

Decentralizing Health Services: More Local Accountability or Just More Central Control?

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This article examines the continuing debate about, and inter-relationship between, the NHS, decentralization and local participation. The focus of the article is the experience of decentralization and participation over the past 25 years and, drawing on a new conceptualization of decentralization, it identifies the extent to which the NHS supports decentralized approaches to participation.

Twenty-five years ago in *Patients First* the Government emphasised the need for as many decisions as possible to be taken at the local level (DHSS, 1979). Today, increased localization and shifting decisions from the centre to the locality are again at the heart of government policy. 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 decentralization in the NHS. Proposals set out in the 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’.

Within the UK, decentralization has a long history embodied in debates between Aneurin Bevan and Herbert Morrison about political and organizational decentralization of the NHS in the 1940s (Baggott, 2004). In policy terms—as evidenced by recent use in the NHS—decentralization is seen as a good thing as it frees managers to manage, enables more responsive public services attuned to local needs, contributes to economy by enabling organizations 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, and makes local politicians more responsive and accountable to the ‘people’. A key aspect of this continuing debate is the issue of accountability and the NHS’s relationship to democratic structures within the UK. In reality the NHS embodies both diversity and uniformity. But is this new move towards decentralization

different from before? Two questions need to be asked:

- To what extent does the emphasis on patient choice change our conceptualization of decentralization?
- Is it true that localization will produce a more responsive, efficient and effective service?

The article explores these questions, focusing on the relationship between decentralization and public and patient involvement. It provides a brief review of previous waves of decentralization and critiques frameworks that have been used to analyse decentralization in the past. Existing frameworks portray decentralization as a relativist concept applied to levels of organization or geography. This article introduces a new analytical framework that aids understanding of decentralization in health care and its impacts upon organizational performance. We conclude that while the assumption of decentralization may suggest greater democracy and participation, this is not what is necessarily achieved.

The Nature of Decentralization

There have been many attempts to develop a clear definition of decentralization. In a recent examination of decentralization in health services Saltman *et al.* (2004) defined decentralization as ‘the transfer of authority and power in planning, management and decision-making from higher to lower levels of organizational control’ (p. 2). This immediately places decentralization within an organizational and geographical context and reflects a fairly consistent approach to defining decentralization. In practice the process of

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decentralization can be seen in two phases.

Initially decentralization was mainly concerned with public administrative goals involving the reorganization of centralized public agencies by devolving activities to lower levels. This view is characterized in the most commonly used framework developed by Rondinelli (1983) who identified four categories:

- *De-concentration*: Shift in authority to regional or district offices within structure of government ministry.
- *Delegation*: Semi-autonomous agencies are granted new powers.
- *Devolution*: Shift in authority to state, provincial or municipal governments.
- *Privatization*: Ownership is granted to private entities.

The second phase has been more concerned with democratization and this is reflected in decentralization frameworks developed from studies undertaken in the UK (Burns *et al.*, 1994; Hambleton *et al.*, 1996). At an international level, there is strong evidence to support the relationship between democratization and participation and decentralization. Bossert (1998) has demonstrated that, in developing countries, democracy and public involvement are enhanced by decentralization and in a study of international primary care decentralization was found to normally be seen as a way of increasing democracy (Meads and Wild, 2003). However, while De Vries (2000), who reviewed decentralization policies in a number of European countries, argued that decentralization enhances civic participation, neutralizes entrenched local élites, and increases political stability, in Norway health service decentralization did not necessarily lead to more democracy (Elstad, 1990). How far these assumptions and findings can be applied to the NHS is not clear.

In health care, it is also important that any definition or discussion of decentralization captures not just organizational contexts but also the individual within the health care system as health care practitioner or patient. In addition, where do policies that have an individual focus, such as patient choice or patient involvement, fit as these combine elements of devolution, delegation and privatization and potentially autonomy for patients? Furthermore, we need to consider the role of the centre and the relationships between the different levels of decentralization/

centralization continuum. In the UK, central agencies have roles as funders, regulators, and stewards of health care and it is important to ask how they are 'steering' local organizations/networks, and not simply what is being decentralized to which 'level'. Applying the concept of decentralization to health is further complicated by the fact that the NHS has a centralized funding structure (with global budgets) and a decentralized provision structure—traditionally operating through regions, districts, hospitals, and professional autonomy (Mohan, 1995)—and local health agencies will always be reliant on funds from central government. In much of the academic literature on decentralization, it is presumed that decentralized agencies will have income-raising potential. While local health agencies in the UK do not have 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 decentralized units there is an incentive to consider revenue maximization. This was an important element in the development of foundation hospitals policy but also an element in the development of primary care-led commissioning in terms of improving allocative efficiency (Le Grand *et al.*, 1998).

Finally, it is important to identify different parts of the system by the functional activities transferred, the authority and power transferred for each, the level or 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 decentralized?) of decentralization, and the nature of the relationships between levels are all problematic.

In order to use decentralization as a variable for analysis, it needs redefining to take account of the individual perspective in health care and to be clear about *what* is being decentralized. One possible way of applying these concepts to health is to set them in population terms so that:

- Decentralization = Nearer/closer/related to the patient/individual/community (or unit of health outcome: usually individuals).
- Centralization = Further away from the individual and is represented by the global population (for example citizens of a country, the world etc.).

In this sense there are no specific points on the horizontal axis as it will depend on how the

framework is applied. It is the vertical axis that causes more problems with the need to provide a contextual framework that can address the *what* of decentralization? The performance literature uses the concepts of inputs, process and outcomes and it is useful to apply these as the second dimension of the framework. Thus a simple two-dimensional framework would look like figure 1.

The input/process/outcome approach within the arrows framework in figure 1 overcomes 'from where' and 'to where' questions, including the individual perspective, and is more specific in categorizing the 'what' question. This article discusses the issues of democratization and participation in the NHS and the arrows 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 decentralization.

Decentralization, Democratization and Participation in the NHS

Concerns about engaging patients and the public and filling the 'democratic deficit' in the NHS are long standing and were only partially addressed by the creation of Community Health Councils (CHCs) in the 1970s and attempts to engage people in local commissioning during the 1980s and 1990s (Lupton *et al.*, 1998). Current government policy has re-emphasised the importance of patient and public involvement in planning and service provision in addition to the collection of patient satisfaction data to strengthen accountability and health service governance as a response to the continuing concerns over this democratic

deficit. The emphasis on local accountability and patient involvement and responsibility is resonant with the decentralist rhetoric of all governments since 1979.

Many British governments have claimed that they wish to decentralize the NHS. Indeed, there have been few claims to centralize the NHS or arguments favouring 'command and control'. Klein (2001) argues that the cycle of experiments with delegation quickly followed by reversions to centralization is one of the themes running through the history of the NHS. Nevertheless, decentralization in the NHS is a problematic concept. Everybody has paid verbal homage to the principle of decentralization, but how was it to be achieved in a nationally-financed service? Similarly, Butler (1992) has argued 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, although different Ministers have held conflicting views. Enoch Powell argued that the centre had almost total control, Richard Crossman maintained that the centre was weak, and Barbara Castle argued that the RHAs were 'pretty subservient'. NHS observers have also offered different views. For example, during the 1980s and 1990s it appears that the NHS was moving in two different directions at once, with some commentators claiming that the *national* character of the health service was undermined (Mohan, 1995); while others argued that the NHS was effectively nationalized (Klein, 2001).

The Conservative Government of 1979

Figure 1. Arrows framework.

Examples of tiers Activity ↓	Global	Europe	UK	England/ Scotland/ Wales/Northern Ireland	Region eg. Strategic Health Authority	Organisation eg. Primary Care Trust	Sub-unit eg. Locality/ practice	Individual
Inputs	← Direction of movement →							
Process	← Direction of movement →							
Outcomes	← Direction of movement →							

stated that: 'We will simplify and decentralize the service and cut back bureaucracy', and most commentators agree that the 1979 consultation paper, *Patients First*, and the resulting 1982 reorganization stressed decentralization. Allsop (1995) argued that with *Patients First* decisions moved closer to the locality, and that the locus of decision-making moved downwards—a view supported by Baggott (2004). These changes were primarily organizational and not really related to patient or public participation and there continued to be an increasing uneasiness with the accountability structures of the NHS particularly in relation to upward and downward (i.e. central/local) accountability (Day and Klein, 1987). While the 1970s had seen the introduction of CHCs and lay representation on health authority boards, these were seen as having major limitations (Lupton *et al.*, 1998). This debate was linked to a wider dissatisfaction with representative democracy and the role of the citizen and their relationship to society and, in particular, state institutions. Two broad approaches emerged in the debate. The first was essentially the concept of community participation and citizen representation, characterized by the CHC movement but also the 'new public health's interest in participation as an important element of improving health (Kai and Drinkwater, 2004; Lupton *et al.*, 1998). There was synergy with the community health movement of the 1980s, providing a new context for public involvement focused on the active involvement of local communities in promoting their own health although highlighting the increasing tension between professional and lay definitions of health (Peckham, 2004). This approach had a strong emphasis on localization with health organizations needing to be closer to, and to engage with, their public. The second was a consumerist strand that developed from the Griffiths' Management Review (DHSS, 1983) and raised the need for an increased focus on the patient as customer. This focus was exacerbated in 1991 with a white paper *Working for Patients* (DoH, 1989) and the introduction of the internal market hailed as a major decentralization of health care organization although most assessments of *Working For Patients* argue that it was associated with centralization (Paton, 1993).

Much of the early development of public involvement, from an NHS perspective, was framed by the consumerist approach pursued by the Conservative Government in the 1980s and 1990s, with an emphasis on patient satisfaction surveys, consumer surveys and the

Patient's Charter (Lupton *et al.*, 1998). However, it has been argued that a consumerist approach is not sufficient to address the problems of representative democracy because it expounds a very narrow view of citizenship based on the relationship between individuals and services. While strengthening accountability in terms of service responsiveness, it does little to confer wider legitimacy to the organizational and political structures of the NHS. The Patient's Charter perhaps provides a clear example of the tension between centralism and devolution. Klein (2001) argues that the Patient's Charter represented a 'mimic consumerism', or 'top down consumerism'—a new hierarchy of command.

Recognition of these shortcomings in the 1990s led to a search for different models of involvement which combined the individualistic and citizen approaches. At first, these focused mainly on the need to consult the public, but later the NHS experimented with citizen's juries, patient and public panels and other forms of direct democracy (Lupton *et al.*, 1998). *Local Voices* (National Health Service Management Executive, 1992) required health authorities to consult with local people before drawing up their commissioning plans, although research on these processes suggests that consultation was often tokenistic and viewed by those consulted as lacking any real significance (Lupton *et al.*, 1998). By the mid 1990s, the Government was asserting that health care policy had increased responsiveness at the local level, with trusts better able to respond to patients' needs through greater freedoms, flexibility and local involvement. It was assumed that greater local responsibility encouraged efficiency and, even more importantly, an increasing sense of pride and job satisfaction. According to the then health minister, Virginia Bottomley, this strategy would uphold and strengthen national accountability while at the same time geared to respecting local freedoms. Merged health authorities would be 'champions of local people' and the reorganized NHS Executive was to offer a 'light touch' management style through its regional offices allowing 'more effective support to the development of local policies'. Paton (1998, p. 159) argued that encouraging *Local Voices* became a bit of a joke—one consequence of increasing centralization upwards was a corresponding decrease in accountability downwards.

Paton concludes that it might be argued that the whole structure of the post 1989 NHS represented devolution although while there

was significant operational decentralization, centralism increased. Of particular interest was the increasing central exhortation towards patient and public participation with centrally run programmes being developed in the mid 1990s under the *Patient Partnership Programme* (DoH, 1998). Though decentralist in rhetoric, to create 'a feeling of greater local ownership of health services' (para. 4) and 'social cohesion within communities' (para. 6), there is an undercurrent of centralization. Local managers manage within closely defined central terms. Such is the 'familiar organizational paradox, that to decentralize, it is necessary to centralize' (Carter, 1989, p. 131).

So is the current move towards decentralization in the NHS any different? There are perhaps two distinct differences: devolution, and the emphasis on the role of the patient. The approach is perhaps underpinned by a belief that the role of the state should change: 'people in localities and communities and groups very often understand their own problems better, they can think up their own solutions more appropriately and tailor made to themselves so the state should be, wherever possible, an enabler' (Reid, 2000).

The rhetoric of decentralization is very clear. In a speech to the NHS Confederation in June 2004, Sir Nigel Crisp, NHS Chief Executive, described the NHS as 'decentralizing'. In future, NHS organizations will 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.
- Shared targets with other NHS bodies and local authorities.

Instead of 80% of initiatives being dictated nationally, with 20% set locally, the NHS would be one where 80% of the NHS's priorities were determined locally. But he 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 decentralized, with accusations not just of postcode prescribing, but of 'postcode health care'.

The present Government 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. The model endorsed by the Labour Government, based around individual patient choice, is perhaps the clearest attempt yet at 'market consumerism' (Greener, 2004) epitomised by policies for extending patient choice, and more formal patient and public involvement structures. Government policy in these directions was also supported by professional and consumer groups though acknowledging that there are limits to, and adverse consequences of, choice (NCC, 2004).

There is a further tension in government policy on patient involvement that relates more to the role of health care professionals. In the NHS professionals have traditionally enjoyed professional and clinical autonomy. There is now, however, recognition of the need for a clearer partnership with patients and professionals driven partly by a greater awareness of the risks and uncertainty of professional practice but also by a recognition of the clinical importance of the patient's perspective and involvement in their own care (Coulter, 1999). More recently, concerns about the number of adverse events and weaknesses in regulatory frameworks (Bristol Inquiry, 2001; Shipman Inquiry, 2004) have contributed to a wider questioning of professional dominance. With this comes a growing recognition that the role of the patient is changing from one which is as a passive recipient to one as informed partner.

This concept of partnership between practitioner and patient involves a whole patient focus, a high degree of knowledge of the patient, caring and empathy, trust, appropriately adapted care, and patient participation and shared decision-making (Lupton *et al.*, 1996). The increased availability of information for patients coupled with higher expectations is perhaps one of the biggest changes in recent years. It is likely that this trend will continue, encouraged by NHS policy, but also supported by the growth of new technologies such as access to the internet, video consoles in GP surgeries, and a growth in consumer health information services and NHS Direct. One major policy initiative that is closely related to this area is the Expert Patient programme. This programme, aimed at 'empowering' patients, has been initiated by the government and appears to support patient autonomy although there have been criticisms of its operation (Wilson, 2001), and there is clear central aspiration that long-term outcomes may be cost effective for the NHS although this has been challenged by a number of the patient

organizations and associations involved in the programme.

Conclusion

On the face of it, the emphasis in policy on decentralization of decision-making and the development of local structures for patient and public involvement, scrutiny, developing patient choice and the expert patient programme suggest a real shift away from the central department to local health organizations, communities and patients. This would therefore seem to support the link between decentralization and participation. However, at the same time, we have seen a strengthening national framework for service delivery, stronger regulatory powers at a central level and a comprehensive centrally driven system of performance management. Therefore, is the recent experience of decentralization the same as the 1990s and earlier? Do the analyses of Paton (1993) and Carter (1989) hold true today? One problem is the weakness of traditional approaches to analysing decentralization as it is treated either as a single independent variable or is discussed in terms of other problematic concepts. A second problem is that traditional approaches to decentralization have ignored the individual. By adopting the Arrows Framework it is possible to unpick these current developments a little more.

What is striking about Labour Government policy since 1997 is the increasing interest in defining the inputs and processes of participation mechanisms in the UK. With an increasing emphasis on how participation and democratization are to be achieved, clear structures and processes have been established in England (Wales and Scotland opted to continue existing arrangements for CHCs and Community Health Boards respectively) with an increasing lay representation on health boards at a local level. It is worth examining the different levels of this decentralization: devolution, localization and patient empowerment. The first and last levels can clearly be classified as being different to previous attempts at decentralization while localization remains part of what Klein (2003a) has described as the 'revolving-door of policy'. Devolution has had important consequences for health and both the Welsh Assembly and Scottish Parliament have placed health firmly on their political agendas with public health developing as a major theme which does appear to have led to positive consequences (Peckham and Wirmann, 2004; Hunter *et al.*, 2005).

Devolution has also led to the decentralization of inputs (funding), process (the NHS) and output and perhaps can be seen as full decentralization with an increase in democratization, albeit that in Scotland the autonomy of the Scottish Parliament is greater than that of the Welsh Assembly.

Localization and participation are characterized by the introduction of lay representation on trust boards, new patient forums in England, local authority scrutiny, community engagement in public health and a strong emphasis on patient and public participation. Here again we see central government developing very explicit frameworks for participation with clear inputs and processes. The contractual model developed by the now defunct Commission for Patient and Public Involvement in Health ensured a degree of national conformity—an attempt to overcome the diversity that developed among CHCs. Lay involvement in trusts is centrally managed and the governance arrangements for foundation trusts demonstrate the extent to which the centre was willing to define the structure and process of governance for local organizations (Klein, 2003b).

Finally, and perhaps of most interest, are the moves towards patient autonomy and empowerment characterized by policies such as Patient Choice and the expert patient programme. There is no doubt that Patient Choice is a centrally driven agenda defining very clearly the processes by which choices will emerge for patients. But 'choice' needs to be viewed in the context of the interaction between organizational and personal factors. Patient choice has always been heavily delineated by the organization of health care, the power of medical professionalism, and individual lay beliefs. While patient choice may theoretically improve quality and efficiency of care it requires flexible capacity within providers and high quality information upon which to base choices. Neither of these currently exists to any great extent and increased choice may lead to greater inequities of access as those with the greatest health needs may not be those able to exercise most choice (Appleby *et al.*, 2003).

So does it matter that inputs and processes for participation have been centrally defined by the Government? The fact that there is a perception in policy that these processes are about ensuring that patients and the public have more say and control over what happens in the NHS and what is achieved means that there is a substantive shift away from the centre.

Leaving devolution aside, as it could be argued that this is really about a shift at the centre, participation in the NHS is perhaps as much at the mercy of the increasing tendency for governments to define the outputs through performance targets, national service frameworks, and central regulatory functions as any other aspect of the NHS. For example, lay involvement on trust boards is centrally managed through the NHS Appointments Commission and the performance of non-executive directors is assessed against nationally agreed criteria and performance targets. Whatever local views are expressed about the NHS, meeting the performance framework standards and targets remains paramount. Recent events at the Bradford Hospital Foundation Trust also highlight the supremacy of the centre over what was billed as independent local governance.

The tension between central performance measures and local participation remains a key point of contention. It would appear that Klein's (2001) summing up of the situation in the 1990s holds true today—everybody is paying verbal homage to the principle of decentralization but we still need to question how this is going to be achieved in a nationally-financed service. It is still not clear whether NHS is a central service that is locally managed, or a local service operating within central guidelines (Butler, 1992). The Government still claims the latter, while actually operating the former. Local public or community accountability may therefore be a myth showing that the centralized Westminster model that drives the NHS is not compatible with local patient and public involvement. ■

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