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August 2016

IPPR

DEVO—HEALTH

WHAT & WHY?

Institute for Public Policy Research

SUMMARY

The purpose of this booklet is to set out the context for IPPR's research on devo-health and the questions which we would like this programme of work to address. We are also setting out some initial hypotheses about devo-health which we will look to test as we proceed.

KEY FINDINGS

1. **At the moment, 'devo-health' is more akin to delegation than devolution.** In Manchester, the health secretary rather than the newly elected mayor will remain ultimately accountable for health and care. Going forward, this may need to change, with local mayors given clearly defined roles in the NHS and the centre stepping away from its responsibilities, in order to give local leaders 'skin in the game' and enable local communities to hold them to account.
2. Devo-health has the potential to drive improvements in health from both within and outside of the NHS. **Devo-health can catalyse reform within the NHS (particularly integration) and can drive improvements in the social determinants of health through the creation of place-based public services.** The latter has particular potential given that health devolution is likely to be part of broader decentralisation deals.
3. **The potential benefits of devo-health do not imply that every area in the UK should take on powers over the NHS**, but rather that it should be considered as one option in looking to drive reform going forward. **There is a better case for proceeding with devo-health in urban areas with clearly established geographic boundaries and with a strong history of joint working between the NHS and local government.** All future devolution deals should adhere to the decentralisation principles set out in IPPR North's report *Decentralisation decade* (see Cox et al 2014): they must have a clear purpose; be joined up across silos; be given time to bed in; have cross-party support; and will necessarily be asymmetrical.
4. **There are risks involved in health devolution.** For example, it is likely that 'devo-health' will ultimately lead to finger-pointing between central and local government as the next round of public sector cuts hit; rhetoric appears to be running ahead of reality, given that history shows that structural changes rarely deliver in terms of efficiency or health outcomes; and in Manchester, local leaders have been unable to reverse any of the additional complexity caused by the 2012 Social Care Act, and are instead creating a series of new forums in an attempt to overcome existing fragmentation.
5. Having said that, **the most commonly cited concern – that we will lose the 'N' in the NHS – has been exaggerated.** Significant variation in the quality of care and the health outcomes achieved already exists across England under our more centralised system. While it is feasible that devo-health could make this worse, that seems unlikely, especially as the NHS Mandate and NHS Constitution will remain in place.
6. **A huge number of unanswered questions remain.** How much freedom should local areas have to differ from national policy? Should full devolution follow delegation? Is there a role for fiscal devolution? How can local areas unlock the potential benefits of devo-health, and what should local areas do with their devolved powers? How do we keep the 'N' in the NHS while also delivering place-based public services? Will the funding pressures on the NHS and local government ultimately undermine efforts at reform? Our programme will look to address these questions and more over the coming months.

ABOUT IPPR

IPPR, the Institute for Public Policy Research, is the UK's leading progressive thinktank. We are an independent charitable organisation with more than 40 staff members, paid interns and visiting fellows. Our main office is in London, with IPPR North, IPPR's dedicated thinktank for the North of England, operating out of offices in Manchester and Newcastle, and IPPR Scotland, our dedicated thinktank for Scotland, based in Edinburgh.

The purpose of our work is to conduct and publish the results of research into and promote public education in the economic, social and political sciences, and in science and technology, including the effect of moral, social, political and scientific factors on public policy and on the living standards of all sections of the community.

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INTRODUCTION

Over the past few decades the one constant in public policy discourse has been the desire to decentralise economic, public service and democratic power within the UK and more recently within England. Labour, Coalition and Conservative governments alike have been part of a growing consensus behind decentralisation. Its latest incarnation – the northern powerhouse agenda – could mark a significant further step forward in that journey.

> *'A true powerhouse requires true power…'*
> George Osborne, former chancellor of the exchequer

In his 'Northern Powerhouse' speech (Osborne 2014), the former chancellor offered to start a dialogue with local leaders about the 'devolution of powers and budgets' to be managed by newly created combined authorities and metro mayors. Greater Manchester became the first new region to take up his offer, gaining new powers over transport, housing, planning, policing, skills and employment support. The most radical element of Greater Manchester's deal, however, was the announcement in February 2015 that the region would also get control over its £6 billion NHS budget.

> *'This has the potential to be the greatest act of devolution … in the history of the NHS.'*
> Simon Stevens, chief executive of the NHS

The surprise inclusion of health in the northern powerhouse initiative has raised a number of fundamental questions which have not, as yet, been fully answered. How far could health devolution go? What are the risks and how can they be managed? What should local areas do with their new health powers? What are the implications for central government of devo-health?

It is these questions and others – being asked at both the national and local level – that IPPR's new programme of research on devo-health will look to answer in the coming months. This introductory paper establishes the context for the IPPR programme, the key questions we wish to address, and some of our initial thinking on a set of foundational questions raised by the emerging devo-health deals in Greater Manchester and across England.

We hope you find this and our future contributions to the debate both useful and interesting.

Rt Hon Alan Milburn
Former secretary of state for health

WHICH AREAS ARE INTERESTED IN DEVO-HEALTH?

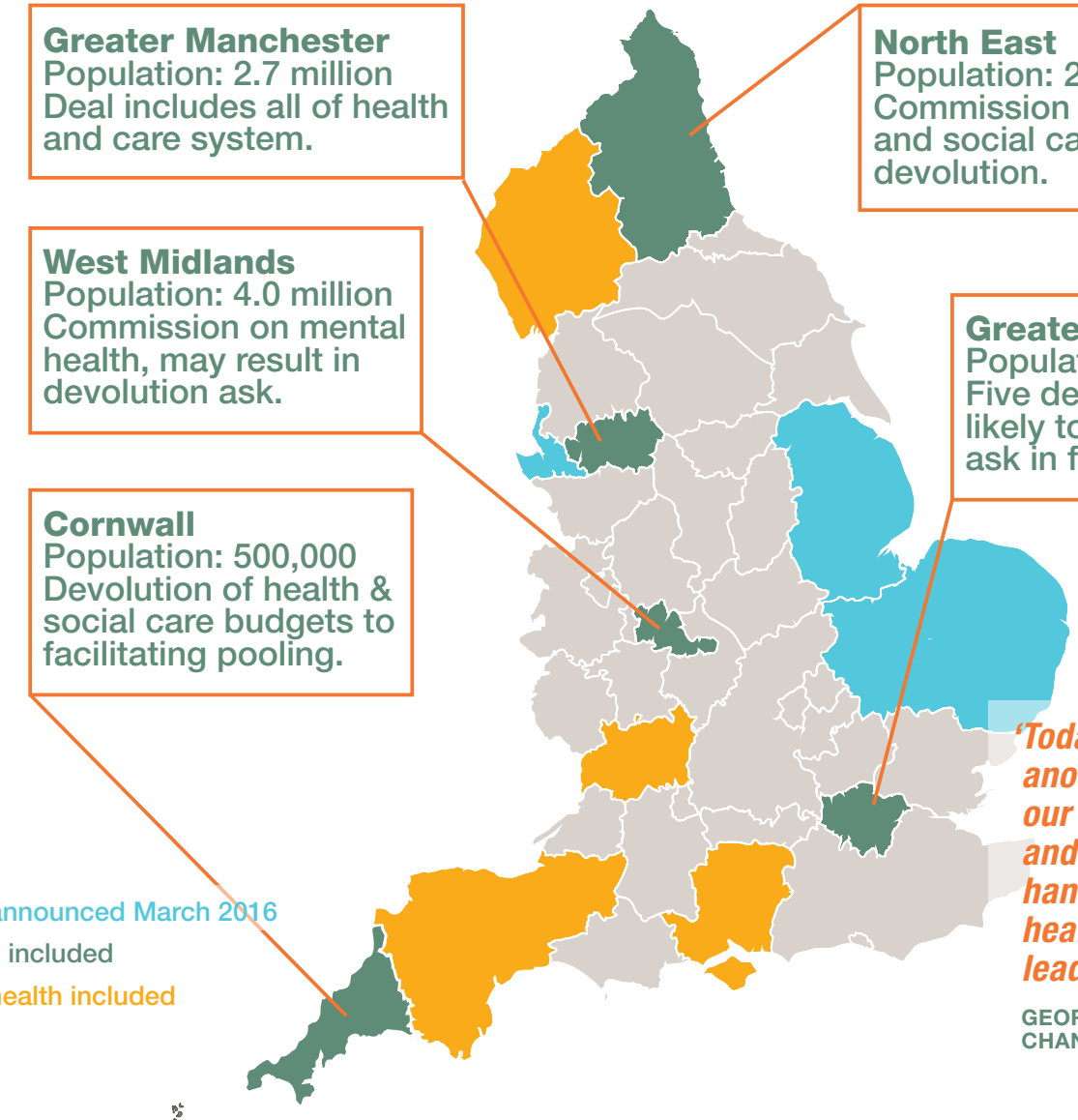
'It's the biggest act of devolution in England's NHS since 1948 – and it now means that Greater Manchester will make its own decisions about the health and social care needs of its residents.'

SIR HOWARD BERNSTEIN, CHIEF EXECUTIVE, MANCHESTER CITY COUNCIL

Greater Manchester is not the only area asking for or considering extra health powers.

Indeed, if all areas currently asking for health powers were to receive them, then around one-third of England's population would be covered by some form of devo-health agreement.

However, as it stands, devo-health is still considered an experiment. In the short term, the government is likely to give significant powers to only a small number of urban areas that have demonstrated a history of joint working between the NHS and local government, and which have a more developed form of local democracy.



'Today's agreement is another crucial step in our devolution revolution, and is the start of our handing over valuable healthcare power to local leaders in London.'

GEORGE OSBORNE,
CHANCELLOR OF THE EXCHEQUER

WHAT DO WE MEAN BY DEVO-HEALTH?

Devolution is the most complete type of decentralisation, meaning the transfer of power from a more national to a more local body. For example, since devolution to Scotland in 1998, the Scottish government has had complete control over its share of the NHS budget and is held to account when it fails to deliver by the Scottish population. In Scotland, health care is no longer the preserve of the Westminster government.

As it stands, however, devo-health in Greater Manchester is not devolution but delegation.

Type of decentralisation	Definition	Example
Deconcentration	The centre prescribes the goal, the method and the running of services, but the latter is conducted through lower-tier actors or regional offices.	NHS England regional offices and specialised commissioning
Delegation	Responsibilities for setting policies and delivery are transferred to semi-autonomous entities but there is still a degree of accountability back to central government.	NHS 'devolution' to Greater Manchester
Devolution	Decision-making is completely transferred to a subnational body that is then held accountable from the bottom up rather than the top down.	The NHS in Scotland, Wales or Northern Ireland

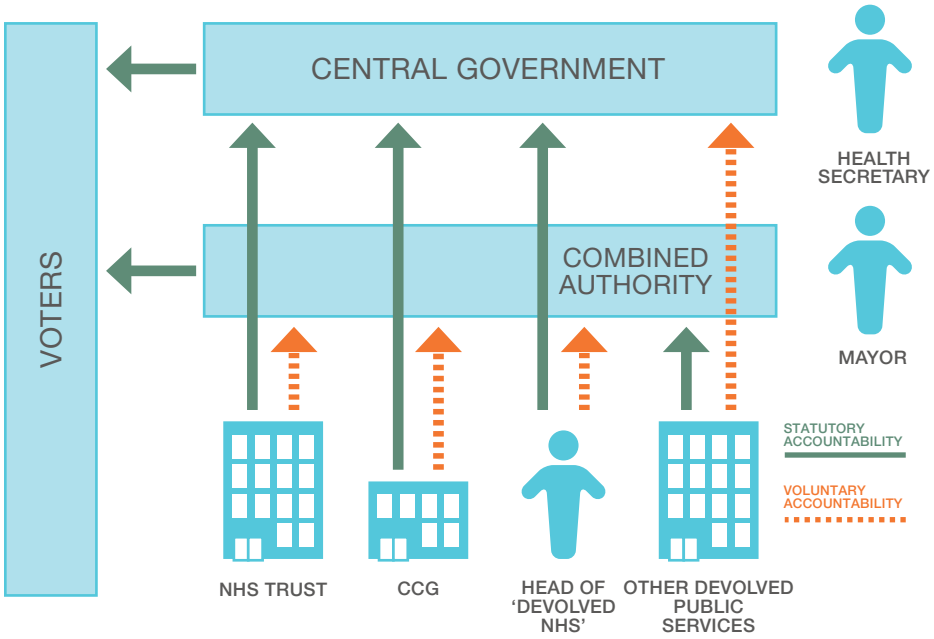
Source: Based on typology developed by Saltman and Bankauskaite 2006

Greater Manchester will receive some more freedoms (see pages 12–13), but through the so-called Warner amendment to the Cities and Devolution Bill (2016) it will be Jeremy Hunt (as health secretary) and not the newly elected mayor who is ultimately accountable for health and care in the region. This means there will still be a significant degree of national oversight and control.

This is reinforced by the retention of existing organisational statutory responsibilities: clinical commissioning groups and foundation trusts will still be accountable to Whitehall rather than to the Greater Manchester combined authority (GMCA). This means that GMCA's influence will be dependent these bodies voluntarily ceding decision-making power to the local level rather than to Whitehall, whose power over these organisations is based on primary legislation.

All this raises significant questions about the degree to which Manchester and other 'devolved' regions will really have the power and 'skin in the game' to steer the ship going forward.

ACCOUNTABILITY AND POWER IN A DEVOLVED SYSTEM



WHO ARE WE ‘DEVOLVING’ TO?

‘Decentralisation of decision-making powers and budgets can occur at a number of levels of government, with the individual at one end of the spectrum and central government at the other.’
Cox et al 2014

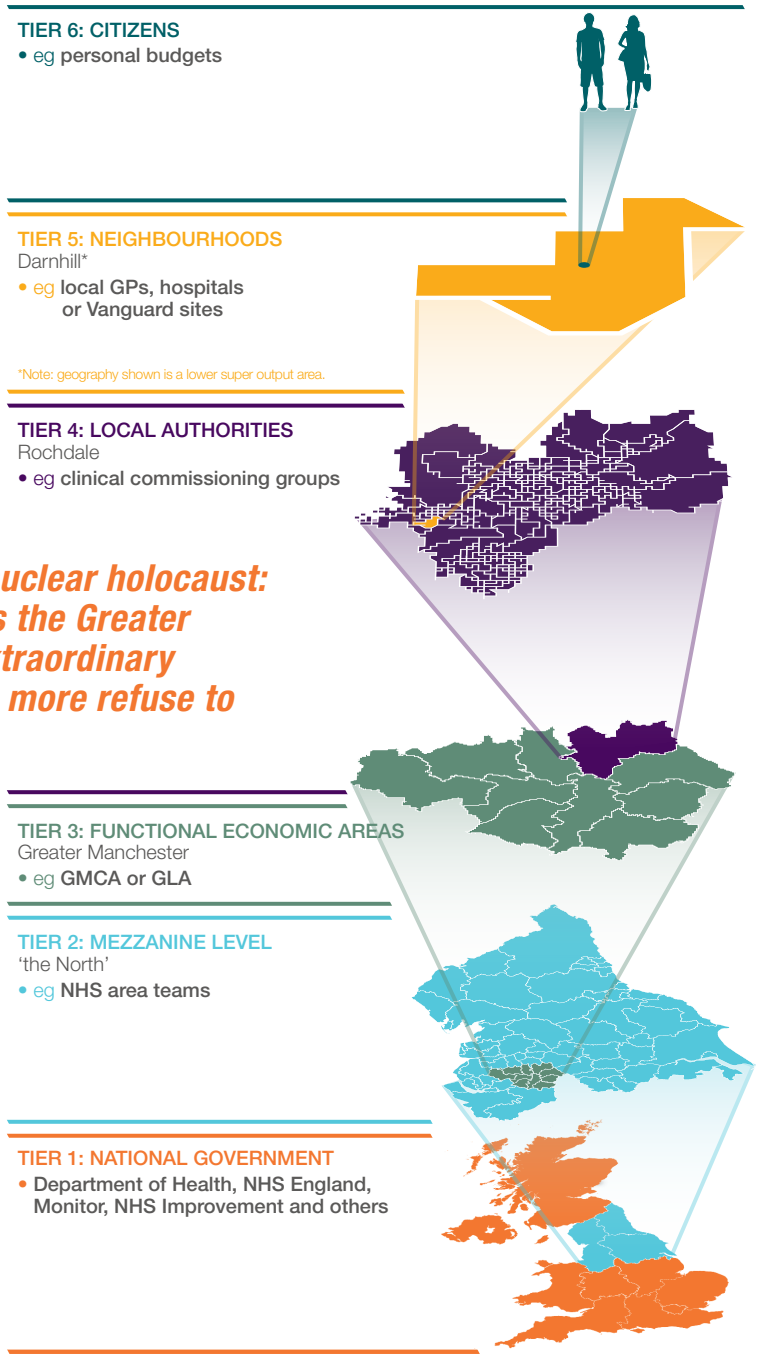
The current decentralisation agenda is interesting because it signals the recreation of a ‘meso-level’ of government, meaning regional or city-level government. This tier has historically been hollowed out by the combination of granting so-called ‘earned autonomy’ to local (micro-level) organisations and the creation of strong management targets focused on central objectives.

‘It’s been said that only two things will survive a nuclear holocaust: cockroaches and regional health authorities. Does the Greater Manchester experiment in devolution show the extraordinary regenerative powers of NHS regions, as they once more refuse to lie down and die?’

FIONA GODLEE, EDITOR, BRITISH MEDICAL JOURNAL

The recreation of some form of regional governance and oversight yields mixed reviews from the health community. Many welcome the greater possibility for system leadership and a more planned system, while others remember the deficiencies of the regional health authority model. In general, given the confusion and fragmentation created by the 2012 Health and Social Care Act, it seems that the former argument might be the more prescient.

However, what is clear is that, while this is undoubtedly decentralisation from the Westminster point of view, for the average citizen in Manchester some decisions are actually moving further away. For example, strategic commissioning decisions about the allocation of funding might be taken by the GMCA rather than by local clinical commissioning groups.



DEEP DIVE: A HISTORY OF DECENTRALISATION IN THE NHS

Decentralisation is far from a new policy idea in England: the current debate echoes Aneurin Bevan's and Herbert Morrision's initial debate about the management of the NHS in 1948. The history of the NHS highlights that, in general, there has been a tendency to centralise, even if the rhetoric has been about decentralisation. This begs the question: is the latest drive for decentralisation going to have any more substance behind it than the previous attempts?

'The sound of a dropped bedpan in Tredegar Hospital will reverberate round the Palace of Westminster.'
Aneurin Bevan

1900–1944: From 'complete' decentralisation towards a National Health Service

Pluralism in providers with voluntary and private providers of acute and primary care alongside workhouse infirmaries and home care for the needy.

Slow move towards a 'more national' system with the 1911 National Health Insurance Act which was extended in the 1920's and the creation of the Department of Health.

1945–1974: A centralising moment

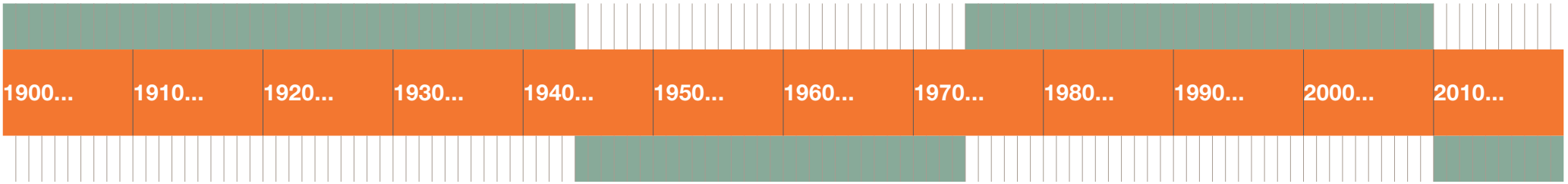
The creation of the NHS through the NHS Act 1946 was precipitated by debate between Aneurin Bevan and Herbert Morrison on whether the health service should be managed by a new central body or left in hands of local government. Bevan and centralisation won the day.

However, despite the structural centralisation contained in the 1946 Act, in practice significant provider autonomy remained, as central government lacked levers to control the frontline.

1975–2010: Decentralising rhetoric, but not in practice

Lots of talk of decentralisation, including the consultation document 'Patients First' (1979) and the 'NHS Plan and 'Shifting the Balance of Power' documents (2000). However, the overarching trend in this period is the rise of centralised standards, with freedoms and finances given upon compliance, through so-called 'earned autonomy'.

The most obvious examples of this include the provider/commissioner split in 1990, the move from regional health authorities to regional NHS boards, and the creation of central standard-setting organisations, including NICE and the Commission for Health Improvement (the forerunner to CQC), culminating in the creation of foundation trusts.



2010–present: Start of a centralisation decade?

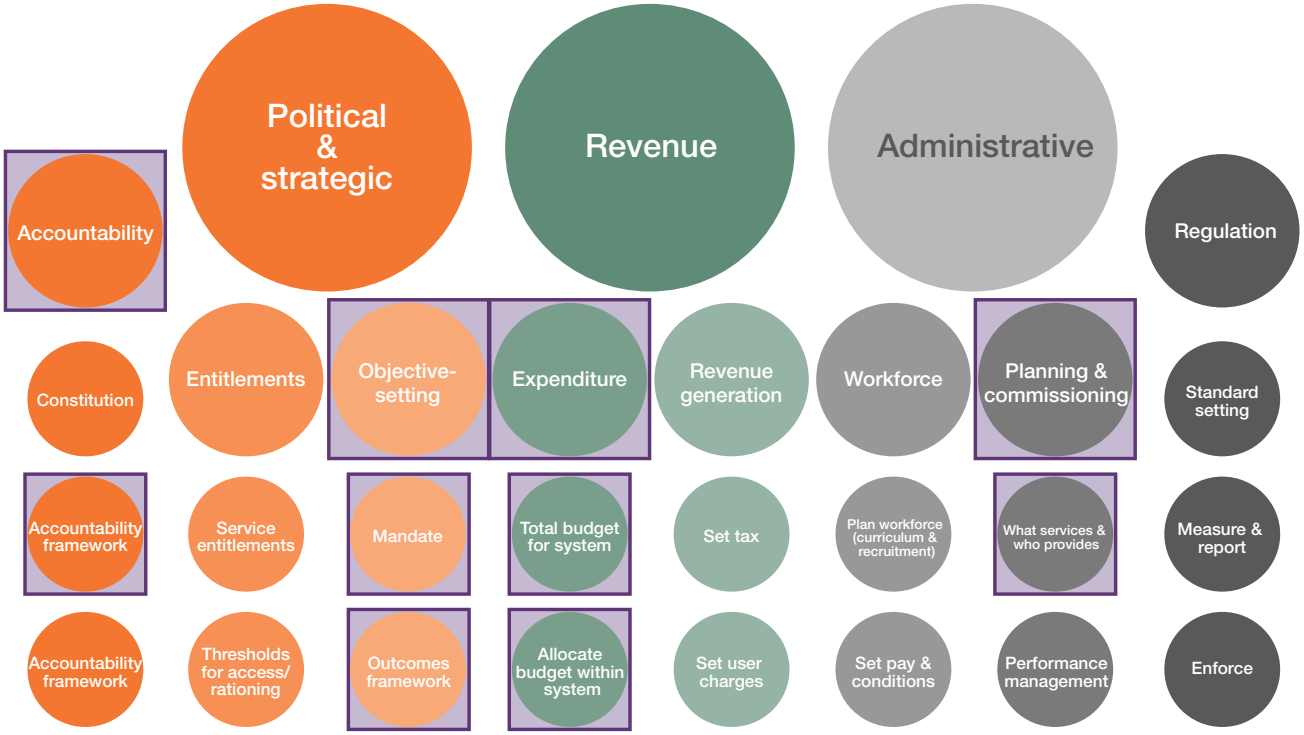
Recent years have essentially seen a continuation of the 'earned autonomy' policies, despite the decentralist rhetoric of the 2012 Health and Social Care Act.

The main exception to this rule has been the increasing interest in devolving to the individual level, as demonstrated by the spread of personal budgets from social care to health.

The announcement in 2015 of the 'devolution' of Greater Manchester's health budget – akin to the recreation of a regional health authority – therefore came as a surprise.

WHAT FUNCTIONS ARE BEING 'DEVOLVED'...?

There is a consensus that decentralisation fits into three broad categories: political, fiscal and administrative (Triesman 2007). This diagram sets out a model of the NHS with functions listed under each of these categories. We have used this to make an assessment of Greater Manchester's devo-health deal to understand where they are and are not receiving new powers.



Source: Based on typology developed by Saltman and Bankauskaite 2006

...AND WHICH ONES AREN'T?

This analysis reveals that while Greater Manchester will have greater (though not absolute) power over objective-setting, funding allocation and planning and commissioning, there are also some significant gaps in their devo-health deal. Notably, existing regulatory and accountability mechanisms will largely remain in place (which will make setting different objectives and moving money around difficult in practice) and there is no fiscal devolution, which will make managing the financial challenges facing public services more tricky.

IS IT JUST THE NHS?

The current decentralisation agenda goes well beyond the NHS. There is a range of other public services and functions that are being devolved to the local level.

This is perhaps one of the most exciting and potentially beneficial elements of the current devo-health agenda because it may allow local areas to join up a variety of public services – for example, the health system and the criminal justice or welfare system – in order to tackle more effectively the social determinants of health and create a health system that is more preventative than responsive (see pages 18–19 for more detail).

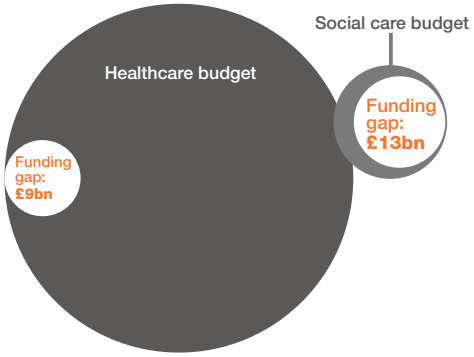
Powers	Cornwall	Greater London	Greater Manchester	North East	West Midlands
Business support	Growth hub	Growth hub	Growth hub, manufacturing advice, export advice (UKTI)	Growth hub and export advice (UKTI)	Growth hub and export advice (UKTI)
Criminal justice	None	None	Commissioning local services, youth justice and prison budgets	None	Youth justice
Employment support	None	None	Work and health programme commissioning and pilot	Work and health programme commissioning	Work and health programme commissioning
Further eduction and skills	Redesign of 16+ further education system 19+ skills funding	Redesign of 16+ further education system 19+ skills funding	Redesign of 16+ further education system, 19+ skills funding, early years pilot and apprenticeship grant for employers	Redesign of 16+ further education system	Redesign of 16+ further education system and 19+ funding
Health and social care	NHS and social care budget	Health and social care commission and pilots	NHS and social care budget	Health and social care commission	Health and social care commission
Housing	Land disposal and utilisation	Spatial planning, land disposal and utilisation, Mayoral Development Corporation, Housing Investment Fund	Spatial planning, land disposal and utilisation, Mayoral Development Corporation, Housing Investment Fund	Spatial planning and land disposal and utilisation	Spatial planning, land disposal and utilisation, Mayoral Development Corporation, Housing Investment Fund
Police and fire	None	Police and fire services to mayor	Police and fire services to mayor	None	Police and fire services to mayor
Transport	Bus franchising and smart ticketing	Bus franchising, smart ticketing, rail and roads	Bus franchising, smart ticketing, rail and roads	Bus franchising, smart ticketing, rail and roads	Bus franchising, smart ticketing, rail and roads

Source: Press cuttings and government press releases
Note: Orange = no powers; blue = partial powers; green = full powers (relative to all devolution deals signed since the northern powerhouse speech.

WHAT'S THE PROBLEM WITH OUR EXISTING SYSTEM...?

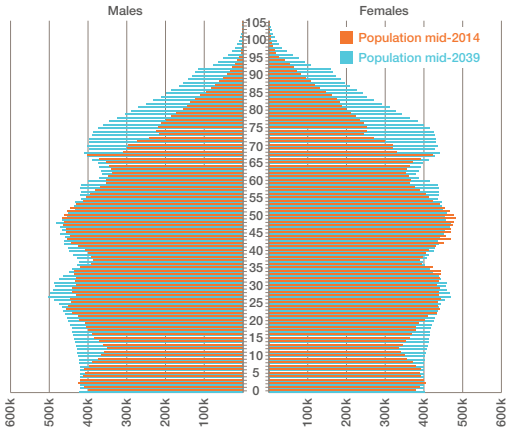
Understanding the broader context in which health devolution is occurring is crucial in explaining why it is seen as a potentially beneficial reform.

1. The economic crisis has had a significant impact on England's fiscal position, which means that there is less money available for public services, including the NHS. This is likely to continue for the foreseeable future.



Source: King's Fund and Health Foundation 2015

2. England has a growing and ageing population with increasingly complex rather than tame health problems and higher expectations of public services. This puts an upward pressure on demand for public services.



Source: ONS 2016

...AND WHY MIGHT DEVO-HEALTH PROVIDE US WITH A SOLUTION?

The existing literature on public service decentralisation suggests that there are four main channels through which health devolution could potentially help solve these problems (Walshe et al 2016).

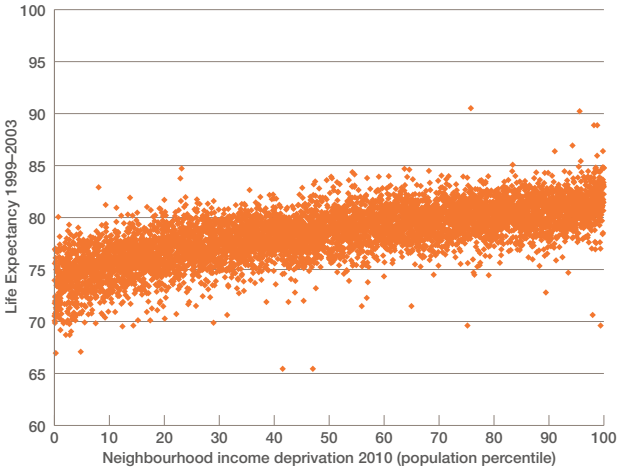
Potential benefit	Mechanism
1. Improved decision-making	better information due to increased proximity increased responsiveness due to better accountability leads to local innovation to solve local problems
2. Increased integration within health and between health, social care and other public services	more coordination between health and care system, and increased ability to move care into the community because of integrated governance, budgets, commissioning, and delivery across silos shift towards prevention and improvements in the social determinants of health through better 'non-health' policy because of aligned accountability and pooled budgets across public services
3. Increased pace and commitment to reform	empowers local leaders on the one hand, and gives them 'skin in the game' on the other leads to increased commitment to reform (vis-a-vis top-down model) and brings on partners more quickly/those who would not have joined in
4. Increased efficiency/reduced cost	reduce demand more quickly and completely and release associated savings remove duplication and inefficiencies in the system and release savings

Some of the these potential benefits hold more promise than others. The most interesting are investigated in more detail on pages 18–21.

DEEP DIVE: THE SOCIAL DETERMINANTS OF HEALTH & PLACE-BASED PUBLIC-SERVICES

Health inequalities in England are large and growing. There is a 20-year gap in disability-free life expectancy between rich and poor across England (Buck and Maguire 2015). Addressing this health gap is not just motivated by a desire for social justice, but also a demand for greater efficiency: it often costs less to prevent ill-health before it happens than to wait it for it to occur and then respond.

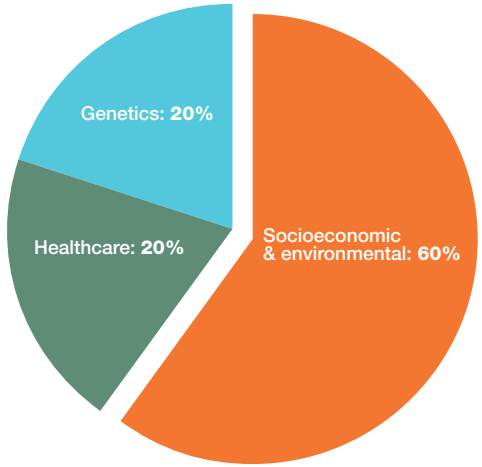
WHAT EFFECT DOES DEPRIVATION HAVE ON LIFE EXPECTANCY?



Source: Buck and Maguire 2015

However, it is perfectly clear that traditional health policy – meaning healthcare systems like the NHS – will be unable to really get to grips with this problem because the majority of variation in health outcomes is determined outside of these systems.

HOW MUCH OF GOOD HEALTH IS DETERMINED BY HEALTHCARE?



Source: Canadian Institute of Advanced Research, Health Canada, quoted in Kuznetsova 2012

Devolution of the NHS and other public services at the same time to the same tier of government may make it possible – and create strong incentives – to better address these so-called social determinants of health by creating genuinely place-based public services (Ham and Alderwick 2016).

This is where resources are pooled across a range of public services and then allocated based on maximising the outcomes for the whole local population through the most effec-tive channel rather than through existing delivery silos. This could allow policy makers to rebalance focus and resources away from just responding to ill-health, towards addressing the causes of ill-health.

The test in places like Manchester will be whether the new mayor and the combined authority can – or will – use new criminal justice powers to deal with complex issues like homelessness, addiction and mental health; transport powers to improve air pollution, reduce social isolation and open up new employment opportunities; and powers over work policy to get those people in long-term unemployment back into work. These interventions could have a much greater impact on health outcomes than reforming the NHS itself.

DEEP DIVE: A CATALYST FOR REFORM

In 2014, Simon Stevens, chief executive of the NHS, published the *Five Year Forward View*. This set the reform agenda for the NHS, including the move towards greater integration within health and between health and social care; better prevention and population health; and the empowerment of patients, so that they can better manage their own health outside of the health service (NHS 2014).

The challenge for Stevens – and for any politician or civil servant at the centre – is how to get local leaders to implement these reforms at the local level, especially at a time when resources are tight and day-to-day pressures high. This dilemma is the driving force behind the creation of the 'Vanguards' and 'Test Bed' sites across the country and the creation of the Better Care Fund, as well as calls for a Transformation Fund for the NHS (King's Fund and Health Foundation 2015).

Devo-health can be seen as another lever for central government to pull in order to catalyse reform. Evidence from Manchester suggests that the process of health devolution has quickened the pace of reform (getting consent for controversial reforms much more quickly) and increased the quality of reform (bringing on partners who would otherwise have been reluctant to be involved).

It is likely that this catalysing effect of devo-health operates through two main channels:

1. **Devo-health empowers local leaders** to instigate and own reform, giving them the confidence to overcome barriers and do something different.

2. **Devo-health makes local leaders more accountable** for their local health economy giving them 'skin in the game', which increases the cost to them of inaction.

EVIDENCE FROM MANCHESTER

There are a number of areas where there is emerging evidence that devo-health has catalysed an increase in the pace and quality of reform:

- **It has sped up the pooling of budgets between services:** pooled budgets will total over £3 billion (approximately 70 per cent of available spend) in the next few years, which is significantly higher than in most other areas in England.
- **It has improved Manchester's 'innovation infrastructure':** agreement has been reached to create Health Innovation Manchester, a fully aligned system of research discovery, innovation and diffusion between the NHS, industry and academia.
- **It has enabled the integration of the health and welfare systems:** Manchester's 'Working Well' pilot of 5,000 people will be expanded to 50,000 people, with the aim of full co-commissioning of the government's Work Programme.
- **It has enabled the acute sector to co-ordinate activity more effectively:** as seen in the creation of 'Healthier Together', which will see teams and resources pooled and shared standards across key clinical areas (starting with general surgery) in order to increase efficiency and move from competition to integration.

'Quite frankly, the progress we have made has been revolutionary for the region and we are in a great place ahead of a new era for health and social care services.'

LORD PETER SMITH, CHAIR, GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

WHAT ARE THE RISKS?

While there are potential benefits to devo-health, there are also a number of risks involved. The following list, while far from exhaustive, summarises the most significant of these.

Some of the these potential risks are more concerning than others. The most interesting are investigated in more detail on pages 25–29.

A significant task for our devo-health research programme going forward will be establishing the extent to which these risks are real; whether they can be mitigated and how this can be done.

> ***'If you're going to stick to the idea of a National Health Service, you can't have a Swiss-cheese NHS where some bits of the system are operating to different rules or have different powers or freedoms ... it does point to further breakup of the idea of a National Health Service.'***
>
> ANDY BURNHAM, SHADOW HOME SECRETARY

Potential risk	Mechanism
1. Complexity of the landscape	**Geographical:** devolution deals don not follow existing organisational boundaries (such as local authorities or clinical commissioning group boundaries). **Functional:** different geographical areas are receiving slightly different powers. **Bureaucratic:** in Manchester, no bodies have been scrapped but new bodies are being created.
2. Equity and the 'N' in the NHS	**Inequality in access:** local area varies access to services. **Inequality in outcomes:** local area moves resources around to benefit certain groups or target certain outcomes, leading to a deterioration in other outcomes.
3. Lack of real devolution	**Funding allocation:** it is not yet clear how far local policymakers will be able to move resources between 'silos'. **Accountability and regulation:** the Warner amendment gives DoH ultimate accountability and the existing statutory obligations and regulations regime remains. **Revenue raising:** real devolution would allow local areas to raise more money for services.
4. Public sector cuts	**Resources:** The potential benefits of decentralisation are inhibited by cuts to frontline services. **Politics:** Decentralisation is used as a political tool by government to distance themselves from the impact of cuts.
5. Local capabilities	**Staff in devolved areas:** both in terms of numbers and experience
6. Distraction from the real issues	**Structural reforms rarely deliver better outcomes:** devo-health may be distracting from the real change which needs to occur.

DEEP DIVE: COMPLEXITY IN THE NHS

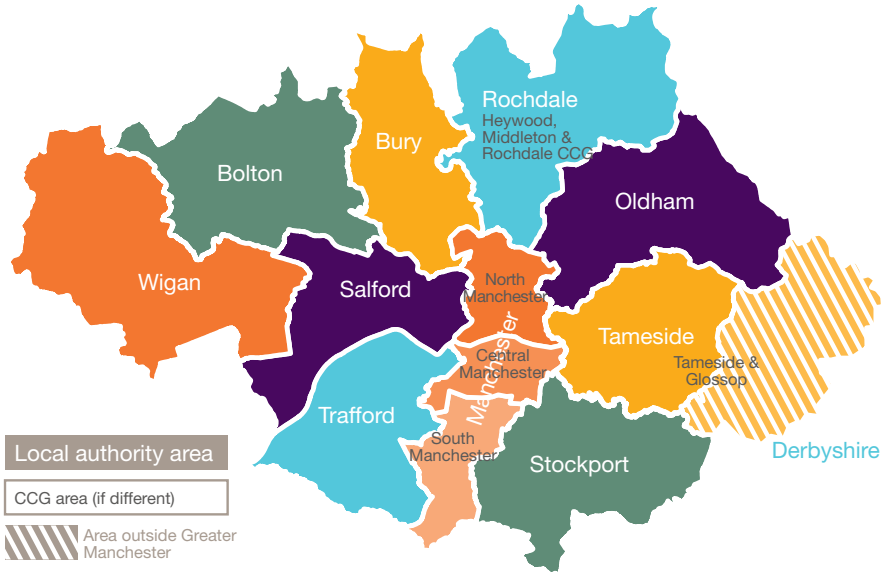
The NHS is one of the largest and most complex organisations in the world. This complexity has increased significantly (and unnecessarily) in recent years as a result of the 2012 Health and Care Act, which was described by Sir David Nicholson, then-chief executive of the NHS, as a reorganisation 'so large, it can be seen from space'.

One of the most significant changes introduced at this time was the dissolution of primary care trusts (PCTs), which commissioned the majority of health functions, including primary care, secondary care and community care. These were replaced by separate commissioners for the various services in health and care. This change has led to an alphabet soup of providers and commissioners at the local level.

For example, prior to 'devolution' in Greater Manchester there were:

- **10 local authorities** commissioning public health and social care
- **10 health and wellbeing boards** planning local health needs
- **12 clinical commissioning groups** buying acute and community care
- **1 local NHS England team** commissioning specialised services and primary care
- **15 trusts and foundation trusts** providing acute, mental health and community care and ambulance services
- **100s of GP surgeries** providing primary care.

GREATER MANCHESTER'S 'ALPHABET SOUP' OF HEALTH BODY AREAS



This complexity has led to significant duplication and fragmentation at the local level, and has made achieving integrated and coordinated care even more difficult. In theory, devo-health could help to undo some of this complexity by creating one local system leader (Timmins 2015), integrating commissioning and provision across organisational silos, and reducing duplication.

However, there is evidence that, as it stands, 'devolution' in Manchester has done little to simplify the organisational environment – indeed, it may have made it more complex (Checkland et al 2016). This is because none of the existing organisational structures will be replaced or changed but they will retain their statutory responsibilities.

Furthermore, they will now be joined by a new set of forums and working groups at the Greater Manchester level designed to overcome the existing fragmentation in the system. However, it remains to be seen whether these arrangements can overcome the strong pre-existing incentives to work within the traditional silos. If this set up does not evolve over time – and is replicated in other devolved regions – 'devolution' may not deliver on its potential in terms of simplification and cost-saving.

DEEP DIVE: KEEPING THE 'N' IN THE NHS

Another concern frequently raised in relation to health 'devolution' is that it will create a postcode lottery in health across England, as local leaders make different policy decisions and operate different health and care systems.

There are two different types of variation worth considering:

1. variation in access to and quality of treatment
2. variation in the health outcomes achieved by public services.

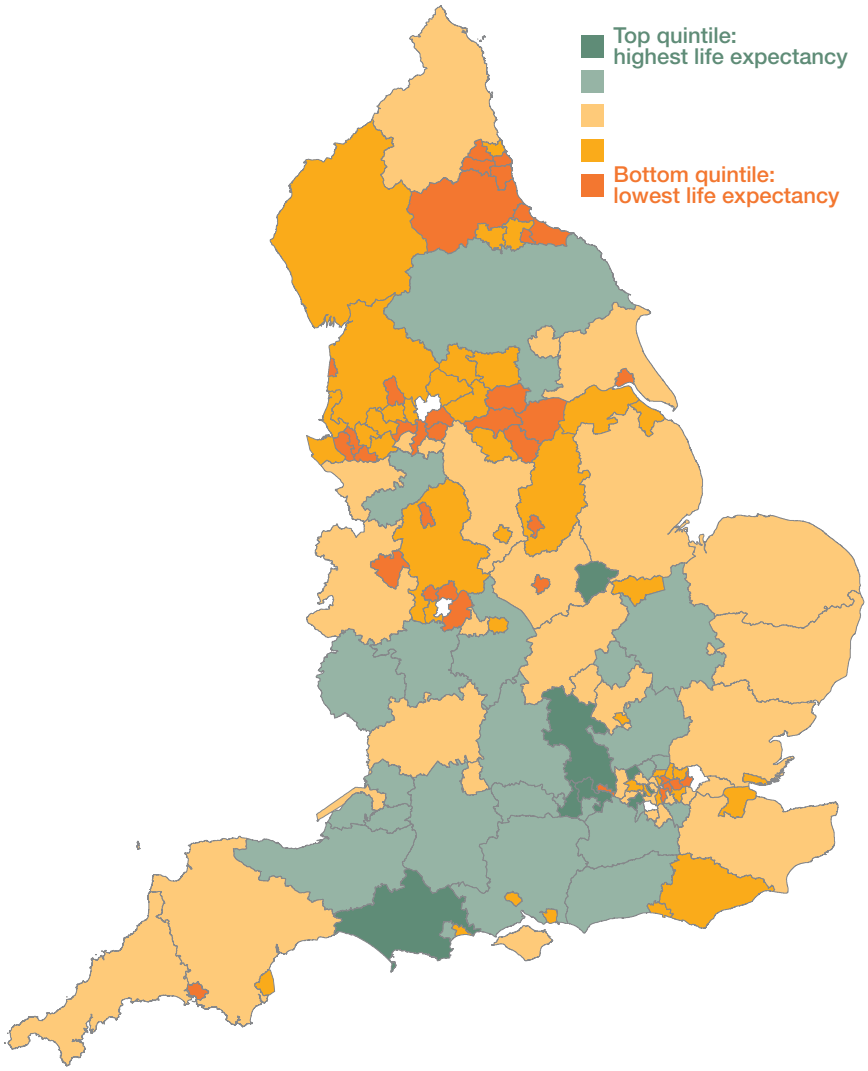
This fear is motivated in part by evidence from other countries, particularly places like the United States, where the quality of care varies significantly across regions (Dormon et al 2016). However, an initial scan of the evidence base on our system (both existing and evolving) suggests that this argument may be overstated.

Concerns about variation in access to and in the quality of treatment received across England are likely to be exaggerated partly because such variation already exists under a centralised system (Atlas of Variation 2016). More importantly, however, it is because the Cities and Local Government Devolution Act of 2016 ensures that areas receiving devolved health powers must continue to comply with the NHS Mandate and NHS Constitution, which set out the entitlements that can be expected across the country.

Meanwhile, as we have highlighted already, variation in health outcomes, such as life expectancy and disability-free life expectancy are already staggering, as shown on the so-called 'Marmot map' (Marmot 2015). While it is possible that devo-health could make this worse, it seems unlikely.

Furthermore, if some of the benefits of health devolution can be realised (see page 17), particularly the creation of effective place-based public services, it could actually narrow the health gap.

LIFE EXPECTANCY VARIES ACROSS ENGLAND



Source: ONS 2016
Note: Quintile ranges for counties and for districts, boroughs and unitary authorities are identical, except in the lowest bound for the lowest quintile. Quintile ranges for counties: 52.1–60, 60–63, 63–66, 66–69, 69–70.65; quintile ranges for districts, boroughs and unitary authorities: 55.25–60, 60–63, 63–66, 66–69, 69–70.65.

DEEP DIVE: RHETORIC OR REALITY?

As highlighted earlier the devo-health agreements being introduced in places like Greater Manchester are much closer to delegation than devolution. This may help to protect the 'N' in the NHS, but it may also make unlocking some of the benefits of devo-health more difficult. There are four main areas where questions remain about the degree of freedom available to local leaders.

1. ACCOUNTABILITY

The Warner amendment to the Cities and Local Government Devolution Bill (2016) ensures that ultimate responsibility for the NHS remains at the national level, with the health secretary, rather than at the local level, with new locally elected mayors or combined authorities. Likewise, existing organisational accountabilities – such as the statutory obligations of CCGs or foundation trusts – remain in place. This is likely to reduce local leaders' 'skin in the game', and therefore may act as a drag on reform. It may also reduce the incentive for local mayors or combined authorities, with powers over policy areas outside of health, to use these powers to address the social determinants.

2. REGULATION

The Cities and Local Government Devolution Bill also ensures that existing NHS regulators (NHS Improvement and the CQC) will remain in place for areas receiving devo-health deals. It is as yet unclear whether regulators will be more responsive to local policy in 'devolved' areas. The extent to which this happens – particularly the extent to which they move towards whole of place rather than siloed regulatory regimes (NHS 2015) – will be crucial in determining the ability of local leaders to truly push forward with reform and do things differently. Without this shift, local leaders may be penalised as regulation continues to focus on organisational targets and silos rather than the integrated services and population-based health outcomes which devo-health is aiming to deliver.

3. FUNDING ALLOCATION

Perhaps the most significant test of the genuineness of devo-health will be the extent to which local leaders can choose where to allocate funding, both within the NHS and perhaps more importantly outside of it too. Can Greater Manchester spend 'NHS money' on social care or policy areas which drive the social determinants of health? There are significant question marks over this, both because the NHS Constitution and NHS Mandate, to which 'devolved' areas are supposed to adhere, can make reference to funding allocation, and because the continuity in accountability and regulation discussed above imply that moving funding between silos may prove difficult.

4. REVENUE RAISING

England is one of the most fiscally centralised countries in the world. Tony Travers of the LSE, drawing on OECD figures, has highlighted that just 1.7 per cent of taxes are set locally (currently, through council tax), which will rise to just 2.5 per cent, as a large chunk of business rates are added. This is very low by international standards: New York receives only 31 per cent of its funding from central government, Paris just 18 per cent and Tokyo less than 8 per cent (LFC 2013).

Local government has actively been calling for more revenue-raising powers. This potentially becomes more important when public services such as health are devolved, because without these revenue-raising powers, local areas cannot be held accountable for local overspends, feel the benefits of financial savings, or be entirely free from the risk of central authorities attaching conditions to funding grants.

OUR EMERGING THINKING ON DEVO-HEALTH...

The purpose of this booklet is to set out the context for IPPR's research on devo-health and the questions which we would like this programme of work to address. We have therefore deliberately not come up with definitive policy conclusions. However, we are keen to set out some of our emerging thinking on this topic.

These statements can therefore be treated as 'informed hypotheses', which we will look to test as we proceed with our programme of research.

1. **Devo-health, while not completely risk-free, has the potential to drive improvements in health, both from within and outside of the NHS.** Devo-health can catalyse reform within the NHS (particularly integration) and can drive improvements in the social determinants of health through the creation of place-based public services.
2. **In order to unlock improvements in the social determinants of health, devo-health must be part of a larger devolution package.** Powers over transport, housing, criminal justice, welfare and employment (alongside existing public health and social care powers) are most likely to be coterminus with health. Funding must then flow across these boundaries.
3. **The benefits of devo-health rely on local leaders having real 'skin in the game'.** Combined authorities and local mayors should be given clearly defined roles in their local NHS and be held accountable accordingly. This implies that, over time, delegation should become more akin to devolution. This might include greater revenue-raising powers at the local level.
4. **At the same time, central government must also relinquish more control, particularly around existing accountabilities and regulatory regimes.** Local areas must have the freedom to really change the way the system works, moving from a model built around organisations to one built around populations, and from responding to ill-health to addressing the causes of ill-health.
5. **The potential benefits of devo-health do not imply that every area in the UK should take on powers over the NHS, but rather that it should be considered as one option in driving reform.** There is a better case for proceeding with devo-health in urban areas with clearly established geographic boundaries and with a strong history of joint working between the NHS and local government.
6. **Devolution deals should also meet the broader decentralisation principles set out by IPPR North in its report *Decentralisation decade***: there should be a clear purpose for decentralising; decentralisation should be joined up across silos; decentralisation will necessarily by asymmetrical (not everyone will be ready to receive the same powers at the same time); decentralised functions should be given time to bed in; and there should be cross-party support for any decentralisation deals (Cox et al 2014).
7. **While there are risks involved in devo-health, the most commonly cited concern – that we will lose the 'N' in the NHS – is exaggerated.** Significant variation in the quality of care and the health outcomes achieved already exists across England under our more centralised system. While it is feasible that devo-health could make this worse, that seems unlikely, especially as the NHS Mandate and NHS Constitution will remain in place, as will the Outcomes Framework.

...AND SOME QUESTIONS WHICH REMAIN UNANSWERED

WHAT?

1. Should the current devolution model – as set out in Manchester – be replicated elsewhere? Will it work in other areas, particularly those that are rural or have significantly larger or smaller populations than Greater Manchester?
2. Should this model be seen as the end state or should full devolution follow delegation? What is the role for fiscal devolution in future?
3. How much freedom will local areas have to differ from national policy, especially given the need to adhere to the NHS Constitution and NHS Mandate?
4. Who will be held ultimately accountable for health in local areas, in light of the Warner amendment and the lack of reform to existing statutory accountabilities?

WHY?

5. Are the potential benefits of devo-health set out in this document correct? Which are the most important?
6. How can we unlock these benefits? What should local areas do with their devolved powers?
7. Is devo-health really likely to drive improvements in the social determinants? How?
8. What other powers outside of health could or should be devolved to maximise the potential of driving improvements in the social determinants?
9. Do the reform-based efficiencies predicted in the *Five Year Forward View* really become more likely in a devolved system?

RISKS?

10. How do we keep the 'N' in the NHS while also delivering place-based public services? How can we ensure that everyone in England can access first-class care when they need it and regardless of income?
11. What is the role for central government in devolved areas? When should they intervene, and how far should they go?
12. Will the funding pressures on the NHS and local government ultimately undermine efforts at reform? Does 'devolution' give central government the ability to blame local leaders for underperformance caused by funding cuts?

Acknowledgments

The author would like to thank everyone who was involved in this project. Particular thanks go to Alan Milburn (chair of the Social Mobility and Child Poverty Commission), Warren Heppolette (strategic director for health and social care in Greater Manchester), Stephen Dorrell (chair of the NHS Confederation), Peter Howitt (deputy director at the Department of Health), Rosemary Granger (head of health and social care, North East Combined Authority) and Tony Lloyd (interim mayor of Manchester), who all took part in our devo-health research programme launch in Manchester in April 2016. Meanwhile, the advice of Dr Martin Gorsky (London School of Hygiene and Tropical Medicine) on the history of the NHS was invaluable.

I am also grateful to IPPR colleagues who have contributed time and energy to this project, including Jonathan Clifton, Luke Raikes, Kellan Palmer-Stephens, Adam Dyster, Mark Ballinger, Ross Fulton, Josh Goodman, Ed Cox and Tom Kibasi.

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