

Understanding the impact of devolution in Greater Manchester on health

29 September 2022

- Hugh Alderwick

Remember 2015? David Cameron was prime minister. The Brexit referendum hadn't happened yet. And the UK was halfway through a decade of austerity in public spending. One of the big policy ideas was that greater devolution of power from Whitehall to local areas in England was needed to improve economic growth and reform public services.

Greater Manchester was – is – a poster child for devolution. Local authorities in Greater Manchester have a long history of working together to manage public services. For example, the region's [10 local authorities formed a voluntary organisation](#) to coordinate planning after the Greater Manchester County Council was abolished by Margaret Thatcher's government in 1986. A [combined authority](#) was established across Greater Manchester in 2011, with delegated powers over public transport, skills, housing, planning and economic regeneration. The range of powers given to Greater Manchester has [evolved over time](#).

Devolution in Greater Manchester

By 2015, Greater Manchester had put in place a wide-ranging [devolution agreement](#) with central government. The deal – often known as Devo Manc – gave the combined authority a mix of investment and decision-making powers. This included [some delegation](#) of planning and decision making for health and social care budgets to a coalition of public agencies. Extra funding of £450m was made available for changes to health and care services.

Greater Manchester was the first area in England to include health and social care within its devolution deal. England is a highly centralised political system by international standards. Most public spending, for example, is [directed by central government](#). The NHS is tightly managed

from the top down too. The idea was that stronger local control by leaders in Manchester would lead to better population health and reduced health inequalities. The route to achieving this can be hard to pin down. But a [mix of mechanisms](#) was intended to help make it happen – including stronger collective decision making by NHS agencies and local government in Greater Manchester, closer coordination of services, and greater investment in prevention and social factors shaping health. Current reforms to the English NHS, which involve creating [42 integrated care systems](#) to plan local services, follow a [similar logic](#).

Links between devolution and health

Has it worked? We commissioned researchers at the University of Manchester to analyse the effects of devolution in Greater Manchester on a mix of outcomes linked to health and social care. The first [paper](#) from the quantitative study has just been published in Lancet Public Health. It looks at changes in life expectancy between 2006 and 2019 in Greater Manchester compared with a control group from elsewhere in England. The researchers estimated the impact of devolution using something called a ‘generalised synthetic control’ method. This means comparing Greater Manchester with a population group that the researchers constructed from various parts of England based on their similarity with trends in Greater Manchester before devolution. The idea is to provide a fair comparison group to estimate how life expectancy might have evolved without Devo Manc. The results can help judge the impact of the policy.

Overall, the authors found a modest improvement in life expectancy in Greater Manchester compared with the control group during the period of devolution. Life expectancy in Greater Manchester was 0.196 years higher on average between 2014/16 and 2017/19 than in the control group – equivalent to a 0.25% increase in life expectancy compared with the period before devolution. Initial improvements in Greater Manchester versus the control group were driven by a protection against the decline in life expectancy experienced elsewhere in England.

Understanding what it means

So, does that mean it worked? The study provides some positive signs about the potential impact of efforts in Manchester to improve population health. But the findings are not a slam dunk for devolution and need to be interpreted with caution. There are three main reasons.

First, life expectancy is shaped by a [complex mix of factors](#), including people's income, employment, housing, education, health services and more. These factors interact to shape health throughout people's lives. And the [biggest factors are likely to lie outside the health and care system](#). The study tells us that life expectancy improved in Greater Manchester during the period of devolution. But it can't tell us how far these improvements were driven by health and social care devolution, devolution of wider public services, or some other longer-run changes in the region – including, for instance, the work of the combined authority or similar initiatives. Life expectancy is also just one measure among many others that could be used to understand the effects of health and care devolution – including process measures that could be more easily linked to the changes introduced.

Second, devolution is complex too. [Qualitative evidence](#) suggests the early years of health and social care devolution in Greater Manchester involved time-consuming work to build relationships, establish governance, and develop new strategies and plans, but changes in services likely took longer to deliver. In practice, the health and social care component of Greater Manchester's devolution deal looked more like '[delegation](#)' of existing powers than stronger devolution. And similar service changes – for example, [to better integrate health and social care services](#) – were being developed elsewhere in England. So identifying the distinctive components of devolution in Greater Manchester can be tricky. And – even then – it's unclear whether these components have been around long enough to have an effect.

Third, the methods used for the study are clever but can only tell part of the story. They are clever because they estimate potential effects of devolution in Greater Manchester on health compared with a smartly constructed control group. But they are limited because, on their own, they don't tell us anything about what interventions were introduced during the period of devolution – for example, changes to strengthen primary care or tackle air pollution – and how these changes might plausibly combine to contribute to the improvements in life expectancy

observed. Devolution is an example of complex [system change](#) because it involves multiple organisations and interventions that change over time. Context is crucial in understanding how these changes work – and a mix of quantitative and qualitative methods are needed for us to understand not just ‘what’ happened but also ‘how’ and ‘why’.

Learning for national policy

The latest reforms to the NHS in England are based on the idea that collaboration between local agencies is needed to improve health and reduce inequalities. Government’s [levelling up white paper](#) earlier in 2022 promised to ‘extend’ and ‘deepen’ devolution in England.

Initial evidence from Greater Manchester provides hope that a mix of changes linked to devolution could contribute to better population health. But the study only gives a limited picture. It tells us that there was an improvement in life expectancy in Greater Manchester during devolution. But it doesn’t tell us why. A longer term evaluation of health and care devolution in the region will be completed by the University of Manchester at the end of 2022, including analysis of some local service changes introduced, assessment of a broader range of health measures, and potential impacts on inequalities. Meantime, policymakers should remember that [the impact of local partnerships is strongly shaped by national policy choices](#) – including levels of investment in local government and other public services.

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<https://www.health.org.uk/news-and-comment/blogs/understanding-the-impact-of-devolution-in-greater-manchester-on-health>