These criticisms seem to have been implicitly accepted, since in the circular (HC(80)8) which followed, greater recognition was given to the community services. The community services on their own were seen as one of the options for unit structures within the district. The Acheson Report on primary health care in inner London published the following year (London Health Planning Consortium, 1981) made a strong plea for the separate organisation of the community health services into a single unit of management in order to give them a higher priority and profile (para 8:11) and to enable them to respond to the urgent need created by

the proposed reductions in the acute hospital sector.

These views was echoed in the case of the Scottish Health Service which introduced reorganisation and general management two years later than in England. In April 1986 Coopers and Lybrand had reported on their commissioning by the SHHD 'to examine the main options for introducing general management into units in Scotland; and to consider whether units require to be restructured before general management is introduced'. They expressed great reservations about separate community units where they existed because although established to help the development of the community services 'in practice, however, partly because of their size they tended to be "overshadowed" by other units and encountered difficulties in integrating with other services' (Coopers and Lybrand Associates, 1986).

But this view, however, was firmly rejected by the circular (1986 (GEN)20) issued by the SHHD in August that year:

> The consultants expressed reservations about community units in paragraph 4.13 of their report. The greater policy emphasis on community services can however be more readily transformed if community services have a district unit structure. While accepting the weaknesses which can attach to such units, Boards should not be inhibited from considering them as a suitable structure for developing local priorities.

The establishment of community units was thus seen as part of the strategy to further the development of community care policies. Whether, in practice, this proves to be effective and how far health authorities also recognise this as part of an over-arching strategy is open to question. The problem referred to by Coopers and Lybrand of community units being 'overshadowed' is a real one and reflects on the relative lack of prestige granted to all things relating to 'community' and 'long term chronic care' in contrast to hospitals and, especially, the high-tech, acute areas of medicine. This has been a continuing problem over many years and has raised doubts as to whether the policies of priority-giving to long term dependency groups will ever be fully successful (Illsley, 1981). Certainly, current emphasis on the effects of cutbacks on the acute services and recent government efforts to head off criticism seem to indicate a gloomy prognosis for the future of the community services.

The philosophy of local authority decentralisation

The transition from institutional to community care advocated within the health policy arena has, of course, been matched within the personal social services. The transfer of patients from institutions to 'the community' immediately requires the provision of services typically seen as the responsibility of local authority social services departments. And within the local authority world decentralisation has become a live issue, although perhaps starting from a different stand-point and having a different philosophical base. Whilst the issue of decentralisation within the health service has had its roots in macro-level policy and political concerns (as is to be expected in a

nationally-based service) and more recently in the 'management ethos' engendered by the present government's predilection for solutions from the business world , the same issue for local authorities has arisen from a variety of micro-political concerns, emanating from both left and right, related to attempts variously to democratise services, to promote user involvement, to de-professionalise the caring services, or to displace responsibility onto the informal caring sector. Some have been related to different ways of practising a particular profession (community social work as opposed to client-centred case work - see the Barclay Report (NISW, 1982)); others have been more concerned with service and organisational structure (the decentralisation of housing departments, of example, as in the case of Walsall). And yet others have attempted a wholesale decentralisation of all local authority services, at the same time as incorporating democratising and participatory mechanisms into the process where possible. The London Borough of Islington is perhaps the best example of this latter approach, where considerable capital investment has been made in the establishment of purpose-built neighbourhood offices serving a network of neighbourhoods based on population sizes of about 7,000. From such neighbourhood offices, the Borough runs its decentralised social services, housing, environmental health and chief executive's departments. The council's explicit objective in decentralising is to achieve 'locally-based, accessible and responsive services'; they are to be services which are 'provided locally with a coordinated approach across departments [with] greater accountability to users and [with] the involvement of the public in decisions about their services' (London Borough of Islington, 1986).

Other local authorities on the other hand have adopted a more narrow-focussed approach. East Sussex, for example, has decentralised its social services department and has been concerned with a 'more neutral notion of [developing] a more effective way of providing services' which reflects a 'dissatisfaction with or reaction to post-Seebohm models of organisation and management'. The East Sussex Social Services department (1984) contrasts the client-centred, reactive and crisis-dominated approach of these models with the community-focussed social work which the Barclay Report recommended. The corollary of this approach is that decentralisation becomes much more to do with looking at the nature of professional practice rather than with organisational and overtly political issues of democratisation, participation and accountability. Questions are raised about the professional role, the nature of voluntarism and the part to be played by informal care networks in the provision of care traditionally provided by state-financed agencies - and in spite of the claim to 'neutrality' the service-focussed approach raises issues which are no less political in nature than the head-on democratising, participatory approach.

They are, after all, issues which link in to the debate on the right about the proper role of the professions and the extent to which they should be permitted to intrude into the private domain of individual liberty - especially in relation to the regulation of children (through the statutory social and education services in particular). The informal Family Policy Group, which the Conservative government established before the 1983 election, was concerned, amongst other

matters, with the extent to which peoples' lives were controlled by professional (and therefore - since they were public employees - the state) interests (The Guardian, 19.2.83). Populist and libertarian notions characteristic of the new right were at work in these deliberations and have formed a thread running through a number of ministerial pronouncements subsequently (Tebbit, 1986).

Academic commentators, too, have expressed similar views. The Bergers, for example, talk about 'the disenfranchisement of families by professionals in alliance with government bureaucrats' and go on to argue that it would be better for what they call 'mediating structures' (that is neighbourhood, church, voluntary associations, ethnic or racial sub-culture) to be brought in in times of crisis to support individuals and their families rather than the professional-state bureaucratic complex. In this way, they say,

> We believe that many of the problems of the modern welfare state would be greatly mitigated if not eliminated if public policy would favour and even utilise these mediating structures more, instead of ignoring or even running over them, as has been the tendency to date (Berger and Berger, 1983).

This is very close to the view in the British context that rather than intervening to supplant informal care networks, greater use should be made of them by concentrating professional and state support to bolster them. Such an approach would

> place far more emphasis on support of the informal carers, whether family, friends or neighbours and volunteers, in order to extend the numbers helped, to try to ensure that no individual carer should have to carry intolerable burdens and to preserve and strengthen community caring networks (Hadley and McGrath, 1984, p 11).

Interestingly, although these views tend to converge with the views of the libertarian right, it has also been argued that moves towards decentralisation from the left also encapsulate some of these same inherently anti-professional tendencies. Hoggett, for example, suggests that such moves raise questions about the 'Labourist' approach to socialism - based essentially on seeking the objective of egalitarianism through quantity rather than quality. Thus the traditional left has favoured a sharing out of, and an increase in, the overall volume of resources, rather than being concerned with the nature and quality of those resources per se. It has been content to leave the definition of these latter issues in the hands of what Hoggett calls 'the professionalised welfare state apparatus'. The advocates of decentralisation, on the other hand, in radical contrast, seek to ask questions about quality and about the source of its definition - by incorporating the views of the consumer as opposed to those of the professional since:

> present systems of local and central government are democratic in token only - the decision makers are, in

> reality, often appointed 'professionals' and the routes by which they arrive at their decisions are obscure and inaccessible' (quoted in: Hoggett, 1984, p 27).

And in this way, Hoggett argues, decentralisation challenges the post-war monopoly of professional control - and in doing so, parallels the challenging of that control from the right. Where it differs, however, is that it does not seek to abandon the concept of collectivist provision of welfare in favour of the market philosophy of the right; whilst both approaches seek to give power to the consumer:

> privatisation, in theory at least, seeks to enhance consumer power by enabling the consumer to play off one producer against another,[but] decentralisation seeks to enhance consumers' power by including them within the process of production itself (Hoggett, 1984, p 29).

Decentralisation and community health services

Decentralisation, whatever form it takes, or whatever its philosophical pedigree, is clearly very much a vogue concept in the 1980s in both the NHS and the world of local government. But that very variability in pedigree suggests that the term masks a degree of confusion and obfuscation which it would be useful to clarify if the real trends and movements in health service organisation and objectives are to be identified - especially in relation to community health services.

In the last decade, as we have seen, a rhetoric of decentralisation in the NHS has been offered by the present Conservative administration as an antidote to what has been presented as over-bureaucratised central control; this has been coupled with a view from the market place that, as the Griffiths inquiry (DHSS, 1983) put it, 'whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question'. The NHS is, according to this view, unlike 'businessmen [who] have a keen sense of how well they are looking after their customers'. For Griffiths, decentralisation is about having a 'small, strong general management body ... at the centre' and ensuring 'that responsibility is pushed as far down the line as possible i.e to the point where action can be taken effectively'. A decentralised structure according to this view is like a conduit which facilitates policy decisions made at the centre by the 'small, strong' management core to be transmitted down in the smoothest, speediest way possible to the point where they can be operationalised. The test of efficacy and appropriateness (i.e. customer satisfaction) is then for the consumer to be allowed to react to whatever action is taken - to say 'yea' or nay'.

And since the advent of Griffiths-style general managers, decentralisation linked to the new management structures in this way has become a popular option at the micro-level (sub-unit level) for community unit general managers (UGMs) in deciding how to organise their community health services. According to a survey conducted in the autumn of 1986 (Dalley, 1987b) over two thirds of the community units in English DHAs [140 Districts out of a total 191] were planning

to decentralise their community health services.

With the establishment of units charged with particular responsibility for those services (sometimes on their own, sometimes in conjunction with priority care services and/or continuing care services in small hospitals), it is not surprising that the decentralised model should be so widely adopted. As noted earlier, community services are characterised by their spatial or geographical nature - they are the health services offered to people in their own homes or in their own localities and as such cannot be centralised in single service points. A form of management and an organisational structure which reflects the spatial nature of the services is thus a logical outcome. It also links with the de-institutionalisation process which disperses priority care services geographically throughout a district. The pyramidal structure of general management then comfortably overlays the spatial dispersal of services - the single general manager (UGM) at the apex, and a host of mini-managers across the base. And indeed this model has been widely adopted - 78% of decentralising units plan to appoint 'locality managers' who will be responsible for a variety of functions (staff management, budgets, planning, service delivery and so on) within their patches.

As a model, a decentralised unit is a neutral construct; but it exists, in reality, in a value-laden environment. And that environment is filled with competing values. Most obvious are the values associated with general management as described above. Emphasis is placed, above all, on the accountability of every manager, for what he

or she does, to the manager immediately above. Policy is determined at the centre and is expected to be applied consistently all the way down the pyramidal structure; operational decisions made at the periphery, or the base, have to be accounted for in terms of those policy objectives set at the top. In these terms to decentralise is to be more managerially efficient.

Linked to this, the concept of consumerism associated with Griffiths-style general management is a reactive one; it becomes the ultimate test of managerial efficacy. In Winkler's (1987) words, it is about customer relations and not patients' rights. The expectation is that consumers' views will be tested on a 'post hoc' basis; attempts should be made to ascertain what consumers think about existing services, but not to involve them in the planning of future services. That would be administratively too untidy.

The Griffiths principles of management and consumerism are closely associated with the centralising philosophy underlying the current government's rhetoric of decentralisation. Pressure from the centre at national level is one of the facts of life with which districts and their units have to contend. Arbitrary decisions (such as those requiring action to be taken over waiting lists, setting target levels for numbers of particular operations and demands for uniformity in setting performance review indicators) are taken by ministers or departmental officials, requiring regions and thence districts to take action without reference to their existing strategic plans. Value is placed on control and uniformity.

All this represents one set of values with which a decentralised structure (at macro or micro-level) has to deal in the contemporary NHS; but if we look at community units in particular, other values and philosophies too can be identified as being in contention with this dominating value-set. The publication of the Cumberlege report on community nursing in April 1986 (DHSS, 1986) is an example of new attitudes being developed in the community health services sector. It offers what is essentially a programme of decentralisation for community nursing but one which in contrast to the 'top-down' structural approach of general management is focussed on the front-line of practice and on identifying the optimum way of delivering user-appropriate services. This involves a

> concern that nurses need to challenge their traditional roles, work more flexibly and ensure that consistency and co-ordination of care are fostered in order to achieve a more effective and appropriate response to the country's health and nursing needs (Part Two, p8)

By dividing nursing staff into neighbourhood teams, dealing with 'natural' communities of no more than 10-25,000 people, with an expectation that nurses should be prepared to adopt a generic approach to the nursing task, and by recommending the formation of neighbourhood-based health care associations, the report is offering a vision of locally-based, user-oriented community health services which has much in common with grass-roots community health initiatives often sponsored by the voluntary sector, the patch-based approach of

community social work and the 'de-bureaucratising' decentralisation moves of a number of local authorities. At the same time, although the report is not directly concerned with unit structures and the principles of general management, the neighbourhood nursing team model can fit very neatly into a decentralised, generally managed community unit (Dalley, 1987a); it is its difference in philosophy which distinguishes it from that top-down approach.

Community health services, then, are subject to a number of 'philosophically-derived' influences related to the principles of decentralisation. They are now a generally managed service and thus under direct and closely monitored pressure from the centre/top. But they are geographically distributed services and therefore decentralised in the spatial as well as the structural sense; this puts them in closer touch perhaps with the demands of the periphery, of both front-line practitioners and users. Further, they are the services which increasingly are bearing the brunt of the process of de-institutionalisation and are the focus of current community care policies (often though without the resources to match). However this means they are seen as central to the successful implementation of those policies by those who are ideologically highly committed to them (namely, many practitioners and their professional associations, a body of academic commentators and some clients).

In addition, the community health services often work in close relationship to many local authority services (home helps, social workers, occupational therapists and so on). The problems of that

relationship are well-known - differences in professional training and affiliation, ideological contrasts and opposing agency allegiance all create barriers to and constraints on effective collaboration. But the differences are often emphasised at the expense of acknowledging some of the similarities: professional commitment to similar policy goals (community care) at the level of principle is common to both health and local authority services; calls for similar developments in practice are heard in both services (Cumberlege and the Barclay Report), and a greater willingness to be responsive to the needs of the user characterise them both.

In relation to this latter point, recognition of the importance of the user is significant. It represents the reverse side of the consumer coin from Griffiths' concern with 'customer relations'. It is part of the movement to democratise public services - already a feature of some of the local authority decentralisation initiatives - making services accountable downwards to their users (in contrast to the accountability upwards of general managers to their superiors at higher levels of the structure). Winkler (1987) describes four models of consumerism which are relevant for the health services: community health councils; democratic accountability; user power; and partnership between providers and users. CHCs, she concludes, need to be more adventurous and more independent if they are to extend their role and be effective. Democratic accountability, as she describes it, generally means 'elections on to health authorities' - a far too limited view of what the term should really mean (because it lacks any <u>theory</u> of consumerism). User power as propounded by Ivan Illich ignores the very

real complexity involved in making decisions about health and ill-health; and user power as defined through the market place is equally lacking in full competence to make complex decisions. The model she advocates is the partnership model and she calls for new institutions and new mechanisms in order for it to be developed. Advocates of decentralised community health services would argue that they provide just those institutions and those mechanisms.

Conclusion

The community health services and the community units which provide and manage them are located in an arena crowded with competing values and structural tensions. Some analyses might conclude that contemporary community units are merely the lowest-level extensions of highly centralised but segmentary organisational pyramids, where emphasis and value is place on the consistent application of centrally-determined, uniform policies at all levels and across all segments of the structure. In such a setting there could be little room for manoeuvre, little opportunity for the entrepreneurial and innovative skills of individual managers and practitioners, and little occasion for user involvement in decision-making down at the grass-roots. Another analysis, however, - and the one being argued here - is that the environment in which community units and their personnel operate is much more fluid than that. It accepts the view that current NHS policy and structure is based - in spite of the decentralist rhetoric - on a highly centralist philosophy. Nevertheless, it argues that because of the particular nature of the community services and the influences under which they operate, the centralist control emanating from the top

meets and conflicts with genuinely decentralising and democratising pushes from below. These themselves are the outcome of a number of factors: developments in thinking about modes of practice; changes in the type of service delivery and structure (de-institutionalisation); grass-roots, often user-derived, community health initiatives; and, indeed, sometimes, an opportunistic seizing of the rhetoric of decentralisation and consumerism, by taking it at face value and making it serve the interests of the periphery rather than those of the centre.

Acknowledgements: Thanks are due to David Hunter and Linda Marks for helpful comments and suggestions.

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