

Devolved Governance Systems

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Abstract

This article assesses the extent, nature and outcomes of the recently devolved health service governance in the four countries which comprise the United Kingdom. This four-part configuration can be seen as a natural experiment in comparative governance which could therefore carry important lessons not only for the UK but in other countries too. While remaining under the aegis of the National Health Service, each constituent devolved administration has developed a substantially different governance system. These systems reflect fundamental issues and priorities concerning the decentring of authority, the production and deployment of authority, the suite of incentives required and the preferred role of quasi-market mechanisms. The paper makes an evaluation of the strengths and weaknesses of each governance regime.

Introduction

Health Services have been one of the main areas of social policy which have been devolved to the new country administrations within the United Kingdom. Hence, while the NHS remains a UK institution there are now some significant differences emerging in the way health services are governed and in the decision outcomes in these four countries. Thus, for example, while a notable feature of the NHS in England is the considerable admix of market-based and hierarchical approaches as seen in practice based commissioning in primary services and Foundation Trust and private sector providers in secondary care in England, Scotland has eschewed this approach. The purpose of this article is to undertake an assessment of the extent, nature and outcomes so far of devolved governance in these four countries. We see this four-part configuration as a natural experiment in comparative governance which could therefore carry important lessons not only for the UK but in other countries too.

‘Governance’ in the context of health is currently both prominent and yet fluid and subject to multiple meanings. It carries multiple connotations including decision making authority, resource allocation, financial probity, regulation, oversight and so on. We see ‘governance’ in the health context as a multi-form, multi-faceted and multi-level phenomenon.

The multi-form element is recognisable in the variety of its manifestations – clinical governance, integrated governance, corporate governance, system-wide governance. Its multi-faceted aspect is recognisable in its usage for diverse purposes such as quality assurance, financial viability [etc]. Its multi-level nature is evident in the tiers of

governance from literal government of the NHS from the Department of Health and No 10 from whence the overall architecture of the service is determined and certain priorities and directions are sent, through to the tiers of governance as witnessed by the Strategic Health Authorities in England, the devolved administrations of the other three countries, the governance regimes of acute trusts and primary care trusts and the cascade of governance within trusts down to the level of the governance of clinical practice.

There have been observable trends in these various forms of governance in the NHS. Clinical governance has emerged with a focus on quality-assured risk assessment and a variety of intra-institutional measures designed to deliver safe health care to patients (for example Donaldson, 1998; Goodman, 1998; Nicholls et al., 2000; Scally and Donaldson, 1998). Clinical governance has become the watchword for the delivery of institutional goals in terms of effective service delivery within hospitals. In a second, but related, development, focus has fallen on how the upper echelons of healthcare organisations control their respective institutions, define broader strategic objectives, and influence its behaviour. The concept of ‘corporate governance’ focuses on the activities of boards as they define strategic priorities for their organisation and adopt measure to influence behaviour within them (Ashburner, 2003; Clatworthy et al. 2000; Ferlie et al., 1995; Harrison, 1998). Taken together, clinical and corporate governance circumscribe the strategic deployment of resources within an organisation as they aim to deliver their services to achieve organisational aims and priorities. Typically, ‘clinical governance’ has attracted the attention of clinical practitioners and it focuses on the specificities of delivering safe and approved medical services. Crucially, it challenges the notion of the completely independent expert. ‘Corporate governance’ focuses on board composition and decision making procedures at the strategic level. Whilst this split represents a difference in emphasis on specific processes, these two forms share a conceptual space in the focus on the micro-processes of interaction through which healthcare organisations define and deliver their services.

These two forms of governance (clinical and corporate) can also be seen as complemented by a third and much more wide-ranging form of governance. As deployed in political science and public administration, governance offers a wider purview on organisational practice (Kooiman, 1999; Ostrower and Stone, 2007). This broader perspective sees governance in terms of the multitude of institutions and the influence they exercise that constitute the context of an organisation’s behaviour. This concept, influenced by debates in the field of regulation theory adopts a macro perspective on organisational behaviour. It seeks to interpret the various ways in which the state distributes elements of regulatory authority and legitimacy to a diverse range of bodies (Black, 2002). This third sense of governance will constitute a central focus in our comparative analysis of governance regimes within the devolved NHS.

The vast bulk of research on the changing forms of UK health policy and practice either implicitly or explicitly is concerned with the NHS in England, with little analysis of institutional variation between the devolved states. This is partly due to the historic presentation of the NHS as being an organisation located in the four home nations with only minor variation among them. At the policy level, the direction is seen to derive from

Westminster and be implemented throughout its territorial reach. There is some general agreement that organisations within the four home nations are marked more by similarity than difference. Accordingly, the nature and implications of devolution within the NHS has received little academic attention. Extant literature tends to focus either on the creation of health policy (Greer, 2001, 2004 a,b,c) or the outcomes (Jervis and Plowden, 2003; Talbot et al., 2004) of the devolution of health policy and provision. This focus on the changes in policy or outcomes tends to underplay institutional re-organisation in general, and changes in governance in particular. Our paper addresses this gap in the literature by examining how these variations in governance regimes are played out in practice. This natural experiment allows some much-needed insight into the interplay between governance, incentives and performance outcomes.

We shall point towards the fact that not only is there policy divergence but also the development of divergent governance regimes within the four nations. This divergence principally revolve around how the system is oriented to the market; the forms of regulation utilised; where the key sites of autonomy lie; the structuring of incentives in the system; the characterisation of the key actors; and, the prevailing modes and meaning of performance measurement. In conclusion, we shall argue that not only has devolution produced divergence in policy but also key divergence in governance regimes. These modes of divergence raise key differences about the meaning of a patient, the meaning of the expert and differing modes and practices of control.

Whilst the discussion section of this paper draws out these features in detail, in anticipation of the conclusion there are certain summary generalisations or ‘tropes’ that capture the prevailing governance system within the each of the four nations. England is marked by ‘Decentering and entrepreneurship’, Scotland ‘Centralisation and autonomy’. Wales ‘Co-location and community’ and Northern Ireland by ‘Admixture and emergence’. In the following sections we look at each of the four systems in turn before making an overall comparative assessment.

NHS England – ‘Decentering and entrepreneurship’

As the largest provider of healthcare services in the UK the English NHS attracts the greatest interest and greatest funding. It is tempting, therefore, that when producing comparative research on the NHS to use NHS England as a base point. The problem with such an approach is that it tends to position NHS England tacitly as some kind of static model from which the devolved states diverge. Whilst it is true that the governance structures of Wales, Scotland and Northern Ireland were initially formed against the backdrop of legacy institutions, NHS England has also been marked by processes of innovation and re-structuring. Indeed, it could be said that NHS England has undergone, and is undergoing, a series of thoroughgoing reforms more extensive than any of the other three nations of the union.

Figure 1. NHS England (Basic Structure)

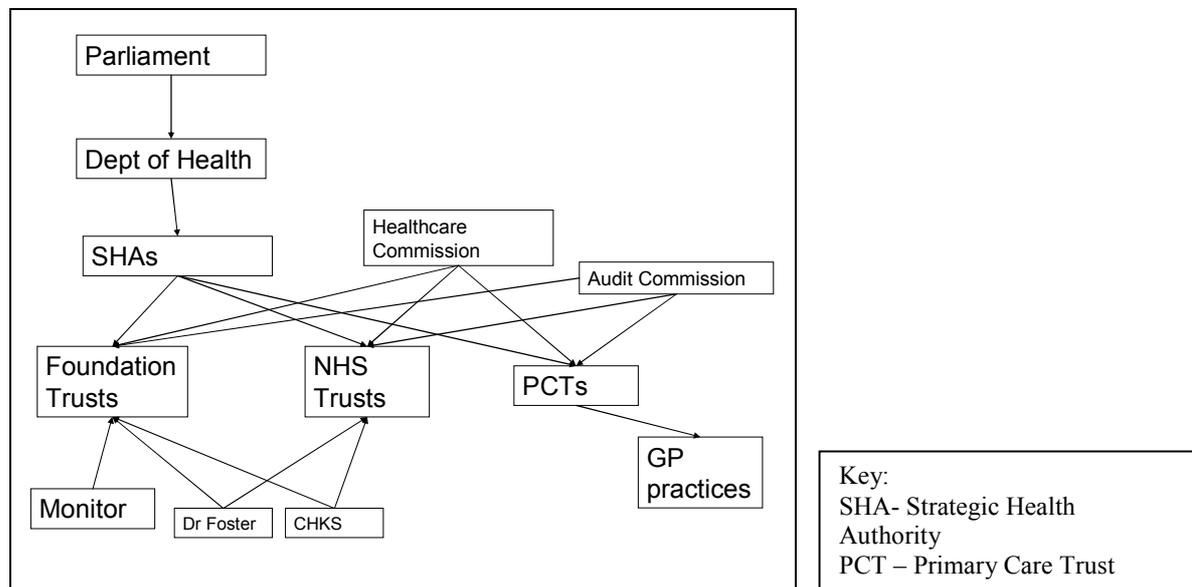


Figure 1 shows the basic, simplified, model of the macro-structures of NHS England. The British Parliament provides the legislative authority while with the remit for policy occurs within the Department for Health. England is subdivided into a series of Strategic Health Authorities whose remit is to act as the arm of the Department in the regions. The SHAs oversee the functioning and development of the full range of health services within their territories. Within each of these geographic areas a variety of organisations exist. The most direct linkage from the SHA is to its constituent group of Primary Care Trusts (PCTs). Their main role is to ‘commission’ (in simple terms i.e. define and purchase) health services. They also provide a certain number of primary care services themselves including dentistry, health visitors and within their geographical boundaries and they contract with general Practitioners. Secondly, there exists a variety of NHS acute service ‘providers’ within each SHA. Essentially these provide hospital services. In governance terms there are now two main types of these – the semi-independent Foundation Trusts, and the SHA-governed conventional trusts. The former are outside the SHA regulation but instead are overseen by a national body, Monitor (an independent regulatory body which wields considerable power).

In addition, PCTs can, and do, commission secondary cares services from Independent Sector providers and from social enterprise providers. Encompassing the model are system-wide regulatory agencies (‘arms-length bodies’) that either use various strategies to monitor aspects of the performance of these bodies or offer system wide information. An example is the National Institute for Clinical Excellence (NICE) which offers guidelines on clinical practice and medicines. Thus, overall at the macro level, NHS England looks like the kind of classical top down model of governance with various geographical splits designed to achieve greater control through producing manageable

divisions of the undifferentiated geographical areas backed up by system wide monitoring.

However, this general impression is tempered by the strategic deployment of a certain degrees of autonomy. In general, the idea of organisational autonomy has increased in currency throughout the system in recent times with emphasis on organisations 'competing' within an internal market for finite commissioning resources. This increasing emphasis on autonomy and the assumed beneficial results of inter-organisational competition has been matched by system-wide organisational monitoring, that de-centres command and control forms of governance to a series of alternate and less prescriptive regulatory strategies¹ (Baldwin and Cave, 1999; Sinclair, 1997). This dialectic of autonomy versus de-centred control is reproduced throughout the system. The following discusses a number of key features that combine to characterise the prevailing governance milieu within NHS England.

The key to generating an internal market is to differentiate buyers and sellers. This purchaser/provider split is achieved through the organisational segmentation with PCTs, acting as the key commissioning agents and the acute trusts offering a set of services to PCTs at a fixed price (Dixon, 2005). Unlike most capitalistic markets, prices do not signal intersections of demands and supply. The fixed tariffs system means that PCTs commission according to other criteria such as perception of quality, capacity, waiting lists, specialties and market variety.

Despite the emphasis on local service provision, PCTs can commission services outside of their geographical areas - termed Out of Area Treatments (OAT). They can also commission private providers and, even more radically, commission services outside of the UK itself. PCTs have finite resources and can choose to ration care in particular sectors according to their strategic priorities. They are required to break-even on their budget and produce commissioning strategies based upon it. The PCT role has become more important due to the abolition of GP fund-holding. That system, first introduced by a Conservative government in the early 1990s, placed the commissioning role further down the system with individual primary care provider units (Klein, 2007). GP fund-holding was considered politically sensitive and arguments abound that it was a failure and/or politically unacceptable (Klein, 2007). It was abolished by the incoming Blair government of 1997. Despite these issues, a new form of fund-holding has been re-introduced under the rubric of Practice Based Commissioning (DoH, 2004 a, b). In its current phase participating GP practices are given indicative budgets, to which they should stick. They can re-invest any surpluses into the practice and any over-spends have to be clawed back in subsequent yeasts. The underpinning of this model is to make GPs as involved rational actors making use of the internal and external market to distribute resources efficiently. They become, in effect, commissioners of care for their patient group. This financial involvement of practices is supposed to produce efficiency gains through the internalisation of consequence at the individual practice level, with GPs

¹ If Power (1997) is correct about the audit society, then NHS England is the *ne plus ultra* of this urge to interrogate every aspect of organisational practice.

looking for viable alternatives rather than defaulting to acute care (for example, by carrying out minor procedures within their local practices or groups of practices).

The porosity of the boundaries of NHS England to the private sector is, perhaps, one of the most radical reforms of the NHS. Whereas the other devolved nations treat the private sector as parallel and separate, NHS England seeks modes of interchange between these providers. Depending on the scale of this activity, it does seem conceivable that cumulatively it could alter the character of the NHS in a quite fundamental way.

Acute care is organized into a number of ‘trusts’ which are governance and management arrangements for one or more local hospitals. Prior to the introduction of the Foundation Trust (FT) model, trusts were broadly under the control of the SHA, each with a system of corporate governance to manage its resources circumscribed by broad strategic planning requirements of the SHA. Upgrading from ‘ordinary’ to ‘Foundation’ Trusts status allows greater autonomy for these trusts and provides the basis for a degree of inter-trust market competition. FTs escape direction and control from the SHAs and become a relatively autonomous actors circumscribed by a set of legislative and service requirements. In order to gain this status, NHS trusts have to produce business plans which are submitted to DH/Monitor for their approval. This autonomy theoretically allows FTs to distribute their resource in a much more business-focussed way. They are encouraged to behave entrepreneurially. Profits can be earned through improved operational efficiency and the elimination of waste, by increasing volumes of existing services and from the creation of new services. Initially, FT status was the preserve of only the higher performing trusts. However, current policy at DH level is that all NHS trusts should be in a position to apply for Foundation Trust status in the near future. Consequently, Foundation Trusts are to be the prevailing organisational form for acute care, generating sets of incentives for acute trusts to act as competitive actors. Growth through mergers and acquisitions are technically possible and a recent example was the merger of Good Hope NHS Trust into the Heart of England NHS Foundation Trust² in 2007).

Associated with systems of public governance are the various modes of regulation designed to oversee performance. Contemporary analyses of regulation have interpreted it as a move away from command and control (Baldwin and Cave, 1999; Sinclair, 1997) and a ‘de-centring’ of the state (Black, 2002; Pattberg, 2006). Within NHS England there is move from direct control to a ‘Standards Driven System’ (DH, 2004c: 2), through which organisations are set a variety of standards in a number of domains. These standards include not only clinical standards but also corporate governance and financial targets. A variety of organisations monitors various targets and assesses their performance. The key bodies are the Healthcare Commission and Monitor but over 30 such bodies operating in NHS England have been noted (Greer, 2004: 12). Table 1 shows four of the key ones and their areas of interest.

² http://www.healthcarecommission.org.uk/yourlocalhealthservices/nhsa-zbyorganisationname.cfm/widCall1/customWidgets.content_view_1/cit_id/2202

Table 1 Illustrative selection of arm's length bodies

Organisation	Domain
HC	Measure of performance on clinical outcomes and value for money
Monitor	Regulation of foundation trusts
NAO	Audits of financial performance
NICE	Guidance on public health, health technologies and clinical practice

While the move away from direct command and control is evident, nonetheless, even under the new disclosure-based regulatory regime, these regulatory bodies retain the authority to intervene directly in the operation of a failing institutions. In the case of the Healthcare Commission, this is called being put under 'Special Measures'. Equally, Monitor can step in and replace the Chief Executive and the senior team.

Additionally, audits results are made public and comparisons through league tables are prevalent. The most notable is the Healthcare Commission's use of Star Ratings, now termed the Annual Health Check which covers both clinical and financial performance. These reports are available in full and they detail the degree of conformance with the specified standards. Summary figures enable a direct comparison between similar organisations. This acts in two ways, firstly giving signal to consumers and secondly incentivising increased performance³. Not only is a failing institution likely to receive intervention, it may also suffer from reduced demand. The second governance strand is the increasing use of non-state bodies in the governance process. This can either take the form of private actors influencing behaviour ('private governance') or the explicit involvement of private actors with the state's regulatory apparatus ('co-regulation') (Pattberg, 2006). In terms of the former, CHKS, a private organisation produces list of high performing acute trusts⁴ – whilst offering a consultancy service to improve performance via their own in-house regulatory assessment tools. In terms of latter, Dr Foster Intelligence, a PPP between Dr Foster Ltd and the Information Centre (the latter is part of the NHS), produces reams of information on both organisational and individual consultant performance. It produces two separate portals of information, one a suite of organisational information sold to trusts, the second a public portal enabling patients to compare 'salient' features of each consultant (including year of qualification and average waiting times). The processes by which these organisations influence the behaviours of trusts is more subtle than the direct interventionist potential of state institution, but evidence in other sectors suggest that they do have impacts particularly when an organisation chooses to pay from the products on offer (Pattberg, 2006).

³ Some of these improvement may be 'achieved' through 'gaming' (Bevan and Hood, 2006)

⁴ <http://www.chks.co.uk/>

In his study of policy choices within the devolved NHS, Greer (2004 a,b) sums up NHS England by the term ‘markets’. In this discussion we have sought to understand how this process affects governance. In NHS England we have seen a radical re-structuring that produces increasing autonomy at the bottom versus a diverse range of governance mechanisms in both quality of regulatory strategies and a de-centring of the state. As we will discuss, this route is one that other nations have diverged from in a significant degree, not only in questioning the market, but in the very quality and means of macro-systems of governance themselves. NHS England is in fact a very circumscribed ‘managed market’. It is subject to fixed prices through the national tariff system, the FTs cannot easily withdraw from the suite of services to which they have been committed and the commissioners (the PCTs) are behoved to operate in a way which is designed not to ‘destabilise’ the system too extensively.

NHS Scotland: ‘Centralisation and autonomy’

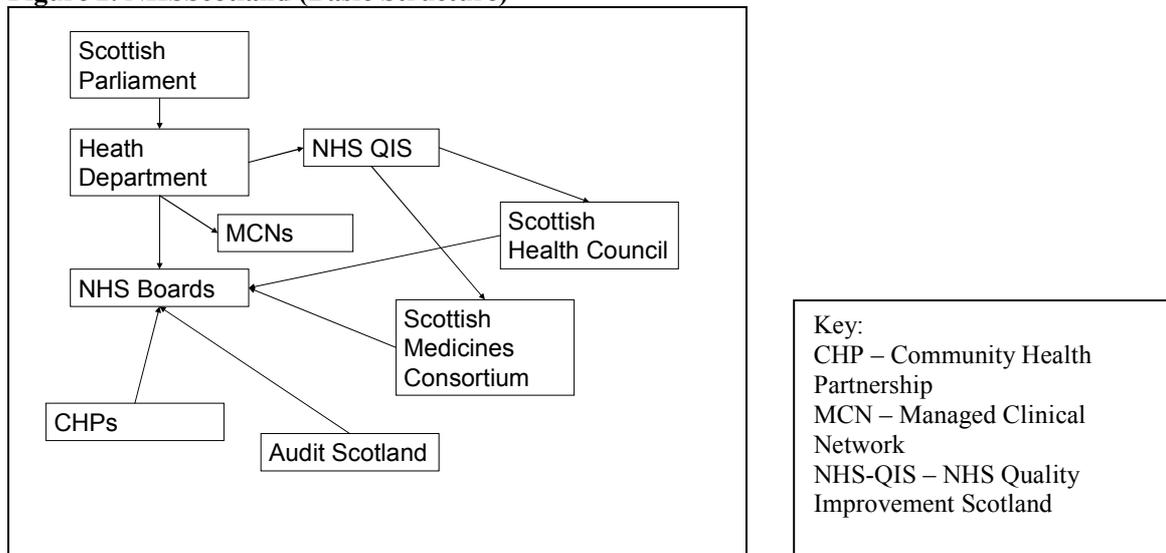
Scotland has adopted distinct health policies when compared to England. Its key policy documents *Our National Health* (SEHD, 2000), *Partnership for Care* (SEHD, 2003) and its most recent major reform (*NHS Reform (Scotland) Bill* passed May 2004) has altered the nature of both its organisational structures and its interpretation of professional practice. It also has made significant attempts to distance and disconnect its institutions from those legacy institutions within the pre-devolved NHS. In broad terms, Scotland has adopted a policy based on institutional simplification, centralisation and bureaucratic de-layering which acts, in part, as an enabler for effective professional practice.

The basic structure of health service governance is shown in Figure 2. At the top of Scottish system lies the Scottish Parliament and its Health Department. In terms of service delivery there exist a number of Special Health Boards (including the Scottish Ambulance Service and a National Hospital⁵) and 14 NHS Boards that are charged with providing primary and acute care to their particular region (see Figure 3 map).

These NHS Boards represent the most radical divergence for NHS Scotland. The change was initiated by a process of consolidating trusts since 1999, followed by their dissolution in 2004 (SEHD, 2003: 57). The explicit mission of the Boards to provide a *unified service* is made clear by the Scottish Executive: ‘The public, patients and staff expect the NHS at local level to be a single organisation with a common set of aims and values and clear line of accountability’ (SEHD, 2003: 57). This consolidation of primary care is designed to prevent explicit inter-organisation competition at the point of care within a particular geographic area. To this extent, the governance concept in structural terms could be said to be precisely the opposite of the diversified forms adopted in England.

⁵ The full list is: NHS 24, NHS Education for Scotland, NHS Health Scotland, NHS Quality Improvement Scotland, Scottish Ambulance Service, State Hospitals Board for Scotland, The National Waiting Times Centre Board

Figure 2. NHSScotland (Basic Structure)



Coterminous with NHS Boards is the development of the Community Health Partnerships (CHP). CHPs are not wholly independent from the NHS Boards but are a statutory part of their existence. As with all such attempts at community involvement, the degree of influence and representativeness is an open question. NHS Scotland also aims to achieve efficiency gains through uniting parallel bureaucratic organisations within a single site. Of course, this re-structuring alters the terrain of incentives covering the system. Whilst NHS England in particular strategically deploys autonomy and competition to widen the incentivisation for performance, the Scottish model represents a return to more centralised forms of control firmly within the Command and Control paradigm with power moving up the hierarchy. To use the language of game theory, the Scottish Executive are decision makers whilst NHS organisations are decision takers. Whilst such structures look like a return to centralised form of bureaucracy with their limited range of strategies and efficacy, such organisational re-structuring is designed to shift the locus of autonomy. Rather than locating autonomy at the level of the organisation, NHS Scotland shifts the balance to the practitioner,

NHS Boards are themselves constructed with a focus on service delivery. They should practice delegation, not only in matters of clinical import, but also in terms of financial decision making, as a recent report by the NHS QIS stated ‘Operating division as integral parts of local NHS systems should have specific delegated authority to act within a defined remit without constant reference to the NHS Board’ (NHS QIS, 2005a: 4). While such notions may be the familiar stuff of policy statements there appears to be some evidence of movement in this direction in the shape of Managed Clinical Networks.

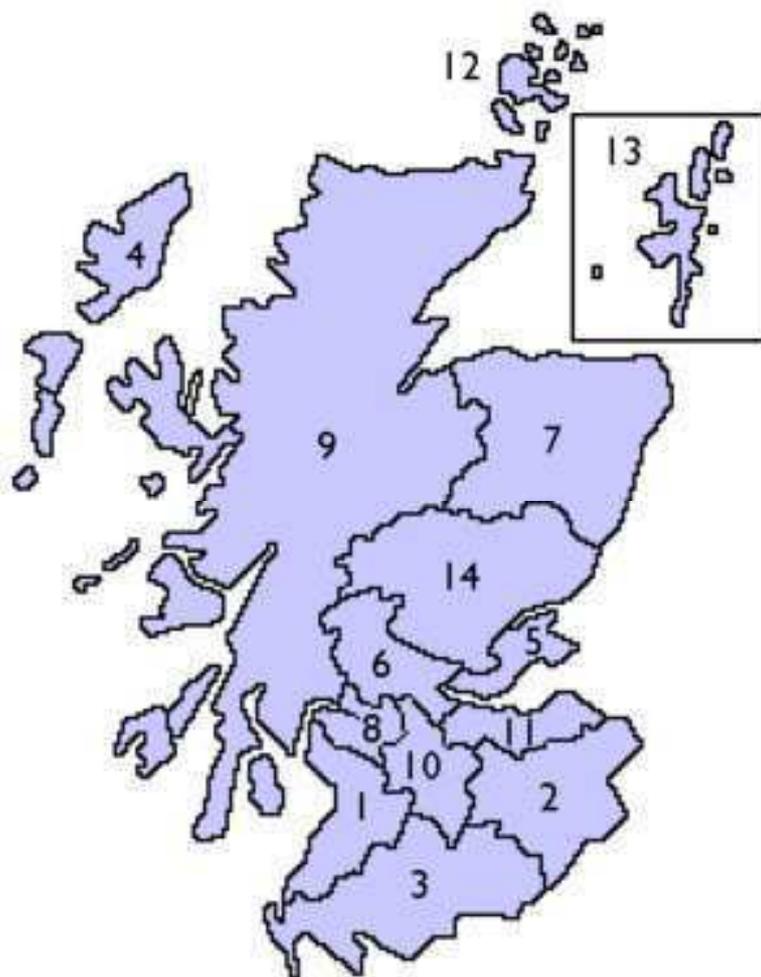


Figure 1: The 14 Health Board Regions in Scotland

Managed clinical networks (MCNs) are, in essence, a formal group of specialists in a particular health area. Unlike the clinical networks within NHS England, who operate as loosely coupled practitioner communities, Managed Clinical Networks in Scotland exist as a central plank of policy. MCNs are ‘unconstrained by existing professional and Health Board boundaries’ (SEHD, 1999:2) – although a number of MCN are developed within a Health Board area. MCNs are seen as collections of altruistically motivated professionals, or ‘knights’ to use LeGrand’s (1997) nomenclature, working across boundaries who can utilise resources to achieve health gains within a specific field. There are a variety of MCNs ranging from Cleft Palates to Cancer. These MCNs are formally accredited by the state which takes a largely hands-off approach to their operation⁶.

The amended role of the National Institute for Clinical Excellence (NICE) is an interesting one in Scotland. The decision to recommend or not-recommend a particular

⁶ MCNs are accredited by NHS-QIS, however SEHD have recently announced that local MCNs are to be accredited by their respective LHB (SEHD, 2007).

treatment, particularly where there is a significant cost attached, can have significant resource implications for the rationing of healthcare. Wales and NI have retained this UK-wide body post-devolution. In contrast, Scotland has adopted a position of retaining NICE only in an ‘advisory’ capacity. It has no formal status and its advice is filtered through the Scottish institutions which can place provisos and riders on the advice. In some case this can lead to the adoption of diametrically opposed policy (c.f. Scottish Medicines Consortium).

Performance monitoring

The emphasis on the ‘knights’ (LeGrand, 1997, 2000, 2003; Welshman, 2007) of the profession extends into the assessment of performance. MCNs exist at the fringes of the formal performance monitoring system. While it may be difficult to assess the performance of an organisation that is not readily identified with an institution, the manner in which MCNs are substantially outside of the formal performance based management emphasizes the normative trust invested into the profession. Professionals within the NHS Scotland are incentivised to act as professionals; the declared aim is to ‘enable’ them rather than control them. This is not to suggest that MCNs have no relationship to the state; they are required to submit a Quality Assurance programme as part of their accreditation and current advice from the SEHD suggest a move towards more formal performance monitoring and quantitative based measures (SEHD, 2007).

NHS Quality Improvement Scotland (NHS- QIS) is the formal body charged with raising standards across NHS Scotland. It acts as an umbrella for two organisations, the Scottish Medicines Consortium which acts as an advisor on treatment regimes (and also filters advice received from the England based NICE) and the Scottish Health Council, which carries out Annual Assessments. Given the emphasis on delegating authority from Local Health Boards to frontline practitioners, it is somewhat counter-intuitive to note the SHC’s Annual Assessments occur at the Board level. As (Farrar et al., 2004: 4) note, these Assessments cover a wide variety of clinical and organisational criteria, namely:

1. Health improvement and reducing inequalities
2. Fair access to health care services
3. Clinical governance and effectiveness of health care
4. Patients’ experience, including service quality
5. Involving public and communities
6. Staff governance
7. Organisational and financial performance and efficiency

At variance from the NHS England system the reports are framed more in developmental terms and do not provide readily comparative data. There is no equivalent of the Star Ratings or Annual Health Check. Thus, the Scottish assessments do not allow or provoke a comparison between units in order to inform patient choice – indeed, NHS-QIS state categorically in *Clinical Indicators* ‘Indicators do not constitute a ‘league table’ of performance’ (NHS-QIS, 2005b: v). Whilst it is possible to generate comparison from some of quantitative data generated by NHS QIS, this data is separate from the detailed

reports on each LHB, is not easily accessible and would require secondary analysis to reach conclusions on comparative performance and improvements⁷ (Farrar et al, 2004: 33). In keeping with the non-adversarial approach, this downplaying of quantitative measures re-emphasises the lack of incentive associated with these indicators. In contrast they operate as developmental reports, with indicators as indicative not comparative⁸.

Health Boards have sometimes been criticised for insufficient delegation of authority throughout their region (e.g. NHS-QIS, 2005a :4). Similarly, the lack of attention to performance indicators is matched by virtually no assessment at all of MCNs. This dialectic of centralisation and delegation characterises the prevailing governance regime. What ostensibly appears to be a command and control system is underpinned by the actions of self-organising and self-regulating altruists⁹. Whilst it is not our intention here to seek to assess the system *in toto*, it is worth noting that Audit Scotland report that the system has experienced the problem of ‘producer capture’ with more resources being consumed through higher levels of staffing with limited impacts on performance (Audit Scotland 2004; Talbot et al 2004: 18-19).

NHS Wales ‘Co-location and community’

Whilst NHS Scotland presents a significant restructuring of the pre-devolution NHS and a departure from the thrust of reform in England, the approach of Wales is more measured. Wales has opted to shift emphasis on certain policies and has designed simpler mechanisms and structures to those employed in England. There is also a greater retention of institutional ties with NHS England organisations. Taking an overview of NHS Wales (Figure 4) it looks somewhat similar to the NHS England mode. At the zenith lies the National Assembly for Wales with the Department of Health and Social Service (Wales) and a series of regional offices. This is followed by a number of Trusts delivering acute services and Local Health Boards (LHBs) acting as the commissioning bodies (essentially equivalent to Primary Care Trusts).

⁷ There is some limited comparative data at the Board level concerning financial performance with the reports of Audit Scotland (2004, 2006a)

⁸ As NHS-QIS says of its Clinical Indicators:

Used carefully and in the appropriate context, indicators can contribute to quality improvement within NHS Scotland, by highlighting variations which can then be investigated and, where necessary, appropriate action taken. However, interpreting the indicators remains difficult. This is because apparent variation in an indicator may be due to a number of factors, which may or may not include the quality of care provided. It is important to re-emphasise that no conclusions should be drawn immediately, from any of the comparisons in this report, about the quality/effectiveness of the services provided for patients by different NHS Scotland organisations or in different regions of the country. (NHS-QIS, 2004b: iv)

⁹ see Sinclair (1997) for a discussion of the ‘false dichotomy’ of Command and Control and Self-Regulation.

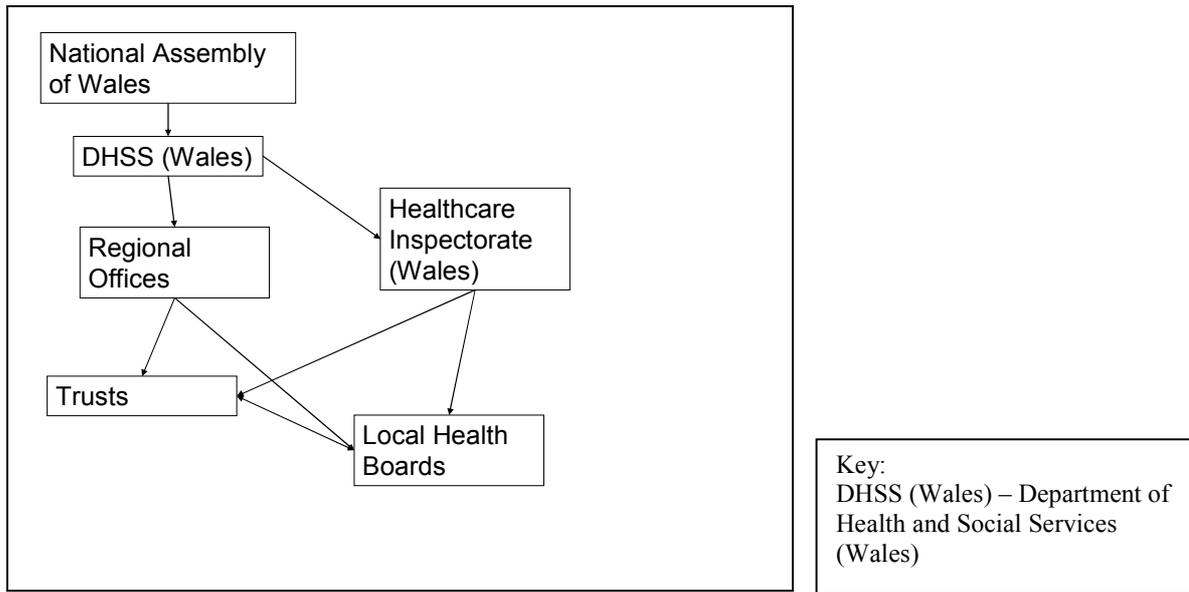


Figure 4. NHS Wales (Basic Structure)

Talbot et al. argues that the apparent institutional isomorphism with England is tempered by its focus on the local community (Talbot et al. 2004; see also Greer, 2004a). LHBs in the Welsh system are linked into community structures in a way that PCTs are not (or if they are, rather more at a symbolic level). In the first instance LHBs are geographically matched with local authorities, who are mandated to be included in discussions (the boundaries are shown on the map in Figure 5). Additionally each LHB consults with a Community Health Council (CHC) in order to emphasise the role of the local community in the healthcare system. Secondly, LHBs and their cognate Unitary Authority and LHC have a broader agenda encompassing a strong emphasis on public health. There is, at least, in Wales an attempt to move from a system that deals mostly with illness, to one that additionally and actively intervenes within its community to improve its general level of health (Greer, 2004a, Smith and Babbington, 2006).

In retaining the purchaser / provider split between trusts and LHBs, NHS Wales retains some measure of the internal market and the imputed positive outcome imposed by the discipline of the market. However, this marketisation is muted to a certain degree by the agenda of localism (Talbot et al., 2004: 14). Trusts themselves possess more autonomy than in the English system due to the minimal of role of Regional Offices. Whilst SHAs have a strong steer on the operation of trusts (until they achieve foundation status), regional offices in Wales have few staff and resources, a limited remit and limited authority. The directive authority of the English SHA is largely absent in the Welsh Regional Offices.

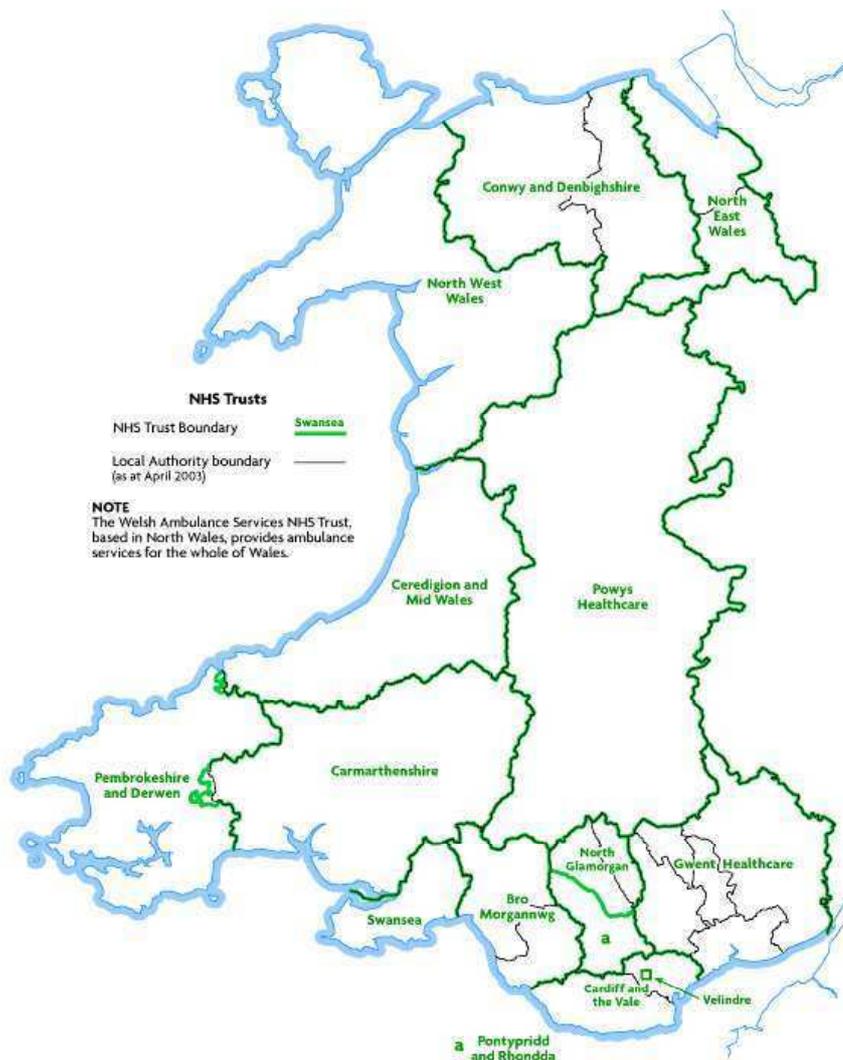


Fig 5: Local Health Boards in Wales

Performance

Prior to 1st April 2006, the Healthcare Commission (and the CHI prior to that date) took on the role of assessing the performance of NHS Wales trust and LHBs. After this date the Healthcare Inspectorate Wales (HIW), established 1st April 2004, took over the key performance evaluation role. Whilst Scotland's structures supplant the operation of English institutions, HIW is not a direct emulation of HCC but a divestment of one its key functions. NHS Wales retains a linkage to legacy institutions within NHS England with the HCC taking the following roles:

- annual report
- national (E & W) improvement services

- ensuring relevant
- ensuring distinctiveness
- reviewing quality of data

(HC website, accessed 2007, get full version of this)

Though restricted, HCC retains an unmediated role in its functions pertaining to NHS Wales, thereby providing key governance function in a ‘foreign’ system. However, the key elements which the organisation inspects, and which organisation sets the inspection agenda, are both retained in Wales (HIW and DHSS respectively). HIW operates a rolling series of inspections of Trusts and LHBs according to criteria set out in *Healthcare Standards for Wales* (Welsh Assembly Government, 2005) which covers four domains, namely:

1. Patient experience
2. Clinical outcomes
3. Healthcare governance
4. Public health

Each of these domains contains a number of standards that are assessed and adjudged by the Inspectors. Reports by HIW are textual documents replete with recommendations and assessments and action plans. However, what the reports do not contain is any form of summative judgement either brief text or some forms of simple summary indicator of ‘quality’ or ‘performance’. Hence, these reports do not allow easy comparison between organisations. This ethos is reproduced in the HIW website (www.hiw.org.uk) and reports eschew reference to comparisons explicitly or the presentation of data to enable simple secondary comparative judgement. As with Scotland, the emphasis of the inspection procedure is not about informing patient choice or constructing league tables but rather is about providing an improvement and developmental tool.

This has obvious implications for the structuring of incentives. Whilst league tables within NHS England underline the competitive internal market, and the ideas such as ‘money follows patient’ enshrines patients as active and informed consumers the lack of such an account problematises the operation of incentives within they system. NHS Wales trusts become suppliers to LHBs within the local health economy rather than businesses attracting individual consumers. This ethos of localism affects the deployment of incentives at anything other than an inter-organisational level. The fact that in 2000/01 7 out of 15 NHS Wales trust were in financial recovery (Audit Commission in Wales, 2002) perhaps suggest that incentives were failing.

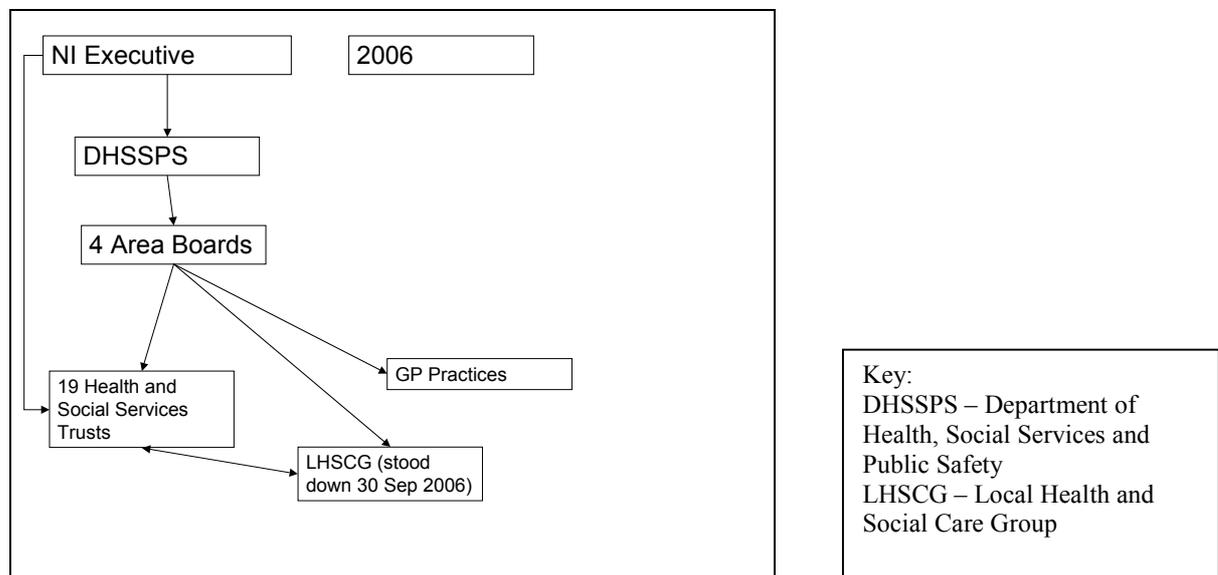
In summary, governance in NHS Wales represents a less radical departure from the English system than the thoroughgoing reconstruction in Scotland. However, NHS Wales does represent a divergence from the English system in a number of ways: an emphasis on the local community which is both policy directed and institutionally framed and a treatment of assessment as solely vehicles for organisational improvement. However, NHS Wales still maintains some links with NHS England, especially in (a) retaining a role for the HCC in key policy areas and (b) retaining, though not deploying, the internal

market in terms of the purchaser provider split. This particular blend of divergence and convergence produces a Welsh NHS that alters the emphasis and structure of incentives compared with NHS England, without re-building the system in a manner reminiscent of NHS Scotland.

NHS Northern Ireland - ‘Admixture and emergence’

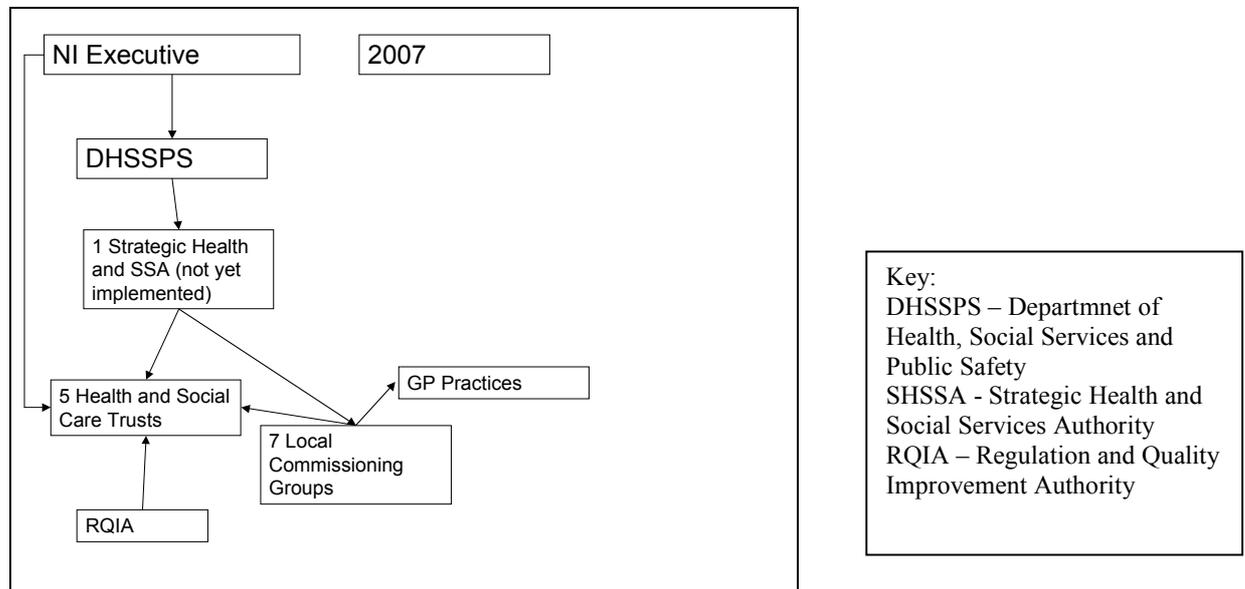
Any discussion of Health Policy, or policy *per se*, in Northern Ireland has to acknowledge that the policy process has been severely hampered by the prevailing political environment within Northern Ireland itself. The Northern Ireland Assembly has been suspended on a number of occasions and political discussion has been dominated by polarised opinions on Northern Ireland’s relationship to the UK mainland. This ‘inertia’ (Smith and Babbington, 2006) has led to policy stagnation¹⁰, with piecemeal transformation which sometime lacks an obvious strategic direction. However, since 2005, a major process of re-organisation, under the auspices of the *Review of Public Administration* (RPA), has produced and/or proposes a series of major changes in the system of governance within NHS Northern Ireland. Figure 6 identifies the macro structures of NHS NI in it’s position in early 2006, whereas figure 7 identifies the proposed changes to in 2007 onwards (where organisation have been stood down or new one implemented this is noted in the figure). As NHS NI is in the process of re-organisation it is worth exhibiting these changes as part of the process.

Figure 6. NHS Northern Ireland (Basic Structure) early 2006



¹⁰ As an example Northern Ireland did not abolish GP fundholding until 2002.

Figure 7. NHS Northern Ireland (Basic Structure) 2007 onwards (proposed)



With its policy making powers the NI Assembly is at the zenith of the structures. The Department of Health, Social Services and Public Safety (DHSSPS) is the relevant ministerial department responsible for healthcare provision. The territory is split into 4 Area Boards (Eastern, Northern, Southern and Western), functionally equivalent to NHS England’s SHAs. Within each of these areas are a number of trusts which provide a wide range of health and social care services including acute care and community. Prior to April 2007 there were 19 such organisations, after this date these have been consolidated into just 5 trusts and renamed Health and Social Care Trusts. The Department of Health is in the process of amalgamating the four Area Boards into a single Strategic Health and Social Services Authority (SHSSA) covering the whole of NI.

Commissioning has gone through substantial change in the NHS NI. Prior to September 2006, commissioning was located in 15 Local Health and Social Care Groups who 'purchase' services for their respective populace. When these LHSCGs were stood down in 30th September, the Area Boards assuming responsibility for both strategic direction and commissioning on an interim basis. The commissioning role is due to be assumed by seven Local Commissioning Groups (LCGs) in April 2008; whose spheres are co-terminus with local government boundaries. This represents a hybrid system between the internal market in England, the focus on community in NHS Wales and the desire for simplification within NHS Scotland. As other commentators have noted, the NI system seems to be a blend of English, Scottish and Welsh systems (Greer, 2004a ; Smith and Babbington, 2006). On these two points, the manner in which they are implemented alters their meaning and implication; this blending itself (which is not discussed in terms of institutional emulation) produces a novel macro-system of governance.

In terms of performance management, DHSSPS publishes Quality Standards based around five key themes. The performance of Boards and Trusts in respect of two of these themes ‘corporate leadership and accountability’ and ‘safe and effective care’ (RQIA, 2007) is being carried out by the recently formed Regulation and Quality Improvement Authority (RQIA). RQIA analyzes each trust and board *in situ* and produces public reports. As with the Welsh and English systems, each major institution is inspected individually. However, in contrast to NHS England and in congruence with Scotland and Wales, these are solely developmental in nature and do not provide easy ways to compare information. However, in NI the principle of publicity and comparability is still deployed to a certain degree. The Health Minister sets explicit targets for waiting lists in particular areas (Woodward, 2005). The figures for each trust’s waiting lists in these are collected and collated by the DHSSPS and published in their website. In this way, DHSSPS retains an autonomy and flexibility to instantiate alternative regulatory strategies.

In summary, NHS NI represents a governance system in the process of re-organisation. From the lens of Wales, England and Scotland it looks like NI is selecting elements of practice from each of these governance systems – local involvement, markets and centralisation – blending them together. The extent to which one can reach a judgement of incoherence is uncertain. Looking at an organisation in the process of development is unlikely to reveal clarity until it has a chance to work out its re-structuring and embed its practice. Rather than seeing NI as a governance system that is unclear, it may be fair to conclude that it is one that is in transition towards an alternative pathway which blends and balances the key elements of governance arrangements found throughout this article.

Discussion

Although macro-processes of governance can be used to deliver a variety of policy outcomes, it is unsurprising that policy makers adopt and adapt governance arrangements to distribute the range of incentives and authority to deliver the best outcomes. There is an elective affinity between policy and governance; indeed they frequently develop in tandem. Of course, governance, just as much as policy, is affected by its location within a particular societal and historical content, but this process is beyond the scope of this paper¹¹. The aim of this discussion is to draw out the comparative governance regimes for NHS healthcare provision within the four devolved nations. In this section we will construct a heuristic typology to highlight the salient elements within the forms illustrated above. Salient features of the development of this model are detailed below.

Governance / Structures

In terms of governance/ structures we shall refer to the macro-structures organising the healthcare system. The most salient features are:

¹¹ For an in depth discussion of the policy process and key players within the devolved NHS see Greer, 2006.

- *Market Orientation.* The way in which the system orients itself to the market, i.e. to what extent and how does the system make use of the market to distribute resources.
- *Regulation.* Where key structures of authority lie, key in this point is the extent to which the state is de-centred from the determinative system of directive control to more diffuse ceding of power through the healthcare system
- *Site of decision autonomy.* Governance systems tend to focus their interest on the function of a key actor (or actors) within a healthcare system

Incentives

Incentives refer to the basic determining conditions that provoke actors within the system to behave in a manner desired by the system designers. There are most often focussed on the site of autonomy within the healthcare system in order to provide the ‘carrot’ for desired forms of behaviour.

- *Key incentives.* In broad terms the central incentives designed into the structures.
- *Characterisation of actors.* The way in which those incentives imply and/or invoke the determining traits of these individuals/ organisations.

Outcomes / Performance Monitoring

Within any healthcare system, performance is monitored to a certain degree. In terms of looking at macro-structures of governance the key points are

- *Number of organisations* involved in performance assessment.
- Which organisations are the *focus of assessment*
- *Focus of measurement:* the meanings and deployment of these measures, i.e. how they operate in the wider milieu

Taken together, these form the characterisation of the salient features of the healthcare governance systems within the devolved nation. The features are detailed in Table 2 below.

Table 2. Summary of Governance Regimes

Category	Sub-category	England	Scotland	Northern Ireland	Wales
Governance / structures	Market orientation	Entrenchment of the market (internal and external)	Excision of market	Non-deployed market	Non-deployed market
	Regulation	De-centred Some private governance and co-regulation	Centralised 'Single system' working	Centralised	Centralised
	Site of autonomy	Autonomy of 'enterprises'	Autonomy of practitioners – the profession -	Unclear	Autonomy of community Local health needs of community
Incentives	Key Incentive	Entrepreneurship	Enabling altruistic behaviour Enabling of professional practice	Need to meet imposed targets	Increasing Health of local community- enabling caritas
	Characterisation of actors	Self-interested profit maximisers	Vocational 'knights'	Unclear	Community-oriented altruists
Performance / Outcomes	No. of agencies	Multiple Agencies	Single agency	Single agency (Exception of target setting by DHSSPS)	Single agency
	Focus of measures	Focus on all organisations	Focus on Boards	Focus on acute trusts	Focus on Trusts and LHBs
	Focus of measurement	Developmental and Comparative	Developmental	Developmental	Developmental

In NHS England, there have been great strides in de-centring authority throughout the system, with various bodies being able to exert their authority within certain bounds. Each unit within the system receives various degrees of autonomy, with an emphasis on increasing autonomy further down the system. The current direction, e.g. the mandatory implementation of foundation trust status throughout the system and the introduction of practice based commissioning, continues to locate decision making and autonomy within organisations in which competition is most apparent, or at least where there can be a purposive relationship to healthcare market. Unlike other devolved systems, the market is treated as a beneficent bedfellow with both the internal, and to a certain degree external, market serving to structure the incentives throughout the system. Essentially, the market offers incentives for organisations to act entrepreneurially. Acute trusts can attract more patients, grow, acquire/ and/or merge with other trusts as any other business organisations. Similarly, GP practices under the practice based commissioning system can re-invest some of their savings on their budget (a corollary of profit in the system) into their practice. This centrality of the market affects performance monitoring and its deployment. In the first instance this is a withdrawal from command and control form of regulation to one based on an admixture of auditing and self-assessment – it points towards regulation through outcomes rather than synchronic regulation through process. Secondly, the information produces provides signals to the marketplace. As these outcomes are produced as public and explicitly comparative data – the concept of the rational consumer and the principle of money following the patient ensures that these outcomes signal consumer demand. This process has been furthered to instances of private governance and co-regulation in organisations like CHKS and Dr Foster.

NHS Scotland present a radical divergence from this view. Authority is centralised, with its emphasis on ‘single system working’ and the purchaser / provider split is denuded into a series of regional boards organising and delivering healthcare within its region. Market principles are excised within the system with its shift to centralised decision making creating the space for the autonomy of practitioners. Whilst organisations are tightly regulated, professionals are understood as vocational ‘knights’ (LeGrand, 1997, 2000, 2003). These ‘knights’ are incentivised as act as knights, more precisely they are enabled to act as rational altruists. In this manner performance outcomes become secondary in two key respects: (a.) they focus at the board level and part of the performance concerns devolving autonomy to practitioners and (b.) they are solely developmental in purpose. These outcomes form a reflexive backbone of organisational learning, not a signal to consumers of resources. In essence, governance in Scotland is an enabling system for key professionals with a strong steer retained at its zenith.

NHS Wales’s key structural principle is the creation of coterminous institutions within the confines of a defined geographical area. Whilst the purchaser / provider split is retained, the structural principles do not use this opportunity to enact the market. The intended focus is the provision of care to the community and a general raising of its level of public health. In what seems like weak incentives there is a sense of deploying *caritas* (Weber, 1991: 300) within a group of community oriented altruists. The affectual investment in the community is designed to incentivise performance for the good of the community itself. External audits are developmental, on the basis of organisational

enhancement. The community structures the mode of governance and acts as the focus for both authority and autonomy.

NHS Northern Ireland does exhibit some emphasis on community, however it fails to reveal a clear emphasis or governing principle *qua* governance. At the system level, this emergent system gives little clue of a defining quality. Indeed most apparent within this miasma is the lack of a defining emphasis on markets, community or simplification. In certain respect the system then becomes hierarchically driven with a single SHSSA at the broad strategic level, with other organisation becoming decisions takers lacking autonomy and becoming reactive to the precepts of those with authority. Similarly, the developmental outcomes measurement is overlaid by the autonomous actions of the DHSSPS to set targets for organisations and render them public. Northern Ireland presents a system of governance in the process of formation that, at the time of writing, seems to present a magma of governance, incentives and outcomes that fail to cohere.

From this detailed picture we can derive summary characterisations of the four governance regimes within the devolved NHS (Table 3).

Table 3 Governance systems in the four nations

	Tropes	Characteristics
England	Decentring and entrepreneurship	A de-centred system characterized by the circumscribed autonomy of organisations, entrepreneurship and competition overlaid by a complex, multi-level de-centred system of monitoring and control.
Scotland	Centralisation and autonomy	A centralised hierarchical model marked by simplified single system working enabling autonomous and co-ordinated professional practice.
Wales	Co-location and community	A system marked by geographically co-located organisations centred on the autonomy and practice of the community.
Northern Ireland	Admixture and emergence	An admixture of community level commissioning, limited internal market and simplification within an emergent two-level system of performance monitoring.

Conclusion

Governance is increasingly seen as a key concept to analyse organisational behaviour and performance. At the micro-level, studies have sought to explore decision-making within institutions (Ashburner, 2002; Cornforth, 2002). In this paper, we have sought to broaden the horizon by exploring the broader macro-structures within the devolved system that constitute the macro-system(s) of governance within the devolved system of NHS in UK. Policy level analysts (Greer, 2001, 2004 a,b,c; Jervis and Plowden, 2003; Talbot et al., 2004) have shown a systematic differentiation within the four systems. This paper has complemented and broadened these analyses by considering the emerging macro-

structures of institutions of governance-structures, incentives and performance monitoring within England, Northern Ireland, Scotland and Wales.

Each of these systems has the broadly similar goal of distributing finite resources to the benefit of the populace with is free at the point of use. What is apparent is that these four nations are adopting distinctive paths that diverge to a considerable degree. Each of them has its critics – for example, accusations of ‘gaming’ in England (Bevan and Hood, 2006), ‘producer capture’ in Scotland (Talbot et al 2004: 18-19) ‘overspending’ in Wales (Audit Commission in Wales, 2002) and ‘excessive waiting lists’ in Northern Ireland (Dyer, 2005). However, each has produced a substantially different governance system reflecting real differences in fundamental issues, concerning the decentring of authority, the production and deployment of authority, the suite of incentives required and the efficacy (or otherwise) of the market. It remains to be seen how these distinct systems play themselves out in the medium to longer terms, not only in macro-level measures of performance but also in terms of affecting the orientation of individual agents within the system. What remains clear is that the devolved nations are developing distinctive and divergent macro-systems of governance shaping the development of healthcare provision under the banner of a National Health Service.

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