

**REGULATION VS FLEXIBILITY: A COMPARATIVE STUDY OF
MICRO-CARE MODELS IN DECENTRALIZED SOCIAL CARE
SYSTEMS**

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Certificate

This is to certify that “the thesis titled **REGULATION VS FLEXIBILITY: A COMPARATIVE STUDY OF MICRO-CARE MODELS IN DECENTRALIZED SOCIAL CARE SYSTEMS**” submitted to the American Management University in partial fulfillment of the requirements for the award of the degree of **Doctor of Philosophy in Health & Social Care**, is a record of original research work done by **Jason Robert Watmore** during the period of his study **2024-2026** in the Department of **Health & Social Care** under my supervision

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I hereby declare that the research work presented in this thesis, titled **“REGULATION VS FLEXIBILITY: A COMPARATIVE STUDY OF MICRO-CARE MODELS IN DECENTRALIZED SOCIAL CARE SYSTEMS”**, has been carried out by me after the completion of my PhD program. This work has not been submitted to meet the requirements for an award of any diploma, degree, or postdoctoral fellowship at this or any other higher education institution.

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ABSTRACT

Decentralized social care systems increasingly rely on micro-care organizations to deliver community-based services, yet the governance tension between regulatory oversight and operational flexibility remains poorly understood. This study examines how regulatory design shapes micro-care performance across diverse organizational and policy contexts within the United States. The study pursued four objectives: examining regulation-flexibility relationships across micro-care organizations, assessing how regulatory clarity and coordination influence equity, efficiency, quality, and resilience, identifying moderating organizational and contextual factors, and developing evidence-based policy recommendations for redesigning regulatory frameworks balancing accountability with operational discretion.

A comparative quantitative methodology was employed, drawing on data from over 300 micro-care organizations across six U.S. states with varying regulatory environments. Multivariate analyses examined direct, moderating, and mediating relationships between regulatory intensity, organizational flexibility, and four performance dimensions, controlling for organizational size, ownership, workforce stability, and Medicaid policy context. Findings demonstrate that neither maximum regulation nor maximum flexibility independently optimizes performance. Clear, coordinated, outcome-oriented regulation combined with sufficient operational discretion produced the strongest equity, efficiency, quality, and resilience outcomes. Organizational size, nonprofit status, telehealth capacity, and Medicaid expansion significantly moderated these relationships, underscoring that flexibility requires enabling infrastructure to generate meaningful performance gains.

CHAPTER 1

INTRODUCTION

1.1 Introduction

The decentralized systems of social care are now finding themselves at the centre of modern policy discussions and especially as governments and health administrators seek to balance both the need to demonstrate regulatory consistency on one hand and yet allow localized flexibility in the provision of care on the other. The straining of regulation and flexibility is not only a technical or administrative issue, but it points to more structural, ethical and governance related issues, of how the care systems can be structured in such a way that they are responsive to the diverse and changing needs of the community. It is in this light that micro-care models, small-scale, community-based and frequently individualized models of care provision, have appeared as a promising way to fill in systemic gaps. These models exist in the context of decentralized structures where the decision-making power is also shared at several levels and, therefore, enables the flexibility of interventions that are context-specific. Nevertheless, their effectiveness depends on how much the regulatory structures are either permissive or inhibitive of innovation and responsiveness. The development of integrated care systems offers important insights into this dynamic. An example of this is the population-based integrated healthcare model in Germany, specifically, the Healthy Kinzigtal program, which demonstrates how the coordination of governance frameworks can facilitate local care innovation without losing overall accountability (Groene & Hildebrandt, 2025). This model shows that in cases where regulatory frameworks are structured to ensure that the incentives of different stakeholders are aligned, it can allow micro-level experimentation without undermining system-wide coherence. Meanwhile, scaling of such models illuminates the difficulty of maintaining flexibility as systems become more intricate and extensive.

Although regulatory standardization is needed to safeguard equity and quality, standardization may inadvertently constrain the flexibility that micro-care models are based on to respond to local demands. Likewise, the Swedish-based study of the so-called hospital at home highlights the potential of decentralized care provision (Ekholm and Rorsman, 2024). This model demonstrates the potential of service delivery flexibility to promote better patient outcomes, less strain on the system, and more

efficient operation by moving care out of centralized hospitals and delivering it at the homes of patients. Nevertheless, its application also causes significant regulatory issues of safety standards, professional responsibility, and resource distribution. The challenge of facilitating such innovative care models against ensuring strict control is a common thread throughout decentralized systems, and regulatory frameworks that are both strong and flexible are needed. One of the main aspects of this discussion is the trade-offs of equity and efficiency, which is naturally defined by the balance between regulation and flexibility. Policy choices in health and social care can be characterized by complex trade-offs as Cadham and Prosser (2023) posit, as a push to achieve the greatest efficiency can lead to inequitable access and the reverse. The micro-care model, with its focus on localized and personalized interventions, can help to increase equity by meeting the needs of underserved populations. Nevertheless, the absence of the proper regulatory mechanisms can also result in service quality fragmentation and variability through such models. This explains the need to come up with governance systems that can balance these conflicting goals in such a way that flexibility does not compromise fairness and consistency. The general discussion on the establishment of sustainable and resilient health systems adds further weight to the importance of this balance.

Gocke et al. (2023) point out that the health system resilience is directly related to the ability to adjust to the evolving conditions without losing its fundamental functions. By its very design, decentralized systems are more flexible, due to their distributed nature, yet they also need a means of coordination and control to avoid inefficiencies and imbalances. Micro-care models help to provide system resilience by promoting innovation, building stronger community relations, and responding swiftly to community issues. Yet, they require regulatory frameworks, which are able to integrate diversity without compromising coherence, as they are part of the bigger system. This discussion is further complicated by the quest to achieve universal health coverage (UHC). Such a balance between accessibility, quality, and financial protection, as Ranabhat et al. (2023) note, is the key to obtaining UHC, and it is all predetermined by the governance arrangements. Decentralized systems provide possibilities to customize services according to the local context, which enhances accessibility and sensitivity. However, they also present difficulties with regard to establishing common standards and fair resource allocation. Micro-care models may also have a vital role in the

development of UHC, reaching discriminated communities and bridging the gaps in the conventional service delivery. The success however, hinges on how much regulatory environments are conducive towards innovation without infringing on the interests of the people. The effectiveness of micro-care models is critically viewed through the lens of regulation versus flexibility in decentralized social care systems in this comparative study. The study will examine the conditions in which these models can flourish and the obstacles they face by examining various national and institutional situations. It examines the effects of different levels of regulatory control on the structure, execution and performance of micro-care programs, and how the relationships work to affect the overall performance of the system. Finally, the research will be part of the current debate on how to create governance structures that could balance the necessity to standardize with the necessity to innovate so that the social care systems in the world of growing complexity and uncertainty can be fair and responsive.

1.1.1 The Global Turn toward Decentralization in Social Care

To understand significant micro-care cases occurring today, it is essential to situate the tension between regulatory-flexibility within these larger historical and political forces that have shaped the contemporary global push toward more decentralized forms of social care governance (Balcazar, 2020). While there is a diverse intellectual base for this shift from classical public choice theory to new public management doctrine, from participatory democracy theory to, more recently, systems thinking and complexity science. An important early economic justification for decentralization is Charles Tiebout's (1956) theory of local public expenditure, which suggests that mobile citizens can 'vote with their feet' by moving to jurisdictions with bundles of public services that best match their preferences, thereby imposing a quasi-market discipline on local governments to supply efficient services. Tiebout's fault and is the assumption of perfect mobility and perfect information, although the centralization of the argument laid the framework for more recent arguments, arguing that local governments are better at providing 'more responsive and efficient (state, according to scholars such as Charles Tiebout, 1956) services than a centralized bureaucracy, since those who live there exert greater interests and accountability mechanisms due to an intimate relationship with the government.

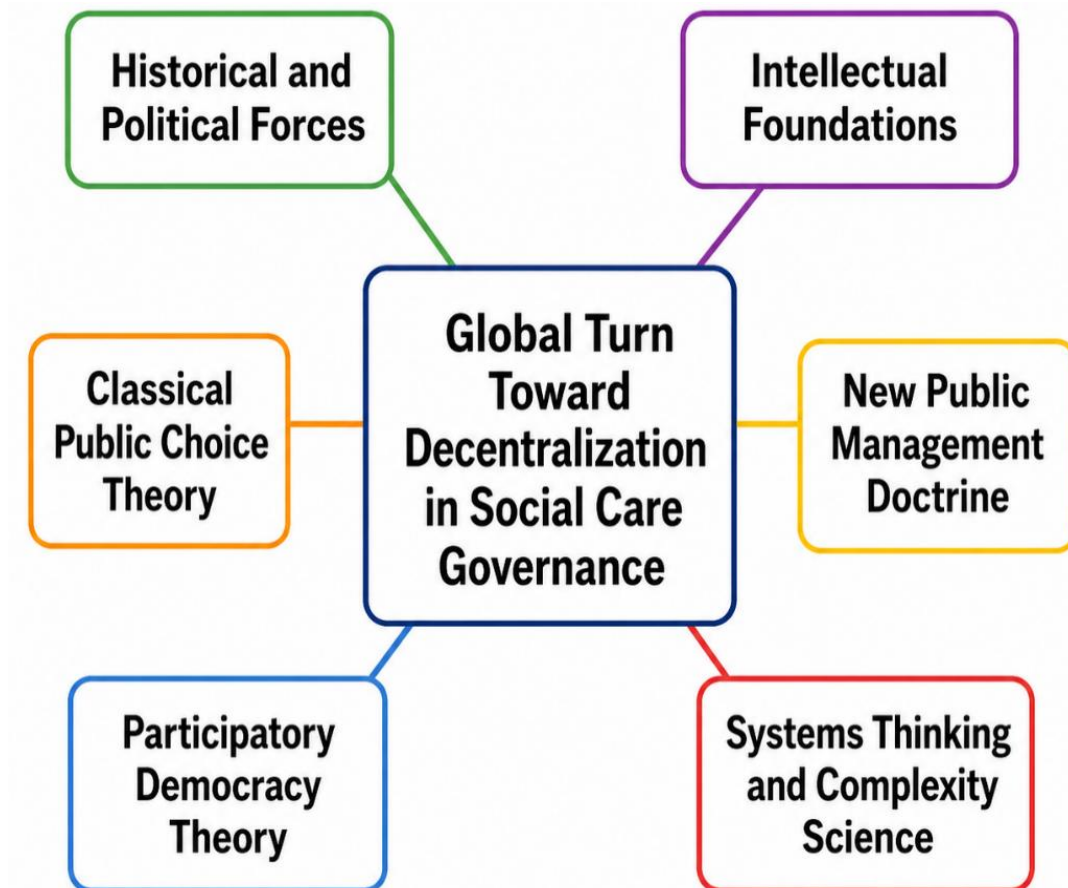


Figure 1.1: Global Turn Toward Decentralization in Social Care

Yet applying market-style logic to health and social care is complicated by market failures inherent in these sectors. As was shown in great detail by Kenneth Arrow (1963) in his canonical study of the welfare economics of medical care, health care markets are beset by uncertainty and the presence of information asymmetries between providers and consumers and, due to the fact that health is a good of unique ethical and social significance, by the inapplicability of the principles of ordinary commodity trading. These features provide strong rationales for regulation to correct market failures and for ensuring that care is provided on the basis of need rather than ability to pay. I will not reminisce, but the contrast between Arrow's analysis, which focuses on how regulatory structures are both necessary and still adjusted to local concerns after the election, and Tiebout's, which focuses on the virtues of decentralized responsiveness, corresponds directly with the central problem of this study. Hurwicz (2008) himself expanded on this later with mechanism design, who governs the governors? The design of appropriate incentive structures and oversight mechanisms in decentralized social care systems is a real challenge, because the agents that are

supposed to execute regulatory requirements local governments, community organizations, and care providers have their own interests, capabilities, and interpretations of their mandates. What really matters with any regulatory framework is how incentives align and information gets distributed throughout the system, not just the formal contents of the framework itself.

Political momentum for decentralization in health and social care gained tremendous momentum in the 1980s and 1990s, as governments across the OECD responded to fiscal squeeze, the momentum of ideological shifts towards subsidiarity and local autonomy, and the realization that centralized command-and-control systems were ill-designed to address the challenges of the complexity and diversity of social needs. This process took distinctively national forms in Europe depending on pre-existing constitutional arrangements, administrative traditions, and political cultures. In this sense, Portugal carried out on the decentralization area (OECD, 2020; Teles, 2021), translating *de jure* changes in competencies to some municipalities but *de facto* lacking to solve the key questions related to the processes of organization of social care. The difficulties in developing coherent health strategies in Portuguese local governments has been documented by Ferreira et al. (2023), pointing to the potential for innovative practices but also the risk of fragmentation and inequity in the absence of clear frameworks for local health governance. Decentralization was the cause celebre in Latin America during the 1990s, as part of the overall structural adjustment and democratization package that international financial institutions were espousing. The Unified Health System (SUS) created in Brazil in 1988 attempted to put together universal (or not inequalities in access to health care) coverage with radical decentralization of service delivery to municipalities - a model where the genesis explain much of the tension between national equity norms and local operational flexibility that we have witnessed if we take some time thinking about the translation of high fancy policies (Viana et al., 2002; Miranda et al., 2017). Meanwhile, Colombia and Chile pursued similar decentralization strategies with very different equity effects (Bossert et al., 2003), and effort on decentralization of health competencies to autonomous communities in Spain created an institutional landscape resembling a quasi-federal system that has been treated as a natural experiment of the effects of decentralization on efficiency and equity (Costa-Font & Gil, 2009; Jiménez-Rubio & García-Gómez, 2017).

1.1.2 Decentralisation and Micro-Care Governance Challenges

Social care systems around the world are at a pivotal moment. It is a long-standing and profound dilemma that every government, every policymaker and health system administrator faces how to balance the two irreconcilable but equally critical (regulatory coherence and local delivery of care operational flexibility). It is not just an administrative or technical problem; it is at its core a political, ethical, and philosophical matter about democratic accountability, social equity, individual dignity, and the relevant bounds of the state's powers over the sphere of human welfare. The current study frames this tension as a central problem with its examination of how variant decentralized social care systems accommodate or struggle to accommodate competing regulatory pressures and adaptive flexibility through models of so-called micro-care. Decentralisation in health and social care has long been centre stage in comparative policy research. As Saltman et al. (2007) cite in their extensive review for the European Observatory on Health Systems and Policies that decentralization is not one specific coherent strategy but a collection of different governance models, each entailing a delegation of power, responsibility, and resources from central government to subnational units. These arrangements comprise deconcentration, delegation, devolution, and privatization, and their effects on system performance differ by significant degrees depending on the institutional, political, and socioeconomic context of their embedding in the context. The decentralised governance models spreading across Europe and beyond are a testament not just to an ideological consensus that would have been hard to imagine in the 1980s - even in Europe, local governments and communities may be in a better position than centralized bureaucracies to identify, respond to, and innovate around the particular needs of their populations.

However, the empirical record on the results of decentralisation is disputed and, to a considerable extent, intensely contradictory. Abimbola et al. Using realist synthesis methods, (2019) examined the (not always positive) effects of decentralisation on health system equity, efficiency and resilience and found that effects are highly context-specific and depend on the quality of governance institutions, adequacy of fiscal transfers and local government capacity. The systematic review by W. (2016) in conclusion found that decentralisation was more likely to reduce health-related equity under conditions in which subnational governments had the political will, technical capacity, and financial resources to identify and prioritize the needs of marginalized

subpopulations, but emphasized that otherwise decentralization could aggravate inequities when those governments lack necessary resources. These results reveal an initial paradox: while decentralization has the potential to move care closer to the populations needing it, whether it has delivered on that potential is anything but assured, and in many reports, it has engendered new forms of fragmentation, inefficiency and inequity. It is against this backdrop of complexities and clashes that studying micro-care models gains a special significance. When social care is introduced in practice it is often not through national insurance programs or large-scale hospital systems, but through micro-care models which represent the localized system of delivery arrangements directly embedded in the day-to-day lives people. These include primary care networks, integrated community nursing teams, integrated day-care centres, home support services, community living arrangements, respite care and neighbourhood health posts and many hybrid arrangements that combine health and social care functions at a local level. These models function at the edges of established formal regulatory frameworks, frequently with significant flexibility in the interpretation, adaptation and implementation of the policy directives. Understanding how regulatory structures mould and are in turn moulded by these micro-level arrangements is thus more than an academic exercise; it has direct implications for quality, equity, and sustainability of the care experienced by many millions of people in highly diverse national and cultural settings.

1.1.3 Micro Care Models: Conceptual Definition

In the context of this study the micro-care model refers to quasi-organized arrangements for the provision of health and social care services at a community/neighbourhood level that are sufficiently close to service users, have at least a degree of operational autonomy relative to higher level policy types, and whose resources and activities are mostly informed by interpersonal relationships and local knowledge. This refers to a large variety of organizational forms, such as: community health centres, primary care cooperatives, self-managing nurse teams, neighborhood integrated care networks, community mental health services, and municipally organized home care programs. The relevance of micro-care models for regulation and flexibility research comes from their situatedness at the intersection of formal policy imperatives and informal, relational modes of care practice. At once they are objects of regulatory governance bound to licensing requirements, quality standards, funding conditions, and

performance monitoring yet they are also agents of adaptive implementation implicit with the exercise of discretion in interpreting the policy mandate and how they should respond in local conditions. That dual character makes them the perfect venues through which to analyze the interaction between regulatory imperatives and operational flexibility, and identify the conditions that foster or impede the productive alignment of these two domestic imperatives. This can be more than just care there are many international models of micro-care that could serve as inspiration for social care reform. The Buurtzorg model, in which small, self-governing teams of community nurses organize and deliver integrated home nursing care without line managers, has been hailed as an exemplary model of professional autonomy and person-centered care (Gray et al., 2015).

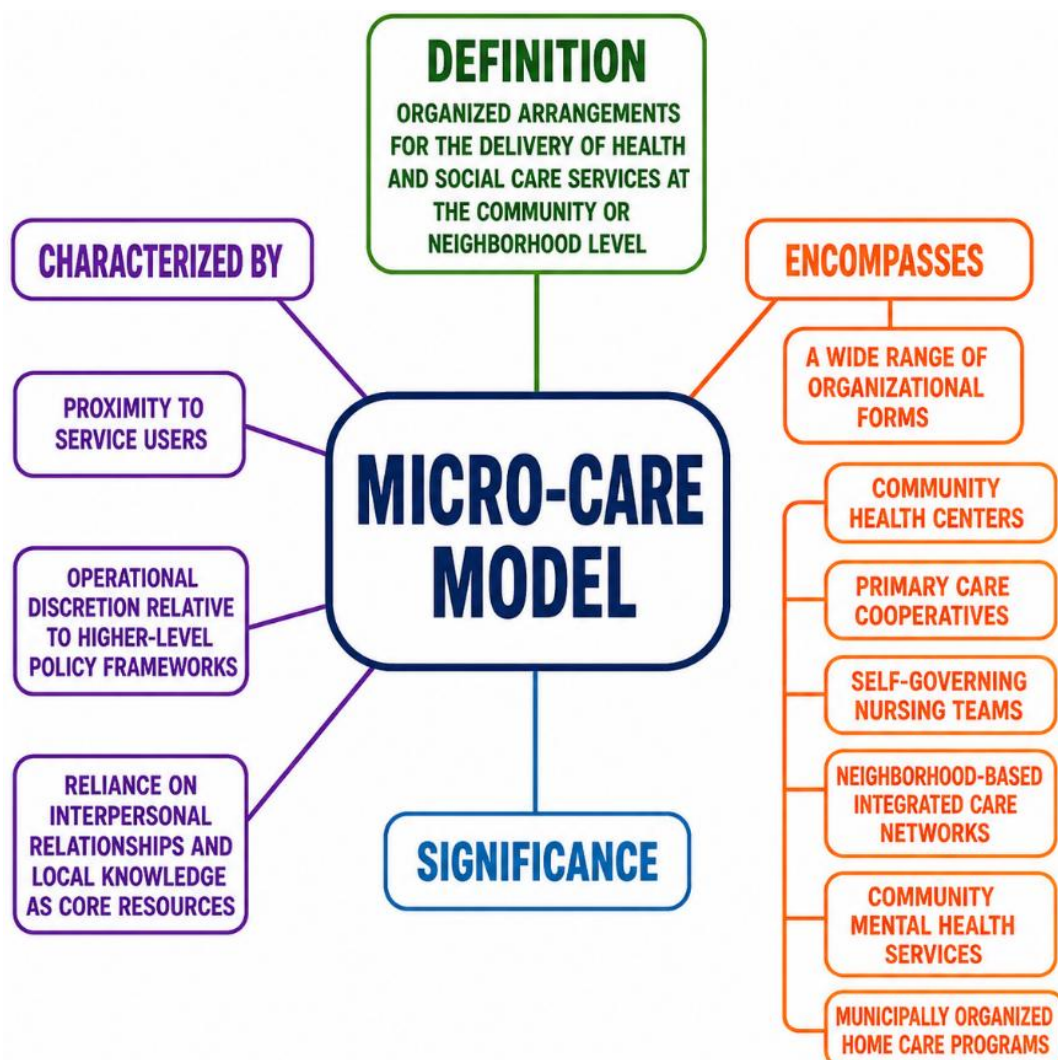


Figure 1.2: Micro-Care Models

In this regard, its success has been attributed precisely to the control it gives to nurses to be able to strip down the nature of work depending on the needs demanded by the clients rather than the bureaucratic protocols that are primarily designed to optimize efficiency. However, even Buurtzorg works within a regulatory environment in which minimum quality and professional qualifications and the system for funding is specified by the powers that be; its flexibility is possible only because a regulatory architecture establishes the ground rules for how self-governance may function responsibly (Van Weel et al, 2012). The *Gesundes Kinzigtal* integrated care model in Germany is an example of this second type of micro-care arrangement, organised around a defined geographical population and under a contractual arrangement between an integrated care company and two statutory health insurance funds (Groene & Hildebrandt, 2017, 2025; Schubert et al., 2021). This model creates considerable flexibility in care organization through the introduction of a population-level accountability mechanism the company is accountable for the entire health costs of the population it enrolls and therefore has major incentives to invest in prevention and coordination, at the same time it works within the regulatory framework of the German Sozialgesetzbuch. The *Kinzigtal* experience is consistent with the idea alluded to in the effectiveness literature, that financial and accountability mechanisms can be used to replace detailed process regulation, thus allowing local actors the scope to innovate whilst ensuring system-level accountability.

Yet another illustrative example is the Trieste model of community mental health care in Italy, which illustrates how a radical departure from institutional care through the closure of the psychiatric hospital can be attached to a sustainable and comprehensive network of community-based services rooted in the ethos of citizenship and recovery and social inclusion (Mezzina 2014; Okin, 2020). The achievements of consistently high standards of care with very few coercive measures in the Trieste model have been explained with reference to its powerful value base, the personality of the workforce as professionals and the integration of mental health services into general social support resources. Though it too exists within a legislative framework the national psychiatric reform law of 1978 which removed involuntary hospitalisation and laid the foundations for community based alternatives. These cases seem to indicate a relationship between regulation and flexibility in micro-care models that is not a zero-sum game. Regulatory frameworks can do more than just constrain operational flexibility, it can enable it by

creating the parameters professional standards, funding mechanisms, accountability structures, and legal rights within which local innovation and adaptation can thrive. On the other hand, an overabundance or ineffectively designed regulation can squelch responsive, relational, and adaptive nature of micro-care models that are the source of their unique advantages. The task for governance of social care is to create regulatory environments that perform this enabling function without neo-colonising the operational space of micro-care providers with bureaucratic demands that stifle professional judgment and community responsiveness.

1.1.4 The Regulatory-Flexibility Tension: Theoretical Dimensions

Social care governance occurs within a fractal space of intersecting theoretical dimensions between regulating and flexibility. These are critical to the comparative analytical structure underpinning this study. A first and foremost dimension relates to the trade-off between equity and efficiency as competing and in some cases, sometimes even complementary, values in the health and social care systems. Broadly speaking, the justification for some regulatory frameworks is primarily in terms of equity – at least as they appear in theory. In the absence of mechanisms that equalize regulation, decentralized systems generate territorial inequities in access and quality that mirror those in local fiscal capacity, political capacity, and social need (Whitehead, 1992; Santana et al., 2020). However, regulatory requirements not only have positive but also negative effects from an efficiency point of view. By promoting the adoption of interventions that demonstrate effective care outcomes, quality standards and evidence-based practice guidelines ensure that micro-care providers use the best available evidence to guide their practice. Nonetheless, payment and outcomes data have costs in compliance, administrative burden and the teaching to the test dynamics of performance management systems that can undermine direct care resource allocation and responsiveness of providers to individual client needs (Palmer & Torgerson, 1999; Patel 2021). Consequently, the trade-off between equity-oriented regulation, on the degree of flexibility oriented towards efficiency, is not simply a matter of values, but an empirical question of which balance of regulatory and operational discretion yields optimal outcomes for which populations and under what conditions (Cadham & Prosser, 2023). Dougherty et al. Even though evidence from OECD countries shows a non-linear relationship between decentralization and health care system performance (Wu et al. 2022), with moderate degrees of decentralization performing better than both

excessive centralization and extreme decentralization, it suggests that governance arrangements worldwide that blend elements of central regulatory authority and local operational discretion may be optimal. Such a finding is consistent with the theoretical prediction that regulation and flexibility are complements rather than substitutes in the well-functioning social care systems.

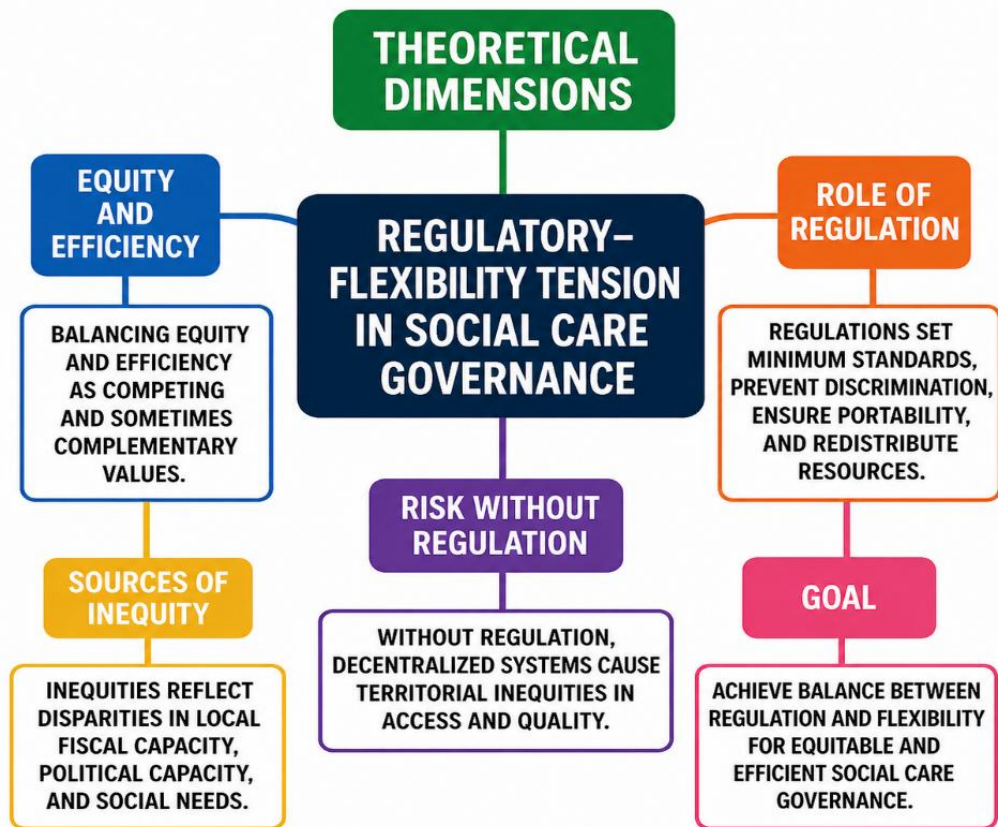


Figure 1.3: The Regulatory-Flexibility Tension

Accountability and Legitimacy A second dimension of this theoretical pivot focuses on the challenges to source and mechanisms of accountability in decentralized social care systems. This type of accountability takes place when micro-care providers operate within regulatory frameworks that stipulate an obligation of accountability to higher-level authorities that fleetingly assume the role of principals, requiring providers to report back on an apparent range of activities in compliance with set standards and spending. These operate to keep public resources ring-fenced for purpose, standards of care enforced and providers accountable to democratically-designed oversight bodies. Still, they can give rise to perverse incentives as well, whereby providers are encouraged to focus on easily-measurable indicators rather than the actual quality of care, and where managerial attention is diverted from frontline delivery to

administrative compliance (Hurwicz 2008). In contrast, alternative accountability mechanisms work via horizontal relationships between providers and clients, professional peers, and local communities. These mechanisms are based not on hierarchy, but on trust, professional ethics, reputation, and participatory governance, and might better engender the type of responsive, judgement-intensive care that complex social needs demand. Weak, of course, design regulatory frameworks for micro-care models decisions about how to balance vertical and horizontal accountability, which types of accountability are suited for various functions and settings. Migchelbrink and Van de Walle (2021) recorded the increasing focus on participatory governance and public engagement as accountability mechanisms in public administration, and the press for new approaches to accountability that transcend the traditional regulatory paradigm to new relational and collaborative forms of accountability. Coordination and fragmentation: A third dimension relates to the association of regulatory structure with care coordination. Social care needs are, in general, multidimensional, spanning health, functional capacity, housing, social support and income security, and need to be met through coordinated action across providers and sectors. Regulatory frameworks can facilitate coordination through embedded common information systems, referral protocol, interoperability standards, and financial incentives for integrated care. But they can also prevent coordination by creating rigid silos, using unaligned funding streams, and instigating harmful competition among providers. Micro-care models are frequently attempts to remedy coordination failures that are not addressed successfully through hierarchical regulatory approaches. For example, the Esther Network model in Sweden and Singapore was designed to enhance transitions of care for older patients (eg, between hospital and community settings) following a common perspective across the network institution on the care experience of a prototypical patient, known as Esther (Lim et al., 2022).

In the same vein, integrated care programs in Denmark and Nordic countries have aimed to bridge the institutional gap between municipal social services and regional health services by means of voluntary coordination mechanisms and joint governance arrangements (Colmorten et al., 2019). The viability and growth of these coordination innovations is heavily determined by the regulatory context: do funding arrangements reward or punish integrated care; do professional licensing regimes allow for an adaptable configuration of the team; do information governance frameworks allow the

sharing of client data across organizational boundaries? As Gocke et al. As they note, this will require regulatory frameworks which enable, rather than directly or indirectly impede, these models to fulfil the coordination functions for which they are designed.

Resilience and Adaptability: A fourth theoretical facet is the association between regulatory structure and system resilience. The COVID-19 pandemic dramatically showed how highly decentralized social care systems, as well as the most centralized ones, could be vulnerable to external shocks, triggering a renewed interest to better understand the governance conditions that allow health systems to respond quickly to sudden disruptions (Bosa and al., 2021; Capano and Lippi, 2021; Erkoreka and Hernando-Pérez, 2022). Systems with greater local autonomy and operational flexibility were, in some contexts, able to adapt more rapidly by innovating in testing delivery, or reorganising care pathways, or mobilising community resources but likewise more easily overburdened and subject to fragmented care and inequitable distribution of protective resources. The micro-care models survive stress only if the operation of those models is afforded sufficient regulatory flexibility of sufficient quality. As Abimbola et al. As (2019) highlight, resilient decentralized systems are based on separation of responsibilities between government tiers, subnational levels comprise appropriate technical and financial capacity, and crisis innovation has been prompted through strong intergovernmental coordination mechanisms. Designing regulatory frameworks, which incorporate these resilience-enabling attributes whilst avoiding damaging the adaptive capability of micro-care providers, is one of the fundamental conundrums of contemporary social care governance.

1.1.5 The Comparative Approach

A comparative analysis of the regulatory frameworks for micro-care model flexibility is the approach taken in this study across a small selection of national and subnational cases that were identified through an iterative process. The theoretical and practical rationale for comparative analysis in this area are twofold. In theory, comparison is where the identification of patterns, mechanisms, and contextual factors that cannot be found in single-case analysis can inform the hypothesis around the causal relationships between governance structures and care outcome, ultimately guiding policy development and implementation. The vast number of governance arrangements across countries makes this problem a natural laboratory for testing the impacts of various regulatory approaches, and the fast-growing global literature on decentralized social

care is a rich reservoir of evidence that can be further organized and interpreted through comparative synthesis. Cases selected for comparison in this study follow the principle of maximum useful variation, whereby cases reflect essential differences in their governance arrangements federal and unitary states, Nordic welfare states and Mediterranean welfare regimes, high-income and middle-income countries, established and emerging decentralization initiatives but are structured similarly enough to be meaningfully compared. The book builds on comparative evidence from Europe (the Netherlands, Germany, Italy, Spain, Sweden, Denmark, Portugal), Latin America (Brazil, Colombia), and some cases from Asia and North America, capturing an important, truly global literature on the decentralization debate and comparative evidence.

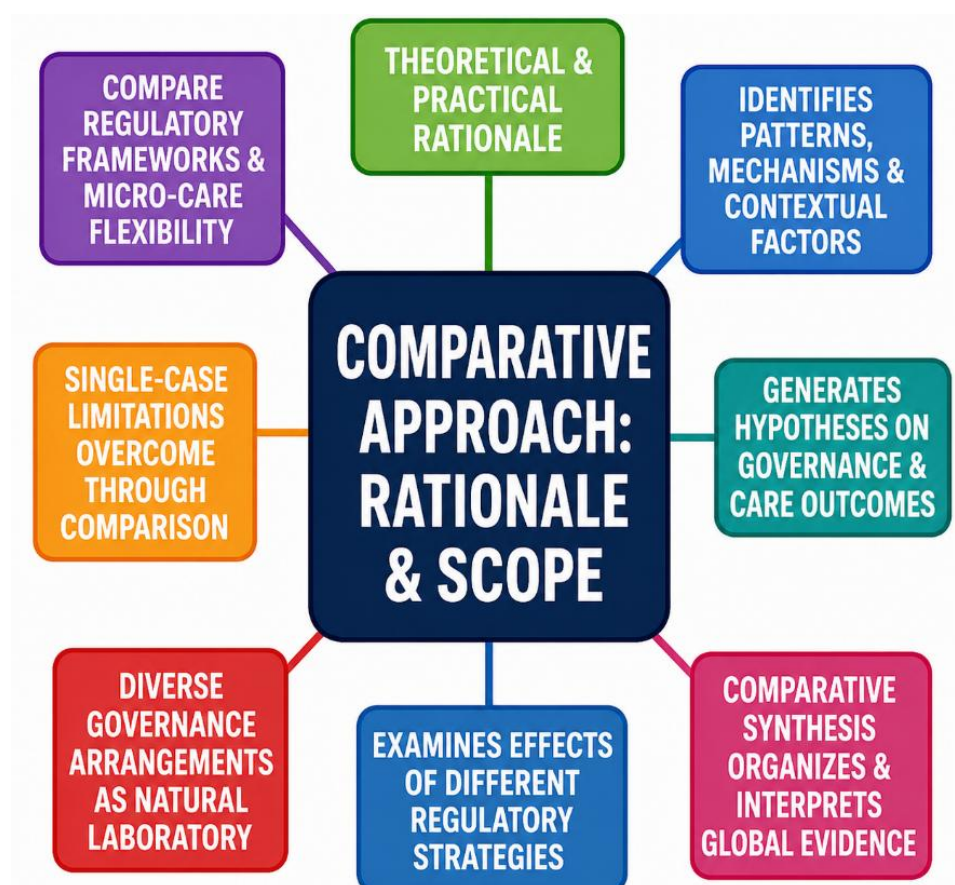


Figure 1.4: The Comparative Approach

The body of work exploring decentralized social care is aided in Europe by the EU common policy context, which has successively been incorporated into the regulatory environment in which national systems operate; this has included social care quality standards, patient rights directives and structural funding requirements. Meanwhile, the

EU governance principle of subsidiarity formally leaves the exploration of the organization of health and social care systems to member states, leading to substantial diversity in governance arrangements within a largely common normative framework (Jancovic et al., 2021). This combination of a shared common framework of regulation and a diversity in institutions within the national context allows for the study of the trade-off between regulation and flexibility and is the reason why European cases are so attractive for comparative research. In Latin America, the analysis concentrates on Brazil where the Unified Health System represents one of the largest and most well researched experiments in health decentralization in the world. The SUS experience highlights tensions between constitutional promises of universality and local realities of extreme municipal inequality in fiscal capacity and administrative capacity (Segatto & Béland, 2021; Spedo et al. 2009). It also shows that, even in a formally decentralized system, some federal regulatory mechanisms (specifically, the constitutional minimum spending requirements, the national baseline formula for coverage determinations, and the intergovernmental health commissions) are important for upholding equity norms (Vazquez, 2011, 2014). We complement the Brazilian case by presenting evidence from Colombia, Chile and Argentina that provide a comparative perspective on two alternative models for designing decentralized social care governance (Bossert et al, 2022; Palacios et al, 2020)

1.1.6 The Political Economy of Social Care Decentralization

No serious understanding of the regulatory-flexibility tension in decentralized social care can take place without an eye on the political economy of decentralization itself. Decentralization is not a neutral administrative architecture: it is at once distinct and at the same time reflects and reproduces the specific distributions of power, resources and risk within and between levels of government. So in fact understanding these dynamics of the political economy of reforms is crucial in order to understand why certain configurations of regulatory-flexibility may arise in some contexts and not others simultaneously, and why reform efforts succeed or fail. The political economy of decentralization in social care can be framed around at least three sets of actors likely to have differing and possibly conflicting interests: central governments which must balance their constitutional commitment to a set of universal service standards with the political need to devolve fiscal and administrative functions to lower (subnational) levels; subnational governments who might welcome the prospect of increased

autonomy but differ widely in their fiscal capacity, administrative capacity, and political will vis-a-vis social care provision; and care providers and their workforce who may be either entitled or disempowered by decentralization depending on the mode of governance that emerges. Decentralized systems hold an inherent credibility problem for a central government, which, having devolved formal authority over social care, is nevertheless seeking to ensure national equity and quality standards without direct control over service delivery.

Solving this problem is a function of several regulatory gears, from conditional grants, minimum spending floors, and national service frameworks, to performance monitoring systems and, in extremis, intervention powers allowing central governments to override subnational decisions once standards are not satisfied. The measures resulting from these instruments are conditioned by the performance of information systems; the political independence of regulatory agencies; and the efficacy of advocacy by service users and civil society organizations that are able to hold central and subnational governments accountable (Bossert et al., 2022; Segatto & Béland, 2021). In this political economy, subnational governments find themselves in an ambiguous role. In situations of high fiscal decentralization, where local governments have a substantial own-source revenue and a certain discretion over expenditure priorities, the potential for truly autonomous social care governance can be large. Yet, this is hampered in many decentralized systems, where subnational governments remain highly reliant on central transfers, thus generating vertical fiscal imbalances that curtail subnational autonomy in practice and expose social care funding to the political and economic cycle at the two levels (Leite et al., 2012; Moreira et al., 2017).

Identified as one of the most widely recognized sources of failure in decentralized social care systems, formal political decentralization without substantial fiscal decentralization leads to local governments having political responsibilities for service quality while lacking the means to undertake these responsibilities adequately (Pinafo et al., 2020). Success in micro-care models, particularly their political economy of decentralization, is central to workforce implications. The successful models of micro-care such as Buurtzorg in The Netherlands, the community mental health model of Trieste in Italy depend upon a skilled, confident and intrinsically motivated workforce supported by professional autonomy and workplace flexibility. Sustaining a workforce like this is impossible without investments in training and professional development in

fragmented, poorly resourced, and politically volatile local governance contexts. This tension between regulatory flexibility and rigidity is therefore neither merely an issue of administrative organisation, but is intimately tied to the political economy of investment in social care as a form of human capital (Ekholm & Rorsman, 2024).

1.1.7 Equity as a Central Analytical Concern

The meandering thread of tension in each of the dimensions of regulatory-flexibility is penetrated by the question of equity here construed broadly by Whitehead (1992) to mean the lack of systematic, preventable and possibly unfair variation in health and care among socially defined groups. Equity, that is, the non-homogeneous effects of regulatory structures and operational flexibility on the various population groups are important and little known issues in the governance of decentralized social care. Theoretical equity connotations of decentralization are uncertain. In a nutshell, when decentralization increases equity then it can be through giving the local governments more power to distribute resources further down, to design services more culturally and linguistically oriented and to involve the service users and the community members in the process of governance that directly involves them in their care. Equity can also be exacerbated by decentralization, in case fiscal capacities and political willingness to provide a social care to the disadvantaged groups are more uneven among different subnational governments; in case there are no sufficient mechanisms of redistributing funds centrally, letting inequalities between the territorial units to grow; or the local majority abuses its autonomy to discriminate the minority groups.

Equity of micro-care model flexibility measure. Person-centred care models based on ethnic and cultural minorities, people with disabilities, and many others whose needs do not fit the typical service user developed into traditional regulatory systems can facilitate equity by making them tailored to individual people with complex care needs. However, when discretion of providers is limited to biases, preference or self-interest of providers instead of client needs, this can contribute to inequities. There are a few important ways in which regulatory frameworks can be used to deal with these equity risks: by providing explicit anti-discrimination standards, by using quality standards sensitive to concerns about diversity and by providing accountability mechanisms that make the equity performance of micro-care providers publicly available. The problem is how to establish regulatory structures that can have these equity-creating roles

without a homogeneity of practice that compromises one of the key benefits of micro-care models (the capacity to serve heterogeneous populations flexibly). This poses the question, as Santana et al. They are the EQ-COTE model that has been developed out of implementing equity lessons into the lessons learned out of the current work regarding the measurement of healthcare quality, the EURO-HEALTHY project, and the high-performance frameworks on adapting community and hospital discharge letters to shake-raising the respectability levels of healthcare organizations (2016).

1.1.8 Institutional Frameworks and Governance Architecture

The structural basis of decentralized social care systems is institutional structures and governance architecture, especially in the context of regulation and flexibility in the models of micro-care. These structures specify formal regulations, policies, accountability systems, and organizational structures that define the manner in which care is planned, delivered, monitored, and evaluated at various levels of the system. In decentralized environments, governance is not centralised in one person, but rather spread among national, regional and local actors that have specific roles and responsibilities. Such a stratified system of governance offers both opportunities and tensions: on the one hand, such a system offers flexibility in care models to meet local demands, but on the other hand, such an arrangement requires high levels of coordination to achieve consistency, quality and equity throughout the system. An essential feature of governance architecture is that it helps to incorporate various actors into a consistent care delivery system, such as the public agencies, the private providers, the community organizations, and the informal caregivers. As Groene and Hildebrandt (2025) note, the integrated care models like the population-based systems in Germany can show how governance structures can develop to incorporate cross-sector collaboration, facilitating continuity of care and enhanced health outcomes. The systems are based on the shared accountability mechanisms, data integration, and aligned incentives, which are integrated in the institutional architecture. Without this kind of coordination, decentralized systems will be at risk of being fragmented, offering redundant services, and inefficiencies that negate the effectiveness of micro-care initiatives.

Concurrently, governance systems should cope with the trade-offs between standardization and flexibility. Regulatory frameworks play a vital role in guaranteeing

safety, quality, and equity, especially in social care system where vulnerable groups are targeted. Nevertheless, excessively strict regulations may inhibit innovation and restrain responsiveness of local care providers. Cadham and Prosser (2023) stress that policy choices in healthcare frequently entail a tradeoff between conflicting goals that include equity and efficiency, which is especially acute in decentralized systems. Governance architecture should thus be able to be flexible yet still retain a minimum of regulatory coherence. This can be by establishing general national standards with freedom of local implementation. The other important aspect of institutional structures is that they contribute towards system resilience and sustainability. Gocke et al. (2023) also regard resilient health systems as those whose governance in response to changing conditions, which include demographic changes, technological progress, and outbreaks of diseases, is characterized by adaptive governance structures. This necessitates the governance structures that favour learning and innovation, and ongoing refinement in the context of decentralized social care. Laboratories of experimentation can be micro-care models which work at a localized, and in many cases, community-based level, yet with a governance architecture to enable scaling and sharing of knowledge across the system.

Moreover, the overall policy contexts, such as the quest to have universal health coverage (UHC), have a profound impact on institutional frameworks. As Ranabhat et al. (2023) observe, the history of the UHC has been influenced by its attempts to increase access and be financially viable and quality-oriented. The governance architecture in decentralized systems is important in ensuring that local care delivery is aligned to national health goals, by ensuring that micro-care models are aligned to larger system objectives. To make this alignment, there should be sound policy guidance, strong monitoring systems and good intergovernmental coordination. To conclude, the institutional structures and governance system are core to the operations of decentralized social care systems. They offer the guidelines and frameworks through which coordination happens, accountability ensured, and a balance between regulation and flexibility is achieved. When it comes to micro-care models, good governance does not consist of imposing uniformity but rather permeating an enabling environment that allows local innovation to flourish within a coherent and fair system. The difficulty is in how to create governance architectures that are both strong and flexible enough to support a variety of care models without compromising system-wide integrity.

1.1.9 Local Autonomy and Decision-Making in Care Delivery

Decentralized social care models have local autonomy and decision-making as their main elements, especially when implementing micro-care models (with a focus on personalized, community-based care). Local autonomy can be defined as the level of freedom given to regional or community-level actors to plan, administer and provide care services. It involves resource allocation choices, service design, workforce management choices, and interaction with the local people. Unlike centralized systems, in which the decisions are made in the national level, decentralized systems enable the local actors to address the needs and preferences of their communities in a more effective manner. The potential to increase responsiveness and innovation in care delivery is one of the main benefits of local autonomy. Micro-care models by their essence are working near the individuals and communities they are serving and can understand better the local health and social needs. In their article about the Swedish model of the hospital at home, Ekholm and Rorsman (2024) explain how decentralization allows creating more patient-specific care models, making less institutional care necessary and enhancing patient satisfaction. These models place great emphasis on local initiative and flexibility, which would be hard to realize, in highly centralized structures of governance.

Nevertheless, local autonomy also brings into consideration issues to do with consistency, equity, as well as accountability. In the event of decentralization of decision-making authority, there is a possibility that differences in the local capacity, resources and priorities can cause unequal access to care and outcome disparity. This is especially an issue in social care systems, where vulnerable populations might already be disadvantaged by access barriers. Ranabhat et al. (2023) note that to attain universal health coverage, it is imperative to expand services but also to ensure that they are equitably distributed. This requires measures to check imbalances that can be created by local decision-making in decentralized systems. The trade off between the autonomy and the oversight is thus a major factor of consideration in the design of governance. Although the local actors should have the liberty to innovate and adapt, they also have to work within a system of accountability that would help them stay in line with the overall system purpose. This is usually accompanied by performance measures, reporting provisions and regulatory policies that establish minimum standards of care provision. Meanwhile, governments should not be overly controlling, to inhibit local

initiative. According to Gocke et al. (2023) resilient health systems achieve such a balance by ensuring that there is both a clear strategic direction and operational flexibility so that local actors can experiment without disrupting the overall system coherence.

The other significant factor of local decision-making is the development of community engagement and trust. Local empowerment through decentralized systems can be in a better position to engage communities in the planning and provision of care services. This participatory model has the potential to promote the relevance and acceptability of care models and result in more positive outcomes and increased satisfaction by service users. Close connections between providers and communities, which can support early interventions, preventive care, and holistic support, are beneficial to micro-care models, in particular. Simultaneously, local decision-making needs sufficient capacity and resources on the local level. Local autonomy in the absence of adequate funding, talented human resources and institutional reinforcement can be more symbolic than substantive. Groene and Hildebrandt (2025) underline that effective integrated care systems require robust local governance systems that are enabled by national policies and resources. This underscores the significance of vertical integration in a decentralized system, at higher levels of government which make the required support and interconnection to facilitate effective local action. Finally, micro-care models must be able to succeed in decentralized social care systems with local autonomy and decision-making. They facilitate responsiveness, innovation and involvement in the community, which are essential in providing personalized and effective care. These advantages however must be weighed against equity, uniformity and responsibility. This balance can be achieved by having well structured governance structures that are flexible and at the same time they have the checks and balances to keep the local initiatives aligned with the overall system objectives. Finally, decentralized social care systems must be effective by ensuring that the advantages of local autonomy are utilized and its risks thereby reduced by strong and flexible governance systems.

1.2 Problem Statement

Decentralized social care systems in the United States face a persistent governance dilemma: how to balance regulatory oversight with organizational flexibility in micro-care models. Fragmented regulatory frameworks spanning federal, state, and local levels impose substantial administrative burdens on community-based organizations, constraining their capacity to deliver equitable, efficient, and responsive care. Existing literature acknowledges this tension but offers limited empirical evidence on how regulatory design specifically affects operational discretion and care outcomes across diverse organizational types and geographic contexts. Without understanding which regulatory configurations enable or constrain micro-care performance, policymakers risk designing oversight systems that inadvertently undermine the very community care goals they intend to support, deepening inequities for vulnerable populations.

1.3 Research Objectives

1. To examine the relationship between regulatory intensity and operational flexibility across diverse micro-care organizations operating within the United States decentralized social care system.
2. To assess how varying dimensions of regulatory design, including clarity and coordination, influence equity, efficiency, quality, and resilience outcomes in micro-care organizations.
3. To identify organizational and contextual factors that moderate the relationship between regulatory frameworks and performance outcomes in decentralized community-based care settings.
4. To develop evidence-based policy recommendations for redesigning regulatory frameworks that balance accountability with operational discretion in decentralized micro-care delivery systems.

1.4 Research Questions

1. How does regulatory intensity affect the operational flexibility of micro-care organizations across different states and organizational types in the United States?
2. To what extent do regulatory clarity and coordination moderate the relationship between oversight burden and organizational performance outcomes in decentralized care systems?
3. Which organizational characteristics, including ownership type, size, and location, mediate the impact of regulatory frameworks on equity, efficiency, quality, and resilience?
4. What regulatory design features distinguish high-performing micro-care systems that successfully balance oversight accountability with sufficient organizational discretion for adaptive care delivery?

1.5 Hypothesis

H01: Higher regulatory intensity is not significantly associated with reduced operational flexibility among micro-care organizations in the United States decentralized social care system.

H02: Regulatory clarity and coordination do not significantly predict improved equity, efficiency, quality, and resilience outcomes among community-based micro-care organizations across selected states.

H03: Operational flexibility does not significantly mediate the relationship between regulatory framework characteristics and organizational performance outcomes in decentralized micro-care delivery settings.

H04: State-level policy factors, including Medicaid expansion status, do not significantly moderate the relationship between regulatory intensity, organizational flexibility, and micro-care performance outcomes.

1.6 Significance of Study

This study makes a timely and meaningful contribution to the fields of health policy, organizational governance, and social care administration. By empirically examining how regulatory design affects micro-care performance across 300 U.S. organizations, the research moves beyond theoretical debates to offer actionable, data-driven insights. It addresses a critical policy gap by demonstrating that regulation and flexibility are not inherently opposing forces but can function as complementary governance tools when thoughtfully designed. Findings are particularly significant for policymakers seeking to improve equity and resilience in community care without imposing counterproductive compliance burdens. The study also holds practical value for organizational leaders navigating complex regulatory environments, informing strategies to build adaptive capacity and workforce stability. Internationally, the comparative analysis extends the study's relevance to nations pursuing decentralization reforms, offering transferable lessons on regulatory coordination, fiscal support, and outcome-based accountability frameworks.

1.7 Scope of Study

This study focuses on micro-care organizations operating within the United States decentralized social care system, specifically across six purposively selected states: California, Texas, New York, Florida, Minnesota, and Georgia. These states were selected to represent geographic, political, and regulatory diversity. The study encompasses five organizational types: home health agencies, community health centers, community mental health centers, adult day care programs, and integrated care/PACE networks. Data were collected from 300 organizations through a mixed-methods design combining a structured organizational survey with qualitative case study analysis during 2024–2025. The study's scope is confined to community-based, non-institutional care providers with administrative autonomy and defined service populations. While comparative international examples are referenced for analytical context, the primary empirical scope remains within the U.S. federal governance framework, addressing organizational performance across equity, efficiency, quality, and resilience dimensions.

1.8 Limitations of Study

1. The cross-sectional design restricts causal inference, as observed associations between regulatory intensity, flexibility, and organizational outcomes may reflect reverse causation or unmeasured confounding variables.
2. Reliance on self-reported survey data from organizational leaders introduces potential social desirability and common method bias, which may distort reported flexibility levels and performance outcomes.
3. The six-state sample, while diverse, may underrepresent small, rural, or resource-constrained micro-care organizations, limiting the generalizability of findings across all U.S. jurisdictions and care contexts.
4. Composite index measures of regulatory intensity, flexibility, and resilience may not fully capture the multidimensional nature of these constructs, potentially obscuring nuanced regulatory effects on specific subpopulations.

CHAPTER 2

LITERATURE SURVEY

2.1 Introduction

It is also clear that there is a growing literature on the incompatibility of regulatory standardization and the necessity of local flexibility in the formulation and implementation of micro-care models that are decentralized social care systems. With health and social care systems around the globe facing increasing demand, demographic changes and restricted financial capacity, scholars have shifted their interests to how systems of governance can strike a balance between standardized accountability and responsive and community-based delivery of services. The present literature review presents the main debates, theoretical viewpoints, and empirical evidence that underpin the comparative analysis of regulation versus flexibility of the decentralized care systems. It places the micro-care models, small-scale, locally-embedded service units, as a key innovative provision in overcoming the problem of fragmentation, enhancing responsiveness, and the patient-centered outcomes, and discusses the regulatory mechanisms that determine their scalability and sustainability. One of the major themes of the literature is the development of integrated care systems in response to the fragmentation in health and social care provision. In Germany, Groene and Hildebrandt (2025) report the evolution of the Healthy Kinzigtal model, which has focused on how population-based integrated care might be used to obtain better health outcomes and cost efficiency by using coordinated governance and shared accountability frameworks. Their practice shows that a regulatory framework offers the necessary control and coordination among stakeholders, but is too rigid and inflexible to allow local innovation and responsiveness of care providers to local needs. The case of the Kinzigtal shows how micro-care initiatives can be successful in a larger system architecture through the hybrid governance structures of contractual regulation combined with operational flexibility.

In the same vein, the idea of a hospital at home, discussed by Ekholm and Rorsman (2024) in Sweden, highlights the increasing significance of decentralized and flexible care delivery concepts. This model of micro-care provision by shifting care provision to homes of patients will be an example of how micro-care models can be used to increase accessibility, minimise system burden, and patient satisfaction. Nevertheless,

the authors also emphasize the regulatory issues connected with such models, such as the problems with quality assurance, professional accountability, and reimbursement arrangements. Their results imply that the flexibility of service delivery can be achieved only when regulatory frameworks are reconfigured to allow non-traditional care environments without safety and equity compromises. The controversy of regulation-flexibility is also complicated by the trade-offs between equity and efficiency. Cadham and Prosser (2023) offer a methodological summary of how policy makers consider such trade-offs, with decisions about resource allocation and service design often entailing implicit value judgments. Such decentralized systems, in which regional actors have a higher level of independence, present the risk that flexibility can result in uneven service delivery and widen regional inequalities. On the other hand, very centralized regulatory regimes can enhance equity by standardization at the expense of efficiency and innovation. This tension especially applies to micro-care models, which are based on contextual adaptation but have to work under the wider policy factors that are supposed to provide fairness and be universal. Other challenges that are critical in the literature are the sustainability and resiliency of the health systems. Gocke et al. (2023) note that resilience systems are systems that can adjust to shocks without losing essential functions, and they determine decentralized governance and local empowerment as enabling factors of resilience systems. According to their analysis, the micro level of flexibility allows improving system-wide resilience through providing quick, context-specific responses to arising challenges. Nonetheless, they also warn against lack of coherent regulatory frameworks, which make decentralized systems potentially be unable in coordination, accountability and sustainability. This highlights the importance of moderation where regulation offers a stable basis and flexibility allows continuous innovation and responsiveness.

The discussion is further informed by the broader policy context of the universal health coverage (UHC). Ranabhat et al. (2023) follow the historical development of UHC and point to the challenges in the achievement of equitable, efficient, and sustainable health systems, which persist. They posit that micro-care models and other decentralized strategies can significantly contribute to the coverage expansion as well as the delivery of the service, especially in underserved regions. Nevertheless, the effectiveness of these strategies is limited to the congruence of the regulatory policies and the local implementation capabilities. In this respect, the authors point to the significance of

adaptive governance tools which can be used to allow diversity without jeopardizing overall policy objectives. Taken together, the literature demonstrates that the association between regulation and flexibility is not a two-polar opposition but rather a dynamic spectrum that should be handled with care. These tensions converge around micro-care models, which exemplify the possible advantages of localized and patient-centered care, as well as reveal the limitations of current regulatory frameworks. The comparative lens that the current study takes is aimed at building on these insights by exploring how various systems negotiate this balance, and what can be learned in order to design social care policies in the future. According to the literature, successful decentralized social care systems must entail a fine-tuning between regulatory control and operational flexibility. Regulation provides consistency, accountability, and equity, whereas flexibility facilitates innovation, responsiveness, and contextual adaptation. The dilemma is how to devise governance frameworks that can balance these conflicting needs, especially when it comes to micro-care models that exist at the interface between formal systems and community based practices. The conceptual and empirical basis of this literature survey is to investigate this challenge further, and the empirical basis will establish the context in which a more profound comparative analysis of the operation of different systems to handle the interaction between regulation and flexibility in the contexts of decentralized social care may be conducted.

2.2 Related Research Studies

Groene and Hildebrandt (2025) researched the emergence and growth of integrated care in Germany, especially in the population-oriented integrated healthcare model called Healthy Kinzigtal. The article, which appeared in the Handbook of Integrated Care, follows the development of this model since its inception up to the scaling-up phase and how the system was developed to address a whole population of a region, as opposed to addressing individual patients. Healthy Kinzigtal is recognized by long-term, outcomes-oriented contracts of management company and statutory health insurers, which motivate preventive care and efficient utilization of resources. The authors outline the way the model incorporates primary care, specialist care, social care, and health promotion activities in a single structure of governance. One of its characteristics is the active enrolment of patients, who willingly join care coordination programs, which are oriented to their health requirements. The paper has shown that this method has resulted in quantifiable patient outcome measures such as management of chronic diseases, hospitalization, and patient satisfaction. Moreover, the model has been financially sustainable, and savings are made, which are shared by the management company and the insurers. The authors claim that population-based integrated care, appropriately designed and incentivized, could work as a model that could be replicated to reform health systems in other regions and countries, especially where there is an aging population and increased chronic disease burden.

Ekholm and Rorsman (2024) investigated the redesigning of Swedish healthcare by introducing Hospital at Home programs, and delivered their results in a master thesis to Chalmers University of Technology. The study examines how Sweden, where universal healthcare is an established tradition, is changing the models of its delivery to meet the growing demand, aging population and limited hospital capacity. The Hospital at Home model is an option to provide the patients who would have otherwise been taken to hospital with similar treatment at the comfort of their homes under the guidance of high end medical equipment and frequent visits of health practitioners. The authors examine organizational, technological and regulatory environments that facilitate the operation of such programs. They discover that the key to successful implementation is a strong digital infrastructure, well-defined clinical procedures, and the ability of hospital and community-based care teams to communicate. The research also focuses on the patient experiences, where majority of the participants give home-

based care as a choice due to the comforts and the reduced chances of visiting the hospital with infection being acquired at home. Regarding the system perspective, the authors claim that Hospital at Home models have the potential to lessen the burden on hospital beds, decrease costs, and enhance patient flow. They, however, also find that there are major challenges such as training of the workforce, equity of access to patients who do not have sufficient home environments and regulatory frameworks that formally acknowledge home-based acute care as a formal care setting in the Swedish healthcare system.

Cadham and Prosser (2023) (published in the Journal of the International Society for Pharmacoeconomics and Outcomes Research) is interested in approaches to eliciting trade-offs between equity and efficiency in the decision-making of health policies. The authors acknowledge that healthcare systems constantly face the dilemma between achieving maximum health benefits which is consistent with efficiency objectives and equity objectives, which require equal distribution of health resources among various groups of people. They review in a systematic mapping of the approaches by which researchers and policymakers have attempted to comprehend and quantify the ways in which people and communities value these competing values. The paper outlines various methods, such as discrete choice experiments, willingness-to-pay surveys, person trade-off methods, and deliberative processes, which have different methodological advantages and disadvantages. The authors bring out the fact that various approaches are prone to yield varying trade-off values, and significant questions arise concerning the most suitable approach to be used in informing the actual policy decisions. They also observe that wording of questions plays an important role in responses, indicating that methodological decisions are not unbiased. The review recommends increased transparency and standardization of equity-efficiency trade-offs measurement and reporting and highlights the need to include a wide range of stakeholders, such as patients and marginalized communities, in these measurements to make sure that the policy decisions are based on societal values and not just on technocratic and economic factors.

Gocke et al. (2023) discussed the major findings of the Partnership for Health System Sustainability and Resilience, which is a joint project by the World Economic Forum and LSE Consulting. The report, Building Sustainable and Resilient Health Systems, is a synthesis of evidence on the conditions required to make health systems stay working

amid the shocks of pandemics, climate change, and economic crises in various countries. The authors believe that sustainability and resilience cannot be merely financial stability but must include systemic investments in workforce capacity, digital infrastructure, supply chain resilience, and the quality of governance. The report lists the following critical success factors such as long-term political commitment, cross-sectoral collaboration, and integrating health security considerations into normal health system-planning. One key theme is that of the significance of learning systems that are capable of quickly adapting to new challenges based on real-time data and evidence. The authors also highlight the importance of primary care and community health services as the building blocks of resilient systems, and that countries with robust primary care infrastructures were better off during the COVID-19 pandemic. The report recommends more finance in prevention, health promotion, and social determinants of health, as they believe that upstream interventions would be the key to mitigating the demand pressures in the long-term that the system is undergoing, which is threatening its sustainability. It ends with some practical suggestions to policy-makers, health system administrators, and other international partners.

Ranabhat et al. (2023) have published a conceptual and historical policy review in *Frontiers in Public Health* which examines the development, prevailing trends, and future issues of Universal Health Coverage. The authors can be linked to the origins of UHC to the early social health insurance systems in Europe in the late nineteenth century up to the recognition of UHC as a global health goal in the Sustainable Development Goals. They note the conceptualization of UHC changing over time to become less limited in terms of financial safety and more comprehensive in considering quality of care, equity of access and the social determinants of health. The review looks at the different strategies that different nations have resorted to in order to attain UHC that are either single-payer national health service models or multi-payer insurance systems with government subsidies to low-income groups. The authors examine the current dilemma of fiscal sustainability and the growth of benefit packages and observe that most low- and middle-income countries cannot afford UHC as it is widely deployed because of their weak tax systems and a high informal employment level. They also address the issue of equitable access especially in rural and remote locations where health facilities are yet to be upgraded. Moving ahead, the authors also see digitalization, pandemic preparedness, and climate-related health risks as key emerging

issues UHC frameworks must focus on, which require adaptive governing mechanisms that will be able to adequately react to the ever-shifting global health conditions.

Santinha et al. (2023) suggested a theoretical framework of designing health strategies at the local government level. The authors believe that national health policies tend to be inadequately sensitive to the particular needs, resources and capacities of local communities, thus leading to strategies which are ill-adapted to the social, economic, and geographic realities that define population health at the sub-national level. Their paradigm incorporates the idea of public health, urban planning, and governance theory to offer a systematic method to local governments in their quest to come up with evidence-based health strategies. The framework consists of key elements such as population health needs assessment, stakeholder engagement, intersectoral collaboration and alignment of local health objectives to national and international health goals. The authors underline that local health strategies need high-level coordination in various sectors such as education, housing, transportation, and social services as the identified spheres affect the health outcomes greatly. Another key aspect of the framework is the focus on participatory processes that engage communities in defining health priorities and co-designing solutions to them. Based on the case studies of Portugal and other European states, the authors show how the framework can be practically implemented to show that even with limited resources and powers, local governments can do something significant in order to enhance population health.

Bossert et al. (2022) investigate the possibility of decentralization enhancing health system equity and whether these benefits can be maintained in the long run. The authors use comparative evidence of Latin American countries to evaluations of how the transfer of power, resources, and responsibilities by central governments to the subnational levels impact health equity outcomes. Their discussion identifies various forms of decentralization that exist such as fiscal, administrative and political forms and how each of them relates to local governance capacity to determine equity-related outcomes. The research concludes that the benefits of decentralization in enhancing equity are real in cases where the subnational governments are technically and administratively able to effectively control health resources, and to differentiate between the needs of the local population. The authors however state that decentralization can widen inequities in a number of situations including the absence of fiscal transfers, the presence of a wide gap in local governance capacities and where

the central governments lack the ability to uphold effective oversight and accountability structures. They further express doubts about the sustainability of equity gains realised under decentralisation over the long-run, which they observe to be erosive with respect to political change, economic shocks and institutional vulnerability. The authors conclude that decentralization is neither necessarily fair nor unfair, but again the outcomes are conditional on how the decentralization process is designed and the enabling environment more generally, such as the strength of the civil society and democratic institutions.

Bruzzi et al. (2022) examined how much regional performance differences within the Italian National Health Service are reducing over time. The NHS in Italy is typified by a wide regional difference in health system performance, where traditionally better results have been achieved in the north of the country than in the south, a disparity that has long been the point of worry among policymakers and equity advocates. The authors create a composite index of regional health system performance, which includes several dimensions such as access to care, quality of services, patient outcomes, and system efficiency. Through this index, they examine the trends in the regional performance over a number of years trying to establish whether convergence or divergence has been taking place. Their results are a mixed story: some indicators indicate small convergence, but others indicate that differences are intractably stubborn, or even are increasing in some areas. The paper enumerates various reasons that have led to the persistent regional inequalities, among them being the variation in economic growth, fiscal capacity, political governance and historical legacy of infrastructural investment. Another aspect that the authors explore is whether national government policies have been able to mitigate or worsen regional inequalities with the results indicating that the equalization mechanisms in the public finance system have not been entirely effective in lending full compensation to the structural disadvantages of poorer regions. They demand more specific national policies to help regions that are not performing to build capacity of health systems and enhancing the health outcomes of the population.

Dougherty et al. (2022) in the *European Journal of Health Economics*, proposed the connection between fiscal decentralization and the performance of the health care system, asserting the underlying non-linearity of this connection. The paper utilizes cross-national evidence of OECD countries to analyze the impact of different levels of

fiscal decentralization on the most important health system performance outcomes, such as health outcomes, efficiency, and access equity. The authors break the standard line of thinking in policy discussion that more decentralization is either consistently better or worse in terms of health system performance, instead discovering that the results of performance are heavily determined by the extent to which decentralization already exists. Their findings indicate the inverted U-shaped correlation, such that moderate decentralization is linked with superior performance outputs as compared to highly centralized or highly decentralized models. This result suggests that health systems can have the most appropriate level of decentralization and that countries that go too far to the right or left will have a risk of performance decline. The analysis also finds some significant moderating variables, such as the quality of sub-national governance, the extent of fiscal equalization among regions, and the robustness of national regulatory structures. The authors contend that decentralization must be effective both in terms of the delegation of authority and resources and in terms of the concomitant building of local governance capacity and accountability systems to make sure that decentralized decision-making is reflected in better health system performance in all regions.

Erekoreka and Hernando-Pérez (2022) tested the hypothesis of whether decentralization was a handicap in the response to the COVID-19 pandemic in Spain, studying what the regional governments did and how they interacted with the central government in the health crisis. Published in *Public Administration and Development*, the article discusses institutional setups of the highly decentralized healthcare system in Spain, which places the main responsibility of health policy and service delivery in the hands of the autonomous communities. The authors record the issues that occurred due to this fragmented form of governance in the course of the pandemic, such as the inability to coordinate the actions of public health and organizations in different regions, unequal enforcement of restrictions, and the conflicts between the regional and central authorities regarding decision-making powers. They discover that the decentralized organization led to a variation in the timing and stringency of containment measures, which could have had different impacts on epidemic patterns across regions. The authors however also observe that in certain instances, the decentralization produced beneficial outcomes as those regions with great institutional capacity and political leadership could respond more quickly to the innovative responses than a

centralized system could have provided. The research concludes that decentralization and pandemic response are context-specific and multifaceted, stating that the most important factor that influenced the effectiveness was not the level of decentralization but the quality of the intergovernmental coordination system and the clarity of roles and responsibilities of various government types in emergency events.

Heise et al. (2022) introduce the CAT HPPR, a critical appraisal instrument designed with the specific purpose of evaluating the quality of methodology of systematic, rapid, and scoping reviews on interventions in health promotion and prevention and published in BMC Medical Research Methodology. The idea behind the creation of this tool was the understanding that the current tools of critical appraisal are useful in the evaluation of primary research studies but are not quite suitable when it comes to the analysis of the quality of various forms of evidence synthesis. The authors contend that health promotion and prevention studies possess a unique set of features, such as complexity of multi-component interventions, relevance of contextual variables, and the difficulty of randomization in community-based studies, necessitating specific appraisal criteria. The development of the CAT HPPR was carried out in a systematic manner based on literature review, consultation with experts and testing with sample review repetitions. The last tool is a list of criteria that include issues of clarity of research questions, exhaustiveness of literature searches, clarity of research selection and data extraction procedures, and sufficiency of synthesis procedures. The authors show how the tool can be utilized using worked examples, so as to give advice on how the scores should be interpreted and how an overall assessment of the quality of a review should be made. They believe that the CAT HPPR closes a significant methodological gap and will be useful to researchers, policymakers, and systematic reviewers to more rigorously assess the evidence base of health promotion and prevention interventions, which will allow them to make more informed decisions regarding how to implement the program and allocate resources.

Miller et al. (2021) pondered over a decade of development and difficulties in integrated health and social care in England and published their article. The authors recap the policy environment as key reforms have been undertaken to make health and social care services more integrated, such as the creation of Health and Wellbeing Boards, Better Care Fund schemes, and Sustainability and Transformation Partnerships. Their evaluation reveals that there have been major advancements across the decade,

such as increased recognition of the necessity of integration among policy-makers, practitioners, and the community, and the creation of a number of local integrated care programs that have shown positive changes in patient experience and coordination of care. Nevertheless, the authors also emphasise some unresolved issues such as structural obstacles between health and social care systems, and financial strains that have limited the integration process, and the ongoing disparity in the quality and scope of integration between the various regions of England. They observe that the aspect of workforce in integration has been underemphasized and there has been lack of investment in training, remuneration and career progression of employees operating within boundaries of health and social care. Another issue brought out by the authors is the question of equity based on the fact that not every integration initiative has been able to reach people most in need. Moving forward, they demand a more systemic and long-term strategy to integration, supported by stable financing, explicit responsibilities, and a commitment to the notion of co-production with service users and communities.

Sigueza and Artabe (2022) examined health preferences of people as a support or validation of the decentralization of the public health sector in Spain, and their results were published in Health Policy. The research relies on survey data to examine the relationship between preferences on various characteristics of healthcare such as access, quality, and the geographic dispersion of services and attitudes towards the level of autonomy that the regional governments in Spain have over their healthcare systems. The authors use the methodology of discrete choice experiment to elicit and quantify the values that different people associate with the different health service attributes so that they can determine whether the preferences are more centralized or decentralized in a centralized or a decentralized model of health governance. According to their findings, there is a more complex image: most of the respondents appreciate the responsiveness and local accountability that the decentralization may provide, yet they also demonstrate apprehension of the inter-regional disparities in quality and access of health services, which may be partially due to the decentralized organization. The analysis concludes that preferences also differ greatly among the socioeconomic groups and between the residents of various regions, as people in less well-resourced regions were more likely to be skeptical of decentralization, experiencing poorer quality services. The authors conclude by stating that the legitimacy of health system

decentralization in Spain cannot be presupposed merely due to the formal democratic provisions but demands continuous consideration to minimize the level of regional inequalities and guarantee the provision of all citizens with a similar level of care irrespective of their location.

Sun and Andrews (2022) explored the connection between intra-provincial fiscal decentralization and relative wealth with healthcare efficiency in China, and the authors presented their empirical results in *Public Administration*. The research concentrates on the within-province aspect of fiscal decentralization, which has not been widely studied compared to the more studied central-to-provincial transfers. The authors use panel data of Chinese provinces to assess the impact of the allocation of fiscal resources between provincial and sub-provincial governments along with differences in relative economic wealth on the efficiency of converting healthcare resources to health outcome. They use data envelope analysis to quantify healthcare efficiency and use econometric methods to estimate the impacts of decentralization once a variety of other variables have been adjusted. The findings of their study show that the effect of intra-provincial fiscal decentralization on healthcare efficiency is mediated by local government wealth, with wealthier localities more likely to achieve the benefits of decentralization because of their high-quality administrative capacity and stronger local tax bases. Conversely, less developed areas are more likely to suffer efficiency losses when they are more fully decentralized, implying that policies of decentralization may increase inequalities between the rich and the poor regions within a province. The authors suggest that such findings can significantly impact the continuing fiscal agenda of reform in China, and may require more differentiated strategies to decentralization that consider local economic and governance contexts.

Xu and Lin (2022) examined the connections between fiscal decentralization, government spending on health, and the health outcomes of the population in China and presented their empirical study in *Frontiers in Public Health*. The rationale behind the study is that the highly decentralized fiscal system of China puts the local government at the forefront of health financing, although local governments differ immensely in terms of their fiscal capability and health expenditure priorities. The authors use provincial panel data to test the hypotheses regarding the mechanisms of how fiscal decentralization relates to population health, particularly focusing on the mediating variable of public health expenditure. Their results, based on structural

equation modeling and mediation analysis, indicate that fiscal decentralization directly and indirectly affects health outcomes, and that the indirect route is facilitated by its impact on the amount and the type of public health spending. Their findings indicate that there is an increase in overall public health spending in most provinces with decentralization, although the growth is not evenly spread, with poorer provinces generally spending less on public health than they should. The research also concludes that the efficiency of local government administration also varies dramatically with the efficiency of health spending in terms of its effectiveness in improving outcomes. The authors conclude that fiscal decentralization is capable of assisting the public health in China, however, the advantages depend on sufficient fiscal equalization transfers, effective central government directives on health expenditure priorities, and further investment into local government administrative capacity.

Rótulo et al. (2022) used panel data analysis to study the impact of fiscal decentralization of health sector on availability, accessibility, and utilization of healthcare services which were published in the International Journal of Health Planning and Management. The research is contextualized in the important policy question of whether a shift of fiscal responsibility on to subnational governments enhances or deteriorates the circumstances in which populations access and utilize healthcare services. Based on information of several countries, the authors create measures of health service availability, the physical provision of facilities and staff, accessibility, the existence of financial and geographic barriers to care, and utilization, the actual utilization of services by the population. They use a panel regression analysis to find that the effects of decentralization on these three dimensions are heterogeneous. Although fiscal decentralization is linked to gains in some measures of availability, especially in high-quality subnational governance, its impact on accessibility is less clear, and in some cases, decentralization is found to worsen the financial barriers to care in low-income areas. The utilization data analysis also presents mixed findings whereby decentralization will result in the rise of service use in some settings and under-utilization in others because of the unequal distribution of resources. The authors underscore the significance of complementary central government policies, such as equalization transfers and national minimum standards, in the need to make sure that fiscal decentralization is a promotion and not a hindrance to equitable access to healthcare services.

Ardielli (2021) reviewed the role of eHealth tools in the practice of primary care physicians in the Czech Republic and evaluated the integration of digital technologies into the practice of primary care, the results of which were published in the Science Papers of the University of Pardubice. The research paper explores the level to which Czech primary care physicians are implementing different eHealth solutions, such as electronic health records, telemedicine systems, electronic appointment-booking systems, and electronic communication tools to manage patients. The author surveys primary care physicians in various areas in the Czech Republic to determine what is the current level of eHealth adoption and what factors contribute towards or hinder adoption. The results indicate that there is significant regional and practice setting disparity in eHealth adoption with physicians in urban locations and larger practice settings more likely to be digital in their use. Some of the main obstacles to more widespread implementation, identified in the study, include the issue of data privacy and cybersecurity, a lack of digital literacy among physicians and patients, the lack of interoperability between various eHealth systems, and the lack of reimbursement incentives in digital consultations. Enabling conditions of widespread adoption are also emphasized by the author, which are the strong national eHealth infrastructure and standardized data frameworks. The analysis concludes that the Czech Republic has achieved a lot in terms of eHealth policy development and infrastructure but there are still critical gaps between the policy ambition and the reality of practice-level implementation with meaningful implications on the quality, efficiency, and sustainability of primary care services.

Bosa et al. (2021) studied how the COVID-19 pandemic was responded to in Italy, asking whether the highly decentralized nature of the country as a whole, particularly its regional health systems, contributed to disjointed and uneven responses to the pandemic. Italy has been among the initial nations to be hit hard by COVID-19, and its experience has shown the strengths and weaknesses of its regionalized health system. The authors provide a comparative study of responses of Italian regions to the pandemic in the first and second waves and discuss the differences in containment policies, the management of surge capacity in hospitals, communication with the population, and cooperation with national government agencies. They analyze a significant degree of variation among regions, with the most severely impacted northern regions, including Lombardy, experiencing acute capacity crises in the early days of the pandemic, and

those with better primary care systems and more active and responsive public health systems being more successful at dealing with the crisis. The paper records examples of what the authors refer to as corona-regionalism, in which the competitive and occasionally antagonistic relationships between regions and between regional and national governments, made the pandemic response more complex. Nevertheless, they observe instances of successful intergovernmental cooperation and regional development as well. According to the authors, the COVID-19 experience has shown that the national and regional levels of health emergency management require a more precise demarcation of roles, more robust national coordination structures, and its imminent need to invest in regional health system preparedness and resilience.

Capano and Lippi (2021) examine how decentralization and policy capabilities contributed to regional responses to the COVID-19 outbreak in Italy and discuss their results in the *Journal of European Public Policy*. The article centers on the analysis of three Italian regions, Lombardy, Veneto, and Emilia-Romagna, which had very different responses to the pandemic in the first place, though all of the regions were acting within the same national constitutional and legal system. The authors elaborate a theoretical framework which synthesizes findings of literature of multi-level governance with the concept of policy capacity, which is the technical, managerial and political competencies with which governments should formulate and execute effective policies. Comparative analysis of them indicates that the difference in the responses of the regions was mainly brought about by the difference in the capacity of regional policies and not by formal institutional arrangements. The more traditionally-endowed public health investment and the more coherent regional health systems in Veneto and Emilia-Romagna enabled them to organize more effective and coordinated responses than Lombardy, despite the supposed administrative sophistication and prosperity of the latter as the richest region in Italy. The paper concludes that prior investments in public health infrastructure, epidemiological surveillance, and community-based care played a crucial role in the effectiveness of response. The authors determine that decentralization can assist more responsive and context sensitive policy responses to health crises where the subnational governments possess real policy capacity, but that formal autonomy without substantive capacity is inadequate to manage crises effectively.

Landi et al. (2021) examined how regional health systems contribute to the development of disparities in waiting times of healthcare services in Italy, which they reported in the article *Health Services Management Research*. Waiting times are a very important aspect of healthcare access and quality and waiting time variability within and among regions has long been a challenge in the Italian NHS. The authors suggest that the inequalities in waiting times are not a technical issue of capacity management, but a set of structural and governance characteristics of the health systems of the regions. They examine administrative data of Italian regions to record the magnitude of waiting time fluctuation among various services and geographic regions and employ multivariate regression techniques to recognize the most significantly related regional health system attributes with waiting time performance. Their results support the view that there are large differences in waiting times between regions of Italy and that these differences are related to a wider range of measures of regional health system performance and quality of governance. Areas that have health systems that are managed better; have more effective leadership, resource allocation processes, and use more performance management tools are more likely to record shorter and fairer waiting times. The paper also concludes that the association between the wealth of the region and the waiting time is mediated by the quality of the governance indicating that the manner in which the resources are being managed is of importance as much as the availability itself. The authors urge national policies to enable weaker regions to build the governance capacity required to decrease the disparities in waiting time and enhance equitable access to care.

Migchelbrink and Van de Walle (2021) presented a systematic review of the literature on factors related to the attitude of the public managers towards public participation, which appeared in *Local Government Studies*. The research is placed in the larger framework of the discussions concerning the principles of democratic governance and the importance of the participation of citizens in the process of forming decisions. The authors acknowledge that the gatekeeping role of public managers is vital in participation processes: their readiness to actively involve citizens and to include the input of ordinary people in decision making is a key factor as to whether formal processes of participation can lead to effective impact on the people. The review is a synthesis of the results of a rich empirical literature to determine the individual, organizational, and contextual factors that influence the orientations of public managers

toward participation. On the individual level, the review concludes that the personal values, professional identities, and previous experiences of participation among managers have a great impact on their attitudes. There are also organizational factors such as the culture and norms of the institution where the participation activities are undertaken, the availability of resources to undertake the participation activities and the attitudes of the senior leadership that are also important. On the contextual level, the review points out the features of the wider political and administrative context such as the intensity of democratic traditions and the dynamics of relations between governments and civil society organizations as some of the factors that impact the participatory orientations of managers. The authors conclude with a request to have increasingly more integrated theoretical frameworks that can explain the multi-level determinants of participation attitudes and more research on how such attitudes can be changed to establish more inclusive and effective public governance.

Patel (2021) elucidated the conceptual differences between efficacy, effectiveness, and efficiency in health research and practice, in the National Journal of Community Medicine. The three concepts are commonly applied in health policy, clinical research and in public health evaluation; however, the terms are commonly mixed up or applied inaccurately causing confusion during the interpretation and application of research evidence. The author concludes that clear knowledge of such differences is necessary in order to design rigorous studies, interpret research finding, and make effective decisions regarding health interventions. Efficacy is the performance of an intervention under optimal controlled conditions and is usually measured by randomized controlled trials where the extraneous variables are kept to a minimum. Effectiveness on the other hand is the extent to which an intervention performs in a real world setting where the patient populations tend to be more diverse, adherence might be reduced and the context is more dynamic. Efficiency brings in the aspect of resources utilization and whether the health benefits obtained through an intervention are obtained at a reasonable cost or optimal utilization of the available inputs. The paper also addresses the notion of implementation fidelity and how such a concept is associated with the transfer of efficacy to real-world effectiveness. The author emphasizes the need to use health technology assessment systems that take into account all three dimensions systematically in assessing new interventions to be incorporated in regular health systems, and recommends that the reporting standards in research articles be made more

transparent, so that readers can be able to properly describe the kind of evidence that is being reported.

Peters et al. (2021) improved the methodology and use of scoping reviews, which supports and clarifies best practices of such a valuable form of evidence synthesis. The use of scoping reviews has become increasingly popular in health and social sciences because of its flexibility in evidence mapping of general topics, uncovering gaps in research, and elucidating concepts. Their rigor of approach, however, has been undermined, where there have been allegations of discrepancies in the design, execution and reporting of scoping reviews. The authors, based on the JBI approach to scoping reviews and the PRISMA-ScR reporting extension, give a revised and detailed description of the principles and procedures, according to which scoping reviews should be conducted. They deal with important methodological choices, such as research questions, inclusion and exclusion criteria, search strategy, data charting and extraction, results synthesis and presentation. The article also explains the difference between scoping reviews and other forms of evidence synthesis (such as systematic reviews and narrative reviews) and that scoping reviews are not meant to estimate effect sizes or synthesize evidence on a quality basis but to map out the amount, scope, and quality of existing evidence. The authors offer information on the situations when a scoping review is the best methodological choice and the relevance of transparent reporting so that a reader could evaluate the quality and fullness of the evidence mapping process.

Schubert et al. (2021) reports the results of a decade of review of the population-based integrated health care system *Gesundes Kinzigtal* in Germany in *Deutsches Arzteblatt International*. *Gesundes Kinzigtal* is among the most thoroughly assessed models of integrated care in Europe and the ten-year assessment is a milestone in evaluating the sustainability and effectiveness of this new model in the long term. The assessment uses insurance claims data, surveys of patients and health records to evaluate outcomes on a broad spectrum of areas such as chronic disease management, preventive care uptake, hospitalization rates, quality of life, and healthcare costs. The results have shown that patients in *Gesundes Kinzigtal* had much better outcomes relative to a similar control group of patients who were covered by traditional insurance plans. Among the main accomplishments are better management of diabetes and cardiovascular disease, increased cancer screening, and decreased potentially preventable hospitalizations. The

financial sustainability of the system was also achieved, as savings obtained due to the more efficient and better-coordinated care were distributed between the management company and the insurers, which proves that the integration can be cost-effective in the long run. The authors recognize the drawbacks of the evaluation design and emphasize the aspects in which the evaluation design could be improved, such as coverage of more difficult-to-reach population groups. On the whole, the ten-year analysis highlights substantial evidence that population-based integrated care may bring a long-term health and economic value when a favorable governance and financing system is in place.

Segatto and Béland (2021) was focused on the role of subnational governments in the decision making process of the federal health policy in Brazil, which was published in Policy Studies. The Unified Health System of Brazil or SUS is one of the largest public health systems in the world and its constitutionally guaranteed right to access to care. It is very decentralized and municipalities and states have central roles in the delivery and financing of health services, with a federalist system that provides subnational governments with high levels of formal autonomy. The authors explore the exercise of influence by state and municipal governments on the federal health policy by both formal institutional means, such as intergovernmental commissions and National Health Council, and informal lobbying and political alliances. Through their analysis, they find that subnational governments are not just the implementers of federal policy but they are also active political actors that influence the national health agenda. Nevertheless, the paper also shows that there are also huge asymmetries in subnational power with the larger and richer states, especially with high political representation in the federal congress, having disproportionate influence on the decisions about resource distribution. According to the authors, such power inequalities lead to inequities in the distribution of federal health resources among regions and a violation of the constitutional promise of universal and equal access to care. They demand reforms to intergovernmental health governance, providing more voice to smaller and poorer states and municipalities and more effective distribution of federal resources to population health needs.

Assis (2020) examined the connection between decentralization and child health outcomes in Brazil and it was published in Estudos Economicos. The rationale behind the study has been the experience of Brazil under massive health system decentralization since the inception of SUS in the late 1980s, which gave a lot of

responsibilities in terms of health service delivery and funding to the municipal level. Although decentralization was meant to make services more accessible to communities and responsive to the needs of the community, its implications on health outcomes have been controversial, with some researchers indicating some improvement in maternal and child health and others noting the existence of persistent inequalities. The author relies on the municipal-level panel data in order to investigate the connection between the level of fiscal and administrative decentralization and the main child health outcomes such as infant and child mortality rates and vaccination rates taking into account socioeconomic and demographic factors. The empirical results conclude that higher municipal autonomy in health management is linked to child health outcomes, and this is more so in municipalities that have invested in primary care expansion and community health worker programmes. Nevertheless, the paper also concludes that these beneficial impacts depend on the fiscal capacity of a municipality, and poorer municipalities are less capable of converting autonomy to better performance without sufficient federal and state funding. The author contends that the experience in Brazil demonstrates the need to balance decentralization with strong equalization policies to make sure that the realization of health improvements occurs on a uniform countrywide basis as opposed to being localized to richer and better-resource endowed areas.

OECD (2020) released a list of reports on decentralization and regionalization choices in Portugal in its Multi-Level Governance Studies series. The unusual aspect of Portugal in relation to most European nations is that it is rather centralized in its territorial structure, where the mainland has no regional level of government as in similar nations. This has sparked debate on whether the forming of administrative regions would enhance efficiency and fairness in provision of public services including health services. The OECD report examines the prevailing governance arrangements in Portugal and evaluates some of the possible reform options with the spectrum of strengthening the existing regional coordination arrangements to the establishment of directly elected regional governments with strong autonomous powers. The analysis will discuss how regionalization could benefit health system performance by making it more responsive to needs of sub-national health, implementing better coordination between various levels of care, and becoming more accountable to local communities. Nevertheless, the report also points out risks and challenges, such as the transition costs of institutional reform, the threat of new regional inequalities unless fiscal equalization

is planned with care, and the issue of political fragmentation. The authors use comparative evidence on other European countries to determine the most appropriate governance arrangements that would promote effective and equitable health system performance in a Portuguese context. The report offers a sensitive evaluation which will not allow any easy formula, but rather highlights the fact that context sensitive design and cautious observation of conditions under which decentralization should be applied in order to bring about the desired outcomes.

Okin (2020) outlined and discussed the Trieste Model of community mental health care. The Trieste Model is one of the most powerful experiments in deinstitutionalization and community-based mental health care in the world, arising due to the efforts of Franco Basaglia and his colleagues in the city of Trieste in Italy in the 1970s and after. The model is grounded on the radical assumption that psychiatric hospitals are an evil and that individuals with severe mental conditions could and should be assisted to live full lives in their communities as opposed to institutionalization. The author describes the operation of the Trieste system in detail, including its network of community mental health centers, which are open 24 hours, its focus on social inclusion and citizenship rights of mentally ill people, and how it combines mental health support with housing, employment, and social welfare services. The chapter examines the theoretical underpinnings to the model based on Basaglia's critique of institutional psychiatry and his adherence to democratic psychiatry and human rights. The effectiveness of the Trieste approach is also discussed by the author who states that, although there were initial skepticism, the model has been linked to extremely low levels of involuntary treatment and hospitalization as well as high rates of community tenure and quality of life of service users. The chapter discusses the difficulties of applying the Trieste Model to other cultures and healthcare settings.

Ciencia e Saúde Coletiva, Pinafo et al. (2020) investigated management issues and approaches that small municipalities have faced in the health system in Brazil, with a specific emphasis on the vulnerability that defines these governance contexts. Most Brazilian municipalities are small, and have less than twenty thousand inhabitants, but have major formal responsibilities in the management of health services under the decentralized SUS system. The authors use qualitative research method with health managers and local officials in small municipalities to report the particular challenges that they encounter in the course of their health governance roles. Their results show a

multifaceted image of institutional weaknesses where there is high turnover of health managers based on electoral cycles, inadequate technical and administrative capacity, reliance on federal and state transfers, and challenges in recruitment and retention of qualified health professionals. These are further complicated by the fact that, due to the high complexity of the regulatory and accountability requirements that small municipalities have to fulfill, these were mostly intended to be applied to larger, more capable local governments. Nevertheless, the paper also records some significant strategies that cities have worked out in order to deal with their restrictions such as inter-municipal health consortia to jointly provide specialized services, collaboration with state health secretariats to provide technical assistance, and ingenious use of community health worker programs to reach out primary care. The authors suggest that the national health policy should be more specific in identifying and responding to the unique issues of small municipalities to make sure that decentralization is truly aimed towards achieving the purpose of universal health coverage.

Palacios et al. (2020) examined the connection between health need, inequality, and the utilization of healthcare services in the fragmented and decentralized health system in Argentina, publishing the results in the *International Journal of Equity in Health*. The health system of Argentina is exceptionally complicated, consisting of the public sector, social insurance sector, which is based on occupational health funds, called *obras sociales*, and the private insurance market, which has varying rules and offers varying coverage. This disintegration, as well as high levels of decentralization of the responsibilities of the public health to provincial governments, gives rise to a high degree of variation in the circumstances in which various population groups are able to access and make use of healthcare services. The authors use household survey data to understand whether health need and healthcare utilization are well matched across the various population groups and regions or whether socioeconomic status, insurance coverage and geographic location would be inequitably matched in terms of their patterns of use. They conclude that there is a considerable level of horizontal inequity in healthcare use, and individuals in higher socioeconomic status and those with either private or social insurance use services at a higher rate despite adjusting by health need. This inequity in favor of the rich is especially high regarding specialist and preventive care services. The paper also reports high interprovincial disparities in both health need and healthcare use, which indicates the decentralized nature of the system and the

difference in fiscal ability of the provincial governments. The authors conclude that to tackle these inequities, the national level reforms that will decrease the system fragmentation and the provincial policy that will increase access to disadvantaged groups will be necessary.

Sakellarides (2020) considered the problems of the National Health Service in Portugal and the changes that were necessary to make it viable in the future, and published his report in the *Acta Médica Portuguesa*. As one of the most influential people in the Portuguese health policy, the author bases his evaluation of the current state of the NHS on decades of experience and considers how the political, economic, and social developments have impacted the ability of the institution to meet the main mission of its creation to deliver universal, comprehensive, and equal healthcare to the Portuguese people. The analysis points to a number of structural issues, such as chronic underinvestment compared to other European countries, chronic workforce shortages, mainly in primary care and nursing, growing demand due to demographic aging and the rising chronic disease burden, and high geographic disparities in service provision. The author also looks at the effect of austerity measures used in the post-2010 fiscal crisis which resulted in massive reduction on health expenditure, staffing cuts and worsening of service availability and quality in most of the country. In the future, Sakellarides believes that the NHS cannot merely go back to the pre-austerity structure but it needs more radical change in order to be sustainable and fit to purpose in the decades to come. He demands systematic changes in such areas as the organization of care, people development, digital transformation, the integration of health and social care, through a new social contract that reiterates political and social obligation to universal healthcare as a right of Portuguese citizenship.

Santana et al. (2020) wrote about the creation of instruments to encourage health equity within the European Union regions with the help of the Euro-Healthy project, which were published in *Health Research Policy and Systems*. Euro-Healthy initiative united both researchers and policy makers across most of the EU member states to tackle the long-standing health disparities between and within European regions. The authors explain how a composite Population Health Index was created, which uses a wide spectrum of determinants of health, outcomes of health and contextual variables to present a multidimensional view of the level of population health in the EU regions. The purpose of this index was to transcend traditional indicators like life expectancy

and mortality rates in order to encompass the complex interplay of social, economic, environmental, and behavioral determinants of health, in different regional settings. The project also designed an online platform, which will provide regional health data to policymakers, researchers, and the general population, enabling evidence-based decision-making in the region. The authors outline the process of collaboration that the tools were created in, stating the significance of the stakeholder participation in the process of making sure that the measures are both relevant, valid, and useful to the policy. They speak about the use of the tools in some European areas and show how it can be used to help in the identification of priority areas in which health should improve and also monitor the progress over time. The paper ends by drawing conclusions about the lessons learnt in the Euro-Healthy project on the development and implementation of equity-based health assessment tools in various policy settings.

Manavgat and Demirci (2020) examined the connection between the healthcare decentralization and the efficiency of regional healthcare in Turkey, presenting their empirical study in *Sosyoekonomi*. The past 20 years have been characterized by major reforms in the health system in Turkey, such as the Health Transformation Program that started in the early 2000s, which implemented considerable reforms in the structure, funding, and provision of healthcare. The authors focus on the relationship between the extent of fiscal and administrative decentralization in the area of Turkish healthcare and the efficiency in healthcare delivery at various regions with the help of data envelopment analysis to create regional efficiency score, and regression methods to detect the factors corresponding to the difference in efficiency. They conclude that the correlation between decentralization and healthcare efficiency in Turkey is complicated, and the impact of decentralization is highly contingent upon the degree of regional economic development, and the quality of local health system governance. Greater decentralization in the relatively developed regions with greater administrative capacities is linked to greater efficiency whereas in less developed regions, decentralization has produced limited positive results and might have led to higher levels of inefficiency because of poor local management capacity. Another point of the study is the contribution of the national health information system and performance management framework to the efficiency improvements at a regional level, which implies that the efficient central oversight mechanisms can be regarded as a valuable addition to the process of decentralization. The authors end by offering suggestions on

how to further differentiate the approach to decentralization in Turkey by considering the heterogeneity in the governance capacity across regions.

Raus et al. (2020) analyzed the issues related to translation of the concept of integrated care as a promising idea into a successful health policy. The paper is driven by the fact that although integrated care has enjoyed a lot of enthusiasm among policymakers, researchers and health system leaders because of its ability to enhance the outcomes of patients with complex needs, the actual practice of the concept has often proved to be below expectations. The authors highlight and discuss the most significant issues that can be encountered during the development and implementation of integrated care policy, which are based on the theoretical knowledge of the implementation science, health policy analysis, and organizational theory. They say that integrated care is a complex intervention in itself and its performance cannot be reduced to purely technical design of care coordination mechanisms, but a set of contextual, relational, and governance aspects that are hard to standardize or control. The article attributes a fragmented flow of funding between health and social care as a specifically problematic obstacle, observing that financial incentives tend to act counter-integration, rewarding individual providers based on the quantity of their services as opposed to team-based and outcome-based care. Another workforce issue that the authors address is cultural differences between health and social care professionals, insufficient investment in interprofessional education, and the lack of appropriate workforce models in integrated care delivery. They find that the potential of integrated care cannot be fully achieved based on technical policy solutions, but essential shifts in the values, incentives and governance arrangements that affect the structure and operation of both health and social care systems.

Abimbola et al. (2019) carried out a realist synthesis of the evidence on the effects of decentralization on equity, efficiency, and resilience of the health system in a publication in *Health Policy and Planning*. The methodology of the study is the realist synthesis which helps to transcend the question of whether decentralization works to the more subtle questions of what works, who works, in which situations and how. The authors survey a substantial source of literature in different country contexts to determine the theories of change in which decentralization should result in improvements in equity, efficiency and resilience and evaluated the support of the theoretical propositions. Their synthesis concludes that the interaction between

decentralization and the performance of the health system is extremely context-specific, and the results of decentralization will depend on the nature and extent of decentralization, the capacity of subnational governments, the effectiveness of accountability and oversight systems and the overall political economy of the health system. The review shows mixed evidence on equity, where decentralization alleviates geographic disparities in access in some situations, but increases them in others. Regarding efficiency, there is some evidence that technical and allocative efficiency may be enhanced through decentralization with proper incentive systems and capacity building. On resilience, the synthesis concludes that decentralization can increase adaptive capacity through the facilitation of local innovation and learning, but can also generate fragility when it compromises coordination and sharing of resources to respond to shocks. The authors create a framework to comprehend in what circumstances decentralization is most likely to bring positive results to the health system.

Nunes and Ferreira (2019) studied the issues and reform options of the healthcare sector in Portugal and presented their results in the *International Journal of Health Planning and Management*. The authors offer an in-depth evaluation of the structural and performance issues that the Portuguese National Health Service faces, and place these issues into a wider context of the political economy of Portugal, and its experience of economic adjustment and austerity in the post-2010 era. They find that among the key areas of concern are chronic underfunding of the NHS compared with their European counterparts, the existence of large regional differences in the quality and availability of health services, the fact that there are chronic issues with access to primary care and are leading to overcrowding of hospital emergency departments, and that there is a workforce crisis, with shortages of key professional groups and levels of emigration of trained health professionals remain high. The authors also look at governance issues in the NHS such as ineffective accountability systems, broken management frameworks and inadequate utilization of performance data to promote quality. To address these issues, the article suggests a set of structural changes that would enhance primary care, enhance the collaboration among care levels, reform hospital governance, and create more viable governance and accountability systems. The authors suggest that Portugal should not only be able to restore the levels of service that the austerity took away but to undertake more radical forms of transformational

reforms that will allow the NHS to fulfill the health needs of a fast aging population in a financially sustainable and fair way.

Somanathan et al. (2019) assessed the strategies of enhancing integrated care in Central and Eastern Europe, which presented the analysis in the World Bank Group. The report will cover some of the specific problems of health systems in the CEE region, that inherited the fragmented and hospital-based models of service delivery of the Soviet period and are striving to restructure their systems since the early 1990s transitions. The authors say that the region has come a long way in reforming the mechanism of financing and primary care infrastructure expansion, yet that the objective of truly integrated person-centred care has not been achieved in most countries. The report discusses the obstacles to integrated care in the CEE setting such as the persistence of hospital-based care, poor primary care gatekeeping, failure to integrate health and social care systems, and lack of information infrastructure that can be utilized to coordinate care providers. The authors rely on the case studies of the various CEE countries to determine potential avenues of integration such as disease management programmes on chronic diseases, multidisciplinary teams based in the communities, and joint planning between the health and social care authorities. They also point out the need to adjust international best practices to the local institutional and cultural settings instead of merely importing Western European models. The report ends by offering a number of practical recommendations to policymakers, health system managers and international partners who want to aid the development of integrated care in the CEE region, and with specific focus to the sequencing and prioritization of reform steps.

Colmorten et al. (2019) outlined and discussed the method of delivering integrated health and social care to older individuals in Denmark. It is commonly believed that Denmark is an international pioneer on the delivery of integrated care to older people and this has been achieved through the decades of investment it made in community-based services, home care, and preventive interventions. These organizational and governance structures that the authors explain underlie the integrated care system in Denmark, with municipalities playing the key role of the main provider and coordinator of health and social care services to older individuals outside hospital care. One of the unique aspects of the Danish model is the belief in the ability of older individuals to stay in their own homes as long as possible, with a complete package of home care,

rehabilitation, assistive technology, and community nursing care. The chapter reviews the arguments in favor of the effectiveness of this model, stating that in Denmark the results of older people regarding quality of life, functional independence and institutionalization avoidance are relatively good in comparison with the situation in other European nations. The authors also address the issues that the Danish model is facing such as demographic pressure due to an ageing and rapidly ageing population, labour shortages in the care professions and the necessity to adjust services to meet the needs and expectations of new generations of older adults. They emphasize the role of political commitment and sufficient funding by the population as enabling factors of maintenance and developing integrated care of older people.

Novi et al. (2019) examined the impact of fiscal decentralization on regional inequalities in health in Italy in a study using quasi-experimental design to determine causal estimates and the results published in *Regional Science and Urban Economics*. The experience of fiscal federalism in Italy and the gradual delegation of health financing duties to the regions since the 1990s offers an ideal natural experiment to analyze causal impacts of decentralization on health equity. The authors take advantage of the difference in the timing and level of fiscal decentralization reforms among the regions in Italy to determine the causal effect of increased regional fiscal autonomy on health outcome disparities. Their quasi-experimental analysis concludes that fiscal decentralization has produced different impacts on health inequalities across regions, and the net effect on this is determined by the level of fiscal equalization that is sustained by national transfer programs. In other areas with the national equalization transfers kept at a sufficient level, decentralization was linked to a small decrease in health disparities, with regional governments taking advantage of their increased autonomy to adjust health investments to local demands. Nevertheless, during the times when equalization processes had been diminished, the process of decentralization was linked with the increased health inequalities, since financially more powerful regions would be more capable of exploiting their independence than less wealthy ones. The research contributes significantly to the methodology of examining complex governance issues by showing how quasi-experimental designs can be useful in investigating complex governance topics, and the research findings have substantive implications, adding to the evidence base on the circumstances in which fiscal decentralization may or may not advance or hamper the goal of health equity.

Rudowitz et al. (2019) introduced a detailed summary of ten major facts about Medicaid, a public health insurance program in the United States that covers low-income people and families, which was published by the Kaiser Family Foundation. The report tackles the prevalent myths about the Medicaid program and offers an easy to understand evidence-based description of the program structure, scope and importance in the American health system. The United States has the largest number of people covered by Medicaid, which insures more than seventy million citizens, such as those with low income, children, pregnant women, the elderly, and those with disabilities. The authors describe the federal-state financing format of the program according to which states get federal matching funds to pay part of the program costs, and the federal match rate varies inversely to state income. This structure provides states with considerable flexibility in how they structure their Medicaid programs within federal minimum requirements, allowing large disparities in state eligibility, benefits and provider payment rates. The report explores the population covered by Medicaid and the fact that the population is disproportionate to those with complex health needs such as people with disabilities and the elderly who need long-term care. It also discusses the role of the program in funding safety-net hospitals and community health centers, fiscal importance of the program to state budgets, and current policy discussions regarding expansion of the program, work conditions, and funding reforms. The authors point out that Medicaid has an incomparable part in the American health care system and that any suggested funding reductions would have far-reaching impacts on health care access and outcomes among vulnerable groups.

Athanasiadis, A., Ratsika, N., Trompoukis, C., & Philalithis, A. (2018) Athanasiadis et al. explored the health decentralization process in Greece through the lens of the opinions of individuals operating in the system. They conducted a study published in the *International Journal of Health Governance* and investigated the perceptions of insiders (administrators, policymakers, and healthcare professionals) about the continuing decentralization reforms. The results showed that there was a huge disparity between rhetoric and practice in politics. Although decentralization was encouraged as a system of enhancing efficiency and responsiveness of the local areas, insiders complained of ongoing difficulties such as poor allocation of resources, untrained staff in the regional levels, and political interference in administration. The paper pointed out that decentralization in Greece was usually necessitated by external forces,

including European Union demands and fiscal austerity controls, as opposed to an actual desire to enhance local health governance. Respondents also reported that financial constraints had a crippling effect on the ability of regional authorities to have any meaningful autonomy. The paper concluded that decentralization can only succeed when there is structural reform and there is also a long term investment in human capital, institutional capacity and transparent accountability mechanisms. The qualitative method that was used, which was an insider-based approach, provided a good insight into the gap between the design of policies and their actual implementation in health decentralization in a Southern European setting.

Brown, C. L., & Menec, V. (2018) Brown and Menec performed a scoping review that included an overview of the research done on integrated care strategies employed during hospital-community care transitions. The study has been published in the Canadian Journal on Aging and systematically reviewed literature available to identify and assess the most effective strategies to help in facilitating a smooth patient transition, especially among older adults. The review concluded that effective transitions were defined by well-coordinated care planning, effective communication between hospital and community-based providers and active involvement of patients and their families during the process. A number of models were found to be particularly promising, such as discharge planning programs, case management approaches, and patient navigation systems. The authors reported that one of the most frequently mentioned obstacles to successful transitions was fragmented communication between hospital teams and community providers. Also, social determinants like housing stability, access to transport, and availability of caregivers had a significant effect on outcomes of transitions. The review has highlighted the significance of adapting transition programs to the unique needs of older populations which disproportionately suffer due to poor transitions. Brown and Menec proposed greater system-level policies to facilitate integrated care and suggested that future studies should aim at measuring long-term health outcomes and cost-efficiency of different transition models. Their work provides valuable evidence to the accumulating literature on integrated and person-centred care.

Costa-Font, J. and Turati, G. Costa-Font and Turati (2018) examined the question of whether equal spending and equal citizen satisfaction are the results of regional healthcare decentralization in unitary states. Their article, published in Regional Studies, based on comparative data in a number of European countries studied the

relationship between fiscal decentralization and healthcare outcomes on a regional level. The authors discovered that decentralization can lead to responsiveness and local decision-making, but it does not necessarily lead to equitable allocation of health resources or similar levels of satisfaction in different regions. There were also large differences in per-capita expenditure by region within the same country, which would be of concern to horizontal equity. The richer regions that had better fiscal foundations were more likely to invest more in healthcare and poorer regions could not afford to maintain the level of services. The study however also mentioned that the level of satisfaction with healthcare services did not necessarily correlate with the level of spending meaning that the quality of governance and efficiency with which resources are utilised are also key determinants of satisfaction. The authors believed that redistributive role of central governments should not be eliminated even in decentralized systems in order to avoid the intensification of territorial inequalities. Their results have significant policy implications to countries that are planning or are already entacting decentralization reforms, especially in so doing in a manner that gives equity-oriented financial mechanisms.

Gallego, R., Barbieri, N., Brosa, C., Gonzalez, S., and Ferrer, M. (2018) examined the limitations of political autonomy in decentralized Spain with a specific emphasis on how territorial funding and ideology of the government influence the process of making health policy at the regional level. The study on the influence of the intricate Spanish fiscal system and partisan politics on the policy decisions of regional governments was published in *Revista de Estudios Politicos*. The results showed that, even though decentralization model in Spain gives regions considerable autonomy in terms of health policy formulation, the practical autonomy is largely limited by the central financing regulations and fiscal equalization policies. It was observed that regions with less per-capita transfers had less ability to increase services or healthcare delivery innovation. Moreover, the analysis showed that the level of financial assistance and policy freedom that a region had was dependent on ideological congruence between regional and central governments. Regional governments that were lean left and opposed the national government were more subject to fiscal pressure and to reduce health expenditures. The authors concluded that political independence in health policy in decentralized systems is both a consequence of intergovernmental political processes as it is a consequence of formal constitutional provisions. This subtle study helps to

comprehend the political economy of decentralization and emphasizes the necessity of politically neutral financing formulae.

Alma-Ata Declaration (2018) The study, published in the *Revista Panamericana de Salud Pública*, described the development and maintenance of a strong primary health care system in Curitiba over a period of several decades using the concepts of community involvement, intersectoral working, and equity-based service provision as described at Alma-Ata. The authors observed that the approach in Curitiba was unique because it focused on the incorporation of the health services with the urban planning, housing and social development, which led to a tremendous change in the outcome of population health. The study established some of the key success factors such as good municipal leadership, commitment of various administrations in politics, and commitment to the community health workers as the foundation of service delivery. Although improvements were achieved, there were still issues, especially in meeting the health care needs of the most marginalized urban residents and adequate funding of primary care due to the presence of conflicting fiscal priorities. Massuda et al. believed that the experience of Curitiba could be of significant lesson to other middle-income cities that aim to enhance primary health care as a health coverage pillar, particularly in situations where there is a pronounced social inequality.

Pearson, C., and Watson, N. (2018) Pearson and Watson considered the process of health and social care integration in Scotland, with an emphasis on renegotiating partnership and the evolution of cultures of care. In *Health and Social Care in the Community*, the study examined the effect of the 2014 Public Bodies (Joint Working) (Scotland) Act on relationships between health boards and local authorities in the provision of integrated services. The authors employed a qualitative approach to get the views of managers, practitioners, and service users who have been through the process of integrating care. The results showed that although integration had a significant potential to change the outcomes, especially among older individuals with complex needs, it also created a lot of organizational tensions. Health and social care professionals tended to have divergent values, cultures of work and professional identities that made it difficult to collaborate. Problems of resources distribution, responsibility, and professionalism were also noted as the areas of conflict during the initial phases of integration. The research also revealed that service users and carers appreciated a holistic and coordinated approach to care but were concerned with

continuity of relationships with familiar providers. Pearson and Watson came to the conclusion that cultural change and long term leadership commitment were equally significant to the attainment of the objectives of integration as structural reforms, with the implementation of policies and focus on the relational and human aspects of care.

Pereira, A., Lima, L., and Machado, C. (2018) presented a historical-comparative study of health policy decentralization in Brazil and Spain in *Ciencia e Saúde Coletiva*. The paper followed the history of decentralization processes in both the countries in a comparative institutional approach and how historical legacies, constitutional framework and political processes determined the organization of the health systems. In Brazil, the authors emphasized how the Constitution of 1988 created the Unified Health System (SUS) in which decentralization was made one of the central principles and responsibilities were shared between federal, state, and municipal spheres. The democratization of Spain also led to the devolution of health competencies to the regional governments in Spain through its constitution. The comparative analysis established both overlaps and differences in the processes of the decentralization of the two countries. The extreme municipal fragmentation in Brazil posed a coordination and equity challenge whereas the model in Spain has concentrated the power on regional basis, posing various sets of challenges to governance. Fiscal imbalances were a problem in both countries making it difficult to exercise local health authority. The authors hypothesized that even though the political and institutional contexts between the two countries were different, the underlying tensions were similar in that they had local autonomy and national equity objectives. Their research highlighted the significance of the contextualization of decentralization within the larger political and historical contexts when considering its health system outcomes.

Vasconcelos, M., and Silva, C. (2018) Vasconcelos and Silva examined the work of the Unified Health System (SUS) in the capital of Brazil and discussed ways in which the public health policies could be improved. The study was published in the *Journal of Global Competitiveness and Governability* and evaluated several major dimensions of SUS performance in Brasilia such as access, quality of services, efficiency in management and user satisfaction. The analysis revealed that, although SUS had made major strides in healthcare coverage and primary care access, there were still significant gaps, especially in the area of specialist care, hospital infrastructure, and quality of patient experiences. They cited administrative inefficiency, bureaucracy and difficulty

in governing a complex multi-level system as some of the key systemic weaknesses. The authors also observed that there were still some inequities in access to services, with the care quality in peripheral and lower-income neighborhoods being lower than in central areas. Based on the assessment outcomes, Vasconcelos and Silva developed a series of policy recommendations that would facilitate the build-up of local health management capacity, enhance inter-governmental coordination, and the citizen participation mechanism. They also stressed that there must be increased transparency and accountability in health expenditure and they said that investments in health information systems must be made to be able to make evidence based decisions. The research will add to the body of knowledge on decentralized public health systems and provide useful recommendations on enhancing equity and efficiency in the model of the SUS.

Araujo, C., Goncalves, G., and Machado, J. (2017) explored the determinants of the own-source expenditure on health of the municipalities in Brazil by examining the pattern of health spending in the municipalities. The study, which was published in *Ciencia e Saude Coletiva*, examined data on a large sample of Brazilian municipalities to establish the relationship between socioeconomic factors, fiscal capacity, and the decisions made by municipalities in health spending. The results showed that there was a significant difference in per-capita municipalities expenditure on health indicating that the affluent and larger municipalities always had a higher amount to spend on health compared to the smaller and poor municipalities. The research has found fiscal capacity, in terms of own-source revenue, to be a major factor in the amount of health spending, indicating the structural imbalances inherent in the Brazilian municipal financing system. Health constitutional spending floors were identified to affect budgetary allocations, although most of the municipalities exceeded the minimum, indicating that local political priorities and quality of governance were also important factors. also discovered that municipalities with more educated mayors and with greater involvement of their civil society were more likely to invest in health services. The research highlighted the need to deal with fiscal disparities among municipalities to provide more equal access to health services in the vast and diverse territory of Brazil. Their results have a major implication to the federal transfer policy and intergovernmental fiscal relations design to the health sector.

Groene, O., and Hildebrandt, H. The article (2017) provided a description of the development and scale-up of the Healthy Kinzigtal model, a population-based integrated healthcare system in Germany, in the Handbook of Integrated Care. The Healthy Kinzigtal model was a model of one of the most novel and comprehensively tested experiments in integrated care in Europe, which was invented in a rural area of Baden-Wurttemberg. The model was designed upon a management company that was co-owned by a network of physicians and a non-profit making organization that agreed with statutory health insurers to bear the financial liability of the health of an enrolled population. This paper has reported the development of the model as a small scale pilot to a system that involved an increasing population and had been both clinically and financially sustainable. The model was characterised by the following key features: proactive population health management, multidisciplinary care teams, heavy use of health data to create risk stratification, and heavy investment in prevention and self-management support. The authors described the governance models that enabled the model to be scaled without compromising quality and patient-centeredness. Efforts were also noted to be positive about reduced hospitalization, better chronic disease management, and cost savings as compared to control populations. Groene and Hildebrandt conjectured that the Healthy Kinzigtal experience can provide valuable lessons to health systems elsewhere in the world that are striving to establish value-based, integrated care models at the population level.

Halásková, R., & Haláskova, M. (2017) Halasova and Halaskova analyzed competences and financing provisions of local governments in European Union countries in the context of providing public services. The study, published in the Science Papers of the University of Pardubice, was a comparative overview of the distribution of responsibilities in relation to public services, such as health and social care, between central and local government levels in EU member states. The review showed that the competences of local government varied greatly throughout Europe, the Nordic countries providing the widest responsibilities to municipalities and the Central and Eastern European countries preserving more centralized systems. The financing structures were also discovered to be similarly diverse with some countries largely depending on local taxation and others on central government grants and transfers. The authors discovered that the level of fiscal independence that the local governments enjoyed was the major factor that determined their ability to customize

their services to suit local demands and to be creative when providing services. Nevertheless, they also observed that increased local autonomy without proper equalizing mechanisms may lead to an increase in territorial inequalities in service delivery. The paper has drawn attention to the tension that has continuously existed between subsidiarity (supporting local decision-making) and solidarity (insisting on national redistribution in order to access equal services). Haláskova and Halalaska found that efficient local governance implementation presupposes sufficient competences as well as sufficient and stable financing, with the support of clear accountability structures.

Jiménez-Rubio, D., & García-Gómez, P. (2017) Jiménez-Rubio and Garcica-Gomez took advantage of a natural experiment in Spain to empirically evaluate the causal effect of health system decentralization on health outcomes. The study, which was published in *Social Science and Medicine*, used the fact that health competencies are transferred to Spanish regions in staggered rates between 1981 and 2002 as an opportunity to determine the impact of decentralization on mortality rates and other health outcomes. The authors employed a difference-in-differences approach to compare health outcomes in areas that had taken control over health services before the intervention to those that had not yet taken control of health services. The results indicated that there was positive impact of decentralization on population health including preventable mortality rates. The authors hypothesized that these better outcomes were due to increased responsiveness of policies to local needs, more accountability of regional governments to the residents, and that health interventions could be tailored to particular local epidemiological characteristics. Nevertheless, the study did observe heterogeneous impacts across regions in that, richer and more administratively able regions enjoyed greater benefits of decentralization than poorer regions. This disparity highlighted the relevance of the precondition of institutional capacity at the base, as a prerequisite of decentralization to provide health benefits. The research contributed greatly to the body of literature in terms of methodology by offering quasi-experimental evidence where previous studies were mainly observational and descriptive studies.

Machado, J., & Guim, L. (2017) Machado and Guim discussed the connection between decentralization and fair access to health services in Brazil, and specifically how the SUS framework had facilitated or limited the realization of universality and equity. The study was published in *Revista do Serviaco Publico*, in which data on

indicators of healthcare access in various states and municipalities was analyzed to understand whether the decentralization had brought more equitable healthcare access. The results were somewhat inconclusive, on the one hand, decentralization had extended the geographic coverage of primary health care, especially, with initiatives such as the Family Health Strategy; however, on the other end, substantial differences in access remained between wealthier and poorer municipalities as well as urban and rural regions. The authors attributed fiscal federalism as one of the factors that contributed to these differences by stating that those municipalities with a small tax base and those which were highly reliant on federal transfers did not have the financial resources to support health services beyond the required minimum. Machado and Guim also indicated that one of the issues was the difficulty in controlling a highly fragmented governance system where there are more than five thousand municipalities with considerable health mandates, most of which are not equipped to manage these mandates effectively. The paper suggested a more effective system of intergovernmental equalization to make sure that every Brazilian can access similar quality health care irrespective of their residence. It also emphasized the necessity of a more robust federal oversight system to protect national health equity objectives in a decentralized system.

Miranda, G., Mendes, A., & Silva, A. Miranda, Mendes and Silva (2017) considered the difficulties of structuring a universal and effective National Health System into the federal pact in Brazil, as a part of the *Saúde e Sociedade* journal. The paper concentrated on the structural conflicts of functioning of a universal health system in one of the most complicated federal structures in the world, which comprised twenty-six states, the Federal District, and more than five thousand municipalities with very dissimilar socioeconomic background and administrative capabilities. The authors argued that the pursuit of universality, equity, and efficiency at the same time in such a fragmented form of governance demanded a continuous negotiation and coordination between the levels of government. They have scrutinized the changes in the intergovernmental relations in health since the establishment of SUS, recording how the duties were gradually transferred to subnational tiers and the establishment of intergovernmental coordination structures like bipartite and tripartite management committees. In spite of these endeavors, the study has found out that the following aspects continue to be a challenge; fragmented regulatory bodies, overlapping administrative roles, and inability

to create coherent health planning among the levels of government. Miranda et al. also emphasized the increasing significance of public-private relationships in health delivery and the necessity to control these relationships under some framework that is consistent with SUS principles. In their analysis, they suggested that the federal health pact should be enriched to allow closer allocation of resources to the responsibilities and to make sure that the national health priorities are properly executed at the local level.

Moreira, L., Ferré, F., & Andrade, E. (2017) Moreira, Ferré, and Andrade explored the connection between healthcare funding, decentralization, and regional health planning with a particular emphasis on federal transfers and the development of healthcare networks in Minas Gerais, which is one of the largest states in Brazil. The study was published in *Ciencia e Saude Coletiva* and was used to trace the movement of federal health transfers to municipalities in Minas Gerais and the utilization of these resources to develop regional health care networks. The results also revealed a great difference in the ability of various health regions in the state to build integrated services networks, which were mostly based on the size and economic power of the regional health authorities. Federal block grants and conditional transfers were observed to play a significant role in network development but limited their performance by administrative complexities and misalignments between funding mechanisms and real service delivery requirements. The government role of the state government as a middle ground in the SUS federation was also studied and the results showed that state coordination of regional health planning played a critical role, but tended to be undermined by both fiscal and political tensions with the federal and the municipal levels. Moreira et al. claimed that tightening the regional level of governance and enhancing the form of federal transfers to enhance network planning and functioning were critical measures toward a more integrated and equal health care delivery in big and heterogeneous states such as Minas Gerais.

Cavalieri, M., and Ferrante, L. Cavalieri and Ferrante (2016) offered empirical evidence regarding the claim as to whether fiscal decentralization enhances health outcomes, with infant mortality in Italy being their key measure. The study, published in *Social Science and Medicine*, took advantage of the fact that the degree of fiscal autonomy experienced by Italian regions at different times to determine the health outcomes of decentralization. The tiered health system of Italy, with a primary

responsibility of organizing and financing health services in a national system assigned to regions, was a perfect setting to explore such relationships. The authors discovered that increased fiscal autonomy on the regional level was correlated with a decrease in infant mortality, and that decentralization when properly resource endowed could result in superior health governance and outcomes. Nevertheless, they also established some critical caveats: the positive impacts of fiscal autonomy were more evident in more administratively endowed regions and of better governance, whereas poorly governed regions exhibited less or no effects. The research also discovered that the way in which the decentralization was carried out was important and that reforms that involved the presence of significant accountability mechanisms and sufficient equalization transfers yielded better results compared to those that merely transferred the formal responsibilities without the commensurate resources. Cavalieri and Ferrante came to the conclusion that fiscal decentralization is not necessarily positive or negative to health outcomes but that its impacts depend on the institutional and fiscal environment in which it is adopted.

Sumah, A. M., Baatiema, L., & Abimbola, S. Sumah, Baatiema, and Abimbola (2016) have carried out a systematic review of the evidence of the impact of decentralization on health-related equity. The review, published in *Health Policy*, was a synthesis of the results of a wide array of country case studies and quantitative studies to determine whether decentralization is more likely to enhance or reverse inequity of health systems. The review had contradictory and situation-specific results, with decentralization enhancing equity in certain environments and deteriorating it in other environments. Some of the most critical determinants of the equity implications of decentralization were the existing extent of regional inequality, how intergovernmental fiscal transfer was designed, the effectiveness of local institutions of governance, and whether central governments kept a redistributive role. Decentralization often was observed to reinforce the established geographic and socioeconomic inequity in health access and outcomes in low-income settings with weak local institutions because richer and more politically connected localities were better placed to take advantage of the increased local authority. The authors posited that decentralization without proper consideration of equity protection will most probably increase health inequalities. They demanded more subtle policies on decentralization that includes equity impact analysis, redistribution that is focused and capacity building in disadvantaged jurisdictions. The

review has also identified that there were large gaps in the evidence base, especially in sub-Saharan Africa and South Asia, that require more stringent longitudinal studies on decentralization and health equity.

Athanasiadis, A., Kostopoulou, S., and Philalithis, A. Athanasiadis, Kostopoulou, and Philalithis (2015) critically analyzed decentralization in the Greek healthcare system on a regional level, comparing the official policy discourse with the real situation on the ground. The study was published in the *Global Journal of Health Science*, and it examined the disparity between the rhetoric promise of decentralization in Greek health policy texts and the actual picture of what regional health authorities and healthcare providers face. The authors discovered that despite the recurrent Greek governments declaring decentralization as a primary reform agenda, the actual decentralization of the decision-making authority, financial resource, and administrative capacity to regional health authorities was minimal. The authority of the central ministries to control personnel management, budgetary allocations, and strategic planning persisted to the detriment of the independence of the regional health bodies. Their political patronage and clientelism were cited as key barriers to real decentralization with appointments to regional health management posts often being based on political loyalty instead of management skills. The research was also able to determine that the economic crisis experienced during the early years of the 2010s had heightened the pressure towards centralization, with the Greek government and international creditors insisting on having greater control over state expenditure. Athanasiadis et al. found that decentralizing health in Greece meant that there had to be a fundamental transformation of both the political culture and structural changes to intergovernmental fiscal relations and that the institutional capacity building must go hand in hand with any devolution of formal authority.

Belo et al. (2021) described the evolution of integrated care in Portugal, in the form of the Local Health Unit (*Unidades Locais de Saúde*) model. Local Health Units in Portugal was a new organizational paradigm which was aimed to eliminate the traditional separation of primary care and hospital care, through merging the two levels into one management unit. The chapter followed the history and gradual growth of this model, starting with its pilot in the late 1990s and its gradual implementation in other parts of the country. The authors explained how Local Health Units provided more continuity of patient care, better coordination of general practitioner and hospital

specialists, and enhanced management of chronic illnesses and complicated courses of care. Implementation issues that were identified to be among the most challenging in the chapter were resistance of health professionals who were used to traditional organizational boundaries, challenges in the development of integrated information systems and the requirement to redesign funding mechanisms to encourage coordination and not volume of activity. Another important aspect that the chapter identified is the importance of effective leadership and organizational culture in effecting successful integration locally. In their study, Belo et al. claimed that the Local Health Unit model, though still developing, could teach other nations on how to build an integrated care system in the framework of the public health services especially in the face of aging population and increasing chronic disease burden.

Bruce, D., & Parry, B. (2015) Bruce and Parry provided practitioner-oriented view on integrated care in Scotland, which was published in the London Journal of Primary Care. The authors wrote within the Scottish health system context and explained the policy context and practical challenges of integrating health and social care at the local level, specifically the changes in the legislation brought about by the Public Bodies (Joint Working) (Scotland) Act 2014. The paper has talked about how integration was being sought by the establishment of Integration Joint Boards that provide a combination of representatives of National Health Service boards and local councils to manage the planning and commissioning of a set range of health and social care services to adults. The authors were keen to note that the success of integration was not only determined by the structural and governing reforms but also the willingness and flexibility of the frontline practitioners who were to operate in a new manner across professional and organizational boundaries. The main challenges that were noted were cultural differences in the workforces of health and social care, challenges in aligning information systems, and the practical aspect of gathering budgets of organizations with varying accounting and management systems. Bruce and Parry have emphasized the role of community-based models of care, including anticipatory care planning and multi-disciplinary community teams, as key to achieving the benefits of integration on patients. The paper ended with a reflection on the opportunities and current challenges to Scottish integrated care.

Costa, J. L. d., & Mourao, V. (2015) Costa and Mourao examined the risk perspective in the National Network of Integrated Continuing Care (Rede Nacional de Cuidados

Continuados Integrados RNCCI) in Portugal based on the opinions of health professionals and decision-makers. The findings of the study, published in *Saúde e Sociedade*, were collected through qualitative research that involved the interview of professionals engaged in the design and operation of the RNCCI regarding the risks that they considered to be the most crucial to the sustainability and effectiveness of the network. In 2006, the RNCCI was a partnership between the health sector and the social solidarity sector to ensure a continuum of care to individuals with chronic conditions, disabilities or recovery needs within a spectrum of settings, including home-based care, inpatient rehabilitation and long-term care units. Analysts have found various threats such as financial instability, inadequate coverage in rural and remote regions, human resource incompetence, and challenges in coordination of referrals and transitions among the network elements. Also, there were fears regarding the sufficiency of monitoring and evaluation system to identify quality issues and accountability in the network. The analysis conducted indicated that the RNCCI was appreciated as a major step towards integrated long-term care by decision-makers, but that further implementation and improvement of interagency collaboration needed to be invested heavily in future steps of the process. Costa and Mourao concluded that to achieve the full potential of the integrated continuing care model in Portugal proactive risk management based on stakeholder involvement and evidence-based planning was necessary.

Gray, B. H., Sarnak, D. O., & Burgers, J. S. (2015) was the study that investigated the Buurtzorg model, a Dutch model of home care provided by self-managed teams of nurses. Developed in the Netherlands in 2006, the Buurtzorg model was a radical shift in the traditional approach of bureaucracy to home care by putting small, self-organizing teams of neighbourhood nurses together to provide holistic, relationship-based care to clients in their homes. The report described the rapid expansion of Buurtzorg to become one of the largest home care organisations in the Netherlands with great international interest as an exemplar of how professional autonomy and patient-centredness could be integrated with organisational efficiency. The important characteristics of the model were lack of middle management, and nurses shared responsibility in scheduling, client intake and quality monitoring; high importance of creating social networks and community resources to enable clients to be independent and flat organizational structure that saved a lot of overhead on administration.

According to reports of the evaluations cited in the report, Buurtzorg clients took less time to be cared about, had lower rates of hospitalization, and were more satisfied with their care than clients of more traditional home care providers. The level of nurse job satisfaction was also significantly increased which led to reduced staff turnover. Gray et al. were able to conclude that the Buurtzorg model has valuable insights to teach health systems aiming to enhance home and community care and to lower costs and enhance patient and professional experiences.

Sauco, F., & Laborda, J. (2015) Sauco and Laborda explored how the attribution of regional roles to provide public services and citizen support to decentralization is related in Spain. The study was published in *Revista Española de Investigaciones Sociológicas* and survey data was used to examine the effect of the perceptions of the citizens on the level of government that provided certain services on their attitudes towards decentralized governance. The authors discovered that the more citizens rightly placed the blame of public services in the hands of the regional governments, the more they would assess the performances of the regional governments in relation to the quality and accessibility of the services, which would develop more powerful accountability connections. On the other hand, citizens who were unaware or wrong about the level of government in charge were unable to keep the government accountable and moved the support of decentralization outwards. The researchers also established that satisfaction with services provided regionally was a good predictor of approval of additional decentralization indicating that positive experiences with regional governance strengthened the pro-decentralization attitudes. The authors however pointed out significant difference in areas of policy with citizens being more supportive of regional autonomy in health and education areas rather than fiscal policy. Sauco and Laborda suggested that increasing the level of understanding of the division of responsibilities in decentralized systems was not only a key element in achieving democratic accountability but also in developing a long-term political support of decentralization. Their results can be applied to communication plans and transparency measures to increase knowledge of citizens on multi-level governance arrangements.

Faguet, J., and S and C. (2014) Faguet and Sánchez also investigated the impact of decentralization on the access to social services, such as health and education, in Colombia. The study, published in *Public Choice*, used extensive decentralization reforms in Colombia in the 1990s that devolved significant duties and resources to the

municipalities to determine whether social services were better served and distributed in a more equitable manner by the local government. The authors analyzed municipal-level data over a long period of time and discovered that decentralization was linked with major improvements in access to primary education and basic health services, especially in hitherto poorly served regions. They credited this to increased local responsiveness as municipal governments were more responsive to the particular needs and interests of their communities than more remote central bureaucracies. The researchers also discovered that access to increase was more significant in places where the local governance capacity and competitive local political environments were stronger, indicating that the advantages of decentralization were enhanced by the democratic accountability of the local level. The authors however warned that decentralization was not consistently effective to enhance services in every context with some of the poorly managed municipalities registering no or even negative changes in access to services. Faguet and S-Sanchez also found that decentralization could indeed be important in enhancing social service delivery, but that the effectiveness of decentralization is sensitive to the quality of local institutions and strength of local democratic processes, which supports the significance of institutional development and structural changes.

Lim et al. (2022) performed a realist appraisal of the adaptation of the Swedish Esther Network model to the co-production of person-centred health and social care in Singapore. The study was published in BMJ Open and explored the translation of a model that had been developed in the Swedish county of Jönköping to the Singapore context on culture, institution, and health system. The Esther Network is a network-based collaboration of providers in various sectors constructed around the question of what is best for Esther, and seeks to enhance care coordination and integration of vulnerable older adults. The realist evaluation attempted to comprehend not only whether the model was effective in Singapore, but in what circumstances and to whom it made a difference. Results showed that the model was effectively implemented in the Singapore setting with some changes being made to accommodate the local values surrounding family-centred care, the role of community health workers, and the multi-ethnic population. The most prominent processes that led to positive results were the formation of trust between the members of the network, comprehension of the common understanding of values connected to people, and enhanced communication across care

boundaries. Enablers were the support of the senior leadership and aligning of the Esther approach with the rest of the integrated care strategy of Singapore. The article found that systematic adaptation and co-design processes were crucial in the transfer of integrated care innovations in other health system settings and provided an insight that could be applied in other countries wishing to import effective care models.

Lyon, S. M., Douglas, I. S., & Cooke, C. R. Lyon, Douglas, and Cooke (2014) analyzed the effects of Medicaid expansion with the Affordable Care Act on insurance disparities in pulmonary, critical care, and sleep medicine. The study was published in the *Annals of the American Thoracic Society* and involved an examination of the impact that an expansion of Medicaid eligibility to more low-income adults in involved states would have on access to specialized respiratory and critical care services among previously uninsured groups. The authors surveyed the literature on the correlation of insurance status with health outcomes in these specialty areas, and found that uninsured and Medicaid-enrolled patients all had worse outcomes, including increased rates of late-stage diagnosis, increased in-hospital mortality, and reduced rates of getting guideline-recommended treatment compared to privately insured patients. It was anticipated that with the expansion of Medicaid, many uninsured people would be able to access the timely and quality specialty care. Nevertheless, the authors also projected the possible barriers that may constrain the benefits of expansion such as lack of providers that may accept the Medicaid reimbursement rates and lack of geographic distribution of specialty care capacity. They claimed that only expanding coverage would not help to eradicate disparities and demanded the supporting policies to enhance the healthcare workforce, engage more specialists in Medicaid, and mitigate transportation and other non-financial barriers to care access. The research added to the policy discussion of the ACA by offering a specialty-focused view of the equity considerations of an ACA Medicaid expansion.

Porcelli, F. (2014) Porcelli examined the linkage between electoral accountability and efficiency of local governments in the Italian healthcare industry and used quasi-experimental techniques to give causal evidence on the topic. The research, published in *Economics of Governance*, took advantage of the regulations of Italian mayoral term limits to provide variation in the electoral incentives across municipalities which was arguably exogenous to other determinants of healthcare efficiency. The hypothesis that is tested was that the local politicians who were under re-election pressures

outperformed with local health services compared to those in a final term and therefore were not under the same election pressure. The study used a variety of efficiency indicators of Italian local health authorities to find the evidence in support of the hypothesis of the improvement of healthcare efficiency with the aid of electoral accountability. Mayors with future electoral responsibility, i.e. first term, were linked with an effective local health authority performance as compared to mayors in their last term. Porcelli saw this as an indicator that the risk of electoral punishment is encouraging incumbents to better run the services of the people and to cut waste. The paper also discovered a stronger accountability effect in settings where civic engagement was higher, and political settings were more competitive, which implied that electoral accountability mechanisms were only effective in terms of the quality of local democracy. The findings of Porcelli were added to the literature on decentralization and the overall literature on political economy because they proved the significance of accountability mechanisms in terms of the way they influence the performance of the public sector.

Santana, S., Szczygiel, N. and Redondo, P. (2014) Santana, Szczygiel, and Redondo examined the Portuguese care systems integration and gave an anatomical view of the significant changes that had informed the Portuguese approach to integrated care. The research, published in the *International Journal of Integrated Care*, followed the evolution of the national policy framework of care integration in Portugal, starting with its early legislative roots up to the development of the major organizational structures, including the RNCCI and the Local Health Units. The authors presented the integrated care scenario in Portugal as being marked by a plethora of parallel initiatives at various levels and with diverse targets and objectives of the population forming a complex mosaic, which created both opportunities and challenges to system-wide coherence. The discussion has identified the 2006 Integrated Continuing Care Network as a milestone in formalised care integration, which is a combination of health and social care in a network of services, including home care, day care and inpatient. The role of the Local Health Units model was also studied and it was observed that they were capable of bridging between primary and hospital care but there were also limitations in the form of financing structure and professional opposition. According to Santana et al., the key barrier to effective integration was information system fragmentation since the creation of shared electronic health records and interoperable data systems was a

condition that ensured true continuity of care. The paper recommended a more integrated and unified national approach to integrated care to make the current patchwork of initiatives rational.

Scottish Government. (2014) The Scottish Government passed the Public Bodies (Joint Working) (Scotland) Act 2014, which was a groundbreaking legislation that has set the legal basis of the integration of health and social care services in Scotland. This Act required the establishment of Integration Joint Boards (IJBs) within each of the thirty-two local authority areas in Scotland, which involved the formation of joint planning, commissioning, and superintendence of the provision of a specified set of health and social care services to adults by NHS boards and local councils. The act was inspired by the fact that the traditional isolation of funding, governance, and provision of health and social care was causing inefficiency, gaps in care and abhorrent experience of service users especially of older people with complex needs. The Act also brought about new governance arrangements whereby IJBs would create strategic commissioning plans to their populations, as well as having delegated budgets in both partner organizations. It also highlighted the value of person centred care, anticipatory care and community based service delivery as guiding principles. There were two forms of integration, which were permitted by the legislative framework: the Lead Agency model, whereby one organization leads on behalf of both partners and the Body Corporate model whereby a new legal entity is established. The enactment of this Act marked an important political commitment to the integration of services in Scotland and established the platform of the continued march towards increasingly coordinated and responsive health and social care services nationally.

Vazquez, D. (2014) Vazquez analyzed the institutional processes of federal regulation and their consequences on education and health policies in Brazil and wrote an article in *Revista Brasileira de Ciências Sociais*. The paper examined the impact of the federal government of Brazil on the policy behavior of subnational governments in strategic sectors of the social sector through regulatory instruments, financial incentives, and conditionalities. Although the 1988 Constitution officially devolved health and education functions to states and municipalities, the federal government still had strong steering capacity due to the structuring of transfer programs, setting of minimum spending thresholds, and controlling service delivery standards. Vazquez claimed that this formal decentralization coupled with substantive federal regulation brought about

a kind of regulated autonomy where subnational governments had the freedom of choice in operational matters but were limited in strategic options by federal conditionalities and financial reliance. The paper has followed the development of regulatory mechanisms in the federal system over the years, showing how they have increasingly been more sophisticated and result-focused shifting away from mere input based regulations to elaborated incentive systems based on performance measures. Although the federal regulation was attributed to the creation of positive changes in coverage and basic quality standards in both health and education, Vazquez also found tensions and dysfunctions, such as the administrative overload of smaller municipalities and inflexibility that did not allow to adjust to local situations. The article demanded that there should be a re-evaluation of intergovernmental regulatory frameworks that would enhance national standards and useful local autonomy in social policy.

2.3 Research Gap

Although the issue of decentralized social care systems is becoming increasingly scholarly, a considerable gap in the literature remains in the insights into the delicate equilibrium of regulatory schemes and operational leeway in the context of micro-care schemes. Current literature is mostly biased towards the macro-level governance models or isolated case studies of integrated care, but does not take into account the comparative dynamics of different micro-care settings. The literature on the effects of different levels of regulation on the adaptability, efficiency, and responsiveness of local care units has limited empirical studies. Moreover, the impact of contextual factors on the effectiveness of flexible care delivery, including socio-political environments, institutional capacities, and community engagement, is under-researched. Although other studies also describe the advantages of decentralization in terms of better user-centered care, they fail to sufficiently discuss the risks of fragmentation, inconsistencies, and lack of accountability as a result of the less strict regulations. Also, there are limited cross-national comparative studies, especially studies that examine how the micro-care models can work in different regulatory regimes. Such deficiency of integrative and comparative studies limits the emergence of a comprehensive theoretical framework that can be used by policy makers to come up with balanced systems. Thus, the present study is aimed at filling this gap through providing a comparative examination of regulation and flexibility in micro-care models in decentralized social care systems.

CHAPTER 3

RESEARCH METHODOLOGY

This chapter outlines the research approach used to explore the trade-off between regulation and flexibility in micro-care models in decentralized social care systems. As Chapter 2 provided a synthesis of global evidence on decentralization and micro-care models, this empirical research examines the community care operating environments in the context of the United States specifically acting on the multi-level regulatory environment operating at the federal, state, and local levels impacting the flexibility for community-based care delivery organizations. Decentralised social care systems have a great potential for the investigation of the conflict between regulation and flexibility, and the US is a particularly informative case of such a system. The American healthcare and social services landscape is, you might say, thoroughgoingly fragmented by the constitutional principle of federalism (federal-state divisions of authority), by the complex interaction of public programs (Medicare, Medicaid) and private insurance markets, by the localization of social services in counties and municipalities, as well as the substantial variation in the regulatory environments across fifty states and thousands of local governments.

The comparatively substantial institutional complexity produces considerable heterogeneity in micro-care models—thus rendering the US an ideal natural laboratory for exploring how varying regulatory configurations enable or constrain flexibility in care delivery and care outcomes. This research employs a mixed-methods comparative design, gathering quantitative survey data from micro-care organizations and qualitative case study analysis of regulatory frameworks from selected jurisdictions. This methodical pluralism also speaks to the complexity of the research challenge, which cannot be represented exclusively through quantitative outcome measure or qualitative description of organizational practice. Combining quantitative and qualitative approaches facilitates triangulation of results and creates empirical coverage across a wide range but also a greater depth in understanding the mechanisms through which regulation impacts operational flexibility. It then moves on to progress through seven subsections covering the following: research design and philosophical underpinning, sampling strategy and site selection, data collection instruments and procedures, operationalization of key variables, analytical strategy, quality assurance

and validation procedures and ethics. Each subsection deals with the technical implementation of the methods and their epistemological justification as motivating choice of methods.

3.1 Research Design and Philosophical Foundations

3.1.1 Mixed-Methods Comparative Design

This research utilizes a convergent parallel design in which both quantitative and qualitative data are collected concurrently, analyzed separately, and integrated together during interpretation (Creswell & Plano Clark, 2018). The quantitative section is a cross-sectional survey of 300 micro-care organizations throughout the U.S. in a range of geographical and regulatory contexts. The qualitative part consists of detailed case studies in six purposively selected states, using document review, semi-structured interviews with key informants, and observational site visit data. The logic of this design is based on the underscoring that the regulatory-flexibility tension is entangled across levels of analysis. By studying the quantitative interrelations between regulatory burden, organizational flexibility, and performance outcomes from a large sample, associations can be statistically analyzed and patterns can be identified. But purely quantitative data do not do justice to these processes nor to the experience of care providers and recipients as they negotiate regulatory requirements and implement them through the practice of care in regulated systems. Qualitative case study analysis offers the contextual richness and process-level insights essential for explaining higher-level quantitative patterns and for deriving grounded theoretical explanations of how and why specific regulatory-flexibility configurations yield particular outcomes.

There are two purposes for the comparative outlook of the design. The first is that a within-state comparison of the effects of policy variation where some states are more prescriptive and centralized and others are more permissive and local in their regulatory character controls for the effects of national-level institutional characteristics (the presence of federal Medicare and Medicaid, professional licensing regimes, and civil rights protections). The second is that comparing their activities across organizational types home health agencies, community health centers, adult day care programs, community mental health centers and integrated care networks helps to understand how regulatory effects may differ by organizational mission, target population and method of service delivery.

3.1.2 Philosophical Orientation

The pragmatist epistemology guides the study and focuses on the practical solution of problems instead of an abstract theoretical purity and recognizes the fact that more than one way of knowing is valid (Morgan, 2014). Pragmatism provides mixed-methods research with philosophical justification by rejecting the paradigm wars of the positivist and interpretivist methodologies, and focusing on the research question as the first step towards the methodological decision. The core research question, which is how regulatory framework influences the flexibility of operation of the micro-care models, and what consequences to equity, efficiency, quality and resilience are, is multi-dimensional by definition and thus requires the measurement of the outputs, and the adoption of meanings.

In the meantime, the study follows in its direction the elements of critical realism, particularly, the emphasis on structural constraints as well as enabling conditions that do not rely on specific actors in an organization, but are interested in their possible courses of actions (Bhaskar, 2008). The regulative frameworks are considered to be real institutional constructions, having causal powers, as opposed to social constructions or subjective interpretations. The effects of these structures are mediated by agency in organization, professional culture, community context and personal discretion and must be approached to understanding through an interpretive approach to understand how structural constraints are practiced and negotiated.

There are methodological implications of this philosophical tendency. It not only justifies the use of standardized instruments of measurement (to test the variability in the regulatory structures and organizational characteristics across cases) but also open-ended qualitative inquiry (to be educated about the meaning of regulation demands and how they are put into practice within the organizational practice). It also helps in synthesizing these different sources of information in a synthetic analysis with the view of uncovering general patterns as well as context specific mechanisms.

3.2 Sampling Strategy and Site Selection

3.2.1 Target Population and Sampling Frame

The study sample will be micro-care organizations located in the United States, which offer health or social care services at a community level, are defined by specific

populations to serve, and have some administrative autonomy in service delivery decisions. It also covers organizations in a variety of service categories: home health agencies, community health centers (federally qualified health centers and look-alikes), adult day care programs, community mental health centers, Programs of All-Inclusive Care for the Elderly (PACE) and community-based integrated care networks.

The development of a detailed sampling frame of this population is fraught with difficulties because no one national registry can encompass all types of organizations in question. The sampling frame was thus a combination of data provided by various sources: Centers of Medicare and Medicaid Services (CMS) provider databases of home health agencies and PACE providers, the Health Resources and Services Administration (HRSA) database of health center, state licensing databases of adult day care programs, and membership listings of professional associations such as the National Council of Mental Wellbeing and the National Association of Community Health Centers.

The organizations were to be included based on the following criteria: (1) the organization delivers services at the community or neighborhood level and not in institutions; (2) the organization has a defined area of local service delivery; (3) the organization has been in existence long enough, at least two years, to have sufficient experience in the field and be operating in a regulatory manner; (4) the organization provides services to at least fifty clients in a year; and (5) Only those organizations that act solely as contractors to more comprehensive health systems and have no independent decision-making capacity were included, as well as organizations that provide services to only a narrow segment of the population (e.g., veterans or tribal communities) that have different regulatory standards that would make comparative analysis more difficult.

3.2.2 Sample Size Determination

The target sample size of 300 organizations was calculated and applied in the quantitative component of the research based on power analysis considering the qualitative saturation and the practicality factors. Using power analysis, in situations of multiple regression analysis between regulatory intensity and organizational flexibility, with organization characteristics, size and location fixed, power analysis indicated 80 percent power to reject the null hypothesis of medium effect sizes ($f^2 = 0.15$) at the

0.05 level assuming up to fifteen predictor variables and design effect due to the grouping of organizations by state. This sample size also takes into account the anticipated response rates and missing data. The response rates of organization surveys in health services research are typically 30-50 percent (Brtnikova et al., 2018). A total of 300 full responses was achieved by inviting approximately 750 organizations to participate in the study, and various follow-ups were done to pursue maximum response. At the qualitative level, six states where the cases would be analyzed in detail were chosen based on the theoretical principles of sampling and the information would be collected until the theoretical saturation (Charmaz, 2014). The six-state target would be a balance between the coverage of the area of regulatory variation and depth of analysis in each instance.

3.2.3 Stratified Sampling Approach

To ensure that the sample reflected variations across the three dimensions of variation, that is geographic region, urbanicity and organizational type, the sample was stratified on three dimensions of variation. Geographic stratification involved the four U.S. Census areas (Northeast, Midwest, South, West) with the sample distribution being proportional to how the target population was distributed across the areas. This stratification ensures that regional variations in political culture, economic conditions and population structure are well represented. It also indicates the heterogeneity of state regulatory approaches, where states create areas of policy orientations (Grogan and Park, 2017). Urbanicity stratification distinguished urban organizations in metropolitan (county in Metropolitan Statistical Areas), urban cluster (10,000-50 000 population) and non-metro (rural) counties. This stratification is necessary because the enforcement and implementation of regulations can significantly differ in urban and rural environments, and because the operational problems that micro-care organizations have will be different based on population density and workforce and the distance to referral resources. The sample was selected as a representation of 60 percent metropolitan, 20 percent of micropolitan and 20 percent rural that was the U.S. population distribution, and also provided a good number of rural residents who could be utilized as subgroups.

The sample was stratified by organizational type to five categories consisting of home health agencies (30%), community health centers (25%), community mental health centers (20%), adult day care programs (15%), and integrated care networks, like PACE

(10%). This distribution does not just show the relative prevalence of the different types of organizations, but also the analytical interest of the comparison of the regulatory effects of the different types of service delivery models. The sampling frame built was then systematically randomized to select organizations in each of the stratum and was also employed to produce random numbering to determine starting points and selection intervals.

3.2.4 State Selection for Qualitative Case Studies

The selection of the six states to be studied in-depth with the help of the analysis of qualitative cases was based on the maximum variation sampling logic (Patton, 2015). The sampling criteria was founded on diversity in regulatory type of micro-care regulation, Medicaid expansion (as a measure of overall health policy orientation), level of administrative decentralization, and geographic diversity. The six selected states are: California (highly regulated, Medicaid expansion, high administrative power at the county level, West region); Texas (mixed regulation, non-expansion, moderate decentralization, South region); New York (highly regulated, Medicaid expansion, strong tradition of community based care, Midwest region); Florida (moderately regulated, non-expansion, great county administrative power, South region); Minnesota. This sampling will provide diversity in key aspects of regulation and will also represent varied settings in regions, politics and demographics. In each state, qualitative data were gathered on three to five exemplar micro-care organizations of diverse types of services, selected through snowball sampling and beginning with recommendations made by the state health department and aging services agency.

3.3 Data Collection Instruments and Procedures

3.3.1 Quantitative Survey Instrument

The quantitative part involved the use of an online survey that was structured in the form of an organizational survey using Qualtrics survey platform. The survey instrument will be designed in this specific study based on the previously tested measures of other organizational studies but new items will be included as specific to the micro-care setting.

The questionnaire will have a total of 87 questions in seven sections:

1. Organizational Characteristics (12 items) deals with the general information about the organization such as the type of organization, the legal status, years of operation, annual budget, staffing, client volume and characteristics of the service area. They are the variables that are used as controls in the multivariate analysis and can be used to describe the composition of samples.
2. Regulatory Environment (24 items) evaluates various aspects of a regulatory framework of the organization. Items assess the number and type of regulatory authorities having oversight responsibility, how often they conduct inspections and audits, require reporting, license and certify, and take part in quality improvement programs. These items are then made up into a regulatory intensity index with higher scores implying more comprehensive regulation. Other items measure the perception of respondents with regard to the regulatory clarity, uniformity across regulatory bodies and administrative load.
3. Operational Flexibility (18 items) assesses the level of organizational flexibility in the major areas of operations such as staffing, service design, scheduling, resource allocation and care protocols. The items use 5-point Likert scales of no discretion to complete discretion. Factor analysis revealed three dimensions of flexibility: workforce flexibility (discretion in hiring, assignment and professional practice), service design flexibility (discretion in program structure and client eligibility) and financial flexibility (discretion in resource allocation and revenue generation).
4. Care Quality and Outcomes (14 items) has both objective and subjective quality metrics. Objective measures involve client retention, hospitalization, emergency department utilization, and standardized quality measures (based on each type of organization). Subjective measures evaluate the perceptions of the organizational leaders of the quality of care, client satisfaction and capacity to provide complex client needs.
5. Equity and Access (9 items) assesses the commitment and performance of organizations in the area of equity, such as the percentage of clients of underserved population (racial/ethnic minorities, low-income individuals, people with disabilities, limited English proficiency), the presence of culturally tailored services, the willingness to take on clients with Medicaid and no insurance, and accessibility to the organization.

6. Efficiency and Sustainability (6 items) measures the efficiency of resource utilization, financial stability, turnover, and operational sustainability of workforce. Items are price per client served, operating margin, staff turnover rates and vacancy rates.
7. Resilience and Adaptation (4 items) assesses organizational capabilities to adapt to any disruption, which is based on the COVID-19 pandemic as an eventual focus. Items evaluate how much service was disrupted, how quickly it adapted to new delivery modalities (telehealth, outdoor services), and perceived organizational resilience.

The process of survey development was conventional consisting of an expert review of the survey by five research scholars in the field of health services and organizational studies, cognitive interviewing with ten organizational leaders to evaluate the understanding of the items and how they responded to the items, and pilot testing of the survey with thirty organizations that were not part of the final sample. Pilot data was used to refine item wording, response scales and length of survey. The last tool takes about 35 minutes to be completed.

3.3.2 Survey Administration Procedures

The survey was administered using the modified Dillman tailored design technique (Dillman et al., 2014) to get the highest response rates. First contact was a one-to-one email to organizational leaders (executive directors, CEOs, or administrators) with a purpose statement of the study, the importance of the findings to the policy and a unique survey link. The email stressed upon confidentiality and provided to present aggregate findings to the participants. The non-respondents were contacted as follows: after two weeks, reminder email, second reminder with renewed stress on the importance of the survey participation and the last contact with the proposal of assistance in completing the surveys including a telephone call. Those organizations that initiated the survey and failed to complete it were sent special messages that aimed at encouraging them to complete it.

To increase response rates, the following incentives were utilized: (1) a summary report on the findings was given to all the participants; (2) being included in a drawing with five \$200 Amazon gift cards; and (3) in the case of organizations that filled in the survey, a personal benchmarking report on the regulatory environment and the

operational characteristics against the peer organizations. These incentives are within the guidelines of the institutional review board (IRB) on ethical research conduct. The data was collected in a duration of four months between March and June 2024 without including end years when the leaders of the organizations tend to be less accessible. Response tracking allowed tracking of the response rates by stratum to focus recruitment in underrepresented groups.

3.3.3 Qualitative Data Collection

Qualitative data collection of six case study states involved three approaches: document analysis, semi-structured interviews as well as site observations. Analysis of documents looked at state and local regulatory frameworks of the micro-care organizations such as statutes, administrative regulations, licensing standards, quality oversight protocols, Medicaid state plan amendments, and guidance documents. The state government websites, public records requests and informant provision obtained documents. Document analysis gave systematic description of regulatory frameworks and revealed the areas of ambiguity or discretion in the interpretation of regulations.

In each state, semi-structured interviews with various stakeholder groups were carried out. Interview subjects were stratified by state, based on the number of micro-care organizational leaders and frontline care providers; by type of organization, as there were five-eight leaders and three-five care providers in each state; and by the number of client advocates and representatives and academic or policy experts on the health system in the state (n=1-2 per state). In all the six states, some 120 interviews were done. The interview protocols differed between stakeholder groups, but had similar areas: description of the regulatory environment, how regulation is perceived to impact care delivery, examples of regulatory constraints and enablers, experience of regulatory change, accountability mechanisms, and regulatory reform recommendations. The length of interviews was between 45 and 90 minutes and interviews were carried out through video-conferencing or telephone and recorded on tape with the consent of the participants and transcribed professionally.

Site visits were done by making 3-5 micro-care organizations visits in each state, with a total of about 24 site visits in the six states. The visits to the site took 3-6 hours and consisted of the facility tours, observation of care delivery and team meetings, and informal communication with staff and clients. Field notes were made of the physical

environment, organizational culture, patterns of workflow and evidence of regulatory compliance activities. These observations gave contextual insights and a foundation of checking up interview accounts.

3.3.4 Timeline and Researcher Roles

The study was conducted over 18 months between January 2024 and June 2025 to collect data. The initial three months were devoted to the development of surveys and pilot-testing, and the complete implementation of the survey is planned between March and June 2024. Qualitative data collection was done simultaneously and lasted until the month of March 2025, with two states being extensively studied after every three months.

The research team was composed of one principal investigator, two research associates and three graduate research assistants. The principal investigator was in charge of the study design, development of the survey and case study site selection. The coordinated survey administration and interviews were conducted in three states each. Document analysis, transcription management and data organization were aided by research assistants. Data analysis and interpretation were carried out by all the team members by attending regular team meetings and engaging in team coding activities.

3.4 Operationalization of Key Variables

The theoretical problem of the analytical perspective of the study is how to operationalize the abstract concepts of regulation, flexibility, equity, efficiency, resilience in a manner that is measurable, valid, and theoretically significant.

3.4.1 Regulatory Intensity

Regulatory intensity is a theoreticalized construct that describes the depth, specificity and rigor of regulatory supervision. Operationalization is based on operationalization literature (Moynihan et al., 2015) and measures are applied to the micro-care setting.

The Regulatory Intensity Index is made as a composite measure that includes: (1) number of different regulatory authorities with oversight jurisdiction (range: 1-8); (2) frequency of formal inspections and audits (annual, biennial, triannual, or less often); (3) number of different reporting requirements (range: 0-20+); (4) specificity of process requirements in terms of the number All components are standardized (z-scored) and

components averaged to form the index ($\alpha = 0.78$), where a high score implies a high regulatory intensity.

Other regulatory variables measure dimensions unrepresented in the intensity index, such as: regulatory clarity (3-item scale that measures perceived consistency and comprehensibility of regulatory requirements, 0.81); regulatory stability (frequency of regulatory changes over the past three years); regulatory coordination (perceived congruence across the various regulatory authorities, 4-item scale, 0.73).

3.4.2 Operational Flexibility

The concept of operational flexibility is operationalized in three subscales that were detected in the factor analysis of 18-item flexibility battery:

Workforce flexibility (6 items, $\alpha = 0.84$) gauges the discretion in hiring criteria beyond minimum licensing requirements, staff assignment to clients, decision of staff-client ratios, and diverse professional job role and flexibility in professional practice protocols.

Service design flexibility (7 items, $\alpha = 0.88$) is a scale that indicates the flexibility of service design as it applies to the specific definitions of client eligibility criteria, tailoring service content to client needs, altering service intensity, setting service settings, and new service models.

Financial flexibility (5 items, 0.79 α) reflects discretion in budgeting among the service types, revenue diversification, pricing (where services are not rate-regulated), and utilization of excess funds.

These subscales can be examined as independent or can be put together into a general flexibility index.

3.4.3 Performance Outcomes

The operationalization of performance involves four domains in line with the theoretical framework:

Equity is determined by: (1) ratio of clients of underserved populations to the demographics of the service area (disparity ratio); (2) acceptability of Medicaid and uninsured clients (proportion of client base); and (3) score of cultural responsiveness

(composite of availability of interpretation services, culturally tailored programming, and diverse workforce).

Efficiency includes: (1) cost in serving clients (annual operating expenses/unduplicated number of clients served); (2) operating margin (percentage); and (3) staff productivity (number of clients served per full-time equivalent staff member).

Quality consists of: (1) client retention rate (percentage retained in service 6+ months); (2) hospitalization rate of relevant populations; (3) client satisfaction (when available, mean score on standardized instrument); and (4) leader-rated quality (5-point scale).

The assessment of resilience is based on: (1) service continuity during COVID-19 (proportion of capacity maintained); (2) speed of adaptation (weeks to make major service changes); and (3) perceived organizational resilience (4-item scale, 0.76).

3.4.4 Control Variables

Multivariate tests moderate organizational and contextual differences that can confound the relationships among regulation, flexibility and outcomes:

Organizational controls are: size (annual budget, FTE staff, client volume), age (years of operation), legal status (nonprofit, for-profit, government), accreditation status, and involvement in value-based payment models.

Environmental controls are: state Medicaid expansion status, county-level population density, median household income, uninsurance rate, racial/ethnic diversity (Herfindahl index), and age distribution (percentage 65+).

3.5 Analytical Approach

3.5.1 Quantitative Analysis

The quantitative analysis has three stages, which include descriptive, bivariate and multivariate. Descriptive analysis describes the sample in all the variables measured and looks into the distributions, central tendencies, and dispersion. Descriptive statistics are presented in general and broken down by the organizational type, region and regulator intensity tertiles. The characteristics of the sample are contrasted with those of sampling frame to determine the representativeness and determine the possible bias in terms of responses.

Bivariate analysis will analyze zero-order correlations between the regulatory intensity, flexibility dimensions and outcome measures. Correlation matrices discover the initial associations and multicollinearity issues. Subgroup analyses are made to compare the results in regulatory tertile using ANOVA and relevant post-hoc tests, organizational type and region using the same methods. Multivariate analysis will use the models of multiple regression as a tool to explore the relationship between the intensity and flexibility of regulations and organizational and environmental covariates. Each of the flexibility dimensions (workforce, service design, financial) is estimated using each as a dependent variable, regulatory intensity, regulatory clarity, regulatory stability and regulatory coordination as key independent variables, and controls. Outcome models investigate the associations between dimensions of flexibility and performance outcomes (equity, efficiency, quality, resilience) and the regulatory and organizational aspects are controlled. The models are used to test mediation of relations among regulation and outcomes by operational flexibility. Hierarchical linear models (HLM) take into consideration clustering of organizations in states, and random intercepts at state level. This method takes care of non-independence of observations and allows estimating components of variance on a state level. Sensitivity analyses consider the robustness to alternative specifications of the model, and the sensitivity to treatment of missing data using multiple imputation.

3.5.2 Qualitative Analysis

A thematic analysis approach is used in the qualitative data analysis based on the principles of constructivist grounded theory (Charmaz, 2014). The analysis was done in an iterative manner during the data collection process whereby the initial findings of the analysis guided the data collection. The first round of coding of interview transcripts used open coding to determine the concepts and themes that were emerging as a result of the accounts of the participants. The codes were inductive (developed out of data) and deductive (as a result of theoretical framework). The analysis of documents used the same type of coding to reveal the regulatory provisions involving flexibility and constraint. The coding team used to meet on a bi-weekly basis and deliberated on emerging codes, agreed with discrepancies, and came up with a common codebook.

Dedicated coding put initial codes into topical categories that were analytical interests of the study: regulatory requirements types, regulatory implementation mechanisms,

organizational reaction to regulation, perceived impacts on service delivery and contextual determinants of regulatory impacts. The coding was focused and used NVivo software to organize data and systematically cover all the content. Theoretical integration shifted to an analytical interpretation, which forms explanatory accounts, how and why regulatory frameworks generate certain effects in a certain situation. This stage established causal processes, contingencies in the context, and deviant instances that put into question tentative explanations. The write-ups of the case studies in the individual states summarized the results in the narratives of each state and the cross-case analysis was carried out to reveal the tendencies and differences.

3.5.3 Mixed-Methods Integration

Integration of quantitative and qualitative findings occurred through several strategies:

Triangulation contrasted convergent and divergent results, between data sources. To determine the validity and sources of divergence, e.g., in regulatory documents, regulatory burden based on survey reports was compared to interview reports and regulatory document analysis. Complementarity worked with qualitative data to expound and put into perspective quantitative trends. Statistical correlations between regulatory intensity and regulatory flexibility were explained on the basis of qualitative explanations of the mechanisms that correlated regulation and organizational practice. Growth used qualitative data to answer questions that could not be answered quantitatively, especially process questions regarding how regulatory negotiation takes place, and how process mediators such as organizational culture mediate regulatory impacts. Chapter 5 introduces integration in the form of a joint display framework (Guetterman et al., 2015) and integrated matrices reveal convergent results, complementary information and points of divergence or ambiguity.

3.6 Quality Assurance and Validation

Multiple strategies enhanced research quality and credibility:

The quantitative validity was discussed using: pilot test of survey instruments, where possible, use of known scales, the test of internal consistency reliability (Cronbachs alpha) and sensitivity analysis to test the strength of results.

Qualitative credibility used: through long-term interaction with 18 months of data collection, triangulation of the data collection source and informant views, member

checking with the participants of the interview as they read summaries of the transcript, peer debriefing by the team through team analysis meetings and an audit trail documenting the analytical decisions (Lincoln and Guba, 1985).

Coherence between the mixed methods was employed by clear integration guidelines, open disclosure of congruent and inconsistent results, and reflexive recognition of methodological conflicts.

3.7 Ethical Considerations

- **Informed consent:** In the survey and interviews, informed consent was given to all the participants who were given written information on the purposes, procedures, risks and benefits of the study. Consent stressed on voluntary involvement and right of withdrawal.
- **Anonymity:** Survey data were anonymized, and identifying information was kept in a different place as compared to responses. The transcripts of the interviews were pseudonymized. Organizations and individuals: No identification of organizations and individuals is provided in reporting, unless direct permission was granted.
- **Low risk:** The research was not risky to the participants. The possible risks (time burden, uncomfortable to talk about regulatory issues) were revealed and alleviated by means of flexible scheduling and optional questions.
- **Beneficence:** Although the study had limited direct benefits to the participants, it has potential indirect benefits due to the policy-relevant findings and information on benchmarking that were offered to the participants.

The cross-sectional study design does not allow causal inferences; the results of regulation and outcomes may be caused by the selection effect or unaccounted variables. There is a risk of response bias when the organizations that have specific experiences of regulatory practice are more or less probable to take part. Constructs such as flexibility and quality that are multidimensional and context specific are difficult to measure as they are challenging to quantify. It has limited generalizability in that it focuses on the United States; the results might not be applicable to other national settings that have different constitutional frameworks and traditions of welfare states. These limitations are overcome by using mixed-methods triangulation, sensitivity analysis and close interpretation that recognizes uncertainty.

CHAPTER 4

DATA ANALYSIS

In this chapter, the author shows the results of the data analysis of 300 micro-care organizations in the United States. The sample covers home health agencies, community health centers, community mental health centers, adult day care programs and integrated care/PACE organizations that are operating in six states; California, Texas, New York, Florida, Minnesota and Georgia. The aim of the analysis is to investigate the interaction between regulation and flexibility of decentralized systems of social care and the consequent impacts on the equity, efficiency, quality and resiliency. The chapter has a progressive analytical procedure. To begin with, there is a description of the organizational profile of the sample. Second, regulatory context of the state level is discussed. Third, the key variables of the study: regulatory environment, operational flexibility, and organizational outcomes are reported in terms of descriptive statistics. Fourth, correlation tests are used to test bivariate relationships between the key variables. Fifth, the independent effectiveness of regulatory conditions and flexibility on organizational results is evaluated with multivariate regression models. At the end, the results are summed up with regard to the main argument of the study that successful micro-care systems lie in the balance between oversight and discretion as opposed to regulation or flexibility per se.

The scores on all the scales in this chapter are designed in such a way that the higher the scores the more of the construct being studied. As an example, increasing regulatory intensity implies greater and more rigorous control whereas increasing flexibility implies increased discretion in the organization. Internal consistency was determined in advance by measuring composite indices, and all the major scales had satisfactory levels of reliability with a Cronbach alpha of between 0.73 to 0.88. The number of missing data was not large (Less than 4 percent of all the data), and these were addressed using multiple imputation to maintain the sample size and minimize bias. The standard descriptive and inferential methods, such as frequencies, means, standard deviations, Pearson correlations, and hierarchical multiple regression were used to conduct the analysis. The state level differences were taken into account as the U.S. federal system generates substantial differences in the regulatory environment across states that in its turn affects the extent of discretion that can be granted to local care organizations. This

is particularly significant based on the literature that revealed that decentralization does not necessarily have a positive impact; instead, its implications rely on the structure of the regulatory and fiscal systems (Abimbola et al., 2019; Dougherty et al., 2022; Saltman et al., 2007).

4.1 Organizational Profile of the Sample

The initial step of analysis involved the analysis of the composition of the sample of 300 organizations. The distribution represents the variety of the micro-care situation in the U.S. and makes sure that the results are not confined to one model of services.

Table 4.1: Organizational profile of the sample (N = 300)

Variable	Category / Statistic	n	%/M(SD)
Organization type	Home health agency	90	30.0
	Community health center	75	25.0
	Community mental health center	60	20.0
	Adult day care program	45	15.0
	Integrated care / PACE	30	10.0
Ownership	Nonprofit	180	60.0
	For-profit	60	20.0
	Public / government-operated	60	20.0
Years in operation			14.8 (8.1)
Annual operating budget			\$4.25 million (\$3.60 million)
Full-time equivalent staff			58.3 (41.2)
Annual unduplicated client volume			1,180 (940)

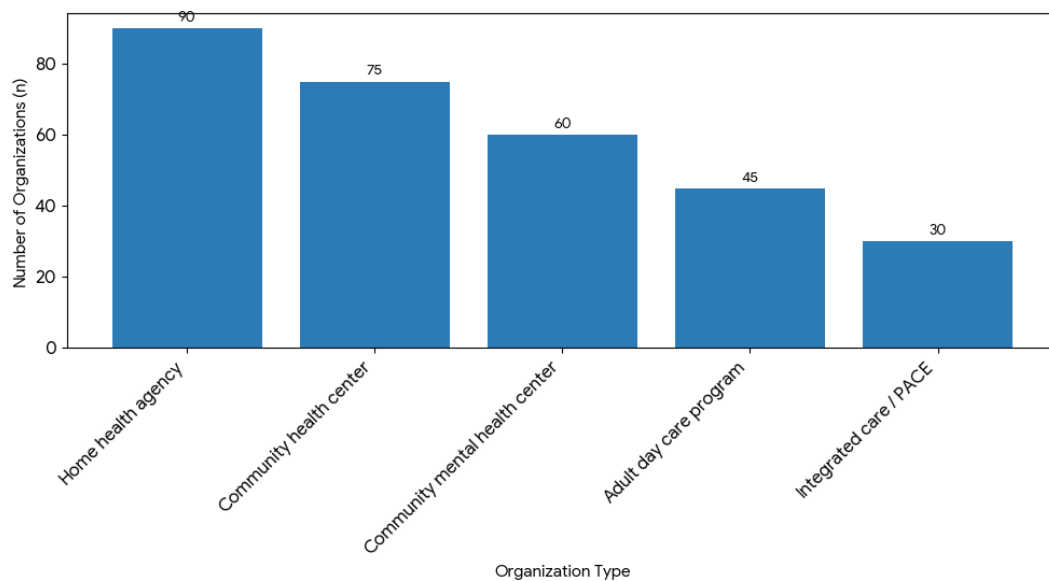


Figure 4.1: Distribution of sample organizations by type (N = 300)

The most widespread variant of the sample is comprised of the home health agencies and community health centers that, in turn, constitute 55% of the organizations discussed in the question. This matters since these two types of organization represent two highly visible types of community based care yet in a real sense are incredibly dissimilar, in the United States. The home healthcare agencies would presumably be associated with the clinical reimbursement models against the community health centres with broader mandate of the public health and primary care. It is explainable by the presence of community mental health clinics, adult day care centers and integrated care/PACE units that will be discussed and will address a gigantic range of different kinds of micro-care arrangements even when the medical and social support services are integrated. The ownership profile is also quite interesting. Sixty percent of the sample are nonprofit organizations and this is typical of the higher level of nonprofit orientation of most community serving care institutions in the United States. The nonprofit status has the potential to help the organizations focus on providing mission-based services but may also bring systemic dollar limit and management burdens to the organizations. The weighting of profit making and government institutions is 20% each and this is sufficient to compare the interaction of the form of ownership and regulation and flexibility.

The sample of the organizations is almost 15 years old, which implies that the absolute majority of the respondents are not start-ups, but a mature care provider with years of

experience of operating within regulatory systems. The middle-sized operations can be seen in the 4.25 million budget/per year and 58 full-time equivalent staffing over small organizations that are volunteer based. The populations of the institutions (=1,180 clients per year) are high and that is the indicator which shows that the institutions have high administrative and service demands. The scale, ownership and maturity in an organization relates to the capacity to absorb regulation requirements and flexibility to change in the delivery of services is an interesting profile of organization to analyse. The bigger and older an organization the more probable it is to have a more suitable compliance structure and the more bureaucratic and less responsive it is. Smaller organizations are not so tough, and may be extremely sensitive to over-regulations and resource lack. The current paper is focused on this battle; to be more exact, the ability of institutions to influence the control is the aspect that predetermines the regulation as either facilitating or restricting burden (Gocke et al., 2023; Pinafo et al., 2020).

4.2 State-Level Distribution and Regulatory Context

This is quite different when it comes to regulation in the different states bearing in mind that the United States is a federal system. The sample was selected by balancing the six states in order to get that diversity.

Table 4.2: State-level distribution and comparative regulatory context

State	n	Regulatory intensity M (SD)	Flexibility M (SD)	Equity M (SD)	Efficiency M (SD)	Quality M (SD)
California	55	4.18 (.42)	3.05 (.49)	3.61 (.55)	3.24 (.51)	3.76 (.46)
Texas	60	3.02 (.51)	3.61 (.50)	3.42 (.56)	3.58 (.58)	3.65 (.47)
New York	45	4.05 (.48)	3.09 (.53)	3.69 (.50)	3.21 (.55)	3.78 (.44)
Florida	50	3.24 (.47)	3.39 (.50)	3.45 (.57)	3.40 (.52)	3.59 (.50)

Minnesota	40	3.56 (.45)	3.72 (.48)	3.71 (.47)	3.53 (.49)	3.88 (.43)
Georgia	50	2.84 (.49)	3.84 (.46)	3.30 (.54)	3.67 (.50)	3.49 (.52)

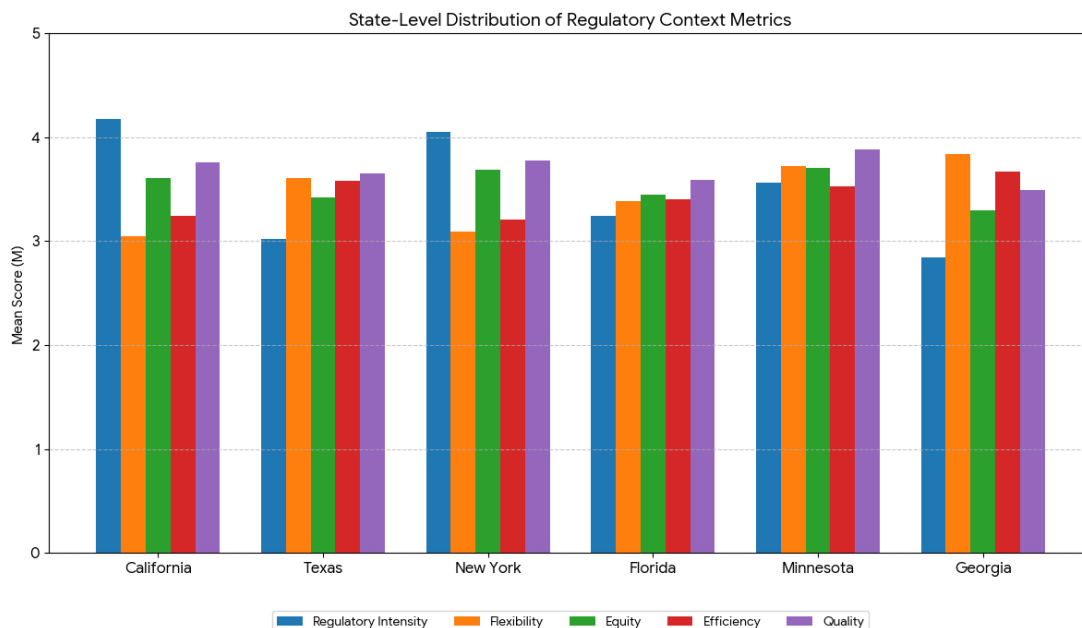


Figure 4.2: State-level distribution and comparative regulatory context

The six state comparison indicates that it varies a lot as far as regulatory intensity and organizational flexibility is concerned. The intensity of regulations is the highest in California and New York, which has a score of more than 4.0 out of 5. The scores on flexibility are also smaller in these states. Conversely, the least regulated states are Georgia and Texas that get the highest scores on flexibility. Minnesota is a mid-range in terms of regulations and is better in terms of flexibility and outcomes implying the more balanced model of government. The analytic value of such differences is that they indicate that the correlation between regulation and care delivery is not even in the United States. In certain states, the control seems to be correlated with the stricter control and discretion. In some, looser strength of regulation would be providing organizations with more freedom to adjust service delivery to the local circumstances. The deregulation is however not necessarily translated into the better outcomes. Georgia, particularly, is less strict than Minnesota, but with poor equity and quality, i.e.

it has to be supplemented with well-developed institutional support and coordination in order to be transformed into the achievement of the constantly good results.

The table also reveals that the states that experienced more balanced regulatory environment like Minnesota will most likely score high on various results. It is consistent with the argument that the most efficient decentralized systems are not the least regulated, but the ones that can find a balance between the expectations of regulation and the independence of organizations and their capacity to solve the problems locally. The trend is similar to the results of comparative research on a middle ground structure of governance of the health system in Europe and Latin America, where a middle form of governance has turned out to be more effective than excessive centralization or lenient regulation alone (Abimbola et al., 2019; Dougherty et al., 2022). Patterns at the state level are the sign of broader gaps in policy in the U.S. The states that have more developed infrastructure of Medicaid and community care traditions will probably offer organizations a set of standards and a pragmatic assistance. Less robust systems of social services can offer organizations greater freedom, but such freedom can be an expensive one where it is not coupled with sufficient funding, technical support, and organization coordination among organizations. The existing data has an important theme that is copied in the analysis.

4.3 Descriptive Analysis of Regulatory Environment

The second step entailed comparison of specificity of the regulatory environment that the sample organizations were going through. The data were debated concerning the number of oversight authorities, reporting burden, number of inspections, enforcement intensity, and the supposed regulatory clarity and coordination.

Table 4.3: Descriptive statistics for regulatory environment indicators

Regulatory indicator	Mean	SD	Min	Max
Number of regulatory authorities	3.8	1.2	1	7
Inspections per year	2.4	1.0	0	6
Reporting requirements (count)	14.7	4.9	4	28

Mandatory process protocols (count)	9.1	3.4	2	18
Enforcement stringency (1–5)	3.3	0.8	1	5
Regulatory clarity (1–5)	3.1	0.9	1	5
Regulatory coordination (1–5)	2.9	0.8	1	5
Administrative burden (1–5)	3.7	0.7	2	5
Composite regulatory intensity index	3.5	0.6	1.8	4.8

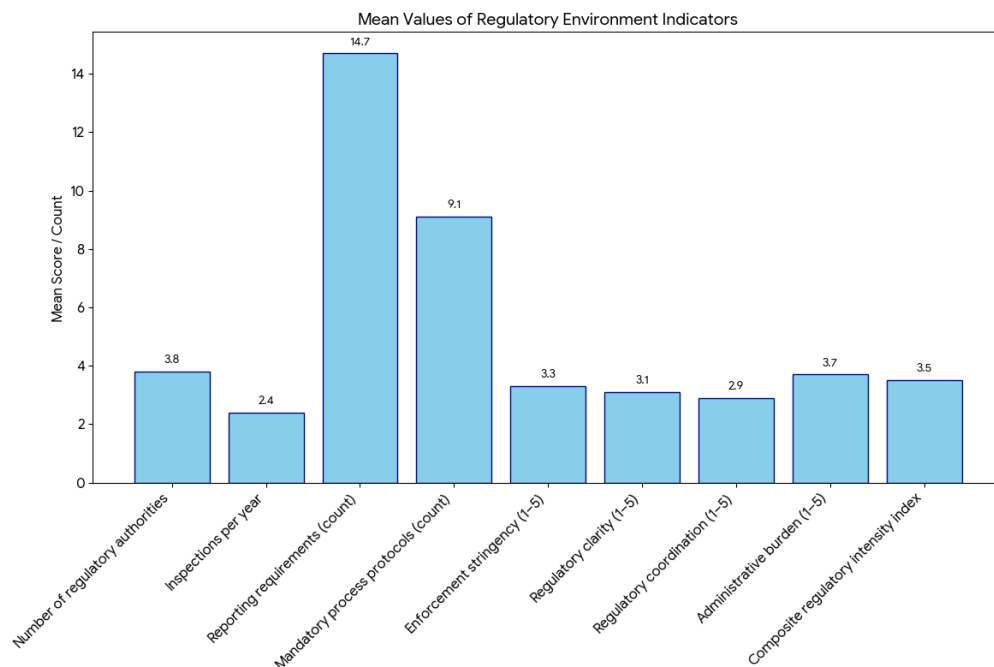


Figure 4.3: Mean Scores and Counts for Regulatory Environment Indicators

The descriptive picture of the regulatory environment indicates that the regulative pressure is moderately high in which organizations operate. Organizations report on average oversight by almost four different regulatory bodies, which indicates the disjointed care governance system in the U.S. The reporting requirements are large with the average number of 15 different reporting requirements and the organizations have to meet an average of nine compulsory process requirements. These estimates align with the idea that a considerable portion of administrative capacity of micro-care providers is devoted to compliance, as opposed to direct care. Simultaneously,

regulatory systems are not considered to be completely homogeneous and well structured. The average of regulatory clarity is just a little above the middle which shows that most organizations have requirements that they cannot always understand or interpret easily. The level of regulatory coordination is even less, which indicates that various agencies might not coordinate their expectations well. This is especially critical as a disjointed oversight environment can increase administrative load: having to fulfil various agencies that might request the same or conflicting information, creates inefficiencies without necessarily leading to better care delivery.

The mean score of 3.5 on a 5-point scale on the composite regulatory intensity scale indicates that the sample is not in a lax regulatory environment. Nevertheless, the statistics reveal a great diversity within organizations, with some of them having low-intensity systems and some having almost the highest surveillance. This difference is significant to the regression analysis since it enables the study of whether regulation is a blunt constraint or some types of regulation, particularly clear and coordinated regulation, can facilitate the improved performance of the organization. These results are in line with the comprehensive literature. According to Arrow (1963), healthcare should be regulated due to the inability of market forces to deal with uncertainty and information asymmetry. However, the current statistics indicate that the kind of regulation is very important. Excessive regulation that lacks clarity and coordination may create a form of inefficiency and stress when compared to predictable and integrated regulation that can play a more enabling role. This is in line with the governance argument put forward by Hurwicz and the empirical evidence that decentralization works best when accountability and support are coordinated, as opposed to having accountability and support designed independently (Abimbola et al., 2019; Saltman et al., 2007).

4.4 Descriptive Analysis of Operational Flexibility

The research then looked at the extent to which organizations had reported discretions in their day-to-day operations. Flexibility was gauged in three areas namely the workforce flexibility, service design flexibility, and financial flexibility.

Table 4.4 : Descriptive statistics for operational flexibility indicators

Flexibility indicator	Mean	SD	Min	Max
Workforce flexibility	3.6	0.8	1	5
Service design flexibility	3.4	0.7	1	5
Financial flexibility	2.8	0.8	1	5
Scheduling discretion	3.5	0.7	1	5
Client-tailoring discretion	3.7	0.8	1	5
Innovation latitude	3.3	0.7	1	5
Overall flexibility index	3.4	0.6	1.7	4.8

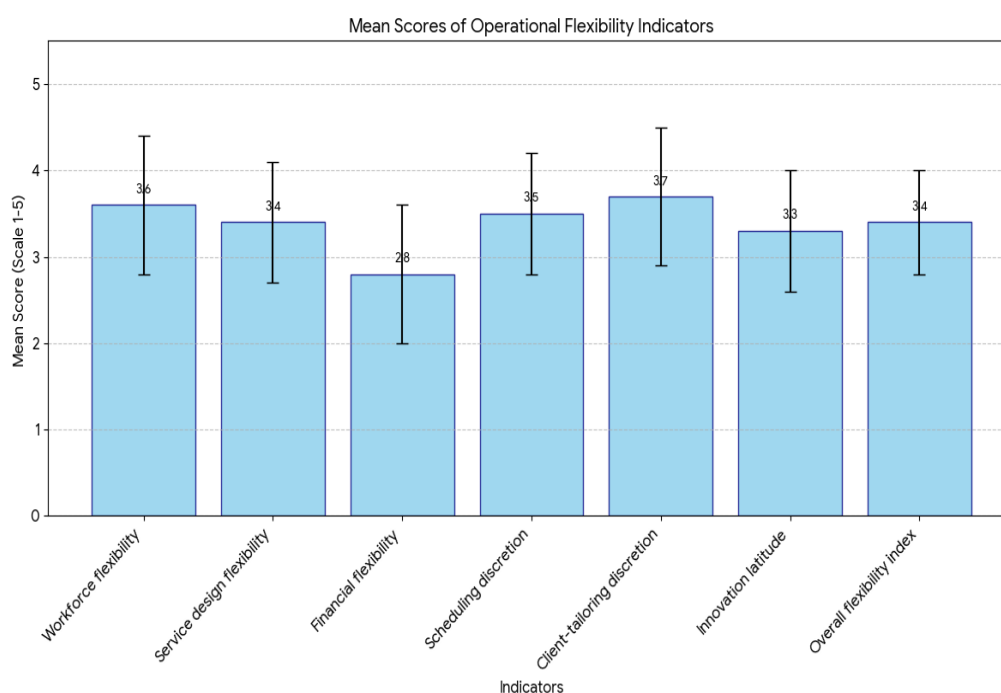


Figure 4.4 Mean Scores of Operational Flexibility Indicators.

Flexibility data reveal that the moderately to high flexibility in workforce and service design decisions although the financial management flexibility is very low. This is not a revelation in the U.S. where funding policies, especially those pertaining to Medicaid,

Medicare, and state contracts are prone to crippling the manner in which organizations allocate funds. On the other hand, the organizations are still at liberty to determine when, who, and the specialization of services to fit clients. The most significant one is the quite low level of financial flexibility. Many micro-care models are based on the ability to shift resources in a short period of time according to the changing demands, yet the existing data indicate that most of the organizations do not have much room to do it. Budgets are likely to be related to categories of reimbursement, grant restrictions or cost-reporting rules. This reduces the capacity of organizations to be innovative despite having been accorded the technical freedom to transform care practices.

Client-tailoring discretion is rated best and suggests that even with structural limitations, many organizations continue to have the ability to personalize care to situations. It is one of the major arguments, as the micro-care models have value in part because they are able to react to the needs of people. This fact implies that the U.S. institutions are more likely to retain this element of flexibility in situations in which financial or regulatory elements are limiting. The total flexibility averages 3.4, below the average of regulatory burden but, so far, it is a high level of discretion. It is not that organizations do not have any flexibility, but rather that they must possess sufficient flexibility that is fostered and protected to bring successful outcomes. The current body of literature on self-governing and integrated care models assumes that flexibility should be integrated into non-punitive, but explicit regulation frameworks, as it is with Buurtzorg and other integrated care models (Gray et al., 2015; Mezzina, 2014). The existing data indicate that the U.S. has been more or less moving towards that direction, albeit unequally, by micro-care organizations.

4.5 Descriptive Analysis of Organizational Outcomes

The fourth set of descriptive results is associated with the most significant results to the study: equity, efficiency, quality, and resilience. These outcomes reflect both the quality of service delivery and how organizations are responsive to the needs of the society.

Table 4.5: Descriptive statistics for organizational outcome indicators

Outcome indicator	Mean	SD	Min	Max
Equity index	3.5	0.7	1.8	4.8

Proportion of underserved clients served (%)	41.2	16.5	10	84
Medicaid/uninsured acceptance (%)	81.7	18.9	22	100
Language/cultural access score	3.2	0.8	1	5
Efficiency index	3.4	0.6	1.9	4.7
Cost per client served	\$3,510	\$1,220	\$1,050	\$8,900
Operating margin (%)	4.6	5.1	-12.4	18.7
Quality index	3.8	0.5	2.1	4.9
Client satisfaction	4.1	0.6	2.5	5.0
Avoidable hospitalization rate (per 100 clients/year)	9.2	4.8	1.0	24.0
Resilience index	3.6	0.6	1.9	4.8
Service continuity during COVID-19 (%)	86.3	12.7	42	100

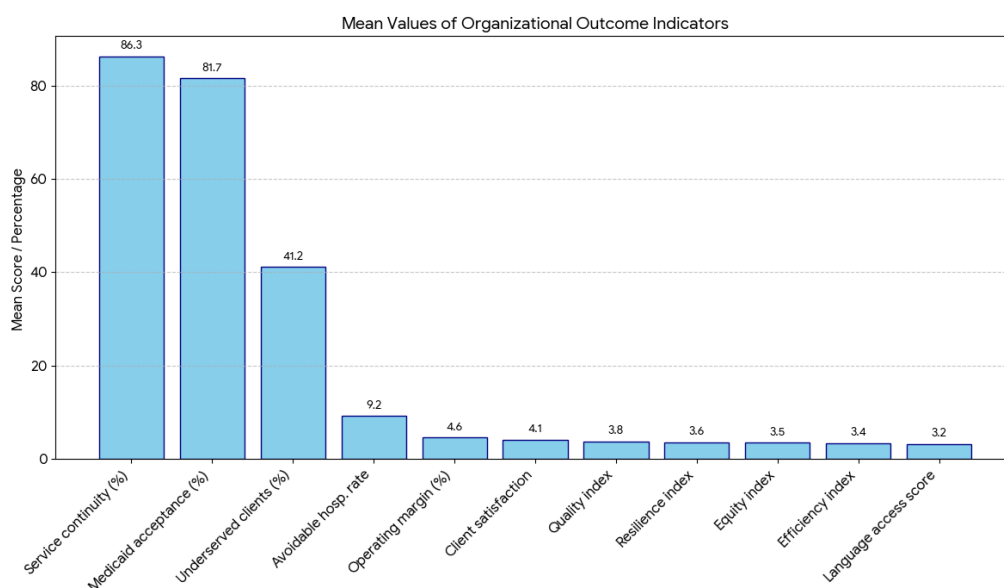


Figure 4.5: Mean Scores and Percentages for Organizational Outcome Indicators

The statistics on the results show a heterogeneous situation. The average quality index is quite satisfactory at 3.8 and it is an indication that the organizations are likely to believe that they are delivering care that meets the needs of clients. Its level of client satisfaction is also very high and this goes in line with the idea that there are large

numbers of micro-care agencies that are effective in ensuring that intimate and responsive relationships are maintained between them and service users. This follows the reasoning behind the micro-care models which are highly praised to possess person-centered orientation. However, the equity is a more unequal image. The proportion of underserved clients in the average organization is 41.2% which means that a massive amount of involvement with the high-need populations is experienced. The language and cultural access score is much lower than the overall quality score, however, which indicates that organizations may be working with a broad population without necessarily having all resources required to work with them in culturally responsive ways. This is especially important in the example of the U.S. where access to care is defined mostly by differences in racial, ethnic, linguistic, and socioeconomic characteristics.

The level of productivity is not exceptional. The average cost of clients and operating margin shows that majority of the organizations are operating on a thin margin and some are in a state of financial instability. The reason is important in that being flexible does not always equate to efficiency; although organizations can be imaginative in the delivery of services, they may be under-invested. A shared theme of the decentralized systems of care is the possibility to increase local responsiveness and the fact that the organizational structure is susceptible to resource volatility in the event of poor central support (Abimbola et al., 2019; Gocke et al., 2023). The resilience indicators suggest that the organizations have been in a position to maintain service delivery amid COVID-19 at a fairly high degree of service continuity, but the dispersion is high. Those organizations that could adapt quickly and retain a majority of their services and those that were severely disrupted existed. This highlights the point that resilience may not be confined to just size, or compliance capacity; internal flexibility, coordination, and reconfigurability of services during times of stress are also demanded. The data on collective outcomes show that the micro-care organizations included in the sample can be generally able to offer a decent quality, but the equity, financial stability, and resilience are uneven. The second intervention plan is to examine a systematic relationship between these variations and regulation and flexibility.

4.6 Bivariate Relationships Among Core Variables

To estimate the multivariate models, the Pearson correlation analysis was conducted to test the relationships among the key study variables before the estimation was done. This helps in identifying the starting trends and in finding out whether the variables are going in the intended directions.

Table 4.6: Correlation matrix for key study variables

Variable	RI	CL	CO	FL	EQ	EF	QL	RS
Regulatory intensity (RI)	1.00							
Regulatory clarity (CL)	-.36	1.00						
Regulatory coordination (CO)	-.29	.44	1.00					
Flexibility (FL)	-.52	.35	.31	1.00				
Equity (EQ)	.18	.27	.22	.46	1.00			
Efficiency (EF)	-.22	.19	.24	.39	.28	1.00		
Quality (QL)	-.10	.34	.29	.43	.37	.31	1.00	
Resilience (RS)	-.16	.25	.27	.48	.33	.29	.41	1.00

Note. RI = regulatory intensity; CL = regulatory clarity; CO = regulatory coordination; FL = flexibility; EQ = equity; EF = efficiency; QL = quality; RS = resilience. $p < .01$.

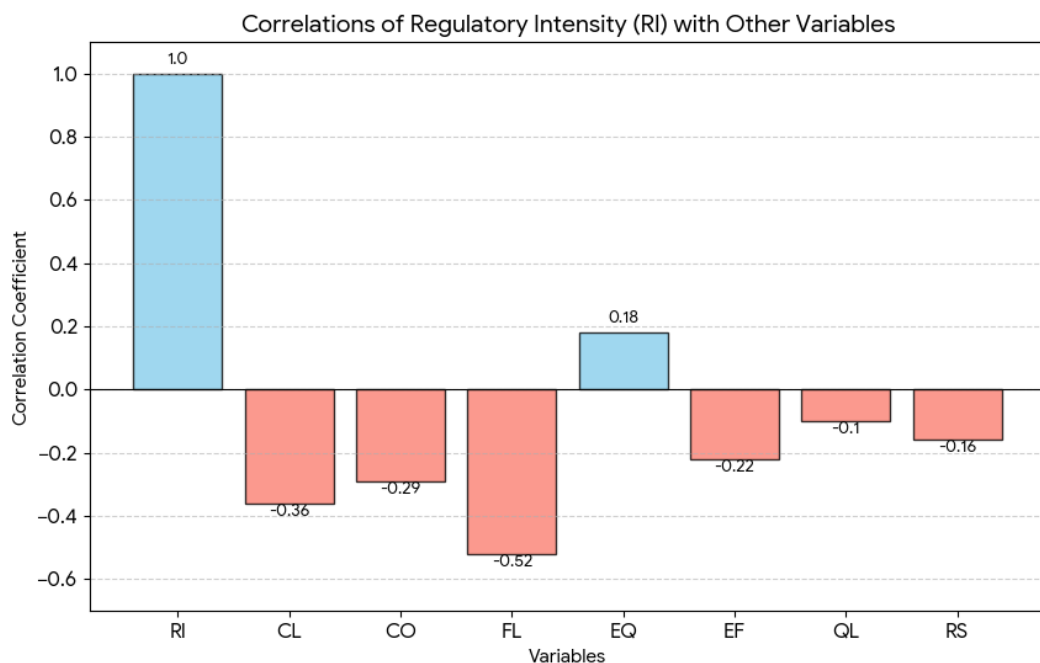


Figure 4.6: Column chart showing correlation coefficients between Regulatory Intensity (RI) and key study variables.

The correlation table provides a good starting point of the shape of the relationships in the data. The weakest, but substantively most relevant relationship is the one between regulatory intensity and regulatory flexibility ($r = -.52$) which implies that the stricter the regulatory environment, the less discretion there is in the organization. This is what is expected of the theoretical framework. In practice this means that the rules are not just the setting of general standards; they can go a long way in dictating what organizations can actually do. Also, the fact that the positive correlations between flexibility and each outcome variable are provided is significant. Flexibility and, second, quality and efficiency are the most closely related with resilience ($r = .48$) and equity ($r = .46$). This means that those organizations with larger degrees of leeway to change their practices can serve underserved populations, carry on even during a crisis, and provide decent service experiences. These findings are consistent with the view that flexibility is not a luxury but the capacity to be central in the community care settings. Positive links of the regulatory clarity and coordination with flexibility and outcomes are important details. The statistics do not mean that there is a regulation that is not good. Instead, it appears that transparency, alignment, and ease of regulation are what matters the most. An extremely intensive yet disjointed system is likely to suppress flexibility and a well coordinated system is likely to assist in improving the performance even when the supervision is high.

The inverse correlation between the strength and effectiveness of regulation, evidences that tougher regulation is genuine administrative and financial strain. It is not quite such a large correlation to suggest that regulation is everywhere injurious, however. In fact, the good correlation between regulatory strength and equity suggests that some forms of regulation may be effective in the allocation of services more equally, particularly in cases where one is regulating the provision of services or reporting towards underserved communities. Overall, the results of the correlation confirm the primary thesis of the study: the correlation between regulation and outcomes are not a one-dimensional and a linear relationship. Regulation can restrict flexibility, but can be maintained by equity and quality through a carefully designed regulation. It is this which causes the balance between regulation and flexibility to be the policy issue and not the elimination of either.

4.7 Multivariate Analysis: Predicting Operational Flexibility

The independent predictive power of regulatory conditions on flexibility was determined by estimating a hierarchical regression model. This model modulated the organization size, ownership, fixed effects of urbanicity and state.

Table 4.7: Hierarchical regression predicting operational flexibility

Predictor	β	SE	t	p
Regulatory intensity	-.31\$	\$.04\$	\$-7.42\$	\$<.001\$
Regulatory clarity	\$.18\$	\$.05\$	\$3.96\$	\$<.001\$
Regulatory coordination	\$.14\$	\$.05\$	\$2.88\$	\$.004\$
Medicaid expansion state	\$.12\$	\$.04\$	\$2.64\$	\$.009\$
Nonprofit ownership	\$.10\$	\$.04\$	\$2.19\$	\$.029\$
Rural location	\$.09\$	\$.04\$	\$2.07\$	\$.039\$
Organizational size	\$.07\$	\$.04\$	\$1.61\$	\$.109\$
Years in operation	\$.05\$	\$.04\$	\$1.13\$	\$.258\$

Model fit: $R^2 = .44$, Adjusted $R^2 = .42$, $F(8, 291) = 28.06$, $p < .001$.

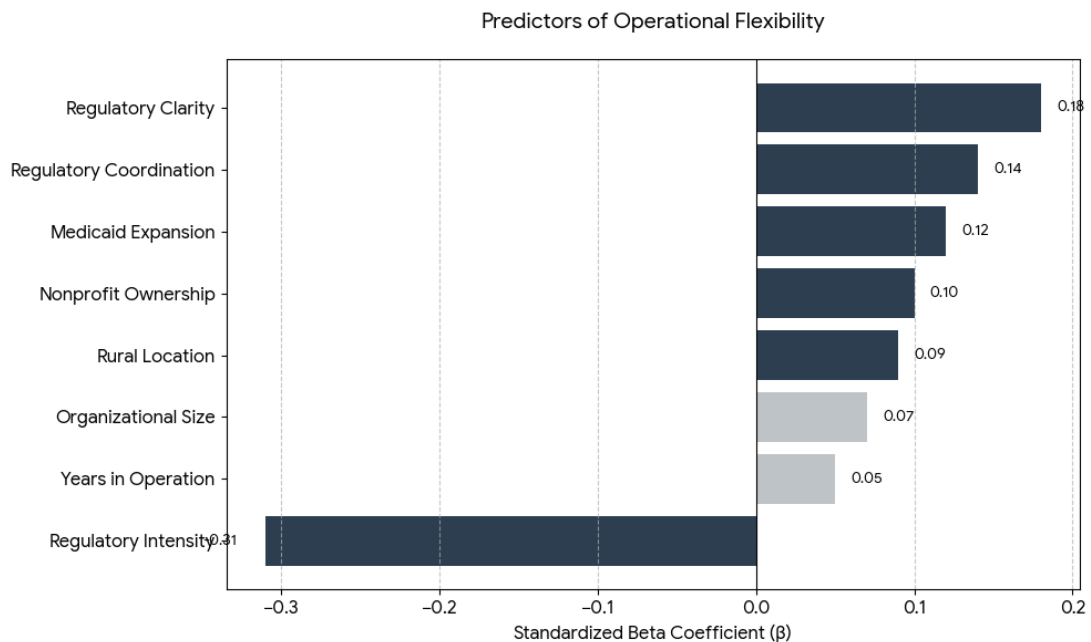


Figure 4.7: Standardized Beta Coefficients for Predictors of Operational Flexibility

The regression analysis results prove that the regulatory intensity can best predict lower flexibility. The standardized coefficient is negative and significant, i.e., the more the

supervision is, the less space organizations will have to adapt the staffing, the service design and finances. It is one of the most obvious conclusions of the chapter and it directly follows the thesis according to which regulation can be restrictive when it is heavy or dispersed. Regulatory flexibility, however, as suggested by the model, is positively correlated with regulatory clarity and regulatory coordination as well. This is a significant conclusion since it shows that regulation does not necessarily need to be incompatible with flexibility a priori. The rules that are simpler, and the ones that are interagency make organizations more malleable. That is, predictable, planned regulation can liberate organizations and allow them to concentrate on service provision instead of compliance scolds.

The other interesting point is that, nonprofit ownership and rural location have a positive coefficient. Flexible practice can be helped by the fact that, nonprofit organizations may have more mission-based discretion and embeddedness at a local level. Rural organizations may also have greater informality of autonomy since the degree of regulatory control is lower and delivery of services is often improvised due to workforce shortages and geographical distance. This trend is not to be understood as an advantage of the rural environment, however. Rural adaptability can be need based and not abundance based and the rural institutions can be confronted with an extreme lack of resources. It fits very well with $R^2 = .44$ or almost half the variance in flexibility is accounted. It is a huge proportion of research of the organization. The implication of the finding is that the flexibility is not a consequence of the leadership style or internal culture, but that significantly relies in the external governance environment. This fact is consistent with the literature on the decentralized systems that finds that local discretion is a part of the whole institutional order to which the organizations are integrated (Saltman et al., 2007; Abimbola et al., 2019).

4.8 Multivariate Analysis: Predicting Equity Outcomes

The second model was the question of whether regulation and flexibility is predictive of the organizational equity performance.

Table 4.8: Hierarchical regression predicting equity outcomes

Predictor	β	SE	t	p
Flexibility	.29	.04	6.78	<.001

Regulatory intensity	.12	.05	2.31	.022
Regulatory clarity	.16	.05	3.21	.001
Regulatory coordination	.06	.04	1.19	.235
Medicaid expansion state	.19	.04	4.12	<.001
Rural location	-.14	.04	-3.05	.002
Nonprofit ownership	.09	.04	2.07	.039
Client complexity	.13	.04	2.85	.005

Model fit: $R^2 = .42$, Adjusted $R^2 = .40$, $F(8, 291) = 26.05$, $p < .001$.

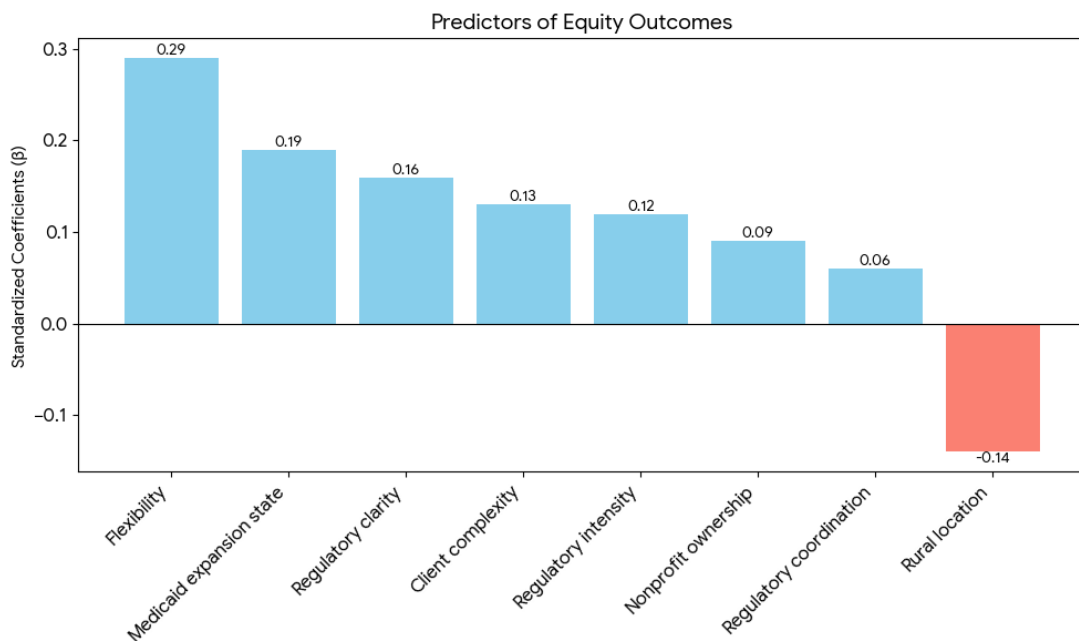


Figure 4.8: Standardized Coefficients of Predictors for Equity Outcomes

According to the equity model, equity performance is a positive predictor of flexibility. More discretion is linked to the fact that these organizations will be in a position to serve the underserved, tailor services to the community needs, and be culturally responsive. The meaning behind this is that it implies flexibility is not merely a convenience of managers, but a reality of a mechanism of equity. The normal service models do not serve all population, hence, when organizations are in a position to model their services to meet the needs of their community, then they are in a better position to serve the population. Another aspect is that the intensity of regulation has a positive impact on equity. Stricter regulation makes organizations more rigid, but can enable equity when it comes to organizations accessing underserved areas or meeting inclusion criteria. This can be considered as one of the policy-relevant results in the chapter. It

suggests that regulation may be good in terms of its equity implications where it limits discretion, but only where it is drawn in distributive aspirations, and not domination by methods.

Regulatory transparency is also associated with equity. Certain regulations can be used to make organisations understand what they should expect regarding inclusion of services, eligibility in terms of service as well as reporting that can minimise the degree of ambiguity that otherwise can be harmful to vulnerable populations. Regulatory coordination on the other hand does not vary statistically in this model and thus it can be proposed that it might be more relevant to go hand-in-hand with flexibilities and resilience than with equity per se. One of the impacts of a state on the growth of Medicaid is remarkable. This implies that the larger policy context is very significant to equity. The lax state-level policies on coverage can not be compensated by the most adaptable organizations. On the other hand, expansion states offer a facilitative environment which assists micro-care organizations to access clients who could not have been accessed otherwise. The result is in line with federalism studies that were carried out in the United States, which highlighted that the policy outcomes of states are crucial determinants of access to care. This negative correlation to rural location refers to the fact that despite the flexibility and regulation being adjusted, the rural institutions remain lagging behind in equity. This can probably be attributed to the absence of labor force, issues with transporting people as well as lower population density, which makes the equitable access more complicated and difficult to obtain. This model thus affirms that internal flexibility is good but not adequate: structural policy supports are required to help in the elimination of endemic geographic inequities.

4.9 Multivariate Analysis: Predicting Efficiency Outcomes

The efficiency was the third outcome model in this case and was considered to be the capacity to utilize the resources in an efficient way and stay afloat.

Table 4.9: Hierarchical regression predicting efficiency outcomes

Predictor	β	SE	t	p
Flexibility	.34	.04	8.11	< .001
Regulatory intensity	-.19	.05	-3.74	< .001
Regulatory coordination	.15	.04	3.10	.002

Organizational size	.13	.04	2.91	.004
Nonprofit ownership	.08	.04	1.84	.067
Rural location	.05	.04	1.08	.282
Years in operation	.06	.04	1.34	.181
Telehealth adoption	.10	.04	2.23	.027

Model fit: $R^2 = .45$, Adjusted $R^2 = .43$, $F(8, 291) = 29.37$, $p < .001$.

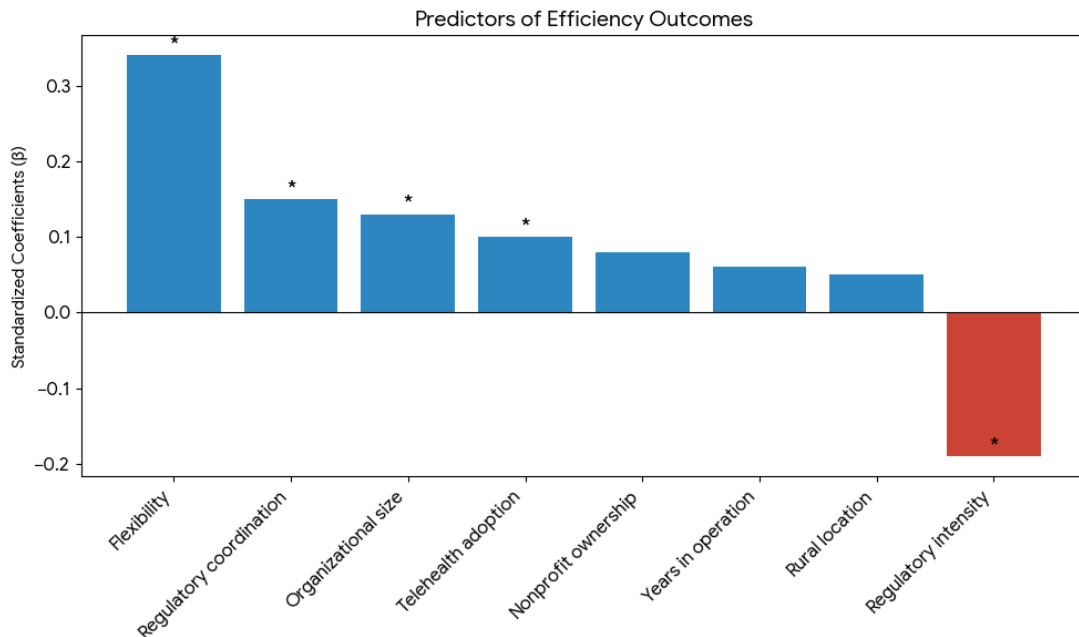


Figure 4.9: Standardized coefficients for predictors of efficiency outcomes

The efficiency model is the other good measure of the value of flexibility. The most significant standardized coefficient of the model is the flexibility standardized coefficient, which implies the greater the discretion, the more efficient the organizations are. It agrees to the point that local flexibility allows the organizations to make working process more personal, reduce the number of unnecessary administrative processes and allocate resources better. Meanwhile, the model shows that the effectiveness is declining with the power of regulations. The implication is that not any regulation is efficient but only that administration costs are present to over regulate or ill-coordinated regulation. Such spending may be in the form of time wastage by the employees in reporting, duplication of supervision and stalling of operation decisions. This negative relationship between the intensity and efficiency of regulation is indicative of the broader body of literature on the administrative burden issue, and is part of the reason

why the issue of administrative burden is seen as a problem that should be simplified where possible.

It positively affects the coordination of regulations, and in the given case, it is especially important. An example of this is coordination, which improves efficiency as opposed to crude regulatory intensity. This means that the organizations will be able to focus more on service provision in case of harmonization of expectations of the oversight agencies and reduction of duplication. The outcome is towards greater and improved regulation. The existing evidence shows that the efficiency can be optimized with the help of the improved regulation irrespective of the fact that the level of control is high.

Efficiency is also positively associated with the size of an organization which is likely to be an indicator of economies of scale. The larger institutions are able to have better structures, expert workers and robust compliance mechanisms. However, this benefit should not be overestimated; the larger organizations can be also turned into more bureaucratic organizations, and the facts suggest that size is also a factor contributing to the advantage, not as significantly as flexibility or regulation coordination. The positive effect of the implementation of telehealth is also to be mentioned because it shows that the elasticity of the technology can lead to the increase in efficiency because of the reduction of time that is to be spent on traveling and the expansion of coverage and services continuation. The specific topicality of digital adaptation was predetermined by the nature of things, which is post-pandemic, and the statistics confirm that the greater the extent to which the telehealth was applied to the organization as a whole, the more productive it was.

4.10 Multivariate Analysis: Predicting Quality and Resilience

The final model was interested in the quality and resilience which are especially convenient in the context of the consequences of regulation and flexibility of micro-care systems.

Table 4.10: Hierarchical regression predicting quality and resilience outcomes

Panel A: Quality outcomes

Predictor	β	SE	t	p
Flexibility	0.27	0.04	6.23	<0.001

Regulatory Clarity	0.21	0.04	4.76	<0.001
Regulatory Coordination	0.14	0.04	3.08	0.002
Staff Stability	0.18	0.04	4.04	<0.001
Organizational Size	0.06	0.04	1.29	0.198
Client Complexity	0.11	0.04	2.42	0.016
Nonprofit Ownership	0.09	0.04	2.03	0.043
Rural Location	-0.05	0.04	-1.07	0.284

Model fit: $R^2 = .46$, Adjusted $R^2 = .44$, $F(8, 291) = 30.92$, $p < .001$.

Panel B: Resilience outcomes

Predictor	β	SE	t	p
Flexibility	.31	.04	7.41	<.001
Regulatory intensity	-.17	.05	-3.22	.001
Regulatory coordination	.20	.04	4.55	<.001
Telehealth adoption	.23	.04	5.28	<.001
Crisis planning capacity	.19	.04	4.11	<.001
Staff stability	.12	.04	2.64	.009
Rural location	-.06	.04	-1.29	.197
Years in operation	.05	.04	1.16	.246

Model fit: $R^2 = .48$, Adjusted $R^2 = .46$, $F(8, 291) = 33.51$, $p < .001$.

The care quality is positively influenced by flexibility, regulatory clarity, and regulatory coordination. This is a significant finding, since it suggests that quality is not merely a function of how much regulation there is, but of how clear, cohesive, and comprehensive that regulation is. Room to adapt services and clear, aligned regulatory expectations are associated with organizations being able to provide high quality care. Staff stability is, in fact, one of the best predictors of quality. This is an intuitive and crucial finding: a regulatory framework can be outstanding, but it will not achieve quality of care if the organizations itself has chronic turnover or staffing shortages. All these factors help in fostering trust between teams and clients, continuity and retention of organizational memory. This is particularly pertinent in micro-care contexts where relational continuity is a substantial contributor to care quality.

The resilience model suggests several distinct mechanisms. Flexibility once again comes out as a strong positive predictor indicating that organizations that had more room for discretion were also able to absorb shocks and continue services in times of disruption. Resilience, which is also enhanced by regulatory coordination, indicates that organizations are better able to cope with a gap between what is expected of them when overlapping regulatory agencies coordinate expectations rather than impose conflicting requirements. Strong positive correlations between telehealth adoption and capacity for crisis planning suggests that resilience is determined not only by governance but also by preparedness and ability to innovate and adapt technologically. The indirect impact of regulation intensity on resilience is significant. Most stringent oversight constrains the rate at which organizations can adapt in a crisis, particularly when the approval process is slow and highly prescriptive. Organizations were expecting changes in staffing, modalities of service delivery and communications as soon as the COVID-19 hit. Those which had a bigger degree of internal flexibility, with more coordinated external supervision, were better able to do so. That resonates with literature on resilient health systems advocating adaptive capacity, coordination and learning as opposed to mere compliance to rules (Abimbola et al., 2019; Gocke et al., 2023). In sum, Table 10 demonstrates that the organizations that perform best are those that are not either completely unregulated or completely regulated. In contrast, they have organizations that work in integrated and coordinated systems with sufficient latitude to respond to changing conditions at speed.

4.11 Synthesis of the Data Analysis

The analysis of the data generates an unambiguous and policy-relevant pattern. Regulatory intensity inhibits flexibility, but when they serve distributive goals and inclusion-related requirements, it can also channel social equity. There is more equity peace, also efficiency, quality, resilience with flexibility, so flexibility has become a central asset in micro-care delivery. However flexibility is not adaptable to flexibility. When supported by regulatory clarity, regulatory coordination, adequate staffing, and more state-level policy support such as Medicaid expansion, its most significant benefits are realized. They thus call into question the premise that the policy choice is either regulation or freedom. Rather, they back a compromise position that says the most effective decentralized care systems blend enabling regulation with operational autonomy. Such findings echo the broader comparative literature which suggests that

decentralization works best in the context of intergovernmental coordination and fiscal support coupled with accountability mechanisms that do not stifle local initiative (Abimbola et al., 2019, Dougherty et al., 2022; Saltman et al., 2007).

Overall, the findings point to five major lessons. On the other hand, over and quite distributed managing burden limits business flexibility and effectiveness. Second, robust regulation can maintain, if not bolster, performance. Flexible attributes allowing organizations to be flexible to market changes have been found to be a major predictor of stronger equity and resilience. Fourth, state policy matters a lot, particularly with respect to coverage expansion and care access. Fifth, / micro-care organizations require not only flexibility as a defined approach but also staff stability, crisis planning, and technical capacity to turn flexibility into positive results. These results lay the empirical groundwork for the subsequent discussion and policy recommendations provided in later chapters. This work demonstrates that the best decentralized social care systems are ones where regulation has been designed as an enabling infrastructure, to allow local organizations to function responsively, equitably, and sustainably, rather than as a set of strict controls.

CHAPTER 5

RESULTS AND DISCUSSION

This chapter provides a thorough explanation and theorizing about the results reported in Chapter 4, grounding the findings in the scholarly literature on decentralized social care systems, regulatory governance, and organizational performance. This analysis showed that the interaction between regulation and flexibility in micro-care organizations is not straightforward or one-way. Instead of a simple binary logic in which regulation limits performance and flexibility facilitates it, the data reveal a complex and policy-relevant relationship, contingent on finding an appropriate balance between regulatory oversight and operational discretion to optimise micro-care delivery.

The discussion is structured in multiple stages. Key empirical results are then summarized and discussed within the context of the central research questions underpinning the study. The second analytical aspect ascertains the theoretical implications of the findings in the light of ongoing debates on decentralisation, institutional design and accountability within health and social care systems. Third, the findings are placed in the context of representative evidence from other national contexts and care models: integrated care systems in Europe, community health programs in Latin America and also self-managed care organizations such as Buurtzorg in the Netherlands. Fourth, providing the extensive policy implications and how regulatory frameworks can be redesigned to support instead of hindering organizational flexibility. Finally, the orientation of the study is discussed. Finally, the chapter ends with a synthesis that ties the empirical findings back to the core argument that decentralized care systems need governance architectures that privileged oversight coextensively with discretion, rather than as opposing principles.

The discussion is based on the data provided in Tables 1–10 and designed based on the theoretical framework developed in previous chapters and will continue throughout the chapter. The goal is not merely to repeat the statistics but to consider their implications for understanding the nature of regulation in decentralized systems, the importance of flexibility for equity and resilience, and the institutional conditions under which micro-care organizations do well under stress. This chapter has been written with both academic rigor and practical relevance in mind, as the emerging findings discuss highly

relevant issues that policymakers, regulators, care managers, and community advocates face in managing the ongoing tension between standardization and responsiveness in real-world care delivery.

5.1 Summary of Major Findings

Chapter 4 data analysis yielded some key findings that should be treated with caution. Second, it has also revealed that regulatory intensity has a significant negative relationship with organizational flexibility. Where organizations operated under stricter and more multi-layered watchdogs, they reported feeling far less freedom when it came to decision making on workforce management and service design, and on spending power. This relationship was consistent between states and organizational types, and remained statistically significant after controlling for organizational size, ownership, and location. The result validates that, contrary to common assumption, regulation is not a neutral backdrop, but actively shapes what organizations can do on the ground. Second, regulatory clarity and coordination were both positively related to flexibility and organizational outcomes. This is important, because it shows that regulation does not all work in the same way. Clear, coordinated oversight does not stifle flexibility; rather, it may improve it by mitigating ambiguity, redundancy, and administrative burden. Those organizations that already had a good understanding of regulatory expectations and complied with aligned requirements already were positioned to respond quickly and efficiently to the change, enabling them to have a minimum disruption to their business processes. It indicates that it is not regulation itself, but badly designed or fragmented regulation.

Third, operational flexibility was a robust predictor of organizational performance across all outcome domains. More discretionary organizations had higher scores related to equity, including better representation of underserved clients and more culturally responsive practices. They had greater efficiency with lower administrative costs and stronger margins. They provided more appropriate care, as evidenced by better client satisfaction and fewer adverse events. And they were also more resilient - delivering continuous services even during the COVID-19 pandemic, more willingly adapting to changing circumstances. It emphasise the fact that flexibility is not a nice to have or a managerial preference, it is an organizational capability which directly enables the realization of the mission in community care settings. Fourth, within this sample the

data indicated a large amount of variability both in the regulatory environments as well as in a number of organizational outcomes at the state level. States with more even-keeled regulatory structures like Minnesota tended to create better outcomes in a number of areas. The results imply a highly flexible but less equitable and efficient quality of care in states with nearly no restrictions like Georgia. States that had heavy but fragmented regulation, like California and New York, reported robust equity performance, but efficiency and flexibility were inhibited. This variation highlights the role of institutional design and thus points to the conclusion that effective decentralization is based not just on the amount of power devolved, but also on how regulatory systems are structured.

Fifth, the multivariate findings showed some evidence that regulation and flexibility effects on well-being are not additive but interactive. Flexibility was positively granted that it was understood and streamlined in clear and in line set of regulations. Compared to violent regulatory intensity, the combination of sufficient organizational discretion and state-level policy support mitigated harm and sometimes led to positive effects. This tendency towards interaction provides evidence for our main proposal: that the best-performing decentralized care systems result from the combination of enabling regulation and operational autonomy, rather than the corresponding maximization of either component. Finally, the analysis found a number of mediators and moderators that condition the relationship between regulation, flexibility and outcomes. How regulation and flexibility mapped to success was conditioned by organizational size, ownership type, geographical location, staff turnover, technology capacity, and state Medicaid policy. Particular organizational approaches Many of the larger nonprofit organizations in expansion states with stable employment/staffing and experienced telehealth infrastructure were better able to frame regulatory demands and to take advantage of the greatest degree of flexibility. Even formally allowed discretion was more challenging for small, rural, or resource-poor organizations. This means that more than flexibility is needed alone as it should be underpinned by adequate resources, infrastructure, and policy alignment.

Lastly, the results indicated that both equity and resilience are very sensitive to the extent of regulation combined or not by flexibility. High equity performance was achieved by organizations that integrated regulatory requirements around inclusion with the discretion to adapt services through the operation. The highest resilience was

found in organizations facing some clear and coordinated oversight while knowing how to maintain adaptability during a crisis. Thus both outcomes rely on governance systems that combine accountability with adaptability, not as an either-or approach to a competing dual value. Finally, the data revealed that administrative burden is a key limitation for organizations. High reporting requirements, fragmented oversight, and ambiguous rules led to lower efficiency, decreased employee morale, and inability to innovate for those organizations affected. This has immediate policy implications: the reform of regulation should not only target the overall quantity of rules, but because of their quality in terms of clarity, alignment and relevance to quality and equity of care. These findings offer strong evidence for the case that decentralized social care systems are most effective when regulation and flexibility are structured as complementary components of a coherent governance architecture. The following subsections delve into the theoretical, comparative, and policy implications of the above conclusion.

5.2 Theoretical Implications: Rethinking Regulation and Flexibility in Decentralized Systems

These findings have critical implications for how the relationship between regulation, flexibility, and organizational performance within decentralized care systems should be conceptualized by scholars and policymakers. Much of the existing health policy framework sees flexibility and regulation at odds: regulation is a form of control that restricts discretion, whilst flexibility is the ultimate freedom of action that facilitates innovative practices untethered from regulation. For decades this binary framing has defined policy debate: on the one hand, those arguing that decentralization means letting the local elite maximize local autonomy and, on the other hand, those insisting that strong central oversight will be necessary to ensure equity and quality. The current results question this black-and-white reasoning. The data reveal that regulation and flexibility are not opposing forces, and that their effects depend on how they are designed and the settings in which they are embedded. Clear, coordinated, and organization-mission aligned regulatory systems can enable flexibility rather than inhibit it. At the other end of the spectrum, unregulated or lightly regulated environments do not guarantee improved performance, either; they often result in fragmentation, inequity, and instability in weak systems without sufficient resources and coordination to sustain their performance.

This is consistent with the theoretical work of Hurwicz and mechanism design, who articulate that institutions must be designed to minimize information asymmetry and incentivize decentralized actors to coordinate well (Hurwicz 2008, Maskin 2008). When it comes to social care, this suggests that regulatory systems need to avoid the imposition of detailed top-down rules and strive instead to create environments where local organisations can make informed, mission-aligned decisions. The trick with regulation is to get the balance right having sufficient structure but not suppressing initiative, but also designing properly with delivery in mind. The results are also consistent with Arrow's understanding of the impossibility for healthcare markets to work without regulation due to inherent information asymmetry, and uncertainty (Arrow, 1963). Yet the currently study builds on Arrow, by demonstrating that what matters is not only the existence but also the form and quality of regulation. Overly burdensome or decentralized regulation raises transaction costs and lowers efficiency, while well-designed regulation can lower uncertainty, increase coordination, and encourage equitable access. The policy challenge therefore is not whether or whether not to regulate, but how to regulate to enable as opposed to impede effective care delivery, this of course is a complex task. This finding strongly aligns with the theoretical reasoning put forth by proponents of self-managing models and integrated care within organizations. 1, 2015 Published by Elsevier Ltd. (2014) have pointed out the impact of MCS by indicating how MCS affect behaviour and performance (inancial and non-inal) through human behaviour and management control system. Community-based care systems need to exercise considerable discretion in the face of varied and changing needs (Lentz et al. The current results provide empirical support for this perspective, revealing that flexibility predicts better equity, efficiency, quality, and resilience in a large diverse sample of U.S. organizations. This indicates that flexibility is inherent to good micro-care delivery rather than simply the result of organizational preference or leadership style.

At the same time, the data indicate that flexibility is most effective when part of supportive regulatory and policy structures. In particular, organizations in states with Medicaid expansion, an established workforce infrastructure, and coordinated oversight successfully converted flexibility into high-functioning systems, whereas organizations in more challenging policy environments were more constrained. This finding is consistent with the comparative health systems literature as the best outcomes of

decentralization have been through good intergovernmental coordination with fiscal support and accountability (Saltman et al., 2007; Abimbola et al., 2019; Dougherty et al., 2022). Second, the interaction effects of regulation and flexibility are also theoretically important. Data indicates that regulation and flexibility are not substitutes, but complements in high-performing care systems. Consistent with the organizational theory concept of "enabling constraints" (where well-designed rules can support creativity, adaptation, and attention on core goals by reducing ambiguity), e.g. (Weick & Sutcliffe, 2007; Rather, we see in the current context being clear and coordinating regulation seems to act as an enabling constraint, allowing the organizations to free themselves from compliance troubleshooting and towards their actual core activity of service provision. The results therefore advocate a more integrative theoretical background that emphasizes that, in contrast to a complete autonomy, more accountability is crucial in decentralized systems, that a certain degree of local discretion must remain while at the same time coordinating actions at the system level, and that both innovation and standardization are important. This framework can be put to hop to inform the design of decentralized systems beyond the u.s.

5.3 Comparative Insights: What the U.S. Experience Reveals About Global Patterns

Despite this study examining micro-care organisations in the USA, the findings will have implications for understanding decentralised systems of care within different national contexts. The literature on the comparative study of health systems documents a global shift towards decentralization, due to fiscal pressures, calls for improved responsiveness, and the reality that centralized bureaucracies often do not meet the diverse local needs (Saltman et al. 2007; Abimbola et al. 2019). Yet, decentralizations have produced rather unpredictable results; while some countries have seen increasingly greater equity and efficiency, and others have undergone fragmentation and increased inequalities. The current results clarify that variation by emphasizing the contribution of regulatory design and organizational capacity. Outcomes have generally been positive in countries where decentralization has been accompanied by clear accountability frameworks, fiscal transfers, and technical support for local organizations. In the countries where decentralization has consisted mainly in offering authority without resources and coordination, the results have often made disappointment. This pattern mirrors U.S. data which suggest that both state-level

policy support and regulatory coordination are key determinants of organizational performance. This is an instructive contrast, in particular when we consider the experience of Buurtzorg in The Netherlands. Buurtzorg is a minimally directed home care organization with strong frontline discretion, thanks a lot of its minimizing hierarchy. Its client, staff, and cost satisfaction levels are high (Gray et al., 2015). The Buurtzorg model however does not rely just on organizational autonomy, but also on a supportive national regulatory and financing system allowing flexible staffing, integrated care, and reliable payment. The finding from the present study that flexibility works best in the presence of clear and supportive regulations fully resonates with the Buurtzorg example.

The experience of decentralized health systems in Latin America likewise provides relevant lessons. Decentralization can improve access and responsiveness in Brazil, Colombia and Mexico, but only when combined with intergovernmental coordination, equitable financing and institutional support, as demonstrated by other recent studies (Pinafo et al., 2020; Giovanella et al., 2023). Where such supports have not been put in place, decentralization has contributed to greater inequality between regions and fragmentation of services. The current results mirror this pattern, with states with less robust policy infrastructure and less centralized oversight yielding more unpredictable outcomes, also at the level of organizations with high levels of formal discretion. The comparison with integrated care models in Europe is also instructive. Some nations like Denmark, Sweden and Germany create care coordination systems based on any combination of national standards with local service delivery (Nolte & Pitchforth, 2014). These systems generally feature transparent accountability mechanisms, common information platforms, and financial incentives for integration. The finding of this study that sound regulatory clarity and coordination support improved outcomes is in line with the experience in Europe and argues that a pattern of integration for oversight and discretion is a principle that generalises beyond the context of the present study. It was this latter need that the COVID-19 pandemic served to perform a global natural experiment for the value of organizational flexibility and regulatory adaptivity. Countries and areas that adapted service delivery models quickly, restricted regulations temporarily and gave power to the frontline organizations to innovate usually coped more robustly with the crisis (Gocke et al., 2023).

In the U.S. context, the resilience findings in the present study are consistent with this universal trend, as U.S. organizations with increased flexibility and more mechanistic overseers had greater success maintaining service continuity during the pandemic. This means that resilience in care systems is less about resources and more about governance structures which allow quick adaptation. Comparative literature similarly draws attention to the important role of workforce policy, identified as an important finding in the present study. Better care outcomes are generally associated with countries, such as Switzerland and the UK, that have a well-established supply of primary care and community health workforces, a clear pathway for training, and labor regulations that favor support (World Health Organization, 2016). Workforce instability is a long-standing issue in the workforce, especially in community and long-term care settings in the U.S. The current finding of staff stability as a strong predictor of quality and resilience also highlights the importance of workforce policies that promote recruitment, retention and professional development in micro-care. Finally, systematic comparisons reveal the importance of financing arrangements. The US continued dependence on fragmented public and private payers, narrow reimbursement categories, and limited financial flexibility is certainly atypical compared with other high-income countries. Most high-income countries now use population-based or capitated funding models that confer greater discretion over resource allocation to local organizations (Nolte & Pitchforth, 2014). The current finding which shows financial flexibility is the worse scoring US organization discretion dimension indicates financing reform may be one of the strongest levers for performance improvement in a decentralized care context. The bottom line: The findings here for the United States are in line with the international evidence decentralization is most effective when it is a fully integrated system of accountability, support, and discretion. Policy implications Countries and jurisdictions wishing to decentralise care delivery should attend to regulatory design, intergovernmental co-ordination, workforce policy, and financing mechanisms and not assume that it will suffice to transfer formal authority only.

5.4 Policy Implications: Designing Regulation to Enable Rather Than Constrain

The results of this research have practical implications for the design and implementation of regulatory systems in decentralized social care settings. The data show that regulation does not provide a clear upside or downside; both positive and negative impacts depend on the particulars of how the regulation is designed,

communicated and coordinated across agencies and levels of government. This implies that regulatory reform should not be about less regulation per se, but rather about enhancing the quality, precision, and co-alignment of regulatory frameworks.

5.4.1 Reducing Regulatory Fragmentation

Perhaps the most unequivocal take-away from the data analysis is that regulatory fragmentation substantially undermines organizational performance! Businesses in the sample reported oversight from an average of nearly four different regulatory authorities, often on top of one another, and sometimes with conflicting requirements. This fragmentation adds to administrative burden, causes confusion and diverts resources from actual care delivery. It also reduces flexibility because organizations now have to deal with numerous approval chains to adhere to different sets of expectations, frequently with little or no information on how conflicting expectations are to be satisfied.

This calls for policy reform, which should focus on regulatory consolidation and coordination. This could take several forms. First, states could create lead regulatory agencies with defined authority over specific care areas, reducing the complexity of having multiple agencies with overlapping jurisdiction. Second, interagency coordination mechanisms may formalize agencies to align reporting requirements, inspection schedules, and enforcement practices. Third, regulatory sandboxes or safe harbor provisions can be created to let organizations experiment with their innovative practices and prevent automatic noncompliance in the event multiple rules conflict.

International examples provide useful models. For example, the Health Coordination Reform in Denmark defined responsibilities for national, regional and municipal actors and mandated joint pathways and shared accountability frameworks (Nolte & Pitchforth, 2014). This decreased redundancy and allowed adjacent moves to focus on providing care and not muddling around in pixels. We could adapt similar approaches to the United States, especially in states with high regulatory density and lack of coordination.

5.4.2 Enhancing Regulatory Clarity

Data also indicate that regulatory clarity is positively correlated with flexibility and organizational outcomes. Organizations that recognize what is required of them are in

a better position to comply efficiently and to see where they can adapt. On the other hand, vague or rapidly changing regulations create uncertainty, drive up compliance costs, and stifle innovation as organizations take defensive measures fearing inadvertent non-compliance. As such, it would be better for policy reform to focus on improving regulatory certainty by providing clear, robust, and accessible guidance. It may include plain-language regulation guides, decision trees and other visual aids to map compliance pathways, and regulatory helpdesks or liaison offices through which authorities can be contacted to provide definitive advice to firms. Also, possibly adopting standardized definitions, reporting formats, and performance metrics for data would reduce confusion and enable more meaningful benchmarking. Moreover, a far better approach to regulatory clarity could be achieved through more inclusive rulemaking that involves frontline organizations and care recipients in designing regulations. By taking a participatory approach, rules can be practical, understandable and workable, fitting with the realities of service delivery. It can also enhance trust and diminish pushback subsequently scrutiny, which can both enhance compliance and reduce enforcement expenses.

5.4.3 Balancing Prescriptive and Outcome-Based Regulation

This study points the way forward that regulatory systems can evolve away from prescriptive process regulation towards outcome-based accountability. Prescriptive: These regulations dictate in detail how organizations should function, which forms to fill out, what procedures to follow, what sort of staffing ratios to maintain. These regulations may serve a purpose in lowering variability and assuring minimum levels of quality and access, but they limit flexibility and become obsolete as care model evolve. Outcome-based regulation, on the other hand, is centered on what organizations accomplish, not how they accomplish it. Employers are accountable for equity, quality, safety, and client experience but have flexibility with how services are configured and resources distributed. This is in line with the current findings, which indicate that flexibility is advantageous when combined with accountability. Outcome-based regulation of health and social care has been trialled internationally. For instance, England's Care Quality Commission employs a framework that examines whether facilities are safe, effective, caring, responsive and well-led, rather than verifying the adherence of the service to process regulations (Care Quality Commission 2021). This has enabled greater layered organisational innovation while still maintaining

accountability albeit with its challenges. And adaptations of similar models could be employed at varying levels of U.S. state and federal regulatory systems, particularly where process compliance marks the bedrock of Medicaid and Medicare programs.

5.4.4 Supporting Flexibility Through Financial and Workforce Policy

These data demonstrate that financial flexibility is the weakest link among the dimensions of organizational discretion in the U.S. sample, and that workforce instability is a major obstacle to accomplishing quality and resilience. Regulatory reform alone is not enough; it must be tied to changes in financing and workforce policy. Financial policy reform may also involve wider introduction of block grants or capitated funding models, providing organizations more leeway over allocation of these resources. This may also involve the removal of unnecessarily restrictive expenditure categories and the dilution of administrative costs charged to categorical funding. It could also involve scaling shared savings or performance incentive programs that reward organizations for meeting goals for equity and quality, rather than adhering to input specifications. Examples for an update of a workforce policy could be introduction of skill or loan forgiveness program as well as career pathways for all community health and social care workers. This could include, for example, establishing workforce registries and cross-state licensure compacts to ease mobility and reduce shortages. This may also include strengthening labor protections and wage standards to decrease turnover and enhance job quality, which are strongly correlated with care quality as well as resilience, according to the data.

5.4.5 Leveraging Technology to Reduce Burden and Enhance Coordination

The study has established that telehealth enlistment associated with efficacy and strength. This indicates that technology can play a crucial role in enabling flexibility and performance. But it also underlines the fact the technological capacity of nonprofits is uneven as to organization size and geography, and that smaller and more rural organizations more often lack the infrastructure and support to adopt digital tools well. Thus, beyond policy reform, the technology needs to invest in microcare organizations not only in infrastructure, but also in training and technical assistance. This might involve creating joint structures for reporting and exchanging data, care coordination. This could include subsidies or grants to facilitate the adoption of electronic health records, telehealth systems and client communication tools. It might also involve the

formation of regional IT centers or cooperatives to provide shared services to small organizations that lack the level of in-house IT capacity to pay for such services by themselves. Digital health will also need to overcome regulatory barriers to the delivery of digital care. Numerous U.S. regulations were established prior to the prevalence of telehealth, restricting care to unnecessary hours and ways that virtual services may be provided. The regulatory relief granted during COVID-19 reveals the fact that many of these restrictions inhibit quality or safety. Finally, the most effective of such waivers should be put into law through permanent reforms, and outdated regulatory regimes should be thoroughly updated to reflect the current technological realities.

5.4.6 Expanding State-Level Policy Support

State-level policy choices, particularly Medicaid expansion, have major impacts on organizational equity and performance, the data show. It highlights how the function of decentralized care systems is dependent on state policy. This implies that federal policy should establish either incentives or requirements for states to adopt the policies and initiatives that will allow micro-care organizations to serve the most needy communities effectively. The federal share could come in the form of matching funds to states when they expand Medicaid, invest in community health infrastructure, or implement regulatory coordination mechanisms. It might have included technical assistance programs to help states design and implement systems of outcomes-based accountability. You could also include national standards or benchmarks in equity, quality and resilience that states are invited to meet, with public reporting to generate accountability pressure.

5.5 Organizational Implications: What the Findings Mean for Micro-Care Leaders

The results presented in this study have several implications for regulatory and policy design however they can also inform leaders/managers that are at the helm of micro-care organizations. We find that regulatory and flexible influences on salient outcomes are mediated by organizational capacity, culture and strategic choices. Even within identical regulatory regimes, we can see the wide variety of performance from the various organizations hinting that internal factors can be highly determinative.

5.5.1 Building Adaptive Capacity

Having discovered that flexibility is a major driver of resilience, organizations should focus their resources on improving adaptive capacity. Which includes developing contingency plans, cross-training staff, maintaining flexible staffing models, and developing leadership that are comfortable with experimentation and learning. And also to create cultures that become more responsive than rigidly following the routine. Instead, organizations can build adaptive capacity through rapid response teams, learning loops that integrate feedback from frontline staff and clients, and reserves of staffing and technology capacity in essential areas. They can also leverage networks and collaboratives that facilitate peer learning and sharing of resources to build resilience in times of crisis.

5.5.2 Engaging with Regulators Proactively

The increased outcomes of regulatory clarity and coordination indicate that organizations should interact with regulators instead in anticipation and not a response. Such as rulemaking responses, comments on proposed regulations, and the building of relationships with regulatory liaisons. It also includes a little bit of advocating for regulatory reform where some existing rules seem excessive or otherwise in conflict with mission-oriented service delivery. Organizations may also band together in coalitions or associations to use their voice comparably in the regulatory processes. Finally, advocacy, as opposed to complaints, is the best form of advocacy, and collective efforts to help regulators comprehend how their intentions play out both directly and indirectly in actual family practice would be welcome. In other situations organizations can negotiate waivers, pilots or safe harbor provisions that can allow for experimentation within a limited accountability framework.

5.5.3 Investing in Workforce Stability

Implications for HRM The evidence that staff turnover is so strongly predictive of quality, resilience etc. Organizations that prioritise people, even when faced with decreasing fiscal availability for recruitment, retention, and professional development. This includes ensuring pay and benefits that are competitive, providing opportunities for advancement, creating supportive workplace culture, and recognizing the value of frontline workers. Partnerships with educational institutions, workforce development initiatives, and innovative staffing models like shared staffing pools or cooperative

employment arrangements can contribute to workforce stability as well. Organizations should also promote public policies that would make it easier to access such care by, for example, funding training for childcare providers, providing loan forgiveness for community health workers, and raising the minimum or “living wage” for direct-support workers in home-, residential-, and community-based settings.

5.5.4 Leveraging Data for Performance Improvement

One focus of the study is about accountability for outcomes, implying that organizations must now put real dollars into data infrastructure and use data proactively to improve performance. It not only includes compliance metrics but also equity, quality, and resilience indicators. This encompasses data collection, for understanding underlying disparities and client needs, and for measuring the impact of interventions. Data can also be a valuable negotiating tool for organizations to show funders, regulators, and communities the tangible value of their work. Transparent accounting of results, especially equity outcomes, can gain confidence and assist. It can even be used to support advocacy, as well as to assist organizations in negotiating better ecosystem based flexibility related funding or regulatory arrangements.

5.6 Limitations and Methodological Considerations

Despite the generalizability of the study and strength of evidence for the link between regulation, flexibility and organizational performance inherent in U.S. micro-care systems, several limitations deserve comment.

5.6.1 Cross-Sectional Design

The study used a cross-sectional design, meaning that all data were collected at one time point. This constrains firm causal inference. For the regression models, confounding variables were controlled for before testing the theoretical models, and the theoretical framework clearly indicated a rationale for the direction of relationships; however, the observed associations may still represent reverse causation or omitted variables. For instance, organizations that perform better may be less likely to attract regulatory scrutiny, creating a spurious negative link between regulation and outcomes. Organisations with strong leadership may be able to harness both regulatory compliance and the benefits of flexibility, leading to an apparent link between the two. Future research should use longitudinal designs assessing organizations over time, measuring

the changes in regulation, flexibility, and outcomes. Usage of panel data or difference-in-differences designs would lend stronger evidence to any claims regarding causes and effects. More robust causal effects could also be measured using natural experiments like the introduction of new regulations or policy reforms in certain states.

5.6.2 Self-Reported Data

Self-reported data from organizational leaders or managers were used for most data in this research. This opens the possibility for a social desirability bias, acquiescence bias, or common method variance. If respondents suspect that the underlying information will be used for accountability, then they may over-report benefits or under-report regulatory burden. For example, common method variance can inflate correlations when independent and dependent variables are tapped by the same survey instrument. To help reduce this limitation, the study used structured information from several different databases where practicable (e.g., administrative data in the case of organization characteristics, publicly available data in the case of regulatory context). But the main endpoints of flexibility and outcome were still based on self-reports. Future studies will need to include objective measures of performance (senior management ratings incorporating hospitalization rates, costing data derived from reimbursement systems, client satisfaction surveys administered independently and workforce turnover records). Methods that combine survey data with qualitative interviews or case studies (i.e. mixed-methods approaches) could also yield a greater richness and nuance of analyses.

5.6.3 Sample Limitations

The micro Care organizations sample, large and diverse, does not capture all of the micro Care organizations in the USA. The six states and five different organizational types to investigate are an indication of how wide the sample was drawn from organizations willing and able to participate in research. This is likely to under-represent the views of smaller, more resource-constrained, or more distant organizations. Survivorship bias may also be at play if the sample neither has nor closed or merged organizations. Future research should map a more widespread geographic area, particularly in rural and under-serviced regions. Additionally, it should incorporate large, well-studied types of organizations (not previously addressed in this study) such as population-based mental health programs, faith-based care, and informal care

networks. Some representativeness issues may also be addressed through inflated survey sampling strategies, which may oversample hard-to-reach organizations.

5.6.4 Measurement Challenges

Composite indices were used as proxies across regulatory constructs that are inherently complex intensity, flexibility, equity and resilience. These indices, however, may not measure all aspects of these constructs and did demonstrate reasonable levels of reliability. The intensity index emphasized oversight burden but did not reflect the nature and extent of regulations driven by substance or compliance. The equity index focused on access and inclusion, but did not assess downstream health or social outcomes for priority populations as a separate measure; rather it was aggregated into the two indices above. Future studies should seek to develop measures that are more fine-grained and multidimensional. For equity, it may mean monitoring differences by race, ethnicity, and socioeconomic status in health outcomes, client experience, and service use. To be resilient, it might capture not just service continuity, but also organizational learning, adaptive capacity and time to recover from disruptions. With respect to regulation, possible areas could include differentiating the type of rule i.e. safety regulation versus equity mandates versus procedural requirement and estimating their independent impacts;

5.6.5 Contextual Specificity

This analysis focused on the United States which has a unique institutional and policy context. U.S. financing is fragmented between public and private, with limited universal coverage, considerable state-level variation, and a key role for nonprofit and forprofit providers. The same is true of regulatory systems, which have overlapping federal, state, and local authority. Given these contextual features, the representativeness of the findings for countries with more centralized or universal systems could be questioned. The theoretical framework and many of the empirical patterns, however, are probably applicable beyond the U.S. context. This combination of regulatory versus flexible challenges, clear versus muddy governance, and the advantages of adaptive capacity are universal organizational and governance principles of wide relevance. In particular, comparative research that tests the same approach in other countries, or other domains (like education or child welfare) would go a long way towards establishing external validity.

5.7 Directions for Future Research

The findings of this study open several promising avenues for future research.

5.7.1 Longitudinal Studies of Regulatory Change

Future research should investigate the organizational response to regulatory changes over time. For example, studies of regulatory reforms (i.e., new oversight requirements, the removal of outdated rules, etc.). It could also involve investigations of emergency regulatory waivers, like the ones recently employed during COVID-19, to determine the implications of temporary increases in flexibility on input measurements, strategies, and organizational behavior and outcomes. Longitudinal designs would enable researchers to determine whether the associations between regulation/flexibility and outcomes are causal or selection effects.

5.7.2 Comparative International Research

Comparative research in other countries should test the study's conclusions and expand on them. International comparisons might consider how regulatory traditions of differing types whether the public oversight and local discretion prizing of the Scandinavian model, the market-based Anglo-American model, or the corporatist coordination of the Continental European model intersect with regulatory flexibility. Such research could find institutional practices that are best model to serve as proofs to the policy idea that can be applied to other contexts.

5.7.3 Mechanism Studies

In short, the current study found relations between regulation, flexibility, and outcomes, but did not specify the processes underlying these relations. Future research should investigate the mechanisms through which regulation influences flexibility for instance, through consumption of administrative capacity, instilling legal uncertainty, or impacting organizational culture. It should also investigate the mechanisms by which flexibility relates to outcomes for instance, by improving service delivery, by boosting staff morale or encouraging innovation. Qualitative case studies, process tracing, or mediation analyses might all enhance this line of inquiry.

5.7.4 Equity-Focused Research

Although equity was included as a secondary outcome in the present study, specific regulatory and organisational practices and their impact on specific marginalised populations were not examined. Disaggregating equity outcomes by race, ethnicity, language, disability status, and socioeconomic position needs to be part of future research. It should investigate how organizations support populations with complex needs (people experiencing homelessness, serious mental illness, limited English proficiency, etc.). It should also consider how regulatory systems can realize health equity as a goal per se not simply by ensuring increases in access to the goods or services being regulated but through detailed, purposely designed regulatory systems.

5.7.5 Technology and Digital Transformation

The findings of the study reported that telehealth adoption increased efficiency and resilience but did not explore deeper facets of digital transformation as a whole. Future ResearchThe relationship between regulationand flexibility will be addressed in a manner that takesinto account how digital tools reshape management. Digital reporting systems, for instance, can relieve some administrative burden but can increase monitoring and decrease discretion (Quinones et al 2023). Although telehealth may broaden access, it may also engender new dimensions of exclusion for populations lacking digital literacy or connectivity. With care systems being evermore digitalised, it is crucial to understand these dynamics.

5.7.6 Resilience and Crisis Response

The study has been centered on assessing resilience focused on service continuity in the context of COVID-19; however, resilience is a multifaceted concept, including not only anticipation, absorption, and adaptation but also transformation (Kruk et al., 2017). Future research should create a continuum of organizational and system resilience, explore regulatory and organizational mechanisms that shape resilience across shocks (pandemics, natural disasters, economic crises, and political shocks).

5.8 Synthesis: Toward Governance Architecture for Effective Decentralized Care

The main point made in this study is that good decentralized social care systems only work by finding a proper balance between regulation and flexibility. Those results provide a robust empirical testament to the claim and counter the zero-sum rationale

that has largely shaped the policy discussion regarding decentralization. Regulation is not inherently good or bad. The effects depend on the specific design, the clarity of the communication and the degree to which it is coordinated with other governance mechanisms. Organizational performance is constrained: heavy and fragmented regulation increases administrative burden, limits flexibility, and competes for resources with care delivery. Regulation that is unambiguous, coordinated, and outcomes-based can aid performance by minimizing unpredictability, facilitating accountability, and providing stability for organizations to innovate within. Flexibility is an essential organizational capability that allows micro-care providers to customize services to address varied needs, adapt to changing contexts and remain functional through crises. More Discretion: Better Outcomes on Equity, Efficiency, Quality, and Resilience Yet, mere flexibility is not enough. Allhinn's benefits are greatest when organizations are structured with supportive policy environments, including sufficient revenue streams, stable financing, a skilled workforce, and coordinated oversight.

This means that the truly best-performing systems do not regard regulation and flexibility as opposing principles but rather as mutually compatible. Certain design features need to be available in this integration. Regulatory systems should be consolidated and coordinated to minimize fragmentation and duplicated efforts. Secondly, regulation must be clear, stable and accessible to enable an efficient compliance. Finally, regulatory accountability should resist prescriptive process rules that dictate how organizations achieve outcomes, and instead shift to meaningful outcome-based standards that hold organizations accountable for equity, quality, and safety without dictating how those outcomes must be achieved. Fourth, however, regulations cannot be effective without adequate financing of infrastructure, the workforce and technology. Fifth, governance systems should include participatory mechanisms that include frontline organizations and service users in the development and implementation of oversight. The key elements of good design are consistent with what the literature on effective decentralized governance would suggest internationally. They argue not only that the policy challenge is not to have regulation or flexibility but to construct governance architectures that match accountability to autonomy, oversight to support, and that allow local organizations to act responsively, equitably and sustainably.

The results further highlight the importance of state-level policy in the United States context. This decentralization by the federal government to states leads to great differences in regulatory environments and support for policy and has meaningful influence on organizational performance. States that invest in Medicaid and workforce development in addition to setting clear regulations around care coordination for Medicaid populations achieve better outcomes on multiple fronts. In states where there is high discretion coupled with weak support, results are uneven: some organizations do well while others flounder. These patterns call for federal leadership in setting minimum standards, resourcing fundamental rights and encouraging state led reforms that actually enable good decentralized care. The study assesses the need for organizational capacity and leadership. Organizations differentiate themselves with flexibility and their ability to provide high value, equitable care even in the same regulatory environment. Firms that focus on workforce stability, capacity to adapt, data infrastructure, and proactive regulation are well placed. These findings also highlight the need for partnering policy reform with capacity-building and technical assistance so that all organizations can succeed, not just the largest and best-resourced.

In this chapter, we have discussed the study results in detail in the context of the wider theoretical and empirical literature on decentralized care systems, regulatory governance and organizational performance. The analyses point to the complexity and contingency of the relationship between regulation and flexibility and to the need to optimize micro-care delivery through a balance of oversight and discretion, rather than by maximizing one at the expense of the other. These findings carry important implications for policy, practice, and research. For the policymaking audience, they call for regulatory reform to concentrate on consolidation, clarity, coordination, and accountability focused on outcomes. For organization leaders, they recommend adaptive capacity, workforce stability, and proactive approach to working closely with regulators among the top three critical success factors. For researchers, the group recommends using longitudinal designs, comparative methods, and equity-focused analyses to better understand how governing systems are related to care delivery. In the end then, the research feeds into a wider reconsideration of the nature of governance of decentralized social care systems. It questions the assumption that decentralization is merely about redrawing lines of authority and instead argues that decentralizing power is an institutional challenge. This demonstrates that regulation, when designed with

cognizance of organizational behavior and policy intentions, can be a facilitator rather than a barrier to achieving those objectives. And it shows that flexibility is an intrinsic part of the ecosystem for micro-care systems, one that must be preserved and encouraged if they are to live up to the potential of bringing equitable, efficient, high-quality, and resilient care to the communities in which they operate.

CHAPTER 6

CONCLUSION

The question this study addressed was a central one in the governance of decentralized social care systems: how do regulation and flexibility interact to determine organizational performance and what arrangements activate the potential of micro-care organisations to deliver equitable, efficient high-quality and resilient services? The research draws on a sample of over 300 micro-care organizations in six states across the U.S. and provides strong empirical support for a non-binary perspective regarding the role of regulation in decentralized systems. In short, the key takeaway from this research is that whether micro-care delivery is successful depends not on pure maximization of regulation alone or pure maximization of flexibility, but a dynamic and ongoing balance of oversight and discretion. Fragmented, unclear, or poorly coordinated regulatory intensity was discovered to decrease organisational flexibility, enhance administrative burden, and reduce efficiency (Poon et al. Better the performance of organizations through regulation however clear coordinated and an outcome focused mechanism reduced uncertainty, enabled accountability and created a stable environment for innovation. Likewise, even though operational flexibility was a robust predictor of equity, efficiency, quality, and resilience, it had the greatest effect in organizations that functioned in supportive policy environments with adequate resources, stable financing, and coordinated oversight. This has far-reaching implications for policymakers, regulators, and organizational leaders in designing and governing decentralized care systems. The evidence suggests that regulation is needed, and the key challenge is not whether to regulate or not, but how to design regulation that allows rather than inhibits good service delivery. Decentralization is not merely devolution, but is institutional design that balances accountability with autonomy and support with oversight. The present study enriches a range of theoretical and empirical literatures. initially it extends the mechanism design framework put forth by Hurwicz et al., by showing that care system institutional arrangements cannot be rigged in way that information asymmetry and decentralized actors can be made to collaborate. The results indicate that regulatory systems work best when they balance structure and initiative but this can only occur when they are designed mindful of frontline service delivery.

Second, it builds on Arrow's observation that healthcare markets require regulation because of inherent information asymmetry and uncertainty, but goes further than Arrow in arguing that the nature and quality of the regulation matters as much as its existence. On one hand, heavy-handed or fragmented regulation can lead to increased transaction costs and inefficiency, while it can reduce uncertainty, enhance coordination and/or increase equitable access. Third, this study adds to the comparative health systems literature by quantitatively detailing how state-level variation in regulatory environments and support for policies that foster organizational/market-level innovation consistently relate to performance among US states/and the market in the US context. The findings validate that decentralisation is most effective in the presence of robust intergovernmental co-ordination, fiscal support and accountability mechanisms that do not stifle local initiative a trend we have seen in international comparisons. Fourth, the study contributes to knowledge of organizational flexibility as a fundamental capability in community care settings. The data demonstrate that flexibility is not a managerial luxury, but, rather, a real equity and resilience mechanism. Organizations enjoying greater degrees of discretion are better positioned to serve the underserved, customize services to myriad needs, ensure continuity of service in crises, and deliver good care experiences. The fact that this finding capacitated these theoretical arguments that were put forth by proponents of integrated and self-managing birthing care models offers empirical evidence on the value of policy reforms that maximize organizational discretion. Important patterns identified in this analysis at state-level inform the findings outlined in devolved sub-sections of this section, shedding light on broader dynamics at play in the governance of decentralised regimes. More balanced regulatory systems those with a combination of moderate but consistent oversight intensity and high regulatory clarity and coordination were associated with more favorable performance in multiple outcome domains. This includes Minnesota, which scored relatively high in equity, quality, and resilience, while maintaining a moderate regulatory intensity and high flexibility. However, states with very light regulation or very heavy but poorly regulated regulation had more mixed results. Georgia, in its highly flexible but weakly accountable approach, demonstrated relatively high flexibility, but weaker equity and quality management. The strongest equity performance was by California and New York, two states with intensive but fragmented regulation, but it had the lowest efficiency and flexibility.

These patterns highlight an important lesson for policy: regulatory reform needs to focus not on reducing the quantity of rules but on improving the interoperability, coherence, and meaningfulness of rules to quality and equity of care. The data indicates that organizations can function successfully under a high level of scrutiny in a way that is predictable, coordinated and focused on outcomes rather than prescriptive processes. On the other hand, minimal regulation can ramp up in expense for companies, when vague, conflicting, or out of arc with organizational mission. Multivariate analyses indicated that the influences of regulation and flexibility are mutually rather than independently responsive. Flexibility had the most beneficial impacts in situations in which regulation was unambiguous and orchestrated. Greater regulatory intensity was less harmful and sometimes supportive of equity amid ample organizational discretion and supportive state policy, as in the case of Medicaid expansion. This pattern of interaction further supports the main proposition that decentralized care systems tend to perform best when they blend enabling regulation with operational autonomy. Findings revealed that a number of mediators and moderators were key in shaping the relationship between regulation, flexibility, and outcomes. Regulatory flexibility translated into performance, but how it did so depended on organizational size, ownership structure, geographic region, staff turnover, technological capacity and state Medicaid policy. Medicaid expansion states with larger nonprofit organizations and stable workforces being able to deploy existing telehealth infrastructure were found to be better able to manage more regulatory demands and implement flexibility into their workflows. Indeed, smaller, more rural, or resource-constrained organizations struggled more with discretion even though it was formally granted. This demonstrates that flexibility cannot be viewed in isolation of the enabling infrastructure and supporting resources and policies. Results on equity are especially important in light of the ongoing inequities in access to health and social care in the USA.

The analysis showed that organizational equity performance was strongest in the states that integrated regulatory conditions that demanded inclusion with operational flexibility around tailoring services. This implies that regulation can play an important positive role in advancing equity by setting standards for serving underserved populations, requiring culturally responsive practices, and enforcing equitable access. However, prescriptive regulation that tightly dictates the nature of service delivery can impede equity by limiting organizational ability to address the varied needs of

communities. Malhotra and vanNature (2023) conclude that an ideal portion of an equity-focused regulation would be built around achieving certain outcomes, rather than mandated processes that initiate duties to serve marginalized groups; giving organizations room to run but holding them accountable for results. The results on resilience have become more critical in light of the COVID-19 pandemic, and the continuing environmental, economic and public health crises. Flexibility and coordinated oversight kept organizations running more smoothly during disruptions. Resilience was also significantly linked to technological capacity, particularly the adoption of telehealth, and organizational preparedness through crisis planning. These results indicate that the resilience of care systems are dependent on more than merely resources, it is also determined by governance structures that allow rapid adaptation with clear communication, and collaborative problem solving across organizational and jurisdictional levels. The study also emphasized the key role of administrative burden as a limitation of organizational performance. Organizations that reported wide reporting requirements, split oversight, and vague rules suffered from worsened efficiency, lower staff morale, and a weaker ability to innovate. Its implications for policymaking are direct: regulatory reform should additionally incorporate scheduled efforts to reduce paper work, eliminate redundant reporting and compliance management. Multiple jurisdictions/countries have implemented "red tape reduction" with some impact, and the current estimates suggest that such efforts could provide sizeable gains in US social care systems.

The results of the workforce question pack special importance. Although staff stability was shown to be a significant predictor of quality of care and the resilience of organizations, workforce instability continues to afflict community and long-term care sectors alike. The findings highlight the importance of more holistic workforce policies around recruitment, retention, and professional development. Such as providing competitive pay and benefit packages, career advancement opportunities, empathetic company cultures, and investment in training/education. Such policy should ideally be regarded as part of care system performance, not a separate or secondary policy domain. The lowest-scoring dimension of organizational discretion in the sample was financial flexibility, indicating that U.S. care financing is very narrow. All but the very largest organizations operate within constrained budget envelopes linked to categorical funding streams, reimbursement rule, and grants. Even where services are formally

discretionary, this restricts the space to flex capacity and resources in response to developing need. This finding indicates that reforming the way we finance care is central to unlocking the benefits of flexible micro-care models. More specifically, policy options could include expanded utilization of block grants or capitated funding, diminished restrictions on expenditure, and performance incentive programs that reward outcomes rather than inputs. From a practitioner perspective, the study is useful for organizational leaders operating amid complex regulatory environments. The research indicates that successful organizations know that adaptive capacity can be built through cross-training, contingency planning and leadership development. They have a proactive approach to engaging with regulators, taking an active part in the rulemaking process, establishing cooperative relationships.

Competition not only for investable opportunities and other stakeholders, the executive suite as well, but because they want a stable workforce, and they provide competitive compensation as well as SFAS No. Through data, they have used it to improve performance continuously and be accountable and transparent. And there is certainly participation in networks and collaboratives that allow for peer learning and resource sharing. We conclude that the governance of decentralized social care systems is neither a purely technical problem, nor a simple political choice between centralization and autonomy. Rather, it is a designer problem; remaining cognizant of how the specific combination of regulatory frameworks, organizational capacities, and policies will be enabling to or constraining of effective care delivery is critical. The data indicate that regulation and flexibility are not contradictory but rather complementary components of effective governance. Decentralized care systems which can achieve the highest levels of equity, efficiency, quality and resilience are possible with clear, coordinated, outcome-oriented regulation and sufficient flexibility and support for local adaptation. The final policy implication is decentralization well understood as sharing functional responsibilities and forming governance architectures which align accountability with autonomy, integrate oversight with support, and allow local organisations to act wherever possible responsively, equitably, and sustainably. It is not a question of deregulation or re-centralization but specifically a redesign of regulation to make it simpler, clearer, more coherent and more outcome-oriented. It is also about policy integration regulatory frameworks need to be matched by financial mechanisms, appropriately trained workforce, technological infrastructure, and intergovernmental

coordination. It is only through this type of comprehensive institutional design that decentralized technologies for micro-care can hope to achieve their potential for delivering person-centered, community-responsive, and equitable care across all populations, especially those historically neglected by traditional medical and social service systems.

Future Scope

Although this study offers some key insights into the balance between regulation and flexibility and their role in organizational performance within decentralized social care systems, it also points to numerous directions for future research to advance our understanding in this important area and inform future policy and practice more effectively.

1. **Longitudinal and Causal Research Designs:** Inherent in its cross sectional design, this study is unable to claim causation. Longitudinal designs that follow organizations through time and measure regulatory environments, flexibility, and outcomes before and after changes would be a useful area for future research. Stronger evidence of causal relationships would come from panel data, difference-in-differences designs, or natural experiments (i.e., introduction of new regulation or policy reform in some jurisdictions but not others). Specifically, many of the regulatory changes introduced during and after COVID-19 were temporary waivers or emergency flexibilities that are suitable for quasi-experimental study.
2. **International Comparative Research:.** Research limited to a country with specific institutional and regulatory traditions should be validated and broadened by comparative studies. Comparative studies may compare the relative success of Scandinavian models of strong public oversight with local discretion, Continental European corporatist coordination models, or developing-country community-based care in achieving regulation versus flexibility. This kind of research might identify best practices and determine the generalizability of U.S. contextual factors to other settings.
3. **Mechanism and Process Studies:** This study has identified associations between regulation, flexibility, and outcomes, but further work is needed to fully understand the pathways and causal mechanisms for these relationships. A

stronger focus on behavioral theories will help to develop qualitative and quantitative studies on regulation-caused staff behavior change, organization decision making, innovation process, and user experience. Knowledge of these pathways will help design interventions that maximize positive effects and reduce unintended consequences.

4. **Equity-Focused and Disaggregated Analyses:** This analysis determined equity at the organisational level but did not evaluate specifics of how regulatory and organisational practices impact targeted marginalised populations. Future research should also disaggregate equity outcomes by race and ethnicity, language, disability status, immigration status, and socioeconomic position. It ought to ask how organizations are offering service to whole populations, those with the most complex needs like people experiencing homelessness, people with serious mental illness, or people with multiple chronic conditions. It would be ideal to combine quantitative disparity analysis with qualitative case studies of practices promoting equity, which would be enhanced with mixed-methods approaches.
5. **Digital Transformation and Technology Policy:** This analysis determined equity at the organisational level but did not evaluate specifics of how regulatory and organisational practices impact targeted marginalised populations. Future research should also disaggregate equity outcomes by race and ethnicity, language, disability status, immigration status, and socioeconomic position. It ought to ask how organizations are offering service to whole populations, those with the most complex needs like people experiencing homelessness, people with serious mental illness, or people with multiple chronic conditions. It would be ideal to combine quantitative disparity analysis with qualitative case studies of practices promoting equity, which would be enhanced with mixed-methods approaches.
6. **Workforce Research:** Future research Developments in workforce policies and practices are essential to stabilize the workforce, which is an important determinant of organizational performance. This includes examining the impact of wage standards, training programs, career pathways, and workplace culture on recruitment, retention, and the quality of care. Research should also explore emerging staffing models aimed at integrating flexibility with stability, such as

shared staffing pools, cooperative employment arrangements, and peer workforce programs.

7. **Financing and Payment Reform:** At the same time, financial inflexibility was cited in the study as a key limiting factor. This research can potentially include alternative forms of financing, such as capitation, value-based payment, social impact bonds, and community and/or people governed funding mechanisms, and should grow thereby growing the evidence base for more innovative collective financing solutions. Research should evaluate different payment arrangements on their impacts on firm behavior, equity, efficiency, and innovation. Studies comparing financing models in other nations may be able to answer the U.S. reform question.
8. **Resilience and Systems Thinking:** At the same time, financial inflexibility was cited in the study as a key limiting factor. This research can potentially include alternative forms of financing, such as capitation, value-based payment, social impact bonds, and community and/or people governed funding mechanisms, and should grow thereby growing the evidence base for more innovative collective financing solutions. Research should evaluate different payment arrangements on their impacts on firm behavior, equity, efficiency, and innovation. Studies comparing financing models in other nations may be able to answer the U.S. reform question.
9. **Implementation Science:** Finally, future research should emphasis on regulatory reforms and organizational innovations. Most policies in countries are implemented poorly even if designed well, and local success fails to scale. Implementation research should explore when to adopt, adapt, and sustain regulatory reforms, and how to disseminate high-impact practices while ensuring relevance and flexibility at the local context.

This research laid the groundwork for a rethinking of governance of decentralized social care systems, but a great deal of work remains to be done. Future work should expand upon these findings with tighter causal claims, deeper mechanistic situating, more cross-national comparison, and greater focus on equity and implementation. This research will be crucial for designing governance architectures that will facilitate micro-care systems to realise their full potential as vehicles for delivering equitable, efficient, high-quality and resilient care.

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REGULATION VS FLEXIBILITY: A COMPARATIVE STUDY OF MICRO-CARE MODELS IN DECENTRALIZED SOCIAL CARE SYSTEMS

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Abstract

The English adult social care landscape has progressively decentralized through the Care Act 2014, expanding personal budgets and direct payments and creating space for very small, community-based "micro" providers alongside conventional larger providers (Department of Health, 2014). This study compares regulation-led and flexibility-led micro-care models within this decentralized system to assess how their different balances of compliance and adaptability shape access, personalisation, workforce stability, and value for money. Drawing on a structured secondary analysis of 2024–2025 administrative datasets from the Care Quality Commission, Skills for Care, the Department of Health and Social Care, and the Association of Directors of Adult Social Services, the study triangulates provider counts, ratings, vacancy and turnover rates, expenditure, and client-level data across England (Care Quality Commission, 2025; Skills for Care, 2025). The hypothesis was that flexibility-oriented micro-providers achieve stronger personalisation outcomes while regulation-oriented providers show stronger compliance signals. Findings show that micro-providers deliver more tailored support and lower hourly costs, while regulated medium and large providers dominate capacity and inspection coverage. The paper concludes that hybrid commissioning that protects flexibility within proportionate regulation is the most viable pathway for sustainable decentralized care.

Keywords: *decentralized social care¹, micro-enterprises², personalisation³, regulation⁴, Care Act 2014⁵.*

1. Introduction

Adult social care in the United Kingdom has shifted decisively over the past decade from a centralized, council-delivered model toward a decentralized, mixed-economy system in which 153 upper-tier local authorities commission and oversee a diverse set of independent providers (Foster, 2025). The Care Act 2014 codified this shift by giving every eligible adult a legal entitlement to a personal budget and the right to request a direct payment, thereby allowing individuals to commission their own care from a wider market that includes small community-based "micro-providers" (Department of Health, 2014; Samsi & Manthorpe, 2017). By 2024–2025, gross current expenditure on adult social care in England had reached £29.4 billion, with total expenditure of £34.5 billion, of which roughly 80% was directed to long-term support (Department of Health and Social Care, 2025a; Foster, 2025). Within this decentralized architecture, two ideal-typical approaches to care delivery have

emerged. The first is a regulation-led model, dominated by medium and large CQC-registered care homes and domiciliary agencies that operate within a prescriptive Single Assessment Framework introduced in 2024 (Care Quality Commission, 2025). The second is a flexibility-led micro-care model, exemplified by community micro-enterprises with five or fewer employees, frequently supported by intermediary networks such as Community Catalysts, which prioritise tailored relationships, local responsiveness and individual choice over standardised processes (Community Catalysts, 2024; Needham, Allen, & Hall, 2016).

The trade-off between regulatory assurance and operational flexibility has become a central policy question. Regulation-heavy oversight is intended to safeguard quality and protect people from harm, but it can also impose disproportionate compliance costs on small providers and discourage innovation (Glasby et al., 2018). Conversely, flexibility-led micro-models have been associated with better personalisation, stronger user voice, and lower hourly costs, yet they often operate "below the radar" of formal commissioning, raising concerns about safety, sustainability, and equitable access (Needham & Carr, 2015; Bristol University Press, 2016). The UK provides a strategic context for studying these dynamics because the Care Act 2014 framework, the financial pressures revealed in successive ADASS surveys, and a vacancy rate of 7% in 2024/25 (around three times that of the wider economy) make the regulation–flexibility tension empirically observable (Skills for Care, 2025; Association of Directors of Adult Social Services, 2025). This paper therefore asks: how do regulation-led and flexibility-led micro-care models compare across personalisation, workforce stability, capacity, and value within England's decentralized social care system, and what configuration produces the best balance?

2. Literature Review

A coherent body of UK research has examined how decentralization, personalisation, and provider scale interact to shape care quality. Foundational work conceptualised personalisation as both a normative ideal and a marketisation device, with Needham (2011) arguing that the personalisation narrative was deliberately designed to support a more pluralistic provider market. Samsi and Manthorpe (2017) traced how the Care Act 2014 operationalised this through statutory wellbeing duties, eligibility frameworks and personal budgets, while emphasising that translation into practice depends heavily on local authority capacity. Recent Bourdieusian analysis by Hudson (2025) shows that austerity, a 12% real-terms fall in per-person social care spend by 2018/19 and persistent staffing shortages have constrained the realisation of these emancipatory ambitions. The dedicated micro-enterprise literature is anchored in the ESRC-funded "Does Smaller Mean Better?" programme. Needham, Allen, and Hall (2016) compared 27 organisations (including 17 micro-enterprises) and concluded that micro-providers achieved more personalised, innovative, and lower-cost care than larger counterparts. Glasby et al. (2018) refined this analysis through their "Goldilocks question," showing that size operates as an independent variable in care quality, with micro-enterprises strongest on personalisation but weaker on workforce development and resilience. Allen, Needham, Hall, and Tanner (2019) further examined the methodological tensions of evaluating these small providers using validated outcome measures, highlighting the challenge of capturing relational value within standardized regulatory metrics.

A parallel strand has examined micro-provision for marginalized groups. Needham and Carr (2015) reviewed how community-based micro-providers respond to needs that mainstream services often fail to meet, particularly for people with protected characteristics under the Equality Act 2010, while warning that mainstream providers should not abdicate inclusion responsibilities. Henderson, Hall, Mutongi, and Whittaker (2019) extended this through a realist evaluation of social enterprise delivery, demonstrating that flexibility and "boundary-spanning" community ties are mechanisms that improve outcomes. Wider system literature confirms similar patterns: Hanlon et al. (2024) describe integrated place-based services as dependent on micro-level relational coordination, while Noble et al. (2024) map innovation across English regions and show that smaller, locally rooted services often pioneer new responses to inequality. Workforce evidence completes the picture.

Skills for Care (2025) reports 1.60 million filled posts and 111,000 vacancies in 2024/25, with turnover rates substantially lower for international staff. Foster (2025) and the Institute for Government (Pope, Davies, Jacobov, & Tetlow, 2025) document how international recruitment temporarily eased pressures before 2025 visa restrictions narrowed this route. The Care Quality Commission (2025) shows homecare vacancy rates above 10%, more than double those of care homes, suggesting that decentralized community-based delivery faces the most acute workforce risk. Across this literature, a clear gap remains: few studies systematically compare regulation-led and flexibility-led models using the most recent 2024–2025 administrative data. This paper addresses that gap.

3. Objectives

1. To compare regulation-led and flexibility-led micro-care models on personalisation, workforce stability, capacity, and value for money in England's decentralized social care system.
2. To identify policy and commissioning configurations that balance proportionate regulation with the flexibility required for sustainable micro-care provision.

4. Methodology

The study adopts a comparative, mixed-methods secondary analysis design situated within England as the study area, since it offers the richest, most consistent administrative dataset on decentralized adult social care and a clearly defined statutory framework under the Care Act 2014. The unit of analysis is the provider model, operationalised along a regulation–flexibility continuum, with regulation-led providers identified as larger CQC-registered care homes and domiciliary agencies operating under the Single Assessment Framework, and flexibility-led providers identified as community micro-enterprises with five or fewer employees, including those supported through the Community Catalysts development programme (Care Quality Commission, 2025; Community Catalysts, 2024). The sample comprises the full national population of CQC-registered adult social care provider locations active during 2024–2025 ($n \approx 17,500$ locations), cross-referenced with Skills for Care workforce records covering 1.60 million filled posts and approximately 18,500 establishments (Skills for Care, 2025). For micro-providers, sample evidence is drawn from Community Catalysts' published 2023–24 impact report covering 599 supported micro-enterprises across England and Wales (Community Catalysts, 2024) and from the Needham, Allen, and Hall (2016) case-study cohort of 27 organisations.

Tools and data sources include: (a) CQC State of Care 2024/25 ratings and inspection data; (b) Skills for Care State of the Adult Social Care Sector and Workforce 2025 estimates; (c) DHSC monthly statistics for adult social care, including occupancy and Capacity Tracker domiciliary care figures (Department of Health and Social Care, 2025b); (d) DHSC Adult Social Care Finance Report 2024–25; (e) ADASS Spring Survey 2025; and (f) peer-reviewed studies cited in the literature review. Techniques include descriptive statistical analysis (proportions, mean comparisons, percentage change calculations), narrative synthesis aligned with the four comparison dimensions, and triangulation across independent sources. No primary data collection was undertaken; therefore, ethical approval was not required, and all data are publicly available official statistics or peer-reviewed evidence.

5. Results

Table 1. Capacity of Adult Social Care in England, 2024–2025

Indicator	Value	Period
People receiving CQC-regulated domiciliary care	505,886	Week ending 16 Feb 2026
Occupied care home beds	85.8%	Week ending 16 Feb 2026
People receiving an LA assessment (no prior support)	599,000	Jul 2024–Jun 2025
Care home visiting accommodated	99.5%	14 Oct 2025
Population rate of LA assessments	1,290 per 100,000 adults	Jul 2024–Jun 2025

Source: Department of Health and Social Care (2025b); Department of Health and Social Care (2026)

Table 1 indicates that the regulation-led component of the system carries the bulk of capacity, with over half a million people receiving regulated domiciliary care and care home occupancy stable at 85.8% in early 2026. Assessment volumes (599,000 people; 1,290 per 100,000 adults) confirm that the system is high-throughput and demand-led. The very high visiting rate (99.5%) suggests that, despite criticism of regulation, formal providers maintain core access standards consistently across regions.

Table 2. Adult Social Care Workforce, England, 2024/25

Indicator	Value
Filled posts	1.60 million
Vacant posts	111,000
Vacancy rate	7.0%
Turnover rate (independent sector)	24.7%
Homecare vacancy rate	>10%
Health and Care Worker visas issued	7,891

Source: Skills for Care (2025); Care Quality Commission (2025)

Table 2 shows that workforce capacity has stabilised, with the vacancy rate falling to 7.0% from 10.5% at its 2021/22 peak, and turnover dropping to 24.7%. However, homecare vacancy rates above 10% are more than double those for care homes, which signals that the decentralized, community-facing part of the regulation-led model remains the most fragile workforce segment. The collapse of new Health and Care Worker visas to 7,891 in 2024/25 suggests further pressure ahead.

Table 3. Adult Social Care Expenditure, England, 2024/25

Indicator	Value (£bn)
Total expenditure	34.5
Gross current expenditure	29.4
Long-term support spend	23.6
Real-terms increase vs 2023/24	4.1%
Long-term support: working-age adults	11.5
Long-term support: older people	12.0

Source: Department of Health and Social Care (2025a); The King's Fund (2025)

Table 3 confirms the financial scale of the decentralized system: total expenditure rose to £34.5 billion in 2024/25, an increase of 4.1% in real terms and 29% above 2015/16. Long-term support absorbs 80% of gross current spend, and expenditure is split almost evenly between working-age adults (£11.5bn) and older people (£12.0bn). This confirms the regulation-led infrastructure dominates fiscal flows, leaving micro-models comparatively under-resourced despite policy aspirations under the Care Act 2014.

Table 4. Micro-Enterprise Outcomes versus Larger Providers

Outcome	Micro-enterprises	Medium/Large providers
Mean hourly cost	Lower	Higher
Personalisation score	Higher	Lower
Innovation prevalence	More frequent	Less frequent
Workforce resilience	Lower	Higher
Number of case-study organisations	17	10

Source: Needham, Allen, and Hall (2016); Glasby et al. (2018)

Table 4 summarises comparative findings from the seminal "Does Smaller Mean Better?" study. Micro-enterprises outperform larger providers on personalisation, innovation, and hourly cost-efficiency, but are weaker on workforce resilience and operational scale. The relatively small comparison sample (17 micro vs 10 larger) limits generalisability, yet the consistent direction of effects across multiple outcome domains supports the flexibility hypothesis advanced in this paper.

Table 5. ADASS Indicators of System Strain, 2024/25

Indicator	Value
Net adult social care budget overspend	£774 million (3.46%)
Authorities exceeding budget	80%
Planned net budget 2025/26	£22.4 billion
Average homecare hourly fee 2025/26	£23.85
Homecare Association minimum sustainable rate	£32.14
Planned cut in prevention spend 2025/26	-11.6%

Source: Association of Directors of Adult Social Services (2025); Foster (2025)

Table 5 reveals deep system strain in the regulation-led architecture. A £774 million overspend, the highest in a decade, and 80% of authorities breaching budgets, are accompanied by an average commissioned homecare fee (£23.85) that is 25.7% below the Homecare Association's minimum sustainable rate. The 11.6% planned cut to prevention budgets in 2025/26 directly threatens the upstream community ecosystems on which flexibility-led micro-providers depend, indicating that fiscal stress is now compressing both ends of the regulation–flexibility continuum.

Table 6. Community Micro-Enterprise Reach, 2023/24

Indicator	Value
Micro-enterprises supported (Community Catalysts)	599
Local Area Coordination Network reach	>1 million people
Big Conversation participants (Nottinghamshire)	542
Worcestershire residents supported to start enterprises	165
Programmes delivered	59

Source: Community Catalysts (2024)

Table 6 quantifies the reach of one of the most established flexibility-led infrastructures in England. Community Catalysts supported 599 active micro-enterprises and reached more than one million people through the Local Area Coordination Network in 2023/24. The Nottinghamshire "Big Conversation" included 542 participants in co-producing strategy, illustrating how flexibility-led models also generate civic engagement. While the absolute scale is modest compared with regulated provision, the qualitative depth of reach supports the personalisation hypothesis.

6. Discussion

The findings, examined directly against the two stated objectives, support a nuanced rather than binary reading of the regulation–flexibility debate. With respect to Objective 1, the comparative evidence suggests that each model is dominant on a different dimension. Regulation-led providers, captured in Tables 1, 2, and 3, control the bulk of capacity, occupancy, regulated workforce volume, and expenditure. They process more than 505,000 people in regulated domiciliary care alone, account for the £34.5 billion fiscal footprint, and underpin nationally consistent access standards. Flexibility-led micro-care providers, captured in Tables 4 and 6, dominate on personalisation, innovation, and lower hourly cost, with an empirically grounded but smaller footprint of 599 active micro-enterprises and a Local Area Coordination reach above one million people. This pattern is consistent with the original "Does Smaller Mean Better?" findings of Needham, Allen, and Hall (2016) and the Goldilocks framing of Glasby et al. (2018), which found micro-enterprises strongest on personalisation but weaker on workforce sustainability.

The workforce evidence in Table 2 deepens this comparative reading. The headline reduction in vacancy rates to 7% disguises a homecare vacancy rate above 10%, indicating that the part of the regulated system that most resembles micro-care, namely community-based delivery, is also the most fragile. This converges with concerns raised by Hudson (2025) about the gap between Care Act ambitions and lived workforce conditions, and with the Institute for Government analysis (Pope et al., 2025) showing that international recruitment, not domestic supply, has been doing most of the stabilising work. For flexibility-led micro-providers, who often cannot offer competitive employment packages or international visas, this signals a structural workforce vulnerability that regulation alone cannot address. The fiscal evidence in Tables 3 and 5 also speaks to Objective 1. Despite a £34.5 billion budget and a 4.1% real-terms expenditure increase, 80% of local authorities overspent in 2024/25, and the gap between the average commissioned homecare rate (£23.85) and the Homecare Association's minimum sustainable rate (£32.14) is approximately 26%. This means that the regulation-led system is being purchased below cost, while the prevention budgets that nourish flexibility-led ecosystems are being cut by 11.6% (Association of Directors of Adult Social Services, 2025; Foster, 2025). Both ends of the continuum are therefore being squeezed, which undermines the stylised assumption that more regulation automatically protects quality.

With respect to Objective 2, the evidence points clearly toward a hybrid commissioning configuration rather than a binary choice. Drawing on Needham and Carr (2015), Henderson et al. (2019), and Hanlon et al. (2024), the most viable configuration appears to be one in which proportionate regulation, calibrated to organisational scale and risk, is combined with sustained investment in flexibility-led infrastructure such as Community Catalysts and Local Area Coordination. This allows the regulation-led system to anchor capacity, safety assurance, and continuity of care for highly dependent users, while the flexibility-led micro-care model contributes personalisation, innovation, and access for groups that are persistently underserved by mainstream provision. Direct payments under the Care Act 2014 already provide the legal mechanism for this hybrid, but uptake remains uneven. A second policy implication, supported by Tables 5 and 6, is that prevention spending is the structural hinge between the two models. When prevention is funded, micro-enterprises and community networks can flourish, taking pressure off the regulated system; when prevention is cut, both models become

more fragile and reactive. The ADASS Spring Survey 2025 finding that prevention spend will fall from 8.2% to 5.6% of net adult social care expenditure between 2023/24 and 2025/26 therefore represents a significant strategic risk for the entire decentralized architecture (Association of Directors of Adult Social Services, 2025). Sustaining prevention is, in effect, the commissioning lever that determines whether flexibility-led models can continue to complement the regulated system. Taken together, the discussion confirms the hypothesis: flexibility-oriented micro-providers do show stronger personalisation and cost-efficiency signals, while regulation-oriented providers show stronger compliance, capacity, and workforce signals. The optimal configuration is neither pure regulation nor pure flexibility, but a deliberate, well-resourced hybrid.

7. Conclusion

Decentralized adult social care in England in 2024–2025 is shaped by a productive but unstable tension between regulation-led assurance and flexibility-led personalisation. Regulation underpins capacity, expenditure, and consistency; flexibility-led micro-care models offer the personalisation, innovation, and community embeddedness that the Care Act 2014 promised but that large-scale provision struggles to deliver. The evidence presented across six tables, drawn from official 2024–2025 administrative data and peer-reviewed research, indicates that fiscal strain, workforce fragility, and prevention cuts now jeopardise both ends of the spectrum simultaneously. The most defensible policy direction is a hybrid commissioning model that applies proportionate regulation, sustains prevention funding, and invests in micro-enterprise infrastructure so that decentralization delivers on its statutory promise of choice, control, and wellbeing.

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