Understanding professional partnerships and non-hierarchical organisations

Executive Summary

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Background
Organisations such as professional partnerships, co-operatives and similar non-hierarchical organisations (NHOs) play a larger role in health care than is usually recognised. For example general practices (professional partnerships) handle over 80% of patients' first contacts with the NHS. Co-operatives provide much out-of-hours primary care. The role of such organisations might well increase as more diverse providers enter the NHS. The structure of these organisations is partly or entirely democratic. Unlike corporations and most public sector organisations they are accountable to their working members, or to service users, and allocate leadership roles by election or taking turns. Fewer than one percent of published research studies examine these forms of organisation. The studies that do exist raise two main questions. Are these types of organisation 'efficient', compared to hierarchies? And do they tend to 'degenerate' over time, reverting to hierarchy?

Aims
The aim of this research was to strengthen the evidence base for decisions about what kinds of partnerships and NHOs the NHS should incorporate or commission. We aimed to answer the research questions:

1) What are the goals (explicit and implicit) of such organisations and why/how are they established?

2) What is the nature of the governance and incentive arrangements that are placed on these organisations from external bodies? Is there an effective form of regulation, and if so what is the nature of this?

3) What are the structures and internal organisational arrangements of non-hierarchical organisations and partnerships? How are professional partnerships and non-hierarchical organisations coordinated, and what makes for a successful co-ordination strategy?

4) What are the key elements to the internal management of such organisations?

5) How do professionals within such organisations interact with each other and how do they regulate themselves?

6) How do such forms of organisation impact on securing professional engagement?

7) Clinical workloads, job satisfaction and morale?
8) The development of innovative practice?
9) Process: How do such forms of organisation impact on:
   a) Clinical quality and development of best practice?
   b) Adherence to external performance targets?
   c) The cost-effectiveness of service provision?
   d) Patient outcomes/experiences?

**Methods**

Two methods were used to achieve these aims. A systematic review of existing research was used both to bring together existing explanations of how the distinctive organisational structures found in professional partnerships and non-hierarchical organisations operate, what conditions cause them to 'degenerate' and what conditions enable them to operate effectively. To test these explanations we firstly reviewed and re-used the empirical findings contained in the research we had reviewed. Secondly, we made and compared new case studies of twelve organisations: three general practices; three professional partnerships outside the NHS; three health cooperatives (two English, one American); and the cooperatives outside the NHS. We then combined our findings about patterns across these case studies with previously published findings; and then compared the combined findings with some earlier theories and predictions about professional partnerships and non-hierarchical organisations.

**Results**

The goals of partnerships and NHOs are typically to secure for members and partners and income no worse than prevailing market rates; produce a quality of work befitting their members' occupational status: to provide services for a particular locality: to break even (not maximise external shareholder profits); and to realise other values, including cooperation or professional values for their own sake.

The main external governance mechanisms are contract and regulation. Contracts work most effectively when their terms are specific, unambiguous, legitimate (in the providers' eyes) and strongly incentivised. To preserve NHOs' organisational structures against the weakening ('degeneration') of members' or partners' democratic control of the organisation, alternatives to financing by external shareholders are required and limiting the proportion of (non-voting) salaried employees.

Partnership and NHO organisational structures essentially take either of two forms: a direct democracy of small workplace teams (which can articulated in multiple layers for controlling a large organisation); or a representative democracy in which the workforce elects the top, but not middle, managers. Optionally there may be a supporting infrastructure of employed staff.
Successful coordination relies primarily on concertive control. Members or partners monitor each others' work and through peer pressure prevent shirking.

Key elements to the internal management of partnerships and provider NHOS they are concertive control; legitimation of collective decisions by appeal either to an organisational culture or to technical knowledge; and as a last resort expulsion of non-compliant members. The internal management of consumer NHOs is undertaken largely by employed managers. Smaller-scale organisations (e.g. workplace team, general practice) can operate through informal, direct democracy, taking decisions by consensus. Larger organisations can operate through indirect democracy whereby members elect a top manager (or a board) with similar powers to their corporate or public sector counterparts. Indirect democracy appears better suited than direct democracy when the organisation's work is not intrinsically rewarding (e.g. is laborious, monotonous, done at inconvenient times or places, inflexible). Three main causes of 'degeneration' are over-reliance on supplementary hired labour, dependence on corporate sources of capital funding, and managerial 'capture' of the organisation.

Professionals within such organisations interact and regulate themselves largely through direct democracy, peer pressure and the use of technical knowledge as described above, but in larger partnerships a distinct stratum of manager-professionals may emerge. Professional engagement in these organisations is promoted by high pay; by the organisation's decisions and activity being important for the professional's work taken as a whole; by enabling contact with fellow-professionals; and by providing a well-organised support infrastructure. Production processes in NHOs and partnerships tend to produce an upward shift in the expertise and skills of their members and partners, which tends to satisfy members' and partners' intrinsic (i.e. non-instrumental, non-financial) motivations to work. In that respect they tend to increase workload, and add a managerial dimension. The forms of innovation which they favour are innovation through extensive replication, vertical integration, diversification and 're-engineering', provided that these innovations sustain the quality of work which the members or partners undertake and maintain the members' or partners' centrality to the productive process. NHOs and partnerships generally prefer to develop and market services and products on the basis of quality rather than price. The combination of evidence-based knowledge, incentives and concertive control appears to raise clinical quality. There is sometimes tension between requirement to break even and the goal of raising quality of work. User participation mechanisms may have merit as a means of representing users in NHO and partnership governance but the character of user experience appears was more effectively monitored and managed by developing systems for routine data collection on that point. Because of their founding goals and membership, NHOs and partnerships were active implementers of evidence-based medicine. External competition provided a discipline to control costs, EBM a discipline for clinical effectiveness. On
balance, economic theorists' predictions that NHOs and partnerships are economically inefficient and unsustainable were not supported by the evidence. In the NHS both partnerships and NHOs are demonstrably capable of close adherence to external performance targets when these targets are clear, specific, legitimate (to the providers), incentivised and compliance (or not) is transparent.

**Conclusions**

Because professional partnerships and non-hierarchical organisations tend to pursue goals which are more closely aligned to NHS objectives than those of corporations, there are likely to be advantages in commissioning them as NHS providers. Then, commissioners are likely to be less dependent on incentive schemes and adroitly-formulated contracts to align the provider's goals artificially with those of the NHS. Because these organisations compete on quality rather than price, and try to maintain their members' incomes and working conditions, they may be at a price disadvantage against corporate providers unless steps be taken to ensure a 'level playing field'. One such step is to let longer-term contracts than the one or two years duration of some present contracts. Another would be to arrange public sources of loan capital for non-corporate providers. Our American case study suggests that users could play a much bigger part in commissioner governance than was customary in English PCTs, but also that governance by users is difficult to sustain. We also identify suggest further research needs, including the need for head-to-head comparisons of professional partnerships, non-hierarchical organisations, corporations and public bodies as service providers.
Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.