

Decentralisation and Performance: Autonomy and Incentives in Local Health Economies

Executive summary

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Executive Summary

Background

This summary presents the findings and analysis from a study commissioned by the NIHR Service Delivery and Organisation Programme (SDO).

Decentralisation remains a strong theme within English health policy, most recently focusing on autonomy for high performing local organisations. Policies such as Foundation Trusts illustrate this. The study examined the impact of national policy (especially autonomy) and local organisational collaboration in terms of the room for manoeuvre in local health economies (LHEs). It also examined the ways in which performance was measured and managed across the local health economy, and effects of measurement on behaviour and outcomes. Incentives such as Payment-by-Results (arguably a centralising measure) have, it is claimed, enabled local autonomy.

The study's methodology was a longitudinal comparative case-study of two contrasting LHEs. The study was conducted between 2006 and 2009. Within each case-study, data were collected through in-depth interviews, observation of meetings and documentation.

Aim

To investigate the relationship between decentralisation, governance, incentives and performance in LHEs.

Objectives:

- a. To examine the impact of decentralisation upon performance;
- b. To describe the local interaction of governance mechanisms;
- c. To evaluate the degree of autonomy available to local health-care organisations;
- d. To assess the incentives associated with different policy initiatives;
- e. To provide lessons for policy-makers and managers at all levels

About this study

This study was an in-depth examination of the ways in which decentralisation in the English health system was interpreted and implemented locally. It described and explained the relationship between autonomy and performance, mediated by incentives, in two contrasting LHEs. It drew on theoretical models and frameworks to provide the conceptual context within which the empirical findings are presented and interpreted. The study used a comparative case-study methodology, involving in-depth interviews, observation and documentary analysis between 2006 and 2009. It found that freedom from the centre did not always facilitate freedom to innovate or be responsive to local needs because local practitioners may have been

unable but were not always willing to exercise autonomy. The emphasis on formal performance (eg. activity or financial metrics) tended to overlook the role played by informal performance (eg. goodwill and trust). The study has implications for the design and implementation of health system reforms in England.

Key findings

1. Decentralisation:

- a. Decentralisation is evident in many English health policies, notably granting autonomy to Foundation Trusts (FTs).
- b. Decentralisation can be sub-divided into inputs, process and outcomes to clarify 'what' is being decentralised.
- c. Whilst greater local autonomy over input and process illustrates decentralisation, centralisation is also evident in terms of tighter control over outcomes through performance management and regulation.
- d. The mix of decentralisation and centralisation has created ambiguity and uncertainty for policy-makers (centrally) and practitioners (locally).

2. Autonomy:

- a. Local decision space (room for manoeuvre) is the sum of vertical (from the centre) and horizontal (from other local organisations) autonomy. Health policy has focused mainly on vertical autonomy.
- b. Without freedom to be innovative or responsive locally, freedom from the centre may be compromised. This will affect the local implementation of health system reforms because both the ability and willingness to exercise autonomy are essential to deliver these reforms.
- c. Our evidence suggests an unwillingness to exercise autonomy because of centralising tendencies, risk-averse behaviour, an uncertain policy environment and an aversion to destabilise the LHE.
- d. We also found that organisations without FT status criticised the benefits available to FTs, as an example of an 'uneven playing field.'

3. Performance:

- a. The current version of decentralisation (to organisations) has been conditional upon their 'good' performance, the measurement of which is often disputed. Moreover, official performance measures are inadequate to inform local decision-making (as data are retrospective and incomplete for all areas of responsibility).
- b. The distinction between formal and informal performance is useful. Formal performance (eg. activity or finance metrics) provides a safety net for poorly performing organisations but offers weak incentives for high performing organisations. Informal performance (eg. reputation, trust) substitutes for and/or complements formal performance, offering rich insights but lacking consistency.
- c. Where informal performance was positive (indicating high trust and goodwill), our evidence showed how some additional *de facto* autonomy was apparent (where trust underpinned inter-organisational relationships) in the absence of formally-granted autonomy.

4. Local health economy:

- a. The LHE is the setting for the local implementation of national policy reforms. So, the success of these reforms will depend on the quality of local inter-organisational relationships. The LHE is thus where national policy intersects with local organisational politics.
- b. The NHS is highly localised (eg. in terms of commissioning patterns), creating complex inter-organisational relationships within LHEs.

Organisations in LHEs are thus often highly dependent on each other (eg. PCT and NHS Trusts) even despite FT status.

Conclusions

Recent English health policy has aimed to increase local autonomy and enhance organisational performance. Decentralisation, it is often claimed, can solve multiple organisational and policy dilemmas. However, it is not be a panacea for these shortcomings. The success of this policy will depend on the impact of vertical autonomy and horizontal autonomy. The broad conclusions are as follows:

1. Decentralisation is a means to an end
 - a. Policy objectives need to be clearly defined
2. Decentralisation and centralisation usually exist together
 - a. Policy attention on decentralisation can mask the centralisation taking place at the same time
3. Clarification is required about `what' is being decentralised/centralised
 - a. Decentralisation has usually been applied in terms of inputs and processes
 - b. Centralisation has usually been applied in terms of outcomes.
4. The impact of decentralisation will depend on the nature of the local health economy
 - a. Decentralisation does not automatically lead to `improvements'
 - b. Its success will depend on the local context including the nature and quality of collaboration between local agencies
5. Decentralisation must be accompanied by regulation
 - a. Decentralisation implies more local autonomy which has the impact of fragmenting health systems
 - b. Regulation and performance management (forms of centralisation) are required to ensure that system-wide objectives are met
 - c. Regulation may stifle local autonomy, if not sensitive to local contexts.
6. Decentralisation cannot achieve specific outcomes always and everywhere
 - a. Decentralisation has mixed benefits
 - b. Policy compromises must be made (say, between equity or efficiency)
7. The study's findings have implications for implementation of the current health reform agenda and the ways in which the NHS will navigate through an era of fiscal constraint.

Disclaimer

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health

Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk