ResearchSummary

Decentralisation: a model to follow in the NHS?

Decentralisation and devolution of power to frontline staff is considered one of the founding principles of recent NHS reforms. Changes to structure and governance are being introduced with the aim of achieving more responsive, locally-accountable services. These changes are often complex and costly to implement, making it imperative that their impacts on health and social care are well understood. To date, the evidence to assess the consequences of policies of decentralisation, centralisation and devolution in the NHS has not been systematically examined.

This research summary presents the main findings of a review of the evidence to enable practitioners, NHS managers and policy makers to understand better the constraints and opportunities posed by the continual shifts in the balance between decentralisation and centralisation. The paper provides a helpful analytical tool – the 'Arrows Framework' – to explain the relationship. The review was commissioned by the NHS Service Delivery and Organisation Research and Development Programme (SDO), and was led by Stephen Peckham, then Reader in Health Policy at Oxford Brookes University.

Key messages

- Decentralisation is not a panacea. It is not a sufficiently strong factor to influence organisational performance compared to other factors such as organisational culture, external environment and performance monitoring processes.
- Any organisation (or individual) can stand to lose or gain from centralisation and/or decentralisation. There is no optimal size/level that provides maximum organisational performance.
- There are trade offs in the choice between a centralised and decentralised service, for example, to the relationship between equity and responsiveness and to economies of scale.
- Local and national health care organisations need to develop a more sophisticated understanding of decentralisation processes; simple assumptions about the benefits, or otherwise, should be avoided.

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Background

'Decentralisation' – more than a buzz word?

Decentralisation in health policy is a contested concept for two interlinked reasons: its elusiveness as an idea; and the varied ways it is applied in theory and practice. The term decentralisation has been used in a number of disciplines such as management studies, political science, development studies, geography and social policy. In each of these contexts the word tends to carry different shades of meaning.

Decentralisation has links with other, related terms such as *autonomy* and *localism*, which as concepts are also subject to differing interpretations. Other terms used include *agency central–local relations* and *'national versus local'*. While *decentralisation* and *devolution* tend to be the terms used most in debate, they are rarely defined or measured, or linked to the conceptual literature.

Interpretations have become increasingly broad and some now argue that 'decentralisation', like 'empowerment' or 'sustainability', can be taken to mean just about anything. Accordingly, one of the aims of the study (Peckham, 2005) was to make sense of this concept and to deepen our understanding of it in the context of current policy debates in the NHS.

A model to follow?

Whatever is understood by the term, prevailing assumptions about the benefits of decentralisation are reflected in much of the strategic thinking underpinning modernisation. In many sectors of public life, including the NHS, decentralisation is usually seen as a good thing because it:

- frees managers to manage
- creates more responsive public services, better attuned to local needs
- reduces the burden on taxpayers by enabling public services to shed unnecessary middle managers
- promotes efficiency of services by reducing bureaucratic hierarchies
- provides incentives to the workforce in the form of increased room for manoeuvre, which in turn can lead to better job satisfaction and thus higher rates of staff retention
- makes politicians more responsive and accountable to citizens.

The study set out to examine the evidence base upon which these and related assumptions might be based, as well as to explore the consequences of policies of decentralisation, centralisation and devolution in the NHS.

How applicable is it to the NHS?

Much of the available literature in this area refers to contexts other than the NHS, for example, elected local government with revenue-raising powers, or is related to changes in 'developing' or lower income countries.

The NHS in England has a different form of governance to that of local government; moreover, it receives its revenue from central grants. Therefore, the straightforward transfer of knowledge and experience about decentralisation gained in other contexts such as local government is likely to be problematic. Insights arising from the latter and other sectors should therefore be interpreted with care.

Specifically, it may be helpful to bear in mind the following potential or actual risks that can arise when applying notions of 'decentralisation' from other sectors to health and social care.

- **Speaking at cross purposes rather than communicating effectively both ways.** There is a lack of clarity regarding the concepts, definitions and measures of decentralisation. Problems of language and speaking to a common purpose may be exacerbated if unexplored assumptions about decentralisation are allowed to go unchecked.
- **Closing down rather than opening up the debate.** Debate about decentralisation, and subsequent analyses of decentralisation, particularly in heath and social care, are still at an early stage. There is unlikely to be a 'one-size-fits-all' model of decentralisation. Different ideas should be shared and their relative merits rigorously assessed so that the debate can become more robust and more nuanced.
- **The urge to 'quick fixes'.** Assumptions about the effects of decentralisation on a range of issues including organisational performance can be incorporated into policy without reference to whether evidence or theory supports such an approach.

Practical findings

The Arrows Framework

How then can we draw together the insights of the literature to better understand processes of decentralisation in the context of health and social care?

Firstly, the notion of decentralisation needs to be considered in a more dynamic way. In particular, decentralisation has to be understood as more than an organisational or geographical concept. Delivery of services cannot be understood without reference to the interplay between the different roles of health and social care professionals and patients/service users. Equally to the point, recent policy has highlighted issues such as professional autonomy and regulation and patient involvement, self-determination and choice.

Discussion of decentralisation in the NHS must, therefore, capture these additional elements as well as exploring ways to link decentralisation to performance.

The study proposed a new framework for understanding decentralisation to take into account these requirements. This framework – the Arrows Framework – is illustrated in Figure 1.

Introducing the framework

Many previous studies have tended to treat decentralisation as a one-dimensional concept. A particular shortcoming of this approach is that important issues such as power and autonomy are insufficiently clarified or taken into account by many frameworks. Relatively little attention has been paid to defining and measuring adequately the where and what of decentralisation. In addition, analyses of decentralisation pay little attention to clearly defining what is being decentralised – e.g. authority, power, decision-making, ownership, resource allocation, or any combination of these.

The Arrows Framework is a conceptual tool designed to chart these and other aspects of the process in the context of health and social care. This is a two-dimensional framework with two axes: horizontal and vertical. The horizontal (or lateral) axis of the framework lists a hierarchy that ranges from the global at one end of the spectrum to the individual at the other. The categories 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 so that:

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

In the context of health care in England, for example, this would see the rest of the UK, the rest of Europe (e.g. the European Union) and the rest of the world (e.g. the World Health Organisation, the United Nations) spreading in one way. Spreading in the other direction would be sub-levels such as regional structures (e.g. strategic health authorities [SHAs]), local organisations (such as primary care trusts [PCTs], hospital trusts) and the sub-local/neighbourhood level (such as general practices or locality services), individual practitioners and patients.

Movement towards the global side would signify concern with larger populations and increasing centralisation; movement towards the individual would signify increasing decentralisation.

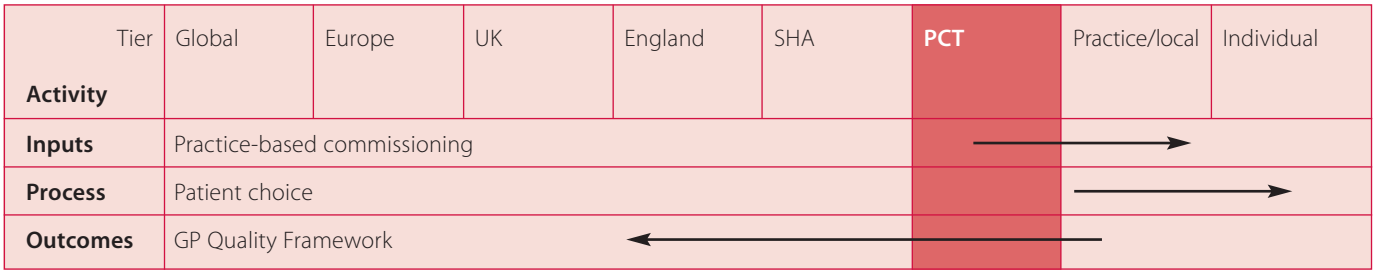
However, key to an analysis of shifts and balances in centralisation/decentralisation is the consideration of what is being moved between the levels and how this movement impacts on performance.

Hence, in the vertical axis the concepts of inputs, process and outcomes are added. These concepts will be familiar to many in the care sector; they are also embedded in public sector management, for example, in performance targets.

Figure 1. The Arrows Framework

Tier / Activity	Global	Europe	UK	England Scotland Wales N Ireland	Region *e.g. SHA*	Organisation *e.g. PCT*	Sub-unit *e.g. locality/ practice*	Individual
Inputs	← Direction of movement →							
Process	← Direction of movement →							
Outcomes	← Direction of movement →							

Figure 2. Arrows Framework applied to PCTs



The horizontal dimension enables the user to first plot movements and directions of drivers. The vertical dimension allows the user to refine the components of decentralisation, that is, the key functions of the particular policy driver being considered.

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 it provides a means of examining inter-relationships between such movements.

Using the activities 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 the 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). The table can be read vertically, e.g. the arrows demonstrate the effect on each hierarchical level (e.g. region, PCT) as well as movements (centralisation/decentralisation) within particular functions or policies. 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 policies and actions at any particular instance, demonstrating both 'direction of travel' (centralisation/decentralisation) or the impact on a particular organisational level. The framework can also be utilised to compare similar policies' actions over time.

Decentralisation and PCTs

Figure 2 applies the framework to the functioning of PCTs (as evidenced in the period up to 2005). This demonstrates the care needed 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 figure gives a clear example of 'input decentralisation': the creation of PCTs represented a significant movement of resources to organisations in the name of local responsiveness. But questions arise about the extent to which PCTs have the capacity to engage in 'process decentralisation'. For example, it is not clear in practice whether PCTs are able to employ these funds discretionally to any great extent. A number of other factors affect the situation, notably the following.

- Contracts are often signed on a timescale of greater than a year, which means 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.
- Decentralisation of resource has an ambiguous relationship with more recent reforms around the 'mixed economy of care' and 'patient choice'.

Conclusions

The pace of activity in health policy in the UK since 2000 makes it very difficult to establish an overall picture of whether the NHS is now more decentralised than it was. This is because particular policies often seem to lead in different directions. Mapping the effects of patient choice, for example, would mean examining its potential for decentralising processes through moving the selection of secondary care treatment as close as possible to the individual patient.

At the same time, however, there are competing centralising tendencies for clinicians in attempting to manage the process so that the best evidence is incorporated into the clinical decision.

Presenting the overall policy direction as either centralising or decentralising is therefore fraught with difficulties. The illustration of PCTs (Figure 2) clearly shows that both are occurring and thus discussions of policy need to move beyond the rhetorical discussion of 'decentralisation' in order to capture the specific nuances of specific policies.

For further examples of the Framework in action and a more detailed discussion of the theoretical and practical issues it raises, please refer to the full report (Peckham, 2005).

Future research

Decentralisation and organisational performance

Decentralisation cannot be marked off as a self-contained area of research and needs to draw upon several disciplinary perspectives. At the same time, increased attention needs to be paid to how the concept is used appropriately in future practice, policy and research.

The review identified two main areas for further analysis and investigation.

1. Relationships between organisations.
2. The changing nature of the dynamics between parts of a system over time. Dynamics can result from the combination of multiple centres of direction and regulation (including financial, political and technical), as well as multiple strategies emerging among the regulated organisations (including collaboration, compliance and competition).

Consideration should be 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 three-year period, in order to capture change over a more realistic period. There is also a need for research that examines specifically the relationships between and within levels by adopting studies that focus on health care economies rather than organisations alone. Future research could usefully be focused in two broad areas:

1. Decentralisation as a concept

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

2. Decentralisation and performance

A relationship between decentralisation and organisational performance exists but it is often specific to the context 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?
- Are there specific receptive contexts 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 a degree of autonomy. Particular areas of organisational performance might include exploring the relationship between decentralisation and accountability, human resources management and professional autonomy.

About the study

This study consisted of a multi-disciplinary review of relevant theoretical literature and empirical evidence about centralisation and decentralisation in public and private organisations. 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, UK literature and English language literature were examined from countries where there are similar centralist and decentralist tensions.

A total of 205 studies meeting the criteria for inclusion were reviewed. A panel of 12 expert advisers was convened to provide insights and perspectives upon the project's methods, findings and conclusions as well as the contemporary policy context. Contact with leading policy makers, researchers and commentators in the field was conducted throughout the life of the project. Networks provided additional sources for policy-relevant theoretical, unpublished and ongoing literature and included the opportunity to discuss interim findings (especially of conceptual frameworks) with academic groups at seminars and conferences.

References

Peckham S, Exworthy M, Powell M, Greener I. 2005. *Decentralisation as an organisational model for health care in England*. Report for the NHS Service Delivery and Organisation R&D Programme. London.

Further information

The full report, this research summary and details of current SDO research in the field can be downloaded at: www.sdo.lshtm.ac.uk

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About the SDO Programme

The SDO R&D Programme is a national research programme managed by the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (NCCSDO) under contract from the Department of Health's R&D Division, and is a constituent of the National Institute for Health Research (NIHR).

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Addendum

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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