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THE IMPACT OF DECENTRALISATION ON PERFORMANCE OF HEALTH CARE ADMINISTRATION

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Introduction

Decentralisation in healthcare has been a major area of controversy as it has had varied impacts on the performance of healthcare. In healthcare, it refers to the transfer of authority and responsibility to regional and local levels (Abimbola et al., 2019). In the UK, the healthcare system has been devolved with each country having its public funding healthcare system (Black et al., 2020). The central government responsible for the overall health is located in England while respective devolved governments operate in Scotland, Wales, and Northern Ireland (Wallace, 2019). The goal of healthcare decentralisation has been to improve efficiency in administration and promote equity service delivery (Rotulo et al., 2022). Although efforts have been in place to ensure its success, major limitations still prevail (Abimbola et al., 2019).

This literature review looks to critically examine both the positive and negative impacts of healthcare decentralisation in the UK. This begins with creating context to the discussion and then vividly discusses the real-time impacts of the phenomenon in the various countries and local facilities within the UK.

Context

Literature by Wan (2020) and Hollinrake (2019) depicts that the UK healthcare system has been shaped by two major legislative acts which include the 1990 NHS and Community Care Act and the 2012 Health and Social Care Act. According to them, the 1990 NHS and Community Care Act introduced internal markets while the 2012 Health and Social Care Act expanded the clinical commissioning groups (CCGs). Each of these two articles is comprehensive in analysing either act in detail. However, each of them gives focuses solely on one act e.g., Wan (2020) focuses on the 2012 Health and Social Care Act while Hollinrake (2019) focuses on 1990 NHS and Community Care Act. Lorne et al (2019) supportthe 1990 NHS and Community Care Act discussion by discussing how the NHS separated the roles of Regional health authorities from those of general providers. The regional health authorities were given budgets to run healthcare facilities and community health centres while the general providers remained outside of this system. This article provides a historical background of health decentralisation by discussing the 1990 NHS and Community Care Act. However, it is

not comprehensive in discussing the separate roles between GPs and regional health authorities. Regarding the 2012 Health and Social Care Act, the role of CCGs expanded to allow general practitioners to plan and engage in hospital and community care services as explained by McDermott et al (2022). CCGs were more engaged in integrated care which promoted primary and social care in local hospitals. This article provides a detailed explanation of how CCGs bridge gaps in decentralised care. However, it ignores broader systemic challenges that come with decentralisation.

The UK experiences different forms of decentralisation. Obasa (2020) explains deconcentrating which involves delegating administrative functions to the various NHS regional offices in the UK. According to the author, it reduces delays and enhances operational efficiency. This article emphasises the role of deconcentrating in enhancing operational efficiency but ignores potential drawbacks related to the phenomenon. Harringtonand Hampton (2024) also discuss devolution which involves moving healthcare services to the various UK countries i.e., Scotland, Wales, and Northern Ireland. This has allowed the regions to adopt distinct healthcare policies that match the existing populations. This article shows how devolution has enhanced healthcare responsibilities in Scotland, Wales, and Northern Ireland. However, it ignores disparities caused by devolution. Additionally, Goodairand Reeves (2022; 2024)discuss privatisation where the UK government outsources some services to private providers to enhance equity and healthcare access among their population. The two articlesare comprehensive and accurate in discussing the role of privatisation in improving healthcare access but fails to thorough consider associated challenges.

Impact on administrate efficiency

Studies have shown varied opinions and facts regarding the impact of healthcare decentralisation on administrative efficiency. Mertens et al (2019) suggest that the different effects have happened due to diversity in the need for health in various regions, socio-economic differences, etc. For example, devolution in the various states e.g., Scotland has allowed these regions to develop policies that favour the local needs of their communities(Merterns et al., 2019). This article succeeds in linking devolution with regional healthcare needs but is limitedly considers political and funding impacts in healthcare decentralisation. However, although this has been achieved, Clelland (2020) suggests that challenges still prevail in terms of limited resources and infrastructure. These limitations have led to the unequal distribution of healthcare resources and incomes in the various regions of the UK e.g., the rural areas. Clelland considers associated limitations in resources and infrastructure and associated impacts. However, it is one-sided in discussing the impacts of devolution.

A study by Dalingwater(2020) shares mixed feelings on the relationship between decentralisation and administration efficiency. On one hand, it has been shown to reduce bureaucratic bottlenecks as healthcare is addressed directly (Dalingwater, 2020). This article provides a balanced view of healthcare decentralisation but lacks detailed examples to contextualise findings in real-world applications. Bear et al (2021) also suggest that CCGs have helped local facilities make localised and holistic decisions on care which have promoted effective and community-centred healthcare. On another hand, the study finds that the phenomenon increases redundancies and misalignment in objectives which undermines local and national priorities. This article also provides a balanced view of decentralisation but ignores aspects related to health disparities in healthcare. Another study by Dougherty et al (2019; 2022)encourages moderate decentralisation as it finds it to encourage effective administration. High decentralisation has been associated with complexities in administration which lowers care quality (Dougherty et al., 2019; 2022). It provides practical and mathematically verified applications of moderate decentralisation but lacks practical examples that make the argument relevant.

Impact on Healthcare Outcomes and Equity

Good administrative efficiency impacts positive performance in terms of healthcare outcomes and equity. Studies by Beazley(2019) show that through decentralisation, healthcare providers can align their services with local demographic needs. The article succeeds in explaining how decentralisation improves local care but ignores associated risks e.g., uneven capacity among different regions. Walters (2023) suggests that it increases flexibility in care, such that providers are free to develop policies that align with the local community's priorities. The article emphasises improved care flexibility but also ignores limitations associated with decentralisation. Shepherd et al. (2019) depict that providers can align care to the local people's culture which promotes respective relationships between the provider and the patient. This eliminates communication barriers and enhances the overall patient satisfaction. This article succeeds in explaining how improved culture enhances overall care but lacks a balanced approach on the overall impact.

Other studies oppose theseclaims by suggesting how decentralisation undermines the quality of care outcomes. Sapkota et al. (2023) claim that decentralisation increases regional imbalances in terms of resource allocation. For example,Kuznets (2019) wealthier areas e.g., in urban centres like London can raise high revenue in terms of taxes while economic disparities raise less revenue. In decentralisation, the disparity areas are more likely to suffer in terms of receiving quality care. The article provides vital insights into inequities caused by decentralisation but insufficiently explores solutions to address the problems. Ferrario

et al. (2023) emphasise the need for centralisation to ensure that every region or state enjoys equal distribution of healthcare resources. Anderson et al. (2022) add that this would eliminate health disparities and increase care equity.Ferrario et al. (2023) and Anderson et al. (2022) succeed in supporting centralisation over decentralisation but fails to deeply delve on centralisation enhances care responsiveness.

Governance and Accountability

Studies by Britteon et al. (2022) suggest that decentralisation has brought power closer to the local population. Kasale et al (2022) add that it has been instrumental in enhancing transparency and community engagement in healthcare. The articlesexplain the power of decentralisation in community empowerment but ignore associated challenges. Kieslich et al. (2024) add that this phenomenon has encouraged communities to have a greater say in healthcare priorities and resource allocation within their area. These local ideas are also considered in decision making which has encouraged accountability in care. The article explains how decentralisation encourages care accountability but overlooks potential local biases where dominant groups may dominate decision-making. Parish (2023) explains that the local health boards have been very instrumental in engaging patients and other healthcare providers in decision-making. This has not only enhanced autonomy in care but also promoted effective and responsive healthcare engagements. The article discusses how decentralisation enhances care autonomy but ignores funding and administrative inefficiencies that may affect care. Regmi and Mudyarabikwa (2020) provide an example of England where the NHS with Darwen Clinical Commissioning Group led to increased community engagement and more participation in decision-making. The article gives a concrete example that enhances research credibility but this limits broader applicability.

On a negative note, this form of governance may have accountability issues. Bigdeli(2020) and Ménard et al (2020) shows that in these forms of systems, there may be policy gaps that may undermine accountability.The articlesoffer a valuable perspective on accountability but lacks specific examples to support the claim. Sreeramareddy and Sathyanarayana (2019)add that local priorities may conflict with national health objectives in decentralised healthcare governance. In this case, governance may lose track which would lead to a loss of accountability among the involved providers in the local setting. It explains how decentralisation may misalign healthcare goals but fails to propose strategies to curb the issue.

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