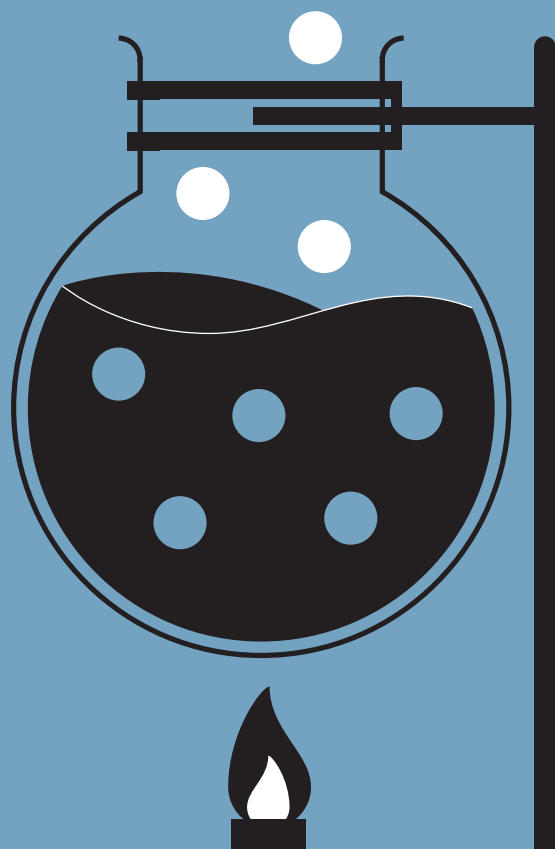


Catalyst or distraction?

The evolution of devolution in the English NHS

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Overview

‘Devolution’ – the transfer of power from a higher to a lower level of government – is high on the political agenda in England, and looks likely to remain so for the course of this parliament at least. While the recent interest in devolution within England has not specifically focused on health care, it has been caught in its wake. In 2015, five Devolution Deals* that included aspects of health care were agreed. Another three Deals that included reference to health were announced in the 2016 Budget.† By far the largest of the agreed Deals is with the Greater Manchester Combined Authority.

This report considers the potential implications for health and care outcomes of health care devolution in England and how policy could best evolve. While the wider devolution agenda includes many public services, which could all have an impact on health outcomes, the focus of this report is primarily on devolution in the NHS. It draws on analysis of the Devolution Deals agreed to date, relevant literature, and international experience with a focus on four European decentralised health systems.

* Capitals are used for ‘Devolution Deal’ as per the government’s explanatory notes for the Cities and Local Government Devolution Act 2016.

† See Figure 1 on pages 14-15 for more details of the agreed Deals.

Key points

- There are three different drivers behind recent interest in devolution in England. These are:
 - considerations of economic growth by George Osborne and HM Treasury
 - ‘Mancunian exceptionalism’: the desire of leaders within Greater Manchester to jointly make more decisions themselves
 - Simon Stevens and NHS England seeing devolution as a pragmatic means to deliver the NHS *Five year forward view*.
- Exactly how the devolution of health care within England will work to improve health and care outcomes is yet to be articulated. However, it seems that devolution is being seen as a potential catalyst for change by improving joint working between services, improving decisions because of the closer proximity of decision makers to their population, and supporting more effective local implementation of decisions which may otherwise have been seen as ‘imposed’ on an area.
- Five Devolution Deals including aspects of health care were agreed in 2015, along with three new Deals in 2016. However, at least in terms of health care, these do not involve any devolution (transfer of power between political levels), and only modest delegation (transfer of

power between administrative levels). The rhetoric around these Deals often suggests a much greater transfer of power than is perhaps the reality. Each of the agreed Deals is different and likely to evolve over time but it is striking how this current interest in health care devolution within England is highly undefined, especially compared to other recent processes of health decentralisation.

- Generally health care devolution is sought more for political reasons than because of evidence that it improves outcomes – this is the case internationally as well as in England. There is no empirical evidence that decentralised health systems consistently outperform centralised ones. Theoretical arguments favouring decentralised systems can be matched by theoretical arguments for centralisation. Experience of decentralised systems shows that tensions remain between levels, particularly regarding equity and funding. It is clear that decentralisation is an ongoing process rather than a fixed state.
- It is highly unlikely – as well as very probably undesirable – that this process of devolution will result in the NHS becoming a fully devolved system. Instead, the focus should be on how current and future Devolution Deals can improve health and care outcomes. Devolution has potential as a catalyst for change through galvanising local leadership, but it could also be a distraction from the relentless focus on improving quality and efficiency required at a crucial point in the NHS’s history. There is risk that this health care devolution agenda becomes another policy ‘fad’ which promises a lot for health and care but delivers little.

- To give Devolution Deals the best chance of being a positive policy intervention for health and care outcomes, three areas need to be addressed:
 - alignment with other initiatives seeking to achieve similar aims
 - a clear vision, process and framework for the powers available for areas seeking a Devolution Deal
 - significant investment in leadership capacity and capability across health care, particularly at the local level.
- Change, including the taking of educated risks, is urgently needed in the NHS – but evidence suggests that potential benefits from decentralisation are uncertain; local leaders and policymakers alike need to proceed with care.

Why devolve now?

In recent years, there have been a number of attempts to devolve powers within England (such as City Deals¹). However, the current distinct phase of interest in devolution can be traced back to George Osborne's 'Northern Powerhouse' speech in June 2014. This was followed by the announcement of the first Devolution Deal involving health care (Greater Manchester) in February 2015, four further Deals agreed during 2015 (see Figure 1) and three further Deals announced in the 2016 Budget. The Cities and Local Government Devolution Act 2016 provides a legislative framework for making orders to transfer powers over public authorities (potentially including health care) to combined authorities with elected mayors.

But why are we talking about devolution, and why now? Arguably there are three separate drivers behind the current interest in devolution in England.

Economic growth

Across government, devolution is unambiguously being led by HM Treasury.² The June 2014 speech by the Chancellor, George Osborne, explicitly identified devolving power as one of four key ways (the others being transport, science and culture) to drive economic development outside London. He said that doing so required elected mayors to assure accountability: 'A true powerhouse requires true power. So today I am putting on the table and starting the conversation about serious devolution of powers and budgets for any city that wants to move to a new

model of city government – and have an elected Mayor.³ It seems likely that the true success of the current devolution agenda will be measured against its ability to deliver economic growth.

Mancunian exceptionalism

Within Greater Manchester there is a longstanding desire for greater autonomy from central government. There is a particular desire to work across boundaries within Greater Manchester to improve integration of health and social care – the title of their devolution programme is ‘Taking charge of health and social care’. As described by Lord Peter Smith, chair of Greater Manchester Combined Authority, it ‘is about decisions **about** Greater Manchester being taken **in** Greater Manchester in an **integrated** way.’⁴ (Authors’ emphasis.)

Perhaps unsurprisingly, Greater Manchester’s Devolution Deal is of a completely different scale to the other Deals agreed to date (see next chapter). While the origins of Greater Manchester’s health care Devolution Deal remain somewhat unclear, it appears that it was driven as strongly – if not more so – by Greater Manchester as by NHS England (with the Department of Health conspicuous by its absence; the 2015 Greater Manchester Memorandum of Understanding references NHS England 47 times, and the Department of Health only five⁵). What is certain is that Greater Manchester’s context is very different to other areas, building on a strong history of joint working and reform.⁶ For example, in 2011 Greater Manchester became the first Combined Authority in England, while in 2013 Greater Manchester’s 12 clinical commissioning groups (CCGs) came together to form a single association.⁷ Greater Manchester

also hosts Vanguards for integrated primary and acute care systems ('Salford Together'), multispecialty community providers ('Stockport Together'), and acute care collaboration (Salford Royal NHS Foundation Trust working both with Wrightington, Wigan and Leigh NHS Foundation Trust, and the Royal Free London NHS Foundation Trust).⁸




Delivering the *Five year forward view*

Devolution in health care is also seen as a way to help deliver the aims of the *Five year forward view*. These are: greater focus on public health, increased involvement of individuals in their care, and the development of new models of care spanning organisational boundaries – all combining to close the 'three gaps': financial, quality and health and wellbeing. While NHS England has been cautious as to the number of areas which enter into a Devolution Deal,⁹ its chief executive, Simon Stevens, has spoken publicly about how the Deal agreed with Greater Manchester can deliver significant change: 'Strong and aligned local leadership in Greater Manchester means that now is the time for courage and for bold moves to deliver the ambitious agenda set out in the NHS *Five year forward view*... Greater Manchester now has a unique opportunity for innovation and improvement in health and wellbeing.'⁴ Although Stevens has been positive about Greater Manchester, he has expressed scepticism about the likelihood of many other Deals.¹⁰ This implies that NHS England's position is likely to be pragmatic rather than supporting devolution on principle; the *Five year forward view* is silent on devolution despite having been published four months after the Chancellor's Northern Powerhouse speech.

This focus on whole system change through strong local leadership is now also the stated purpose of the ‘Sustainability and Transformation Plan’ process,¹¹ which requires NHS organisations within locally agreed ‘transformation footprints’ to agree a shared plan for their local area.

One thing each of these strands have in common is that their arguments are not about devolution per se, but rather decentralisation as a broader concept, including but not limited to devolution (political decentralisation). The differences between these terms* may seem slight, but are significant.

Table 1: A typology of decentralisation in health care
(from Rondinelli)¹²

Decentralisation	An umbrella term describing the transfer of power from a more national to a more local body
	Devolution Transfer of power down political levels of government: from more national to more local, independently-elected bodies.
	Deconcentration Transfer of responsibility and power from a smaller number to a larger number of administrative actors within a formal government administrative structure.
	Delegation Transfer of power down to semi-autonomous administrative levels outside government

* This paper uses the definitions of the terms as set out in Table 1.

Decentralisation in health care can be pursued for many reasons, with different rationales provided as to how these benefits will be achieved (see Table 2).

Table 2: Objectives, rationale and controversies of health decentralisation (from Bankauskaite and Saltman¹³)

Objectives	Rationale	Issues and controversies
To improve technical efficiency	Through fewer levels of bureaucracy and greater cost consciousness at the local level	May require certain contextual conditions to achieve it Incentives are needed for managers
To increase allocative efficiency	Through better matching of public services to local preferences Through improved patient responsiveness	Increased inequalities among administrative units Tensions between central and local governments and between different local governments
To empower local governments	Through more active local participation Through improved capacities of local administration	Concept of local participation is not completely clear The needs of local governments may still be perceived as local needs
To increase the innovation of service delivery	Through public participation Transformation of the role of the central government	Concept of public participation is not completely clear Accountability needs to be clearly defined in terms of who is accountable for what and to whom

Objectives	Rationale	Issues and controversies
<p>To increase quality of health services</p>	<p>Through integration of health services and improved information systems</p> <p>Through improved access to health care services for vulnerable groups</p>	
<p>To increase equity</p>	<p>Through allocating resources according to local needs</p> <p>Through enabling local organisations to better meet the needs of particular groups</p> <p>Through distribution of resources towards marginalised regions and groups (through cross-subsidy mechanisms)</p>	<p>Reduces local autonomy</p> <p>Decentralisation may improve some equity measures but may worsen others</p>

It is worth reflecting that beyond speeches (eg George Osborne: ‘we all know that the old model of trying to run everything in our country from the centre of London is broken’¹⁴) and elements of Greater Manchester’s plans (‘we believe having the freedom to radically transform the health of our population and to build a clinically and financially sustainable model of health and social care is a huge opportunity’⁷), exactly how devolution in England is expected to improve health and care outcomes has not been articulated by either local or national bodies. This is important, not least because it makes this large policy experiment extremely hard to evaluate. It also makes it impossible to assess whether or not there is consensus around how devolution is meant to work.

Building on Bankauskaite and Saltman,¹³ the implicit policy model for devolution in English health care is that it acts as a catalyst for change in three distinct ways.

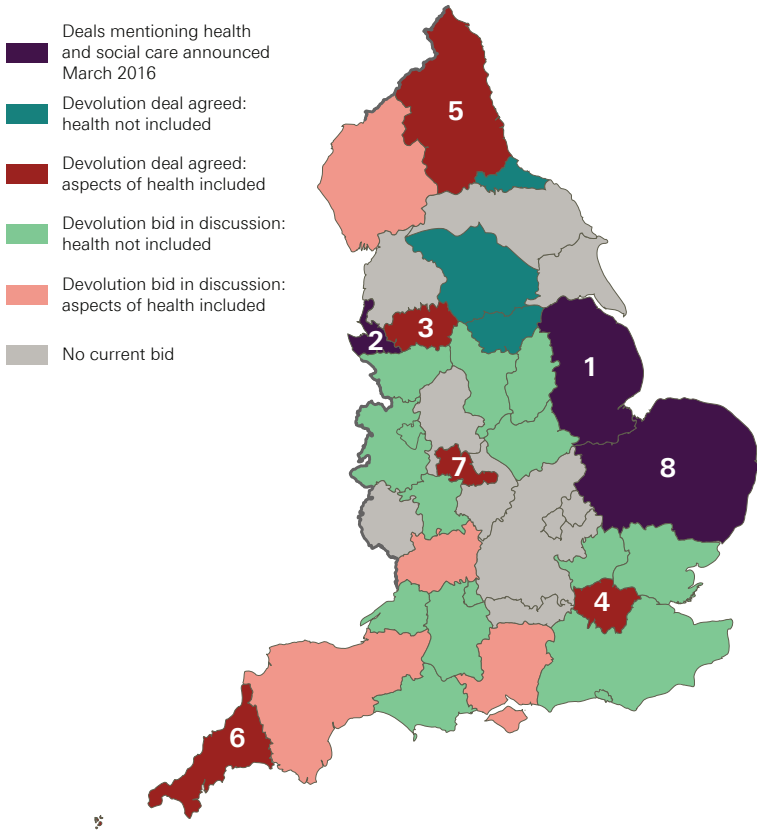
- **Improved joint working** between health care, social care, public health and wider public services, in order to deliver better integrated services (such as joining up health care and social care) and planning (such as a focus on the social determinants of health). This is reinforced by aligning public services power and leadership (both through downwards decentralisation and upwards regionalisation) at a common level, and at a scale which makes joint working manageable.
- **Improved decisions** because of the increased proximity of decision makers to their population, in order to produce services which are better adapted to the population of the local area. This is reinforced by better innovation and

greater responsiveness of services through a reduction in national constraints (whether actual or perceived) and an increase in local accountability.

- **More effective local implementation** of difficult decisions which might have otherwise been viewed (both by staff and citizens) as being ‘imposed’ on an area, in order to support the implementation of system-wide change.

This model (especially improved joint working) is in keeping with the global trend in health care reform (from accountable care organisations in the United States to integrated services in Jönköping, Sweden) to develop holistic approaches to population health and wellbeing, working across organisations to deliver joined-up public services.¹⁵ However, in this context, it is worth asking if decentralisation is needed to achieve these aims.

Figure 1: Health inclusion in devolution bids, by local government area



Source: News items and council websites

1 Deal with: Greater Lincolnshire Combined Authority
Population size: ~0.95m
Health content: Sustainability and Transformation Plan to explore the potential for devolution
Other areas involved: Housing, transport, skills and accelerated growth
Date agreed: March 2016
Current status: Deal signed

2 Deal with: Liverpool city region
Population size: ~1.5m
Health content: 'Ongoing dialogue' over health and care devolution, with further proposals to be made
Other areas involved: Transport, housing, employment and skills
Date agreed: November 2015 and March 2016
Current status: Deal signed

3 Deal with: Greater Manchester Combined Authority

Population size: ~2.7m

Health content: Control over £6.2bn Health and Social Care budget including greater commissioning powers over specialised acute services.

Other areas involved: Transport, Planning and housing, Policing, Business support, and Skills and Employment.

Date agreed: 1st MOU signed in February 2015

Current status: Strategic plan for health and social care published in December 2015 with new powers and governance structures set to begin in April 2016.

4 Deal with: Greater London

Population size: ~8.6m

Health content: Five pilots exploring new approaches to public health, developing new models of care, estates, and integration.

Other areas involved: Only health in most recent Deal but already has powers over transport, policing and planning.

Date agreed: December 2015

Current status: Deal signed

5 Deal with: North East Combined Authority

Population size: ~2m

Health content: Commission for Health and Social Care Integration but no formal transfer of powers

Other areas involved: Transport, Strategic Planning, Skills and Employment, Business support,

Date agreed: October 2015

Current status: Commission chaired by Duncan Selbie and should report back in the summer of 2016.

6 Deal with: Cornwall

Population size: ~500,000

Health content: Integration of health and social care including pooled budgets but fiscally neutral Deal

Other areas involved: Transport, Planning and housing, Skills and Employment, Business support, Environment

Date agreed: July 2015

Current status: 'A lot of work' is needed before health care powers will be devolved to Cornwall.¹⁰

7 Deal with: West Midlands Combined Authority

Population size: ~4m

Health content: Setting up a commission on mental health and wellbeing but no formal transfer of powers

Other areas involved: Transport, Skills and Employment, Business support, Housing, Justice

Date agreed: November 2015

Current status: Commission set up and chaired by Norman Lamb MP

8 Deal with: East Anglia Combined Authority

Population size: ~2.2m

Health content: Counties to develop separate Sustainability and Transformation Plans to a shared vision

Other areas involved: Transport, skills and employment

Date agreed: March 2016

Current status: Deal signed

Progress to date

As shown in Figure 1, five Devolution Deals that include health care were agreed with English regions in 2015, with three further Deals announced in the 2016 Budget.* Further detail relating to these Deals, particularly the Greater Manchester and Cornwall Deals, is provided in the King's Fund's paper¹⁶ and Walshe et al's recent analysis.⁶

A number of conclusions can be drawn from the progress of the Deals to date.

- **The health care aspects of the Deals are not formal devolution.** While some elements of power are being decentralised, this has not – even in Greater Manchester – involved the formal transfer of power from national to local government. As such, describing these Deals as 'devolution' could be seen as misleading. This is played out in the Cities and Local Government Devolution Act 2016, which was amended during its passage to make clear that power could not be devolved on a number of NHS areas (such as regulation).† So it seems that areas are **behaving** as if they have been given greater freedom than they have in

* Three other Devolution Deals with areas that did not seek to include health were agreed in 2015.

† During the Bill's passage, government spokeswoman Baroness Williams made clear that the secretary of state retains their existing abilities to intervene even with regard to 'devolved' areas, stating: 'I was not saying that the secretary of state would overrule them for overruling's sake, but if it was fundamentally a wrong decision, I am sure that he would have the power to intervene.'¹⁷

reality (particularly in Greater Manchester). The rhetoric around these Deals often suggests a much greater transfer of power than is perhaps the reality.

- **Powers being decentralised are relatively modest.** Administrative decentralisation (delegation) of power has happened (for example Greater Manchester’s plans to develop protocols which standardise care pathways across specialised services), or is being actively explored (for example London is looking at better use of NHS estates). However, there is an absence of political decentralisation (devolution). Annex A analyses where power sits in public health, health care and social care between Greater Manchester and non-devolved areas. There are stark differences between the three services – social care particularly is much more decentralised. The lack of decentralisation in health care is particularly acute with regard to workforce, where the majority of power over pay, professional regulation, education and training, and workforce planning is held nationally – and looks unlikely to change in any of the Devolution Deal areas.¹⁸ Given the importance of effective workforce policy to help the NHS meet its quality and financial challenges, this is a potentially significant omission.
- **Each Deal is different and likely to evolve.** All of the Deals are very different to each other, with Greater Manchester a clear outlier in terms of the scale of ambition. It is likely the Deals will evolve: for example, the North East Deal will create a commission to consider the future of health and care; in London, pilot areas are being asked to create detailed business cases and show benefit

before any negotiations on transfers of power take place. This is a cautious approach; London asked for control over bailouts to NHS trusts but they only got a commitment to ‘explore collaborative and cooperative decision making with London Partners.’¹⁹

- **Decentralisation is only one part of a complex picture of shifting NHS power.** The balance of power in the NHS in England in 2016 is complex, and moving in a number of ways (as shown in Figure 2). All Devolution Deals to date have included centralisation of power from individual organisations to regions. In Greater Manchester 37 organisations are coming together, partly to control decentralised powers, but also to pool powers already held by those bodies. A Devolution Deal is not required to achieve this ‘pooled sovereignty’, but it could be a catalyst for it. In addition, Sustainability and Transformation Plans are centralising power both to regional ‘transformation footprints’ and to national bodies through the withholding of significant ‘sustainability and transformation funds’ to be released at the discretion of the national bodies. This centralisation is also seen in the increased intervention on autonomous foundation trusts in recent years by Monitor, now NHS Improvement. In the other direction, personal health budgets are decentralising power to individuals.*

* A further decentralisation would happen if the UK were to leave the EU, reverting powers currently held by the EU to national government.

Figure 2: ‘Arrows Framework’ (adapted from Exworthy and Powell²⁰): Power shifts in the NHS in 2016 (a selection).

Arrows to right indicate decentralisation; those to left indicate centralisation.

Levels	Global	Continental institutions, eg EU	National government and bodies, eg NHS England	Regional agency	Health care organisation	Practice/locality	Individual
Processes							
A: Devolution Deals			→ ←				
B: Sustainability and Transformation Plans			←	←			
C: Personal health budgets					→	→	
D: Oversight of NHS foundation trusts			←				

Above all, while it is not unusual for decentralisation to be invoked to mean a range of things, capable of delivering a range of benefits (enjoying a ‘special status as a panacea in healthcare organisations and health systems around the globe’²⁰), England is unusual in how uncertain this current decentralisation process is. For example, it is not clear which powers are on the negotiating table, how decisions are being made, or where the process is likely to lead.

There is a fundamental difference between what is happening now and the devolution processes and outcomes of 1997–98 which resulted in significant new devolved powers for Scotland, Wales and Northern Ireland. In these cases transfer of powers was highly codified, and followed government white papers, referenda and highly detailed legislation – none of which is evident today (the Cities and Local Government Devolution Act 2016 is a broad piece of legislation designed to enable further legislation at a later date). Even as administrative delegation, ‘devolution’ in 2016 is significantly more ad hoc than how power in the NHS was intended to decentralise as part of the Health and Social Care Act 2012 (which involved over 400 pages of primary legislation and numerous government strategy papers).

It appears a new form of English decentralisation in health care has been created, the substance of which is ambiguous. It therefore remains unclear how best to make it work for health and care outcomes.

What can we learn?

Given this rapid policymaking process over the past two years, what can England learn from the academic evidence base about decentralisation and the experience of other countries? We reviewed the experience of decentralisation in the health systems of four European developed countries (Spain, Sweden, Italy and Finland), as well as relevant literature (see Annex B for more details). From this review, five themes stand out.

1. Beware the ‘fantasy of the optimum scale’:²¹ there is no evidence-based correct ‘dosage’ of decentralisation for a health system

Empirical evidence about the impact of decentralisation on health outcomes is highly ambiguous, with no clear answer as to how decentralised a health system should be to maximise health and care outcomes. In reviewing a range of studies, Saltman et al found mixed evidence. Some studies showed evidence of increased capacity to innovate, greater cost consciousness and greater local accountability, but other studies showed greater inequalities or no clear benefits.²² For example, in studying the impact of decentralisation on clinical outcomes in the Nordic countries, Russia and Canada, Kinnunen et al found: ‘It is difficult to connect specific decentralization or recentralization decisions to particular clinical outcomes.’²³ Theoretical arguments abound for potential benefits of decentralisation

(for example, one set is outlined in Table 2). However, as noted by Vrangbaek, ‘Depending on the specific historical and ideological context, one can also find performance-based arguments favouring centralisation.’²⁴

Is this ambiguity of evidence because decentralisation does not make a consistent difference, or it is too hard to measure? It is likely to be both, although the complex, multidimensional nature of decentralisation does not lend itself well to evaluation. As Kinnunen et al conclude: ‘a firm link between decentralization and clinical outcomes is not only unclear in the currently available evidence, but it may be very difficult to establish under any circumstances except at the most general and thus least valuable level.’²³

Part of the methodological issue, making it difficult to make comparisons, is the population scale of ‘decentralised’ regions – both between and within countries (see Figure 3). For example, in Sweden, power and responsibility for health care largely sits with 21 counties which range in population from around 50,000 to over 2 million people. In Finland health care is devolved down to municipalities (they do not have a regional tier), where the average population is approximately 17,000. In Spain, power largely sits with 17 regions, which vary in population size from around 300,000 to over 8 million.

It is clear that health care decentralisation changes cannot be viewed as an evidence-based means of improving health and care outcomes. Given the inevitability of transaction costs, Foster and Plowden’s view that the ‘costs of changing the status quo in any direction are greater than the efficiency gains of doing so’²¹ is hard to dispute based on empirical evidence, and has

significant overlap with the *Five year forward view*'s statement on NHS structural change: 'There is no "right" answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind.'²⁵

2. Context matters: history, politics and culture drive health decentralisation more than evidence

The recent English experience of seeking health care devolution without an explicit rationale about how this will improve health outcomes is actually the standard for processes of decentralisation. Health care decentralisation is driven far more by politics, history and culture than by technical health policy considerations;²⁶ Saltman and Vrangbaek go so far as to state 'the decision to decentralize... is not so much an evidence-based decision as a political decision.'²⁷

For example, both Spain and Sweden are highly decentralised, but for different reasons, and neither borne of a technical evaluation of the evidence. In Spain, health powers were progressively devolved from central government to 17 regions between 1980 and 2002 principally as a response to the ultra-centrist dictatorship which had gone before. Spanish regional governments are responsible for the majority of health care, with municipalities generally responsible for social care. The national government guarantees equitable health funding, has legislated for a minimum set of health care entitlements and regulates pharmaceuticals.

Figure 3: Scales of European devolution

Please note: Area size is proportionate to population size per devolved unit.

ENGLAND

53.9m people

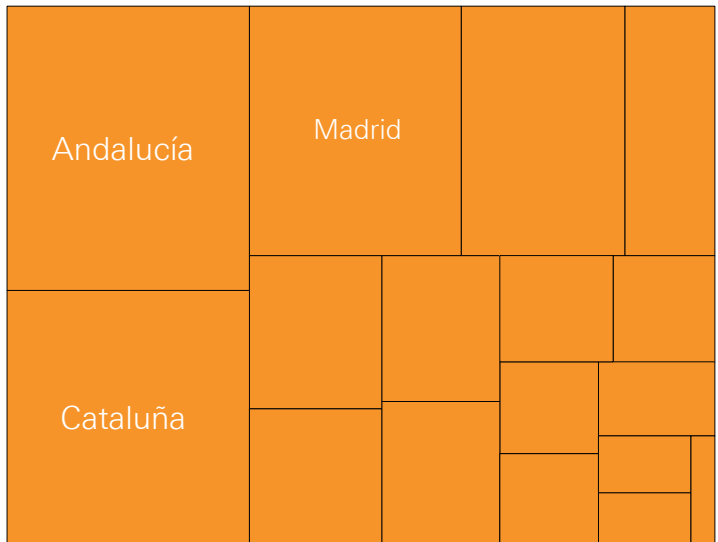
211 CCGs:
100,000 –
900,000
people
(average
300,000)



SPAIN

46.4m people

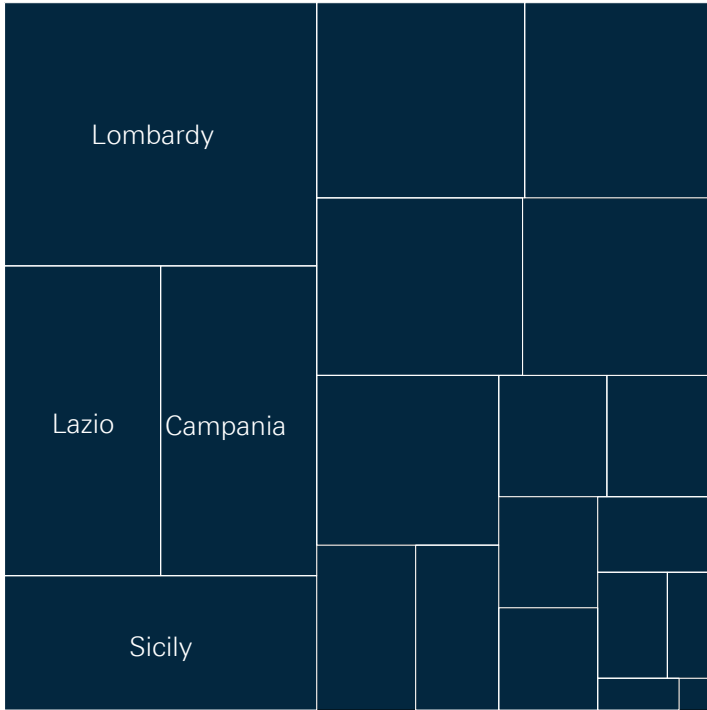
17 regions:
300,000 –
8.4m people
(average 2.7m)



ITALY

60.8m people

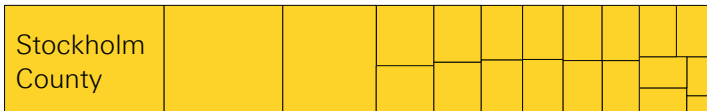
20 regions: 100,000-10m people (average 3m)



SWEDEN

9.8m people

21 counties: 100,000-2.2m people (average 500,000)



FINLAND

5.5m people

317 municipalities: 100-600,000 people (average 17,000)



In contrast, devolution in Sweden has been driven by a long history of localism and public engagement in local government. The Swedish health care system is devolved to 21 counties and the municipalities – all of which are self-governed. The county councils' primary responsibility is the provision of health care, including highly specialised care which is organised through banding into six larger medical care regions. The central government is responsible for overall health policy and system oversight.

The financial context also influences attitudes to decentralisation – and can change more rapidly than cultural attitudes. Tightening finances can lead to more centrist action. For instance, in Italy overspends in some regions in a climate of austerity have led to central government imposed recovery plans, and in Spain central 'bailout' funding for health care has been ring-fenced – whereas generally funding to the regions is not.

3. Decentralisation is not a fixed state, but an ongoing process

The oscillation of power between different levels is frequent across countries. For example, in Italy, reforms in the 1990s and early 2000s devolved health care responsibilities to the 20 Italian regions, all with elected councils. Each regional council produces a regional health plan and sets budgets for its local health authorities. Local health authorities and districts sit within each region to deliver or commission care. National government sets the overarching policy for the health system, the minimum benefit package regions have to provide, and national budget allocations. However, there are constant debates over the level at which health care should be organised; plans to

further fiscal devolution for health spending were abandoned following the financial crisis and central government actually reduced the autonomy of some regions.

Constant debate is also seen in Finland, the most decentralised health system in Europe.²⁸ There is no regional tier: small municipalities are responsible for social care and the majority of health care, in addition to education and other public services. Like Sweden, this reflects the strong Finnish tradition of local government and citizen involvement in government.²⁸ However, concerns about long waiting lists, diseconomies of scale and geographical inequalities in access have all been blamed on the level of devolution.²⁹ There has been a policy of voluntary merger of municipalities, but little progress has been made and few cost savings have been made from mergers.³⁰ Because of this, and seeking to make savings, the government is planning to move responsibility for health care to new, non-elected, regional bodies. This was a politically controversial move with the Finnish coalition government almost collapsing because of it.^{31,32,33}

4. The quality of leaders is crucial in decentralisation systems working effectively

As in England, international experience of decentralisation frequently focuses on the role and competence of individual leaders. For example, in Italy, poorer outcomes in southern regions are partly attributed to difficulties in recruiting leaders

to these areas compared to the north. In Spain, the presence of a dynamic minister of health in the Basque region has been suggested as contributing to its success in tackling inequalities.

In her overview of decentralisation in Europe, Bremner concludes with an implication that leadership and management matter more than structures: ‘The freedom and flexibility we give to our front line staff and managers to adapt and tailor services to meet needs and engage in their broader communities is crucial... while some of the answers may lie in the system structure, many of them lie in broader issues of culture and management.’²⁶

5. Tensions remain – particularly on equity and budgets

Equity, equivalence and variation between decentralised (particularly devolved) areas are common sources of tension in devolved health systems and often fuel the debate around the most suitable role of each level of government. Sweden and Finland have both introduced national reforms to tackle variation in waiting times between areas, a source of public and national concern. This top-down approach is in contrast to most reform in these countries, which tends to originate from the devolved areas.

Equity is also a major problem in the Italian health system. The regions in the north are far more economically prosperous than those south of Rome and differences in health outcomes are well established (for example, neonatal mortality is four times higher in the south than in the north). Within the health care system itself patients from the south often have to travel to northern

regions to receive their care due to the higher concentration of doctors and hospital beds in those areas. Toth found that these differences have been getting worse, causing significant tension between the regions themselves and also with central government.³⁴

Budgets and funding also remain controversial. Devolved and national organisations often disagree about levels of funding, flexibility in spending, and the financial burden that national requirements place on devolved bodies. In Spain there is negative rhetoric on both sides, with deficits either blamed on poor regional management or national underfunding. Even in the case of Sweden, where most health care is funded locally as tax raising powers are also devolved, there are disagreements between local and national levels on the equalisation of funds across counties.

Where next?

It appears very unlikely that the end goal of devolution in health policy is to turn the English NHS into a devolved health system under the control of local government.

Politically, there has been no indication that this is the aim, and the power of the 'N' in NHS remains exceptionally strong; significantly more time was spent during the passage of the Health and Social Care Act 2012 debating the role of the secretary of state than was spent debating competition. Likewise, there seems to be little public enthusiasm for such a move. When asked, the public support local areas having more control of public services, but the majority are not in favour of some areas offering treatment that others do not.³⁵ Equally, when asked about setting local thresholds for national targets people, although initially positive, are quickly unsure about the value of variation in standards.³⁶ Cultural acceptance of guidelines and minimum standards point to a public and professional consensus that a uniform package of care is desirable in health care.³⁷

Persuading politicians, the public and those working in health care to think differently is very challenging, not to mention the disruption involved in large-scale structural change and the lack of evidence that a decentralised system will outperform a centralised system. As such, formal devolution in the NHS is both highly impracticable and probably undesirable.

The relevant question, therefore, is the extent to which the current limited form of decentralisation, evident in the Devolution Deals, can improve health care outcomes at a time of severe health system stress.

Devolution Deals can certainly play a role: they offer a mechanism for galvanising leaders and efforts locally, and may be an effective way for areas to gain national ‘permission’ for changes which would otherwise be seen as too risky. The achievement of 37 organisations working together in Greater Manchester with a single, aligned, long-term plan is very significant – and something that the process of the Devolution Deal is likely to have catalysed.

However, there are also costs associated with negotiating and implementing a Deal. In particular, if there is little local autonomy (spurred by increasing central grip on finances³⁸) these costs may outweigh any potential gains. Health policy must be ever watchful for the fad;³⁹ the lack of evidence for decentralisation improving health and care outcomes is not a positive starting point.

Given that Devolution Deals are likely to remain a fixture of health policy for the remainder of this parliament at least, how can policy evolve to give it the best chance of making a positive contribution? We suggest three areas.

Alignment with wider policy

The core of the rationale for the Devolution Deals is how they can support local aligned leadership across an area. However, they are only one part of a broader policy tapestry working on

these aims – as shown in Table 3 – with a lack of clarity as to how these initiatives are supposed to fit together and mutually reinforce each other. This speaks to a wider issue of coherence in English health care policy: 184 quality-related policy measures have been announced by the government between June 2011 and March 2016.⁴⁰

Such a focus on the importance of collective leadership and local innovation is positive.¹⁵ However, at a time of reducing management capacity and high leadership vacancies, a multiplicity of initiatives with the same overarching aims is unlikely to be the best way to utilise limited leadership headspace. Instead, a coordinated approach is needed to ensure the cumulative effect of national policy best supports aligned local leadership. This will involve addressing underlying issues, fewer initiatives, and alignment between those that remain. At present, it appears Devolution Deals and Sustainability and Transformation Plans are competing processes to tie local leaders together; far greater clarity as to their relationship is needed.

A framework for Devolution Deals

There is the need for a clear framework in which Devolution Deals can operate. This could usefully include the following.

- **A vision.** A clear articulation of where devolution in the NHS is going that will allow local and national organisations to focus their energies appropriately. The vision does not need to be comprehensive. However, it does need to address how much devolution the NHS is aiming for and how much variance is acceptable within the system.

Table 3: National policy initiatives designed to support place-based leadership of health care

Initiative	Lead body	Stated purpose
Devolution Deals, and the Cities and Local Government Devolution Act	HM Treasury; NHS England	The government... is ready to have conversations with any area about the powers that area wishes to be devolved to it and about their proposals for the governance to support these powers if devolved. ⁴¹
New care models programme, including Vanguards	NHS England	Through the new care models programme, complete redesigns of whole health and care systems are being considered. ⁴²
Quality in a Place programme	Care Quality Commission	To understand the extent to which we can provide evidence to support whether reporting on the quality of care in a place can be a lever for improvement. ⁴³
Integrated Care Pioneers programme	NHS England	Developing and testing new and different ways of joining up health and social care services across England. ⁴⁴
Sustainability and Transformation Plans	NHS England, NHS Improvement	Every health and care system will be required, for the first time, to work together to produce a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021. ⁴⁵
Better Care Fund plans	NHS England, Department of Health	A local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services.
Success Regime	NHS England, NHS Improvement	A new regime to address [longstanding] issues, and create the conditions for success in the most challenged health and care economies. ⁴⁶

- **A clear process.** The process for agreeing changes to powers needs to be transparent, fair and navigable. Expectations – such as the need to engage local communities in plans, making good on the promise of decentralisation to bring decisions closer to people – should be clear. As well as the route to devolution the process should cover the support that areas should expect, how national bodies will relate to areas (reflecting the likely situation that there will be variation in the flexibilities areas have) and situations in which devolved areas could expect to lose powers.
- **A transparent structure for powers.** Setting out what powers are ‘on the table’ – which can then be debated – would support both local and national leaders in understanding the boundaries when making Deals.

Such a codification of what Devolution Deals are there to do, and their limits, would provide local leaders with greater clarity and allow for a clearer explanation of the mechanisms linking the Deals with improvements in outcomes.

Support for local leadership

There is a need for national policy to address some of the underlying issues limiting local collective leadership. The benefits of Devolution Deals and other initiatives looking to integrate care rely on the collective commitment and ability of local leaders. There are structural and systemic issues (such as high job insecurity, unrealistic expectations and limited support) which mean that leadership jobs in health care and

local government are often stressful and unattractive.⁴⁷ To entice and keep a high calibre of leaders these must be addressed. Aside from structural issues, careers and development could reflect the new vision for the health system – for instance through joint NHS and local government graduate schemes, joint training, and developing career paths that move between different local services. This may help to give people a holistic view of an area and the pressures different services face, fostering joint working and collective leadership.

In addition, there could be greater focus on how learning will be shared between areas. If health services innovate locally there will be more opportunities for areas to learn from each other, and the financial pressure makes this more important than ever. Spreading innovation is not a historical strength of the NHS – making it happen could be a central part of NHS Improvement’s role. The devolving of powers to Wales, Scotland and Northern Ireland in the late 1990s was not accompanied by mechanisms by which these different experiments in health policy could be studied for mutual benefit. It will be important not to make the same mistake.

Taken together, this combination of policy actions could give Devolution Deals the best opportunity to be a constructive part of health policy. Given the lack of a track record of decentralisation efforts resulting in improved health care outcomes, policy will require humility about the potential of the Deals. Potential benefits are uncertain; local leaders and policymakers alike need to proceed with care.

Annex A: Decentralisation in English health care, public health and social care systems

In England power is distributed in different ways for health care, public health, and social care. Figure 4 overleaf illustrates this, dividing power as follows.⁴⁸

- **Political and strategic:** setting direction and entitlements, and being accountable for health in its totality. Examples include defining which medicines will be funded, being accountable for failures in care organisations and describing the vision for services.
- **Administrative:** day-to-day running and organising of services. For instance, providing and buying services, regulating them and agreeing pay rates for staff.
- **Fiscal:** raising and spending money for services. This includes setting tax rates, the overall budget, the distribution of funding between different services, and user charges.

For health care, government powers and responsibilities sit almost entirely at the national level (limited devolution). However, there are administrative powers held at the subnational level (moderate delegation). While local areas have responsibility for organising and providing services to fit their population, this is within a strong national framework which

includes budgets and charges, organisational and professional regulation, and entitlements such as access to medicines and waiting times for services.

In addition, national NHS organisations have significant informal power that local organisations are likely to comply with. For instance, NHS England, Monitor and the NHS Trust Development Authority (now NHS Improvement) recently specified how fines for non-performance against contracts are to be used – theoretically a matter on which CCGs had authority.⁴⁹ This informal power and how it is used makes a significant difference to how a health system operates in practice.³⁷

For public health, government powers and responsibilities for public health improvement are predominantly local since the passage of the 2012 Act (moderate devolution and high delegation). However, health protection government responsibilities sit nationally, yet with local administration (limited devolution and moderate delegation).

For social care, government powers and responsibilities sit almost entirely at the local level (high devolution and delegation). Individual providers are regulated by a national body, but provision, standards, user charges and dealing with failure are all largely a local responsibility.

None of the Devolution Deals have so far affected the level of devolution, and have made only limited changes to the level of delegation. Even Greater Manchester has seen only modest formal changes (Figure 5). They will have greater direction-setting responsibility locally and more flexibility over allocating spending to different services. However, they remain subject to the centrally determined NHS constitution and mandate, and formal accountability for health care stays with the secretary of state.

Figure 4: How decentralised are health system powers in England?

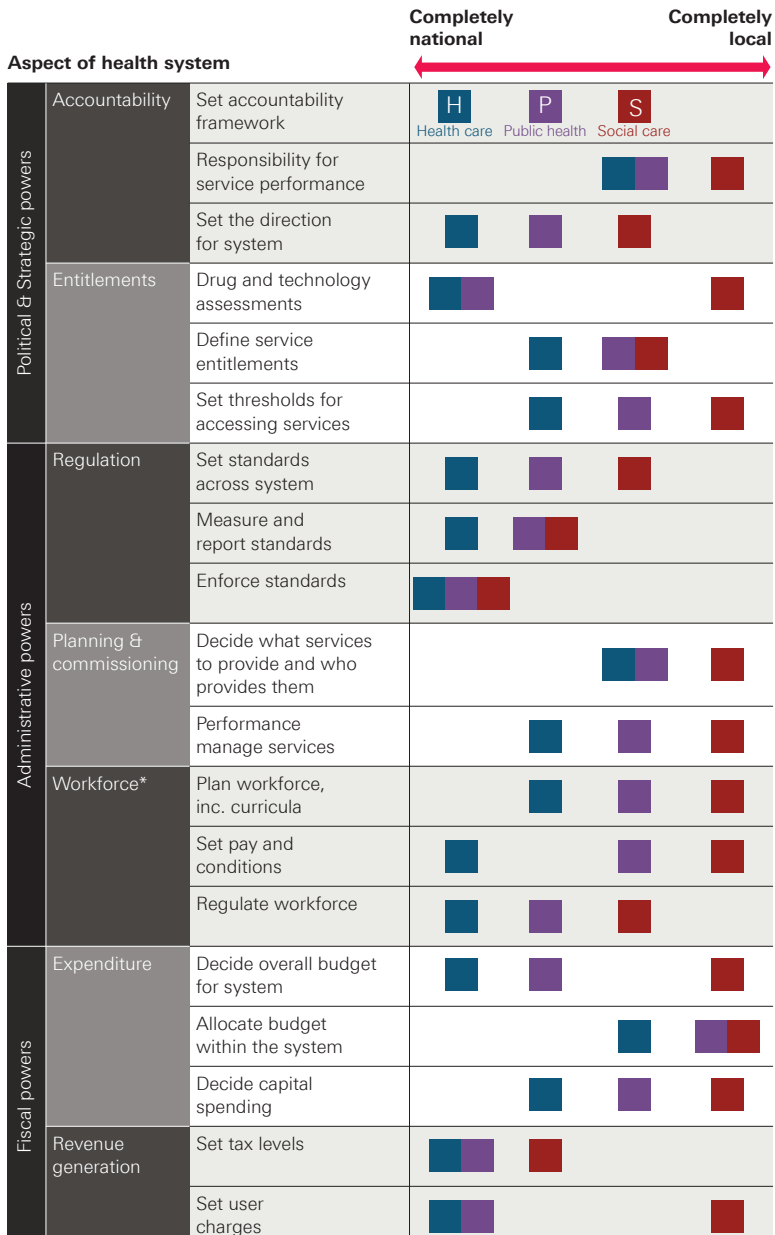
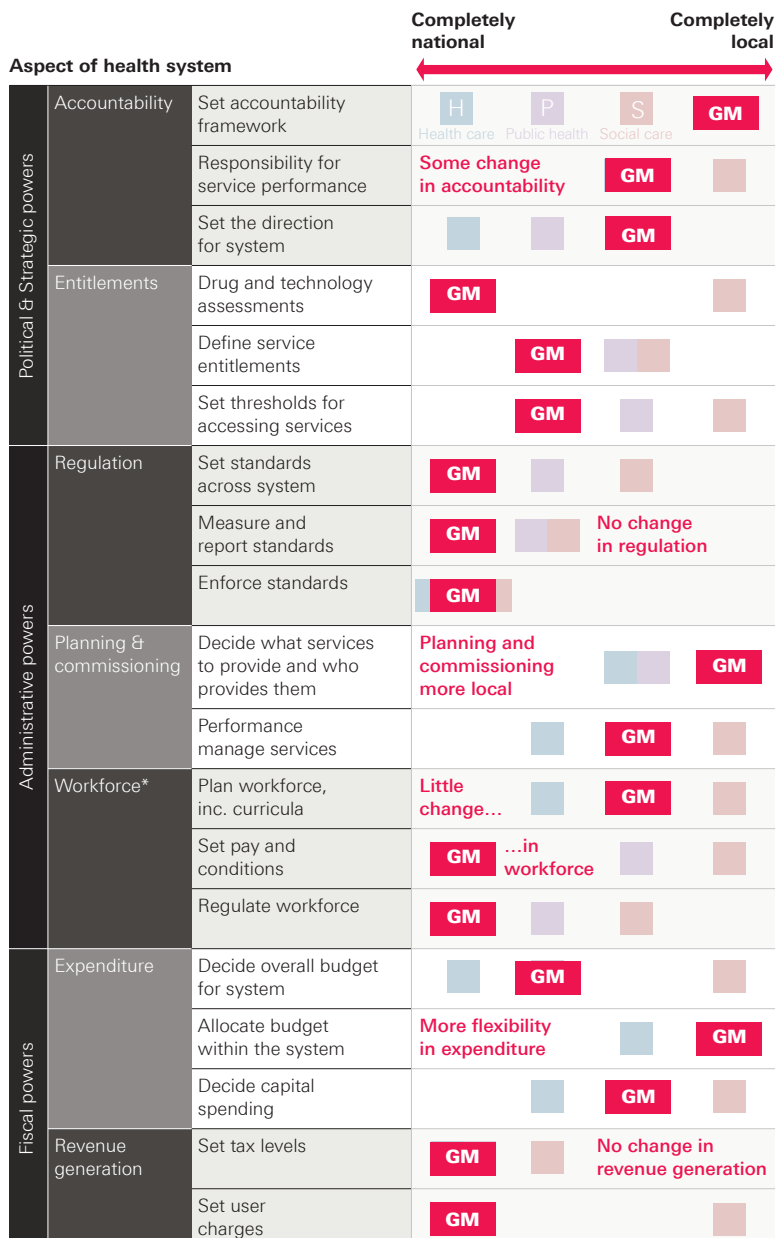


Figure 5: How does the Greater Manchester Devolution Deal change health system powers?



Annex B:

Decentralisation in four European health systems

This annex explores devolution in four European tax-funded health systems, including:

- the shape of the health system
- how it is financed
- some of the ongoing politics and reforms.

Each system works within its own historical, political, financial and cultural context, which leads to different flavours of devolution. We consider two Nordic countries (Sweden and Finland), known internationally for their strong tradition of local government control over local public services. Both countries provide interesting examples of systems trying to balance national equity and fragmentation with a core belief in local autonomy.

We also cover two countries which have more recently moved from national to devolved health systems: Spain and Italy. Devolution occurred for political rather than ideological reasons, meaning a very different debate and shape to the system.

The countries examined work across very different population sizes – one country's region might be the same size as another's national population. Size and other contextual differences make direct comparisons problematic (see Figure 3). International

case studies cannot provide a model for devolution. However, they do give insight into the practicalities involved in running a devolved health system, some of the perennial issues and also some of the opportunities.

Decentralisation in four European health systems

Local system

Sweden	Finland
<p>The Swedish health care system is devolved to 21 counties and the municipalities – all of which are self-governed. The county councils' primary responsibility is the provision of health care, including highly specialised care which is organised through banding into six larger medical care regions. The municipalities provide social care for older people and people with disabilities.</p>	<p>Finland is the most decentralised health system in Europe.²⁸ There is no regional tier: municipalities (average population 17,000) are responsible for social care and the majority of health care, in addition to education and other public services. Municipalities are a compulsory part of larger 'hospital districts' where they coordinate with others to provide acute and specialist health care.</p>
Italy	Spain
<p>Reforms in the 1990s and early 2000s devolved health care responsibilities to the 20 Italian regions, all with elected councils. Each regional council produces a regional health plan (through its own departments of health) and sets budgets for its local health authorities. Local health authorities and districts sit within each region to deliver or commission care.</p>	<p>Since 1980 (and the end of the dictatorship) health powers have been progressively devolved from the centre to the 17 regions, with this process completed in 2002. Spanish regional governments are responsible for the majority of health care, with municipalities generally responsible for social care.</p>

National government

Sweden	Finland
National government is responsible for overall health policy and system oversight, operating through the Ministry of Health and Social Affairs and eight government agencies.	National government has a relatively weak steering capacity, and has previously not managed to enforce its reforms on municipalities. Since 2002 there has been more national involvement in health care through laws mainly setting standards and entitlements – for instance specifying maximum user charges.
Italy	Spain
National government sets the overarching policy for the health system, the minimum benefit package regions have to provide, and national budget allocations.	National government guarantees equitable health funding, has legislated for a minimum set of health care entitlements and regulates pharmaceuticals. It spends only 3% of the health budget. ⁵⁰

Financing

Sweden	Finland
<p>Health care is predominantly funded by public taxes levied at the municipal, county and national level. The majority of revenue comes from county council taxes: the health system has one of the lowest levels of central funding in the Nordic countries.⁵¹ National grants, weighted by population factors, are used to ensure equity in financing between the counties.⁵² Despite autonomy over health care budgets, county spending tends to follow historical lines, which may not necessarily reflect population needs.</p>	<p>The majority of health funding comes from local taxes, with municipalities relatively free to set taxes. Municipalities complain about the financial burden of national standards (despite having a relatively loose national framework in health care terms),²⁸ and some smaller municipalities struggle to provide a full range of health care services.³⁰ Municipalities' finances have been deteriorating since the early 2000s, and deficits are predicted to increase.³⁰</p>
Italy	Spain
<p>Regions are able to raise their own revenue in relation to health (to which an equalising national allocation is added), as well as having relative autonomy over the structure and planning of their individual systems. The richer northern regions raise most of their health care revenue themselves,³⁴ which causes tensions with the centre and between regions^{34,53,54} – with changes to the funding formula in 2000 blocked through legal action.⁵³ Concerns about finances led to devolution of further powers being shelved and closer regulation from the centre. This included centrally-imposed regional recovery plans in (mainly southern) areas that were over-spending, and reduced autonomy of those regions.⁵⁵</p>	<p>Although national funds (the source of the majority of revenue) are allocated via a formula, regionally-levied taxes mean there are wide disparities in budget per capita across the country.⁵⁶ 'Health-specific' national bailouts were provided to regions several times in the 2000s and since. Spain had to make significant savings in response to the financial crisis. In health this included a mix of national and regional action – sometimes national and local action coordinated, sometimes regions actively worked to unwind national policy, or strayed into areas of national competence.⁵⁷</p>

Equity

Sweden	Finland
<p>Most innovation and reform in Sweden is initiated by the county councils or municipalities.⁵² This can lead to variation between the systems in each area. However a culture of disseminating and replicating reforms, led by the local authorities' national body, results in a relatively uniform health system across the country. Despite this, there are still regional differences in access and outcomes, largely influenced by population factors.⁵² Nationally aggregated data on quality and efficiency indicators for each county has helped unmask this variation, but has only been published since 2006.⁵⁸</p>	<p>Finland has high socio-economic and geographic health inequalities.^{28,30} Differences in health spending (there is some national equalisation of funds between municipalities but richer municipalities still have more to spend), user charges and services between municipalities are all likely to contribute to inequalities. For instance, the emergency care system has been described as fragmented, with particular issues in smaller municipalities and those that do little to regulate service provision.²⁸ There is wide public support for equal access to services and inequalities are a continued source of debate.³⁰</p>
Italy	Spain
<p>It appears devolution has not helped address inequality and some argue it has made it worse.³⁴ There are well-established differences between regions, which are again particularly prominent along the north–south divide. These include: health outcomes,^{34,55} infrastructure and human resources available within the regions,⁵⁵ patient satisfaction and engagement,^{34,53} quality of care,⁵⁵ and efficiency.⁵³</p>	<p>Devolution was implemented in a phased way, with some regions devolving before others, which means there is some empirical evidence on the impact (though it remains fairly sparse). Inequalities in health provision and health appear not to have changed post-devolution.^{59,60,61} In addition, patient satisfaction was slightly worse in devolved areas,⁶² however health care activity⁶³ and reserve capacity⁶⁴ were slightly higher in devolved areas.</p>

Politics and reform

Sweden	Finland
<p>Sweden is struggling to find the right scale on which to run different aspects of its health system. The 1990s and 2000s saw an effort to reduce the fragmentation which resulted from such a decentralised system through increased national influence and coordination.⁶⁵ This tends to manifest as guidance on resource allocation and clinical prioritisation, rather than governance structures which vary across counties. For instance, the centre has begun producing evidence-based clinical and care guidelines, in part to address variation in quality of care across counties.⁶⁶ Sweden's long history of localism and public engagement in local government has hampered regionalisation initiatives (both real and perceived) from the centre. In 2007, a national commission recommended the consolidation of the county councils into six to eight regional structures⁶² but this was never fully realised, at least in part due to the strong resistance from local areas.⁶⁷</p>	<p>Concerns about long waiting lists, diseconomies of scale and geographical inequalities in access have all been blamed on the level of devolution.²⁹ There has been a policy of voluntary merger of municipalities, but little progress and few cost savings have been made.³⁰ Because of this, and seeking to make €3m of future savings, the government is planning to move responsibility for health care to new, non-elected, regional bodies. This was a politically controversial move – the coalition government almost collapsed because of it.^{31,32,33} A regional solution has been tried before in Finland, without much success. In the Kainuu area 60% of municipality responsibilities and funding was delegated upwards to a regional body from 2005–12. The experiment improved service availability and quality, however it did not make significant financial savings and was abandoned after one municipality refused to continue taking part.³⁰</p>

Politics and reform (continued)

Italy	Spain
<p>The public plays a limited role in holding leaders in health to account, partly explained by public apathy following previous political scandals and corruption. The political context also negatively impacts governments' abilities to make change happen. Before the reforms of the 1990s the centre was formally responsible for planning but struggled to use these powers – the first national health plan took 16 years to develop. Locally, in 1992 reforms were introduced reducing the power of municipalities in health care, aiming to reduce politicisation (and corruption) and inefficiencies.⁵³ This had limited success, and politics is still strongly involved in the regional organisation of health care.</p>	<p>Devolved Spanish regions take different approaches to providing health care. These include varying involvement of the private sector, the extent of integration between health and social care, and experimentation with outcomes-based contracting and other governance mechanisms. Small regions can struggle to adequately fund a comprehensive set of services, which clashes with political desires for self-sufficiency. Although Spanish devolution is well established, the majority of the public (84.7% in 2011) believes new services should be offered to all citizens rather than in just some regions and around half of people perceive regional inequalities in access to health care.⁶⁸ Devolution appears to have made national agreement and coordination more difficult: no national strategy for health care has been agreed since devolution, and disagreements between national and regional actors have caused delays in implementing social care reforms.</p>

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

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