Decentralisation, Centralisation and Devolution in publicly funded health services: decentralisation as an organisational model for health care in England

Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)

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prepared by

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Executive Summary

Background

Current National Health Service (NHS) policy sets out a number of broad themes that include organisational freedom from central control, patient empowerment and clinical empowerment. These reflect many of the assumptions made in the literature about the benefits of decentralisation. In other sectors, as in the NHS, decentralisation is usually seen as a good thing because it:

- frees managers to manage
- enables more responsive public services, attuned to local needs
- contributes to economy by enabling organisations to shed unnecessary middle managers
- promotes efficiency by shortening previously long bureaucratic hierarchies
- produces contented and stimulated staff, with increased sense of room for manoeuvre
- makes politicians more responsive and accountable to the 'people'.

Aims of the study

This review examines the nature and application of decentralisation as an organisational model for health care in England. The study reviews the relevant theoretical literature from a range of disciplines relating to different public- and private-sector contexts of decentralisation and centralisation. It examines empirical evidence about decentralisation and centralisation in public and private organisations and explores the relationship between decentralisation and different incentive structures, which, in turn affect organisational performance.

Methods

The review encompassed two main activities. The first was an analysis of the conceptual literature on decentralisation to clarify parameters that could be measured. Second we undertook a review of the extant literature:

- to map the available literature
- to provide a critical overview of existing work in relation to appropriate themes
- to identify areas where more research may be of use
- to consult with users to complement and enhance overall findings.

Findings

It is clear that decentralisation in health policy is a problematic concept. First, there are significant problems of definition. The term decentralisation has been used in a number of disciplines, such as management, political science, development studies, geography and social policy, and appears in a number of conceptual literatures such as public choice theory, principal/agency theory, fiscal federalism and central–local relations. It has links with many cognate terms such as autonomy and localism, which themselves are problematic. Other commentators tend to use different terms, such as agency central–local relations, and national versus local. Whereas decentralisation and devolution tend to be the dominant terms, they are rarely defined or measured, or linked to the conceptual literature. Second, much of the literature refers to elected local government with revenue-raising powers or is related to changes in so-called developing or lower-income countries. Application to the English NHS, which is appointed and receives its revenue from central grants, is therefore problematic.

The discussion in this report identifies three main problems associated with the analysis of decentralisation. These are as follows.

- There is a lack of clarity regarding the concepts, definitions and measures of decentralisation.
- The debate about decentralisation, and subsequent analyses of decentralisation, lack any maturity and sophistication.
- Assumptions about the effects of decentralisation on a range of issues, including organisational performance, are incorporated into policy without reference to whether evidence or theory supports such an approach.

Clarity of the concept

Previous studies have tended to treat decentralisation as a uni-dimensional concept defined by concepts that lacked conceptual clarity, such as power and autonomy. Little attention was paid in the literature to adequately defining and measuring the *where* and *what* of decentralisation. In addition, analyses of decentralisation pay little attention to clearly defining what is being decentralised and our new Arrows Framework (see overleaf) provides a useful way of conceptualising this aspect of the process.

The Arrows Framework

Tier… / Activity	Global	Europe	UK	England/Scotland/Wales/ Northern Ireland	Region, e.g. SHA	Organisation, e.g. PCT	Subunit, e.g. locality/practice	Individual
Inputs					←		→	
Process					←		→	
Outcomes					←		→	

Arrows indicate the direction of movement.

PCT, primary care trust; SHA, strategic health authority.

Evidence on decentralisation and organisational performance

Decentralisation is not a completely discrete area of research and more attention needs to be paid to how it is utilised as a concept in future practice, policy and research. The brief for this review identified two areas for analysis relating to relationships between organisations. In addition, the changing nature of the dynamics between parts of a system over time, resulting from the combination of multiple centres of direction and regulation (including financial, political and technical) and multiple strategies emerging among the regulated organisations (including collaboration, compliance and competition), was also identified as an area for investigation. There was little evidence in our review to be able to comment on these areas and further substantive reviews may be required.

The key message from this review is that decentralisation is not a sufficiently strong individual factor to influence organisational performance as compared to other factors such as organisational culture, external environment, performance monitoring process, etc. Neither is there an optimal size/level that provides maximum organisational performance. Different functions and the achievement of different outcomes are related to different organisational sizes and levels. There are, therefore, trade-offs or compromises between different activities and outcomes; for example, different approaches to equity, responsiveness versus economies of scale and so forth.

Key messages for policy and practice

It is important that in making decisions policy-makers and managers recognise inter-relationships between inputs, processes and outcomes and levels in the sense that any organisation (or individual) can gain and lose. They also need to be aware that the evidence base for the impact of decentralisation on organisational performance is poor and that there is little substantive evidence to support the key assumptions made about decentralisation.

It is also essential that decentralisation is seen as a process – one of a number of factors – that can be employed for achieving particular goals rather than as an end in its own right. This review has demonstrated that much discussion of decentralisation is based on assumptions that are not substantiated by theory or evidence. A key problem is that benefits in one context are incorporated into general assumptions and are often transferred to other contexts, despite the problems associated with doing this. Local and national health care organisations need to develop a more sophisticated understanding of decentralisation processes and learn that simple assumptions about the benefits, or otherwise, should be avoided. Health care managers and practitioners should therefore give more explicit recognition to the compromises/trade-offs between performance criteria (e.g. equity versus efficiency versus responsiveness, etc.) when developing strategies. Policy-makers and managers also need to understand that decentralisation is not a

panacea – it is a process which among other factors can have an impact on organisational performance – but which should not be seen as an end in itself.

Areas for further research

We were asked to specifically examine gaps in the current literature and knowledge base. In general we recommend that consideration is given to research that addresses the issue of context with the use of good-quality case studies and also to research that takes a longer time span than the normal 3-year period, in order to capture change over a more realistic period. In addition, we believe that there is a need for research that examines specifically the relationships between and within levels by adopting studies that focus on health care economies rather than simply organisations. We suggest that in addition to these general comments future research is focused in two broad areas.

Decentralisation as a concept

Further research is needed on the development of conceptual models (and especially the Arrows Framework) for health services decentralisation and the way it is measured. The only dimension that is measured (albeit poorly) is fiscal decentralisation and further research is required to identify the key indicators for measuring decentralisation.

Decentralisation and performance

A relationship between decentralisation and organisational performance exists but it is often contextually specific or equivocal. Future research in this area should therefore incorporate decentralisation but should also address the different contexts of decentralisation. In particular, what function works best at what level and is there a specific receptive context for particular functions? In addition, research on decentralisation needs to move beyond a focus on single organisations to explore the extent to which local health economies or communities have autonomy. Particular areas of organisational performance might include exploring the relationships between decentralisation and accountability, human resources management and professional autonomy.

The Report

Section 1 Background to the study

1.1 Context to the study and to decentralisation

The issue of a national, centralised versus a local, decentralised service was one of the major debates in the formation of the National Health Service (NHS) between the then Minister of Health, Aneurin Bevan, and the Deputy Prime Minister, Herbert Morrison, in the 1940s. Throughout the history of the NHS there has been a trend of thought advocating 'democratising' and/or decentralising the NHS (e.g. Powell, 1997; Hudson, 1999). There has been some reassessment of the Bevan orthodoxy (Szreter, 2002; White, 2004). Blunkett and Jackson (1987) termed nationalisation 'Labour's great mistake' and ministers such as John Reid, Alan Milburn and David Blunkett have advocated different shades of 'new localism'. Campbell (1987) writes that:

> *all the fundamental criticisms of the NHS can be traced back to the decision not to base services on local authorities. The various medical services were fragmented instead of unified; the gulf between the GPs and the hospitals widened instead of closed; there was no provision for preventive medicine; there was inadequate financial discipline and no democratic control at local level. In retrospect the case for the local authorities can be made to look formidable, the decision to dispossess them a fateful mistake by a Minister ideologically disposed to centralisation and seduced by the claims of professional expertise.*
>
> Campbell (1987: 177)

Without doubt the NHS embodies diversity and uniformity. Within a *national* health service that is (notionally) committed to equity, the pressures for uniformity appear strong. The national (UK) character of the health service, financed from general taxation, provides reasonably equitable access to hospital-based and primary care services. However, a series of local health services, rather than a single national one, is evident (Mohan, 1995; Exworthy, 1998; Powell, 1998); this diversity might provide locally contingent services and local horizontal integration (Exworthy and Peckham, 1998) but it may also represent inequality and fragmentation (Peckham and Exworthy, 2003). Butler (1992: 125) summarises the dichotomy: is the NHS a national service which is locally managed or a series of local services operating within national guidelines? Hunter and Wistow (1987) cite some other reasons for assuming uniformity across the UK:

- historical commitments and limited increments in financial growth (limiting major change)
- pressure-group activity from professional bodies (e.g. the British Medical Association and trade unions)
- UK-wide agreements such as pay, terms and conditions

- the relative lack of policy-making resources in the territorial offices (compared with London).

However, there are countervailing pressures encouraging diversity, including the forces for political devolution, territorial cultures and traditions, the way in different types of policy are implemented, the territorial regimes of governance and the restructuring of the state in the light of broader pressures. Therefore, many variations within UK health policy might relate as much to political and administrative factors as to health or health care factors.

In a recent King's Fund discussion paper (King's Fund, 2002) two key problems were identified with the NHS: over politicisation and over centralisation. To address these, three strategies were suggested, involving (a) greater distance between the Government and the NHS, (b) separate providers from central control and (c) greater devolution from the centre. Central to these proposals are the concepts of decentralisation and devolution. Decentralisation is a complex concept that is utilised in a wide range of disciplinary contexts including political science, geography, management studies and organisational theory (Smith, 1985; Burns *et al.*, 1994; Exworthy, 1994; Pollitt *et al.*, 1998). Whereas essentially the literature identifies two basic typologies relating to geography (spatial dimension) and level (organisational dimension), decentralisation remains a contested concept. Within the UK decentralisation has a long history embodied in debates between Bevan and Morrison about political and organisational decentralisation of the NHS in the 1940s (Nissel, 1980; Baggott, 2004).

Current debates about the role of the centre, patient choice, primary care trusts (PCTs), practice-based commissioning and the creation of foundation trusts and new governance arrangements provide the context for the present wave of decentralisation in the NHS. Government proposals set out in the new NHS Five Year Plan emphasise shifting power from the centre, described by the Prime Minister as finding the balance between 'individual choice and central control'. In his speech to the NHS Confederation in June – following John Reid's launch of the new NHS Five Year Plan – Sir Nigel Crisp, Chief Executive of the NHS, described the NHS as decentralizing, to move away from Bevan's adage that 'the sound of a bedpan dropped in a distant hospital should reverberate through Whitehall'. In future, NHS organisations would be asked to set local targets according to five principles: identified gaps in services, the needs of the local population, an 'equity audit' – paying particular attention to the needs of black people and those from ethnic minorities, evidence-based interventions and, where possible, shared targets with other NHS bodies and local authorities. Instead of 80% of initiatives being dictated nationally, with 20% set locally, 80% of the NHS's priorities would be determined locally. But Crisp warned, 'The journey will not be a straight line. There will be times when the centre seems to be too interfering and too controlling, and other times when everything will seem too decentralised, with accusations not just of postcode prescribing, but of "postcode healthcare".'

Government policy is also committed to allowing patients a greater say in their own health care, for example by choosing or sharing in the decision

about where they should be treated, what kind of treatment to have or who should carry it out, decentralizing decisions further than simply to local NHS organizations and professionals. Not only is it seen as right that patients should have such involvement, but that such a policy has beneficial consequences, for instance making patients feel more satisfied because they get services which suit their needs better, or improving the general quality of health services because of competition between providers, or enhancing equity by giving more choice to those who have been disadvantaged in the past. The model endorsed by the later Labour government, based around individual patient choice, is perhaps the clearest attempt yet at 'market consumerism' (Greener, 2004). This model was outlined in *The NHS Plan* and in the policy documents *Extending Patient Choice* and *Delivering the NHS Plan* (Department of Health, 2000, 2001a, 2001b, 2002). Later came *Building on the Best: choice, responsiveness and equity in the NHS* and the establishment of the Commission for Patient and Public Involvement in Health (Department of Health, 2003). Government policy in these directions has also been supported by professional and consumer groups, supporting greater choice for consumers, though acknowledging that there are limits to, and adverse consequences of, choice (National Consumer Council, 2004).

Current NHS policy sets out a number of broad themes that include organisational freedom from central control, patient empowerment and clinical empowerment, reflecting many of the assumptions made in the literature about the benefits of decentralisation. In policy usage – as evidenced by recent use in the NHS – decentralisation is seen as a good thing because it:

- frees managers to manage
- enables more responsive public services, attuned to local needs
- contributes to economy by enabling organisations to shed unnecessary middle managers
- promotes efficiency by shortening previously long bureaucratic hierarchies
- produces contented and stimulated staff, with increased sense of room for manoeuvre
- makes politicians more responsive and accountable to the 'people'.

The important link here is that decentralisation is seen as having the potential to improve organisational performance through localisation and organisational change, usually conceptualised as smaller independent organisations rather than simply as subunits of larger bureaucracies (e.g. PCTs rather than local offices of the NHS). Current government policy in relation to the NHS also promotes decentralisation as a way of releasing local health services from the constraint of central direction and thus underpins the drive towards improvements in health care (Department of Health, 2000, 2004; King's Fund, 2002). It is argued that decentralisation with devolved power creates autonomy to act and manage. This is clearly a key element of current policy rhetoric with regard to PCTs and foundation hospitals for example. Presumably the goal of decentralisation in health care systems is to increase performance and/or improve health outcomes and an analysis of

decentralisation must, therefore, relate to examining what is being decentralised and for what purpose.

Thus it is essential to identify the theoretical underpinning of the concept of decentralisation before exploring its application in policy and practice. This review identifies, therefore, a number of key theoretical positions – such as public choice theory, democracy and organisational theory – and key concepts and measures relating to decentralisation to develop a typology of approaches to decentralisation drawing on existing empirical studies identified in the review. A secondary approach will be to identify frameworks for defining decentralisation/centralisation. In particular, implementation theory discusses the need to balance professional and organisational discretion (suggesting a devolved and decentralised organisational structure) and the need for central policy control to achieve policy delivery – the concept of professional discretion being particularly relevant in relation to delivery of health care services (Harrison and Pollitt, 1994; Hill, 1997). Capturing this individual context of health care delivery as well the shift towards patient autonomy are key issues that are addressed in the conceptual discussion of decentralisation found in this report. In relation to exploring the effectiveness of decentralist approaches we examine concepts of contingency, local responsiveness and the tensions between local responsiveness, innovation and opportunity (decentralist tendencies) as compared with central performance monitoring and control (centralist tendencies; Burns, 2000). In addition, the continued fragmentation of health services in England raises issues of vertical decentralisation and devolution between local agencies (such as PCTs, care trusts and NHS hospital and specialist trusts) and nationally (such as the Department of Health, Modernisation Agency and regulatory organisations such as the Commission for Health Care Audit and Inspection (CHAI), professional bodies, etc.). Thus for the NHS in England, the concept of decentralisation is also associated with centralisation in relation to the need to identify national standards and devolution in terms of devolved power.

This undercurrent of centralisation is also evident in theoretical and conceptual approaches to decentralisation. This tension is based on different models that emphasise democracy, uniformity and equity (Newman, 2001). The tension between national standards, central performance monitoring, central accountability and regulatory approaches (CHAI, National Institute for Health and Clinical Excellence (NICE)) and encouraging local responsiveness, opportunity and innovation is an inherent element of public service delivery in the UK (Burns, 2000) and in the last 2 years the Government has been introducing policies explicitly aimed at decentralising and even devolving power, such as earned autonomy, devolution of budgets to PCTs and proposals to establish foundation hospitals while establishing central regulatory frameworks (CHAI, NICE) and national standards through the national service frameworks, national performance targets and the Modernisation Agency. Such policies need, however, to be set within the context of wider and longer-term developments in decentralisation and devolution in health care – such as the promotion of primary care and changes in local government and other public services from the 1970s onwards (Burns *et al.*, 1994; Paton, 1996; Pollitt *et al.*, 1998; Powell, 1998;

Boyne *et al.*, 2003; Peckham and Exworthy, 2003). These developments have included administrative decentralisation, the internal market and, more recently, developing new devolved organisational structures with new governance arrangements (PCTs and foundation hospitals). Furthermore, current proposals for devolution to English regions provides a further context to this debate (Hunter *et al.*, 2005).

1.2 Aims and objectives

The aim of this review is to examine the nature and application of decentralisation as an organisational model for health care in England. The study briefly reviews the relevant theoretical literature from a range of disciplines relating to different public and private contexts of decentralisation and centralisation. It examines empirical evidence about centralisation and decentralisation in public and private organisations and explores the relationship between decentralisation and different incentive structures, which in turn affect organisational performance.

The research brief given by National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (SDO) requested a study to inform policy and set the agenda for further empirical research in this area. The research brief required the review to address the following questions.

1 What is meant by each of the terms centralisation, decentralisation and devolution and are there any ways to measure the extent to which each is occurring?

2 In hierarchies what degree of decentralisation and devolution (or centralisation) in relationships between public service organisations is most effective in terms of the quality of those relationships, both vertically up and down the hierarchy and horizontally between organisations in the same tier in the hierarchy?

3 In hierarchies what degree of decentralisation and devolution (or centralisation) in relationships between public service organisations is most effective in terms of enhancing the performance of those organisations?

4 What are the implications of the foregoing issues for the organisation of health services in England?

The brief identified the need for the literature review to include the relevant theoretical literature in a range of disciplines including organisational economics, political science, organizational studies, sociolegal studies, organisational sociology and organisational psychology. We were required to examine the theoretical literature relating to privately owned and run firms, but also that the extent to which it is relevant to public services should be discussed. Empirical evidence about centralisation and decentralisation in public and private organisations should also be summarised and discussed. We were required to examine whether there are relevant lessons from sectors other than health, and include evidence from countries outside the UK, where relevant. Differences between different sectors (i.e. the publicly owned sector, the for-profit sector and the voluntary sector) should be discussed.

Although the main theme of this review is centralisation, devolution and decentralisation, the SDO brief required us to take account of the different literatures in this area as it was likely that a more complex and dynamic relationship existed than perhaps the concepts of centralisation, decentralisation and devolution appear to indicate. These concern the changing nature of the dynamics between parts of a system over time resulting from the combination of multiple centres of direction and regulation (including financial, political and technical) and multiple strategies emerging among the regulated organisations (including collaboration, compliance and competition).

In discussing these themes and undertaking an initial exploration of the literature the research team clarified the research questions in the research brief, identifying the purpose of the research project as being to examine the evidence from the UK (and elsewhere) to do the following.

1 Define the terms centralisation, decentralisation and devolution and how these can be measured.

2 Identify the relationship between the degree of decentralisation and devolution (or centralisation) in relationships between public service organisations and the effectiveness and quality of those relationships, both vertically up and down the hierarchy and horizontally between organisations in the same tier in the hierarchy.

3 Identify what degree of decentralisation and devolution (or centralisation) in relationships between public service organisations is most effective in terms of enhancing the performance of those organisations.

4 Identify key lessons for the organisation of health services in England.

1.3 The literature review

This study reviews the relevant theoretical literature and examines empirical evidence about centralisation and decentralisation in public and private organisations. In particular, it explores the relationship between decentralisation and different incentive structures, which in turn affect organisational performance. Three broad areas of performance were examined relating to producer quality (staff satisfaction, inter-organisational relationships, technical and allocative efficiency), user quality (outcomes for patients, equity) and accountability (local and central performance targets, national quality standards, national protocols and guidelines). In order to draw lessons for the NHS in England we examined UK literature and English-language literature from countries where there are similar centralist and decentralist tensions. This is a multi-disciplinary review and a key goal has been to develop a framework drawing on different disciplines and theories, identifying the implications for different concepts and measures.

The method adopted for this literature review followed methods used in previously successful studies (Robinson and Steiner, 1998; Exworthy *et al.*, 2001; Arksey and O'Malley, 2005). The main objectives of the review were:

- to map the available literature

- to provide a critical overview of existing work in relation to appropriate themes
- to identify areas where more research may be of use
- to consult with users to complement and enhance overall findings.

The review appraised empirical studies but it did not measure the effectiveness of particular interventions. It does, however, identify the effect of particular decentralised/devolved organisational, structural, procedural and accountability arrangements, and their relationship to performance, identifying lessons for the NHS in England. This approach reflected the expected large number of studies that could have potentially been studied.

Unlike standard literature reviews, this study took into account recent and current policy contexts in the UK and elsewhere. The focus was primarily on health care systems and organisations but other spheres of the public sector and the private sector were also considered. Moreover, a significant grey literature was anticipated; this proved correct. Although each item in this literature was not examined in detail, it informed the study in terms of policy context and contemporary relevance. Thus the review modified the standard approach in order to accommodate the nature of the anticipated evidence and policy context. In summary, given the diversity and volume of literature available and following consultation with the SDO and our expert panel, attention was focused on evidence that contributed to the following.

- Understanding of the UK policy context, including empirical studies as well as literature from political science, organisational studies and social policy.
- Understanding of the organisational and performance impact of decentralised/devolved structures.
- Relevant methodological issues that may be considered in commissioning future research.

1.4 Review methods

1.4.1 Search strategy

Our initial strategy was to identify literature that examined the concept of decentralisation. This was mainly books and monographs. Each of the research team members read books to develop a clearer understanding of the conceptual and theoretical debates related to decentralisation. This initial review informed search strategy and this covered three key parameters.

1 Key words: decentralization, centralization, devolution, organizational autonomy, subsidiarity, federal, localism, centralism, regionalization and central–local relations. Alternative spellings were also included (e.g. decentralisation).

2 Time period: literature published since 1974 was sought on the assumption that more recent evidence would have greater applicability to the current context.

3 Coverage: for practical reasons, only English-language papers were identified (although the potential value of some evidence published in other languages was recognised).

1.4.2 Data search

The search strategy was applied to five sources of evidence (See Appendix 1 for a summary of database search results).

1 Electronic database searches including ASSIA, Business Source Premier, Medline, BIDS, HMIC, IBSS, Sociofile, King's Fund library and SIGLE on grey literature in Europe.

2 Electronic searches of current research (including the Department of Health National Research Register and ESRC) and manual searches (including reference lists and forthcoming reports).

3 Manual and electronic search of grey literature (e.g. policy statements, reports, unpublished research) and ephemeral literature (e.g. pamphlets and newsletters).

4 It was expected that health service/policy organisations would hold documents relating to decentralisation. We found further evidence via the King's Fund and policy think-tanks such the Institute for Public Policy Research (IPPR) and DEMOS.

5 A cumulative search of references within retired articles identified further sources of evidence.

1.4.3 Data categorization and appraisal

An initial batch of 20 articles was analysed by all team members and summaries were compared. This ensured that consistency of terminology and approach was secured at the outset. Variance was discussed, and a common approach agreed. From an initial trawl of over 500 items of evidence, 205 were deemed relevant in terms of quality of the evidence and relevant to contemporary English health care organisations.

For each of the 205 items of evidence, a summary was produced (see Appendix 2) drawing on the analytical frameworks identified from theories of decentralisation and methodological appraisal. This summary differed from the research application to incorporate preliminary conceptual analysis.

Summary of evidence according to:

- Author(s)
- Year of publication
- Quality: peer reviewed; disciplinary field
- Methods: quantitative/qualitative; brief description
- Context: national system; sector (public/private; service field, e.g. health, education)
- Year of study
- Terms used: key words from search strategy (see *Search strategy*, above)

- Measurement: which variables of decentralisation were measured?
- Functions: which service-related functions were studied?
- Performance domain: which aspect of performance (from evaluative criteria) was studied?
- Impact on organizational performance: what conclusions about organizational performance were drawn?
- Other comments

1.5 Analysis

The summary of evidence provided the basis for in-depth analysis across each of the performance domains, required by the SDO Research Brief. Two other performance domains emerged from the literature and were included in the evidence summary and subsequent analysis. These included responsiveness and accountability. Analysis followed a template to ensure consistency within the project team and across each performance domain. This template comprised:

- assumptions underlying the performance domain: the presumed relationship between decentralisation and that performance domain
- caveats related to these assumptions
- evidence in support of the main assumptions
- evidence against the main assumptions
- balance of evidence
- relevance to the NHS.

1.6 Involvement of experts

From the outset of the project, experts from research, management and policy fields were involved with this review in three main ways.

1 Expert panel: a panel of 12 experts was convened to provide insights and perspectives upon the project's methods, findings and conclusions as well as contemporary policy context. The panel comprised academic researchers, NHS representatives (from the Department of Health, a strategic health authority, a PCT and an NHS trust provider), a researcher from a think-tank and a national journalist. The panel met three times (April, September and December 2004) in Oxford. Three experts joined the panel as so-called virtual members in the sense that they did not attend meetings but papers were sent to them and their comments were digested by the project team.

Membership of the expert panel	
Pauline Allen	London School of Hygiene and Tropical Medicine/SDO
Paul Anand	Open University/SDO governance project team
Anna Dixon	Department of Health and London School of Economics
Nigel Edwards	NHS Confederation
Nick Goodwin	London School of Hygiene and Tropical Medicine/SDO
Andrea Humphrey	Department of Health
Ed Macalister-Smith	Nuffield Orthopaedic Hospital, Oxford
Brian Mackness	Thames Valley Strategic Health Authority
Geoff Meads	Warwick University
Deborah Roche	IPPR
David Walker	*The Guardian*
Andrea Young	Oxford city PCT
Virtual members	
Ewan Ferlie	Royal Holloway–University of London
Richard Saltman	European Observatory, Madrid
Perri 6	University of Birmingham

2 Open University/SDO governance project: from the beginning of the project close contact was kept with the partner SDO project on governance being undertaken by Professor Celia Davies and colleagues at the Open University. One of the governance project team members was a member of our expert panel and Dr Mark Exworthy attended the Open University project meeting of academic peers in September 2004.

3 Research networks: contacts with leading policy-makers, researchers and commentators in the field were conducted throughout the project. This network provided additional sources for policy-relevant theoretical, unpublished and ongoing literature. These networks included the opportunity to discuss interim findings (especially of conceptual frameworks) with academic groups at seminars and conferences.

1.7 The structure of the report

The remainder of this report is divided into six sections. In Section 2 we examine the theoretical and conceptual literature on decentralisation. The section also presents a framework for conceptualising decentralisation that we use in this report in our assessment of the evidence. Sections 3 and 4 examine the history and current policy context of decentralisation in the English NHS. Section 3 provides an overview of decentralist policies and organisational changes in the NHS and how these have been previously

assessed. In Section 4 we explore current policies in the NHS and examine their relationship to decentralisation.

Section 5 uses the key performance criteria to discuss the literature on decentralisation and organisational performance. Key assumptions about each criterion are presented and then the extent to which these are supported by theory and evidence is examined. In Section 6 this review is then applied to the NHS, identifying the strength of evidence to support each of the individual performance criteria.

In the final section we identify the implications for the English NHS that arise from this assessment in terms of policy and practice. We also identify where there are gaps in the evidence and highlight areas for further research.

Section 2 Understanding decentralisation

2.1 Introduction

There is an extensive literature on decentralisation, centralisation and devolution that covers a wide range of disciplines including politics, public administration, health services research, economics, management, sociology and organisational studies. The diversity of the literature and the use of a wide range of definitions creates problems for any analysis of decentralisation. In this section we examine some of the main definitions of decentralisation and briefly review the main frameworks that have been used in studies of decentralisation in the UK and abroad. Drawing on these frameworks we then present a new framework that is more appropriate for an analysis of decentralisation in the UK health care system.

Central to how decentralisation is understood in this report is that fact that it is inappropriate to solely view decentralisation in terms of an organisational or geographical concept. Health and health care have an individual as well as an organisational context. No examination of the delivery of health care can be undertaken without reference to the roles of health care professionals and patients and the fact that much recent policy has focused on professional autonomy and regulation and patient involvement, self determination and choice. Thus, any discussion of decentralisation in the NHS must capture these elements as well as the more traditional spatial and organisational context. Therefore, in this section we present a new decentralisation framework that addresses this aspect. In addition, this review links decentralisation to performance and the new framework takes this aspect into account.

2.2 Overview of academic disciplinary approaches to decentralisation

There are two main problems associated with the breadth of the literature on decentralisation. First, many associated phenomena are examined using cognate terms rather than the term decentralisation. Second, the literature on decentralisation is found in a large range of disciplines and theories, often with few links between them.

The main cognate terms appear to be autonomy (Brooke, 1984; Gurr and King, 1987; Boyne, 1993; Pratchett, 2004), discretion (Page and Goldsmith, 1987; Page, 1991; Bossert, 1998) and localism (Page, 1991; Stoker, 2004), and tend to be found in the disciplines of political science and management. Page and Goldsmith (1987: 3) state that it is conventional for cross-national descriptions to use terms such as 'centralization', 'decentralization', 'central control' and 'local autonomy', but these terms do not on their own provide adequate concepts on which to base a comparative analysis. Terms do not clarify what particular aspect of the process of government is decentralized. Consequently, it is easy for studies to talk past each other. Some studies,

such as Page (1991), on localism tend to use other terms, like autonomy and discretion. However, it is unclear whether decentralisation equals autonomy (Brooke, 1984: 9) or whether the terms are simply related. Moreover, defining one problematic term by using another does not clarify analysis very far.

According to Brooke (1984: 4), accountants, anthropologists, economists, historians, lawyers, philosophers, psychologists, sociologists and theologians as well as administrative, management and political scientists have been called as expert witnesses. However, most reviews tend to focus on single disciplines or theoretical areas. One of the few accounts to stress the multi-disciplinary nature of the literature is that by Bossert (1998), who reviews the four major analytical frameworks that have been used by authors to address problems of decentralisation in the health sector: public administration; local fiscal choice; social capital approach and principal/agent approach. Although this is a much cited typology, it appears to be not fully comprehensive or coherent. His public administration category is linked to the four-fold typology of Rondinelli (1981) of deconcentration, delegation, devolution and privatisation (see *Frameworks of decentralisation*, Section 2.5). However, public administration approaches are much wider than that of one writer, whose main contribution is in the field of development studies. Local fiscal choice is largely the contribution of economists writing about fiscal federalism, and is covered briefly below. Social capital is linked to the work of Putnam (1993), which suggests that localities with long and deep histories of strongly established civic organization will have better performing decentralized governments than localities which lack these networks of associations. This builds on the work of de Tocqueville and is linked to work on local democracy and democratic theory (below). Finally, Bossert's favoured approach is principal/agent theory, which he develops into his concept of a decision space (Section 2.6). This draws largely on the work of economists who examine the relations between the principal, who has specified objectives (e.g. central government), and the agent, who achieves these objectives (e.g. local authorities or hospitals). Its essence focuses on the different ways (e.g. using hierarchical, market or network strategies), under conditions of information asymmetry, that objectives can be achieved. As Bossert's framework is partial, we set out a very brief review of the main disciplinary approaches to decentralisation.

Political science saw some of the earliest debates on decentralisation. In the nineteenth century, Chadwick and Toulmin Smith represented the polar extremes of the centralisation/decentralisation debate in local government. A long line of political philosophers, including Mill, Hobbes, De Toqueville, Burke, Cole and the Webbs have contributed to the debate. Defenders of localism such as W.A. Robson, D.N. Chester, George Jones and John Stewart have fought a rearguard action against the tide of centralism. This debate has been covered in fields such as local democracy and democratic theory (Hill, 1974; Burns *et al.*, 1994) central control and the central domination thesis (Carmichael and Midwinter, 2003), central–local and intergovernmental relations (Griffith, 1966; Rhodes, 1981, 1988; Bulpitt, 1983). Very broadly, many political scientists believe that there has been too much centralisation in

the UK, and that a return to localism would be beneficial. This has prompted an emphasis on the so-called new localism (Stoker, 2004; but see Walker, 2002). Other contributions have been in the field of federalism, which examines the division of functions between national and local states (Anton, 1997; Palley, 1997), the politics of government grants (King, 1984; Newton and Karran, 1985; McConnell, 1999; Glennerster *et al.*, 2000) and political devolution (Ross and Tomaney, 2001; Bradbury, 2003; Jervis and Plowden, 2003). Finally, the work of Smith (1980, 1985) is a notable contribution to the study of decentralisation, as his 1980 article is one of the few that sets out possible measures of decentralisation, and his 1985 book was a relatively early and influential full-length treatment of the subject.

The contribution of economics falls within two broad areas. Public choice theory (Niskanen, 1971) argues that efficiency is associated with competition, information on organizational performance and small organization size (Boyne *et al.*, 2003). Fiscal federalism (Buchanan, 1950; Oates, 1972; Bennett, 1980; Levaggi and Smith, 2004) is based on determining the optimum size for units carrying out the basic functions of public finance (Musgrave, 1959). This area is one of the few that has produced a clear – if heavily criticised – measurement of decentralisation: social expenditure at the local level as a percentage of national social expenditure.

Historians have focused on local government, including the Chadwick/Toulmin Smith debate (above) and a stream of government reports on differentiating local from central functions in Victorian and Edwardian Britain (Smellie, 1968; Keith-Lucas and Richards, 1978; Foster *et al.*, 1980; Ashford, 1982, 1986) running to the report of the Layfield Committee (1976) and the current Balance of Funding Review (Stoker, 2004). There have also been contributions on central–local relations (Bellamy, 1988), grants (Foster *et al.*, 1980; Baugh, 1992) and urban history (Daunton, 2000). Unlike political science, few social administration texts focused on central–local relations (but see Simey, 1937). Contemporary historians (Szreter, 2002; White, 2004) have reassessed historical debates and attempted to determine whether history has lessons for current reforms. Journalists have entered the fray, with the battle of the broadsheets favouring (Jenkins, 1996; Marr, 1996; Freedland, 1998) or opposing (Walker, 2002) localism, while there has also been the tussle of the think-tanks (Mulgan and 6, 1996; Bankauskaite *et al.*, 2004).

Development studies has seen a great deal of work on decentralisation (Cheema and Rondinelli, 1983; Conyers, 1984; Collins and Green, 1993, 1994; Mills, 1994; Manor, 1999; Bossert and Beauvais, 2002). The dominant conceptual framework was developed by Rondinelli (1981), with further frameworks by Bossert (1998) and Gershberg (1998). However, the very different context of developing countries means that the transferability of findings may be problematic (see *Understanding and interpreting the evidence*, Section 6).

Contributions from management include Bourn and Ezzamel (1987), Brooke (1984), Bromwich and Lapsley (1997), Common *et al.* (1992), Hales (1999) and Pollitt *et al.* (1998). There is a large number of sub-areas within

management research, such as organization theory, quantitative approaches, political economy approaches and accounting approaches (Brooke, 1984: 149–50). One of the few attempts to operationalise decentralisation involves the locus of decision-making: who is the last person whose assent must be obtained before legitimate action is taken? (Brooke, 1984).

Finally, there are fewer – but equally diverse – contributions from geography (Paddison, 1983; Pinch, 1991; Atkinson, 1995). Although written by an author from a university geography department and published in a geography journal, Atkinson's (1995) review on tracking the decentralisation debate focuses largely on development studies, cites few geographers and does not appear to offer any distinctive geographical point of view. Pinch (1991) compares service distribution in two Australian cities, but his claim that they represent different levels of decentralisation is not supported by any evidence. Paddison (1983), within a general text on political geography, provides a useful review of some of the decentralisation literature, including early definitions and measures.

All this means that the vast literature on decentralisation and associated concepts, with differences in concepts, contexts, measures and findings, makes any attempt at summary and synthesis extremely difficult. In particular, decentralisation has been used as a comparative concept rather than as an absolute measurement. Decentralisation has been analysed primarily within historical and political contexts. Studies have sought to examine trends over time or within or between political structures and systems. The literature on decentralisation has tended to reflect these two contexts and frameworks developed to examine decentralisation reflect these contexts. These points are discussed later in this section. As this review demonstrates, application of decentralisation to the NHS also reflects these contexts. The political context of the NHS is, as identified in Section 1, one where political power is held centrally by Parliament with no sharing of political authority by the NHS. This situation has remained unchanged since the inception of the NHS in 1948, although outside of England there has been devolution to political assemblies in Scotland, Wales and Northern Ireland. However, historically there has been a long-term interest in decentralisation and this context is discussed in Sections 3 and 4.

2.3 What is the purpose of decentralisation?

Before examining what is meant by decentralisation it is worth exploring what decentralisation – or, for that matter, centralisation – is meant to achieve. This is a question about policy goals or ends. The research brief outlines two fundamental questions that relate to why services may be centralised or decentralised.

1 In hierarchies what degree of decentralisation and devolution (or centralisation) in relationships between public service organisations is most effective in terms of the quality of those relationships, both vertically up and down the hierarchy and horizontally between organisations in the same tier in the hierarchy?

2 In hierarchies what degree of decentralisation and devolution (or centralisation) in relationships between public service organisations is most effective in terms of enhancing the performance of those organisations?

At the heart of these questions are assumptions about the purpose of decentralisation. Specifically are there degrees of decentralisation that can improve relationships between organisations and improve organisational performance? As discussed above the literature on decentralisation is very broad but there is a predominant view that decentralisation is in itself a good thing, both in terms of the process and as an outcome, as demonstrated in Tables 1 and 2. Table 1 presents the measures of organisational performance defined by the SDO whereas Table 2 identifies two further performance criteria identified from the literature. The tables then outline the key assumptions that have been made about the outcomes of decentralisation that have been identified in the theoretical, conceptual and empirical literature. However, as Pollitt *et al.* (1998) have observed:

> *In short, [decentralisation is] a miracle cure for a host of bureaucratic and political ills. Academics with a taste for post-modernism would no doubt refer to it as an attempt at a meta-narrative – a conceptual and linguistic project designed simultaneously to supersede (and therefore solve) a range of perceived ills within the previous discourse of public administration.*
>
> (Pollitt *et al.*, 1998: 1)

The view that decentralisation is a good thing is not, though, universally shared and a number of commentators have identified that increasing decentralisation may in fact lead to adverse consequences. In particular, Walker (2002) has argued that increased decentralisation leads to inefficiencies of scale and increasing inequities, consequences that are identified in the broader theoretical literature (De Vries, 2000; Levaggi and Smith, 2004). Walker's arguments go further though, as he argues that centralisation can produce many of the results claimed for decentralisation, such as innovation. The point being made here is that it is not the level (more or less centralised/decentralised) of organisation that is important. This raises a key question therefore about whether decentralisation can produce the benefits identified in Tables 1 and 2 and what arrangement of decentralisation – that is, what is decentralised to where – provide the maximum benefits. In order to do this it is necessary to clearly define decentralisation and the parameters that relate to it.

Table 1 Key assumptions about the impact of decentralisation on SDO-defined organisational performance criteria

SDO criterion	Assumptions about the benefits or otherwise of decentralisation	Theoretical background	Comments
Outcomes (for patients/health outcomes)	• Assuming decentralisation is linked to (professional) autonomy: advocates of professional autonomy claim that their discretion in responding to individual patient needs (diagnosis, treatment, prescription/referral) makes their (clinical) decision-making more effective in terms of patient outcomes. (Note: this conflicts with evidence-based medicine, assuming that the evidence is clear-cut in directing clinical decision-making.) (Friedson, 1994) • A decentralised and participative form of organisation is most conducive to effectiveness from an organisational perspective (Likert, 1967; Agyris, 1972).	Professional autonomy Fiscal federalism	Assumes that autonomous professionals make the best decisions for patients Assumes that improved effectiveness produces better outcomes Relates to effectiveness of services: see also allocative and technical efficiency
Process measures	• Reduces the decision load by sharing it with more people (De Vries, 2000) • Allows more organisational flexibility and enables quicker responses (De Vries, 2000) • Allows easier co-ordination between individuals; but overall co-ordination hampered (Carter, 1999)	Intergovernmental relations Federalism Fiscal federalism Principal-agent theory	Extends hierarchical lines of control – more stretched, more intrusive?
Humanity	• Being closer to the public makes agencies more conscious of their responsibility to and relationship with local communities (Hambleton *et al.*, 1996). • Organisations and the people within them are more visible to local service users and communities, leading to a desire to be seen to do the right thing, be more open and be accountable locally (Burns *et al.*, 1994; Hambleton *et al.*, 1996).	New public management Democratic theory	Assumes democratic organisations are more effective at meeting local needs and therefore outcomes are more effective Relates to staff morale/satisfaction and responsiveness
Staff morale/ satisfaction	• Develops staff: job satisfaction, loyalty (Burns *et al.*, 1994) • Freedom to manage; managerial autonomy (DHSS, 1983) • Generates higher morale (Osborne and Gaebler, 1992; see De Vries, 2000)	Human resource-management theories	

	• Recruitment of skilled officials more difficult at local level (De Vries, 2000) • Increases satisfaction, security and self-control (Pennings, 1976) • Decentralised and participative form of organisation is most conducive to effectiveness from an employee perspective (Likert, 1967; Agyris, 1972)		
Equity: horizontal but not vertical	• Increases equity by allowing services to meet better the needs of particular groups (argument against), possibly through targeted funding (Bossert, 1998).	Intergovernmental relations (Rhodes, 1997)	Note the common assumption that decentralisation widens inequality as the potential for local variations is widened
Efficiency (allocative)	• Improvement in the quality of public services: more sensitive service delivery - achieves distribution aims: target resources to areas and groups (Burns *et al.*, 1994) • Improves (allocative) efficiency as patient responsiveness and accountability improves (e.g. improved governance and public service delivery by increasing the allocative efficiency through better matching of public services to local preferences) (Saltman *et al.*, 2003) • Is more likely to reflect local preferences (De Vries, 2000)	Public choice theory Principal-agent theory	Relates to effectiveness and responsiveness
Efficiency (technical/ productive)	• Improves as managers devote greater attention and are more responsive; fewer layers of bureaucracy*; better knowledge of costs (e.g. improves governance and public service delivery by increasing technical efficiency through fewer levels of bureaucracy, and better knowledge of local cost) (Saltman *et al.*, 2003) • Experimentation and innovation (Oates, 1972) • Smaller organisations perform better (Bojke *et al.*, 2001) • Increases technical efficiency through learning from diversity (De Vries, 2000) • Centralisation generates more waste: local people, local provision and local services are cheaper (De Vries, 2000) • Controls costs (Burns *et al.*, 1994)	Public choice theory Fiscal federalism	Relates to effectiveness *Assumes some restructuring (e.g. delayering), especially at the centre and regional tiers

	• Allows more organisational flexibility and enables quicker responses (De Vries, 2000)		
Adherence to performance targets and evidence-based protocols	• Decentralisation strengthens the hierarchical chain of command between the centre and locality (the transmission belt) and thereby ensure that central targets are adhered through contractual relations (Hughes and Griffiths, 1999).	Intergovernmental relations Principal-agent theory	Literature on getting evidence into practice shows that independence of practitioners is a constraint (e.g. Harrison *et al.*, 1992).

Table 2 Key assumptions about the impact of decentralisation on additional organisational performance criteria

Additional criterion	Assumptions about the benefits or otherwise of decentralisation	Theory	Comments
Responsiveness	• Is seen as a way of increasing responsiveness (Meads and Wild, 2003) • Enhances civic participation; neutralises entrenched local elites and increases political stability (De Vries, 2000) • Strengthening of local democracy: visibility, community development and encourages political awareness (Burns *et al.*, 1994) • Is more likely to reflect local preferences (De Vries, 2000)	Local democracy and democratic theory	Also refers to responsibility and accountability to the patient/public
Accountability	• Enhances civic participation; neutralises entrenched local elites and increases political stability (De Vries, 2000) • Increases democracy and accountability to the local population (Burns *et al.*, 1994; Bossert, 1998; Meads and Wild, 2003) • Makes agencies more conscious of their responsibility to and relationship with local communities (Hambleton *et al.*, 1996)	Democratic theory Participative democracy New public management	

2.4 What is decentralisation?

In a recent examination of decentralisation in health services Saltman *et al.* (2003) found that:

> *According to widely accepted definitions, decentralization is the transfer of authority and power in planning, management and decision making from higher to lower levels of organizational control.*
>
> (Saltman *et al.*, 2003: 2)

This immediately places decentralisation within an organisational and geographical context. This is a fairly consistent approach to defining decentralisation. For example, Smith (1985) argues that 'Decentralization entails the subdivision of a state's territory into smaller areas and the creation of political and administrative institutions in those areas' (p.1). Burns *et al.* (1994), in their discussion of local government, distinguish two types of decentralisation: 'On the one hand, it is used to refer to the physical dispersal of operations to local offices. In a second sense, it is used to refer to the delegation or devolution of a greater degree of decision making authority to lower levels of administration or government. In common usage, these meanings are sometimes combined' (p.6). Similarly, Levaggi and Smith (2004) suggest that 'in broad terms it entails the transfer of powers from a central authority (typically the national government) to more local institutions (p.3). Pollitt *et al.* (1998) identify a further dimension of decentralisation with the observation that 'Common to most of these [academic] treatments is an underlying sense that decentralisation involves the spreading out of formal authority from a smaller to a larger number of actors' (p.6). This definition draws together both vertical and horizontal concepts of decentralisation. Authority can be decentralised by authority being transferred to lower levels of an organisation (vertical decentralisation – delegating or devolving) and by the spreading out of authority from a central point (horizontal decentralisation – deconcentrating). These terms are those commonly used in definitions and descriptions of decentralisation and are discussed below.

Boyne (1992) has further clarified the vertical and horizontal dimensions of decentralisation, identifying the processes of concentration and fragmentation. Activities may be spread across (fragmented) the vertical and horizontal axes or concentrated at particular levels or in particular organisations. In health, for example, while there are a number of levels from the Department of Health to practitioners there is a concentration of functions in PCTs. In the local horizontal context we might also define PCTs as concentrating a number of local health functions.

From this brief discussion it is clear that there are a number of concepts that are associated with decentralisation, including power, authority, delegation and devolution. This creates problems when defining decentralisation, although Deeming (2004) has argued that 'decentralization' is a relatively straightforward concept to define, in that:

> *A public service is more or less decentralized to the extent that significant decision-making discretion is available at lower hierarchical levels, with the*

> *managers and staff who are closer to the people receiving services. In such circumstances substantial responsibilities for the control of budgets are at a level closer to the service user, allowing services to be responsive to individual need (Harrison and Pollitt, 1994). For example, doctors and nurses in primary care controlling most of the NHS budget.*
>
> (Deeming, 2004: 60).

However, this definition incorporates a further concept – that of discretion. This points to the need to identify not only what is being decentralized to whom but what power or autonomy exists in terms of the freedom to make decisions. This will always be a balance in any large organization between individual discretion and the application of rules of behaviour (Hill, 1997). It also clear that any discussion of decentralisation in both a vertical and horizontal sense lead to questions about what the converse movement is; that is, centralisation. If decentralisation refers to a vertical shifting of power downwards or a deconcentration of power then centralisation must be the opposite of this. Decentralisation and centralisation are alternative modes of control (Harrison and Pollitt, 1994). Therefore, a public service is more or less centralized to the extent that significant decisions are taken upstream at the centre of government within a tighter system of control and accountability. It would mean politicians in government (through the channels of the Department of Health and NHS Executive) controlling important decisions about how the NHS budget is spent on local health care services (Deeming, 2004: 60). Before examining these concepts in more detail it is important to examine the different ways that writers have classified decentralisation.

2.5 Frameworks of decentralisation

The concepts that emerge in this discussion of how decentralisation is defined are found in frameworks developed to describe decentralisation. However, much of the literature focuses on either local government or at least the organisation of public administration within a specific country. This has important implications for the conceptual frameworks that are drawn upon and the extent to which frameworks are relevant to health care services and the UK. Discussion of decentralisation has tended to be within a political context with assumptions about democratic frameworks and fundraising powers. Thus the transfer of political power from one level to another forms part of the context and conceptual framework for decentralisation. Devolution is the moving of democratic, governmental authority from higher to lower levels of the state, such as the shift of responsibility from the UK Parliament to the Scottish Parliament and Welsh Assembly, which both have responsibility for health care in their respective countries. Clearly, within England there is no similar devolution and while it may be useful to examine the effect of such devolution on health care services it is not relevant in the current context of the English NHS. Whereas no political transfer of power occurs in England there is administrative decentralisation in the sense that local NHS organisations have responsibilities and exercise authority over many aspects of health care services. These points are reflected in the frameworks of decentralisation discussed in this section of the report. However, of particular importance is the fact that in filtering the evidence on

decentralisation later in this report this distinction becomes important in terms of selecting relevant evidence (see Sections 5 and 6). However, it is worth briefly examining some of the main frameworks that purport to define decentralisation.

Many commentators agree that there are problems of defining decentralization. As Gershberg (1998: 405) put it, the concept of decentralisation is a slippery one: it is a term – like empowerment or sustainability – empty enough on its own that one can fill it with almost anything. Hales (1999: 832) claims that a review of the extant literature does little to dispel Mintzberg's (1979: 181) observation that decentralisation 'remains probably the most confused topic in organization theory'. Page and Goldsmith (1987: 3) claim that it is conventional for cross-national descriptions to use terms such as centralisation, decentralisation, central control and local autonomy, but these terms do not on their own provide adequate concepts on which to base a comparative analysis. Terms do not clarify what particular aspect of the process of government is decentralised. Consequently, it is easy for studies to talk past each other. In order to make valid comparisons, it is necessary to have a framework for comparison that removes the ambiguity in existing terminology.

The most commonly used framework is that developed by Rondinelli (1983), who identified four categories:

1 de-concentration: a shift in authority to regional or district offices within the structure of government ministry
2 delegation: semi-autonomous agencies are granted new powers
3 devolution: a shift in authority to state, provincial or municipal governments
4 privatisation: ownership is granted to private entities.

This framework was developed from research in developing countries with a focus on the legal framework of decentralised organisations. Whereas this is the most widely quoted framework, there are some key problems. The first is that power and authority appear to be conflated. It is not entirely clear how delegation and devolution differ, for example, although in use devolution is generally referred to as a political decentralisation whereas delegation is seen as an administrative decentralisation. However, the categories are often used interchangeably in the literature. Despite Rondinelli's claim for a radical category the inclusion of privatisation is also a problem, as not all privatisations are decentralisation. In fact privatisation may occur centrally or in decentralised units and it may or may not involve a transfer of power or authority, depending on the nature of the market or contractual relationship that is established (Bossert, 1998). Rondinelli's framework has been most widely used as the basis for later analyses of decentralisation although a number of differing frameworks have been developed.

For example, Burns *et al.* (1994), in the *Politics of Decentralisation*, identify five dimensions of decentralisation. These are:

1 localisation: physical re-location to local offices away from a central point
2 flexibility: multi-disciplinary teams and multi-skilling

3 devolution: decision-making powers delegated

4 organisational: re-orientation of organisational values and culture

5 democratisation: widening opportunities for public involvement.

They argued that:

> *It is helpful, in discussions about local government, to distinguish two types of decentralisation. On the one hand, it is used to refer to the physical dispersal of operations to local offices. In a second sense, it is used to refer to the delegation or devolution of a greater degree of decision making authority to lower levels of administration or government. In common usage, these meanings are sometimes combined.*
>
> (Burns, *et al.*, 1994: 6)

This approach is very structured in terms of what the dimensions represent and are associated with a particular approach in local government to developing processes for achieving a different relationship between local people and their local government. In contrast, in a paper for the Local Government Management Board Hambleton *et al.* (1996) identified four broad categories:

1 geography-based: physical dispersal

2 power-based: decision-making authority

3 managerial: improving the quality of services

4 political: enhancing local democracy.

Here, however, there is a potential overlap between categories, for example between the power and political categories. Like Burns *et al.* (1994) the dimensions are also related specifically to local government in that it assumes that there are elected representatives. There is also some synergy with Burns *et al.* as both frameworks relate to geography, organisational change and a shift in power from a ventral or higher authority to a lower and or dispersed authority. These themes recur again in work by Pollitt *et al*. (1998) on decentralising public services management. They identify three categories but with binary options:

1 politics: authority decentralised to elected representatives; administration: authority decentralised to managers or appointed bodies

2 competitive: competitive tendering; non-competitive: agency given greater authority to manage its own budget

3 internal: decentralisation within an organisation; devolution: decentralisation to a separate, legally established organisation.

These frameworks still tend to focus on organisational and geographical decentralisation. They are concerned with describing the institutional framework of government or administrative systems.

In contrast, in his paper *Decentralisation: managerial ambiguity by design* Vancil (1979) was more concerned with what was being decentralised. His view was that real decentralisation is marked by the degree of autonomy in organisations – the extent to which organisations have a high degree of authority over particular functions and activities with limited responsibility (or accountability) to others. In respect to health we can also see how this relates

to individuals as well (clinicians and potentially patients). Clearly most writers make some reference to power but it is not explicit within the frameworks.

In many of the articles the application of decentralisation is mainly focused at a macro level, using the three elements of fiscal, administrative and political (authority) decentralisation. These are broad categories and clearly contain a wide range of sub-categorisation that is rarely referred to in the literature. How useful then is decentralisation as a concept? There is:

> *…the danger of being deceived by the disarming familiarity of a word which our experience suggested usually masked a multiplicity of prescriptions addressed to different symptoms. There is a sense in which decentralisation is almost an empty term, a kind of camouflage behind which a diverse range of (often incompatible) political and organisational strategies find cover.*
>
> (Hoggett, in Hambleton and Hoggett, 1987: 215)

In summary then, there is limited applicability of any single framework that can be applied in all circumstances. With respect to health and health care it is also important that any framework can capture not just organisational contexts but also the place of the individual within the health care system as clinician, health care practitioner or patient. Another factor in relation to health care is to capture the role of central governments as funder, regulator and steward (Saltman and Ferroussier-Davis, 2000) of health, increasing international contexts of health and the important role of central professional and regulatory bodies. This does raise the question as to whether it is feasible to look for a meta-framework. The where (from where and to where?) and what (what is being decentralised?) of decentralisation are both problematic. Vancil's (1979) 'autonomy' framework has the potential to provide most applicability because it defines the relationship between different organisations and considers the extent to which organisations need power (authority) over an activity. However, there is still a question of applying this in practice. What is meant by responsibility and for what? Does responsibility simply equate to accountability? In a health care system there are a number of cross-cutting accountabilities to central government, professional bodies and the patient. Also we need to consider what an organisation or individual has autonomy over. Is it over a major area of work or a minor area? What other constraints are there on autonomy? For example, a PCT has 75% of the NHS budget but its autonomy over the allocation of that resource is limited by a range of factors including historical spending patterns, the shape of the local health economy, performance targets and local need. In this sense we would want to identify the extent of autonomy, and what area of activity or responsibility that autonomy relates to.

Another problem with the dominant focus of frameworks on organisational decentralisation is how to accommodate policies such as patient choice. Drawing on Rondinelli's framework, patient choice combines elements of devolution, delegation and privatisation and, potentially, autonomy for patients, which does not form part of this framework. Here current UK health policy demonstrates not only that the categories are problematic but also that you need to draw on other concepts from other frameworks including, for example, the concept of autonomy (in this case applied to individual patients)

and problems of transaction costs, information asymmetry and spill-over effects (Vancil, 1979; Levaggi and Smith, 2004)

Furthermore, we need to address the role of the centre and the relationships between the different levels of decentralisation–centralisation continuum. Central agencies, particularly in the UK, have roles as funders, regulators and stewards. Following Klein and Day (1997), if the government is 'decentralising', is it pertinent to ask how they are 'steering' local organisations/networks, and not simply what is being decentralised to which 'level'. Incentives and steering mechanisms might be different for each policy. Bossert (1998) has also argued that it is important to examine what space central agencies allow subordinate agencies or those with delegated or devolved powers. Drawing on principal/agent theory provides one approach to examining these relationships (Bossert, 1998, 2000). Bossert argues that it is not simply that the centre might steer a local agency but that it also defines the parameters – the space – within which the agency operates. Applying the concept of decentralisation to health is further complicated by the fact that in the literature decentralisation is associated with local resource raising. This reflects, perhaps, the focus on local government in the UK literature. The NHS has a centralised funding structure (with global budgets) and a decentralised provision structure – traditionally operating through regions, districts, hospitals and professional autonomy (Harrison and Pollitt, 1994; Mohan, 1995). This has implications given the UK's (centralised) ability to contain overall costs through the global budget. It also means that decentralised organisations cannot raise funds from other sources and they will always be reliant on funds from central government. In much of the literature on decentralisation the presumption is that decentralised agencies will have income-raising potential (explicitly so in the fiscal literature; Tiebout, 1956; Oates, 1972). Whereas local health agencies in the UK do not have such revenue-raising power they can affect overall revenue use as they have the ability to cut costs and/or make savings and thus for local decentralised units there is an incentive to consider revenue maximisation. This was an important element in the development of policy on foundation hospitals but is also an element in the development of primary-care-led commissioning in terms of improving allocative efficiency (Le Grand *et al.*, 1998). Finally, Atkinson (1995: 488) citing Conyers (1986) has argued that different parts of the system need to be identified by the functional activities transferred, the authority and power transferred for each, the level of area to which each is transferred, and the legal and administrative means by which each is transferred. The where (from where and to where?), the what (what is being decentralised?) of decentralisation, and the nature of the relationships between levels are all problematic. Also, while concepts of power, authority and autonomy are useful they lack a preciseness for measurement and they do not articulate the functions that are associated with, for example, health care.

Two issues arise from this discussion about the nature of decentralisation. The first is the extent to which decentralisation as a process impinges on performance and, given the breadth of decentralisation, what approach or functions, processes, etc. produce better or worse outcomes. These reflect

Bossert's (1996) view that there are two key questions that need to be asked about decentralisation (p.150).

1 Does decentralization improve equity, efficiency, quality of services, health outcomes and democratic processes?

2 And, if it does, which forms, mechanisms and processes of decentralization are most effective in achieving these outcome and output objectives?

Similarly Saltman *et al.* (2003) identify that:

> *It has not been customary to assess the outcome of decentralization in the light of health gain, equity, quality of care and consumer choice.*
>
> (p3)

However, their discussion is still contained primarily at an organisational level, reviewing changes in health care systems and drawing on what is primarily the fiscal, administrative and political dimensions framework with particular reference to Rondinelli's framework. In their review of decentralisation in European health care systems (Bankauskaite *et al.,* 2004) drew on Rondinelli's framework but identified that a number of frameworks may be pertinent, including a principal/agent approach, local fiscal choice and social capital (Bossert, 1998). However, they focused their analysis on three main questions:

- decentralisation to whom?
- what is decentralised?
- with what regulatory controls?

Their review considered system-wide effects only and focused, like many previous reviews, on the organisational and geographical aspects of decentralisation. However, a key finding of their review was that decentralisation can only be seen as '…a first step in a series of choices among complex policy options, and contingent on an equally complex set of external and internal contexts'. (Bankauskaite *et al.,* 2004: 25).

In relation to health care and public health the debate is further complicated as it moves beyond a simple organisational context to include issues relating to professionalism, patient care, etc. We therefore need to look for a way of conceptualising decentralisation/centralisation in health in such a way as to not get caught up in simple geography/levels discussions or tied to an organisational context. Any definition needs to be able to capture the dimensions set out above.

A number of points can be made about the frameworks, particularly applied to a health care context. First, there is a high degree of ambiguity in definitions used. Some terms are not defined in sufficient detail. Some frameworks appear to use different terms for similar phenomena (e.g. Burns *et al*.'s localisation and Hambleton's *et al*.'s geographical basis). Others use the same terms with different meanings. For Burns *et al.*, devolution is the delegation of decision-making powers; for Pollitt *et al.*, it is decentralisation to a separate, legally established organisation, while for Rondinelli, it represents a shift in authority to state, provincial or municipal governments. Saltman *et al.* (2003)

point out that, illustrating the complexity of decentralization concepts, some commentators do not consider the devolution and privatization elements of Rondinelli to be types of decentralization. There is little cross-referencing between the accounts, although Bossert (1998) does cite Rondinelli (1981). Second, most frameworks are highly contextual in terms of time and place; transferability and generalisability are thus limited. For example, many are based on developing countries. There is often an implicit or explicit assumption of a setting within an elected local government system. Whereas this is relevant for systems such as those in the Nordic countries, it may be more problematic for systems based on social insurance or a national health basis. Third, emphasis tends to be placed on decentralisation from national government to provincial/regional/local government, and tends to overlook the potential for decentralisation to individuals and/or centralisation beyond the nation state. In other words, only a limited part of the centralization–decentralization spectrum tends to be used. Finally, there is little indication of how to operationalise decentralisation (see below). Most frameworks are typologies or lists, and do not give much assistance in comparing decentralisation beyond nominal categories. With the exception of some dimensions in Bossert (1998), it is difficult to see how the frameworks might be operationalised. Indeed, Gershberg (1998) advocates using the word decentralisation as little as possible and instead suggests focusing on the important dimensions of the reform.

In short, the frameworks appear to have been little used. Rondinelli's is classified a public administration approach (Bossert, 1998; Saltman *et al.*, 2003), and is regarded as the most commonly used definition of decentralisation (Atkinson, 1995: 487) or the predominant framework (Bossert and Beauvais, 2002). However, as Bossert (1998: 1513) points out, 'A comparative analytical framework should provide a consistent means of defining and measuring decentralisation in different national systems.' Similarly, Gershberg (1998: 405) claims that to be operationally useful, unravelling of the definitions must go further than the four-part dissection by Rondinelli (1989). Atkinson (1995: 488) suggests that there has been a 'somewhat sterile debate in classifying and valuing governments or public sectors as one typology or another'. Bossert and Beauvais (2002) claim that the predominant framework pioneered by Rondinelli (1981) and applied to the health sector in developing countries by Mills (1994) contributes to the simplistic view of decentralization, and tells us little about the crucial aspect of decentralisation, namely the range of choice that is granted to the decision-maker at the decentralized level. As Hales (1999: 832) puts it, there is considerable ambiguity and disagreement about what is devolved and to whom. Similarly, Mills (1994) points to three crucial questions: decentralisation to what level, to whom and what tasks?

2.6 Measurement issues

Whereas these frameworks provide a way of describing decentralisation they do not constitute criteria by which decentralisation, or centralisation, can be measured. The criteria presented in most frameworks are broad concepts that require clarification in themselves, such as power, autonomy and geography.

These lack clarity and definition and it is not possible to apply measurements to them directly.

What is clear is that we need to measure both the extent of decentralisation and its achievements. The extent of decentralisation relates to spatial and organisational criteria that are effectively vertical in terms of levels of organisation. Within the NHS spatial and organisational aspects interrelate along the central–local dimension. However, it is important to recognise within a health context that this does not simply equate to organisations but also needs to include individuals as health care relates to patients and the public. Thus it is critical that individuals comprise one end of the spectrum of decentralisation. This point has been made by a number of commentators in relation to health (see Bossert, 1996; Levaggi and Smith, 2004) but does not feature in any decentralisation framework. For the NHS the parameter will be the individual, which can be seen as maximum decentralisation, where patients have total autonomy over their health care and how they meet their health care needs. This equates with a market model of health but also refers to individual patient–professional interactions and ideas of choice, patient autonomy, etc. In contrast to the individual would be a population perspective; whether this is a general practice and its patient list, a primary care organisation focusing on its local population, central government making decisions about the NHS or at the European or world health level. The World Health Organization (WHO) has developed a framework for assessing health systems that focuses on measuring health outcomes and equity, the fairness and equity of financing systems and the responsiveness of health systems to patients and populations in terms of the level of achievement (average over the whole population) and the distribution (equitable spread of this achievement) to all segments of the population (De Silva, 2001).

Bossert (1998) in particular has been critical of the fact that there is a lack of an analytical framework to study how decentralisation can achieve goals. In the organisational and management literature conceptual frameworks have tended to relate to structure, process and outcome (see Sheaff *et al.*, 2004a and Donabedian, 1980) or input, process and outcome (Hales, 1999). What these frameworks do is allow an analysis of the factors that relate to organisations. It is useful, therefore, to draw on these frameworks to help identify what is being decentralised. For example, it is possible to see finance as an input and commissioning as a process. The efficient use of resources and effective commissioning should produce better health outcomes. While such a conceptual framework is also not without problems it does provide a way of separating out different activities and policies. However, we also need to develop a framework that provides for an analysis of decentralisation and centralisation simultaneously; that is, to track movements in both directions. This is complex but a key benefit of such a framework will be to demonstrate that decentralisation is not simply a one-off process and that policy environments are highly complicated with a range of interactions between policies. There may in some cases be an overlap where policy, in particular, sees something as a means (or process) and an end (or outcome). For example, patient choice is a means towards reorganisation of health care and to achieve increased responsiveness but is also an end or a desired outcome.

The need to develop more clarity in the use of decentralisation as a variable for analysis is supported by the findings of a recent study on organisational performance that concludes:

> *There is no consistent or strong relationship between organisational size, ownership, leadership style, contractual arrangements for staff or economic environment (competition, performance management) and performance.*
>
> (Sheaff et al., 2004a: 6)

Similarly, Anell (2000), who examined decentralised structures in Sweden, argues that it is difficult to isolate single decentralisation measures and their effects on performance domains. He suggests that decentralisation is not a solution to organisational or service problems. This conclusion is also made in other studies exploring aspects of decentralisation and performance (Atkinson, 1995; Arrowsmith and Sisson, 2002).

Conversely, there is some literature that does attempt to analyse micro dimensions of decentralisation. With a focus on localisation the public welfare economic literature derived from the Tiebout principal (Tiebout, 1956; Oates, 1972, 1999) explores fiscal federalism. This attempts to quantify fiscal (and other) gains relating to decentralisation. The decentralisation theorem of Oates (1972) states that in the absence of economies of scale and inter-regional spillovers, welfare maximising local authorities may tailor the supply of local public services to local tastes and thereby achieve a solution that in welfare terms is superior to the solution provided by central government. Indeed 'The tailoring of outputs to local circumstances will, in general, produce higher levels of well-being than a centralized decision to provide some uniform level of output across all jurisdictions. Such gains do not depend upon any mobility across jurisdictional boundaries' (Oates, 1994: 130). As discussed in later sections there are some studies that support the view that decentralisation of certain services is beneficial as they are closer or more responsive to local populations or patients. However, many of these papers refer to decentralisation of community services (such as family planning, child health) in developing countries and most of these types of service are already locally based in the UK. Also, more recent Swedish research suggests that fragmentation of providers can lead to more culturally and group-specific services that might be construed as meeting people's needs more effectively than uniform services (Blomqvist, 2004).

Thus it seems right that some concept of the individual patient or, in a public context, members of local communities (citizens, patients, households) should be at one end of the scale and that collections of patients or the population should be at the other end. The goal will be to identify at what distance from the patient/population best or maximum use is made of any resource (finance, clinical skill, physical resource, staff, etc.). Similarly, frameworks for decentralisation need to capture the actions of individuals. This is one of the strengths of Vancil's (1979) framework and its reference to autonomy. For example, clinical autonomy and the individual freedom of a doctor to practice medicine in the best interests of the patient are key concepts in health care. Professional autonomy is clearly an important aspect of health care that directly relates to decentralisation, particularly with recent policy emphases

on moving decision-making closer to the patient and empowering front-line workers. There is an extensive literature on professional autonomy but this is rarely discussed in relation to decentralisation in health care services. However, changes in professional autonomy have direct relevance to our understanding of how far health care services are decentralised in terms of devolved decision-making and service delivery (Harrison and Ahmad, 2000). Many discussions of decentralisation do not operate at such an individualised level given their organisational focus. Bossert (1996) has argued that decentralisation needs to be seen primarily in relation to health care quality and that most studies of decentralisation fail to do this. Bossert has also developed an approach to analysing decentralisation based on the idea of decision space (Bossert, 1998; Bossert *et al*., 2003). Bossert sees the interaction of the vertical and horizontal dimensions of decentralisation as key to developing an assessment of the degree of decentralisation. This can perhaps be best understood drawing on Boyne's concepts of fragmentation and concentration and the relationships between agencies or actors on the vertical and horizontal dimensions. Thus while an agent or agency may have been given power to make decisions on the vertical dimension their ability to act depends on the network of relationships at the horizontal level, such as the need to work in partnership with other agencies or having to operate within existing relationships such as local contracts for services with provider agencies.

2.7 Summary of the shortcomings of frameworks and development of the Arrows Framework

From the above brief analysis of decentralisation it is clear that the decentralisation literature provides a clear conceptual framework for looking at where decentralisation occurs – where it is from and to – but lacks clarity about what is being decentralised. The frameworks tend to be muddled about important concepts such as power, authority, responsibility and what in fact decentralisation achieves. The exceptions are Vancil's approach to the notion of autonomy and perhaps Bossert's notion of decision space – the room for manoeuvre that helps develop the concept of autonomy to something that can be more usefully applied and tested. However, to examine decentralisation it is important to think about *what* is being decentralised. While concepts of power, authority and autonomy are useful they lack a preciseness for measurement. Neither do they articulate the functions that are associated with, for example, health care.

The first problem is how to define the outer limits of the *from where* and *to where* dimension that is intrinsic to all frameworks of decentralisation. One possible way of applying these concepts to health is to set them in population terms, such that:

- decentralisation means nearer/closer/related to the patient/individual/community (or unit of health outcome, usually individuals)
- centralisation means further away from the individual and is represented by the global population (citizens of a country, the world, etc.).

This represents the hierarchical scale (spatial and institutional) that forms the lateral or horizontal axis of the framework. In the English context this would see the UK, Europe (e.g. European Union), world (WHO, United Nations) spreading one way and then sub-levels such as regional structures (e.g. strategic health authorities), local organisations (such as PCTs, hospital trusts), sub-local/neighbourhood level (such as general practices or locality services), individual practitioners and then patients spreading the other. Movement towards the world would signify concern with larger populations and increasing centralisation and movement towards the patient would be decentralisation. However, key to an analysis of centralisation/decentralisation is the consideration of what is being moved between levels. How, therefore, is it possible to provide a contextual framework that can address the *what* of decentralisation? Our suggestion is that given that the performance literature uses the concepts of inputs, process and outcomes (such as performance targets), that it is useful to apply these as the second (vertical axis) dimension of the framework. The role of the framework is to first plot movements and directions along the horizontal dimension. The vertical dimension allows the refining of the components of decentralisation – the *what* meaning functions or policy. The framework, in itself, does not say whether such movements increase or decrease performance; however, it does provide a way of identifying the pattern of movement – centralising or decentralising – and sets a framework for examining interrelationships between such movements. Thus a simple two-dimensional framework would look like the following, which we are calling the Arrows Framework (Figure 1).

This input/process/outcome approach within the Arrows Framework overcomes questions about from where and to where, including the individual perspective, and is more specific in categorising the what question. In this review we are mainly discussing the issues of democratisation and participation in the NHS and the framework will be used to show why it is important to be much clearer in terms of the analysis of policy and action in relation to decentralisation. It also includes the individual–global focus, giving it an advantage over frameworks from other studies that tend to consider the organisational dimension only (central government to local agencies) without recognising supra-national bodies or an individual perspective.

What is still missing is some assessment of the extent of what any decentralisation or centralisation gives to an organisation or individual. This is where Vancil's and Bossert's work becomes important in terms of examining and defining the extent of autonomy. Using examples of inputs, processes and outputs it is possible to plot movements of decentralisation/centralisation. This structure provides a way of plotting both the direction of transfer and different functions that can be actions or policies. To use the Arrows Framework effectively the start and end points of each arrow are significant for each component (inputs, process and outcomes). Each table can be read vertically; for example, the arrows demonstrate the effect on each hierarchical level (e.g. region, PCT) as well movements (centralisation/decentralisation) within particular functions or polices. This allows comparison between levels and components and demonstrates that

centralisation and decentralisation can occur simultaneously. The framework also provides a way of comparing different polices and actions in any particular instance, demonstrating both direction of travel (centralisation/decentralisation) and the impact on a particular organisational level (see Sections 3 and 4). The framework can also be utilised to compare similar policies and actions over time.

2.8 Conclusion

This section has provided an overview of the main conceptual and definitional debates about decentralisation. From our analysis of this literature it was clear that previous discussions of decentralisation lack sufficient clarity to apply the frameworks to our analysis of decentralisation in health care services. Two principle problems arise from the literature. The first is the lack of conceptual clarity of the criteria that have been identified as characteristics of decentralisation. In practice many of the criteria are themselves contested concepts. Second, most studies of decentralisation focus on the interaction of the level of organisation and geographical coverage. Again, given the emphasis within health care on individuals and populations and that it is important to examine what is being decentralised rather than just where, existing discussions have only limited relevance to health care. In order to develop a more useful approach to our analysis of decentralisation we have therefore developed a new framework that focuses more on what and where, which will allow a clearer comparison of the evidence and its implications for policy and practice in the UK health care system.

Figure 1 Decentralisation – the Arrows Framework

Tier… / Activity	Global	Europe	UK	England/Scotland/Wales/ Northern Ireland	Region, e.g. SHA	Organisation, e.g. PCT	Subunit, e.g. locality/practice	Individual
Inputs					←		→	
Process					←		→	
Outcomes					←		→	

Arrows indicate the direction of movement.

SHA, strategic health authority.

Section 3 A history of decentralisation policies in the NHS

3.1 Introduction

This section examines decentralisation, centralisation and devolution in the NHS between 1948 and 1997. It presents the accounts of decentralisation given by articles in our search as well as a sample of key books on health policy. This indicates that the extant accounts of decentralisation in the NHS are unclear. The term is rarely defined or operationalised, and little reference is made to the conceptual literature. Moreover, some of the conclusions are conflicting, with some commentators arguing that certain periods and policies tend to be decentralising while others claim that they are centralising. We attempt to resolve some of these contradictions by applying our conceptual framework that was introduced in Section 2.7.

Many British governments have claimed that they wish to decentralise the NHS. Indeed, there have been few claims to centralise the NHS or arguments favouring 'command and control'. Klein (2001) argues that the cycle of experiments with delegation quickly followed by reversions to centralisation is one of the themes running through the history of the NHS (see also Paton, 1993; Kewell *et al.*, 2002). Nevertheless, decentralisation in the NHS is a problematic concept. First, as we saw earlier, there are significant problems of definition. Some writers tend to use cognate terms such as autonomy and localism which themselves are problematic. Second, much of the literature refers to elected local government with revenue-raising powers. Application to a national health service which is appointed and receives its revenue from central grants is problematic. As Klein (2001: 106) puts it, 'everybody paid verbal homage to the principle of decentralisation, but how was this going to be achieved in a nationally-financed service?' Similarly, Butler (1992: 125) writes that it is unclear whether the NHS is a central service that is locally managed or a local service operating within central guidelines. Governments have tended to claim the latter, while actually willing the former.

All this means that assessing the level of decentralisation is the NHS is difficult. Different ministers have held conflicting views. Enoch Powell argued that the centre had almost total control. Richard Crossman maintained that the centre was weak. Barbara Castle argued that the regional health authorities (RHAs) were 'pretty subservient' (Ham, 2004: 174–5). Commentators also present different views. For example, during the last Conservative period of office it appears that the NHS was moving in two different directions at once (Powell, 1998). Some commentators claimed that the national character of the health service was undermined (e.g. Mohan, 1995); others argued that the NHS was effectively nationalised (e.g. Klein, 2001; Jenkins, 1996).

3.2 The classic NHS (1948–79)

Our search found only two articles that addressed decentralisation in the 'classic NHS'. Powell (1998) argues that the NHS was a national service, as compared with the local service that it replaced, for three main reasons. First, it was set up as a national service, operating on an agency basis. The Minister of Health in the 1945 Labour Government, Aneurin Bevan, stressed central Parliamentary accountability for the NHS: 'when a bedpan is dropped on a hospital floor its noise should resound in the Palace of Westminster' (Jenkins, 1996: 65). Bevan (quoted in Hansard, 1946, cols 48–9) stated that the appointed NHS boards 'will be and they must be the instruments of the Ministry'. Second, there should be national as opposed to local funding. but Bevan decided to centralise the whole finance of the country's hospital system, taking it right out of local rating and local government because in any local government system 'there will tend to be a better service in the richer areas, a worse service in the poorer' (in Klein, 2001). Third, central control and funding should lead to provision which is equitable according to centrally determined standards. Bevan argued that his scheme was the only way of achieving 'as nearly as possible a uniform standard of service for all'. His aim was to 'provide the people of Great Britain, no matter where they may be, with the same level of service', to 'universalise the best' (in Klein, 2001). Exworthy *et al.* (1999) point out that the so-called hierarchy in the classic NHS might be better termed a 'quasi-hierarchy' as it could not fully 'command and control', and the period was also characterized by strong professional networks. They suggest that hierarchy became stronger after 1974 when 'authority' was introduced into the NHS when regional and area health 'authorities' replaced the existing regional hospital boards and hospital management committees.

Turning to the texts, although the early NHS is often seen as a model of command and control ('everybody's favourite example of a command and control health care system'; Moran, 1994), the situation was more complex (e.g. Exworthy *et al.*, 1999). Whereas Bevan often stressed the 'national' elements (see the previous paragraph), he also claimed that he wished to see maximum delegation to local bodies (e.g. Webster, 2002: 19). Although he saw local bodies as his 'agents', he hoped to give members 'substantial executive powers' (Allsop, 1995: 44). Klein (2001: 37) views the NHS as attempting to reconcile national accountability and local autonomy, but concludes that 'the circle refuses to be squared'. A 1950 report by civil servant Sir Cyril Jones identified 'the fundamental incompatibility between central control and local autonomy'. Bevan responded that 'in framing the service we did deliberately come down in favour of a maximum of decentralisation to local bodies, a minimum of itemised central approval, and the exercise of financial control through global budgets' (Klein 2001: 38).

Commentators such as Klein (2001) claim that in the 1950s the balance had swung towards local autonomy. Local bodies were more independent than the term agent implies. The hallmark of Ministry of Health policy-making in the 1950s was 'policy making through exhortation' (Klein, 2001: 39–40). Ham (2004: 22)

writes that the bodies that were responsible for the administration of health services were not just ciphers through which national policies were implemented. They had their own aims and objectives, and, equally significant, they were responsible for providing services where professional involvement was strong. On the other hand, Allsop (1995: 39–40) writes that after an initial phase of laissez-faire, the tendency was towards increasing central control.

Klein examines the 1962 Hospital Plan as a central–local relationship. On the face of it, this appeared to be the assertion of central authority designed to bring about national standards throughout the country. In the event, it set the pattern for subsequent attempts in the 1970s to introduce national norms of provision in the two priorities documents published in the mid-1970s. Its neat package of norms was subverted by two principles: infinite diversity (national norms have to be adapted to local circumstances) and infinite indeterminacy (national norms have to be interpreted and adapted flexibly as the future unfolds). In practice, the command structure became a negotiated order, with power at the periphery. As Secretary of State, Richard Crossman put it that there were 'powerful, semi-autonomous Boards whose relation to me was much more like the relations of a Persian Satrap to a weak Persian Emperor' (Klein, 2001: 61). Klein (2001: 64–66) claims that financial power was concentrated at the centre; clinical power was located at the periphery, but there was a complex and subtle relationship between central policy-makers and clinical decision-makers at the periphery.

The 1974 reorganisation was based on the phrase used in Keith Joseph's consultative document on NHS reorganisation, 'maximum delegation downwards, matched by accountability upwards'. As Webster (2002: 101) puts it, 'This scheme may have been redolent with meaning for the expert, but it was opaque to the public'. Allsop (1995: 59) argues that despite its faults, the 1974 reorganisation began the transformation of the NHS into a national service with national standards. The more lassisez-faire period of the 1960s was replaced by a planning system which identified national priorities even though local strategies were often inadequate. The RHAs in the 1974 reorganisation were the links between the DHSS and the area health authorities (AHAs) in the chain of command (Klein, 2001: 72–3). In theory, the centre would lay down policy objectives and the periphery would implement them; in practice, it was more complex. For example, the centre set priorities, but accepted that local plans would not often correspond to the order of national priorities proposed, and expenditure objectives were not specific targets to be reached by declared dates in any locality. In practice the language of norms and objectives turned out to be merely a vocabulary of exhortation (Klein, 2001: 96–8).

Table 3 gives a very basic summary of the accounts of decentralisation. Unlike later periods, it focuses on broad periods as the accounts give insufficient information to evaluate individual policies. Two points emerge. First, there are many empty cells, implying that we lack information about many periods and policies. Second, there is some degree of disagreement between accounts. For example, whereas Ham and Klein see the 1950s as tending towards

decentralisation, Allsop views this period as moving towards centralisation. It is difficult to adjudicate between these accounts as definitions and measures tend to be absent or at least implicit.

Table 3 Accounts of decentralisation in the NHS over time

	Allsop (1995)	Baggott (2004)	Boyne (1998)	Ham (2004)	Klein (2001)	Paton (1993)	Powell (1998)	Webster (2002)
1948	C				C			
1950s	C			D	D			
1960s	D							
1974	C							

C, centralisation; D, decentralisation.

3.3 The Conservative Government (1979–97)

The 1979 Conservative manifesto stated that 'We will simplify and decentralise the service and cut back bureaucracy', and most commentators agree that the 1979 consultation document *Patients First* (DHSS, 1979) and the resulting 1982 reorganisation stressed decentralisation, with decisions at local level and the minimum of central interference. Allsop (1995: 56) writes that with *Patients First* decisions moved closer to the locality, and that the locus of decision-making would move downwards. Baggott (2004: 100) considers that the 1982 reorganisation approach was 'decentralist rather than directive'. However, Ham (2004: 174) points out that the Secretary of State suspended the Lambeth, Southwark and Lewisham AHA in 1979.

There is less consensus on the implications of the 1983 Griffiths Report (DHSS, 1983), which recommended that general managers would be introduced at all levels in the NHS. Griffiths (DHSS, 1983: 12) argued that the centre 'is still too much involved in too many of the wrong things and too little involved in some that really matter'. On the one hand, Griffiths stressed the freedom to manage, noting that the 'process of devolution of responsibility, including discharging responsibility to the Units, is far too slow' (DHSS, 1983: 12). According to Webster (2002), in its origins the Griffiths initiative was more integrally related to preceding developments than seems evident at first sight. Patrick Jenkin (Secretary of State at the time of the 1982 reorganisation) reported the words of a 'shrewd hospital head porter' that there was 'too much administration and not enough management' in the NHS. Allsop (1995: 158) writes that the Griffiths Report was concerned with freeing managers at the centre and periphery. However, Klein (2001: 111) writes that from the Griffiths Report onwards the main priority was value for money: if that meant reversing the previous drift to decentralisation then so be it. Baggott (2004) sees the general managers suggested by Griffiths as instrumental in the increasing central direction of the planning and review process during the 1980s and 1990s. Baggott (2004) asks whether Griffiths was centralising or decentralising. On the one hand, managers

were meant to be responsive to consumers, and once objectives were set then managers should be given the freedom to achieve them. On the other hand, there was performance management and lines of accountability and authority to the centre.

There is general agreement that performance management increased centralisation with the centre or the regions pulling the strings. Klein (2001: 121–3) states that the system of performance reviews designed to monitor progress towards very specific targets were associated with a tighter system of control and accountability than had ever existed in the previous history of the NHS. However, the centralisation of 1980s spoke a different language, with the accent on outputs. In the 1970s priorities were in terms of inputs, but in the 1980s activity was the priority. The Trent Region was set a target of 2250 extra maternity patients, provoking somewhat ribald questions about who was to be responsible for increasing the birth rate (Klein, 2001: 121–3).

The white paper *Working for Patients* (Department of Health, 1989) and the 1990 NHS and Community Care Act suggested a purchaser/provider split, with decentralised institutions of self-governing NHS trusts and general practitioner fundholders (GPFHs). Although much of the rhetoric was decentralist, with the exception of local pay bargaining (Klein, 2001), it is broadly agreed that the implications were centralist (Allsop, 1995: 188). This is largely associated with a clear line-management system that Stalin himself would have envied (Timmins, 1996: 511, in Powell, 1997: 80–1). Klein (2001: 167, 182–3) states that in the case of health authorities and NHS trusts there was no longer any doubt about accountability to the Secretary of State: the reforms represented the ultimate logic of Bevan's principle that health authority members were the agents (or in Morrison's words, creatures) of the Minister for Health. He continues that, almost 50 years after the NHS was first created, in the second half of the 1990s it became a national service, with one unified structure and lines of accountability running clearly to the centre. Paton (1998: 151–2) writes that although the NHS is sometimes characterised as 'command and control', it is the new NHS which has really seen central diktat. According to Jenkins (1996), Margaret Thatcher 'completed what Bevan began: the nationalisation of the health service'. Whereas Bevan's falling bedpans were intended to be heard in Westminster, Thatcher's were 'picked up, emptied, cleaned, counted and given a numbered place on the Whitehall shelf'.

Like *Working for Patients*, despite the decentralist rhetoric, most commentators agree that the move from regional health authorities to regional offices of the NHS Executive were centralist, as regional staff became classified as national 'civil servants' rather than as 'local' NHS personnel. Ham (2004: 164) writes that the effect was to strengthen the grip of the centre over local management by moving towards the single chain of command for the NHS proposed in *Working for Patients*, setting targets and monitoring performance. Similarly, according to Baggott (2004), the NHS regional offices were expected to be less independent than the bodies they replaced. The move from RHAs to regional offices

compounded this process of centralisation. Webster (2002) claims that this resulted in the centre of gravity of power and initiative firmly shifting to the NHS Executive and its eight regional offices.

With two exceptions, the books pay little attention to the Patient's Charter (Department of Health, 1991) and to Local Voices (National Health Service Management Executive, 1992). Klein (2001: 180–1) argues that the Patient's Charter represented a 'mimic consumerism', or 'top down consumerism' – a new hierarchy of command. Paton (1998: 159) writes that encouraging Local Voices can become a bit of a joke. In other words, it appears that one consequence of increasing (upwards) centralisation was a corresponding decrease in downwards accountability.

In short, the Conservative period saw decentralist rhetoric and decentralisation in some spheres, such as devolution of actual purchasing budgets (if not of real power in determining priorities) and of local pay (Paton, 1998: 138–9). Klein (2001: 182–3, footnote 188) notes the differences between decentralised and centralised spheres. The attempt to decentralise pay bargaining – 'one of the most contentious issues by the mid-1990s' – contrasted with the centre's refusal to offer a standard NHS menu of services. Many commentators contrast operational devolution with increased central strategic control. For example, Paton (1998: 54) points to the 'centralisation of objectives' in the NHS market. Rhetoric about decentralisation and local control has masked the reality of market forces combined with central control. On balance, the clear consensus is that the period saw increased centralisation (see Table 4).

There are fewer, but still many, empty cells in Table 4. There is also more consensus: that *Patients First* (DHSS, 1979) represents decentralisation, while performance management, *Working for Patients*, regional offices and the overall trend suggest centralisation. The only policy area characterised by a lack of consensus is the Griffiths Report (DHSS, 1983).

The articles covering this period focus on different periods and policies. Exworthy (1998) focuses on localism, claiming that some commentators have viewed the organisation of the NHS as a series of local health services which operate within a hierarchical framework of the NHS. Over the past 20 years central–local relations in the NHS have been characterised by the implementation of decentralisation policies, with the devolution of administrative and financial responsibilities to lower organisational levels and most of these management appointments were at district level or below and hence reinforced the notion of a localised health system. Exworthy (1994) argues that decentralisation in community health services only really emerged following two key policy shifts in the 1980s: the 1982 creation of district health authorities (DHAs) and the formation of discrete management units such as community health services, and the 1983 Griffiths Report. Exworthy views Griffiths as the 'right to manage', free from 'external interference', and this has been promoted by various decentralisation policies, but in practice resulted in a compromise 'partial decentralisation'. In Exworthy's

case-study areas the decentralisation policy was shelved 18 months after it had begun.

Table 4 Accounts of decentralisation in the NHS – analysis of policy documents

	Allsop (1994)	Baggott (2004)	Boyne (1998)	Ham (2004)	Klein (2001)	Paton (1993)	Powell (1998)	Webster (2002)
Patients First (DHSS, 1979)	D	D			D		D	D
Griffiths Report (DHSS, 1983)		CC/D	?		C?			D?
Performance indicators			C		CC	CC	C	C
Working for Patients (Department of Health, 1989)	C		C	C	CC	CC	C	C
Patient's Charter (Department of Health, 1991)					C?		?	
Local Voices (National Health Service Management Executive, 1992)							?	
Regional offices (DHSS, 1979)		C	C	C				C
Summary of the period		C	C	C	CC	CC	C	CC

C, centralisation; CC, a higher degree of centralisation; D, decentralisation; DD, a higher degree of decentralisation.

Writing on locality planning, Balogh (1996) points to a wide variety of experimental schemes for locality-based commissioning in the internal market. She writes of 'the impetus towards decentralisation' and stresses the move to decentralisation of certain functions contained in the Griffiths Report and *Working for Patients*. Decentralisation is the central feature in the Financial Management Initiative, but the nature of decentralisation within the initiative was far from straightforward, and early critics drew attention to its 'top-down' character. Following Hoggett (1990), Balogh suggests that whereas operational matters may be devolved, strategic control has remained centralized. Rowe and Shepherd (2002) focus on the element of new public management identified by Barberis (1998) as 'controlled delegation'. They claim that new public management was

first introduced into the NHS in the 1980s following publication of the Griffiths Report. The task of the Griffiths general managers was to achieve the central governmental goals of financial restraint through modern management tools such as programme budgeting and performance monitoring. Rowe and Shepherd follow Hoggett (1996) by stating that that this restructuring enabled administrative decentralisation and managerial devolution at the same time as further reinforcement of centralized budgetary and strategic control.

Some writers, from a tradition of human resources management, point to decentralisation in *Working for Patients*. According to Thornley (1998) the key aim of the reforms embodied in the 1990 NHS and Community Care Act was to encourage trusts to determine pay locally. She adds that there was decentralisation of collective bargaining in the NHS before 1990 which is described as the 'drive to decentralisation'. Similarly, Lloyd (1997) writes that decentralisation (in the form of decentralized collective bargaining) within the NHS stems primarily from the 1990 NHS and Community Care Act.

However, most writers claim that *Working for Patients* was associated with centralisation. The most extensive and most quoted treatment of devolution is the discussion by Paton (1993) of *Working for Patients*. According to Paton *Working for Patients* was presented as promoting devolution, taking decisions at the lowest possible level. However, it is a 'mixed bag' (Paton, 1993: 87). He defines devolution as the handing down of responsibility from the centre for determining local health objectives (to purchasers) or for defining key aspects of business (to providers). While it is a truism that various operational responsibilities have been 'devolved' in recent years, Paton emphasises the difference between responsibility and power, concluding that 'in certain instances responsibility but not power has been devolved' (see also Day and Klein, 1987). In the NHS, the delegation of responsibility without power would in essence mean that general managers are really only administrators. On this interpretation, devolution is passing the buck. Paton continues that if political control for health boards becomes more blatant – as it did unequivocally throughout the 1980s – then supposedly devolved responsibilities (whether or not power accompanies them) are increasingly seen as having a central mandate. Devolution of management responsibilities to self-governing trusts removes local control of such providers and instead makes them responsible to the Department of Health directly. Devolution allows them to set their own priorities (within limits); raise capital and set prices more freely than directly managed units and – most importantly in practice – to 'reprofile their workforces'; that is, hire and fire more easily. However, this is not devolution in the political sense.

The introduction of a market to a service previously operating through planned provision in fact requires a heavy dose of centralism, as the new economies of the old Eastern Europe are finding. Paton (1993) discusses three models of clinical directorate – full devolution, managed devolution and central control – and views medical audit as centralism. However, an area where there has seemingly been a large shift in policy from centralism to devolution has been in

the management of human resources and industrial relations generally. However, in practice, devolution may not be all that it seems. The Patient's Charter perhaps provides a clear example of the tension between centralism and devolution. In practice, central regulation to achieve central mandates means that not only is centralism asserted over devolved responsibility for the setting of priorities, but that the alleged philosophy of *Working for Patients* is in fact undermined. Paton concludes it might be argued that the whole structure of the post-1989 NHS represented devolution, in practice; however, it was easy to interpret this as central control under the guise of local ownership: the Conservatives pursuing central objectives through local placemen. In short, while there was significant operational decentralisation, centralism increased.

This is similar to Exworthy's (1994) view that central government has recently espoused ostensibly decentralist policy goals, claiming that decisions should be taken as close to the patient as possible (Department of Health, 1989). However, decentralisation in the NHS generally and community health services in particular is increasingly being associated with mangerialism to the extent that these developments are almost synonymous. Though decentralist in rhetoric, there is an undercurrent of centralisation. Local managers manage within closely defined central terms. Such is the 'familiar organisational paradox, that to decentralise, it is necessary to centralise' (Carter, 1989: 131). Exworthy (1994) concludes that decentralisation is a misnomer in that it implies a changed relationship between the centre and the locality of an organisation and the term fails to recognise the significant undercurrent of power towards the centre. Seeing decentralisation in terms of central–local relations helps to interpret the motives, meanings and implications of the government's policy of decentralisation.

Hardy *et al.* (1999) argue that the Secretary of State for Health has direct strategic and operational management responsibilities for the NHS. Although many responsibilities are delegated to health authorities, these have been dominated by government appointees and the effect of reforms to NHS management during the last few decades has been to strengthen the powers of the centre by 'introducing for the first time a clear and effective chain of management command running from districts to the Secretary of State' (Department of Health, 1989).

Moon and Brown (2000) examine shifting constructions of the local and place and space signifiers such as community, proximity, local and decentralized. By 1993 Department of Health press releases were placing a clear emphasis on assertions that health care policy had increased responsiveness at the local level, such as trusts being better able to respond to patients' needs through greater freedoms, flexibility and local involvement. Greater local responsibility encourages efficiency and even more importantly an increasing sense of pride and job satisfaction. According to Secretary of State Virginia Bottomley this strategy would uphold and strengthen national accountability yet would be geared to respecting local freedoms. Merged DHAs and family health services authorities would be 'champions of local people' and the reorganised NHS Executive was to offer a

'light touch' management style through its regional offices, allowing 'more effective support to the development of local policies'. The Department of Health claimed that 'the old hands-on style of the regions is, however, no longer appropriate', with the new outposts presented as planned elements of a decentralized NHS Executive in which a monolithic single entity was fragmented to enable greater local sensitivity. According to Virginia Bottomley, the whole purpose of the change was precisely to devolve responsibility to DHAs who champion the interests of local people. She continued that prior to 1989 management was exercised through a cumbersome, command-and-control bureaucracy, but we have passed responsibility down to local level. The result has been a fundamental shift of power towards the patient.

The successful devolution of responsibility to local level inevitably meant that the role of RHAs would reduce: they were the last bastions of the old command-and-control system from which we have now escaped. This was criticised by Labour's Health spokesperson, Margaret Beckett, who stated that Bottomley was not devolving power. Rendering power and responsibility more diffuse shifts blame and disperses responsibility. As Moon and Brown (2000) put it, the regional offices were to be in the regions but not of the regions, a part of central government rather than regulated but semi-independent fiefdoms (see Crossman, in Sections 3.1 and 3.2). They quote Alan Maynard that Whitehall and its organ of Stalinist control, the NHS Executive, shower managers in the NHS with instructions and inform them, ever so nicely, that if they do not dance to their tune they will be removed from the dance floor.

Kewell *et al.* (2002) focus on the NHS creating networks in the 1990s, but stress that the term 'network' is being used in a very particular manner: managed networks which can deliver national targets, which are radically different from the concept of a 'policy network' (Rhodes and Marsh, 1992). Within the managed network, government retains a directive role, with network structures mandated from above. The NHS is a 'reforming' bureaucracy which is continually balancing the twin principles of hierarchy and decentralisation. At one level, the internal market opened the way for more decentralized and 'entrepreneurial' styles of management, at least within the devolved provider units. Progressively, however, the internal market changed into a 'managed market', subject to ever-increasing political direction and top-down regulation. Lines of command between the executive and the field were reinforced by the introduction of performance management. They then move to discuss 'the birth, decline and rebirth of the regional offices?' In the Conservative period of office, new regional offices were created to act as civil service outposts of the NHS Executive, and they were given a mandate to implement national policy.

In general terms, the articles discussed here (see also Table 5) argue that despite devolutionary rhetoric and some devolutionary elements (e.g. local pay), the balance of the period was clearly centralist in nature. However, there are no clear verdicts on many policies, and no clear consensus on policy initiatives such as the Griffiths Report.

This brief review of decentralisation in the NHS has shown that there are many gaps in our knowledge and that there are some conflicts in judgement, partly because accounts tend not to link to the conceptual literature or provide clear definitions of terms or rationales for their decisions. The next section examines decentralisation in the NHS with reference to our conceptual framework to see whether it can sharpen up the picture of decentralisation in the NHS.

Table 5 Empirical accounts of decentralisation in the NHS by policy document

	Balogh (1996)	**Exworthy (1994)**	**Exworthy (1998)**	**Hardy *et al*. (1999)**	**Kewell *et al*. (2002)**	**Lloyd (1997)**	**Moon and Brown (2000)**	**Paton (1993)**
Patients First (DHSS, 1979)		D						
Griffiths Report (DHSS, 1983)	D/C	D/C						
Performance indicators								CC
Working for Patients (Department of Health, 1989)	D/C					D		CC
Patient's Charter (Department of Health, 1991)								D/C
Local Voices (National Health Service Management Executive, 1992)								
Regional offices (DHSS, 1979)					CC		CC	
Summary		D/C	D?	C	CC		CC	CC

C, centralisation; CC, a higher degree of centralisation; D, decentralisation; DD, a higher degree of decentralisation.

3.4 The Arrows Framework

This section aims to illustrate the utility of our conceptual framework, which was introduced in Section 2. This presents information on the what and where questions of decentralisation. First, in the vertical axis decentralisation may be seen in terms of inputs, processes and outcomes. Second, the horizontal axis shows the origin and destination of decentralisation. This indicates direction (centralisation and decentralisation) and strength as, *ceteris paribus*, a longer line suggests more decentralisation. For example, decentralisation from the nation state to the organisation is greater than decentralisation from the nation state to the region.

The maximum degree of decentralisation within the UK would be represented by decentralisation on all three dimensions from the state to the individual. In the period covered, there are – unsurprisingly – no examples of this type. The 1979 consultation paper *Patients First* and the resulting 1982 reorganisation perhaps give the clearest example of decentralisation (see Figure 2). In terms of inputs, they reduced the size of the main organisational unit in the NHS from AHAs to DHAs. Turning to process, the rhetoric stressed a significant degree of autonomy for the districts, although the regime was not in operation for sufficient time to determine this before centralisation associated with performance management. Finally, for the brief period between 1982 and 1983 there was no strong national performance-management system imposing outcome targets on local agencies.

Despite the rhetoric, most commentators regard *Working for Patients* and the resulting 1990 NHS and Community Care Act as centralising (see Figure 3). The main reason for this appears to be associated with the strong chain of command from national to local, with local managers having to respond to centrally determined targets. More arguably, there was some centralisation of processes with the introduction of medical audit, and more generally the guidelines and evidence-based medicine movements. However, it can be argued that *Working for Patients* contained some decentralising measures, notably local pay and GPFH. Local pay represents an input decentralisation, taking pay determination from national scales to the local level. GPFH appears to decentralise inputs, by reducing the organisational size from health authorities to practices and devolving budgets to practice level. It may also be associated with decentralising processes as practices had autonomy to spend this money. This resulted in greater use of complementary therapies, consultant clinics at the practice, and the use of extra-contractual referrals rather than block contracts. Many commentators illustrated their view of power moving to practice level by the anecdote that while general practitioners (GPs) used to send christmas cards to consultants, in GPFH the reverse sometimes occurred.

The fact that policies can have elements of both centralisation and decentralisation squares with the views of writers such as Hoggett (1996), who attempts to explain some of the apparent paradoxes of decentralisation. For example, Hoggett (1996) views the Conservative internal market of competition between decentralized units as an attempt to decentralise operations while centralising strategic command. This may be compared with Paton's (1993) claim of operational decentralisation and central strategic control, and with the view of Glennerster and Matsaganis (1993) of top-down versus bottom-up approaches to decentralisation). Hoggett continues that we have simultaneous centralisation and decentralisation, and that the concept of centralized/decentralisation has become an established part of the new organizational literature. He follows Kikert's (1995) paradigm shift in control strategies from ex-post (input) to ex-ante (output) control; indicators of results rather than inputs or processes or 'control at a distance'. In other words, it reflects Thomas and Levacic's (1991) centralizing in order to decentralise. From a different perspective, Peters and Waterman (1982: 15, 318) write that the excellent companies are both centralized and decentralized or loose–tight. It is in essence the co-existence of firm central direction and maximum individual autonomy: what we have called having one's cake and eating it.

Figure 2 The Arrows Framework applied to *Patients First* (DHSS, 1979)

Tier… Global Europe UK England/Scotland/Wales/ Northern Ireland Region AHA DHA Subunit, e.g. practice Individual **Activity**
Inputs: size of operational unit →
Process: decision-making power →
Outcomes: performance framework →

Figure 3 The Arrows Framework applied to *Working for Patients* (Department of Health, 1989)

Tier… Global Europe UK England/Scotland/Wales/ Northern Ireland Region DHA Subunit, e.g. practice Individual **Activity**
Inputs: responsibility for pay; →
funding for purchased services →
Process: commissioning →
Outcomes: performance framework ←

3.5 Conclusion

It has been shown that not only has the direction of change – decentralisation against centralisation – varied over time, so too have the content and scope of decentralisation. Our framework allows a more fine-grained examination of decentralisation.

Many of the problems surrounding decentralisation in the NHS stem from the perennial question of attempting to reconcile national priorities and uniform services with local freedoms (Paton 1998: 177; see also Klein, 2001). The NHS has never approached either extreme ideal type. According to Klein (2001: 216) there will be 'no return to "command and control", but such a system had never existed' (see also Exworthy *et al.*, 1999). The first few decades can be more accurately described as one of 'exhort and influence'. The system gradually evolved and tightened with the introduction of performance indicators in the 1980s and the creation of a more hierarchical managerial system in the 1990s. Webster (2002: 258) argues that it is entirely misleading to caricature Bevan's health service as some kind of obsolete Soviet-style command-and-control system.

Equally, however, compared with local government, the potential for decentralisation in the NHS remains limited. Ham (2004: 170) argues that although NHS bodies are part of an NHS for which the Secretary of State is accountable to Parliament, they do not simply carry out central wishes. They are the Secretary of State's agents, but the agency role does not involve merely implementing instructions received from above. These bodies are semi-autonomous organisations which themselves engage in policy-making and as such exercise some influence over the implementation of central policies. There is a complex series of interactions between the centre and the periphery. Whereas the existence of parliamentary accountability gives the appearance of centralisation in the NHS, the reality is rather different. The Department of Health is able to exercise control over total spending and its distribution, but has less control over the uses to which funds are put (Ham, 2004: 185). Baggott (2004: 186–7) concludes that there are problems with devolution in the NHS: as long as the NHS continues to be perceived as a national service, is funded out of taxation and remains high on the political agenda, ultimate responsibility for the service will remain focused at the centre. Paton (1998: 116–7) argues that if the concept of a NHS is to retain legitimacy, there must be national decisions as to priorities. The long-term consequences of genuinely local choice could be the demise of central funding and central resource allocation, as 'local choice implies local revenue generation'.

Section 4 Decentralisation under New Labour: policy since 1997

4.1 Introduction

This section of the report brings our account of decentralisation in NHS policy up to date, starting in 1997 and considering New Labour's reforms in the context of the material suggested by our review, but also examining the literature based specifically around the public sector reforms that have occurred in that time period.

Following the analysis of Section 3, this section explores what five commentators have said about the centralising and decentralising tendencies of New Labour policy. Necessarily, there are fewer accounts from which to draw than in Section 3 because of the relative recency of the events concerned, and to the four authors considered above we add the account of Glennerster (2000).

4.2 Labour and the NHS

In 1997 Labour came to power with explicit targets for the reduction of waiting lists, but relatively little in terms of other commitments for the NHS. A new white paper appeared quickly, 1997's *New NHS, Modern, Dependable* (Secretary of State for Health, 1997). Baggott (2004) considers this to be a statement that promised increased localism for health services, but which resulted instead, because of the creation of centralising organisations such as NICE and the Commission for Health Improvement, in the opposite. The focus on waiting times and the attempts to reduce them because of the Labour manifesto commitment of 1997 also led to strong central pressure. Ham (2004) appears to broadly agree with this analysis, noting that there were claims of decentralisation of operational management to NHS trusts, but a focus on the reduction of variations in health policy – a restatement of the national in the National Health Service, again through organisations such as NICE and through the introduction of national service frameworks. Klein (2001) notes the pragmatism of New Labour policy upon returning to office, and confirms both Baggott's and Ham's view that, whereas much of the language upon assuming office was exemplified by the language of decentralisation and devolution, the modernisation agenda pushed policy in the opposite direction, requiring a greater role for the centre. Klein, building on Ham's argument in many ways, suggests that the centre became more involved as a consequence of the perceived failure of the local, both in order to reduce health variations, as well as to correct local management failures where they were occurring. New Labour were perceived to be an active government, straining between their apparent wish for greater responsiveness and democracy on one hand, and a need to be more involved with greater central control on the other.

Webster (2002) is rather less explicit about centralisation and decentralisation in his account of New Labour policy until 2002, focusing instead upon the welcome (in his view) long-termism of Labour's policy after 2000, and the focus upon primary care, where significant structural changes are noted as taking place. Webster notes a new emphasis on prevention and public health, especially clear in Labour's use of Health Action Zones, but concludes by saying it is not clear what direction future policy will take. Finally, Glennerster (2000) apparently presents a view in common with many of the points raised by Baggott, Ham and Klein on one hand, and Webster on the other, by suggesting that New Labour's approach represents a political break with the old method of central planning present in social policy, which was abandoned because of it was perceived to be no longer delivering. He perceives social policy, including the NHS, as moving towards a goal-centred approach in which social justice and equal opportunities are emphasised instead. NICE and the Commission for Health Improvement are perceived to be agencies kept at arm's length for the delivery of policy, but not especially centralising.

Overall New Labour's policy upon returning to office, certainly between 1997 and 2000, can perhaps be categorised by the majority of authors as at least having centralising tendencies, justified by the need to correct either organisational failures or health inequalities. At the same time, however, many of the mechanisms through which these policies operated (such as Health Action Zones) allowed considerable local discretion. This was achieved by the centre laying down the result it expected, and requiring local co-operation with these targets, but allowing local choice in how they were to be obtained. It is difficult, however, to interpret this as an unqualifiedly decentralised use of health policy, with perhaps most commentators agreeing that at least some centralisation occurred as a result.

By the end of 2000, *The NHS Plan* (Department of Health, 2000) had become perhaps the most important health policy document released in a generation. Baggott explains the release of *The NHS Plan* in relation to increased media pressure in 1998 and 1999, which focused on medical failures of governance and difficulties in providing care because of Labour's pledges to remain within Conservative spending limits in their first 2 years of power. *The NHS Plan* is seen by Baggott as having centralising tendencies, continuing from earlier policy, but also in allowing a substantially larger role for the private sector, and so increasing reliance upon non-public sector organisations in the delivery of health, which is decentralising in entirely another way. The Wanless Report (Wanless, 2002) is seen as a continuity in the pledges made in *The NHS Plan* for greater funding for health care, but also has a strong centralising overtone because of the demands for reform, inevitably driven from the centre, that came as a consequence of this. Ham confirms Baggott's explanation for the timing of *The NHS Plan*, and suggests it was a new delivery model for an NHS framework to support delivery, putting in place arrangements for the inspection and performance measurement of health organisations that are strongly centralising. High-performing organisations could gain autonomy, greater control over their own affairs, whereas low-performing

organisations receive greater intervention instead. Klein's account does not take account of *The NHS Plan*, but does make a number of relevant points, suggesting that greater responsiveness and local autonomy from health services might result in an increase in national health inequalities, against the wishes of the Labour government. Klein is also rather cynical about the possibility of organising health services to achieve greater local responsiveness and autonomy, however, noting that the reorganisation of the NHS has been attempted several times with these goals in mind, but never successfully (see Section 3).

Webster, as noted, welcomes the long-term aspects of the NHS, but appears rather uncertain that they will be carried through because of his claim that the future of health services is so uncertain. Webster also welcomes the additional resources coming from *The NHS Plan* and Wanless Report, but criticises NICE because, he claims, it has become compromised because of its political significance in the NHS, and has become perceived to be a blocking device rather than meeting its wider brief.

The NHS Plan, then, is generally perceived by these authors to be a centralising policy statement, but allowing some potential for greater autonomy for high-performing organisations. The definition of high-performing, however, is very much decided by the centre, and so this might be perceived as a continuity of earlier policy in allowing greater local autonomy, but only so long as very prescribed national targets are first met.

Finally, we can find commentary on a further policy document, *Shifting the Balance of Power* (Department of Health. 2001c), that appeared a year after *The NHS Plan*. Baggott, perhaps in contrast to his earlier analysis, suggests that this is a move from top-down approaches to policy to local leadership, decision-making and accountability, and the introduction of a more 'light touch' system for the governance of health care. He does, however, note that many of the centralising tendencies previously noted remained very much in place, and so the effect of the new document were very much tempered by these, and so the overall effect of the 'modernisation' of health services remained centralist. We can perhaps discern, however, that *Shifting the Balance of Power* was an attempt to begin to reverse policy towards a more decentralising direction. Ham appears to agree with this, emphasising again the key role of primary care in New Labour's health organisation with 75% of the NHS's budget controlled by PCTs by 2004, and the potential for greater decentralisation that this entails. Ham, however, also suggests that the structural upheaval that the changes will result in will reduce the effect of the policy.

Table 6 attempts to summarise the account presented above.

4.3 Considering New Labour policy thematically

Since 1997, we can perhaps discern three specific periods of health policy (Greener, 2004, 2005). In the period leading up to 2000 Labour were effectively

constrained in their expenditure decisions by the pre-election decision to comply with the outgoing Conservative Government's expenditure plans. This

Table 6 Five views of policy post-1997

	Baggott (2004)	Ham (2004)	Klein (2001)	Webster (2002)	Glennerster (2000)
The New NHS: modern, dependable (Secretary of State for Health, 1997)	CC	CC	C	C	C
The NHS Plan (Department of Health, 2000)	CC	C	–	C	
Shifting the Balance of Power (Department of Health, 2001c)	D	D	–	–	

C, centralisation; CC, a higher degree of centralisation; D, decentralisation.

made radical reform (unless it could be made cost-neutral) remarkably difficult. There are a number of characteristics of Labour's policy between 1997 and 1999.

First, there is a continuation of the Conservative's emphasis on primary care. The 1996 white paper *A Service with Ambitions* (Secretary of State for Health, 1996) is an odd document, perhaps an attempt to demonstrate the potential for inter-agency working, but also how primary care could be the hub around which health services could be organised. As the 1990s went on, there were continuing references to the future being one in which we would have 'primary-care-led NHS', in which case there would be appear to be a clear trend towards using organisations 'closer' to the patient, which would also be a form of decentralisation.

Labour's particular approach to primary care led to the abolition of GPFHs set up in the 1990-model internal market, replacing them instead with primary care groups (PCGs). This was meant to lead to a number of changes (Secretary of State for Health, 1997). However, it appeared to be a part of the replacement of the internal market with longer-term contracting and a concentration of purchasing away from individual contractors towards a more grouped approach. As such, the purchaser/provider split remained, but was rationalised and remoulded. The new model was one in which PCGs appeared as the most significant change of the early period of Labour policy. This reform of primary care illustrates the difficulties of attempting to specify whether reforms have been centralising or decentralising: from the perspective of the movement from GPFHs to PCGs, we have a centralisation. From the perspective of the state the changes were centralising in that they incorporated GPs (both fundholders and non-fundholders) in PCGs, and so into the NHS, in a way that had never been realised before (Peckham and Exworthy, 2003). But the movement can also be seen as decentralising from a health authority perspective, moving purchasing (or initially advice about purchasing) to smaller units in the name of greater local responsiveness.

The second aspect of Labour's policy before 2000 was its extraordinarily conciliatory tone. The white paper *The New NHS: modern, dependable* (Secretary

of State for Health, 1997) appears to suggest that by allowing health professionals the autonomy they need, the NHS will get better. The blame for the decline of the health service is laid firmly on the door of the command-and-control and market systems that the document suggests have been present in the past, both of which led to bureaucratisation and meant that clinicians and other health professionals were prevented, through a series of perverse incentives, from doing their jobs as they wished. The Government was now going to allow them these freedoms. This sounds a great deal like decentralisation borne out of a hark back to the Fabian principles upon which the health service was founded, principles upon which health professionals were afforded considerable autonomy by the state (Klein, 2001). However, at the same time as this early commentators noted the potential need for very strong central involvement to manage the changes to primary care that were proposed in the name of greater autonomy (Klein and Maynard, 1998).

A third element of Labour's policy is in relation to funding. In 1997 Labour continued with the discourse of their predecessors in claiming that the problems of the NHS had organisational rather than financial solutions. Indeed the difficulties of the NHS had been 'exaggerated' in the past (Secretary of State for Health, 1997: section 1.19). There appears to have been considerable confidence that the combination of a push towards primary care and the renewal of clinical team-working coming from the alleged removal of the internal market would be enough to improve the NHS. There was no mention of 'reform' in the first few years of the Labour Government – instead 'quality' and 'improvement' appears to be more focal points. Retaining the same levels of budget can be seen as largely neutral on our decentralisation/centralisation scale in terms of input, with the reforms of the internal market (though the movement to PCGs) being rather complex in terms of its effects on processes (see above).

In terms of public health, the 1998 white paper *Our Healthier Nation* (Department of Health, 1999) represents something of a paradox when considered for its centralising and decentralising effects because of its tendencies in both directions. On the one hand the imposition of public health targets by the Government marks a centralising tendency – one that again has some continuity with previous Conservative policy in the form of the *Health of the Nation* white paper of 1992 (Department of Health, 1992). This tendency can be seen both organisationally, in which PCGs (and later PCTs) were given very specific targets for a wide range of public health indicators. However, PCGs were also given at least some autonomy in the means by which they were allowed to reach the targets set, and there was often significant funding attached to putting in place projects to tackle specific public health issues (e.g. smoking cessation). This created the possibility of bottom-up organisation, in which teams of health professionals worked almost autonomously within the NHS to meet centrally specified objectives. There are then aspects of the decentralisation of the processes designed to meet public health targets, but centralisation of the outcomes required. Perhaps less ambiguously decentralising was the widespread funding of Health Action Zones in the first few years of the Labour Government

(Matka *et al.*, 2002) – some of which continue now. In such projects considerable decentralisation often took place, with local agencies setting targets for improvement, as well as deciding how those targets would be met. Unfortunately, many Health Action Zone projects failed to find private funding after their period of central funding ran out – perhaps demonstrating the need for the involvement of the centre in public health after all. Public health is the perhaps the area where the tension between centre and locality is often most visible (Exworthy *et al.*, 2002) – it is where central targets are often imposed upon local agencies, and where the means of their achievement may or may not be specified in terms of their local constitution. There is also the possibility that many of the targets set at local level were set additionally to the national targets: they were additions rather than substitutes.

By 2000, however, we can discern a change in the direction of policy. The Government was beginning to face criticism that it had not played enough attention to the NHS in its first term of office, and a more radical approach was beginning to appear. *The NHS Plan* (Department of Health, 2000) marked the beginning of a very different approach to the one seen pre-2000, but with some degree of continuity.

First the subtitle of *The NHS Plan – a plan for investment, a plan for reform* – gives us clues as to the direction of policy. Health care, directly linking analysis to that of the Third Way (Giddens, 1998), was now to be about 'investment', suggesting that the Government was to devote significant sums to the NHS, breaking away from the spending patterns inherited from the Conservatives in a decisive way. But this investment was not unconditional, leading to the second part of the title. In return for the increased investment that the Government was to offer the NHS, it had to change significantly. Gone was the expression of professional faith from the Government in 1997, policy was now to have teeth. The announcement of the performance-assessment framework for the NHS is the most obvious manifestation of this, putting in place a grading system for every hospital trust in the country according to national criteria. The performance-measurement system central to the NHS was clearly a centralising measure, putting in place clear systems for measuring both outputs and processes.

We again need to be very careful in unpackaging the effects of this change in policy in terms of centralisation and decentralisation. Increasing the sums available to the NHS clearly has the potential to be decentralising if it allows the discretionary sums available to purchasing organisations to increase, and for local responsiveness to occur as a result. Giving additional funding to trust organisations clearly then creates the potential for decentralisation. On the other hand, we have seen that the sums made available were only done so on the condition that reform occurred, and the exact reforms required were specified in terms of a wide range of particular performance measures that were to be combined to give 'star ratings', initially to hospital trusts, and then to PCTs as well. Untangling all of this is difficult, but it would seem that we can say that the policy of giving additional funding is an example of input decentralisation. The

specification of specific targets as part of a performance-assessment framework is an example of output centralisation, but as well as this, because there is increasing evidence that the output measures chosen significantly change the behaviour of those working within health services (Painter and Clarence, 2000; Talbot, 2000; Sanderson, 2001; Smith, 2002; Greener, 2003, 2005), it is also process centralisation. But because the specific processes that must be met are not specified in performance-assessment frameworks, this effect is not entirely intentional on the part of the Government – instead we might consider it to be an isomorphic effect of the type described by March and Olsen (1984), in which the industry, through its standardisation (in terms of output), leads to a standardisation of practice through central specification of output measures.

In addition to this, *The NHS Plan* presents specific targets and dates for improvements stretching over a time period well beyond the Government's term in office into the future. Reductions in waiting times, long a feature of government policy, were one aspect of this and were very much a focus, with specific target promises across a number of specialties (Economist, 2000).

Changes in the delivery of primary care continued. PCGs were to be reformed into PCTs, being placed eventually on to the same inspection system as hospital trusts, and increasing the scope of their brief to bridge the gap between health and social services. PCTs were hugely significant for policy; not only were they to be a significant driver of integrated care, but they were also to be the site where the majority of the NHS's budget was to be delivered. PCTs were to be both significant purchasers and providers of care, at the heart of the Government's plans to drive reform of the NHS. Perhaps most significantly of all, PCTs became the major purchasers in the NHS, with, at the time of writing, some 75% of the health service's funds at their command. This is clearly an example of input decentralisation, representing a significant movement of resources to organisations in the name of local responsiveness (see Figure 4.1). But we can question the extent to which this leads to process decentralisation because the extent to which PCTs are able to employ these funds discretionally is not clear: contracts are often signed on a time scale of greater than a year, meaning that markets are more about contestability than competition; there are political problems in removing funding from established providers of care where it might lead to financial problems on their part and, finally, this decentralisation of resource has an ambiguous relationship with more recent reforms around the mixed economy of care and patient choice (see below, this section).

From 2001 an increased emphasis appeared on the purchaser/provider split in the NHS that New Labour had initially claimed to have abolished in 1997, but which now took to a whole new level. Consultative documents around patient choice (Department of Health, 2001b) suggested that patients should be able to visit primary care centres and, when they need additional treatment, choose from a list of potential service providers and book their care, at the location and time of their choosing, online. This is a clear decentralisation policy, attempting to put choice (a process) in the hands of individual patients. After this document's

release, proposals for the 'new' internal market grew at some pace. The 'mixed economy of care' proposed allows public, private and not-for-profit organisations to compete to provide care in the NHS, so long as they agree to charge the NHS 'tariff' or price for their services, and to be a part of the new unified NHS inspection regime. Once again, this takes some unpicking. Patient choice is a process decentralisation, but the specification of the NHS tariff and the requirement to meet a unified inspection regime is process centralisation. Patients gain greater choice at the expense of health providers, who must conform to central standards to be able to offer their care. The entry of private and not-for-profit organisations into the mixed economy of care is input decentralisation though, with non-public sector organisations becoming more involved in the provision of care in the NHS, albeit on terms not entirely of their own choosing.

The new mixed economy of care, as we noted above, also has a rather ambiguous relationship with the decentralisation of funding that PCTs are meant to be enjoying. If secondary and tertiary care decisions are increasingly to be made by patients rather than PCTs then this removes at least some of the autonomy from PCTs (on the purchaser side), leading to greater decentralisation (patients make choices rather than PCTs). But it also creates the opportunity potentially for PCTs to put together new care offerings on the provider side that correspond more closely to their local population needs and to 'market' such offerings directly to patients. The mixed economy of care can decentralise funding decisions away from PCTs (inputs), but provide the potential for them to focus greater attention on their provision, and so a potential decentralisation of processes and outcomes.

The policy of 'earned autonomy' (Department of Health, 2000; Secretary of State for Health, 2002) and the associated idea of 'foundation trusts' again illustrates the simultaneous centralisation and decentralisation of policy. Earned autonomy, as the name implies, leads to organisations with the demonstrated ability to excel at meeting the specific criteria of the performance-assessment framework (outcome centralisation), the ability to have greater freedoms from inspection, and additional rights including, for example, the ability to borrow from the private sector and set up joint ventures with it. Outcome centralisation leads to process decentralisation, but with a remaining element of outcome centralisation in place (foundation trusts, the clearest example of earned autonomy, may not run at a deficit).

In addition to this, the Expert Patient programme (Department of Health, 2001a) has the potential to decentralise the care of the chronically ill to a far greater extent to the individual patient, being a clear example of process decentralisation. But it also has the potential to free up considerable primary care resources because of its explicit approach of moving to a model of care in which there is less reliance on health professionals, and where, from the document itself, substantial time savings can be achieved (an up to 80% decrease in the use of health professionals is claimed for some illnesses using the programme).

This creates the potential for PCTs and GPs to have greater local discretion in their employment of resources, so potentially achieving more of the aims that moving 75% of resources to these groups is meant to achieve (see above, this section).

Another future reform also muddies the water here. Practice-led commissioning will allow greater participation for individual GPs in the new mixed economy of care, and so a potential process decentralisation back to policy of the 1990s with an approach that might appear to have a remarkable amount in common with GP fundholding. However, as with PCTs the impact of policy and practice changes on general practice are not uniform (see Figure 5).

Finally, in what sometimes seems like an avalanche of health reform, we have a new white paper on public health (Department of Health, 2004). The Government's new statement on public health has some centralising tendencies in terms of processes and outcomes. Specific targets appear, meaning that outcomes are becoming more clearly specified. As well as this, the potential ban on smoking in public places means that organisations beyond the NHS are being expected to take a role in protecting the public health, meaning that we have a process centralisation for both NHS and non-NHS organisations. But the policy is, again, likely to be more ambiguous than this, with substantial opportunities for local trust organisations to bid for extra money which will allow them considerable discretion in how they achieve particular public health targets. This is outcome centralisation, but process decentralisation.

Thus analysis of current policy presents a complex view of centralisation and decentralisation. Figure 4 shows how policy can affect a single organisational tier and Figures 6–8 demonstrate how the framework can be used to draw out specific directions of current policies and programmes. These are presented in terms of inputs, processes and outcomes, providing a useful way of comparing different policies and organisational change. What is immediately clear from this mapping of the direction of change across a range of areas is the general decentralisation trend of inputs and processes but the clear centralisation of outcomes: setting of performance targets or health goals.

Figure 4 The Arrows Framework applied to PCTs

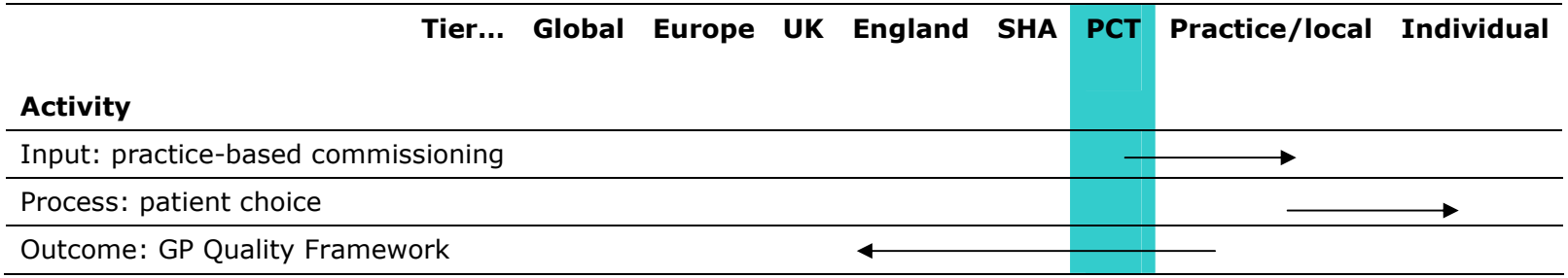


Figure 5 The Arrows Framework applied to general practice

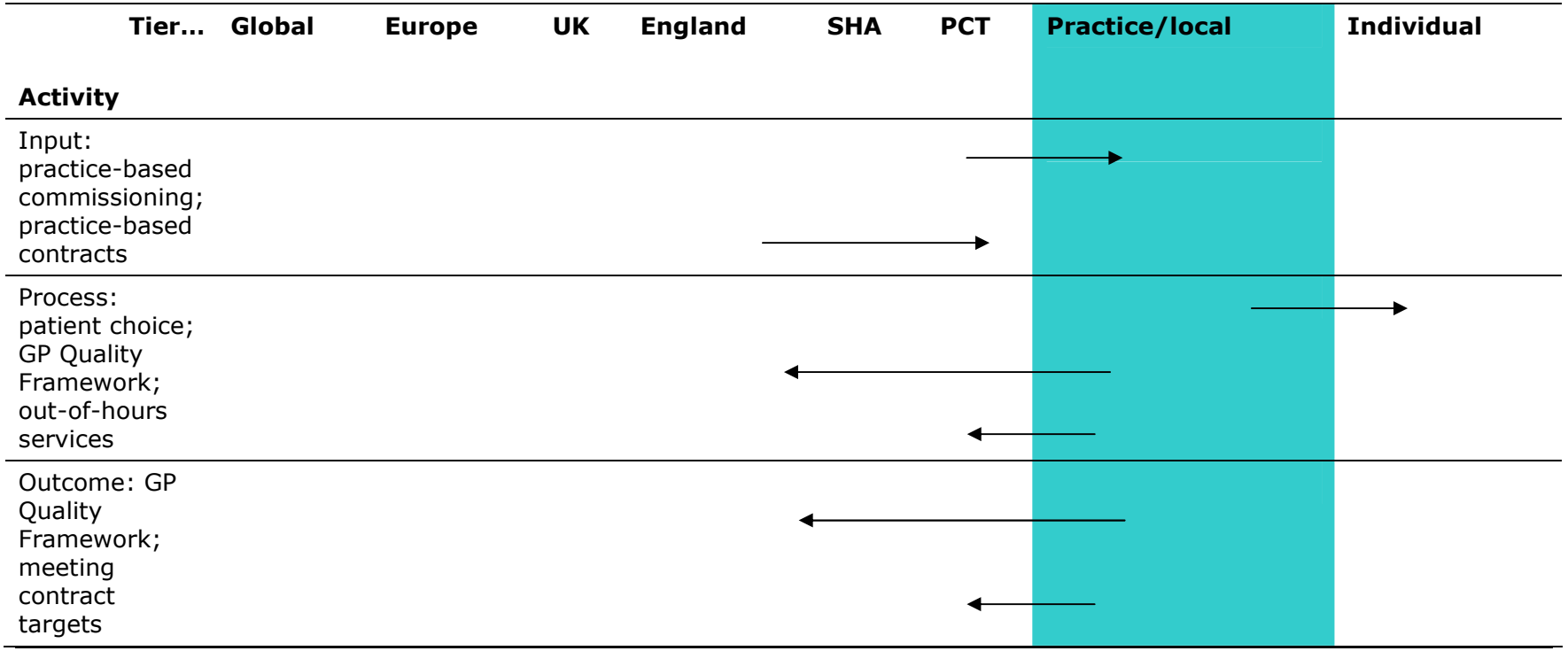


Figure 6 Inputs (funding, staff, etc.)

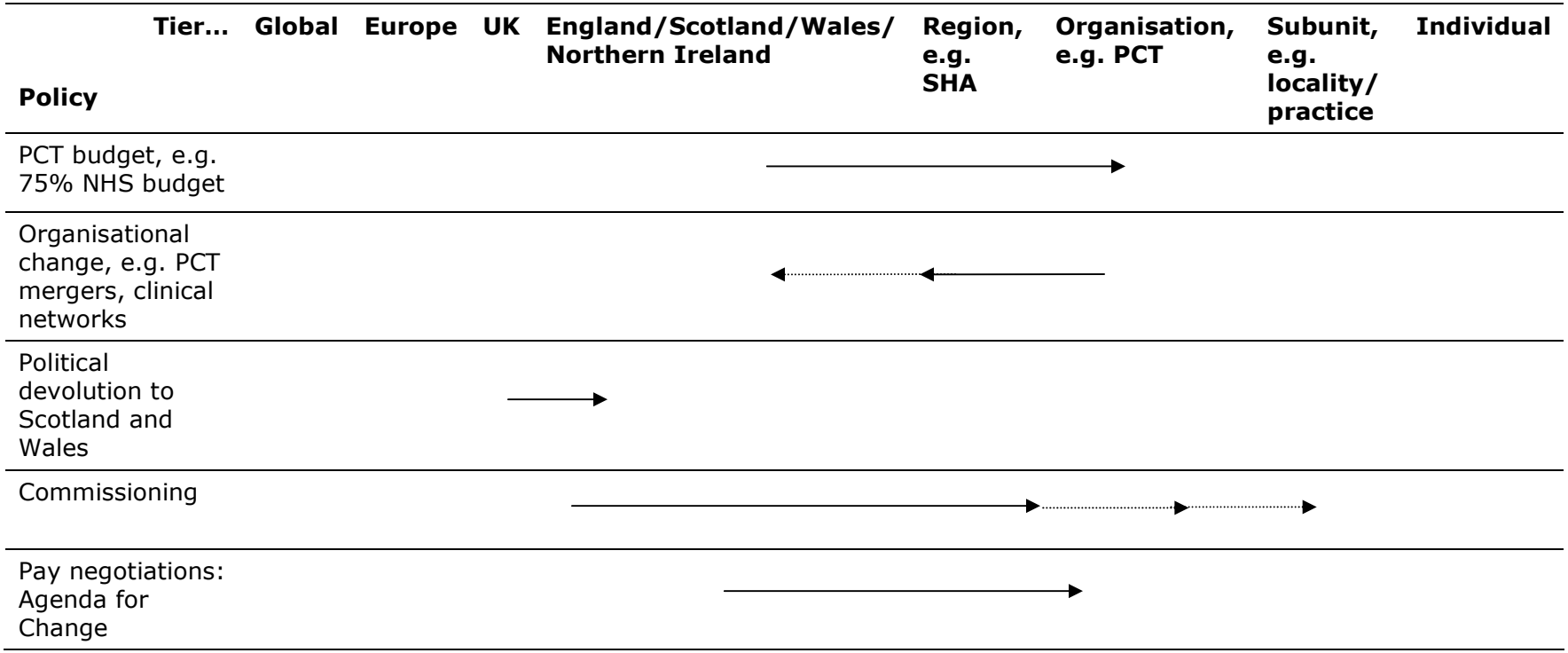
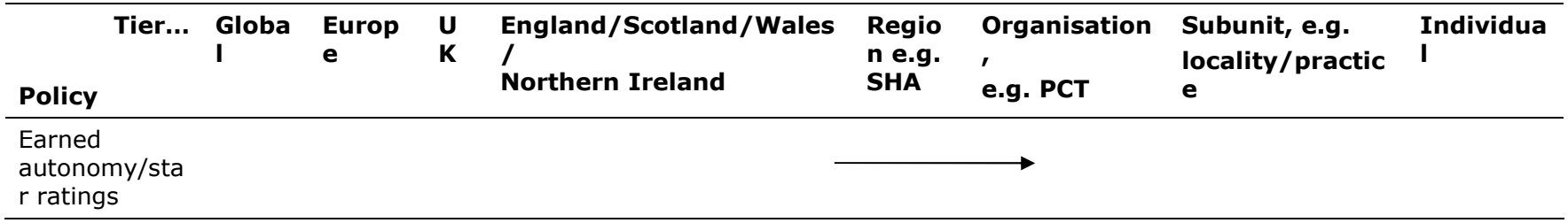


Figure 7 Process (decisions)



Foundation trust	→
Patient choice	→
Clinical governance	→

Figure 8 Outcomes (patient health, targets, etc.)

Tier… / **Policy**	**Global**	**Europe**	**UK**	**England/Scotland/Wales / Northern Ireland**	**Region, e.g. SHA**	**Organisation, e.g. PCT**	**Subunit, e.g. locality/practice**	**Individual**
Payment by results					←			
Performance management: targets and performance indicators					←			
Inspection and regulation, e.g. CHAI/ Healthcare Commission, monitor					←			
Evidence-based policy. e.g. NICE		⇠		←				

4.4 Conclusion

Policy under New Labour is extremely difficult to pin down in terms of its effect on centralisation and decentralisation. This demonstrates the extreme care we must take when attempting to assess whether particular policy initiatives are centralising or decentralising – they may often be both, depending on whether we are looking at their implications in terms of input, or process, or outcome.

The flurry of activity in health policy since 2000 especially also makes it incredibly difficult to establish on overall picture of whether we can say the NHS is now more decentralised than it was. This is because particular policies seem to often lead us often in very different directions; if we were to map the effects of patient choice, for example, we would have to examine its potential for decentralising processes through moving the selection of secondary care treatment as close as possible to the individual patient. But at the same time as this, there are competing centralising tendencies for clinicians in attempting to manage the process so that the best evidence is incorporated into the clinical decision, and this is potential force, at least, of the isomorphism of health provision, and at most a strong centralising tendency. Presenting the overall policy direction as either centralising or decentralising is therefore fraught with difficulties. The figures in this section clearly show that both are occurring and thus discussions of policy need to move beyond the rhetorical discussion of decentralisation and capture specific nuances of specific policies.

In addition to this, it might be more helpful, following Jessop (1999, 2002), to consider a movement from national to postnational level rather than from centralisation to decentralisation. This is because it permits the possibility of showing how policy might also move upwards from the national level as well as down. Writers such as Pollock (2004), for example, suggest that much of the impetus towards patient choice in present policy comes from Government commitments in other forums to deregulate the rather closed (to the private sector) nature of health care in the UK, requiring us to think of the influence of transnational effects on UK health policy. Equally, as European Union health policy becomes more coherent and specified, it has the potential to have a considerable effect upon the NHS. Policy is therefore becoming postnational in the sense of it becoming more localised (and we must certainly consider the effect of devolutionary policies in Scotland especially in these terms), but also more multinational – with the second movement difficult to capture in the centralised/decentralised terminology.

Section 5 Analysis of the evidence

5.1 Introduction

In this and the next section the extant evidence is reviewed and then applied to the NHS in England. The analysis utilises the Arrows Framework described in Section 2. This framework extends previous conceptualisations of decentralisation to make it more relevant for health care services (and potentially other sectors) by including the individual as the furthest limit of decentralisation. The Arrows Framework also incorporates a new approach to identifying what is being decentralised. Other frameworks have primarily addressed the *where* (organisational/spatial hierarchy) but have not examined the *what* (what properties are being decentralised) with clarity. Much of the evidence views decentralisation as a uni-dimensional in that previous studies have taken the concept of decentralisation without specifically addressing exactly what was being decentralised. As a result studies tended to view decentralisation in organisational terms. If decentralisation is to be used as a unit of analysis more clarity is required about what is being decentralised, as well as defining from and to where it is being decentralised.

In this report we have presented a framework that separates inputs, processes and outcomes as a way of bringing further clarity to the concept of decentralisation. It is important when discussing fiscal decentralisation, for example, to identify whether resource inputs are decentralised (input), whether there are specific guidelines for how the resource should be used (process) and whether there are controls over what resources and how much of it should be spent on specific things (outcome). More importantly, given the complexities that arise in discussing decentralisation, it is important to examine the inter-relationships between the decentralisation of different sorts of inputs, processes and outcomes. Of particular interest is the relationship between the three strands. For example, what is the cumulative and catalytic effect of decentralisation across two or more strands? In addition, it is important to weigh up the relative impact of one strand vis-à-vis the others. Is one strand more important than the others? In terms of tracking from where and to where our framework includes a clear recognition that any analysis of decentralisation should include an individual context – whether this is the professional, the individual patient or a member of the public.

The framework is particularly useful as it enables comparisons to be made between and within policies. For example, policies can be compared over time, such as the difference between *Working for Patients* and current Government health policy (see Sections 3 and 4). Current policies can also be compared, such as practice-based commissioning (decentralising) and national service frameworks (centralising). It is also possible to make comparisons within policies

such as patient choice where, for example, the outcome is centrally specified in terms of the range of choices but the process is left to PCTs.

The review of extant evidence presented in this section uses the organisational performance criteria as set out in the research brief together with the addition of two other criteria (see Section 2). The review highlights a number of key points about the nature of the evidence and its value to informing policy and practice on decentralisation. The evidence review is organised by criteria of specific areas of performance criteria according to the SDO and outlined in Section 2. Each performance criterion is discussed in terms of the assumptions defining its association with decentralisation, caveats linked to these assumptions, evidence supporting or challenging these assumptions and an overall assessment of the balance of evidence. Although the analysis has been separated into the separate performance criteria, there are inevitable links and overlaps between each. For example, allocative efficiency, responsiveness and accountability share similar assumptions and caveats. There are also relationships between the criteria. For example, outcomes are dependent on the effectiveness of other criteria.

In order to examine the inter-relationships between these variables, Section 6 synthesises the evidence to draw out key lessons about the relationship between decentralisation and the organisation and performance of health care systems in England. Sections 5 and 6, therefore, combine these two elements of the review to test the framework and to indicate gaps in our knowledge and policy/practice implications.

5.2 A review of the extant evidence

As discussed in Section 1, given the nature of this review we could not apply strict methodological criteria such as hierarchy of evidence relying solely, for example, on high-quality research papers. One general problem in the literature is that when studies examine decentralisation they often use ill-defined criteria as their basic assumptions to test another criteria (e.g. decentralisation is more democratic, which therefore leads to more accountability). A further problem in appraising such evidence, given the need for multiple evaluative criteria and the multi-faceted nature of decentralisation, is identified by Bossert (1998), who argues that:

> *There is no clear evidence to suggest that we know what combined package of policies can maximise the achievement of the objectives of equity, efficiency, quality and financial soundness.... There are some choices we have reason to believe are effective in reaching health reform objectives, either by strong theoretical logic or experience in other countries.*
>
> Bossert (1998: 1522)

The sections are, therefore, structured around a process of filtering the evidence. This section examines the assumptions about the impact of decentralisation on health care organisation and performance and what evidence exists to support

such assumptions. The relevance and transferability of the evidence to the NHS in England are discussed in Section 6.

5.2.1 Assumptions about decentralisation

A range of assumptions about the impact of decentralisation on organizational performance was identified in Sections 2 and 4. The assumptions identified in our initial literature search were contextualised within the organisational performance criteria identified by the SDO (see Tables 1 and 2). The majority of assumptions about decentralisation are linked to positive organisational performance but at this point decentralisation was viewed as a uni-dimensional concept. As we argued in Section 2, it is important to be clearer about both the where and what of decentralisation. We introduced the Arrows Framework which splits the what into the decentralisation of inputs, processes and outcomes. Thus, in examining these assumptions we need to extrapolate the assumptions to see what they say about the inputs, processes or outcomes associated with each organisational performance criterion.

In Table 7 we identify whether assumptions about decentralisation map onto the inputs, processes and outcomes framework against each of the organisational criteria reviewed in the previous section. This suggests that even when extrapolated across the different dimensions of decentralisation the assumptions still hold true. This reflects the general discussion in the literature and also in policy rhetoric about the benefits of decentralisation identified in Sections 2 and 4. The table is based on assumptions about whether decentralisation improves or worsens organisational performance, or whether this is unclear. However, a note of caution is expressed by De Vries (2000: 193), who highlights that the same arguments are sometimes used in favour of both the decentralisation and centralisation of public policy and that in different countries opposite arguments are used to support the same claim.

5.2.2 Theoretical propositions

In order to test these assumptions we explored the theoretical literature to examine whether there are specific theoretical propositions that support the various assumptions. The theoretical evidence is a lot weaker. The discussion in Section 2 of the definitions and frameworks for decentralisation shows that there is no single theory of decentralisation and that a key problem with decentralisation is that its explanation relies invariably on another set of contested concepts (e.g. power, authority, autonomy). However, decentralisation features in a number of bodies of literature and these draw on a range of theoretical constructs to discuss decentralisation. In general, though, there are not strong theoretical propositions that support specific outcomes with decentralisation. The exception is perhaps in relation to fiscal federalism. In Table 8 we have summarised the main propositions made about decentralisation but using the Arrows Framework to map the theory in relation to inputs, processes and outcomes against each of the performance criteria. Table 8 demonstrates

whether there are theoretical propositions that support, or do not support the assumptions identified in Table 7.

5.2.3 Availability of evidence

Our search strategy identified over 500 papers and studies. Following an initial sifting process when all abstracts were reviewed by two or more members of the research team 205 papers were selected for inclusion in the review. Results from one database search was screened by all four team members, and a consensus on relevant articles emerged through discussion. In addition we examined a number of papers and books that discussed theories and concepts of decentralisation. Previous discussions and reviews of decentralisation and health have identified that there is little high-quality available evidence suitable for policy and practice (Atkinson *et al.*, 2000; Saltman *et al.*, 2003; Levaggi and Smith, 2004; Rubio and Smith, 2004).

As discussed in Section 1 our review searched a wide range of literature for papers and studies on decentralisation. Much of the literature, especially as it relates to health care, refers to studies in developing countries. There are few studies of decentralisation in developed countries and most of these refer mainly to local government. Some of these studies are relevant to UK health care systems and these are given more weight. However, the lack of high-quality studies and empirical evidence on many aspects of decentralisation and organisational performance are in themselves important findings of this review. It is significant to note that many apparently relevant studies (e.g. 1990s internal market evaluations) were not identified in the evidence search because they did not explicitly use decentralisation as an analytical criterion. This highlights the need in future research studies to recognise specific aspects of decentralization, as illustrated in our Arrows Framework. The selection of studies for inclusion in this review was based on two tests of quality and relevance to the NHS in England.

5.2.4 Quality and relevance of the evidence

In assessing the quality of the evidence we used three general criteria. The first was the quality of the study reviewed in terms of other evidence hierarchies (Arksey and O'Malley, 2005). In Section 1 we outline our approach for extracting papers to include in our review. Using an assessment based on a conceptual hierarchy of evidence combined with measures of methodological quality, quality of journal, etc. we classified the evidence as strong, medium or weak. Based on this assessment of quality and the extent to which assumptions are supported by theory Table 9 summarises the strength of the evidence in support of whether decentralisation produces the outcomes that are assumed in the literature (see Table 7).

Table 7 Assumptions about whether decentralisation improves or worsens organisational performance

Criterion… Aspect decentralised	Outcomes	Process measures	Staff morale	Humanity	Equity	Responsiveness; allocative efficiency	Technical efficiency	Adherence	Accountability
Inputs	+	+	+	?	−/+	+	+	−	+
Process	−	+	+	+	−/+	+	+	−	+
Outcomes	+	+	+	?	−/+	+	+	−	+

+, Improved organisational performance; −, worsened organisational performance; ?, unclear.

Table 8 Decentralisation – theoretical propositions

Criterion… Aspect decentralised	Outcomes	Process measures	Staff morale	Humanity	Equity	Responsiveness; allocative efficiency	Technical efficiency	Adherence	Accountability
Inputs	√	?	?		√	√	√	?	√
Process	√	√	√		√	√	√	?	√
Outcomes	√	?	√		√	√	√	√	√

√, Support the assumptions in Table 7; ?, no clear link between theory and assumption; blank, no theoretical proposition.

Table 9 Decentralisation – the quality of the evidence

Criterion… Aspect decentralised	Outcomes	Process measures	Staff morale	Humanity	Equity	Responsiveness Allocative efficiency	Technical efficiency	Adherence	Accountability
Inputs	+				+	?	++	?	?
Process	+	+	?		+	?	+	?	
Outcomes	+	?	−	−	+	++	+	+	++

Evidence: ++, strong; +, moderately strong; −, moderately weak; ?, mixed quality; blank, insufficient.

A common problem in applying the evidence is the lack of a precise definition of decentralisation. As De Vries (2000) argues, 'the same arguments are sometimes used to advance either claim and…in different countries opposite arguments are used to support the same claim' (De Vries, 2000: 193). Furthermore, he goes on to argue that:

> *…The main characteristic of decentralisation policies, namely that some actors lose power and others gain power…are found in metaphors like 'increased efficiency', 'democratization of policy processes' and 'effectiveness'.*
>
> (De Vries, 2000: 194–5)

Similar points have been made by other authors. Atkinson (1995**)** comments that the:

> ***…****range of technical, developmental and humanitarian goals involved [in decentralisation] are more difficult to nail down and measure than assessing whether outcome and efficiency goals have been met.… These multiple goals are reflected in multiple constituencies…and it is not clear who should define what represents effectiveness or quality or acceptability and so forth.*
>
> (Atkinson, 1995: 498)

A further complexity raised in the literature is that the advantages and disadvantages of administrative arrangements are not necessarily a property of the arrangements as such (Ostrom, 1974; Ostrom and Ostrom, 1977). So for De Vries, 'Thinking in terms of centralisation and decentralisation is, in this conception, less useful to the study and composition of complex, multidimensional administrative practice, as it restricts these complex relations to a one-dimensional vertical relation' (De Vries, 2000: 201).

This raises questions about the nature of the evidence. Even where the evidence is of high quality in a study that is well designed the problem is that the variables used may lack sufficient clarity to be of any real use in analysing the effects of decentralisation. The discussion in Section 2 raises a number of questions about how decentralisation and the associated concepts are defined, concluding that there is not sufficient conceptual clarity for terms such as decentralisation, power, authority, autonomy, etc., to be used as independent or dependent variables. As we have seen, decentralisation is not a uni-dimensional variable. The following sections therefore review the evidence by each of the performance domains identified in Section 2.

5.3 Outcomes

5.3.1 Introduction

According to Rubio and Smith (2004: 2) it is surprising that little attention has been paid to the evaluation of decentralisation in the health care sector. There are relatively few studies that examine the relationship between decentralisation and outcomes. However, these studies tend to be rather different to the bulk of studies that examine other criteria, in that they tend to be quantitative, focusing

on the relationship between outcomes as the dependent variable and decentralisation as the independent variable, with a range of control variables. Robalino *et al.* (2001: 2) note that despite compelling arguments in favour of decentralisation there is little evidence that countries which have decentralised management and budgets within their health systems have improved health outcomes. They point out that qualitative studies provide 'mixed results', and the magnitude of the impact of decentralisation on health outcomes remains unquantified, so 'this paper is an attempt to fill, in part, the void of quantitative measurement of the impact of decentralisation' (Robalino *et al.*, 2001: 3).

The main studies reviewed in this section are very diverse in terms of context, data, and dependent and control variables. Khaleghian (2003) examines immunization in developing countries. Robalino *et al.* (2001) focuses on infant mortality in a panel of low- and high-income countries covering the period 1970–95. Rubio and Smith (2004) analyse infant mortality for a panel of the 10 Canadian provinces for the period 1979–95.

5.3.2 Assumptions

The quantitative studies tend to take a public economics or fiscal federalism approach. Economic arguments in favour of decentralisation include better local information, clearer knowledge about preferences, improved local co-ordination, increased efficiency, and more accountability, equity, innovation and competition. However, there are also economic arguments in favour of centralisation, some of which directly contradict the previous arguments such as flawed information, economies of scale, transaction costs, spillovers, equity, macroeconomy and competition (Levaggi and Smith, 2004; see also De Vries, 2000). Rubio and Smith (2004) note that fiscal federalism theory maintains that decentralisation of public goods and services with localised effects is likely to produce efficiency gains. Robalino *et al.* (2001) focus on the route through improved technical and allocative efficiency. Khaleghian (2003) argues that many of the proposed benefits of decentralisation are based on the premise that it brings local decision-makers closer to the constituencies they serve, but many of the inherent assumptions such as information, channels for the public to express wants and preferences and the incentive environment motivating decision-makers to respond are open to question, especially in developing countries. Two conclusions follow from these points. First, improved outcomes are a result of improvements in other criteria such as efficiency. It is important to examine the mechanism through which improved outcomes occur. For example, if it is technical efficiency, then if there are no clear improvements in technical efficiency as a result of decentralisation (see Section 5.6), then it is hard to see how this can feed into improved outcomes. Second, the context may vary significantly. Particular decentralisation strategies might lead to improved outcomes in some settings, but not in others (see Section 6). Putting these two together takes us close to the equation of 'realistic evaluation' that 'context=mechanism=outcome' (Pawson and Tilley, 1997).

5.3.3 Caveats

The study authors are very aware of the deficiencies in their data. Robalino *et al.* (2001: 3) admit that their measure of fiscal decentralisation – the ratio between total expenditure of central and local government – is 'only a rough proxy for the fiscal administrative process'. Khaleghian (2003) uses three measures: subnational expenditure as a share of total government expenditure, health spending as a proportion of all subnational expenditure and a binary variable taken from the Database of Political Institutions (Beck *et al.*, 2000) representing the presence of subnational taxing, spending or regulatory authority. It is admitted that 'decentralisation is a complex phenomenon, and the use of quantitative methods with a small number of control variables runs the risk of over-simplification' (Khaleghian, 2003: 16). Rubio and Smith (2004: 6) remark that all existing empirical studies on the relationship between decentralisation and health outcomes have evaluated the effect of public sector decentralisation as a whole on health performance, but 'a precise measure of health care decentralisation is difficult to find. Health care decentralisation is a complex phenomenon encompassing a number of political, fiscal and administrative dimensions. Many of these aspects are, yet, unquantifiable'. They continue that 'up to now the only available quantitative measure of health care decentralisation is a fiscal one', but 'fiscal indicators of decentralisation are only a rough guide, however, in the sense that local spending decisions may not be autonomous' (Rubio and Smith, 2004: 7; see Section 2). Outcome indicators used are infant mortality rates (Robalino *et al.*, 2001; Rubio and Smith, 2004) and immunisation rates (Khaleghian, 2003).

All the quantitative studies use control variables, but the selection is generally not justified, and they vary between studies. Khaleghian (2003) uses a range of economic, social and political variables, taken largely from the World Bank's World Development Indicators data-set. Robalino *et al.* (2001) also include variables on gross domestic product (GDP) per capita, corruption, political rights and ethno-linguistic fractionalisation. Rubio and Smith (2004) include an indicator of social capital (education) and a measure of needs (low birth weight). It is not clear whether a different set of control variables may have changed the results of the studies. This is related to the problem of causation. It is rare that decentralisation strategies operate in isolation, and it may be difficult to disentangle their effects from the effects of other policies (see Khaleghian, 2003: 9).

However, the most important point is the crudity of the independent variable. The most common measure – local spending as a proportion of national spending – is a crude measure of fiscal decentralisation, and fiscal decentralisation is one concept of the wider dimensions of decentralisation (see Section 2). However, the outcome studies discussed in this section are those few that attempt – however crudely – to measure decentralisation.

5.3.4 Evidence that decentralisation improves outcomes

Rubio and Smith (2004: 5) state that 'there is little evidence that countries with a more decentralised health system have better health outcomes', but then review studies which find that 'on the whole these studies find a positive association between fiscal decentralisation and some indicators of health outcomes'. Yee (2001) finds a beneficial relationship between several indicators of health care performance, including mortality rates and fiscal decentralisation for panel data for 29 Chinese provinces for the period 1980–3. Ebel and Yilmaz (2001) report that intervention by sub-national governments is positively related to increased immunisation rates for measles in six developing countries.

Robalino *et al.* (2001) report the results of six models that generally find that fiscal decentralisation is likely to improve health outcomes. However, whereas higher fiscal decentralisation is consistently associated with lower mortality rates, its benefits are particularly important for poor countries. Khaleghian (2003) finds that decentralisation is associated with higher immunization coverage rates in low-income countries, but lower coverage in middle-income countries. There is only one that gives information for high-income countries, and that examines variations within rather than between countries. Rubio and Smith (2004) suggest that in Canada decentralisation did have a positive and substantial influence on infant mortality.

5.3.5 Evidence that decentralisation worsens outcomes

There is little empirical evidence that decentralisation decreases outcomes. As already noted, Khaleghian (2003) finds that decentralisation is associated with lower immunization rates in middle-income countries, but there is no evidence for high-income countries. However, Khaleghian (2003) argues that *theoretical* studies of decentralisation generally predict a negative impact for services with inter-jurisdictional externalities and public good characteristics (Bardhan and Mookerhjee, 1998; Besley and Coate, 2003), and immunization has aspects of both.

5.3.6 The balance of evidence

Whereas the balance of evidence suggests that decentralisation is associated with better outcomes, the implications for the British NHS are far from clear. The evidence is limited in quantity, and covers a wide range of contexts. In particular, apart from Rubio and Smith's (2004) study of Canada, most of it is based on low- and middle-income countries. Whereas the sophistication of the statistical modelling is impressive, most of the studies admit that the measure of decentralisation used as the independent variable is extremely crude. Most of the studies use general local-government fiscal measures rather than measures of health care decentralisation (but see Rubio and Smith, 2004). Moreover, there is little justification for and consistency in the choice of control variables, which means that different control variables might have led to different conclusions.

Whereas the study of Canada (Rubio and Smith, 2004) suggests a positive relationship between decentralisation and infant mortality, it would not be wise to assume that this result can be generalised to wider health outcomes in very different health systems such as the UK.

5.4 Process measures

5.4.1 Introduction

Process measures attempt to capture perhaps the most difficult element to measure of organisational activities – those aspects that transform inputs into outputs. In the organisational literature, processes are what add value to the organisation (Barney, 1995) and, as such, include elements that can be notoriously difficult to measure or capture, coming somewhere before outputs, although processes are clearly implicated in the resulting outputs. In service-based organisations, such as health care, where outputs can be extraordinarily difficult to define, processes often form the main basis of measurement in attempts to capture what the organisation does (Carter *et al.*, 1992). By processes, then, we mean the activities that lead to output generation.

5.4.2 Assumptions

Decentralisation is assumed to have a number of impacts on process measures, with the advantages of decentralised organisations usually being couched in terms of the following (taken from Osborne and Gaebler, 1992: 253).

- They are far more flexible and can respond quickly to changing circumstances and customers' needs.
- They are far more effective than centralized institutions…they know what actually happens.
- They are far more innovative…innovation happens because good ideas bubble up from employees, who actually do the work and deal with the customers.
- Decentralized institutions generate higher morale, more commitment and greater productivity…, especially in organizations with knowledge workers.

Many of these points are effectively expressed in terms of the assumption that centralisation leads to the opposite in each case – it results in 'over-regulation' (De Vries, 2000: 193), for example, leading to a reduction in responsiveness, as well as suggesting that administrative and 'red tape' costs could be substantially reduced though greater decentralisation (Enthoven, 1991). In addition to this, decentralisation is often held to be central to establishing a more democratic means of running health services – a justification used in the case of French reforms in the 1990s (Schedler and Proeller, 2002), which were justified using the legitimisation of 'modernisation' (Maddock, 2002).

Decentralisation is also presented as a means of achieving greater, rather than less, co-ordination than centralisation is able to achieve. From the theoretical perspective of game theory this is because it becomes rational for individuals to adopt a policy of co-operation towards one another rather than relying upon a central state organisation (Carter, 1999). Alternatively, network theorists suggest that complexity can be better managed through decentralised strategies because 'emergent' means of dealing with the difficulties of public service delivery will appear (Kickert *et al*., 1997; Kickert, 2001). As such, decentralisation becomes a means of removing the regulation often associated with centralisation, and improving communication between individuals in a 'network' or 'N-form' organisation (Ferlie and Pettigrew, 1996). Equally, decentralisation can be a form of marketisation, a means through which services become more accountable to their 'consumers' through greater choice (Department of Health, 2003).

5.4.3 Caveats

Much contemporary management theory, then, appears to favour decentralisation, but a number of issues must also be faced.

First, there is the difficulty in finding appropriate process measures for an organisation as complex as the NHS. The problems of using inappropriate measures, especially based around attempts to capture organisational performance in the NHS, are well documented (Goddard *et al*., 1999), and there are dangers that utilising inappropriate measures can lead to distorted clinical priorities (Smith, 2002; Greener, 2003).

In addition to these problems, there is a central need for health services to be co-ordinated to ensure that no gaps in service delivery appear (Carter *et al.*, 1992), and so we must be extremely clear in decisions about the extent and scope of the powers that are decentralised in a public service (Clarke and Newman, 1997). There is also the danger that decentralisation can lead to a greater duplication of administrative functions as control is passed to a larger number of organisations (Le Grand *et al.*, 1998), possibly removing economies of scale and scope achieved in larger purchasing functions, for example (Jessop, 1999). Certain policies require technologies that will involve large-scale investments and economies of scale (Walsh, 1996 p.72), and these may not be achieved where policy is decentralised beyond the point where these economies are no longer possible. There is likely to be a trade-off, in other words, between responsiveness and economies of scale and scope.

Overall, a significant caveat is one of context – we must be extremely careful in assuming that decentralisation suits as an all-purpose solution, and that 'going down to the local' (Atkinson *et al.*, 2000) with every service is appropriate, while ignoring political and social factors.

5.4.4 Evidence in favour

Germain and Spears (1999), in a study examining management outside the public sector, suggest that 'Strategic decentralisation correlates with quality management because delegation over issues affecting the entire firm…creates a general work environment that empowers employees' (p.386). As such, this evidence would suggest that decentralisation leads to an improvement in processes through its psychological impact upon staff morale (see Section 5.6), a view that is also suggested by the Dutch public administration literature (Klijn *et al*., 1995; Klijn and Koppenjan, 2000).

Hudson (1999) presents similar findings in relation to an early study of primary care groups, suggesting that achievements amounted to 'some improvements in morale, better inter-professional relationships and minor changes to some community-based services' (p.170).

Finally, the importance of context is again raised as a crucial factor in achieving success through decentralisation. Putnam (1993), one of the most influential writers on community and local democracy, suggests from his studies in Italy that decentralisation will work well to improve local democracy in districts that already have a number of civil, community-based organisations, but rather less well where this is not the case. This appears to highlight the importance of existing infrastructure – where this is absent, decentralisation may be problematic (Atkinson *et al.*, 2000).

5.4.5 Evidence against

Boyne (1996) suggests that a number of factors concerning local government performance improve with scale; 'Councils with a higher level of output provide a better service at lower cost' (p.59). Boyne's work links output with process, suggesting that organisational form can be linked, in terms of scale, to the success of its output. Boyne makes clear that population size is not an especially good measure of scale, with performance less clearly related to this measure than to more sensitive indicators for the specific area concerned – suggesting that we must be extremely careful in how we define scale when examining decentralisation. Other writers suggest that finding the level of decision-making that is optimal is the 'fantasy of the appropriate scale' (De Vries, 2000: 203) as large populations in one country may be comparatively small to another, suggesting that both 'centralization and decentralisation are relative concepts' (ibid), and that, when it comes to process measure improvement and decentralisation, what is 'missing in most of the theories is an empirical base' (ibid: 217). Powell (2003: 66) notes the confusion over the optimal size for purchasing in the NHS. As such, attempting to find appropriate organisational size, to base assumptions around reforming processes through scale may not lead to a better output.

In the limited amount of empirical evidence that does exist, an 'analysis showed that decentralisation could not be claimed to make any important difference to

health service performance' (Atkinson, 1995: 496), whereas detailed work from Thomason *et al.* (1991) highlights a fundamental contradiction between the desire to decentralise on the one hand, and the need to promote equity in the distribution of services and resources on the other. The difficulty appears to be that politicians cannot resist getting involved in decision-making when it becomes politically expedient to do so (Klein, 1998: 68; Boyne *et al.*, 2003).

5.4.6 Balance of evidence

Theory suggests there are a number of process-associated benefits to decentralisation, but we lack the empirical evidence to support the majority of them. We can perhaps attribute this to two specific problems:

1 a lack of empirical evidence; there would appear to be a need for detailed studies of decentralisation process to determine whether the many claims made by Osborne and Gaebler (1992) can be empirically borne out;

2 the need for the political centre to interfere in the running of health services so that, where decentralisation does occur, an additional effect is introduced with the government keen to take control of processes again where problems might begin to occur.

In all, there is strong theoretical evidence for an improvement in processes coming from increased decentralisation, and some of the claims made by this literature concerning improvements in staff morale can be borne out to a degree. However, there is also evidence that increased decentralisation (or at least reduced scale) can result in a reduction in indicators concerned with service improvement and cost, signalling that scale and scope economies in the public sector remain significant, and that reducing size or scale beyond a particular point can actually reduce performance. At the same time as this, however, we have a significant number of authors warning us that attempts to find an optimal size or scale for public services is largely a waste of time, as history and geography show us that what we might regard as a decentralized service in one time or space would be a centralized service in other, and so the need to define scale rather more precisely than is often the case is extremely important, as is the need to take the existing contextual situations of localities into account.

5.5 Humanity

5.5.1 Introduction

There is no clear definition of humanity within health care texts and its use in health policy is also limited. In general usage humanity is either a collective term for the human race or it is used in terms of the way individuals should be treated; for example, with respect for their humanity. *Webster's Dictionary* describes humanity as 'the quality or state of being humane'. A clearer definition of humanity from the *Oxford English Dictionary* includes 'The character or quality of being humane; behaviour or disposition towards others such as befits a human

being – civility, courtesy, politeness, good behaviour; kindness as shown in courteous or friendly acts, obligingness'. Thus humanity can be seen as distinct from the concept of responsiveness (see Section 5.7), is clearly associated with both this and accountability (see Section 5.10), but is particularly related to being seen to do the right thing as defined by what are seen as good standards of conduct and practice by the community. One useful concept that may be applied that is increasingly being used in health care is the concept of human rights. Within this context the WHO (Gostin *et al.*, 2003) has identified eight domains relating to responsiveness in health care services that are also associated with humanity:

- respect for the dignity of persons,
- autonomy to participate in health-related decisions,
- confidentiality of information,
- prompt attention,
- adequate quality of basic amenities,
- clarity of communications to patients,
- access to social support networks and family and community involvement,
- choice of health care provider.

Clearly respect for the dignity of persons, autonomy, confidentiality, prompt attention, adequacy, clear communication and social support have direct relevance to the concept of humanity in respect of health care provision. In relation to decentralisation in the NHS this can be translated into the extent to which NHS organisations focus on the well-being of the population/service users. This will include whether closeness to the community or patient reduces the feeling of remoteness and the extent to which organisations may feel accountable to local communities or service users for their conduct. Humanity may also relate to the way organisations treat their own staff in terms of providing humane places and organisations to work within.

5.5.2 Assumptions

Within the literature on decentralisation there is a clear assumption that decentralised agencies are closer to their communities, as they are seen to be more responsive to local needs, are seen as being more openly accountable and improve humanity as greater attention is paid to individual patient needs. Decentralised organisations are also closer to the public/individuals and are therefore less remote and more user-friendly. The key assumption is that local organisations will therefore be more likely to act in the best interests of their local populations or their patients. While this includes being responsive to local needs (Meads and Wild, 2003), Burns *et al.* (1994) also suggest that in a local-government context it strengthens local democracy, increases visibility and community development and encourages political awareness. Furthermore, De Vries (2000) argues that decentralisation also enhances civic participation, neutralises entrenched local elites and increases political stability. However, these

aspects may be less important to the NHS. In a service with a high degree of professionalisation, such as health care, it is also assumed that it is important for individual professionals to have a high degree of autonomy in their dealings with individuals – in this case patients (Harrison *et al.*, 1992; Hill, 1997). Thus for the NHS humanity as a performance criterion relates to the way it treats patients, staff and the wider public. Manifestations of humanity in the NHS include the *Patient's Charter*, issues of consent and the importance of a public service ethos.

5.5.3 Caveats

The lack of clarity of definition means that relating evidence to this outcome is difficult. There is some question over the extent to which the concept of humanity relates to the individual, to communities or to the public more widely. Bossert (1996) has argued that the extreme expression of decentralisation is that the patient is the ultimate object of this process and the framework used within this report reflects this conceptualisation. If the patient is the ultimate expression of decentralisation the way that the patient is treated is also of importance.

5.5.4 Evidence that decentralisation promotes humanity

Granting greater autonomy to decentralised agencies enhances trust. Trust is crucial when performance is ambiguous and behaviour is unobserved (Perrone *et al.*, 2003). This is particularly relevant to health care where there is a high degree of autonomy granted to health care practitioners to treat patients based on the patient's needs and the professional's experience and skill. Decentralisation has also been shown to enhance worker empowerment (Sheaff *et al.*, 2004a). There is also evidence to suggest that local health-agency board members have a greater sense of responsibility to the local community (Ashburner and Cairncross, 1992, 1993).

5.5.5 Evidence that decentralisation is detrimental to humanity

One of the key arguments against decentralisation and humanity derives from democratic theory. In particular, minorities may be disadvantaged by dominant local groups (Bjorvatn and Cappelan, 2002). When areas are small the minority groups have fewer members and thus may be more easily muted or dominated by local majorities. However, when connected in a national context such minority groups may have a more powerful voice.

Two interesting perspectives suggesting that decentralisation does not increase local perspectives of humanity come from Sheaff *et al.* (2004a), who found evidence that decentralisation involves an extension of hierarchical control, and Hales (1999), who found that local managers may be unwilling to use decentralised powers and/or may be conditioned by former centralised regime. In addition, although worker autonomy and empowerment may be increased it is

not clear within a highly regulated environment whether trust is eroded, leading to a loss of respect.

5.5.6 Conclusion: the balance of evidence

There is no direct evidence to support the assumption that decentralisation increases humanity based on the criteria defined by the WHO. There is some evidence suggesting that local boards may have an increased responsibility to their local community. However, there is evidence to suggest that decentralisation is a form of centralisation achieved by weakening local power. In addition, democratic theory has consistently portrayed the problem of minority views as a problem with decentralised units. This would seem to suggest, and there is evidence in the participation literature (Lupton *et al.*, 1998) as well, that in decentralised units there will be dominant groups and groups that are unable to get their wishes recognised. Interestingly, in the development of governance arrangements for foundation hospitals the concerns centred on the perceived problem that specific minority-interest groups would be able to dominate the governance arrangements of the trusts and fairly complex governance frameworks were established to guard against this (Klein, 2003a). While there is evidence to suggest that closer partnerships with patients improved health care (Coulter, 1997), there is little empirical evidence demonstrating that professional autonomy is equated with improved communication and respect for patients. In fact, some studies suggest that the opposite may be true (Rogers *et al.*, 1999).

5.6 Equity

5.6.1 Introduction

Equity is widely adopted as an evaluative criterion in health policy including studies of decentralisation. Its definitional ambiguity and feasibility raise important questions in terms of weighing the evidence on the impact of decentralisation.

5.6.2 Assumptions

There are two basic and opposing assumptions concerning the impact of decentralisation upon equity.

The first and probably the most widely held is that decentralisation reduces equity (and/or increases inequality) by enabling greater variations in health service access, provision or use (e.g. Kleinman *et al.*, 2002: 28; López-Casasnovas, 2001: 18; Rubio and Smith, 2004: 4). As Levaggi and Smith (2004) argue:

> *Unfettered local government may lead to greatly varying services, standards, taxes, user charges and outcomes. These variations may compromise important equity objectives held at a national level....*

(Levaggi and Smith, 2004: 6)

Local managerial autonomy is increased by decentralisation and, in the absence of a central co-ordinating function or of central directives, the potential variations are likely, indeed bound, to occur.

The second assumption presents the opposite argument. Decentralisation increases equity (and reduces inequality) by enabling local organisations to meet better the needs of particular groups (such as minority communities or vulnerable groups) whose needs were previously poorly served by the former 'centralised' system (e.g. Bossert, 1998). For example:

Local governments may be better placed than national governments to ensure that resources are allocated equitably within their borders.

(Levaggi and Smith, 2004: .5).

Decentralisation might also enable:

Greater equity through distribution of resources towards traditionally marginal regions and groups.

(Bossert and Beauvais, 2002: 14)

The use of targeted funding (such as deprivation payments) is a common redistributive mechanism in this strategy.

These different assumptions largely rest on where the goal of equity is being pursued: centrally/nationally or locally.

5.6.3 Caveats

In linking decentralisation with equity impacts, several caveats are apparent. First, equity may be defined in multiple ways. Policy documents and many research papers often employ vague or ambiguous interpretations and definitions of equity (Powell and Exworthy, 2003). There is, for example, rarely an explicit recognition of the difference between equality and equity. The former represents the equal allocation of a commodity (such as access to health care) whereas the latter presumes an equal allocation modified according to criteria. In the NHS, a common criterion is need; hence, equal access is not necessarily the policy objective goal, rather equal access for equal need (Powell and Exworthy, 2000). Equity of (health) outcomes may also be a valid goal for health policy.

Another common misunderstanding concerns horizontal and vertical equity. Horizontal equity aims 'to treat like cases alike' (e.g. equal access for those in equal need) and vertical equity aims to treat 'different individuals differently' (e.g. allocating more resources to particular areas or groups; Powell and Exworthy, 2003: 59). Kleinman *et al.* (2002: 34) (citing Bramley, 2002) illustrate these definitions (in terms of grants from the centre to local authorities):

- trying to achieve 'horizontal equity' so that given types of taxpayer face similar local taxes for similar services in different localities;

- trying to achieve 'categorical equity' by encouraging different localities to provide similar standards of service in key areas like education;
- trying to correct the vertical distribution of income, particularly where local authorities are involved in redistributive services.

Finally, given the geographical organisation of the NHS, it is common to consider spatial/geographical notions of equity. However, area-based redistributive policies are often a blunt instrument in the policy-maker's tool kit (Kleinman *et al.*, 2002: 35). Moreover, other forms of equity may be relevant, including social class, gender, age and ethnicity. Consideration also needs to be given to equity aspects of health care: expenditure, access, provision, use and outcome. Often, attention is focused on ensuring equity of resource allocation, although this does not guarantee equity in other aspects.

5.6.4 Evidence that decentralisation promotes equity/reduces inequality

Evidence underpinning this assertion is often hypothetical/rhetorical. The ability of decentralised organisations to target vulnerable or minority groups is often cited as an advantage. For example,

> *Decentralisation increases ability to target improved health spending.*
>
> (Bossert, 1998: 1522).

Some commentators claim that variation per se is not bad and is indeed the price of a decentralised/devolved system. This is often cited in the case of US federalism (e.g. Leichter, 1997). Such arguments also claim that the advantages of (increased, local) autonomy are deemed to outweigh the disadvantages of (reduced) equity (Perkins and Burns, 2001).

Another aspect of this assertion relates to the greater ability of smaller scale/size of organisations to respond to the varied pattern of local need (see Section 5.8). For example, the World Bank argues that decentralisation can '…improve equity in the distribution of infrastructure as smaller governments away from the political centre gain more latitude and funding to serve their constituents' (see www1.worldbank.org/publicsector/decentralization/).

Empirical evidence of such assertions remains rather limited. Countries with long traditions of decentralisation/devolution and research programmes provide some insight into the effects upon equity although this evidence can be mixed. For example, in Spain, Rico (2000) found that there was a limited rise in (regional) inequality partly because of the constrained fiscal powers that regions enjoyed. By contrast, Quadrado *et al.* (2001) found that, in the context of health policies in the 1980s, decentralisation may have 'helped to reduce regional inequality although no firm conclusions can be drawn yet' (p.783). They note a rise in regional inequality in Spain between 1974 and 1981 but a fall between 1981 and 1991 (p.797). They suggest that this is because of an under-estimation of inequality due to spill-overs from the contiguity of provinces/regions. In the UK,

the equity objectives have never been explicitly stated by policy-makers, making evaluation problematic (Powell and Exworthy, 2003).

5.6.5 Evidence that decentralisation hampers equity/widens inequality

The notion that decentralisation adversely affects equity is widely cited (e.g. Atkinson, 2000; De Vries, 2000; Mouzinho *et al.*, 2001; Quadrado *et al.*, 2001; Levaggi and Smith, 2004). The justifications for such assertions include permissible variations resulting from autonomous decision-making, the loss of equity advantages of centralisation and the unequal distribution of health care facilities.

Variations in decision-making are likely because of the ability of autonomous organisations to diverge from previous (central, equity-promoting) policies. Some organisations may, for example, 'neglect the public health and macroeconomic consequences of their services' (Levaggi and Smith, 2004: 15).

Some justifications allude to the converse, namely that centralisation is more effective in securing equity. For example, Koivusalo (1999) stresses the need for legal powers (in Finland) to 'guarantee equitable provision'. Also, Mouzinho *et al.* (2001) argue for 'clear guidelines, monitoring and adequate resources' to minimise inequities arising from decentralisation. Walker (2002) notes central government's 'ability' to 'achieve equality'. However, it should be noted that centralisation (at whatever level) does not, in itself, ensure an equitable distribution. Uniformity at the centre (whether central or regional government) may not reflect the variable pattern of need, for example. However, some centralising pressures (such as national wage agreements or the influence of national professional bodies) do make it difficult to decentralise (Exworthy, 1998). (The shift away from uniformity in the private sector has also been problematic; Pendleton, 1994.) Moreover, equitable service (whether concerning access, provision or use) is difficult to attain in practice (Elstad, 1990; Powell and Exworthy, 2003). Decentralisation may not only lead to inequity but, in doing so, it can also weaken the role and power of the centre (Collins, 1996) and hamper co-ordination (Levaggi and Smith, 2004: 10).

Few studies distinguish between different notions of equity. For example, Levaggi and Smith (2004: 13) argue that 'a guarantee of patients' mobility can reduce inequity when the provision of hospital care is not equally distributed.'

Empirical evidence to support the claims (above) that decentralisation harms equity can be found in terms of service provision, regional inequality and the (non-)decisions of central government.

- *Service provision:* much of this evidence derives from the GP fundholding schemes in the 1990s. Smith and Barnes (2000) claimed (from other evidence) that fundholders sought to improve access to services for their patients but, in doing so, 'some inequity of provision emerged' (p.46). Another aspect of fundholding was the 'perception of increasing inequity in

[Total Purchasing Pilots]' by some health authorities (Leese *et al.*, 2001: 174). Goodwin (1998) identified 'strong reasons to believe that the practices of fundholding GPs have enjoyed better access to hospital treatment than other patients' (p.55), although he concluded that claims of cream-skimming (the preferential selection of patients by GPs) was supported by little evidence despite the potential for fundholding GPs to do so. In a different context, Grogan (1993) found that decentralisation in the USA was associated with further variations in service provision.

- *Regional inequality:* much of this evidence is from countries with strong regionalised (meso-level) structures. In Italy, Bankauskaite *et al.* (2004) note the 'high risk' of inequality between regions. Giannoni and Hitris (2002) also note that Italian regionalisation has been associated with a persistence or even widening of inequality. While health care costs have been contained, the reforms did not curb higher-spending regions. Regional differences in New Zealand were magnified by the decentralisation of purchasing structures (Barnett and Newberry, 2002). Lomas *et al.* (1997) express similar concerns in Canada. Some of these issues may emerge within the UK if/when a regional (health) agenda develops.
- *Central government policy:* De Vries (2000) argues that decentralisation poses a 'threat to the principle of equality' (p.199). Central government policies have not always promoted equity. For example, in the USA, Medicaid (supposedly aimed at providing financial assistance to the poor) has been 'so restrictive that less than half of the poor received coverage' (Sparer, 1999: 146). This was magnified by 'significant interstate variation in eligibility coverage', which raised concerns about equity. This raises questions as to how much variation or diversity is or should be permitted by central government (Klein, 2003a). Empirical evidence (including negative public perceptions) of increasing inequity (associated with decentralisation) is leading some countries (such as Finland, Canada and New Zealand) to 're-centralise'. For example, Meads and Wild (2003) note that:

> *Switzerland, which 'de-concentrated' its health services to its cantons before any other European country did anything similar, is now struggling with the continent's widest disparities in national service distribution.*

Others note the need for redistributive policies to counter the inimical effects of decentralisation upon equity (e.g. World Bank, see www1.worldbank.org/publicsector/decentralization/, p.2). To remedy inequities associated with decentralisation, Bossert *et al.* (2003) calls for an 'equity fund' to redistribute between regions and groups (p.366).

5.6.6 The balance of evidence

Bossert's (2000) conclusion that 'Decentralisation improves some equity measures but worsens others' is widely applicable. For example, he shows that, whereas per-capita expenditure may increase following decentralisation, wealthier areas tend to spend more than poorer areas and there is no direct link

to overall service improvement. Likewise, Janovsky (1997) finds that there is 'no clear evidence' that decentralisation has increased equity. Such partial conclusions make it difficult to attribute the equity consequences of decentralisation (Bossert and Beauvais, 2002: 26).

Despite such equivocal conclusions, a number of key themes emerge from the literature. First, the (spatial) scale at which equity is sought and measured is crucial. In short, is equity sought between areas or within areas (or groups)? While López-Casasnovas (2001) argues that the 'main equity concern relates to intra-regional differences rather than inter-regional differences' (p.19), the Spanish context of this statement underlines the need to consider the context of such equity conclusions. López-Casasnovas (2001) identifies a strategy whereby decentralisation (enabling full autonomy) is constrained if, in doing so, it threatens the achievement of equity goals (p.18). This is theoretically attractive though practically hard to implement.

Second, local autonomy may not always be exercised by organisations. They may, for example, follow previous strategies and seek to conform to equity at a macro scale. For example, equity is widely ascribed as a value of the NHS and so decentralisation may challenge the core value of NHS staff. Nevertheless, the uneven diffusion of (organisational or clinical) innovations will inevitably mean that (in-)equity issues will arise. Central structures and processes can help to shape a culture in which equity issues are addressed. For example, tackling the postcode lottery or ensuring national standards are but two ways of achieving this. These are desirable objectives but, as Kleinman *et al.* (2002) argue, 'Enhancing local autonomy and providing territorial equity are *both* desirable policy goals – but they can and will conflict' (p.16; original emphasis).

This last point raises a crucial issue, the third consideration in these conclusions: clarification of the equity objectives. In noting the centripetal force of equity, Klein (2003a) urges greater clarification of equity, this 'chameleon concept in the context of the new localism and pluralism' (p.196). Klein points out that it could mean:

1 equality in the ability to design local services, or

2 equality in the type, level and kind of service delivered.

The Haskins Report (King's Fund, 2002) reaches a similar conclusion, urging a broader 'understanding of equity of treatment' (p.19). This report argues that the notion of equity needs to extend beyond clinical need to include other factors important to patients including preference for location of treatment and perceived clinical quality. This is especially important, the report argues, in the context of 'patient choice' policies.

Whereas Klein poses the question 'can health services a la carte be reconciled with a national menu?' (Klein, 2003a: p.196), the Haskins Report (King's Fund, 2002) supports centralised tax-based funding (on equity grounds; as does Wanless, 2002) but also '…equal opportunity for patients to choose the best available option to meet their individual needs without denying similar choices to

the next person' (King's Fund, 2002: 19). Achieving this balance will take considerable skills and judgment.

5.7 Staff morale/satisfaction

5.7.1 Introduction

Human resources management is a key area of decentralisation. The majority of health care resources are spent on human resources and thus any reorganisation of health care systems or shifting of responsibility for functions within health care systems will impact on human resources. Kolehmainen-Aitken (1999) identifies four human resource issues emerging from the decentralisation process:

- the adequacy of available information on human resources;
- the complexity of transferring human resources;
- the impact of professional associations, unions and registration bodies on the design and implementation of management structures and jobs;
- the morale and motivation of health staff.

This section examines the fourth of these in detail although reference is made to broader issues of human resources management and this issue is returned to later in the report.

5.7.2 Assumptions

There are four broad staff-morale assumptions that are made about decentralisation. The first and often most widely quoted is that decentralisation improves job satisfaction and morale (Osborne and Gaebler, 1992; Burns *et al.*, 1994; see De Vries, 2000, 198). The assumption here is that a decentralised, participative form of organisation leads to increased effectiveness from both an organisational and employee perspective (Likert, 1967; Argryis, 1972). As Pennings (1976) notes: 'Presumably a decentralized participative structure promotes satisfaction, feelings of security and self-control and leads to increased effort when it encourages employees to commit themselves to higher production goals', hence higher morale (p.688). Decentralized institutions generate higher morale, more commitment and greater productivity….especially in organizations with knowledge workers (Osborne and Gaebler, 1992: 253).

The second assumption is that decentralisation empowers middle managers (Hales, 1999). This is clearly related to the first assumption but it is useful to identify as a separate impact. In his report on the management of the NHS Sir Roy Griffiths (DHSS, 1983) argued that managers should have freedom to manage with managerial autonomy to improve health services efficiency and effectiveness. Thus the distinction here is that not only does decentralisation bring improved morale and satisfaction but giving managers freedom can lead to improvements in organisational performance.

A third assumption that arises from decentralisation is about pay bargaining, with claims being made that local pay systems would lead to improved conditions for staff and help motivate staff, with better recruitment and retention, the ability to attract higher calibre staff and establish better conditions of employment (Thornley, 1998).

Conversely the final assumption is that decentralised units lack capacity for managing human resources and have inadequate skills and managerial competence (Kolehmainen-Aitken, 1999). De Vries (2000) has also noted that it may be more difficult to recruit skilled officials at a local level and recent events in the UK have suggested that there is a managerial skills shortage in PCTs leading to management mergers.

5.7.3 Caveats

A key problem in assessing improvements to staff morale and satisfaction is the being able to directly attribute any increase or decrease directly to decentralisation processes. Many writers note that organisational change often leads to a lowering of staff morale (Kolehmainen-Aitken, 1999). Hales (1999) also suggests that decentralisation within an organisation, such as the NHS, may have problems as local staff and managers, in particular, are used to working within a rule-based hierarchy. The evidence base is also relatively weak as there are few studies that specifically examine issues of human resource management and decentralisation. The major focus of attention has been in relation to developing countries where circumstances are clearly different to the UK, as decentralisation often relates to physical relocation from the centre to the locality and issues of staff skills and management competencies are also very different (Kolehmainen-Aitken, 1999). The following sections draw on evidence that primarily relates to the UK and developed health care systems.

5.7.4 Evidence that decentralisation promotes staff morale and satisfaction

In his review of the impact of decentralisation on managerial behaviour Hales (1999) reports a number of claims that giving divisional/unit managers greater autonomy, challenge, variety, sense of contribution and feedback will enhance their job satisfaction and improve their morale. This concurs with the findings of Pennings (1976: 695) from a survey of staff in 40 local offices of a US brokerage firm that staff had higher morale in more autonomous units. Similarly Germain and Spears (1999), in a study examining management outside the public sector, argue that 'Strategic decentralisation correlates with quality management because delegation over issues affecting the entire firm…creates a general work environment that empowers employees' (p.386). More recently, in a review on organisational form and performance Sheaff *et al.* (2004a) conclude that decentralisation is linked to higher levels of involvement and commitment (van der Vlist, 1989; Elden, 1994; Spender and Grinyer, 1995; Perrone *et al.*, 2003; Prince, 2003; Sheaff *et al.*, 2004a) and that job satisfaction is increased.

Pennings (1976) suggested that these benefits are associated with participative, decentralised and autonomous organisations, arguing that these forms of organisation are most effective. In a study of three non-profit organisations in Israel, Schmid (2002) found that decentralised management is appropriate in organisations where structure and management are informal and professionalism is high. He found evidence of improved confidence, self-control and commitment (Schmid, 2002: 379). In a review of the literature on surgical teams Zetka (1998; quoted in Sheaff *et al.*, 2004a) found some evidence that decentralisation to flexible teams increases worker empowerment and democracy.

Studies of the NHS have shown that decentralisation of human resources management to trusts has led to changes in working times and shift patterns in local organisations: 'Trusts were able to develop local initiatives over working time, in particular shift patterns, flexible working and part-time working, through collaboration of line managers, [human resources] and in direct consultation with staff' (Arrowsmith and Sisson, 2002: 372). In a review of locality commissioning in the NHS in the 1990s Hudson (1999) found that decentralised commissioning at a locality level was associated with some improvement in morale.

5.7.5 Evidence that decentralisation decreases staff morale and satisfaction

However, there is also evidence to suggest that decentralisation has a negative impact on staff morale and satisfaction. Ahmad and Broussine (2003) found that UK NHS reforms are generating feelings of disempowerment and control among local staff and Greener (2004) has argued that changes in Labour health policy are likely to breed cynicism and disaffection among staff. More recently a study of one PCT found that increased autonomy is not always welcomed by staff (McDonald and Harrison, 2004). This reflects the finding of Bojke *et al.* (2001) that changes, in this case mergers, are likely to adversely affect staff morale and satisfaction. In his analysis of decentralisation in the UK public sector Hoggett (1996) concluded that changes have led to a high-output, low-commitment workforce.

Whereas some studies have shown that local autonomy has increased staff morale and satisfaction, Simonis' study of local government in the Netherlands (Simonis, 1995) found that some local governments are wary of greater autonomy. In his study of social work ManoNegrin (2004) reported that social work staff saw decentralisation as a response to or sign of poor management. Zetna (quoted in Sheaff *et al.*, 2004a) also found that staff in teams often saw decentralisation 'as a despotic extension of hierarchal control'.

Finally, studies have clearly shown that decentralisation is not a sufficient indicator or determining criterion directly related to staff morale, satisfaction or the success or failure of human resources management in decentralised units. Arrowsmith and Sisson (2002) identify the importance of external factors, citing for example the case that very little localization of pay took place partly due to

limited financial reserves for transitional costs. Internal factors are also important, with managers' background, training, experience, careers and the physical and technical demands of the work system combining to shape managers' jobs regardless of its organisational context (Hales, 1999). Furthermore, local managers may be unwilling to use decentralised powers as they may be conditioned by former centralised regimes into acting in particular ways and not using their new autonomy (Hales, 1999).

5.7.6 Conclusion: the balance of evidence

As discussed in the introduction to this section there are a number of broader human resources management issues associated with decentralisation in addition to staff morale. There is very little on staff morale and motivation in the literature although there may be important relationships to other aspects of human resources management that require further research.

The evidence to link decentralisation and improved staff morale is at best equivocal. The existing evidence suggests that there is a wide variety of factors that influence morale and motivation and that decentralisation may not be a single determining factor. A key problem is the complexity of transferring human resources. Bossert (1996) has argued that for decentralisation to work central officials must possess skills in policy-making and monitoring while local-level officials need operational and entrepreneurial skills. More importantly, as Anell (2000) has argued there is a need for motivation of the decentralised level and the capability to make decisions or take appropriate actions. It is pertinent to note that Anell's study of Swedish councils found that delegation of responsibility often precedes the delegation of authority.

A key problem identified by Sheaff *et al.* (2004a) is that decentralisation and centralisation occur simultaneously within the same organisation and therefore it is difficult to clearly identify specific outcomes of human resources management to decentralisation per se.

Singh's (1986) study on organizational performance suggests that decentralisation is positively related to good performance in that better performance means that there is generally less central control. In a decentralised organisation there is also more risk-taking as local staff have more autonomy. Conversely, poor performance is associated with increasing centralisation, less risk-taking and less autonomy. However, it is clear that internal and external environmental factors play an important part in the success or otherwise of achieving staff benefits in decentralised organisations (Hales, 1999; Arrowsmith and Sisson, 2002). Interestingly, as discussed in Section 5.3, decentralisation is seen to lead to an improvement in processes through its psychological impact upon staff morale (Klijn *et al.*, 1995; Klijn and Koppenjan, 2000). Similar findings in the UK by Hudson (1999) suggest that there is a link but a clear problem is identifying which variable – decentralisation, processes or staff morale – is the independent one.

There was no specific evidence on the relationship between decentralisation and the adequacy of available information on human resources or the impact of professional associations, unions and registration bodies on the design and implementation of management structures and jobs in decentralised organisations. In the NHS the latter aspect is still dominated by a national pay structure and there is little evidence to demonstrate developments in local pay, although there is some evidence to suggest that human resources management may benefit from important bottom-up initiatives and this requires further research (Arrowsmith and Sisson, 2002).

5.8 Responsiveness and allocative efficiency

5.8.1 Introduction

Responsiveness has been identified as a key outcome indicator for health care systems by the World Health Authority (De Silva, 2000; Gostin *et al.*, 2003). This is not one perspective but links governance, stewardship and health services delivery, focusing on the extent to which health care systems meet the needs of those receiving health care. It is complex in that it addresses individual health needs and population health needs. As described in Section 5.3 there are eight dimensions to the WHO's conceptualisation of responsiveness. Some of these areas have been discussed in relation to humanity (Section 5.5) and discussion here focuses on the following dimensions:

- autonomy to participate in health-related decisions,
- prompt attention,
- clarity of communications to patients,
- access to social support networks and family and community involvement,
- choice of health care provider.

Responsiveness also suggests, however, that health care systems are applying resources appropriately in accordance with need. In economic terms efficient allocation of health care is when the health care system is producing exactly the quantity and type of health care that society wants – in this sense being most responsive to the distribution of needs. Thus this section also examines the evidence in relation to allocative efficiency as a further dimension of responsiveness. There are also close links to issues of accountability, which are dealt with in Section 5.10.

5.8.2 Assumptions

Local responsiveness to the needs of local people is one of the key claims for decentralisation of public services. Derived from welfare economics and public choice theory, decentralisation is ' …better apt to take into account the different preferences of the community's members than are extremely unitary states with their systematically uniform approach' (Frey, 1977). Tiebout (1956) suggested

that the most efficient allocation of public resources is attained if such services are provided (and paid for) by governments responsible to those most directly affected.

Burns *et al.* (1994) argue that decentralisation will result in the improvement in the quality of public services with more sensitive service delivery and achieving a better distribution of resources through targeting resources to areas and groups in most need. This view is echoed by Saltman *et al.* (2003), who argue that decentralisation improves (allocative) efficiency as patient responsiveness and accountability improves – improved governance and public service delivery is achieved by increasing the allocative efficiency through better matching of public services to local preferences. The link between decentralisation and responsiveness has also been noted by Meads and Wild (2003) and is supported by De Vries (2000), who argues that decentralised organisations are more likely to reflect local preferences. Osborne and Gaebler (1992) also argue that they are far more flexible and can respond quickly to changing circumstances and customers' needs and are far more innovative; innovation happens because good ideas bubble up from employees, who actually do the work and deal with the customers.

These assumptions are also inherent in the Niskanen (1971) critique of monopoly public services, which are seen as inherently inefficient and producer-dominated and therefore need to be broken up to achieve efficiency gains but also to '…break through…inflexibility and make services more responsive to users' (Pollitt *et al.*, 1998: 34). Seabright (1996) has argued that accountability increases responsiveness and overall performance (despite spillovers). Decentralisation is believed to stimulate innovation, initiative, experimentation and risk-taking (Hales, 1999). Similarly Kanter (1985; quoted in Hales, 1999) argued that there is a need to encourage innovation by dismantling bureaucratic constraints and empowering middle managers. It is also claimed that diversity encouraged by decentralisation offers incentive for innovation (Levaggi and Smith, 2004: 5, 10).

5.8.3 Caveats

Previous research on the NHS suggests that both external and internal contexts affect the way organisations and those within them work (Pettigrew *et al.*, 1992; Sheaff *et al.*, 2004a). There is also a problem in identifying what local organisations or individual professionals are being responsive to. For example, there are tensions between responsiveness to individual consumer choices and wishes expressed by groups in local communities. Essentially we see here the tension between market and more community-based or collective approaches to health care that have characterised much recent debate about health policy in the UK (see Section 4).

5.8.4 Evidence that decentralisation promotes responsiveness

In their review of organisational performance Sheaff *et al.* (2004a) did find evidence of increased adaptation and flexibility resulting from decentralisation, a finding also supported by Reed and Blunsdon (1998). Research from the devolution process in Spain also found increased innovation (Rico, 2000). In a study of the decentralisation of health service in New Zealand managers report increased accountability, commitment and innovation (Malcolm *et al.*, 1994). Research in New Zealand and Sweden has suggested that decentralisation and fragmentation of services can lead to increased responsiveness to specific groups. In New Zealand Craig (2003) found that Maori providers were able to use the purchaser/provider split to channel funds into identity-based programmes. In Sweden the introduction of choice and number of providers into local public welfare services increased the stratification and cultural diversity of local services (Blomqvist, 2004).

5.8.5 Evidence that decentralisation decreases responsiveness

There is little evidence that diversity encouraged by decentralisation leads to innovation (Levaggi and Smith, 2004). Although it is claimed that diversity is encouraged by decentralisation and therefore offers an incentive for innovation there is scant evidence to support this hypothesis from health care in the USA (Levaggi and Smith, 2004: 5, 10). Furthermore, organisational coherence is reduced by decentralisation (Sheaff *et al.*, 2004b).

Decentralisation aimed to offer managerial autonomy and to be locally responsive but analysis of UK reforms found that local organizations have not been responsive to local populations because of a highly centralised state (Milewa *et al.*, 1998). In fact Hales (1999) found that managers in decentralised agencies rarely develop innovative practice because of continued pressures, constraints and controls traditionally exerted from the centre. Similarly Deeming (2004) found that purchasers are locked into previous decisions and they have a fear of destabilising the local health economy by their decisions. In their study of decentralised firms Singh (1986) found that some organisations aim for satisficing levels of performance and that some organisations tend to respond to poor performance by centralisation. Finally, Moran's (1994) review of health policy in the USA, UK, Scandinavia and Germany found that where institutional structures encourage innovation, cost inflation results.

5.8.6 Conclusion: the balance of evidence

The concept of increased responsiveness is perhaps central to the conceptualisation of decentralisation. Economic theories have identified decentralisation closely with allocative efficiency based on a strong link with fiscal theory (Tiebout, 1956; Oates, 1972) and a specific approach to democracy.

However, local innovation is linked to free-riding but there is no evidence to suggest that decentralisation is more innovative than centralisation, or vice versa (Oates, 1999). The evidence seems to suggest that there will be increased responsiveness to patients and local communities. However, there is some room to question this positive finding as there is an assumption made about increased accountability. Studies show, for example, a link between increased accountability and responsiveness (e.g. Seabright, 1996) but do not necessarily demonstrate that there is increased accountability. There is then a paradox that centralisation and participation co-exist but that there is a tension between them. The crux is how power is shared between powerful interests and patients within the health care system (Quennell, 2001).

Responsiveness does not therefore seem to be directly associated with decentralisation. Clearly some aspects of health care rely on some decentralised activities. For example, the autonomy of patients to participate in health-related decisions does require that the professionals they engage with are able to grant autonomy and respond to patients' wishes. Thus, patient autonomy is predicated on professional autonomy. There are problems associated with this and there have been a number of debates surrounding, for example, the concept of patient-centred care and the expert patient regarding the nature of autonomy (Little *et al.*, 2001; Wilson, 2001). There is no evidence to link prompt attention to decentralisation. In fact, in the UK most shifts towards reducing waiting times have been centrally driven (Patient's Charter, waiting-time initiatives, patient choice and book and choose), although there is some limited evidence that GPFHs in the 1990s made changes to the outpatient processes in local hospitals (Le Grand *et al.*, 1998). Similarly the recent initiative regarding copying letters to patients was also centrally driven and other approaches to patient/clinician communication have been professionally led. Choice of provider is linked to issues of access and the availability of multiple providers. 92% of the English population live within 1 hour of two or more hospitals and most people have a choice GP practice. The development of additional providers is being driven centrally but this does suggest deconcentration of providers. Choice requires fragmentation of services and the Swedish experience in social care does suggest more responsiveness to specific groups of the population (Blomqvist, 2004). With regard to access to social support networks and family and community involvement this requires the availability of networks outside of the NHS. These are by nature more likely to be localized around neighbourhoods and communities rather than centralized.

5.9 Adherence to performance targets and evidence-based protocols

5.9.1 Introduction

The notion of adherence to externally defined measures is intuitively at odds with the autonomy that decentralisation is supposed to confer upon local organisations

and individuals. However, if decentralisation retains a connection between the centre and locality, it is feasible that decentralised agents are incentivised to adhere to central performance targets and/or evidence-based protocols. This reinforces the under-current of centralisation that is inevitably associated with decentralisation (De Vries, 2000).

Both targets and protocols are external performance controls upon the decentralised organisation. As such, they can be examined together. However, targets are likely to be organisationally or institutionally specific whereas evidence-based protocols are likely to be more generic.

5.9.2 Assumptions

The notion that decentralisation might improve/ensure adherence to targets is based upon an assumption that decentralisation introduces a stronger performance-management framework upon local agents. Hence, local organisations and individuals are held more accountable for their decisions. Smith (2002) identifies three facets of performance management: guidance, monitoring and enforcement. Each has elements of centralisation although the degree to which guidance becomes direction, monitoring becomes interference and enforcement becomes control is the crux of the decentralisation/centralisation balance. Bossert (1998) argues, for example, that decentralisation should be different from directed change.

In terms of evidence-based protocols, decentralisation might improve adherence if it enhances trust and professional commitment to evidence-based practice. This might also be enhanced by a general improvement in morale (see Section 5.7).

5.9.3 Caveats

Adherence to performance targets assumes an effective 'transmission belt' between the centre and the locality which has not always been present in the NHS (Powell, 1997). In other words, there needs to be a mechanism which links those who steer and those who row. Klein and Day (1997) found that this separation was blurred in the Department of Health and NHS. Rowers (local health care organisations) were hampered in their task by direction from those supposed to be steering (the Department of Health). This account of 'interference' is familiar in much of the literature (e.g. Exworthy *et al.*, 2002; Ahmad and Broussine, 2003; Greener, 2004).

Adherence is also based upon clear and powerful incentives which persuade local (decentralised) agents to adhere to clear performance targets. Often, such incentives are ill-defined, contradictory and/or not strong enough to effect the desired change. The internal market (1991–7) did not fully achieve its intended impacts partly because the incentives were insufficiently strong (Le Grand *et al.*, 1998; Le Grand, 2003). Limited local capacity might also explain the failure to adhere to performance targets; local organisations and individuals may thus lack

sufficient resources to bring about local service changes, advocated by the centre.

In terms of adherence to evidence-based protocols, there is a large literature on why the practices of clinicians (and managers) are not always consistent with the evidence (e.g. see Davies *et al.*, 2000; Walshe and Rundall, 2001). Professional/clinical autonomy is one explanation for such inconsistency. Decentralisation would have no (direct) impact upon adherence if clinical autonomy permitted 'variations' in practice. Such autonomy might also be dependent on the ways in which clinical governance is 'managed' by professional leaders (Gray and Harrison, 2004; Sheaff *et al.*, 2002). This begs the question: to what extent are local variations permissible? Variations have recently become less tolerated as attention on health care inequalities has risen (Roche, 2004). It also seems to contradict one of the supposed benefits of decentralisation – that it promotes innovation and experimentation (Smith, 1980: 148; see also Section 5.8).

Caveats to both aspects of 'adherence' highlight the need for a clear framework within which decentralised agents operate. Without it, the ambiguity inherent within decentralisation becomes intolerable (Vancil, 1979). It also reinforces the notion that decentralisation and centralisation are inextricably linked. In short, decentralisation involves freedom within constraints.

5.9.4 Evidence that decentralisation improves adherence

The evidence for the notion that decentralisation improves adherence to performance targets and evidence-based protocols concerns the retention or redefinition of centralisation. Evidence suggests that this operates at institutional and individual levels. At an institutional level, the separation between policy/strategy and operations/practice (i.e. between steering and rowing) may be 'impossible to maintain' (Bromwich and Lapsley, 1997: 200). Bossert (1998) claims that central authorities manipulate decision space and shape (including the control of information), which might tighten performance control of decentralised organisations.

At an individual level, Hales (1999) argues that decentralisation may not realise intended benefits because it:

> *may engender great caution and adherence to known procedures rather than innovative…behaviour.*
>
> (p.847)

This may be due to poorly communicated messages from the centre, negotiated settlements between the centre and locality, strong incentives allowing little local autonomy or an aversion to risk on behalf of local managers. This last point is significant if local managers have become accustomed to central direction and control, and are wary of the new decentralised regime. Adherence may be achieved through the legacy of the former centralised system rather than decentralisation.

In terms of evidence-based protocols, decentralisation is often associated with greater autonomy, which can enhance trust. This trust is crucial when performance measurement is ambiguous and/or behaviour is unobserved, as often happens in the health care (Perrone *et al.*, 2003). Schmid (2002) also argues that decentralisation is appropriate where the organisational structure and management are informal and where professionalism is high; this includes non-profit voluntary and health care organisations. Bojke *et al.* (2001) argue that there is 'no evidence that clinical governance benefits from scale economies', rather 'larger organisations encounter increased problems in sustaining professional commitment and involvement in quality improvements activities' (p.600). Such commitment is critical in aiding adherence to evidence-based protocols.

5.9.5 Evidence that decentralisation reduces adherence

By granting autonomy, decentralisation might reduce the adherence to central performance targets as autonomy and central targets may not be compatible. However, decentralisation is often accompanied by measures of centralisation (partly to foster adherence). Evidence that decentralisation reduces adherence is relatively weak.

Blom-Hansen (1999) found that guaranteed waiting times for hospital treatment in Scandinavian countries were associated with lower local autonomy. Regional variations in health service provision in New Zealand were not tackled partly because performance accountability was lacking (Barnett and Newberry, 2002). Moreover, Craig (2003) found that uneven local organisational capacity in New Zealand hindered development of decentralised organisations. In England, Dixon (2004) notes that the freedom (autonomy) of purchasers is 'heavily restricted' and the local capacity to deliver within these restrictions is 'questionable'. She argues that the centre should be less 'over-bearing, trust more and experiment'. This would seem to place less emphasis on central targets and local adherence to them. Hales (1999) offers theoretical evidence of how organisations in centralised systems learn to operate within the regulations, thereby affording them a degree of 'de facto managerial freedom' (p.847). This finding offers the prospect of adherence within some degree of autonomy.

Decentralisation shifts the relationship between professionals/clinicians and managers. It is one means to increase (managerial) power over professionals. Exworthy (1994) found that community health nurses disputed the need for and legitimacy of local management. Subsequent developments have sought to foster management by professionals (rather than managers; Gray and Harrison, 2004). This accords with the notion that the routine, local practices of professionals become the de facto policy of the organisation despite central directives (Lipsky, 1980). It also reflects the management of professional groups, often by (senior) professionals in clans and across networks (Bourn and Ezzamel, 1987; Ferlie and Pettigrew, 1996; Ferlie and McGivern, 2003; Sheaff *et al*., 2004a).

Given such discretionary behaviour, McDonald and Harrison (2004) question the extent to which autonomy can be exercised given 'top-down directives' (see also Deeming, 2004). They conclude that central control can be achieved through recognition of (professional) autonomy but especially by the 'internalisation of central values' which might reflect central performance targets and/or the tenets of evidence-based practice. They also note that this strategy is both more effective and less costly than direct control.

Organisational change in the NHS has created larger primary care organisations which have established new internal systems of professional management (i.e. clinical governance; Sheaff *et al.*, 2004a). These systems are, in part, designed to foster adherence to evidence-based protocols. They are, however, likely to reduce 'professional engagement' as they become more 'centralised and hierarchical' (Bojke *et al.*, 2001: 601).

5.9.6 Balance of evidence

The emphasis of performance targets and evidence-based protocols in the NHS has been strong over the last few years. However, it appears that, in terms of the former, a subtle shift took place in 2004 with the demise of the 'star rating' system (Stevens, 2005). In terms of the latter, evolving systems of clinical governance have also subtle shifts whereby clinicians occupy lead positions, influencing colleagues to meet targets and to conform to evidence-based protocols. The extent to which clinical governance leads can maintain collegial identity with the rank-and-file colleagues will largely explain whether adherence in decentralised organisations (such as PCTs and foundation trusts) will improve or decline.

The evidence reviewed here does not permit a definitive conclusion as to whether decentralisation permits or hinders adherence to performance targets and/or evidence-based protocols. It does, however, highlight that the answer depends crucially on the form of decentralisation implemented, the local organisation configuration (especially the balance of power between managers and professionals) and the historical legacy of the previous centralised regime. A significant aspect of the answer will be the template of centralisation (in systems, processes and attitudes) that remains despite an espoused policy of decentralisation. More specifically, it raises a question as to whether a compromise be found between market pressures and the centralization of performance targets while at the same time encouraging local learning networks (Ferlie and McGivern, 2003: 13).

5.10 Technical efficiency

5.10.1 Introduction

Technical or productive efficiency is defined as the production of goods and services using the lower-cost combination of inputs (Hurley *et al.*, 1995: 4). Kleinman *et al.* (2002) state that technical efficiency refers to:

> *…maximising outputs (ideally outcomes) per input. Improving technical efficiency is about reducing waste, duplication and poor management so as to maximise the productive potential of a given range of inputs.*
>
> (p.17)

Leese *et al.* (2001) offer another, simpler definition:

> *Efficiency is broader and is concerned with both the costs (inputs) and benefits (outputs) of programmes.*
>
> (p.174)

However, Kelly (2003) argues that 'Efficiency…lacks a precise definition' (p.467) and is made more complicated in the context of 'interpersonal public services' (p.469).

These definitions of efficiency are those most easily understandable and that relate directly to the categorisation of decentralisation (used in this study), *viz*. inputs, process and outcomes. As the inputs might involve any combination of material, financial or human resources, the potential technical efficiency deriving from decentralisation is likely to be manifest in various guises. This makes evaluation problematic.

5.10.2 Assumptions

Several assumptions underlie the assertion that decentralisation can improve technical efficiency of organisations and/or systems. First, there is a widespread assumption that centralisation in the public sector is often associated with negative aspects of bureaucracy such as unnecessary paperwork, impersonal and inappropriate use of resources (e.g. Gershberg, 1998: 407; Johnson, 2001: 523) and 'unnecessary' administrative tiers (Saltman *et al.*, 2003: 2). In short, centralisation implies waste; therefore, decentralisation implies a more (technically) efficient use of resources. Decentralisation involves 'local people, local provision, local services' and is therefore 'cheaper' (De Vries, 2000: 198). A related aspect of this concerned the association of quality and efficiency; the former was the product of the latter (Arrowsmith and Mossé, 2000: 287). Technical and allocative efficiencies would thus be aligned.

A second and related assumption concerns the 'better' performance of smaller organisations (e.g. see Bojke *et al.*, 2001). By being closer to the communities they serve, smaller organisations are not only more responsive (see Section 5.6) but also are less hierarchical, and have shorter lines of accountability and fewer

overheads. Decentralised organisations have fewer tiers of bureaucracy and a better of knowledge of inputs (Saltman *et al.*, 2003: 2). Decentralised organisations may be better able to identify and tackle inefficiencies (Coulson, 1999; Levaggi and Smith, 2004). There is thus greater local 'cost consciousness' (Bossert and Beauvais, 2002: 14). These aspects are also associated with the third assumption: that decentralisation fosters greater experimentation and innovation (e.g. Oates, 1972). Local staff cannot only be more attentive to the mix of local inputs but they can also apply lessons from experimentation elsewhere. They can thus 'learn from diversity' (De Vries, 2000: 197) and apply lower-cost techniques.

5.10.3 Caveats

These assumptions are subject to several caveats. For example, smaller organisations may not necessarily derive technical efficiencies from decentralisation. By duplicating services in each decentralised organisation, such efficiency might be impaired. Moreover, organisational scale and size may not be dominant influences upon organisational performance. Equally, smaller, decentralised organisations may be unable or unwilling to exert the same efficiency controls that centralised systems can. Finally, unless effective processes of policy learning/transfer are in place, local services may lose the benefit of comparative advantage that can be derived from cheaper locations elsewhere.

Another set of caveats concerns the motivation and willingness of managers in decentralised organisations. Unless supported by effective incentives, local managers may not be inclined to seek out the lowest cost combination of inputs. (Hales, 1999). Furthermore, decentralised organisations may have limited managerial capacity to ensure that technical efficiency is realised.

Decentralisation creates a number of external ('spill-over') effects. One such effect is the 'free-rider', whereby organisations enjoy benefits without incurring associated costs. Another is the 'tragedy of the commons' whereby resources are employed excessively to the point of dis-benefit (De Vries, 2000: 199). Decentralisation may also foster the over-provision of services in the form of duplication (Levaggi and Smith, 2004: 13); this is sometimes referred to as 'producer capture' and is thought to be especially prevalent in professionalised, expert services.

As cited elsewhere in this report, the lack of information hampers any robust debate about the impact of decentralisation upon technical efficiency, especially in a comparative dimension:

> *This lack of information and analysis is most striking with respect to the effects of decentralization reforms on efficiency and financial soundness of the health system.*
>
> (Bossert and Beauvais, 2002:.26)

This point is supported by the World Bank (2004; see www1.worldbank.org/publicsector/decentralization/) and Kleinman *et al.* (2002). The latter argue that even at the level of technical efficiency, there are problems:

> *…the evidence is currently inadequate to distinguish managerial inefficiency from the sheer difficulty of the task of providing services in cities.*
>
> (Kleinman *et al.*, 2002: 17)

Finally, by nature of the definition, efficiency measures are mainly concerned with (the lowest-cost combination of) inputs. This is inevitably a limited and partial view of organisational effectiveness. For example, technical efficiency is not necessarily connected to notions of accountability (Hurley *et al.*, 1995: 9). Also, the assumed link between decentralisation and technical efficiency presumes that the former has created an 'institutional environment' which generates sufficient 'levels of political, administrative and financial authority' (Saltman *et al.*, 2003: 2; quoting World Bank, 1997).

5.10.4 Evidence that decentralisation improves technical efficiency

Evidence in support of the claim that decentralisation improves technical efficiency consists of positive support for decentralisation and a negative reaction against centralisation. For example, Malcolm and Barnett (1995) claim that decentralised organisations seemed to achieve increased efficiency and accountability while Moreno (2003) claims that 'central state apparatuses are often clumsy and inefficient' (p.279). Some of these claims distinguish between national contexts. For example, Bankauskaite *et al.* (2004) cite 'high technical efficiency' in decentralised Nordic countries while Johnson (2001) argues that 'systems of local governance' in developing countries have been shown to improve the efficiency..of public officials' (p.527). Evidence in support of these claims can be grouped into three main themes.

Lower costs

Manor (1999) claims that lower transaction costs were among the efficiency gains associated with decentralization. Sheaff *et al.* (2004a) cites evidence that organizational efficiency is associated with lower costs of care. Much of the evidence for such efficiency gains is derived from the private sector; for example, Young and Gould (1993; quoted in Ferlie and Pettigrew, 1996) found that over 50% of private companies involved in decentralisation (in the form of 'down-sizing' corporate headquarters) were doing so in order to reduce costs and improve efficiency. Others refine this general point by noting the efficiency gains of decentralization achieved by 'limiting the leakage of funds and other resources' (Kolehmainen-Aitken, 1999; Saltman *et al.*, 2003: 8). Additionally, Lomas (1997) argues that efficiency gains might only be expected while there is 'still slack in the system' (p.817). However, transaction costs are not likely to be 'materially higher under decentralisation' (Levaggi and Smith, 2004: 15).

Related to cost reduction is the notion that variations in costs are associated with efficiency gains. Hurley *et al.* (1995) argue that the 'gain in technical efficiency is directly proportional with the degree of variation in production-relevant local conditions' (p.10). Variations in knowledge about costs might also be a justification for decentralisation by virtue of the 'better knowledge of local governments about the efficiency of local providers' (Levaggi and Smith, 2004: 11). Indeed, the argument may be applied to 'smaller' organisations in general. The case of the GP fundholding scheme provides some support for this. In reviewing the evidence on commissioning, Peckham and Exworthy (2003) found that, while it was difficult to attribute efficiency gains to health authority commissioning decisions, GPFHs did achieve some efficiency gains:

> *The technical efficiency of GPFHs can be gauged by considering, for example, prescribing.... Evidence points towards a lower rate of increase in prescribing costs among GPFHs than among non-GPFHs, at least in the first few years of the GPFH scheme. Whereas increases were evident in both groups, the Audit Commission (1995) concluded that differences were only statistically significant in the first-wave GPFHs.*
>
> Peckham and Exworthy (2003: 146)

Markets and competition

Efficiency gains are claimed from the separation of purchaser and provider functions through market-style relations (e.g. Litwinenko and Cooper, 1994; Bromwich and Lapsley, 1997; Bossert, 1998). Such claims have also been applied to the NHS; for example (see also Arrowsmith and Mossé, 2000: 289):

> *In the current NHS, competition has been seen as a driving principle, perceived as the route to efficiency and effectiveness.*
>
> (Kessler and Dopson, 1998: 62)

Efficiency is derived from greater experimentation and innovation (Rubio and Smith, 2004). This follows the Tiebout (1956) mode whereby 'under certain circumstances, competition between jurisdictions supplying rival combinations of local public goods would lead to an efficient supply of such goods' (Seabright, 1996: 62).

Examples of claims of efficiency gains have been in terms of market testing and contracting out. Banner (2002) claims that 'the most single important measure for increasing efficiency is market testing. It leads to a drop in prices…' (p.224). However, Banner cautions that a market orientation may overlook quality in favour of price. Equally, some client groups may demand 'maximum quality (frequently synonymous with maximum cost)' (ibid: 224). This could, Banner claims, lead to deterioration in quality.

In the NHS, the internal market system (1991–7) has been associated with increased patient throughput and reduced length of stay. Finished consultant episodes increased by 29% between 1991 and 1995 and length of stay decreased from 11 to 8 days over the same period (Peckham and Exworthy, 2003: 145). In the more recent NHS context, Dixon (2004) claims that the fixed national tariff is

an incentive to providers to examine their own organisational efficiency and to compete with other providers on the basis of quality rather than price (p.970).

Organisational size

A major debate linking decentralisation and efficiency concerns the optimal organisational size for specific functions. It is complicated by the multiple functions that organisations undertake, the technology enabling them to execute these functions, notions of political control and subsidiarity (Sass, 1995; Tester, 1994). The debate has assumed particular relevance in recent years in the NHS given the interest in organisational mergers (e.g. Bojke *et al.*, 2001; Fulop *et al.*, 2002; Walshe *et al.*, 2004).

In support of smaller organisational size, Bojke *et al.* (2001) claim that mergers often fail to deliver their anticipated benefits because organisations suffer from adequate infrastructure and skilled managers. Walshe *et al.* (2004) support this notion. Bojke *et al.* (2001) argue that (primary care) organisations with more than 100 000 patients may not generate improved performance. They claim that there is no 'good evidence' that mergers work because there is no single optimal size for organisations. Further evidence that mergers will bring efficiency gains comes from Australia; Drummond (2002) argues that the search for cost savings through organisational mergers is 'misguided' partly because central government (state and federal levels) is more inefficient and unlikely to yield better cost savings:

> *Australia's large federal units provide many public goods and services less efficiently than could be achieved through a country-wide agreement and are much too large to achieve scale economies in the provision of sub-national public goods and services.*
>
> (Drummond, 2002: 53)

By contrast, in Italy, regional cost-sharing in health care contributed to lower levels of public expenditure (Bankauskaite *et al.*, 2004). Petretto (2000) argues that the decentralisation of financial responsibility to lower administrative tiers also brings about improved financial responsibility from these organisations (p.217).

Evidence for the performance of smaller organisations is somewhat mixed and varies according to the criteria used and the services delivered. Boyne (1996) shows how perceptions have changed relating to organisational size:

> *The Local Government Commission analysis suggested scale economies were possible up to one million population and diseconomies above one million. By 1995, the Local Government Commissions reached the view that, on the whole, larger authorities did not perform better.*
>
> (p.55)

Boyne (1996) concludes that improved performance of local authorities is linked to organisational scale in non-metropolitan areas but the evidence was equivocal. Smaller authorities tended to perform better in housing and planning services

whereas larger authorities tended to perform better in refuse-collection services. He warns that valid measures of scale and performance are essential to such analyses.

Such evidence on performance may be explained by informational asymmetries between local and central governments. Gilbert and Pichard (1996) argue that 'smaller local governments have an informational advantage concerning public goods' production costs and the central government has imperfect information on spillover effects induced by local projects' (p.19). They conclude that the optimal balance is a 'compromise between small jurisdictions so as to benefit from the geographical proximity effect on information and large entities in which spillover effects are more easily internalized by means of linear or non-linear taxation schemes implemented by the Centre' (ibid: 19).

5.10.5 Evidence that decentralisation hampers technical efficiency

The notion that decentralisation hampers technical efficiency is refuted by other evidence (e.g. Reich, 2002). The same themes used in support of the assertion can also be used to counter those arguments.

Higher costs

Scale economies limit the benefit of decentralisation (Andrews and Schroeder, 2003); a centralised structure may therefore be more efficient (Schmid, 2002: 379). Whereas decentralisation does shift responsibility to lower administrative tiers, it does not necessarily generate cost savings (Esping-Anderson, 2000).

Van der Laan (1983) found that fiscal centralisation is associated with lower levels of health care expenditure although the federal-unitary status of government had no impact on such spending. This assertion is supported by empirical evidence from India where Varatharajan *et al.* (2004) found that local government allocated lower levels of funding to primary health care than central government and concluded that 'decentralisation brought no significant change to the health sector.' Also, Spain encountered cost-containment problems under devolution (Rico, 2000). In France, tighter financial control has been used to increase efficiency (Arrowsmith and Mossé, 2000: 287), an approach similar to the UK, according to McEldowney (2003: 70). Luft (1985) argues that regionalisation of health care provision (here, implying a degree of centralisation) may contain costs (although it increases travel costs). Furthermore, central financial allocations to decentralised organisations incur inter-jurisdictional conflicts, the degree of which varies by the amount of spill-over and local preferences, according to Besley and Coate (2003). In summary, Kelly (2003) concludes that:

> *…only exceptionally are the promised efficiency expectations fulfilled, a situation precipitated by factors such as overestimation of available savings and the costs of reorganization and rationalization.*

(p.468)

Markets and competition

The shift from hierarchical and/or network-based structures to market-based structures has been identified with a 'fall in efficiency' (Iliffe and Munro, 2000: 318). Decentralisation may not 'always be efficient, especially for…network-based services' as it can lead to a loss of scale economies and control over scarce financial resources (see www1.worldbank.org/publicsector/decentralization/). The variable levels of managerial or technical capacity may further reduce efficiency. Equally, institutional structures (such as markets) which foster innovation tend to result in cost inflation (Moran, 1994). Greener (2004) also identified the fragmentation of decision-making and distortion of priorities despite the aim of improving efficiency (p.305–306). Thus, even with market-style incentives, organisations may not necessarily search for efficiency but rather legitimacy (Ferlie and Pettigrew, 1996).

Organisational size

Bojke *et al.* (2001) and Walshe *et al.* (2004) conclude that the size (of primary care organisations) is only one factor in shaping their performance. Perceptions that organisations are too small to be effective or efficient has, however, driven the push towards organisational mergers in the UK and elsewhere (e.g. Sweden; Anell, 2000).

Recognising the potential benefits of scale economies, some decentralised functions do not generate improved efficiency. Kleinman *et al.* (2002) identify 'limited evidence of improved efficiency from local tax-rising powers (as opposed to central grants).' Also, Travers *et al.* (1993) claim that:

> *It is not possible to say that larger [local] authorities perform better than smaller or smaller authorities perform better than larger even in one specified services.*
>
> (quoted in Boyne, 1996: 56)

Optimal size varies with function but organisations conduct multiple functions, therefore making any organisational size a compromise between competing 'optimalities'; for this reason, De Vries (2000) notes the 'fantasy' of optimal size. Kleinman *et al.* (2002) offer a different perspective by highlighting the disjuncture between 'the most efficient spatial scale in relation to economic activity' and the spatial scale at which citizens vote (e.g. constituency or council; p.26).

5.10.6 Conclusion: the balance of evidence

Oates (1999) argues that 'there is not much evidence on the relationship between fiscal decentralisation and economic performance' at macro-economic level. (The World Bank (see www1.worldbank.org/publicsector/decentralization/, p.9) qualifies this conclusion by arguing that the design of decentralisation policies is crucial to determining their impact on technical efficiency.) However, at

the macro level, there are strong efficiency (and equity) justifications for financing (collection and expenditure) health care through centralised systems (e.g. King's Fund, 2002; Wanless, 2004). Nonetheless, the weight of evidence (such as it is) does tend to point towards decentralisation offering some gain in technical or productive efficiency at organisational levels.

Improvements in technical efficiency have been reported in various contexts (World Bank, 1993; quoted in Varatharajan *et al.*, 2004: 48) but equally, poorly designed policies may compromise any efficiency gains. Technical efficiency has become a key criterion for the NHS and other public organisations. It has, for example, set the parameters of 'success' and 'effectiveness'; efficiency has become the 'ground for central intervention' in 'failing schools', for example (McEldowney, 2003: 81).

5.11 Accountability

5.11.1 Introduction

As discussed in earlier sections on humanity (Section 5.5) and responsiveness (Section 5.8) there is thought to be a strong relationship between decentralisation and how the decentralised agency or, in many cases the professional with decentralised responsibility, relates to their local constituency (whether community, patients or individual service user). So far we have examined notions of humanity and responsiveness. In this section we examine issues of accountability. Accountability is conceptualised in two forms:

- accountability to – to be held to account to another for actions taken;
- visibility or openness – to be seen as open to scrutiny by others.

Both types of accountability are relevant to the NHS but it is more relevant to conceptualise the NHS as consisting of a number of accountabilities (Lupton *et al.*, 1998). Klein (2003a), in discussing accountability arrangements for foundation trusts, for example, states:

> *In the first place, foundation trusts will be accountable to the newly created independent regulator who will license them, monitor them, decide what services they should provide, and if necessary dissolve them. In the process, the regulator will be able to impose additional requirements on the trusts, remove members of the management board, and order new elections. The regulator will also determine the limits of the trust's capital spending and will be informed by the reviews carried out by the new Commission for Health Audit and Inspection. Foundation trusts will also have to answer to the overview and scrutiny committee of the local authority (which may interpret the wishes of the local population rather differently). Finally, foundation trusts will be accountable to PCTs (who may have yet another, yet again different view about the local population's needs) for fulfilling contracts.*
>
> (Klein, 2003a: 175)

5.11.2 Assumptions

Within current debates about decentralisation there is a strong assumption that it will lead to more accountable organisations. De Vries has argued that it enhances civic participation, neutralises entrenched local elites and increases political stability (De Vries, 2000: 197). Much of the literature on public sector decentralisation places a strong emphasis on the link between increasing democracy and decentralisation, especially as it relates to local government (Burns *et al.*, 1994). Being closer to the public makes agencies more conscious of their responsibility to and relationship with local communities (Hambleton *et al.*, 1996). With respect to health decentralisation has been seen as a way of promoting democracy and accountability to the local population (Bossert, 1998; Meads and Wild, 2003). The central assumption is that decentralisation enables the local performance of agents to be easily identified and thus enable greater accountability.

Accountability has also been linked by some writers to performance. Accountability mechanisms are critical to improving efficiency (Hurley *et al.*, 1995). Accountability is poorly defined but is closely related to allocative efficiency (Levaggi and Smith, 2004: 5). However, others have argued that seeking legitimacy is better than searching for the most efficient geographical unit (Mulgan and 6, 1996) and accountability is wider than simple allocative efficiency, especially in terms of both being held to account and openness. Thus a focus on the accountability, democratic and participative mechanisms is more useful.

5.11.3 Caveats

There are, however, problems relating to the relationship between decentralisation and accountability. First the relevance of democracy to the NHS is limited, although recent debates about foundation trusts have raised issues about what the appropriate balance between representative and direct democracy should be. De Vries has pointed out that turnout is lower in local elections (De Vries, 2000: 200) and elections for Centres locaux de services communautaires (Quebec Community Health Councils) also had a low turnout, averaging 13% (Abelson and Eyles, 2002).

Second, there is a need to explore inter-relations between dimensions of accountability (Gershberg, 1998). Accountability in health care is complex, with many accountabilities (Klein, 2003a). Accountability needs to more clearly defined in terms of accountability for what and to whom. There is a need to balance accountability and autonomy: autonomy to overcome interests but accountability to public. A certain degree of re-centralisation may be needed (Johnson, 2001).

5.11.4 Evidence that decentralisation promotes accountability

In their study of the devolution arrangements in the UK Ezzamel *et al.* (2004) found that devolution is associated with more openness, transparency, consultation and scrutiny regarding budgets. In health New Zealand has possibly moved further than other countries in decentralisation, accountability and integrated systems due to the creation of area boards rather than from market reforms (Malcolm, 1993). Craig (2003) has suggested that common accountability platforms in New Zealand involve agreements between local providers and central government (including measurable service outcomes). Managers in New Zealand report increased accountability, commitment and innovation (Malcolm *et al.*, 1994) and decentralised organisations seemed to achieve increased efficiency and accountability (Malcolm and Barnett, 1995).

In their study of decentralisation in the UK Ferlie and Pettigrew (1996) found that greater decentralisation was balanced by tighter (central) accountability in HQ reforms. Thus whereas decentralisation is associated with greater accountability this may not necessarily mean local accountability. However, Ashburner and Cairncross (1992, 1993) found that local board representatives were more likely to feel that some accountability to the local community was necessary.

5.11.5 Evidence that decentralisation decreases accountability

In his study of Norwegian health service decentralisation Elstad (1990) concluded that decentralisation does not necessarily lead to more democracy. In fact Fattore (2000) argues that there has been a traditional lack of accountability. A greater role for the centre regarding accountability and comprehensive care is required. With decentralisation there are problems of co-ordination, accountability and control in diversified/multi-divisional organisations (Hill and Pickering, 1986). In New Zealand decentralisation was accompanied by monitoring, performance management and accountancy control. This link raises questions about the link between decentralisation and performance and uncertainties exist in both upwards accountability to funders and downwards accountability to electors (Jacobs, 1997; Craig, 2003).

5.11.6 Conclusion: the balance of evidence

The evidence relating to the extent to which accountability is increased through decentralisation is mixed. In fact there is evidence of dual trends – centralisation and decentralisation and therefore the impact on accountability is uncertain (Wistow, 1997). Clearly the complex nature of accountabilities in health care makes a simple assessment of accountability limited. There is little research that examines the relationship explicitly between accountability and decentralisation and what information does exist uses a simplistic approach to the analysis of decentralisation. On balance decentralisation is likely to further increase the

complexity of accountability as it increases the number of accountability relationships. More research is needed on the relative weights and benefits of different forms of central and local accountabilities. The tension between central performance measures and local participation is perhaps best summed up by Abrahamson (1977: 208): 'It is hard to deny that centralisation, concentration of resources, increasing expert functions very often leads to gains in efficiency. But the ethos behind participatory democracy is to ask "*whose* efficiency" or if we are to consider efficiency always presupposes an outcome "*whose* outcome"?'

5.12 Conclusion

The SDO and additional criteria do offer a reasonably comprehensive assessment of the impact of decentralisation. However, a number of problems have been identified relating to the coverage of the literature and how far it is possible to assess the balance of evidence that supports the assumptions made about the effects of decentralisation on organisational performance. In addition, having completed the analysis, it has become apparent that other criteria could potentially have been included, such as participation and quality (user and technical). Furthermore, some criteria are defined too narrowly (for example, staff morale) or too vaguely (for example, humanity).

As identified at the beginning of the section the review identifies the fact that the performance criteria are not discrete and there are substantive overlaps between the different criteria. The review of evidence confirms that some of the studies identified use one performance criterion as a variable to measure another. This raises questions about the strength and quality of the evidence. In addition, the review demonstrates that the balance of evidence is often equivocal at best or does not provide any real conclusion. These issues are addressed in the next section, which examines the application of the evidence to the NHS in England.

Section 6 Understanding and interpreting the evidence

6.1 Relevance of the evidence to English health care organisations

In this section we synthesise the review of the evidence, taking into account the relevance of the evidence to English health care organisations. The discussion takes into account the need to address key questions about the link between decentralisation and organisational relations and performance within the English health care system. Of particular concern here is the extent to which the empirical evidence is transferable to the UK NHS.

Context is seen as highly relevant to the identification of effective interventions and there is a clear view in the policy-implementation and -evaluation literature that any intervention is likely to be context-specific, limiting its relevance to other contexts and thus its transferability (Pettigrew *et al.*, 1992; Rogers, 1995; Pawson and Tilley, 1997; Dolowitz *et al.*, 2000). Context here is defined in terms of temporal, spatial and institutional dimensions. The review of the extant literature in the previous section includes a wide range of studies including those on local government, health care and the private sector, and also examines decentralisation in a wide range of countries. Therefore, evidence is filtered through a hierarchy of contexts relating to where the evidence comes from (UK, developed country, developing country), the area of activity (unified health care system, social insurance system, mixed model, local government, etc.) and when the study was undertaken (more recent is more relevant than older studies). The most *relevant* evidence would be recent studies of the NHS in England whereas weaker evidence refers to studies from non-health contexts, other countries or older studies. In particular, as discussed in Section 2, the English NHS is an administrative structure with funding determined centrally so that while authority can be shifted between levels political control is retained centrally.

There is little explicit evidence that relates to the UK health care context. Much of the evidence on outcomes relates to developing countries and relates to activities that are on the whole already decentralised in the UK – family planning, child and welfare services, immunisation, etc. Table 10 (at the end of this section) summarises the relevance of the evidence to the UK.

In order to highlight aspects of the relevance to English health care organisations to each of the performance criteria the following sections summarise the main points from the review in Section 5.

6.2 Outcomes (for patients/health outcomes)

The evidence on the link between health outcomes and decentralisation is weak. The main area of theory that underpins a positive association between outcomes and decentralisation is fiscal federalism. As discussed elsewhere this has little relevance to English health care as budgets are set centrally and although resources are allocated to purchasers on a per-capita basis there is no opportunity for local purchasers to raise revenue locally. However, the incentives associated with cost savings rather than just revenue raising are significant to health care organisations. For example, GPFHs were able to retain some of their unplanned savings, thereby affecting their autonomy. In addition, most evidence of outcomes is predominantly located in developing countries and, therefore, of little direct relevance to the UK. One recent study in Canada (Rubio and Smith, 2004) does link decentralisation positively to improved infant-mortality outcomes. However, the relevance of this to the UK is limited given the differing fiscal and child welfare service arrangements between the two countries. The UK is more fiscally centralised than Canada, where Provinces have some fiscal leeway and child welfare services in the UK are already more decentralised, organised around GP practices and community services than their counterparts in Canada. In fact many of the benefits in terms of outcomes associated with decentralisation in developing countries refer to services that in the UK we would see as already at a very localised level (e.g. immunisation). Thus, can a centralised funding system be reconciled with decentralisation of (public or private) provision?

6.3 Process measures

There a number of key assumptions that link decentralisation to improvements and benefits in process, including co-ordination, accountability, responsibility and cost. Game theory and organisation theory (network model) provide some support for the assumptions of improved co-ordination and communication. However, there is a lack of any real definitive empirical evidence to support the key assumptions that have been made. In particular there is a continuing debate between the scope for economies of scale *vis-à-vis* responsiveness. There is some UK literature that has specifically addressed health care purchasing warning that decentralisation can lead to duplication (Le Grand *et al.*, 1998). In local government studies have suggested that performance improves with scale but there is also a body of literature stating there can be no optimal size for making specific decisions or undertaking functions (De Vries, 2000) and Atkinson (1995) concluded that decentralisation does not make any difference to performance.

6.4 Humanity

The concept of humanity lacks clarity when applied to health care services and performance. The concept is closely linked to responsiveness but perhaps focuses more on issues of respect, autonomy, confidentiality, promptness, adequacy and

clear communication. In the NHS this relates to well being of the patients/population served in terms of how they are treated and the relationship organisations have with their local communities/patients. In this respect decentralised agencies are seen as being closer to the populations/patients they serve. There is some limited evidence from the UK that local boards feel more responsible to their local populations. However, the participation literature identifies the dangers of local agendas being dominated by groups with more resources and some people may, therefore, be excluded. There is good evidence to conclude that closer patient partnerships improve outcomes and the Expert Patient programme is predicated on the assumption that people with long-term chronic conditions can take more control over their own care. However, whereas studies in the States support the notion of self care there have been questions raised about the nature and delivery of the programme in the UK (Wilson, 2001).

6.5 Responsiveness (including allocative efficiency)

There is a strong assumption that decentralisation will improve allocative efficiency. The theoretical approaches associated most closely with this assumption are welfare economics and public choice theory. There are a number of studies that relate to this area and some that are specifically UK-based or relate to other Western European countries, so their relevance is strong. Studies of decentralisation in local government in the UK have suggested that decentralisation results in an improvement in the quality of public services achieving a better distribution of resources (Burns *et al.*, 1994; Hambleton *et al.*, 1996). In their review of health care systems and decentralisation Saltman *et al.* (2003) argue that decentralisation increases allocative efficiency as services are more responsive and accountable to patients. There is also a link to the literature suggesting that decentralised agencies are more innovative (Osborne and Gaebler, 1992; Levaggi and Smith, 2004). However, as Seabright (1996) has argued, while there is a link between increased accountability and decentralisation this does not demonstrate that increased accountability will necessarily result/be achieved. In addition there is no evidence to show that decentralisation is more innovative than centralisation. The evidence on this is mixed. Also, if innovations are linked to decentralisation, it is important to have a mechanism to aid policy transfer and learning. In fact Walker (2004) has argued that many innovations are centrally driven. There is some limited UK evidence that decentralisation led to improved patient outcomes with respect to GP fundholding in the 1990s (Le Grand *et al.*, 1998) but many current innovations in health service delivery are centrally driven (see Section 4). There may also be some evidence to support the view that fragmentation of services may lead to more responsive services for specific groups in the community (Blomqvist, 2004). However, these gains may need to be balanced against other measures of performance such as economies of scale and equity.

6.6 Staff morale/satisfaction

There has always been a strong relationship between decentralisation and human resource management. In particular, decentralisation has been associated with innovative management and freedoms in approaches to human resource management, increased staff morale and staff satisfaction (Argryis, 1972; Pennings, 1976; Osborne and Gaebler, 1992; Thornley, 1998). However, there is little empirical evidence to support these claims. The evidence that exists is also contradictory, in that organisational change has been shown to lower staff morale and that managers do not significantly change their behaviour simply through organisational change (Hales, 1999; Kolehmainen-Aitken, 1999). There is little empirical evidence that directly relates to health care in developed countries although studies of the private and non-profit sectors do show increased satisfaction and morale in professional decentralised organisations (Pennings, 1976; Schmid, 2002; Sheaff *et al.*, 2004a). Studies of the NHS in the UK have tended to focus on pay bargaining and there is no evidence to show that this is improved through decentralisation; there may be other benefits in decentralised health care organisations, but these require further research (Arrowsmith and Sisson, 2002). However, studies of the NHS suggest that it is likely that internal and external environmental factors may play a more important role than decentralisation per se (Hales, 1999; Arrowsmith and Sisson, 2002). However, Arrowsmith and Sisson suggest that there may be bottom-up benefits in terms of the local organisation of human resources management but that this requires further research.

6.7 Equity

Decentralisation can either increase equity by better meeting the needs of different groups (vertical equity) or reduce equity by creating differences between groups in equal need (horizontal equity). Fiscal federalism theory supports the view that decentralisation can provide a better distribution of resources that meet local needs. However, much depends on where the goal of equity is pursued (centrally or locally) and also on what sort of equity is sought (spatial, class, age, gender, etc.). Empirical evidence to demonstrate the impact of decentralisation on equity is scarce and a key problem is that few studies distinguish between different forms of equity. Research on regionalisation in Spain found little conclusive evidence that decentralisation had either a negative or positive effect on equity, while in Italy and New Zealand the evidence suggested a widening of inequalities and Switzerland, the most de-concentrated health care system in Europe, is currently struggling with the worst disparities in service distribution. There are few UK studies but research on fundholding in the UK suggested that this led to some inequalities in access. Therefore most evidence seems to imply that decentralisation will lead to inequity at the inter-area level (though it may assist intra-area equity via improved responsiveness). This is of particular relevance to UK important given the NHS emphasis on equity and fairness and concerns about a postcode lottery.

6.8 Efficiency (technical/productive)

Two assumptions link decentralisation to increased technical efficiency. The first is that large, centralised bureaucracies are wasteful and the second is that small organisations perform better as they are closer to the communities they serve. Public choice theories point to a number of problems with these assumptions including, spill-over effects, duplication and excessive employment of resources. In addition it is not clear that scale and size have any influence on organisational performance (Sheaff *et al.*, 2004a). There is some evidence from the private sector, health care systems in Europe, North America and the UK that decentralisation may help reduce costs both as a result of better resource use and where competition arises. However, these gains need to be set against lack of economies of scale and transaction costs. The empirical evidence regarding size of organisation and performance is equivocal, with contradictory findings from local government in the UK. In relation to health care, studies in the UK suggest that size is only one of a number of factors that shape performance. This is a strong theme in the decentralisation literature. The evidence does indicate some gain in technical efficiency from decentralisation in different contexts. There is, however, mixed evidence on whether decentralisation increases or decreases costs. The idea that there is an optimal size is a fantasy; multiple functions mean organisations need to compromise between different optimal sizes for each function.

6.9 Adherence

While the concept of adherence to centrally determined performance targets or other centrally defined goals appears at odds to the autonomy granted to decentralised units, the nature of the vertical relationship between the centre and periphery and between higher and lower levels of organization are central to any discussion of decentralisation. Adherence implies centralisation to institutional targets or generic evidence-based protocols although targets and evidence-based protocols are different, reflecting institutional goals and professional autonomy. This is particularly relevant in the UK context of the NHS which is a single-payer health system. The assumption is that the process of decentralisation can introduce a stronger performance framework based on guidance, monitoring and enforcement (Smith, 2002). Organisation theory does highlight the fact that decentralised organisations will learn to operate within a centralised system, affording them a degree of managerial freedom (Hales, 1999). The evidence tends to point to the fact that in systems that are decentralised some form of centralisation is retained. Bossert (1998) claims that central authorities will always manipulate the decision space and shape within which decentralised agencies will operate. There is also evidence to suggest that when organisations are decentralised managers' behaviour tends to continue to be shaped by adherence to previously centrally determined procedures. However, decentralisation is also seen as important in terms of gaining trust, which is useful where performance measurement is ambiguous, and as being beneficial to

sustaining professional commitment and involvement in quality improvements (Bojke *et al.*, 2001). Conversely, in New Zealand uneven local organisational capacity developed because of a lack of central performance accountability, hindering the development of decentralised organisations. Context would appear to be a significant factor in shaping the conclusions – type of decentralisation, organisational configuration and historical legacy/template.

6.10 Accountability

Accountability has always been an area of tension within the NHS (Klein, 2001). Recent debates around governance arrangements for NHS foundation trusts, patient and public involvement – especially local authority scrutiny and patient and public involvement forums – have demonstrated the broad range of opinions and concerns held at central government level, in the NHS and in local communities (Klein, 2003a). There is a strong assumption in the literature that decentralisation improves accountability. However, there are some contradictions in the literature as it is seen both as increasing local accountability (De Vries, 2000) and as an approach to increasing central control and accountability (Ferlie and Pettigrew, 1996). In relation to health at an international level decentralisation is associated to improved accountability (Bossert, 1998; Meads and Wild, 2003). The evidence from New Zealand found that the development of local boards did increase local accountability and when boards were established for DHAs in the 1990s local representatives saw themselves as accountable to local communities even though specific mechanisms for achieving this did not exist (Ashburner and Cairncross, 1992, 1993). Yet, similarly to the UK, in New Zealand the improved local accountability was accompanied by increased central monitoring, performance management and accountancy control. As Wistow (1997) has observed there are dual trends of centralisation and decentralisation, both of which have an impact on accountability.

6.11 Conclusion

The discussion in this and the previous section points to some important weaknesses in the evidence base. While there are a number of key assumptions about the positive benefits of decentralisation there is less theoretical support for these and even less evidence to support them. This becomes increasingly true as the evidence is applied to health care organisations in England. A brief review of Tables 7–10 underlines this point and there is clearly a lack of good-quality, relevant evidence to support the link between decentralisation and organisational performance.

A key problem in the evidence base is the way decentralisation is used as an independent variable. This is then compounded by the fact that other variables employed in studies also lack conceptual rigour or different performance criteria are utilised to demonstrate that other criteria are affected by decentralisation. For example, decentralisation leads to increased staff morale so this improves

managerial processes (Germain and Spears, 1999). However, the evidence supporting a link between decentralisation and improved staff morale is itself not clear, so the central assumption of this study is not sound.

There is also a question of weighting. Decentralisation is a complex process and clearly operates alongside centralisation. These are complementary processes. However, the evidence does not identify whether the decentralisation or centralisation of one activity or function should carry more weight than another. For example, if funding decisions (process) are decentralised to PCTs from central government so that they have freedom to spend money as they decide, how should this be measured against the need for PCTs to meet specific performance criteria set at the centre (outcomes). There are also trade-offs between different performance criteria. Is it better to have decentralised inputs, processes or outcomes and how do we weigh up the difference between say equity and responsiveness? These are crucial service questions but the current evidence base does not provide clear answers. Similarly there are key questions about the degree of decentralisation – how far should functions be shifted to produce the best performance?

Finally the review of evidence again highlights the importance of context. It is clear that while many assumptions are made about the effect of decentralisation – both in policy and practice – which have some support within the general literature on decentralisation, there is little substantive empirical evidence to support these. In Tables 7–10 we have demonstrated that whereas most assumptions are positive about the effect of decentralisation on organisational performance (the exception being adherence), there is less support for these assumptions in the theoretical literature, less general evidence and, with respect to health care organisations in England, very little relevant empirical evidence. Thus context is clearly very important and points to the need for further empirical research on these areas within the UK. Transferability of evidence from other countries and contexts is difficult (Pettigrew *et al.*, 1992; Rogers, 1995; Pawson and Tilley, 1997; Dolowitz *et al.*, 2000). Much research is focused on developing countries, is on local government or relates to health care contexts that are significantly different to England.

Table 10 Decentralisation – relevance to English health care organisations

Performance criterion… / Aspect decentralised	Outcomes	Process measures	Staff morale	Humanity	Equity	Responsiveness; allocative efficiency	Technical efficiency	Adherence	Accountability
Inputs			––		?		+	?	
Process		?	––		?	–	+	?	
Outcomes	––	–	––		?	––	++	+	–

+, Some evidence; ++, strong evidence; –, quite weak evidence; ––, weak evidence; ?, equivocal evidence; blank, no relevant evidence.

Section 7 Conclusions: outstanding research questions and further work

7.1 Introduction

In this final section we present the key findings from the review and identify key messages relating to health care practice, policy and research. It is clear from this review that decentralisation/centralisation are highly relevant concepts in health care systems and are of current health policy concern in the UK and elsewhere. However, despite the wide general discussion about decentralisation it would appear to be a neglected aspect of health services and policy research.

7.2 Summary of the main findings

It is clear that decentralisation in health policy is a problematic concept. First, there are significant problems of definition (Atkinson, 1995; Gershberg, 1998; Hales, 1999; Saltman *et al.*, 2003; Levaggi and Smith, 2004). The term decentralisation has been used in a number of disciplines, such as management, political science, development studies, geography and social policy, and appears in a number of conceptual literatures such as public choice theory, principal/agency theory, fiscal federalism and central–local relations. It has links with many cognate terms such as autonomy and localism, which themselves are problematic (Page, 1991; Boyne, 1993; Pratchett, 2004; Stoker, 2004). Other commentators tend to use different terms, such as agency (Ham, 2004), central–local relations (Baggott, 2004), hierachies, markets and networks (Exworthy *et al.*, 1999; Le Grand, 2003; Ham, 2004), and national versus local (Powell, 1998). While decentralisation and devolution tend to be the dominant terms, they are rarely defined or measured, or linked to the conceptual literature. Second, much of the literature refers to elected local government with revenue-raising powers. As discussed previously, application to a national health service, which is appointed and receives its revenue from central grants, is problematic.

The discussion in this report identifies three main problems associated with the analysis of decentralisation. These are that:

- there is a lack of clarity regarding the concepts, definitions and measures of decentralisation;
- the debate about decentralisation, and subsequent analyses of decentralisation, lack any maturity and sophistication;
- assumptions about the effects of decentralisation on a range of issues including organisational performance are incorporated into policy without reference to whether evidence or theory supports such an approach.

Current analyses of decentralisation pay little attention to clearly defining what is being decentralised and our new Arrows Framework provides a useful way of conceptualising this aspect of the process. However, the literature and evidence on decentralisation makes little reference to the relationships between different levels and within different levels and the results of the governance project will help inform the development of analyses that address these issues in future research.

Decentralisation is not a completely discrete area of research and more attention needs to be paid to how it is utilised as a concept in future practice, policy and research. The brief for this review identified two areas for analysis relating to relationships between organisations. In addition, the changing nature of the dynamics between parts of a system over time resulting from the combination of multiple centres of direction and regulation (including financial, political and technical) and multiple strategies emerging among the regulated organisations (including collaboration, compliance and competition) were identified as an area for investigation. There was little evidence in our review to be able to comment on these areas and further substantive reviews may be required. We only found one NHS paper that specifically examined partnerships (Hudson, 1999). However, there are clear links between the evidence examined in this review and the review of organisational performance undertaken for the SDO (Sheaff *et al.*, 2004a) and the review on governance also commissioned by the SDO at the same time as this review. The findings of these reviews may also have implications for future research on decentralisation.

The evidence base, while extensive, is very diverse and only loosely connected to organisational performance. This finding is similar to that in Sheaff *et al.* (2004a). The evidence is often equivocal and there is little good-quality evidence that supports key assumptions about decentralisation that is also supported by theory. In particular, much of the evidence is context-specific and we found little evidence of high quality that is specifically relevant to the UK context. However, as discussed in Section 4 decentralisation remains a strong emphasis in current Government policy but this review suggests that there is little evidence to support assumptions made in policy.

7.3 Implications for the development of health care organisations in England

The key message from this review is that decentralisation is not a sufficiently strong individual factor to influence organisational performance as compared with other factors such as organisational culture, external environment, performance-monitoring process, etc. Neither is there an optimal size/level that provides maximum organisational performance. Different functions and the achievement of different outcomes are related to different organisational size and level. There are, therefore, trade-offs or compromises between different activities and outcomes. For example, different approaches to equity, responsiveness versus economies of scale and so forth.

In addition, policy-makers and managers need to view decentralisation and centralisation together and simultaneously. Given the fundamental commitment in the UK to keeping the NHS as a public service funded from taxation (Wanless, 2002) there will always need to be a recognition that health care services in England will be set within the context of central–local relations. Therefore, every decision by policy-maker or a manager affects the balance between decentralisation and centralisation. It is important that in making decisions policy-makers and managers recognise inter-relationships between inputs, processes and outcomes and levels in the sense that any organisation (or individual) can gain and lose. It also essential that decentralisation is seen as a process – one of a number of factors – that can be employed for achieving particular goals rather than as an end in its own right. Decentralisation is a *means* rather than an *end* of policy. There should also, therefore, be a recognition of the changing nature of dynamics over time – as demonstrated by the discussion in Sections 3 and 4.

The specific context of the English NHS means that discussions of decentralisation are within the context of administrative rather than political decentralisation. Local NHS organisations do not have devolved political power or the ability to raise finance. Funding comes from the central body. Thus while it is possible to discuss political decentralisation or devolution in a UK context referring to Northern Ireland, Scotland and Wales, when examining the organisation of the English NHS this does not apply. While developments such as lay representation on executive boards and foundation trust governance arrangements suggest local independence they operate within a tight, centrally defined structure.

The lack of a strong and relevant evidence base has important consequences for policy and practice. This review has demonstrated that much discussion of decentralisation is based on assumptions that are not substantiated by theory or evidence. A key problem is that benefits in one context are incorporated into general assumptions and are often transferred to other contexts despite the problems associated with doing this (Pettigrew *et al.*, 1992; Rogers, 1995; Pawson and Tilley, 1997; Dolowitz *et al.*, 2000). As Boyne *et al.* (2004) have argued in relation to local government organisational performance, there is a real need to improve the connection between theory and practice. Therefore in developing an evidence base attention should be paid to the contribution of theory. As this review demonstrates, currently there is little relationship between the assumptions, theory and evidence base about decentralisation in health services.

However, from this analysis it is possible to identify a number of key recommendations for policy-makers and managers. However, as identified in Section 6 our key recommendation is for further empirical research that addresses the gaps in the current evidence base.

7.4 Recommendations for policy

In 2001 the Performance and Innovation Unit of the Cabinet Office published a paper, *Better Policy Delivery and Design* (Policy Innovation Unit, 2001), that identified the need to develop a balance between decentralism and centralism and suggested that more attention needs to be paid to identifying the type of decentralisation – for example over process and over outcomes (e.g. performance targets). Our conceptual framework presented in this report clearly identifies the need for policy-makers to more clearly take into account the *what* of decentralisation and the inter-relationships between the decentralisation and centralisation of different functions and responsibilities. It is important that policy-makers develop a more sensitive and sophisticated approach to the way decentralisation is developed within policy and the Arrows Framework provides a simple framework for addressing these issues (as shown in Sections 3 and 4). Clearly there are important questions that need to be answered about whether key policy assumptions about freedom, earned autonomy, patient choice, effective commissioning, localisation, accountability, equity, etc. that are to be achieved within health care services can be achieved through a simple approach to organisational decentralisation.

The analysis in this report suggests that currently, whereas a number of key inputs and processes are being decentralised, the retention of outcomes at a central level limits the extent of decentralisation and the autonomy of local health care organisations. In addition, as the discussion in Sections 3 and 4 demonstrates, whereas responsibility for outcomes may have been decentralised from the Department of Health to DHAs in the 1990s its re-centralisation after 1997 has been to the Health Care Commission not the Department of Health. Thus changing central relationships are as key a characteristic of decentralisation/centralisation as relationships between organisations at other levels. Policy-makers therefore need to:

- be more explicit about the aims and objectives of decentralisation in relation to inputs, processes and outcomes based on a clear awareness of the poor evidence base;
- be more aware of the importance of context in transferring mechanisms;
- recognise that decentralisation is a process and not a single event;
- address the changing central context as responsibility over outcomes shifts between central organisations.

7.5 Recommendations for practice

The application and implementation of policy is clearly one area where managers and practitioners will be concerned with issues of decentralisation. However, organisations also need to understand what impact the flows of decentralisation and centralisation have on their organisations. For example, using the Arrows Framework it is possible to identify that for an English PCT there are a number of

cross currents of decentralisation/centralisation as shown in Figure 9 (at the end of this section).

This means that within health care organisations more attention does need to be paid to the impacts of decentralisation. With current key policy initiatives on practice-based commissioning, patient choice, foundation trusts, etc. local as well as national health care organisations need to develop a more sophisticated understanding of decentralisation processes and simple assumptions about the benefits, or otherwise, should be avoided. Health care managers and practitioners should therefore:

- give more explicit recognition to the compromises/trade-offs between performance criteria (e.g. equity versus efficiency versus responsiveness, etc.) when developing strategies;
- understand the equivocal nature of evidence and, in particular, the important role of context;
- understand that decentralisation is not a panacea – it is a process which among other factors can have an impact on organisational performance – but which should not be seen as an end in itself.

7.6 R&D questions and further work

There are clear links between some of the issues arising from our examination of decentralisation and other SDO programme areas. In particular research on organisational performance, human resource management and workforce issues are clearly linked to decentralisation. One area the SDO may want to consider is the value of comparative research across these programme areas. The research proposals outlined here have been identified from existing gaps in the evidence that relates to health care organisations in England. Comparisons within the UK to examine and compare developments in England with Northern Ireland, Scotland and Wales as well as the impact of devolution itself may provide further significant insights. In particular, we recommend that consideration is given to research that addresses the issue of context with the use of good-quality case studies and also for research that takes a longer time span than the normal 3-years, to capture change over a more realistic period. In addition, we believe that there is a need for research that examines specifically the relationships between and within levels by adopting studies that focus on health care economies rather than simply organisations. Nine areas for further research are identified, as follows.

7.6.1 Conceptual framework

Further research is needed on the development of a conceptual model and framework for health services decentralisation. In this study we have extended the current conceptual frameworks of decentralisation to include a recognition of the individual dimension and also clarity about defining what property is being decentralised. The concept of decentralisation is often poorly used with the

purposes of decentralisation being unclear and confused. A clearer conceptual model is particularly important in policy development. Further research is needed to refine this conceptual framework and examine how it is applied in practice. Much of the evidence identified in our review has been generated in other contexts – sectors, countries – and further research is needed to examine what is transferable or generalisable. What theories (e.g. on local government) are applicable?

7.6.2 Measuring decentralisation

There is little research literature on measuring decentralisation as a dependent variable. As a concept it is multi-dimensional and therefore the measures must be as well. Often, the only dimension that is measured (albeit poorly) is fiscal decentralisation. Further research is required to identify the key indicators for measuring decentralisation. Our research establishes some of the key principles but there is little literature that measures decentralisation in terms of key criteria such as access, equity, responsiveness, etc. This may also include examining health outcomes and a more explicit use of measurement criteria of decentralisation policies is needed. Decentralisation presumes many benefits which may not always be realised in practice. We need to ask the question about under what conditions might these be achieved. How might the compromises between these objectives be managed? That is, how to resolve the common efficiency-equity trade-off? (Other trade-offs may provide significant avenues for future research.) We need a much clearer appreciation of the key criteria for measuring decentralisation and organisational performance. This will also include gathering stakeholder views at different levels (centre, locality, practice, individual) to provide a range of perspectives about the nature and impact of decentralisation and also develop an understanding of how to weight the different criteria.

7.6.3 Links to organisational performance

There is a clear relationship with organisational performance research but which factors are more important: organisational size, structure, the people in it, population served, organisational mechanism, autonomy (over what?) or leadership? Decentralisation is not a single mechanism in its own right; it is multi-dimensional. It is however, an approach for examining other aspects of organisational and policy performance. Research on organisational performance should therefore incorporate decentralisation as one aspect to be studied.

7.6.4 Decentralisation and function

More research is needed to examine the contexts of decentralisation. In particular, which function works best at what level? Is there a specific receptive context for particular functions? There remains uncertainty around what decisions are best taken where and the size of the constituency – this might vary across

different areas. There is little consensus about the level that is most efficient for provision – for example, commissioning and practice-based commissioning. Where are commissioning, financial management, public health, etc. best located? What are the factors that would enable an area/function to fare best with decentralised services, and to what extent is this related to existing context and culture? These questions are particularly important in relation to earned autonomy and the relationship between different agencies at any particular level. Is earned autonomy only related to an organisational context? Can earned autonomy be achieved by specific services within an organisation or across local health economies? What is the impact of this? Does 'one size fit all' or is decentralisation more suitable for some activities but not for others? Is there a trade-off between criteria? The literature suggests that there is no single optimal size so any organisational arrangement in decentralisation will involve trade-offs between functions. In addition, research is needed to explore how actual policies (e.g. earned autonomy) relate to decentralisation concepts and measures?

7.6.5 Decentralisation and decision space: relationship between decentralisation and local health economies

Another key issue is to conduct research that moves beyond a focus on single organisations. To what extent can it be said that local health economies or communities have autonomy? To what extent does differing levels of local organisational autonomy (e.g. one-star PCT and three-star trust) affect the organisational performance of each organisation? A case-study approach would be most applicable here. Bossert's conceptualisation of decision space – the freedom to act within a given local health system context and at a particular vertical level (e.g. clinician, PCT, SHA) – may provide a useful approach to this. It may not be possible to examine decentralisation in isolation and thus it is important to measure the effect of decentralisation alongside other factors and system changes. It is recognised that it will be difficult to hold other factors/changes constant and research needs to take account of the challenges of analysing complex contexts. There are difficult causation/attribution problems to address as it is important to examine both the vertical and horizontal dimensions of decentralisation. However, a key question is to determine how much decision space organisations in a system have – in terms of between levels and in terms of relationships with other agencies.

7.6.6 Decentralisation and participation

It has long been recognised that the NHS lies outside of local democratic structures and many attempts have been made to address what has been described as a democratic deficit. However, given the strong assumption made about participation and democracy being improved through decentralisation it is important that further research is undertaken in the UK to address this aspect of organisational change. What level of decentralisation is best for public involvement and meeting public preferences? There is a need for further research

on how the public relates to local health agencies and the methods and mechanisms of engagement. Do foundation trusts have better systems through their governance arrangements? What levels of influence do local consumer health groups have on local health services and what is the balance between different types of group? How does this relate to issues of accountability, humanity and responsiveness of local health services?

7.6.7 Decentralisation and human resources management

There are important questions about autonomy and capacity in organisations. Human resource management is clearly an important organisational issue for decentralised agencies and there are concerns about capacity in relation to the operation of specific functions. Does freedom to manage deliver better organisational performance notwithstanding skill base and capacity issues? There is a need to examine the motivation of local managers who may be used to central control. Also, how do local organisations manage competing pressure for autonomy and control from the centre and also increasing autonomy for lower level organisations, more professional autonomy, patient autonomy, etc. An important area for further research in this area is the link between decentralisation and professional roles and professional autonomy.

7.6.8 The impact of decentralisation on the centre

An important area that is rarely addressed in the literature is the impact of decentralisation on the role of the centre. Further research is needed on the design and implementation of steering mechanisms such as how the centre should conceptualise decentralisation that distinguishes between inputs (resources), processes (commissioning, patient choice processes, etc.) and outcomes (targets, indicators). There is little research that addresses the impact of shorter hierarchical lines of authority. Also, no literature was found that explicitly addresses the relationship between multiple centres examining the inter-relationships between the role of regulatory agencies (monitor, Healthcare Commission, professional bodies) or between territorial centres (in Scotland, England, Wales and Northern Ireland). Research should also take account of the movement towards the European Union (e.g. Health Protection Agency).

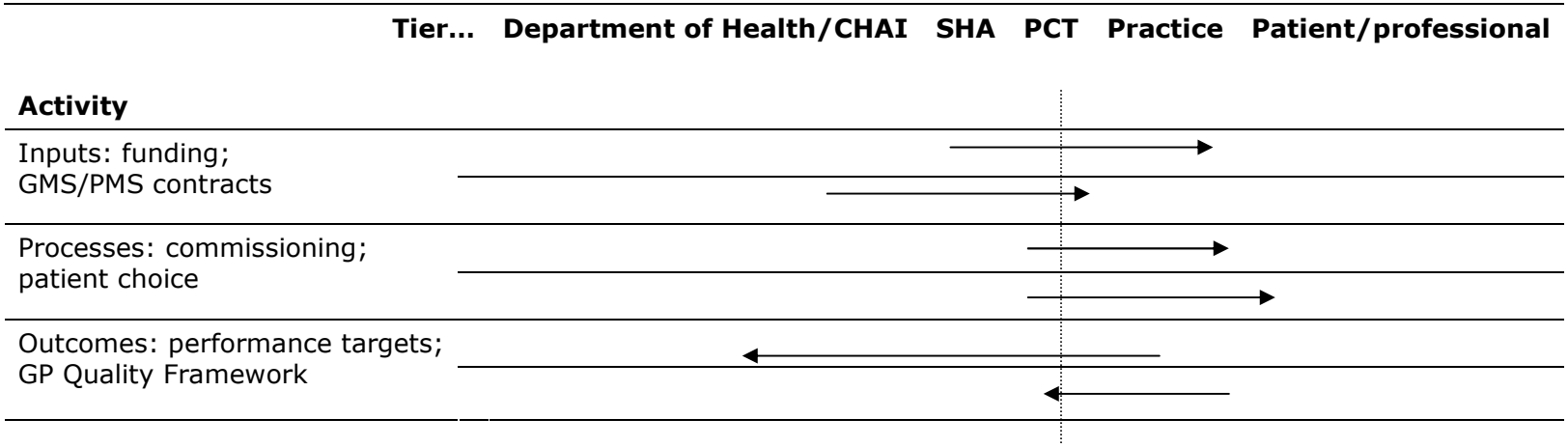
7.6.9 Longitudinal studies of decentralisation

The process of decentralisation and its effect on organisations takes many years to develop. Further research is needed on the dynamic nature of decentralisation to capture change over time. This also links to other areas of SDO interest in relation to organisational change and performance. This includes the need to examine the impact of continual re-organisation upon organisational and personal development. (e.g. the impact on governance structures of anticipated PCT mergers before and after the 2005 general election).

7.7 Conclusion

It would appear that Klein's (2001: 106) summing up of the situation in the 1990s holds true for today, in that everybody paid verbal homage to the principle of decentralisation, but how was this going to be achieved in a nationally financed service? Similarly, it is still not clear whether the NHS is a central service that is locally managed or a local service operating within central guidelines Butler (1992: 125). Klein's (2003a) analogy of decentralisation as a revolving door is also apt as it reflects the ways in which decentralisation falls in and out of fashion. To extend this analogy, there is a need to learn from the current previous revolutions of this door to inform future policy and practice. Given that decentralisation is a major part of policy rhetoric and current policy development there is an urgent need to develop a strong evidence base to support these developments.

Figure 8 Decentralisation/centralisation at a PCT level



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Appendices

Appendix 1 Summary of evidence

Author(s) and year	Quality	Methods	Context	Year of study	Terms	Measurement	Function	Perf domain	Conclusions: impact on org perf	Other comments
Abelson *et al*. 2002	PR; public admin	QV: 59 interviews	Canada: Ontario and Quebec; health	1999 – 2000	Devolution (provincial govt to regional HA)	Why and when to consult? How to consult? How to measure success?	Public involvement	Accountability	• Public consultation: means or end – views divided • Preoccupation with consensus	
Ahmad and Broussine 2003	PR; public mgt	QV: critical case sampling	UK: public sector	nd	Dec. (as part of UK modernisation programme)	Subjective assessment from interviews	Various	Perception of (lack of) trust	• Feelings of disempowerment and control	• Ambivalence re. modernising cent.
Amin *et al*. 2003	Report	Commentary	UK	nd	Dec; de-centre	Inequality between regions	Socio-economic inequality	Equity; efficiency	• Concept of regions flawed in era of networks • UK unequal structure helps explain regional inequality • New econ regionalism requires more than devolution of power: instead, multinodal nation • Against devolution as a tool of bureaucratic efficiency	• Concentration of political power sustains regional inequality • SE England does not 'succeed' by its own intrinsic

									• Disenchantment w/centre→new localism	qualities
Anderson 1998	PR	Review: states' policy	USA: health	1991 –4	Federalism	Relations between state and federal govt.	Health services	Efficiency Responsiveness Acctbly	• Review of Reforming States Group: to develop guide to organising state legislative action • Governor meeting catalysts	• Reform process of state health policy-making
Andrews and Schroeder 2003	PR; devel studies	Normative arguments, models and empirical evidence	Sub-Saharan Africa	nd	Dec: assignment of services to subnational govts	Congruence between theory and practice	Primary health care and rural roads	Efficiency	• Legislated models of decentralisation are largely informed by normative theory • Disjoint between what govts decentralise in a formal sense (in law) and what they decentralise in an actual sense, explained by limits to dec	• Limits to dec: spillovers, scale economies, bureaucratic politics and capacity constraints
Anell 2000	Comment ary	Policy review; principal/agent nt theory used	Sweden	1990s	Dec: change in locus of power between different admin levels	Assessment of dec impact in terms of perf domains	Health services	Efficiency; equity; quality	• Difficult to isolate single dec measures, so effects of dec on efficiency, equity and quality remain unanswered. Also lack of interest in answers • Two requisites: motivation of dec level and local capability, e.g. some managers unwilling to tackle equity concerns • Delegation of resp often precedes delegation of authority • Concern that Swedish councils too small→ merger	• Dec does not end w/formal delegation; mgt devel and support systems • Dec not a solution to problem; better opportuni-ties for dealing w/problems

									• Cent via guidelines	
Anton 1997	PR	Policy review	USA; health (shift from ADFC to TANF, 1996)	1990s	Federalism; intergovernmental fiscal relationships	'Devolving authority'	Administration of federal programmes; 'local' flexibility on programme design and implementation	Allocative efficiency (though term not used)	• Debunking myths re. size, control, uniformity, sustainable separation and disorder • Functional specialisation among national, state and local govts based on pragmatic decisions • Devolution cannot mean separation; limits mean that close political ties remain	• States will continue to be leading players • Inter-state differences are increasing • Debate over entitlement versus block grants
Arrowsmith and Sisson 2002	PR; mgt; IR	Survey and case studies; firm-in-sector approach	UK; health	1995–8	Dec: linked to marketisation and privatisation	Respondents' views and attitudes	Employment recruitment and retention	• Staff morale/satisfaction • Local flexibility	• Very little localisation of pay partly due to limited financial reserves for transitional costs • Impact of dec shown by trust-specific employment contracts (less so in hospitals)	• External factors were main constraints on localisation • Dec is not a solution per se; conflict with scale economies
Atkinson 1995	PR; geographical	Review	Intl	nd	Dec: transfer of authority to plan, make decisions and manage public functions (Rondinelli)	• Participation, implementation, org scale • Eval at national, regional and local levels • Main input: decentralised or non-	Mgt of health service	Responsiveness versus equity	• National: few studies explore processes which facilitated success and only rarely report failure • Regional: dec alone could not claim to make difference to health service perf. Limited definition of perf used (output~coverage)	Simple indicators of dec are inadequate

						decentralised			• Local: lack of autonomy due to central control	
Atkinson *et al*. 2000	PR; anthropological	Case study	Brazil: health	1990s	Dec: not defined; assumes a geographically defined local govt	• Sources of income • Information • Local voice in planning • Mgt style • Personalised leadership • Commitment	Health services	Social org, social and political culture	Two types of impact: (a) equity, efficiency, quality, outcomes, democracy (b) mechanisms and processes (Bossert)	Need to recognise social/political culture: spaces for autonomy, local voices and spaces for practice and acctbly
Atkinson 2002	PR; geographical; anthropological	Case study	NE Brazil	nd	Dec	Impact of political culture on health mgt	Health service planning	Equity	• Health research failed to recognise cultural impact • Unless research addresses cultural issues, dec likely to widen inequalities between districts	
Balogh 1996	PR; social policy	Review	UK: health	1990s	Dec: devolution of operational functions and resp	Localities as units of mgt and decision-making	Health services: primary care	Commissioning	• Move towards locality-based commissioning but little analysis of experiences • Locality initiatives part of wider agenda re. collaboration, dec and community devel • Notion of locality varies	• Can dec be an 'add-on' or is radical restructuring required?
Bankauskaite *et al*. 2004	Report (Institute for Public Policy Research)	Policy comment and analysis	Europe (federal and unitary states; tax and social insurance finance)	2004: current	Dec (ref to Rondinelli) Dec to whom (only agencies), what functions	a. How far have services been dec'd? b. Why was dec implemented? c. Improved	Health services	Outcomes (weight given to each outcome?); efficiency; outcomes; acctbly	• Governance structure shapes outcomes • Nordic countries: patient satisfaction high due to dec and choice/voice ability • Denmark and Finland:	• Decision to dec often made at general policy level first and then applied

			Case studies: Nordic countries, Spain, Italy		and w/what regulation? Autonomy	outcomes?			cost control via local tax and provision functions. • High-tech efficiency despite political factors • Spain: dec took 20 years and led to policy experiments. Variations in drugs and spending; others marginal • Italy: incr acctbly, reduced spending, incr inequality risk • Anticipated outcomes may not always be attained. Dec is statement of political intent not policy framework	to health • Dec involves continued supervision by state • To ensure consistent and acceptable outcomes, state relies on regulation
Barnett and Newberry 2002	PR; HSR	QV	NZ public sector	1997	Dec, privatisation, flexibility: not defined	Subjective assessment from interviews	Mental health	Efficiency	Regional variations; lack of perf acctbly	Market system combined with central control
Besley and Coate 2003	PR; economics	QT: economic modelling	Theoretical	nd	Dec; cent; ~allocation of costs and authority	Trade-off between dec and cent provision of local public services	Local public services	Efficiency; acctbly	• Sharing costs of local public spending in cent system →CoI between juridisdictions • Amount of conflict of interest varies by spillovers and local preferences	• Draws on Oates 1972
Bjorkman 1985	PR; politics	QV and QT	UK, Sweden, USA; health	1970s and 1980s	Dec; participation and representati	Subjective assessment; patterns of expenditure	Various	Various	Greater cent seems inevitable	Central–local tensions persist; dec is a way of

					on					coping
Blom-Hansen 1999	PR; public policy	Policy review	Sweden, Norway, Denmark; economic, health and child policy	1980s and 1990s	Central–local relations; local autonomy; dec used but not defined	Patterns of local expenditure	Organiz-ation and funding of health services, especially waiting times	Various, mainly efficiency	Policy networks and stakeholders influenced policy outcomes, e.g. extent to which national waiting-time guarantees reduced local autonomy	Policy stakeholder: expenditure advocates, guardians and topocrats
Bogdanor 1999	PR; politics	Political review	UK	C20; mainly 1990s	Devolution; dec	Distribution of political power	Various: mainly division of resp and revenue allocation	Acctbly; responsiveness	• Devolution to Scotland creates new 'constitution' for UK, dividing power to legislate • Emergence of asymmetric federalism (Westminster has differing area resps)	Focus on political devolution w/in UK
Bojke *et al.* 2001	PR; HSR	Review	UK: health	nd	Dec and devolution not used as terms	Org size	Primary care	Efficiency (scale economies)	Optimal size varies with function	Agencies above 100k patients may not generate improved perf
Boles 2002	Report	Policy commentary	UK	nd	Dec	Tensions in resolving three key issues	Public services	Acctbly; equity; efficiency	• No consensus about what a decentralised is or how to achieve it • Three issues: role of choice in giving individuals control; role of private sector; level to which power should be devolved	• Individual should be the ultimate point of dec • More agreement about move away from c/govt than destination
Bossert	Chapter in	Review of	Intl	nd	Dec:	Difficulty of	Health	Equity;	• Extreme expression:	• Need to

1996	Janovsky report; public admin	literature and research			distribution of authority and responsibil-ity; refers to Rondinelli models	isolating dec effects	services	efficiency; quality Difficulty of developing and agreeing criteria of perf	patient is the ultimate object of dec; emphasis on efficiency and quality thru choice and market • Tension between pursuit of equity and efficiency • Most research assumes dec will achieve objectives; not in practice • Need to examine mechanisms of control, policy process	clarify form and impact of dec • Most research in public admin, not regulated market
Bossert 1998	PR; devel studies	Review: conceptual	Intl; Colombia, Chile, Poland	nd	Dec~ expansion of local choice; defined re. principal/agent theory, public admin and social capital	Decision space, incentives, local govt characteristics	Finance, org, HR, access and governanc e	Equity, efficiency, quality, financial soundness	• No clear evidence about combined package of policies to maximize achievement of objectives • Efficiency improved by separating financing and provision, competition • Equity: incr targeted funding • Lack of analytical framework to study how dec can achieve goals • Need info re. amount of choice, what local choices available, what effect choices have on perf • Principal/agent and decision space might help • Central authorities manipulate decision space, incentives, sanctions and control of information	• Lack analytical framework on impact of local autonomy on perf • Dec different from direct change

Bossert 2000	Report (US AID)	Case studies of implementation of dec policies and application of decision-space model	Chile, Colombia and Bolivia: all leaders in Latin America dec	1990s	Dec: transfer of authority for planning, mgt, service delivery from Ministry to other institutions Dec: not a single act (refers to Rondinelli model)	Decision space	Health services	Equity; efficiency; quality	• Wide decision space initially but reduced over time • Wide space: contracting and governance • Moderate space: financial allocations • Limited space: HR, services, targeted programmes • Dec ~ improve some equity measures (per capita expendit) but worse others (richer areas aspent more, widen inequality; no link to wider improvement) • Institutional capacity had some impact on dec	• Lack of robust data, so partial view. No before/after data • Per capita expendit= intermediate indicator • Little evidence that quality improved. e.g. dec no impact on waiting time or views on quality
Bossert and Beauvais 2002	PR; devel studies	Review; conceptual (Rondinelli, principal/agent and decision space)	Ghana, Uganda, Zambia and Philippines	1990s	Dec= granting authority from central national govt to other institutions at the periphery	Decision space	Finance, org, HR, access and governance	Efficiency (allocative and technical); innovation; quality; equity	• Variety in types and degrees of dec • Philippines; devolution to local govt most varied.; Delegation to autonomous health service least varied in Ghana, Uganda, Zambia • Insufficient evidence of impact of dec on decision space to assess system perf	Danger of viewing dec as a single activity (advanced by Rondinelli)
Bourn and Ezzamel 1987	PR; mg	Review; financial devolution	UK: health and universities	1980s	Devolution (defined in financial terms)	Financial	Budgetary decision-making	Efficiency ~ 'budgeting'	• Devolution as a means to increase (managerial) power over professionals Budgetary devolution can	Griffiths and Jarratt reports on health service and

									counter institutional stagnation • Mgt by (professional) clans	universities
Boyne 1996	PR; public mgt	QT: secondary data	UK: local govt	nd	Org scale	Various: financial	Various	Service quality, speed, efficiency	Perf linked to scale in non-metro areas	
Boyne *et al*. 2004	PR; public mgt	Review: conceptual	UK: local govt	nd	Public service improve-ment	Perf measures: cost, efficiency, quality, effectiveness, access and user satisfaction (based on Best Value)	Local govt	Structure, culture, formulation and content of Best Value	Perf assoc w/bureaucracy, cent and integration in a simple and stable environment but negatively associated in complex and dynamic environment	• Research on perf in public org is in its infancy • Difficult to do an *a priori* eval of impacts
Bradbury 2003	PR; politics	Concepts applied to UK political devolution	UK	1997 onwards	Regionalisation (sub-state); devolution	Loyalty, background conditions, socio-economic groups, policy, authority	Political machinery	Political authority	• Sub-state regionalisation different from supranational level • Territorial loyalty makes political mobilisation difficult	
Bradbury and McGarvey 2003	PR; politics	Political review	UK; England	2002	Devolution (political)	Differences in political leadership and acttbly between Scotland, Wales and Northern Ireland	Devolved functions	Acctbly; responsiveness	• Asymmetric devolution • UK operated four different forms of devolution (plus London/England=5) • Only Scotland showed degree of stabilisation, confirming legitimacy	• First years of devolution= tranquil • Centripetal and centrifugal forces remain
Bridgen 2003	PR	Review of policy	UK: health and social	1946 –	Joint planning,	Domain consensus	Joint planning	Collaboration	• Collaboration involves loss of control	

			care	2003	collaboration (dec not used)	(agree what each agency will do)			• Collaboration hampered by org differences and lack of domain consensus	
Bromwich and Lapsley 1997	PR; accountacy and mgt	Review of policy: Next Steps and Financial Management Initiative	UK; c/govt	nd	Dec not defined	n/a	C/govt policy-making	n/a	• Services subject to political control; likely to have objectives at higher org levels which are difficult to define • Public sector mgt and accounting do not keep abreast of developments	Separation of policy and operations may be impossible to maintain
Brooks and Cheng 2001	PR; politics	QT; survey data	USA; public policy	1974–96	Devolution, federalism	Public's confidence in govt institutions	Federal govt	Public support/confidence in federal govt	• Public confidence in govt limited effect on policy preferences; symbolic effect • High levels of support for public provision • Devolution may not restore confidence	Change in party partly affects presidential confidence
Bryson *et al*. 1995	PR; mgt; IR	Policy review and interviews	UK; health	1992–3	Dec of pay determination	Extent to which pay determination has been dec'd	Pay determineation	Staffing/pay	• Union recognition: not all trusts recognise all unions • Bargaining: single-table forum most common • Staff pay: shift to reward loyalty to trust not occupation	• Evidence of partial exclusion of unions • Few trusts had moved to local pay determineation
Burns 2001	PR; tax journal	Policy review	Canada	Post-1945	Central–provincial govt relations; localism used (once) with respect	Central–provincial govt relations	Various: public policy	Various	• Provincial powers may be required to meet responsibilities but these are incompatible with national sovereignty • Need for strong c/govt generally recognised	Provincial right to direct taxation

					to province					
Busse 2000	Comment ary	Policy review	Germany	1990s	Dec; deconcentra tion	Balance of power between federal govt and Lander and self-regulatory actors (sickness funds)	Health services (esp. legislation)	n/a	· Undevolved devolution: powers were never passed down though Lander=dec · Delegation of powers to self-regulatory actors: statutory sickness funds · Hospital financing: no powers in Constitution but federal govt bought right to pass legislation · Balance between actors and govt moved to and fro	· Health not an area for exclusive federal legislation · Other actors= provider associations · Deconcentra tion: only minor importance
Cameron and Ndhlovu 2001	PR	Literature review	Europe; Canada; developing countries	nd	Subsidiarity (spatial distribution of power); federalism	Regionalism	Various public services	Various, mainly efficiency (allocative and technical)	· Economic case for regionalism? · Few economists favour radical dec in federal system	Fiscal federalism= public sector with two or more levels of decision-making (Oates)
Cameron 2001	PR; local govt	Conceptual and policy review	South Africa; local govt	1994 –7	Dec, autonomy	Dec (transfer of workload of central to local govt); autonomy (incl. constitu-tion, treasury and staff)	Various local govt services	Accountability	Different motives for and views on dec: integrational (functional interdependence) and autonomous (separate)	· Three-tier govt: municipality, province and national govt
Cartei 2004	PR; public law	Review of public law	Italy; public policy: schoolsand police	nd	Devolution Subsidiarity Regional autonomy	Central-regional relations	Various: public policy	Legislative competences	· Competencies assigned to regions. Eg health · Constitution inclined to favour regional	Will regional autonomy affect national

					Federalism Dec				autonomy. • Devolution part of dec process but federalism part of centralising process	cohesion?
Carter 1999	PR; philosophy	Conceptual (game theory)	n/a	nd	Dec (not defined)	Geographical concentration	Geographical org of population (urbanis-ation)	Coordination	• Arguments for and against dec in environmental debates • For: overcomes free-riding • Against: Prisoner's Dilemma, co-ordination (need for coercive action) • Conditional co-operation (co-operate, then imitate) generates most benefit	• Carter: strong case for dec
Chapin and Fetter 2002	PR; public policy	Policy review; some conceptual	USA	Mainly late 1990s	Federal, state, municipal (dec rarely used)	Contracting through quasi-market	Public health, contracting	Efficiency; acctbly	• Willingness to pay flawed in public health • Problem in establishing buyer value • Zero sum game: two-buyer co-operative strategy • Five impacts: fiscal and descriptive acctbly, skill devel, defining objective attainment and political survival	• Local govt provide bulk of public health services
Christensen 2000	PR; public admin	Policy review	Denmark; local govt	1970 onwards	Dec (authority from natl to sub-national govt); re-cent Autonomy	Transfer of functional responsibilities to local govt (policy 1970+)	Local govt services (mainly health and care of elderly)	Equity	• Central and local govt actors have mutual incentive to negotiate joint solutions • Multi-level interdependencies provide dynamic process of dec	• Dynamic change can occur in corporatist and multi-level public sector

									which helps local govt	
Cole 2004	PR; politics	QV; thematic analysis	Wales; Brittany	1998 onwards	Dec; devolution	Changes to regional governance processes	Public services	Acctbly; responsiveness; efficiency (allocative)	• Outcomes ~ institutions, relations, identifies, political opportunity structures and environmental constraints • Wales~1998 Act; Brittany~ dense network of relationships • Political opportunity structures shape political space	• Identity, territory and institutions inter-linked
Collins 1996	Chapter in Janovsky report; public admin	Policy analysis	Intl	nd	Dec: transfer of functions, resources and authority from centre to periphery	Measured according to aims of dec (see perf domain); role of centre	Health sector reforms	Equity; efficiency	• Many dec policies not implemented as they fail to overcome cent forces • Where implemented, dec often fails to achieve aims • Conceptual approaches (a) social devel ~ equity (b) market ~ efficiency • Dec cannot be reduced to simple statements: overall conditions for implementation • Dec can lead to fragmentation, weakened centre, inequity	• Privatisation may not be dec but cent via incr state control • Org/al models of dec=ideal types • Dec provides cover for hidden agendas
Craig 2003	PR; social policy	Policy review re. 'third way' ideas	NZ	1990s onwards	Dec =devolving resources commensurate with responsibility; multi-	Various	Health services; inter-agency collaboration re. determina	Spatial scales: functions and levels; acctbly	• De facto dec; i.e. 'not premeditated technically as one' • Common acctbly platforms: agreements between local providers and c/govt (including	

					layered governance; subsidiarity		nts of health		measurable service outcomes)	
Davidson 1997	Comment ary	Review of other papers	USA: health	nd	Political consideratio ns	n/a	Policy	n/a	Importance of politics	
Defever 2000	Comment ary	Policy review	Belgium	1990s	Dec	Relations between federal govt, pronvinces, communities and municipalities	Health services	Resource allocation and expenditure (average expenditure: 96 out of 100 (national average) in Flanders, 102/100 in Wallonia)	· Federal structure: overlapping regions (non-personal matters) and communities (personal) · Segmented pluralism; devel of organised and powerful interests · Pacification: conflict muted; emphasis on co-operation but policy-making complex · Call for autonomy from Flemish community	· 50% Belgian hospitals were run by religious orders · Subsidiarity principle espoused in Flanders
Deeming 2004	PR; social policy	QV; income/expe nd data	UK	2001 –2	Dec (relatively straightforw ard concept to define): extent that signif decision-making discretion is available at lower hierarchical levels	Share of local spending determined by the centre and how much by health care purchasers	Health spending by a single district purchaser	Efficiency (allocative); equity	· Purchasers locked into part decisions · Fear of destabilising local health economy · Centralist approach to allocation of growth funds · Little evidence of shift in power and resp from centre to local purchasing authorities	· Level of central control appears to be distorting central priorities · Pay and price inflation absorbed 1/3 of growth money

De Roo and Maarse 1990	PR; mgt	Conceptual and empirical	Netherlands	n/a	Central–local relations	Strategic org behaviour; policy space	Health care services	Efficiency	• Problems of policy implementation especially if not based on valid theory of policy space • Negotiation and mutual adaptation vital to manage policy space and interdependencies	
De Vries 2001	PR	Review: conceptual	Intl: Germany, England, Sweden, Netherlands	nd	Dec= devolution of power and responsibility over policy (United Nations)	Various	Various	Various: mainly efficiency and democracy	• Little published on effects of dec • Fantasy of optimal size • Values in political culture more impt than inherent features of dec • Same arguments often justify dec *and* cent	Arguments for/against dec are subjective; third approach - differences between policy areas
Di Matteo 2000	PR	QT; expenditure analysis	Canada: health	1975–96	Public-private expenditure	Financial: various	Finance	Efficiency/finance	• Determinants of public-private mix: per-capita income, govt transfers and % of total income held by top 1/5 • Federal decisions since 1975 explain recent changes	
Dixon 2001	Op-ed; economics	Policy review	UK; health	1997–2001	Cent (not defined)	Various	Various health services	Equity; efficiency: alloc and technical; acctbly	• Freedoms of purchasers and providers in internal market heavily restricted • Vision 'right' but NHS capacity to deliver? • Centre should be less over-bearing, trust more and experiment	
Drummond 2002	PR; public admin	QT and conceptual	Australia	nd	Dec; federalism	Spending by central, state	Resource allocation	Efficiency	• Regional states or central–local models	• AU is most centralised

						and local govt	and expend.		could save over AU$20bn • 'Duplicated centralism' costs AU$20bn • Evidence shows potential of cost-effective dec	federal structure
Elstad 1990	PR	Review of policy	Norway: health	1984–8	Dec not defined	• Staffing ratios • Control over annual budget	Primary care	Equity; democratisation	• Increased primary care staffing numbers • Distribution of services has not become more equitable • Dec does not necessarily lead to more democracy	Uncertain whether dec promotes growth of services
Esping-Anderson 2000	PR; social policy	Diagnosis of welfare policy reforms	Intl	nd	Dec	Various	Welfare state services	Various	• Reform strategies: privatisation, dec and familialisation • Dec linked to growth of third sector • Dec will shift responsibility but not generate savings	
Estes and Linkins 1997	PR	Policy analysis	USA	1980s–97	Dec; devolution (devolution revolution)	Various	Long-term care	Equity; finance	• How will states use policy discretion to balance gap between social services and acute care? • State discretion may alter capacity of non-profit org to deliver long-term care	• Forces for change: shorter length of stay, technology, ageing population
Exworthy 1993	PR; geography, policy	QV: policy analysis	UK	1991–2	Dec; cent	Org/structural changes to NHS	Health services	Responsiveness; equity; efficiency	• Internal market reforms led to HA merger *and* search for locality structure	• Need for policy direction regarding hierarchy of

									• Costs and benefits of merger and dec; south-west region savings from HA mergers: £1.3–2.7 million per annum	purchasers
Exworthy 1994	PR; social policy	QV: interviews	UK	1988–91	Dec (territorial: district HA to neighbourhood)	Staff interviews	Community health services	Responsiveness; equity	• Dec generated prof–managerial conflict: nurses disputed need for local mgt • Fluid concept of 'local'	
Exworthy 1998	PR; geography	QT; secondary data	UK; health	1995–6	Localism: multiple definitions	Financial: % HA budget	Commissioning	Equity; efficiency	Limited effect of internal market due to embedded social and institutional relations	Power of local org relations
Exworthy *et al.* 1999	PR; public admin	Policy analysis	UK	1945–90s	Cent	Balance between market, hierarchy and network	Health services	Efficiency; equity; acctbly; responsiveness	• Decline of hierarchy false as market, hierarchy and network co-exist • Mix of market, hierarchy and network impt • Hierarchy never was fully centralising • Third way is a different mix of market, hierarchy and network • Catalytic effect of mix?	• Command-and-control: never able to command or desire to control
Ezzamel *et al*. 2004	PR; public mgt/accunting	Policy analysis	UK	1997 onwards	Devolution	Change in responsiveness and accbtly following UK political devolution	Public services	Acctbly; responsiveness; efficiency (allocative and technical)	• Devolution ~ more openness, transparency, consultation and scrutiny regarding budgets • Extensive information overload	
Fattore 2000	Commentary	Policy review	Italy	1990s	Dec; regionlisatio	Relations between state	Health services	Acctbly	• Traditional lack of acctbly	• Regions: where willingness

					n	and regions			· 1992 reforms aimed to concentrate functions from centre and locality to region. · Greater role for centre re. acctbly and comprehensive care · Future balance between regional autonomy and national system uncertain	to devolve powers is tested; risk of further fragmentation
Ferlie and Pettigrew 1996	PR; mgt	Lit review; descriptive case studies: business process and Department of Health (no impact data yet)	Intl	nd	· Dec: resp and authority · Cent (over-cent ~ bottleneck) · Also delayering, downsizing	Change in nature and role of corporate HQ	Evidence mainly from private sector but public sector case study (Department of Health)	Efficiency; acctbly	· Practitioner concern with effective head office design and defining value added · HQ change ~ often downsizing driven by cost but also over-cent. 50% not prepared for downsizing · Dec strategy→ incremental approach; centre too weak · Greater dec balanced by tighter acctbly · Hetarchy: geog diffusion of strategy and coord/n · Promise of HQ change greater than reality · Theory ~ managerial strategy, new institutionalism, power, networks, value creation	· Some parallel in public sector (e.g. Department of Health) · Often no downsizing but regulatory agencies expanding · Hard to access to study · Most =insider reports · Staff=resp of which level? · Coord/n less cost than control
Ferlie and Shortell	PR; HSR	Policy review,	UK and USA	nd	Dec (not defined; US	Quality of service	Health services	Quality improvement/res	· Core properties: leadership; pervasive	·Success due to

2001		secondary data			dec *cf* UK)	provision		ponsiveness	quality culture; effective teams and IT • Multi-level: individual, groups, org and system	ability to resolve trade-offs: UK cent • Approach and bottom-up devel
Frank and Gaynor 1994	PR	QT; financial analysis	USA: mental health	1985 –91	Various	Financial; access	Mental health services	Equity; finance	Financial incentives	
Gauld 2002	PR	QV: policy analysis	NZ	1989 – today	Dec; cent; autonomy	Central–local balance	Health services	Efficiency; responsiveness	• 1997–9 involved cent='headquarters' controlling planning and purchasing w/distance from provision • 1999–today: devolution of considerable autonomy but w/strong central control	• Apart from market, policy developed an adequate environment for effective planning and purchasing
Gershberg 1998	PR; devel studies	Review	Mexico, Nicaragua; health schools	1990s	Dec definition problematic; re-cent (*cf* cent)	Various, linked to framework	Educational and health service provision	Efficiency; equity; acctbly	• Whole-system (dec and cent) framework: -finance -auditing/eval -regulation -demand-driven mechanisms -democratic mechanisms -provider choice/mix -mgt systems (staff and IT) • Framework focuses on functions • Favours term acctbly rather than dec	• Re-cent =aspects of provision and acctbly that c/govt must develop to maintain effectiveness of dec'd reform • % of finance w/sub-natl source is misleading • Method

									• Need to explore inter-relations between dimensions of acctbly	commentary
Giannoni and Hitris 2002	PR; economics	QT	Italy	1980s 1990s	Dec: transfer of autonomy in political and econ power to sub-central authorities; devolution; subsidiarity	Health service expenditure by region (change over time)	Health services	Equity	• Health costs contained but regional inequality has persisted/widened • Higher spending regions continued to spend more even after reforms • Diversity measured financially	Italian health service aims for equality of provision but regional diversity exists
Gilbert and Pichard 1996	PR; economics	QT: economic modelling	n/a e.g. French education	n/a	Territorial dec	Optimal size of local jurisdictions	Local govt services	Efficiency; responsiveness	• Local govt have informational advantages and c/govt info disadvantage ~ spillovers • Shape of transfer schedules from centre to local crucial	• Uncertain~ private cost of public suppliers and spillovers may explain division of resp
Goggin 1999	PR	QT: multi-variate model	USA: health	1997	Determinati on of variables	Various	Administr ation	Expenditure; planning	Importance of political and economic variables	
Gray 1988	PR	Historical analysis	Canada and Australia	1980s	Federalism (catch-all term)	Degree of policy change	Policy; health services	Policy outcomes	• Devel of policy not inhibited by dec • Search for universally valid theory of federalism seems likely to be unrewarding • Fed inst seem less impt	• Power of medical profession had enormous impact on policy outcomes

									in policy impact than initially thought	
Greener 2004	PR; social policy/ public admin	Critical discourse analysis of documents	UK: health	1997 – 2003	Dec not used; central–local localisation	Analysis of key words in texts	Health policy/ services	Various -efficiency -staff morale	• Labour's health policy moved through three stages ~ driver for change: quality, perf, choice • Discourse of health consumerism likely to remain • Moments likely to breed cynicism and disaffection among staff	
Griffiths 1999	PR; public admin	Policy review	UK: Wales Housing, education	1980s 1990s	Devolution	Policy devel	Housing and education	Acctbly	• Significant autonomy of Welsh territorial ministries by late 1980s • Claims of Welsh exceptionalism exaggerated; uniformity w/England	Legislation and financial coercion enforced local govt compliance w/ c/govt policy
Grogan 1993	PR	Literature review and policy analysis	USA: health	1990s		Finance	Finance	Finance	Variation in decentralised services	
Hales 1999	PR; mgt	Review: conceptual/ mgt studies	Intl; mainly private sector	nd	Dec (transfer of power and resp down); devolution	Managerial behaviour	Various	Innovation, morale	Transfer of power alone is insufficient to improve perf	Recognises terms are ambiguous
Hamilton 2000	PR; mgt	QV: 1 in-depth case study (north-west England)	UK	1990s	Dec (not defined)	Analysis of negotiation between union and managers	Pay negotiations	Staffing; acctbly	• No formal negotiation structures introduced but more issues for over which local formal negotiation has been	

									est'd • Local pay flexibility not always achieved • Persuasion important to gain assent for IR changes	
Hardy *et al*. 1999	PR; public admin	Policy review	UK, Netherlands : health/ social care	1990s	Hierarchical relations; collaborate and compete, needs led provision	Comparison of vertical and horizontal structures	Health and social care: integrated care	Degree of integration	• England: hierarchy important; Netherlands: bargaining in networks important • Barriers to joint working	• No single locus for policy formul, funding or implem
Hill and Pickering 1986	PR; mgt	QT; postal survey of 500 chairmen of largest UK companies (28% response)	UK; private sector	1982	Dec (multi-divisional org w/ autonomy)	Survey responses re. org structure, reasons for dec, location of decision-making, financial perf	Org decision-making and structure	Efficiency; acctbly; profit	• 75 had no more than 6 divisions • Diversification/multi-divisional org (dec): -limited evidence of improved profitability -problems coord/n, acctbly and control • Dec not a panacea: impt to consider size and shape of divisions	Structure may only partly explain outcomes; ways resources are used is also impt
Hoggett 1996	PR; social policy, public admin	Conceptual analysis	UK (and intl relevance)	1990s	Dec (operation/strategy; loose/tight; rowing and steering); Centralized dec=standard part of org/al literature.	Degree of control (self and external) Operation/strategy difference =socially constructed. Dec units=cost centres	Various public sector functions	Morale (low job insecurity); efficiency; acctbly; process	• Dec to operational units *and* cent to strategic control • Competition is main way of co-ordinating dec'd units • Perf mgt and monitoring of dec'd units • Changes involve 'control at a distance' ~	• Dec, market and perf mgt =post-bureauratic control • Changes lead to high output, low commitment workforce

					Dec w/o autonomy				regulation and autonomy • Central co-ordination via incentives/changing rules of the game	
Howell 2004	PR; HSR	Review of policy	NZ, UK	NZ: 1993–9 UK: 2003 onwards	Dec: operation and mgt	Thematic comparison between NZ and UK	Hospital services	Acctbly; efficiency; governance	• Devolution to hospital governance in 1990s (NZ) • Foundation trusts pose challenges to governance and control of assets • UK (+) local acctbly and competition may be more responsive • UK (−) soft budget constraints and boards=regulated and local beneficiaries • Foundation trusts bearing risk outside their control?	• Improvement not just due to structural form but whole sector and info • How to ensure acctbly? • How to resolve competing interests?
Hudson 1999	PR; social policy	Review of policy	UK; England	1990s	Dec not defined; Burns framework (five dimensions) used	Localisation, flexibility, devolution (org relocation) and democratisation	Primary care: commissioning	Inter-agency and inter-professional collaboration	Locality commissioning associated w/some improvement in morale, better inter-professional relationships and minor change to some community-based services	
Hudson and Hardy 2001	PR; public admin	Policy review: 33 interviews in 1998	UK: England and Scotland	1997–2000	Dec not defined; refers to purchaser not provider	Degree of localisation: power and control (market/ hierarchy/ network)	Inter-agency partnerships	Governance; acctbly	• Recognition of de facto dec despite uniformity rhetoric • Uncertain role of centre given localisation	
Hughes and	PR;	QV: 31	UK; Wales	1990s	Dec;	Subjective	Health	Acctbly	• Governmentality:	• Contracts

Griffiths 1999	sociology	interviews and meeting observations (c80)			centralism	assessment	service: Patients Charter, waiting times		action/steering at a distance replacing bureaucratic control (via contracts) • Informal resistance counters dec governance • Need for more weight to centralising processes and local discretionary power	advance central policy through choices made by actors w/local concerns
Hurley *et al*. 1995	PR	Review	Canada	nd	Dec= dispersal of authority among smaller org units that function w/some autonomy	Availability and use of information	Various health services	Efficiency (tech and alloc), acctbly and patient involvement	• Critical factors: -nature of information -decision-making context • Dec has potential to be more efficient (via ability to incorporate info and system innovation) • Dec has potential to exploit context-specific info • Acctbly mechanisms critical to improving efficiency	Variation in values, preferences and needs are beyond policy-makers control
Hutchcroft 2001	PR; politics and social policy	Analytical framework	Intl; mainly developing countries	n/a	Dec; means of promoting democratic and devel aims	Measurement of dec cannot be precise	Various	Acctbly; responsiveness	• Lack of framework to assess central–local relations • Continua (political and admin) proposed: 2x2 • Position on continua affects outcomes (dec harm>good?): starting point for dec and area/function balance	• Character of central–local ties critical
Iliffe and Munro 2000	PR	Policy analysis	UK: health	1991 –	Reforms, market	Quality; effectiveness	Commissioning;	Quality; equity; effectiveness	Market model=regulation from centre	

				2000	forces		finance			
Jack 2003	PR; politics	Policy review	Nicaragua	1990s	Dec; autonomy	Incentives related to perf	Primary and secondary care	Acctbly	• Policy: managerial freedom over inputs • Incentives: perf agreement and bonuses (17% hospital funds)	From socialism to market system
Jacobs 1997	PR; accountancy	PR; policy analysis	NZ	1980s 1990s	Policy uses various terms and definitions	Author interpretation	Various public sector services; education case study	Acctbly	• Dec accompanied by monitoring, perf mgt and accountancy control • Questions link between dec and perf	Privatisation, market, reform, empowerment, and restructuring
Janovsky 1997	WHO seminar	Review of policy and literature	27 developing and developed nations	n/a	Review of evidence	n/a Constraints of measurement identified	Health services	Various	• Dec serves various aims including competition and solidarity • Implementation and meaning context-specific • Streams: shift to district mgt, forms of NPM, new relations private and wider public sector reform • Impact difficult to measure: lack of data and fragmented implem • Regulation and implem units aid dec	• Dec not a magic bullet • No clear evidence that it improves equity or a focus on primary care • Some functions benefit from cent
Jervis and Plowden 2003	Report	Policy review/ analysis	UK	1999 – 2003	Devolution (political)	Changes in relations between Whitehall and devolved admin	Devolved health services	Acctbly	• No departure from values of NHS but now family of health systems (not just one NHS) • Greater similarity between Scotland, Wales and Northern Ireland than w/England • Apparent divergence	• Little desire for private sector role in S,W,NI • Limited English devolution • Adaptive

									from England: decreasing lines of acctbly, decreasing volume of Whitehall activities	prof org . Department of Health success in UK-wide role
Johansson and Borell 1999	PR	Policy analysis	Sweden: health	1992 –7	Networks; eval; incentives	Equity; finance	Old age care	Finance; equity	Steering and economic incentives	
John and Chathukulam 2003	PR; devel studies	QT	India	n/a	Dec (definitions problematic) ; devolution	Subjective assessment by 9 'experts'	Various		· Measuring dec underdeveloped due to lack of common standards and lack of consensus about meaning of dec · Model scores 0–5 · Kerala scores 2 despite dec policies; low score due to planning concerns	· Vengroff and Salem model (Tunisia)
Johnson 2001	PR; devel studies	Literature review	Intl: developing countries	n/a	Dec: deconc and devolution ~ downward delegation of authority	Review of evidence	Anti-poverty policies	Acctbly; democracy	· Little evidence that democracy or dec necessary for poverty reduction. Some evidence that they are c/produtive · Need for acctbly/autonomy balance: autonomy to overcome interests but acctbly to public · Certain degree of re-cent may be needed	· Support from external actors important
Jones 2000	PR?	Policy commentary	USA	1980s 1990s	Dec, cent (not defined)	Org arrangements for policy making and funding	Various, incl. academic medical centres	Efficiency	· USA has no centralised policy-making or financing org · Dec allows flexibility but never resolves financing	· Is health care a business or public service

							and Medicare		or service questions	· Muddling through
Kapiriri *et al*. 2003	PR	QV	Uganda	n/a	Dec: various forms recognised		Public participation	Responsiveness; acctbly	· Local councils and committees facilitate participation · Structural- and individual-level barriers to participation identified; poverty (and demotivation) most important	· Leaders and public experience of participation
Kelleher and Yackee 2004	PR; public admin	Policy analysis	USA (North Carolina)	1997	Devolution: authorizer and recipient govts; multiple meanings	Changes in welfare caseload, family poverty and workforce participation	Welfare services	Efficiency; staff involvement (?)	· 100 counties w/additional policy-making authority since 1997 · Perceived level of increasing authority (post-devolution) had no impact on outcomes · Fiscal flexibility important to achieving welfare reform goals	· Devolution affects perception of policy-making effectiveness (symbolic value) but outcomes are mixed
Kelly 2003	PR	Documentary analysis and interviews	UK: local govt	2000–1	Audit practices	Various	Audit; regulation	Efficiency; effectiveness; finances	Impact of levels of audit	
Kessler and Dopson 1998	PR; mgt	Policy analysis	UK	1990s	Dec; cent	Balance of power between Department of Health/civil service and NHS	NHS org	Various; mainly efficiency	· Dec/cent tension in Care Programme Approach: autonomy and role of centre? · Dec essential to int mkt · Civil service/NHS culture difference · First, second and third-order decisions	· Tension and ambiguity similar to private sector

Kewell *et al.* 2002	PR	Interviews observations ; documentary analysis	UK: health	1999	Networks; regional approaches		Cancer services - networks	Decision-making; responsiveness	Network models moving to convergence	
Khaleghian 2003	World Bank paper	QT and literature review	Cross-national: health	1980 –97	Differential effects of dec	Financial; equity; health outcomes	Immunisation	Equity; finance; health outcomes	• Differential effects of dec • Need to identify institutional correlates of successful dec but no evidence that incr capacity makes dec more/less effective	
Klein 2003b	Editorial	Commentary ; policy analysis	UK	1997 – 2003	Localism; cent; dec	Various	Health services (esp commissioning)	Equity; responsiveness	• Revolving-door analogy • Localism associated w/pluralism • Dec questions role of c/govt – how much scope for diversity? • Equity: gravitational pull to centre • Rhetoric to reality still distant	• Cent'g power *and* blame • Treasury may not welcome local powers to spend
Klein and Maynard 1998	Editorial	Commentary ; policy analysis	UK	1997 –8	Cent	Capacity of c/govt	Health services	Equity; efficiency	• 'New NHS' will involve more control from c/govt in directing change • Questions central capacity to implement national service frameworks	• Command and control concentrate blame and conflict • Ministers may rethink cent strategy
Kleinman *et al.* 2002	Research report for	Literature review	UK	nd	Central–local	Finance and non-finance elements of	Local govt services	Acctbly: local choice; efficiency	• Lit focuses on finance, delivery, polit structures,	• Limited evidence ~ improved

	govt				relations	local govt		(allocative)	and delivery • Local govt reform supports Tiebout approach • Measurement problems ~ input, output, outcome • Funding and structure not fully separable	efficiency from local tax (*cf* central grants)
Koivusalo 1999	PR; HSR/ health policy	Policy analysis	Finland	1990s	Dec	Changes in funding of services following dec	Health services	Efficiency; equity	• In 1990s, c/govt dec'd powers to municipalities w/tax raising powers (mainly user fees) • Local governance does not guarantee equitable provision w/o legal powers. • Danger of reduced c/govt subsidy and rising user fees	• Need for subsidies to poorer areas continue • To ensure equity, dec must consider quality and financing
Kolehmainen-Aitken 1999	Book	Policy analysis	Africa, Asia, Latin America	1990s	Dec	Policy impacts	Health services	Equity; efficiency	• Lessons and challenges on implementing dec in different countries	Case study: Indonesia
Ladenheim and Kee 1998	PR; public admin	Policy analysis; legislative framework	USA	1996	Federalism	Balance of power and resp between federal and state govt	Structure and functions of Medicaid	Acctbly	• Federal/state differences made compromise difficult over Medicaid • Criteria to assess federalism: structure, stabilisation, distribution and allocation of power and funding	
Leese *et al*. 2001	PR; mgt	QV (52 Total Purchasing Pilots); policy	UK	1995 –7	Dec; cent	Not stated	Primary care	Various evaluative criteria (total purchasing eval)	• Simultaneous dec and cent • Broad goals need to be operationalised for eval	• Eval of success problematic

		analysis							• 3 years=short period to evaluate 'success'	
Leichter 1997	PR	Commentary	USA	nd	US states as labs of democracy	Differences between States	Various, mainly spending and outputs	Variation ~ equity	Variation is not always bad and it is the price of federalism	Inter-state variation requires evaluative criteria
Levaggi and Zanola 2003	PR	Expenditure analysis	Italy: health	1989 –93		Financial	Expenditure	Financial	Finance related to quality and access	
Levaggi and Smith 2004	Working paper/ chapter; public economics	Review: conceptual/ fiscal federalism	Intl	nd	Dec: transfer of powers from a central authority to more local institutions	Various: mainly financial	Various	Mainly purchasing of services	• Transaction costs will be higher under dec • Little evidence that diversity encouraged by dec leads to innovation • Sensitivity of QT weights on measures (e.g. acctbly)	• Logic: dec to household • Arguments for/against dec and cent • Discussion of diversity, information asymmetry and spillover effects
Litwinenko and Cooper 1994	PR; mgt	Staff questionnaire (*n*= 1050 sent; 51% response)	UK	Early 1990s	Delegation of resp to org; org culture	Org culture ~ role, power, trust, support	Health services	Staff satisfaction/ morale	• Main org culture before and after trust status: combination of role and power • Trend towards more power and less task/support	• Main culture shift in clinicians and managers, not non-clinicians
Lloyd 1997	PR	Case studies	UK: health	1993	Union activity	Various	Human resources	Negotiation	External factors impacting on unions	
Locock and Dopson 1999	PR; mgt, public admin	QV: 'tracer study' of 2 regional health authorities/ offices	UK; England	1994 –6	Dec; cent	Relations between central agencies	Health care planning and mgt	Not stated	• Centre of NHS cannot be treated as one org • Increased central HQ control *and* market-style devolution	

									• Regional offices occupy boundary position in NHS	
Lomas 1997	PR; HSR	Policy analysis; survey of board members in 5 provinces	Canada	n/a	Devolution of authority from provinces to regional or local boards	Opinions from board members	Health care org and mgt	Acctbly; responsiveness	• Devolution ~ community empowerment, service integration and conflict containment • Need to trade off • Canada: 123 devolved authorities in 9 provinces	• Devolved authorities will deflect blame from Provinces
Lomas *et al*. 1997	PR; HSR	Survey of 62 boards in 5 provinces	Canada	1990s	Devolution of authority; most devolution ~ dec or de-concentration	Opinions from board members	Health care org and mgt	Acctbly; responsiveness	• Variations in scope of devolved services, acctbly, number of tiers, funding and degree of authority ~ different objectives. Narrow objective ~ efficiency aim • No revenue raising power	• Much scepticism about devolution (not just a good thing) • Dev authority between c/govt and public
Loudoun and Harley 2001	PR; mgt	Legislative and policy review	Australia	1996	Dec of IR	Social/ economic impact of dec IR	IR	Staff morale	• Impact of growth of 12-hour shifts • Onus on workers to identify H&S impacts	
Lowndes 2002	Policy analysis; public admin/ local govt	Policy review	UK	2001	Dec; cent; central–local relations	Balance of power between c/govt and (individual) local govt	Local govt white paper (2001); no mention of autonomy	Acctbly	• 'Confessions' of prior cent do not reverse cent trend of Labour govt • Dec mainly managerial not political • Shift from bilateral relations to individual relations with local authorities	• Individual relations aided by perf mgt • Lack of joined-up govt centrally may hinder local delivery

Luft 1985	PR; public health/ HSR	Editorial	USA	1980s	Regionalization: arguments for and against	Cost; quality	Health services	Outcomes; efficiency (costs)	• Wax and wane of regionalization, partly due to lack of research • Higher volume-better outcomes relations unclear • Regionalization may contain cost but incr travel	
Malcolm 1989	PR; health policy	Policy analysis	NZ	1980s	Dec; devolution	Expected changes following dec	Health services	Efficiency; acctbly	• Elected area health board ~ funding and co-ordination • Models (deconc, devolution, delegislation, privatisation) evident	• Dec policy will reverse cent trend of last century • Primary care part of area boards
Malcolm 1993	PR?; HSR	Commentary	NZ	1990s	Dec	Anticipated impact of reforms	Health services	Acctbly	• NZ possibly moving further than other countries in dec, acctbly, integrated systems due to area boards not market reforms	• Crown Health Enterprises shaping primary care services
Malcolm *et al*. 1994	PR; health service mgt	QV	NZ	1990s	Dec	Views of general managers	Health services	Acctbly	• Dec of general mgt to programme or product groupings widely implemented • Managers report increasing acctbly, commitment and innovation	• Population-based (not institutional) approach to mgt
Malcolm and Barnett 1995	P; health services mgt	Survey of senior managers	NZ	1990s	Dec	Views of impact of new dec'd org strcuture	Health services	Efficiency; acctbly	• Respondents favoured new org structure • Seemed to achieve incr efficiency and acctbly • Services have replaced	• Dec~ decision-making to integrated patient

									hospitals as org entities	groups
McClelland 2002	PR; social policy	Review	UK: Wales	1992 –7	Devolution (political and admin)	n/a	Policy-making	n/a	• Little evidence of major changes in service delivery • Welsh NHS plan strengthens central control but lack stringent targets (as in England)	Closely integrated policy community in Wales
McDonald and Harrison 2004	PR; social policy	Case study (*n*=1); QV	UK	2001 –3	Dec; autonomy	Views and attitudes of staff	Primary care	Various	• Dec policy focus on primary care • How far can autonomy be exercised given top-down directives? • Central control via autonomy~ internalisation of central values • Strategy more effective and less costly than direct control	• Unintended consequences likely • Cent via targets and indicators • Earned autonomy vs loose/tight org • Incr autonomy not always welcomed
McEldowney 2003	PR; law	Review: admin, law	UK: local govt	1997 onwards	Devolution; dec	n/a	Public services	Efficiency (allocative); responsiveness	• Modernisation complicated by devolution to Scotland, Wales, Northern Ireland and London • Centre retains control via legal/econ instruments →limited local autonomy • Privatisation changed service delivery	• Local freedom based on perf • Financial relations vs complex
McFarlane and Meier	PR	Policy analysis and	USA: health	1982 –94	Programme impacts -	Financial; outcomes	Family planning	Finance; equity	Type of finance linked to outcome	

1998		model to test			finance					
McKee *et al.* 1996	Peer reviewed	Policy analysis	EU: health	1985 –95	EU policy impact	Human resources; equity	Human resources	Equity	Lack of policy impact	
Meads and Wild 2003	Practitioner journal article; HSR/ health policy	Policy review/ commentary and comparison	Canada; Finland; NZ	nd	Dec	Changes in control of org features	Primary care	Responsiveness; equity; quality	• Devolutionary tide may be turning in countries which have dec'd primary care services • Central control over standards in UK, NZ and Canada • Dec seen as way of incr responsiveness and democracy • Dec of control (NZ)	• Localism at high point in Finland, Canada and NZ due to negative public perceptions about equity and quality
Milewa *et al*. 1998	PR; social policy	a. Survey of 12 South Thames HAs b. Two case studies	UK: 2 case studies	nd ~ 1990s	Dec (internal rather than external); autonomy	Attitudes of and views of managers	Health services: public involvement	Responsiveness 'Consumerist acctbly'	• Dec aimed to offer mgrl autonomy to be locally responsive • Reforms have not been responsiveness to local populations • Context of highly centralised state	
Miller *et al*. 1980	PR; public heath/ HSR	Epidemiological/ HSR study	USA (Tennessee)	1970s	Dec (not defined)	Changes in health status	Neighbourhood clinic (10 000 patients, 500k visits over 7 years)	Outcomes: BP, hospital days, outpatient visits (of 1004 patients)	• Dec neighbourhood clinics effective in providing services (otherwise gone to o/pat) • Nurses are main providers in dec clinics • Clinic costs less than hospital	
Mills 1994	PR; devel studies	Review	Intl	nd	Dec= transfer of	Forms and levels of dec	Revenue raising,	Acctbly; efficiency; equity	• Trade-offs and tensions associated with acctbly,	Term (dec) often used

					authority/ dispersal of power (Rondinelli)		policy-making, resource allocation, funding and coord/n		efficiency and equity • Tasks and balance of responsibility between levels will influence degree of local power	w/o discussion of level
Mohan 2003	Report	Commentary	UK: England	Post-1945	Dec	Impact of central–local relations	Health services (foundation trusts)	Equity; acctbly	• Labour's policy: only partly due to diversity and consumer choice; also, catering to middle-class voters in marginals • Potential to destabilise smaller hospitals, exacerbate staff shortages, be unrepresentative, threaten access to services	• Claims of mutual benefits overstate their benefits in the past
Moon and Brown 2000	PR	Discourse analysis	UK: health	1992–7	Spatial language	n/a	Reorganisation	Responsiveness	• Contested terms • Notion of govermentality	
Moran 1994	PR	Review of policy	UK, USA, Scandinavia, Germany	nd	Dec not defined	Balance of power between interests	Various	n/a	• Where institutional structures encourage innovation, cost inflation results • Where institutional structures curb innovation, rationing becomes politicized • Cent systems vulnerable to technical changes • Americanisation of health care resulted in open and unstable networks	Features previously shared by countries: dec, implict rationing, weak democratic control and medical dominance

Moreno 2003	PR; politics	Policy analysis	Europe Case study: Spain	nd	Dec; subsidiarity; 'cosmopolitan localism'	Differences in ideiology, goals, funding, etc. (typology)	Welfare services	Responsiveness; acctbly; efficiency (allocative)	· Dec of safety net policies to meso-level · Dec policy linked to cultural/identity considerations; also innovation and effective mgt	· Dec ~ 1992 Maastricht treaty: subsidiarity · Typology: EU welfare system
Mouzinho *et al*. 2001	PR; devel studies	QV	Mozambique	1990s	Dec	Views of managers on impact of dec	Health services	Equity; responsiveness	· W/o clear guidelines, monitoring and adequate resources (human/financial), dec will have a low impact and inequalities will incr	· Dec= common feature of reform programmes
Mulgan and 6 1996	DEMOS article	Comment/ opinion	UK	1990s	Dec	Central–local relations	Local govt services	Efficiency; acctbly	· Limits to local autonomy in centralised nation · Legitimacy better than most efficient geographical unit · Empower competent authorities, not just all authorities · Empower by each service	
Mullen 1995	PR; mgt	Policy eval	UK	Early 1990s	Devolution	Eval of different models (low–high) according to criteria	Health services	Efficiency; equity (and other author defined criteria ~ eval)	· Dev of funding and contracting is problematic for low volume, specialised services · No model was ideal · Model may vary between sectors	· Value conflicts
Mulligan 2001	PR; accounting/mgt	QT; 30 US computer companies	Ireland	1994–5	· Dec/cent ~ resp for decision-	5 ratios of cash mgt functions	Cash mgt functions of multi-national	Efficiency	· Is cent cash mgt of multi-national companies more effective than dec	· Main reason for cent=risk

		Interviews			making • Regional cent		companies		cash mgt? • Literature: favours cent of treasury mgt functions and no generic optimal structure	control
Nativel *et al*. 2002	PR; geography	QV: 5 case studies of New Deal for Young People (200 interviewed)	UK	2000–1	Dec; localisation	• Dec~ improved learning, partnership, innovation and resource targeting	Services ~ New Deal for young People	Responsiveness; efficiency; equity (territorial)	• Workforce associated w/dec and localisation of welfare delivery agencies • New Deal: some local discretion and co-operation w/in central constraints	• Limited dec yielded some benefit • Cent labour market resistant to change
Oates 1999	PR; economics	Theoretical	Mainly USA	n/a	Dec; cent; fiscal federalism	Benefits and costs of dec and cent	Various public services	Responsiveness	• Goal to align resp and fiscal instruments w/proper levels of govt • Trade-off: spillover and local diversity • 'There is not much evidence on the relationship between fiscal dec and econ perf'	• Efficient output vary by costs and preferences • Local innovation ~ free-riding but neither dec nor cent more innovative
O'Neill 1998	PR	Policy review	UK and Canada: health	1984–90	Impact of medical profession	n/a	Participation; policy	n/a	Who shapes change?	
Onyach-Olaa 2003	PR; devel studies	Policy analysis/ review	Uganda	1993 to now	Dec ~ local democratic empowerment	Descriptive changes	Local councils	Responsiveness; acctbly; efficiency (allocative)	• Elections mean shift on central–local relations • Benefits: improved governance and service delivery • Problems: technical capacity and stakeholder conflict	

Palley 1987	PR	Policy analysis	Canada: health	nd	Fiscal federalism	Financial; equity	Commissioning	Equity	Variation between states	
Palley 1997	PR	Policy analysis	USA: health	1994–7	Patterns of reform	Financial: various	Finance	Finance; equity	Contain costs Improve access Quality of care	
Paton 1993	PR; social policy	Review of policy	UK	Late 1980s / early 1990s	Devolution (handing down responsibility); centralism (locating power for decisions at centre of policy-making system)	Power and responsibility (see Other comments)	Purchasing and service provision	Strategic decision; operational/ administrative roles	· Cycle from centralism to devolution and back · 3 models: -full devolution/autonomy -managed devolution -full control · Potential that devolution may mask centralism · Cent of agenda/objectives but operational dec in late 1980s	· Power: discussion of definitions · Responsibility: beholden to higher authority
Pendleton 1994	PR; mgt	Policy analysis	UK: railways	1980s and 1990s	Dec (decision making and); devolution	Org impact of changes in IR	IR in British Rail	Efficiency	· Thatcher reforms ~ managerial autonomy · 2 main IR changes: retreat from standardisation (incr diversity) and access of trade union reps to decision-making · Limits on the move from uniformity	· Dec ~ conflict between sectors · Structural changes encourage short-term approach to IR
Pennings 1976	PR; mgt	Survey of 901 staff (88 response rate)	USA	nd	· Cent: distribution of influence among org units	Control in 40 offices of US brokerage firm	Private sector	Effectiveness	· Criteria for effectiveness: total production, decline in prodn, financial loss, morale/anxiety	· Cent= distribution of control+ total amount of control

					· Org autonomy				· Participative, dec and autonomous org are most effective	· Effectiveness is multi-faceted
Perkins 2001	Book review: Kolehmainen-Aitken	n/a	USA	Book published 1999	Dec	n/a	n/a	n/a	· Autonomy/inequality trade-off · Dec can shift blame for downsizing	· Regionalisation in Canada=dec and cent
Perrone *et al*. 2003	PR; org science	QV/QT; interview and questionnaire	Not stated	nd	Role autonomy; discretion to interpret and enact their roles	Autonomy ~ functional influence, tenure and clan culture	Buyer–supplier relations	Staff morale/satisfaction	· Granting greater autonomy enhances trust · Importance of org/al context and understanding trust	· Trust crucial when perf is ambiguous/ behaviour unobserved
Petretto 2000	PR; economics/politics	QT	Italy	nd	Regionalisation devolution: provision decided by a region and financed by its revenues	· Marginal benefit > marginal cost? · Spillover and redistributive effects	Health services	Equity; efficiency	· Regional fiscal autonomy is more desirable than benchmark social welfare framework	· Dec: ratio of local to central expenditures
Pinch 1991	PR; geography	QT	Australia; public sector	1980s	Cent (not defined)	Indices of need by area	Elderly care services	Equity; territorial justice	Cent aids redistributive policies; dec aids responsiveness	
Powell 1998	PR; public policy	Policy analysis	UK		Cent; dec	Central–local relations	Health services	Acctbly; responsiveness; equity	· NHS moving in 2 directions at same time: dec and cent · Lack of clear definition about what is 'national' or 'local'	· Trends suggest worst of both: central control and diversity w/o autonomy
Powell and Exworthy	PR	Comparative	UK: health	Up to 2002	Equity	Equity: various	'Old and new' NHS	Equity	Focus on variation which could reduce	

2003		analysis								
Provan and Milward 1995	PR; mgt	QT and QV	US public sector	1991 –2	Network effectiveness	Client outcomes	Mental health	Network integration	Client outcomes ~ network cent and system stability	
Quadrado *et al.* 2001	PR	QT; modelling	Spain: health	1964 –91	Regional inequality	Equity: various	nd	Equity; finance	Inequality related to devolved govt	
Quennell 2001	PR; mgt	QV	UK	1999 – 2001	Dec; cent	Views/ perspectives of key stakeholders in NICE	Health services: evidence-based medicine	Effectiveness; responsiveness	• Policy paradox: cent/participation • Tension: sharing power between powerful interests and patients	
Ranade and Hudson 2003	PR; local govt	Review of policy	UK	nd	Term dec not used	Resource dependency (money and authority)	Health and social care services	Inter-agency colaboration	• C/govt limited in steering local networks • Governance should not be confused w/org form • Most productive partnerships ~ loose/tight structure (local freedom w/in agreed framework)	• Co-evolving partnerships • Imposed partnerships • Reticulists
Redoano and Scharf 2004	PR; economics	Economic modelling; fiscal federalism	n/a	nd	Cent; dec	Degree of responsiveness to public preferences	Public services	Acctbly; responsiveness; efficiency (allocative)	• Compares outcomes under direct referendum and representative democracy • Cent more likely if choice to cent made by elected policy-makers • Policies converge to level of jurisdiction that least favours cent	• Assumes heteregenous policy preferences and spillovers
Reed 2003	Comment	Policy comment	UK	nd	Dec: no agreed definition Localism	Power	Public services	Democracy= responsiveness, acctbly	• Localism=any measure of structural dec; little to do w/devolving power • Democratic input important when difficult	

									decisions need to overcome vested interests	
Reich 2002	PR; devel studies	QV	Intl; developing countries	nd	Dec	Fiscal measures; decision-making powers	Public health	Efficiency (technical and allocative)	Dec does not always improve efficiency	Dec is part of reshaping state-above, below and within
Rico 2000	Commentary	Policy review	Spain	1990s	Regional devolution; autonomy	Power symmetry and aymmetry between regions and govt	Health services	Effectiveness; coordination; equity	• 7 special regions w/high political autonomy (62% population); 10 regions have limited admin powers (e.g. public health) • In 10 regions, health care governed by state • Dec pro/con resemble market: incr effectiveness but lacks co-ordination • Devol: incr innovation • Some cost containment problems; limited rise in inequality due to low fiscal powers	• 2 of special regions have full fiscal autonomy • Spenish reform: moderate, incremental • Full political autonomy at expense of decr central political and financial control
Rico *et al.* 2003	PR	Literature review and policy analysis	Western Europe: health	1990s	Collaboration; shift in resources and acctbly	Various	Restructuring	Various	Influence of pre-existing model Potential for reduced costs	
Robalino *et al*. 2001	World Bank paper; economics	QT	Developing countries	1970–95	Fiscal dec; recognises variety of terms used	Infant mortality rate	Health spending	Efficiency tech and alloc; share of local spending as % of national spending	Higher fiscal dec consistently associated with lower infant mortality rate	Effects enhanced by strong political rights but reduced by ethnic

										divisions
Robinson and Dixon 2003	Fabian report	Policy comment	UK: England	1997 – 2003	Autonomy	'National standards versus local autonomy' (Chapter 3)	Health services	Efficiency; equity; acctbly; responsiveness	• Need to address excessive central direction. Govt must have more confidence in local managers and to steer with a lighter touch • No easy answers to dilemma of finding acceptable balance between central control and devolution of resp	Stability required to bring about sustainable improvements, with greater continuity than in previous decade
Roche 2004	Report (Institute for Public Policy Research)	Policy review	UK: England	2001 – today	Dec; autonomy		Health services: primary care, commissioning		• PCTs are semi-autonomous • PCTs squeezed between dec and secondary care • Need to unlock PCT discretionary budgets (though small), aided by payment by results • Strong need for centre to balance autonomy w/acctbly as PCT become only link between centre and providers • Need to identify what is best commissioned at what level by whom • Shifting comfort between diversity and variations	• PCT constrained by lack of information and own mgt systems • Potential not being realised: commissioning and public involvement • Chronic conditions being better managed especially w/GPSIs
Roos and Lyttle 1985	PR; public health/ HSR	QT	Canada	1973 –8	Access rates across population	Geographical access by population groups	Access to total hip replacement	Effectiveness	• Impact of cent facilities on access to care (total hip replacement) • No differences in access	• Total hip replacement numbers incr in

									to care between urban and rural populations • Cent probably not restricted rate of performing total hip replacement	1970s • Total hip replacement amenable to cent
Ross and Tomaney 2001	Peer reviewed	Policy analysis	UK/England health, regional govt	1999 – 2000	Devolution; regional policy	Health outcomes; equity	Regional service delivery	Equity; finance; responsiveness	Regional distinctiveness/ local policies	
Rowe and Shepherd 2002	PR	Policy analysis and survey	UK: health	1997 – 2000	Participation	Ownership; participation	Public involvement	Decision-making	Participation needs culture change	
Rubio and Smith 2004	Conference paper	QT; economics	Canada	1979 –95	Dec	Fiscal measures (only QT measure)	Infant mortality	Efficiency (alloc and tech); health outcomes	Dec leads to an improvement in health outcomes	Precise measures are difficult to find
Saltman *et al*. 2003	WHO paper	Review (book proposal)	Intl: Europe	nd	Dec: vertical, horizontal and re-cent	Autonomy	Health policy implementation, costs	Equity (mainly); also efficiency (alloc and tech)	Effects of dec depend upon its design and institutional arrangements governing implementation	Debates disciplinary approaches (Rondinelli, Bossert)
Sass 1995	PR	Literature review	Western Europe: health	nd	Individual responsibilities	n/a	Policy change	Expenditure; equity	Basic needs/cost constraints	
Schmid 2002	PR; mgt	Questinnaires in 3 non-profit orgs	Israel	nd	Dec/cent	Empowerment, control, equity, training and working conditions	Community centres, home care and boarding schools	Adaptation, satisfaction and assessment of perf	• Very high probability that relations between structural properties and org effectiveness are statistical and causal • Dec mgt appropriate in voluntary non-profit org where structure and mgt are informal and professionalism high	

Schneider 2003	PR; devel studies	Factor analysis	Intl; 68 countries	1996	Dec: transfer of power and resources away from c/govt	Core dimensions of dec: fiscal, admin, political	Fiscal: cede fiscal impact locally; admin: autonomy Political; represent ation	Fiscal, political and admin factors	• Little agreement on what dec means/how it should be measured • Comparisons of disciplinary definitions	• Radar diagram of balance between 3 dimensions
Schram and Weissert 1999	PR	Policy analysis	USA: health and other public sector	1998 –9	Roles of levels of govt	Financial; org	Policy change; finances	Financial; equity	Contention between state and federal roles	
Seabright 1996	PR; economics	Economic modelling	Theoretical	nd	Dec: power to decided what a policy should be is devolved to mechanism of local public choice	Merits of dec and cent	Various public services	Responsiveness; acctbly	• Dec~problem of allocation of control rights under incomplete contracts • Cent ~ ↑ co-ordination, ↓ acctbly • Acctbly ↑ responsiveness and overall perf (despite spillovers)	• Trade-offs inevitable • Dec/cent as a means to give incentives to act in citizen interests
Segall 2003	PR; mgt	Policy review	Intl/develop ing countries	nd	Dec	Advantages/ disadvantages of reform	Health care especially primary care	Acctbly; responsiveness	• Critique of World Bank policy (relegate primary care to seond-generation reform) • Dec likely to benefit most systems but exact form needs careful implementation • Democracy and public involvement enhances dec	
Simonis 1995	PR; local govt	Review of policy	The Netherlands	nd, 1990s	Dec not defined;	n/a	Local govt spending	n/a	• Differentiation between municipalities does not fit	Local autonomy

				?	term 'territorial and functional dec' used				the Dutch egalitarian admin culture • Some local govts wary of autonomy	has been incr though central safeguards remain
Singh 1986	PR; mgt	QT modelling; survey of 173 firms	USA, Canada	1973 –5	Dec	• Profit • Subjective view of perf	Private sector	Efficiency	• Poor perf reduces dec and good perf incr dec • Link between org perf and risk-taking - direct relationship negative (when perf is below standards) - indirect relationship positive (mediated by dec and org slack) • As competition incr, org slack decreased and control (cent) also incr	• Innovation and perf: mixed evidence • Satisficing levels of perf • Org respond to poor perf via cent
Smith 1980	Book chapter	Review of literature	n/a; reference to UK	n/a	Dec: geographical dimension of state apparatus	Hypotheses tested against evidence	Public services	Measures~ a. functions b. taxation c. field offices of c/govt d. delegation to area political authorities e. methods of creating local govt f. local expend as % of total g. single/multi-tier authorities h. % of local govt revenues	• Dec is a variable; need a method to measure it • Control may be a function of technology • Incr dec does not imply more autonomy • Hypotheses re. situations w/more or less dec • Dec associated with greater distribution of power w/in community, govt less remote, higher participation, incr potential for conflict, more acctbly, uncertain efficiency, more innovation, more	• Impt to distinguish dec from its political, econ and ideological context

								i. personnel j. org size	problems w/vertical integration	
Smith 1997	PR; politics	Review of policies	Intl; developing countries	nd	Dec re. decision-making structures of the state; other terms too broad	Optimum size to conduct decentralized powers	Various functions at different levels	Acctbly; equity; participation	Specifying functions assumes political decisions	Participation capable of intensifying political conflict
Smith and Barnes 2000	PR	Policy analysis	UK: health	1999	Central/local priorities	Local priorities	Commissioning	Various	Diversity of implementation	
Smith and Scheffler 2003	Research report	Spending analysis	USA: California	1986 – 2000	Dec	Changes in health spending by state and county	Publicly funded health services	Efficiency	• Realignment had a dampening effect on public health spending including a sharper decline of spending in poorer counties • Counties were able to transfer funds between health, mental health and social services • The spending 'pie' of health services became less evenly cut due to dec	• California 1991 Realignment Legislation shifted resp for county health services from state to counties
Snape 2003	PR; local govt	Review of policy	UK	1974 onwards	Central–local relations	n/a	Health and social care services	Partnership; service improvement	30 years of centralised control may have produced local govt tier conditioned to top-down policy: learnt behaviour	Barrier to collaboration is differing perf mgt systems
Sparer 1999	PR	Policy analysis	USA: health	1990s	Privatisation	Various	Org; policy	Finance; equity	Govt involvement in various functions	
Stevens 2004	PR; health policy	Policy analysis; comment-	UK; England	1997 – 2004	Localism; autonomy	Hierarchy; local control	Various	Efficiency; equity; acctbly; responsiveness	Three-dimensional reform involves: a. Provider support: staff,	Health policy: new pragmatic phase (not

		ary							infrastructure b. Hierarchy: national standards, inspection, perf targets, direct intervention c. Localism: active purchasing, choice, provider incentives, pluralism, democractic accbtly	path-dependent) ~ constructive discomfort
Talbot 2004	Book chapter	Policy review; public admin	UK mainly	n/a	Agency: arm's length from hierarchical spine of c/govt. Structural separation often confused w/Dec	Autonomy of agencies (e.g. earned autonomy)	Various	Acctbly; efficiency	• 3 central elements of agencies: - structural disaggregation -perf contracting -deregulation • Cycle between focus and co-ordination (policy and execution; purchase and provision) • Have agencies given managers more freedom?	• Structural separation by degree, not absolute • Agency failures rarely lead to punitive action
Tang and Bloom 2000	PR; health service mgt	Case study	China	1990s	Dec	Changes in funding following dec	Rural health services	Equity; efficiency; effectiveness	• Case study: dec to township (lowest level of govt) • Little evidence of incr resources or ability to tackle mgt problems	• Dec used to achieve equity, efficiency, effectiveness
Taylor 2000	Policy journal	Comment	UK	1997 Labour's 1st term	Dec	Changes in central–local govt relations	All public services	Innovation	• Labour objectives (quality, fairness) required cent • 1999 modernisation excluded dec as a goal	• Cent may be anti-innovatory • Rise of freedom for modernisati

									• Spatial policymaking (zones)=central direction • Challenge cent as default but what should be dec'd? Can cent → dec?	on/reward to do what you are told
Tester 1994	PR; social policy	Exploratory study	Germany: social care	1992	Subsidiarity	Financial	Financial	Equity	Regional inequality	
Thompson 1986	PR	Policy review	USA: health	1980s	States capacity	Financial	Financial	Financial	Economic limits, variation in provision	
Thornley 1998	PR	National survey, case study	UK: health	1996	IR	Various	HR; finance	Finance	Devolved mgt and local pay	
Van der Laan 1983	PR; social science	QT analysis: secondary data	Intl (57 nations); health	1970	Federalism Cent: a. fiscal b. legal c. representation	Bi-variate relationships between different aspects of cent	Health spending	Efficiency; acctbly	• As fiscal cent, health spending decreases • Federal-unitary status has no impact on health spending • Fiscal cent has negative impact on expenditures • Govt cent is not uni-dimensional concept	
Vandenburgh 2001	PR; sociology	Review of forces underlying cent and dec	USA	1990s	Dec; cent	Impact of relative forces behind cent and dec	Health services	Efficiency (versus) responsiveness	• Cent via payers tightening funding controls; dec via consumerism • Patient control likely to be ephemeral given globalisation • Cent: technology, managed care, disease mgt • Dec: prosumerism (purchasing portions of	• Cent and dec likely to continue in a tense relationship • Cent will dominate

									services), alternative medicine, medical globalisation	
Varatharajan *et al*. 2004	PR; devel studies	Survey all Kerala local govt and QV	India: Kerala	1997–9	Dec	Resource allocation	Primary care	Efficiency; equity	• 1996 reform: primary health centres managed by local govt (=dec) • Local govt allocated lower share of funding to primary health care than c/govt • 'Dec brought no significant change to the health sector' • Active local govt support led to 'positive' results	• Second-degree dec: ¾ tasks dec (admin, mgrl, fiscal but not risk) • Dec still at nascent stage
Walker 2002	Report	Policy commentary	UK	nd	Centralism; devolution	Competency of c/govt (especially re. equity)	Public services	Equity; efficiency; acctbly	• Localism might be reaction to c/govt failure • C/govt ability to regulate markets and to achieve equality	
Walshe *et al*. 2004	Editorial HSR/ health policy	Policy commentary	UK: England	2004	Devolution; merger	Org capacity of PCTs	Primary care orgs: PCTs	Efficiency; responsiveness	• Possible PCT mergers 100–150 PCTs? • No good evidence that mergers work • PCT: no 1 right size • No evidence that larger HAs were effective • PCT mgt gaining in experience • In devolved NHS, top-down merger outdated	• Epidemic of merger after 2005 election? • Mergers are clumsy tool; seldom deliver
Wasem 1997	PR	Policy analysis	Germany: health and social care	1992–6	Home care	Financial	Acute care/ elderly	Financial	Choice	

West 2001	PR; HSR	Literature review	UK	n/a	Dec	Comparison of literature 'research traditions'	Various (public and private sectors)	Job satisfaction	• Theoretical and method problems w/studies of org/mgt link • Private sector evidence ~dec, participation and innovation • Importance of structure, strategy and environment	• Longitudinal studies and multilevel modelling needed
White 1996	PR; public admin	Policy review	UK	1980s to mid-1990s	Dec	Public services pay baragaining	Public services	Effectiveness	• Resilience of national pay bargaining despite political rhetoric • Dec is not panacea for poor perf and not problem free (cost escalation and leapfrog) • Incr pay dec but within tighter central limits	• Contradictio n of govt: keen to devolve pay decision and economic regulator
Wistow 1997	PR; social policy	Review of policies	UK: England; health and social care	1980s and 1990s	Dc.	Patient/client activity	Hospital services; home/ social care services	Service provision	Dual trends; cent and dec uncertain; acctbly	
Yesilkagit and De Vries 2002	PR; public admin	QV and policy analysis	The Netherlands	1980s	Dec a. transfer of tasks and discretions from c/govt to local govt b. internal admin org	Unintended consequences of dec and managerialism	South Holland banking scandal link to central and local govt	Democracy; efficiency	• Policy aimed to increase democracy and efficiency, linked to NPM (mgrl autonomy) • Over-reliance that dec would enhance quality of l/govt	• Dec to provincial and municipal authorities ~ deconc and deregulation
Zweifel 2000	PR; HSR/ public admin	Policy commentary	Switzerland	1990s	Dec (central–local relations)	Changes to central–local relations	Publicly funded health services	Efficiency; acctbly/ responsiveness; equity	• Switzerland has very dec political system: central=social health insurance; local=public hospital funding	• 1994 introduction of managed competition

	• 1996 reform: aim to shelter c/govt budgets

Quality: PR, peer review; Op-Ed, opinion-editorial. Methods: QT, quantitative; QV, qualitative. Context: Intl, international. Terms/Impact/Other: Cent, centralisation; Dec, decentralisation. Misc. terms: acctbly, accountability; admin, administration; alloc, allocative; c/govt, central government; coord/n, co-ordination; deconc, deconcentration; devel, development; econ, economic; est'd, established; eval, evalaution; expend, expenditure; govt, government; GPSI, GPs with special interest; HA, health authority; HR, human resources; H&S, health and safety; HSR, health services research; implem, implementation; impt, important; incr, increased; info, information; int mkt, internal market; IR, industrial relations; mgt, management; natl, national; nd, no date; NPM, new public management; NZ, New Zealand; org, organisation/organisational; perf, performance; prof, professional; resp, responsibility; tech, technical; w/, with; w/in, within;w/o, without.

Appendix 2 Database search results

The following databases were searched. The results are given in the corresponding tables on the following pages.

1 BIDS IBSS

2 HMIC HELMIS 1994–98 and DH-Data and King's Fund database 2004-01

3 CINAHL

4 PubMed

5 ASSIA

6 SIGLE

7 Sociological Abstracts

8 Zetoc (British Library)

9 Business Source Premier

10 Emerald Full Text

Search terms

decentralisation/decentralization

centralisation/centralization

localism/centralism

devolution

subsidiarity

federal and federalism

concentration/deconcentration

centering/centring

decentering/decentring

central-local relations

inter-governmental relations

organisational/organizational autonomy

health policy

Table A1 Database: BIDS IBSS (International Bibliography of the Social Sciences)

Term	Limit	Years	Hits	Date
Decentralisation	TI, KW,AB	1974–2004	626	15/3/04
Decentralization	TI, KW,AB	1974–2004	3562	15/3/04
Centralisation	TI, KW,AB	1974–2004	101	15/3/04
Centralization	TI, KW,AB	1974–2004	751	15/3/04
Decentralisation and health	TI, KW,AB	1974–2004	23	15/3/04
Decentralization and health	TI, KW,AB	1974–2004	143	15/3/04
Centralisation and health	TI, KW,AB	1974–2004	5	15/3/04
Centralization and health	TI, KW,AB	1974–2004	15	15/3/04
Decentring	TI, KW,AB	1974–2004	15	15/3/04
Decentering	TI, KW,AB	1974–2004	20	15/3/04
Centring	TI, KW,AB	1974–2004	35	15/3/04
Centering	TI, KW,AB	1974–2004	39	15/3/04
Deconcentration	TI, KW,AB	1974–2004	112	15/3/04
Deconcentration and health	TI, KW,AB	1974–2004	2	15/3/04
Concentration	TI, KW,AB	1974–2004	3176	15/3/04
Concentration and health	TI, KW,AB	1974–2004	50	15/3/04
Devolution	TI, KW,AB	1974–2004	896	15/3/04
Devolution and health	TI, KW,AB	1974–2004	25	15/3/04
Subsidiarity	TI, KW,AB	1974–2004	283	15/3/04
Subsidiarity and health	TI, KW,AB	1974–2004	4	15/3/04
Localism	TI, KW,AB	1974–2004	119	15/3/04
Localism and health	TI, KW,AB	1974–2004	2	15/3/04
Centralism	TI, KW,AB	1974–2004	112	15/3/04
Centralism and health	TI, KW,AB	1974–2004	1	15/3/04
Federal	TI, KW,AB	1974–2004	8883	15/3/04
Federal and health	TI, KW,AB	1974–2004	180	15/3/04
Federalism	TI, KW,AB	1974–2004	4045	15/3/04
Federalism and health	TI, KW,AB	1974–2004	58	15/3/04
Central-local relations	TI, KW,AB	1974–2004	22 075	29/3/04
Central-local relations and health	TI, KW,AB	1974–2004	392	29/3/04
Inter-governmental relations	TI, KW,AB	1974–2004	3210	29/3/04
Inter-governmental relations and health	TI, KW,AB	1974–2004	117	29/3/04
Organisational autonomy	TI, KW,AB	1974–2004	0	15/3/04
Organizational autonomy	TI, KW,AB	1974–2004	5	15/3/04

Health policy	TI, KW,AB	1974–2004	4829	15/3/04

Notes: no facility to limit to English language. Includes books and book reviews. TI, KW, AB means that the title, keywords and abstract were searched.

Table A2 Database: HMIC (Health Management Information Consortium) HELMIS 1994–98 and DH-Data and King's Fund database 2004-01

Term	Limit	Years	Hits	Date
Decentralisation	Anywhere	1974–2004	693	15/3/04
Decentralization	Anywhere	1974–2004	81	15/3/04
Centralisation	Anywhere	1974–2004	186	15/3/04
Centralization	Anywhere	1974–2004	20	15/3/04
Decentralisation and health	Anywhere	1974–2004	511	15/3/04
Decentralization and health	Anywhere	1974–2004	58	15/3/04
Centralisation and health	Anywhere	1974–2004	144	15/3/04
Centralization and health	Anywhere	1974–2004	6	15/3/04
Decentring	Anywhere	1974–2004	0	15/3/04
Decentering	Anywhere	1974–2004	0	15/3/04
Centring	Anywhere	1974–2004	29	15/3/04
Centering	Anywhere	1974–2004	8	15/3/04
Deconcentration	Anywhere	1974–2004	3	15/3/04
Deconcentration and health	Anywhere	1974–2004	3	15/3/04
Concentration	Anywhere	1974–2004	577	15/3/04
Concentration and health	Anywhere	1974–2004	293	15/3/04
Devolution	Anywhere	1974–2004	309	15/3/04
Devolution and health	Anywhere	1974–2004	247	15/3/04
Subsidiarity	Anywhere	1974–2004	15	15/3/04
Subsidiarity and health	Anywhere	1974–2004	10	15/3/04
Localism	Anywhere	1974–2004	9	15/3/04
Localism and health	Anywhere	1974–2004	5	15/3/04
Centralism	Anywhere	1974–2004	14	15/3/04
Centralism and health	Anywhere	1974–2004	11	15/3/04
Federal	Anywhere	1974–2004	701	15/3/04
Federal and health	Anywhere	1974–2004	486	15/3/04
Federalism	Anywhere	1974–2004	13	15/3/04
Federalism and health	Anywhere	1974–2004	8	15/3/04
Central-local relations	Anywhere	1974–2004	3	29/3/04
Central-local relations and health	Anywhere	1974–2004	1	29/3/04
Inter-governmental relations	Anywhere	1974–2004	1	29/3/04

Inter-governmental relations and health	Anywhere	1974–2004	0	29/3/04
Organisational autonomy	Anywhere	1974–2004	0	15/3/04
Organizational autonomy	Anywhere	1974–2004	0	15/3/04
Health policy	Anywhere	1974–2004	7577	15/3/04

Notes: allows combining of searches. Multiple database searches simultaneously.

Table A3 Database: CINAHL (Cumulative Index to Nursing and Health Literature)

Term	Limit	Years	Hits	Date
Decentralisation	Anywhere	1974–2004	37	15/3/04
Decentralization	Anywhere	1974–2004	322	15/3/04
Centralisation	Anywhere	1974–2004	38	15/3/04
Centralization	Anywhere	1974–2004	165	15/3/04
Decentralisation and health	Anywhere	1974–2004	33	15/3/04
Decentralization and health	Anywhere	1974–2004	202	15/3/04
Centralisation and health	Anywhere	1974–2004	26	15/3/04
Centralization and health	Anywhere	1974–2004	107	15/3/04
Decentring	Anywhere	1974–2004	2	15/3/04
Decentering	Anywhere	1974–2004	38	15/3/04
Centring	Anywhere	1974–2004	13	15/3/04
Centering	Anywhere	1974–2004	124	15/3/04
Deconcentration	Anywhere	1974–2004	0	15/3/04
Deconcentration and health	Anywhere	1974–2004	0	15/3/04
Concentration	Anywhere	1974–2004	6350	15/3/04
Concentration and health	Anywhere	1974–2004	2861	15/3/04
Devolution	Anywhere	1974–2004	135	15/3/04
Devolution and health	Anywhere	1974–2004	117	15/3/04
Subsidiarity	Anywhere	1974–2004	5	15/3/04
Subsidiarity and health	Anywhere	1974–2004	2	15/3/04
Localism	Anywhere	1974–2004	6	15/3/04
Localism and health	Anywhere	1974–2004	5	15/3/04
Centralism	Anywhere	1974–2004	3	15/3/04
Centralism and health	Anywhere	1974–2004	3	15/3/04
Federal	Anywhere	1974–2004	10 177	15/3/04
Federal and health	Anywhere	1974–2004	8109	15/3/04
Federalism	Anywhere	1974–2004	72	15/3/04
Federalism and health	Anywhere	1974–2004	64	15/3/04

Central-local relations	Anywhere	1974–2004	0	29/3/04
Central-local relations and health	Anywhere	1974–2004	0	29/3/04
Inter-governmental relations	Anywhere	1974–2004	0	29/3/04
Inter-governmental relations and health	Anywhere	1974–2004	0	29/3/04
Organisational autonomy	Anywhere	1974–2004	1	15/3/04
Organizational autonomy	Anywhere	1974–2004	7	15/3/04
Health policy	Anywhere	1974–2004	12 727	15/3/04

Notes: English language limit set.

Table A4 Database: PubMed

Term	Limit	Years	Hits	Date
Decentralisation	Anywhere	1974–2004	102	15/3/04
Decentralization	Anywhere	1974–2004	24 049	15/3/04
Centralisation	Anywhere	1974–2004	105	15/3/04
Centralization	Anywhere	1974–2004	516	15/3/04
Decentralisation and health	Anywhere	1974–2004	71	15/3/04
Decentralization and health	Anywhere	1974–2004	13 214	15/3/04
Centralisation and health	Anywhere	1974–2004	39	15/3/04
Centralization and health	Anywhere	1974–2004	144	15/3/04
Decentring	Anywhere	1974–2004	8	15/3/04
Decentering	Anywhere	1974–2004	28	15/3/04
Centring	Anywhere	1974–2004	48	15/3/04
Centering	Anywhere	1974–2004	674	15/3/04
Deconcentration	Anywhere	1974–2004	39	15/3/04
Deconcentration and health	Anywhere	1974–2004	8	15/3/04
Concentration	Anywhere	1974–2004	602 451	15/3/04
Concentration and health	Anywhere	1974–2004	9459	15/3/04
Devolution	Anywhere	1974–2004	148	15/3/04
Devolution and health	Anywhere	1974–2004	99	15/3/04
Subsidiarity	Anywhere	1974–2004	25	16/3/04
Subsidiarity and health	Anywhere	1974–2004	22	16/3/04
Localism	Anywhere	1974–2004	7	16/3/04
Localism and health	Anywhere	1974–2004	4	16/3/04
Centralism	Anywhere	1974–2004	4	16/3/04
Centralism and health	Anywhere	1974–2004	4	16/3/04
Federal	Anywhere	1974–2004	59 164	16/3/04

Federal and health	Anywhere	1974–2004	14 111	16/3/04
Federalism	Anywhere	1974–2004	139	16/3/04
Federalism and health	Anywhere	1974–2004	99	16/3/04
Central-local relations	Anywhere	1974–2004	3	29/3/04
Central-local relations and health	Anywhere	1974–2004	2	29/3/04
Inter-governmental relations	Anywhere	1974–2004	1	29/3/04
Inter-governmental relations and health	Anywhere	1974–2004	1	29/3/04
Organisational autonomy	Anywhere	1974–2004	40	16/3/04
Organizational autonomy	Anywhere	1974–2004	1336	16/3/04
Health policy	Anywhere	1974–2004	39 298	16/3/04

Notes: English language limit set.

Table A5 Database: ASSIA (Applied Social Science Index and Abstracts)

Term	Limit	Years	Hits	Date
Decentralisation	Anywhere	1975–2004	231	16/3/04
Decentralization	Anywhere	1975–2004	486	16/3/04
Centralisation	Anywhere	1975–2004	82	16/3/04
Centralization	Anywhere	1975–2004	134	16/3/04
Decentralisation and health	Anywhere	1975–2004	33	16/3/04
Decentralization and health	Anywhere	1975–2004	116	16/3/04
Centralisation and health	Anywhere	1975–2004	8	16/3/04
Centralization and health	Anywhere	1975–2004	15	16/3/04
Decentring	Anywhere	1975–2004	6	16/3/04
Decentering	Anywhere	1975–2004	9	16/3/04
Centring	Anywhere	1975–2004	26	16/3/04
Centering	Anywhere	1975–2004	58	16/3/04
Deconcentration	Anywhere	1975–2004	21	16/3/04
Deconcentration and health	Anywhere	1975–2004	1	16/3/04
Concentration	Anywhere	1975–2004	958	16/3/04
Concentration and health	Anywhere	1975–2004	173	16/3/04
Devolution	Anywhere	1975–2004	227	16/3/04
Devolution and health	Anywhere	1975–2004	62	16/3/04
Subsidiarity	Anywhere	1975–2004	42	16/3/04
Subsidiarity and health	Anywhere	1975–2004	3	16/3/04
Localism	Anywhere	1975–2004	26	16/3/04
Localism and health	Anywhere	1975–2004	1	16/3/04

Centralism	Anywhere	1975–2004	19	16/3/04
Centralism and health	Anywhere	1975–2004	3	16/3/04
Federal	Anywhere	1975–2004	2136	16/3/04
Federal and health	Anywhere	1975–2004	447	16/3/04
Federalism	Anywhere	1975–2004	192	16/3/04
Federalism and health	Anywhere	1975–2004	12	16/3/04
Central-local relations	Anywhere	1975–2004	10	29/3/04
Central-local relations and health	Anywhere	1975–2004	0	29/3/04
Inter-governmental relations	Anywhere	1975–2004	5	29/3/04
Inter-governmental relations and health	Anywhere	1975–2004	0	29/3/04
Organisational autonomy	Anywhere	1975–2004	1	16/3/04
Organizational autonomy	Anywhere	1975–2004	4	16/3/04
Health policy	Anywhere	1975–2004	1787	16/3/04

Notes: English language limit set.

Table A6 Database: SIGLE (System for Information on Grey Literature in Europe)

Term	Limit	Years	Hits	Date
Decentralisation	Anywhere	1974–2003	144	16/3/04
Decentralization	Anywhere	1974–2003	72	16/3/04
Centralisation	Anywhere	1974–2003	16	16/3/04
Centralization	Anywhere	1974–2003	41	16/3/04
Decentralisation and health	Anywhere	1974–2003	10	16/3/04
Decentralization and health	Anywhere	1974–2003	3	16/3/04
Centralisation and health	Anywhere	1974–2003	1	16/3/04
Centralization and health	Anywhere	1974–2003	1	16/3/04
Decentring	Anywhere	1974–2003	0	16/3/04
Decentering	Anywhere	1974–2003	2	16/3/04
Centring	Anywhere	1974–2003	5	16/3/04
Centering	Anywhere	1974–2003	5	16/3/04
Deconcentration	Anywhere	1974–2003	2	16/3/04
Deconcentration and health	Anywhere	1974–2003	0	16/3/04
Concentration	Anywhere	1974–2003	1366	16/3/04
Concentration and health	Anywhere	1974–2003	70	16/3/04
Devolution	Anywhere	1974–2003	178	16/3/04
Devolution and health	Anywhere	1974–2003	8	16/3/04
Subsidiarity	Anywhere	1974–2003	35	16/3/04

Subsidiarity and health	Anywhere	1974–2003	0	16/3/04
Localism	Anywhere	1974–2003	7	16/3/04
Localism and health	Anywhere	1974–2003	0	16/3/04
Centralism	Anywhere	1974–2003	7	16/3/04
Centralism and health	Anywhere	1974–2003	0	16/3/04
Federal	Anywhere	1974–2003	2236	16/3/04
Federal and health	Anywhere	1974–2003	62	16/3/04
Federalism	Anywhere	1974–2003	125	16/3/04
Federalism and health	Anywhere	1974–2003	1	16/3/04
Central-local relations	Anywhere	1974–2003	0	29/3/04
Central-local relations and health	Anywhere	1974–2003	0	29/3/04
Inter-governmental relations	Anywhere	1974–2003	0	29/3/04
Inter-governmental relations and health	Anywhere	1974–2003	0	29/3/04
Organisational autonomy	Anywhere	1974–2003	0	16/3/04
Organizational autonomy	Anywhere	1974–2003	0	16/3/04
Health policy	Anywhere	1974–2003	197	16/3/04

Notes: English language limit set.

Table A7 Database: Sociological Abstracts

Term	Limit	Years	Hits	Date
Decentralisation	Anywhere	1975–2004	48	16/3/04
Decentralization	Anywhere	1975–2004	1175	16/3/04
Centralisation	Anywhere	1975–2004	11	16/3/04
Centralization	Anywhere	1975–2004	832	16/3/04
Decentralisation and health	Anywhere	1975–2004	10	16/3/04
Decentralization and health	Anywhere	1975–2004	107	16/3/04
Centralisation and health	Anywhere	1975–2004	3	16/3/04
Centralization and health	Anywhere	1975–2004	51	16/3/04
Decentring	Anywhere	1975–2004	13	16/3/04
Decentering	Anywhere	1975–2004	87	16/3/04
Centring	Anywhere	1975–2004	11	16/3/04
Centering	Anywhere	1975–2004	337	16/3/04
Deconcentration	Anywhere	1975–2004	95	16/3/04
Deconcentration and health	Anywhere	1975–2004	1	16/3/04
Concentration	Anywhere	1975–2004	2137	16/3/04
Concentration and health	Anywhere	1975–2004	236	16/3/04
Devolution	Anywhere	1975–2004	287	16/3/04

Devolution and health	Anywhere	1975–2004	39	16/3/04
Subsidiarity	Anywhere	1975–2004	31	16/3/04
Subsidiarity and health	Anywhere	1975–2004	0	16/3/04
Localism	Anywhere	1975–2004	635	16/3/04
Localism and health	Anywhere	1975–2004	24	16/3/04
Centralism	Anywhere	1975–2004	121	16/3/04
Centralism and health	Anywhere	1975–2004	8	16/3/04
Federal	Anywhere	1975–2004	11 748	16/3/04
Federal and health	Anywhere	1975–2004	1389	16/3/04
Federalism	Anywhere	1975–2004	548	16/3/04
Federalism and health	Anywhere	1975–2004	52	16/3/04
Central-local relations	Anywhere	1975–2004	7	4/4/04
Central-local relations and health	Anywhere	1975–2004	0	4/4/04
Inter-governmental relations	Anywhere	1975–2004	1	4/4/04
Inter-governmental relations and health	Anywhere	1975–2004	0	4/4/04
Organisational autonomy	Anywhere	1975–2004	0	16/3/04
Organizational autonomy	Anywhere	1975–2004	34	16/3/04
Health policy	Anywhere	1975–2004	2093	16/3/04

Notes: English language limit set.

Table A8 Database: Zetoc (electronic table of contents from the British Library)

Term	Limit	Years	Hits	Date
Decentralisation	All fields	1993–2004	743	16/3/04
Decentralization	All fields	1993–2004	1135	16/3/04
Centralisation	All fields	1993–2004	156	16/3/04
Centralization	All fields	1993–2004	404	16/3/04
Decentralisation and health	All fields	1993–2004	29	16/3/04
Decentralization and health	All fields	1993–2004	91	16/3/04
Centralisation and health	All fields	1993–2004	2	16/3/04
Centralization and health	All fields	1993–2004	14	16/3/04
Decentring	All fields	1993–2004	39	16/3/04
Decentering	All fields	1993–2004	75	16/3/04
Centring	All fields	1993–2004	70	16/3/04
Centering	All fields	1993–2004	560	16/3/04
Deconcentration	All fields	1993–2004	61	16/3/04
Deconcentration and health	All fields	1993–2004	N/A	16/3/04

Concentration	All fields	1993–2004	111 993	16/3/04
Concentration and health	All fields	1993–2004	1587	16/3/04
Devolution	All fields	1993–2004	1318	16/3/04
Devolution and health	All fields	1993–2004	60	16/3/04
Subsidiarity	All fields	1993–2004	355	16/3/04
Subsidiarity and health	All fields	1993–2004	1	16/3/04
Localism	All fields	1993–2004	145	16/3/04
Localism and health	All fields	1993–2004	3	16/3/04
Centralism	All fields	1993–2004	43	16/3/04
Centralism and health	All fields	1993–2004	3	16/3/04
Federal	All fields	1993–2004	38 316	16/3/04
Federal and health	All fields	1993–2004	1584	16/3/04
Federalism	All fields	1993–2004	2695	16/3/04
Federalism and health	All fields	1993–2004	72	25/3/04
Central-local relations	All fields	1993–2004	75	29/3/04
Central-local relations and health	All fields	1993–2004	0	29/3/04
Inter-governmental relations	All fields	1993–2004	4	29/3/04
Inter-governmental relations and health	All fields	1993–2004	0	29/3/04
Organisational autonomy	All fields	1993–2004	1	16/3/04
Organizational autonomy	All fields	1993–2004	36	16/3/04
Health policy	All fields	1993–2004	12 942	16/3/04

Notes: unable to set English language limit. Only available since 1993; updated daily.

Table A9 Database: Business Source Premier

Term	Years	Hits	Date
Decentralisation	1974–2004	1232	2/4/04
Decentralisation and health	1974–2004	60	2/4/04
Centralisation	1974–2004	550	2/4/04
Centralisation and health	1974–2004	20	2/4/04
Centralization	1974–2004	550	2/4/04
Centralization and health	1974–2004	20	2/4/04
Decentralization	1974–2004	1232	2/4/04
Decentralization and health	1974–2004	60	2/4/04
Decentering	1974–2004	12	2/4/04
Decentring	1974–2004	10	2/4/04
Centering	1974–2004	63	2/4/04

Centring	1974–2004	17	2/4/04
Deconcentration	1974–2004	46	2/4/04
Deconcentration and health	1974–2004	1	2/4/04
Concentration	1974–2004	3697	2/4/04
Concentration and health	1974–2004	235	2/4/04
Devolution	1974–2004	299	2/4/04
Devolution and health	1974–2004	16	2/4/04
Subsidiarity	1974–2004	124	2/4/04
Subsidiarity and health	1974–2004	1	2/4/04
Localism	1974–2004	127	2/4/04
Localism and health	1974–2004	0	2/4/04
Centralism	1974–2004	72	2/4/04
Centralism and health	1974–2004	0	2/4/04
Federal	1974–2004	173 579	2/4/04
Federal and health	1974–2004	9583	2/4/04
Federalism	1974–2004	1365	2/4/04
Organisational autonomy	1974–2004	1	2/4/04
Organizational autonomy	1974–2004	16	2/4/04
Central local relations	1974–2004	26	2/4/04
Central-local relations and health	1974–2004	2	4/4/04
Inter-governmental relations	1974–2004	12	2/4/04
Inter-governmental relations and health	1974–2004	0	2/4/04
Health policy	1974–2004	2033	2/4/04

Table A10 Database: Emerald Full Text (management and library and information services)

Term	Limit	Years	Hits	Date
Decentralisation	All fields	1974–2004	50	5/4/04
Decentralization	All fields	1974–2004	122	5/4/04
Centralisation	All fields	1974–2004	24	5/4/04
Centralization	All fields	1974–2004	27	5/4/04
Decentralisation and health	All fields	1974–2004	2	5/4/04
Decentralization and health	All fields	1974–2004	12	5/4/04
Centralisation and health	All fields	1974–2004	2	5/4/04
Centralization and health	All fields	1974–2004	4	5/4/04
Decentring	All fields	1974–2004	3	5/4/04
Decentering	All fields	1974–2004	2	5/4/04
Centring	All fields	1974–2004	11	5/4/04

Centering	All fields	1974–2004	5	5/4/04
Deconcentration	All fields	1974–2004	0	5/4/04
Deconcentration and health	All fields	1974–2004	0	5/4/04
Concentration	All fields	1974–2004	279	5/4/04
Concentration and health	All fields	1974–2004	35	5/4/04
Devolution	All fields	1974–2004	45	5/4/04
Devolution and health	All fields	1974–2004	6	5/4/04
Subsidiarity	All fields	1974–2004	8	5/4/04
Subsidiarity and health	All fields	1974–2004	0	5/4/04
Localism	All fields	1974–2004	2	5/4/04
Localism and health	All fields	1974–2004	0	5/4/04
Centralism	All fields	1974–2004	5	5/4/04
Centralism and health	All fields	1974–2004	0	5/4/04
Federal	All fields	1974–2004	254	5/4/04
Federal and health	All fields	1974–2004	22	5/4/04
Federalism	All fields	1974–2004	7	5/4/04
Federalism and health	All fields	1974–2004	0	5/4/04
Central-local relations	All fields	1974–2004	0	5/4/04
Central local relations			7	
Central local relations and health	All fields	1974–2004	0	5/4/04
Inter-governmental relations	All fields	1974–2004	1	5/4/04
Inter governmental relations			0	
Inter-governmental relations and health	All fields	1974–2004	14	5/4/04
Organisational autonomy	All fields	1974–2004	14	5/4/04
Organizational autonomy	All fields	1974–2004	57	5/4/04
Health policy	All fields	1974–2004	365	5/4/04

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