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ScienceDirect
Health Policy 86 (2008) 204–212
HEALTH POLICY
www.elsevier.com/locate/healthpol

# Room for manoeuvre? Explaining local autonomy in the English National Health Service

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**Abstract**

Decentralisation has returned as a key theme in English health policy in recent years in policies such as Patient Choice and Foundation Trusts, among many others. The goal of these policies appears to be to stimulate self-sustaining incentives to continuous organisational reform and performance improvement through creating a pluralist model of local provision. However, the ability of local organisations to exercise autonomy and to deliver such performance is highly contingent upon their local context, not least in terms of existing patterns of dependencies.

Explaining variation in local outcomes of national policies demands an understanding and explanation of local autonomy and its effect on performance which takes into account the role of the local 'health economy' – the local context within which organizations are embedded. It is this combination of vertical and horizontal autonomy which effectively determines the local room for manoeuvre in decision-making.

The aim of the paper is to examine the local dimension of decentralisation policies. It draws from different strands of literature to discuss the room for manoeuvre of local organisations within local health economies in England with specific reference to Primary Care Trusts. It draws conclusions about the nature of decentralisation itself and the impact of such policies.


*Keywords:* Decentralisation; Primary Care Trusts; National Health Service; Local Health Economy

## 1. Introduction

Decentralisation has, once again, returned as a key theme in English health policy in recent years [1–3]. Most emphasis has been on the vertical dimensions, *i.e.* the hierarchical transfer of power from central government to individual local organisations such as the purchasers (Primary Care Trusts; PCTs) and providers (National Health Service (NHS) Trusts and independent providers). However, a neglected aspect has been on conceptualising the way in which local organisations exercise their varying degrees of autonomy from higher authorities and within the local network of statutory and independent agencies. As such, this paper seeks to move the decentralisation debate forward to

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doi:10.1016/j.healthpol.2007.10.008

a more rounded perspective of the distribution of powers within an increasingly differentiated polity [4] and congested state [5].

The paper is divided into four sections. First, it reviews the concept of local autonomy in the context of decentralisation by drawing on different strands of literature. Second, it examines the specific context and content of decentralisation being implemented in English health policy. Third, in light of this policy and evidential review, the paper discusses room for manoeuvre of organizations in local health economies (LHEs) in England, illustrated by PCTs. Fourth, the paper makes tentative conclusions about the direction, pace and impact of current decentralisation reforms.

## 2. Understanding and explaining local autonomy

Scholars from different disciplines have variously discussed the theme of decentralisation and provided several models [6,7,3,2,8]. Given this diversity, decentralisation is notoriously difficult to define and some would argue that it is a futile exercise [6,9,10]. However, Fleurke and Willemse [11] offer a succinct definition; it is a:

"a dynamic process of redistribution of tasks, competencies and other resources over all tiers of government" (p. 530).

Nonetheless, this decentralisation literature provides inadequate insight into the properties being decentralised, the organisational and spatial dimensions of such decentralisation and changing role of the centre. The literature also fails to account for new political and organisational contexts.

Adding to these deficiencies, there have also been relatively few attempts to operationalise notions of local autonomy within the context of decentralisation [12,7]. This lacuna arises from the multiple perspectives and paradigms that have tended to dominate writing and commentaries on decentralisation [13,3]; these debates have often been conducted in parallel, rather than building on each other.

Much of the 'autonomy' literature draws on evidence from local government and/or US studies. The democratic/political mandate of local government inevitably shapes the nature of how decentralised powers are exercised which can lead to fragmentation and concentration [14]. The fiscal federalism literature is largely concerned with financial autonomy and with tax raising powers [13]. This has been less applicable to National Health Systems except for the ability of healthcare providers to retain their 'savings' or to raise finance from private sources. Clinical autonomy is also less applicable other than the notion that the decisions of local agents (street level bureaucrats [15]), reflect a certain degree of *de facto* autonomy [16].

In the context of health-care organisations, Bossert [7] provides a model of autonomy in terms of decentralisation. Using principal-agent theory, this model seeks to explain the interaction between national context and local context in shaping local decision making which, in turn, shapes the local (organisational) performance. Bossert's decision space framework (DSF) is a means to conceptualise the way in which the processes of decentralisation contribute to its apparent objectives. It does so by distinguishing between three elements:

- "the amount of choice that is transferred from central institutions to institutions at the periphery of health systems,
- what choices local officials make with their increased discretion (which may entail innovation, no change or directed change) and
- what effect these choices have on the performance of the health system" (p. 1513).

"Decentralisation inherently implies the expansion of choice at the local level" (p. 1518). The (extent and type of) choices that are permitted by higher authorities (usually central government) through the properties being decentralized and the rules and regulations determine the 'decision space' (or rules of the game) that is available locally. Bossert divides the properties being decentralized into functional areas (such as finance or human resources) and defines the dimensions of decision space in each of these areas. The functional areas listed are those in which decisions are likely to affect the performance of the health system (loosely defined) in terms of objectives such as equity and efficiency.

Although the DSF recognises the role of local context in determining local choices in decentralised health-care and reflects the role of performance, it conceptualises local autonomy mainly in the context of vertical decentralisation – the relationship between