



Angles

New Perspectives on the Anglophone World

15 | 2022

Cities in the British Isles in the 19th-21st centuries

Manchester's health deal: Is devolution truly beneficial for the region?

Louise Dalingwater



Electronic version

URL: <https://journals.openedition.org/angles/5764>

DOI: 10.4000/angles.5764

ISSN: 2274-2042

Publisher

Société des Anglicistes de l'Enseignement Supérieur

Electronic reference

Louise Dalingwater, "Manchester's health deal: Is devolution truly beneficial for the region?", *Angles* [Online], 15 | 2022, Online since 15 November 2022, connection on 16 January 2023. URL: <http://journals.openedition.org/angles/5764> ; DOI: <https://doi.org/10.4000/angles.5764>

This text was automatically generated on 16 January 2023.



Creative Commons - Attribution 4.0 International - CC BY 4.0
<https://creativecommons.org/licenses/by/4.0/>

Manchester's health deal: Is devolution truly beneficial for the region?

Louise Dalingwater

Many thanks to the interviewees for their views on the process of devolution.

Mike Barker, Strategic Director of Commissioning and Chief Operating Officer for Oldham Council and Oldham CCG

Will Blandemer, Executive Director of Strategic Commissioning for Bury

Professor Donna Hall, Chair of NHS Foundation Trust

Warren Heppollette, Executive lead for strategy system development with the health and social care partnership

Mel Maguiness, Director of integrated commissioning at Stockport CCG

Jessica Williams, Director of commissioning for Tameside and Glossop CCG

Introduction

- 1 In 2015, Greater Manchester was chosen to be the first English region to run its own £6 billion a year health and social care budget. Simon Stevens, NHS England's Chief Executive, hailed the move as "the potential to be the greatest act of devolution there has ever been in the history of the NHS" (Hudson 2015). It represented a significant move to improve health outcomes in the Northern region, given that the North West has comparatively poor health outcomes. However, in the wider literature on decentralisation, the effectiveness of devolving health budgets to the regions has been rather inconclusive. As far as England is concerned, while there is much support for the decentralising and democratising process, there is concern that it is still largely driven at national level. Proponents argue that while devolution may not bring significant changes to the way in which NHS services are run, it could well have a significant impact on overall health, and especially health inequalities, because devolution has also transferred more powers to the region over housing, employment and transport.

However, the health deal has not led to an increase in the overall budget. The concern is that while regions and localities may have innovative ideas to improve the health of their citizens, they may not have sufficient funding to implement such changes.

- 2 This chapter thus seeks to assess, six years after devolution of the health budget to Greater Manchester, whether the ambitions to improve healthcare delivery and health outcomes have been achieved. It will do so through analysis of secondary data (academic research, local government literature and empirical data) and original interviews with health and social care providers and principal stakeholders in the region.

Conceptualisation and framing health devolution

- 3 In order to assess the impact of health devolution on the Manchester region, it is necessary to define the concept within the general boundaries of decentralisation. Sumah *et al.* (2016) describe decentralisation as “the transfer of authority and power in the public planning, management and decision making from national or higher levels of government to subnational or lower levels”. Drawing on Rondinelli’s widely used framework (Rondinelli 1981), the authors refer to a four-part typology for decentralisation: devolution, delegation, deconcentration and privatisation, which they argue reflect legal and institutional arrangements but do not necessarily tell us much about the degree of local autonomy. Bankauskaite and Saltman (2007) differentiate between the four forms of decentralisation by explaining that devolution is the transfer of authority to a local political level, delegation to a lower organisational level and concentration to a lower administrative level (p.32). The significance of decentralisation of powers depends upon the already existing strength of sub-national governments and the level of autonomy in decision-making according to the structure of health systems and budget allocation. In the specific case of Greater Manchester, observers have described the process as delegation or “soft devolution” because the responsibility for setting policies and delivery has been transferred to the local level, but there is still a degree of accountability which is retained by central government and NHS England (Quilter-Pinner *et al.* 2017).

Figure 1: Types of decentralisation

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: Quilter-Pinner and Antink, 2017.²

- 4 Having established a conceptual framework, it is important to consider why there is significant support for decentralising decision-making powers and health budgets to the local level. The main impetus to decentralise health care is to improve population health outcomes. Using the decentralisation theorem, Cantarero Prieto and Pascual

Saez (2006) posit that decentralisation of health care has gained traction because it has become increasingly clear that local decision-makers tend to have more knowledge of population health needs than those at the national level. Yet to date there is a paucity of data to prove that decentralised health systems lead to better health outcomes (Cantarero Prieto and Pascual Saez 2006).

- 5 A number of studies have nevertheless found a positive association between decentralisation and health outcomes. The results of Robalino *et al.*'s study, which includes panel data of low and high income countries over a period of 25 years, show that decentralisation was associated with lower mortality rates (Robalino *et al.* 2001). A longitudinal study of decentralisation and its impact on health care outcomes in the European Union for the period 1990 to 2003 also found that decentralisation, when accompanied by other significant drivers (income, health care resources and healthy lifestyles), did have a positive influence on the reduction of infant mortality and an increase in life expectancy (Cantarero Prieto and Pascual Saez 2006). Positive outcomes can be expected because fiscal decentralisation can result in allocative and productivity efficiency gains (Oates 1999; Cantarero Prieto and Pascual Saez 2006). Even so, central intervention may still be necessary to avoid inefficient practices at local level, location of facilities and local decisions made in respect of local electors. Jimenze and Smith (2005) reported that decentralisation in ten provinces of Canada had positive effects on public policy to improve population health. Kang *et al.*'s panel dataset of 22 countries from 1990 to 2005 also showed positive effects of decentralisation on population health but only within a certain threshold (Kang *et al.* 2005). They note that the institutional setting and the extent to which health systems depend on the market for provision have an impact on whether decentralisation has positive outcomes or not. The authors also underline that the literature on decentralisation tends to be based on small case studies and more general theoretical discussions than strong empirical analysis.
- 6 Many of these studies have concentrated on health outcomes for a limited number of criteria (mainly mortalities and life expectancy). Ambiola *et al.* (2019) underline that the drivers of decentralisation can be more diverse than health outcomes and may also be intended to reduce poverty, deepen democracy and a whole number of other factors. Beyond improving health outcomes, it is expected that decentralisation will result in greater technical and allocative efficiencies, greater power to local governments, more transparency and accountability and result in both cost and equity gains (Bankauskaite and Saltman 2007; Regmi *et al.* 2010; Couttolenc 2012; Mwinkaara 2016). It depends upon the extent to which health sector stakeholders at the local level have the necessary strategies and agency to maximise the positive impacts of decentralisation (Ambiola *et al.* 2019). There might also be underlying political intentions which go beyond the objectives of improving a population's health related to increasing competitive markets (Ambiola *et al.* 2019). Public choice theorists Buchanan and Tullock (1962) posited that transaction costs made it more efficient to organise collective action in smaller rather than larger political units (Ambiola *et al.* 2019). Taking public choice evaluations into account, Ambiola *et al.*'s study measures the resulting impact on equity (defined as the "unnecessary and avoidable disparities in health outcomes"), efficiency (defined as the relation between resources and outputs/health outcomes) and resilience (the capacity of the given system to resist shocks). The authors describe these three outcome measures as goals to which health systems should aspire.

- 7 Some studies have found that decentralisation can also have negative externalities. In separate studies, Rodden (2003) and Jiminez and Smith (2005) point to the potential for lower fiscal discipline if local governments are dependent on transfers, weaker oversight and increased corruption at local levels. Too much financial autonomy may lead to inefficient provision (Oates 1999). The reliance on transfers also means that local governments are still dependent on central government. The inability to achieve significant economies of scale at lower levels has also been underlined in the literature (Jiminez and Smith 2005). Difference in tax rates across the localities may also result in higher inequalities. Doyle and Johnstone's review of international literature found that there was little evidence to suggest that devolution improved clinical outcomes or health status (Doyle and Johnstone 2016). The overall issue with many of these studies, as Sumah *et al.* (2016) and Liwanag and Kaspar (2017) point out, is the general challenge to establish causal relationships between health outcomes and decentralisation.
- 8 Despite the mixed evidence on the benefits of decentralisation, a number of countries have undertaken decentralisation reforms since the 1980s, particularly following the Alma Ata Declaration and calls from institutional bodies such as the WHO for governments to ensure health services reach rural communities (Görge and Schmidt-Ehry 2004; Ambila *et al.* 2019). Sumah *et al.* (2016) further underline that decentralised governance of health care has been increasingly enacted in recent years as a management strategy. Beyond the drivers to improve health processes and health outcomes, decentralisation is also closely aligned with neo-liberal reforms to minimise state expenditure and reduce state involvement in the provision of health care. Decentralisation reforms can also be related to New Public Management or greater managerial autonomy (Peckham *et al.* 2008; Saltman *et al.* 2007; Mitchel and Bossert 2010). A push to introduce ever more competition and increase the role of the private sector is clear in some decentralisation processes (Bossert *et al.* 2000; Sumah *et al.* 2016). In high income countries such as the USA, the UK, Spain and Italy the process of fiscal decentralisation has been part of a much broader process of devolving decision-making to regional and local authorities (Litvak 1998; Mills 1990; Saltman *et al.* 2007; Sreeramareddy *et al.* 2019). However, the forms that this has taken vary widely from one country to another and depend on the structure of central health systems. The danger is that this process may rely on inadequate regional infrastructure, regional planning or governance arrangements (Harrison and Hoyler 2014: 2249; Hodson *et al.* 2020).
- 9 Another process that has also weighed heavily on the trend towards decentralisation of health services is the emergence of city regions over the last two decades (Hodson *et al.* 2020). Some critics argue that this is the result of late capitalism in which the state actively takes a decision to give city regions more power to make them more amenable to international competition and to attract inward investment. Greater Manchester is thus seen within the broader context of the creation of city regions and the general process of devolution which began in the UK in the late 1990s (Hodson *et al.* 2020).

Decentralising health care in the UK

- 10 Indeed, in the UK, the increasing role given to the city region (a city and its hinterland) has been described as a search for a “new spatiotemporal fix for capitalism” (Harrison 2012: 1247). This has thus led to sub-national spatial reorganisation and new

governance patterns. More generally, devolution is promoted in the UK to secure inward investment and tackle economic disparities (Hodson *et al.* 2020).

- 11 However, until very recently, the UK was considered to be a very centralised country following what has been called “the Westminster model” (McKenna and Dunn 2015). The UK is considered to be one of the most centralised countries in the OECD with just 25% of public expenditure handled directly by local government (McKenna and Dunn 2015). The NHS also followed a tradition of central control for much of the 20th century. From 1997 and the devolution process in Scotland, Wales and Northern Ireland, it was expected that transfer of power to the regions would be high on the political agenda, but initial attempts to create directly elected mayors failed to get much support. It was not until 2010 that a consensus emerged across political parties that power should be devolved to local communities on a much grander scale, which led to the Localism Act of 2011, the creation of Local Enterprise Partnerships and 26 City Deals. The City Deals were an attempt to decentralise policy programmes with key objectives for performance in the cities. Nevertheless, central control was still maintained over spending decisions which meant that little transformation could take place. In 2014, this led to a call from a number of think tanks to push for more radical devolution (McKenna and Dunn 2015). From this came former Chancellor George Osborne’s “northern powerhouse” speech of June 2014 in which he called for more significant devolution of powers and budgets to cities. NHS England’s *Five Year Forward View* report of 2014 underlined the need to decentralise health policy stating that “England is too diverse for a ‘one size fits all’ care model to apply everywhere” (NHS England 2015). By 2015, 38 submissions had been filed for devolution of powers, with Greater Manchester leading the bids. Specific reviews such as the 2014 NHS Five Year Forward and the 2019 NHS Long Term Plan have promoted collaboration through the integration of community-based health services and the joining up of acute and community care and health and social care services; that is, integrated teams of GPs, community health and social care workers. It has been argued that this will improve person-centred care, reduce costs of delivering joined up services and improve staff morale by working through more organised structures. NHS England has committed to supporting local approaches to health and social care provision. In the future, integrated care system bodies will be given increasing autonomy to deliver services at the local level operating on a single budget and one line of management (Devo Connect).
- 12 One of the main motivations to devolving a budget for health and social care was to rise to one of the major challenges that England is currently facing; that is, the delivery of high quality health and social care. This has become increasingly an issue because people are living longer and chronic diseases are more common, which puts significant pressure on health and social care services. To better coordinate these services and deal with the extra demand and funding, local health and care institutions have been moving towards the integration of care services (Dalingwater 2020). Health care in England is free at the point of use, paid for through a central taxation system and commissioned by local providers accountable to NHS England (Devo Connect). Health services are delivered by both public and private providers. Social care services on the other hand are means tested, so only people with savings and assets below a certain threshold can receive local authority funding. The care for those that meet the criteria is paid for out of local council taxes. Care is commissioned by local councils and service providers are mainly private sector institutions or charities (Devo Connect).

- 13 While the integration of health and social care services is therefore complex, it has been possible to work this through local initiatives, greater autonomy through delegated local powers and the creation of the Better Care funding initiative (Devo Connect). Social care funding is one of the most significant barriers to integration and the biggest threat to the future success of health devolution. There are many challenges to achieving full integration of health and social care. The biggest issue is the problem of government funding, which has significantly decreased since 2010. Moreover, the introduction of a new council tax social care premium has meant that the amount received actually varies significantly from one area to another. The number of people eligible for social care also varies from one locality to another.
- 14 Moreover, there is an inherent difficulty in decentralising an extremely centralised public health system. The National Health Service (NHS), which is an essential player in the new devolved city region landscape, is somewhat in contradiction to the decentralisation processes. The creation of the NHS in 1948 was in itself a process of centralisation of local health services, creating central parliamentary accountability in the process and central funding through national insurance payments. These payments were then redistributed to the regions (Allen 2006). However, local decision making and autonomy was still supported. Nevertheless, reorganisation in 1974 led to an even greater degree of centralisation. In 1983 the Griffith reforms have also been considered as an attempt to further centralise the NHS (Allen 2006). However, with the creation of the internal market in the 1990s, there was a more decentralised process of self-governing, giving general practitioners (GPs) discretionary powers on how the NHS care budget should be spent at the local level¹ Yet local players still had to answer to central authority. The performance management system of purchasers and providers introduced by New Labour in the late 1990s, with a number of performance measures and the termination of the internal market scheme, represented once again a more centralised and top down process (Allen 2006). The same can be said for introduction of the “Private Finance Initiative and Private Public Partnership schemes, which increased the level of implication of the private sector within public health service provision, representing a certain continuity with the Conservative marketization of the system.
- 15 Nevertheless, during its second term in office, New Labour began to promote “new localism” (Allen 2006 22, 23). In line with the ideas of new localism, more choice of providers was introduced under the Patient Choice Policy. In addition, Primary Care Trusts (PCTs) were created following the new localism trend. These groups were local health service providers, responsible for planning and commissioning at the local level (Allen 2006: 31). The creation of Foundation Trusts (FTs) was also part of a more decentralised approach because hospitals which gained Foundation Trust status were granted more autonomy and were no longer directly accountable to the Secretary of State. The provision of services was still inspected by the centralised Healthcare Commission in the same way as standard NHS trusts (Allen 2006). The creation of Clinical Commissioning Groups (CCGs) to replace the PCTs was also considered to be an extension of the decentralisation process. CCGs were created under the 2012 Health and Social Care Act. Under this act, responsibility for health prevention was transferred to the local authorities and health and wellbeing boards were established. The latter were also intended to ensure collaboration among local authorities and partners to meet the needs of the local population.

- 16 In the Spending Review of November 2015, full integration of health and social care in the regions was called for by 2020. Each area was to set out clear integration plans in 2017 (LGA 2016). In addition, under the NHS Planning Guidance of December 2015, each locality within NHS services was called upon to develop sustainability and transformation plans explaining how partners would work together to address future health challenges (LGA 2016). Sustainable and Transformation Plans (STPs) were created in many localities to cut health and social costs by pooling health budgets and those of local authorities and allowing for joint commissioning of health and social care services. The upshot of these plans has been the creation of new organisational forms of care models including accountable care organisations. In addition, Locality Plans have been created in the regions, which are local care models for managing health and wellbeing in local areas. They are either alliances of providers through a main provider with single contracts for health and social care, bringing together CCGs, local authorities, NHS trusts, FTs and private and voluntary service organisations (Sutaria *et al.* 2017). Quilter-Pinner and Antink (2017) underline the specific logics underpinning decentralisation of healthcare in the UK. Indeed, the possibility of pooling budgets through the integration of commissioning functions within the NHS, and also between other public services at the local level and the NHS, enables the transfer of resources to focus more on care in the community, the joining up of health and social care and thus greater prevention initiatives. Such changes are intended to improve patient outcomes, reduce inequalities and reduce costs. The move towards integration of services shows a recognition of the fact that many of the determinants of population health are beyond the remit of the NHS in areas such as housing and general welfare policies, so this must be taken into consideration in any devolution process.
- 17 However, coordination across different sectors may be problematic at the regional level. The essential ingredients for improving population health (a progressive tax and benefits system, support for those at the lower end of the social gradient, a minimum income to ensure healthy living, an increased budget for early years learning, an increase in social protection for very low incomes and building programmes for decent social housing) require significant budget allocations from central governments (Mckenna and Dunn, 2015). Yet in a highly centralised system, local leaders do not have the power to bring about change. Transfer of power to the local level thus can empower local leaders to carry out reforms, address local needs, etc. (Devo Connect). But in England, it is questionable whether decentralisation has transferred enough power to make the most of the benefits of this process (Devo Connect). It is not clear either whether the budget is sufficient and to what extent central statutory responsibilities reduce powers in the localities. The fact that England is still very much centralised in fiscal terms means that it is difficult to manage possible overspending in local areas (Devo Connect). The centralised statutory responsibilities also mean that hospital closures and some local decisions can still be overridden by NHS England and other central bodies. In light of these extremely complex dynamics, the devolution of Manchester's health budget will thus be examined.

The decentralisation of health policy and provision in Greater Manchester

- 18 The City Region of Manchester is located in North West England and has ten local authorities: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. In 1986, metropolitan counties were abolished and the ten local authorities joined together to form the non-statutory Association of Greater Manchester Authorities (Lorne *et al.* 2020). As part of the national momentum to support city regions, Manchester and its hinterland were presented as a model thanks to a series of regional initiatives. As Lee (2017) argues “narratives of Greater Manchester’s history of joint working and pragmatic political leadership have long been used to lobby successive governments for increased devolved powers and resources”. This included a number of growth strategies which provided evidence-based research and confirmed the relationship between health and economic potential in the region (the Manchester Independent Economic Review (MIER) and Greater Manchester Evidence Review) (GMHSCP 2021). It also included collaborative initiatives such as the GM Stroke service, the Making it Better and Healthier Together programme, associations between PCTs and later CCGs, etc. (GMHSCP 2021). In 2011, the Greater Manchester Combined Authority was created to represent the city region and later developed its devolution deal in 2014 (Ayres *et al.* 2018, Lorne *et al.* 2020)². Greater Manchester also had some key examples of how successful boroughs were able to work together as a single system and management team, Salford and then Tameside being good examples.
- 19 The devolution deal was sealed through the signing of a memorandum of understanding between the 10 local authorities in Greater Manchester, the government, NHS England, 12 CCGs and 15 NHS providers and trusts in the region (McKenna and Dunn 2015). The transfer of powers followed the 2014 general devolution process of powers to Manchester, which led to the creation of a directly elected mayor responsible for a devolved transport budget and housing investment fund control plans (Hudson 2015). Decisions on health were primarily transferred to a newly established strategic partnership board: Greater Manchester Health and Social Care Partnership (GMHSCP) which brought together the NHS, local authorities, charities, and voluntary community and social enterprise groups (GMHSCP 2018). In addition to the annual budget, GMHSCP was also granted a £450m pound Transformation Fund to enable a transfer to a health and social care system (GMHSCP 2021). Localities were called upon to draw up plans to show how these funds could be used to achieve the ambitions set on the signing of the memorandum. A vision and a series of objectives were set forth in the publication *Taking Charge of our Health and Social Care in Greater Manchester* ahead of the formal devolution of funding which took place on 1 April 2016 (GMCA 2015). The vision was “to deliver the fastest and greatest improvement in the health and wellbeing of the 2.8 million population of GM, creating a strong, safe and sustainable health and care system that is fit for the future” (GMCA 2015). The overall objectives were to create a new health and care system and reach a new deal with the public. Specific objectives were also set which are included in the table below:

Table 1: Objectives contained in the Memorandum of Understanding (MOU)

- To improve the health and wellbeing of all the residents of Greater Manchester (GM) from early age to the elderly, recognising that this will only be achieved with a focus on prevention of ill health and the promotion of wellbeing. We want to move from having some of the worst health outcomes to having some of the best;
- To close the health inequalities' gap within GM and between GM and the rest of the UK faster;
- To deliver effective integrated health and social care across GM;
- To continue to redress the balance of care to move it closer to home where possible;
- To strengthen the focus on wellbeing, including greater focus on prevention and public health;
- To contribute to growth and to connect people to growth, e.g. supporting employment and early years' services; and
- To forge a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population.

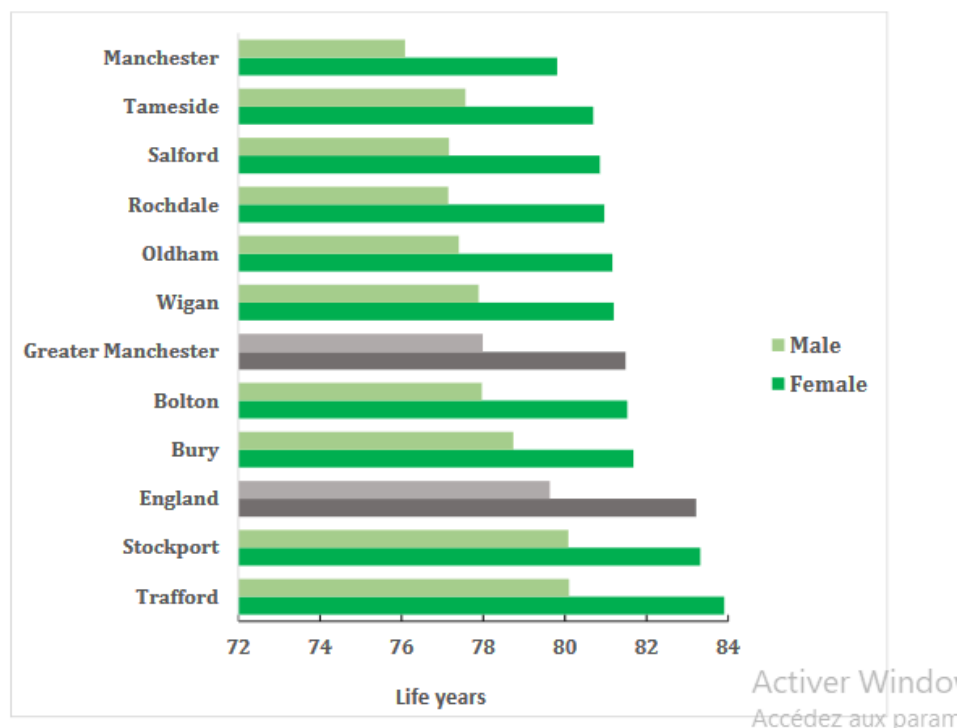
Source: GMCA 2015

- 20 In order to achieve these objectives a number of plans were put in place: to upgrade population health prevention, transform community-based care and support, standardise acute hospital care and clinical support. Extra commitments were made in January 2017 which focused on improving quality of life.
- 21 With devolution of the £6 billion budget, new structures were created within Greater Manchester: Local Care Organisations (LCOs) in the ten Greater Manchester councils and new commissioning bodies composed of civil and clinical leaders with a single accountable officer. The LCOs contain Primary Care Networks servicing populations of between 30 and 50,000 (DevoConnect). In the localities, health and social care resources have been pooled into a single budget and managed through integrated Single Commissioning. Hospitals have begun to work together across the wider region.
- 22 Devolution has been phased in gradually so Greater Manchester is still developing its autonomy and powers. The amount of autonomy is also limited. NHS bodies must still respect standards set out in national guidance, abide by statutory requirement and duties, remain accountable to NHS England and national regulatory bodies, and apply national performance indicators. Devolution of health and social care therefore does not have full statutory status. For the moment, by creating new and better partnerships, sharing governance and decision-making and pooling budgets for health and social care, Greater Manchester is actually following national priorities for integrated care. In many ways, other regions have as much freedom to pursue such criteria without any formal devolution agreement (Lorne *et al.* 2021). Given the previous discussion on decentralisation, commentators have thus described Greater Manchester's increased health autonomy with light touch monitoring from the centre as delegation rather than genuine devolution. Greater Manchester does not have the power to set full policy. Only some powers have been passed down and accountability remains with central government. The city region has received new powers to commission special care, primary care and transformation initiatives, but it still remains accountable to the Secretary of State for Health and Social Care. Moreover, Greater Manchester, unlike Scotland, Wales or Northern Ireland, cannot abolish or transform local organisations set up under national legislation such as Clinical Commissioning Groups and Foundation trusts (McKenna and Dunn 2015). As Warren Heppollette, executive lead for strategy system development with the health and social

care partnership and one of the architects of the health devolution bid argues: “it was a pragmatic mechanism for NHS England to provide a vote of confidence in a model of collaboration at a Greater Manchester level and do what they could in the absence of formal devolution that we might compare with Scotland, Wales or Northern Ireland” (Warren Heppollette, personal communication, 16 August 2021). Yet the delegation of powers can be seen to strengthen relationships thanks to the possibility to create new decision-making bodies.

- 23 The significant poor health of the North West and its drag on economic performance was a factor in supporting decentralisation of health and social care provision. Indeed, it was reported that 250,000 people out of work in the region have mental health problems. The average health life expectancy for men in some parts of Greater Manchester is as low as 57 years (LGA 2016). Greater Manchester is indeed an area which suffers from significant socioeconomic deprivation. The chance of dying in 2010 before the age of 75 years was reported as being 20% higher than in the south of England. Socioeconomic deprivation explains as much as two-thirds of the high mortality rates in this region. Greater Manchester has some of the worst health performance rates in England. Some of the most deprived people live in Greater Manchester. Three of the CCG areas have the lowest life expectancy rates in England (GMCA 2016). Life expectancy is lower than the average for England in eight out of ten Greater Manchester boroughs (see Figure 2).

Figure 2: Life expectancy at birth, 2016-2018



Source: ONS, 2018; Institute of Health Equity, 2020

- 24 For this reason, the Greater Manchester Combined Authority set forth a number of objectives to be reached in light of the devolution process, which included 1,300 fewer people dying from cancer, 600 fewer people dying from cardiovascular disease, 580 fewer people dying from respiratory disease, 270 more babies being over 2,500g which

makes a significant difference to their long term health, more children reaching a good level of social and emotional development, 3,250 more children ready to start school aged 5, and support for people to stay well and live at home for as long as possible and, finally, 2,750 fewer people suffering serious falls. In order to achieve these gains, the plans for the region mainly include identifying priority health action plans, focusing on health prevention to address disease in Greater Manchester, community based action, sharing services for acute care (namely in hospitals), making better use of digital services and standardising clinical support and back office and investment in transformation (GMHSC 2018).

The outcomes of devolution: A health and social care transformation over the last six years?

- 25 This section draws on interviews conducted in 2021 to consider the outcomes of devolution over the six-year period since the signing of the Memorandum of Understanding. In 2021, Greater Manchester was facing the short and long term effects of Covid 19, shortages of staff owing to Brexit and potential disruption from a massive overhaul of the NHS with the introduction of a new Health and Care bill³. In light of these challenges, six interviews with executive managers in the region, who have played a significant role in the devolution process, were carried out, namely health and social care leads in the ten localities (including two of the original architects of the devolution bill). The semi-structured interviews focused on the devolution process in light of these new challenges and were carried out from July to September 2021 via videoconference.
- 26 As an all-party parliamentary group observed, while all British Governments and main political parties in recent times have been supportive of devolution and localism, enthusiasm for taking steps to really allow power and decision-making to be transferred to the local level is variable. They also point to the contrast with the mixed enthusiasm at national level and the overwhelming support for devolution at local level. They note that local leaders tend to speak with one voice in their support of true devolution (APPG 2021).
- 27 So the interviewees will have been working closely with the labour leader of Manchester City Council, Richard Leese and Andy Burnham in the process of the bid and the roll out of devolution in the city-region. While it is apparent that institutional views and support for devolution was at the forefront of many comments, this does not mean that the interviewees did not criticise or call into question parts of the rollout and achievements of devolution. So the views expressed were a mixture of institutional and personal views.
- 28 As well as focusing on health outcomes, the following analysis of the results covers some of the wider objectives of devolution mentioned in the literature, namely poverty reduction, deeper democracy, greater technical and allocative efficiencies and more transparency and accountability.

Improving health outcomes

- 29 Part of the devolution plan is to work on the wider determinants of health. As the health and devolution partnership underlines, a focus on unemployment, education and healthy lifestyles are important contributions to the bigger picture of mental and physical health. Priority has thus been given to assisting people to get good employment, making sure that children go to school at the right age and various initiatives focusing on encouraging healthier lifestyles. One such initiative is Healthy Lifestyles which aims to promote and develop health lifestyle choices within school, reduce excess weight, etc. A range of interventions by health professionals have taken place in schools on healthy eating and physical activity. Another is the babyClear model which specifically helps smokers who are expecting to have the right advice to quit smoking. This specific programme was introduced when it was found that 1 in 8 new mothers in Greater Manchester smoked. Smoking before and after pregnancy has been identified as one of the most significant causes of miscarriage, stillbirth and early infant deaths (GMHSCP 2018).
- 30 However, the challenges in addressing health disparities and poor health in Greater Manchester are still significant. As Mike Barker, Strategic Director of Commissioning and Chief Operating Officer for Oldham Council and Oldham CCG, underlined:
- The problem with the North of England really is that it has quite a lot of reliance on old industrial manufacturing economic bases and there are places where people are more prone to things like COPD [Chronic Obstructive Pulmonary Disease], to poor housing, damp conditions, all that kind of stuff, so there are very different challenges up in the north particularly than there are in some South West parts or South East parts of the country. (Mike Barker, personal communication 26 July 2021)
- 31 All interviewees mentioned the benefits of a devolved budget to enable localities to address the wider social determinants of health. Mike Barker explained:
- It has allowed us to go an awful lot further than perhaps other parts of the country so we have been really able to bring the NHS into things like homelessness in a way that perhaps we would not normally do in different parts of the country” (Mike Barker, personal communication, 26 July 2021).
- 32 Indeed, while homeless has increased in Greater Manchester since 2010, several initiatives brought in after devolution such as Housing First, the Entrenched Rough Sleeper Social Impact Bond and A Bed every night enabled the city region to bring down the rate of rough sleeping rates by 53% between 2017 and 2021 (GMCA 2021).
- 33 For Mel Maguiness, Director of Integrated Commissioning at Stockport CCG, health devolution has opened up a real opportunity to address the wider determinants of poor health. This can be done through the pooling of resources as she argued:
- Really recognising the significance of the voluntary sector, of the wider determinants of health, so bring our housing partners into the picture, recognising that actually what we really need to do is to develop and grow, through employment, opportunities, ensure equity and equality of access. (Mel Maguiness, personal communication 27 August 2021)
- 34 From this perspective, she contends that devolution offers the possibility to design pathways to really focus on prevention, early intervention and early help by working together across the system and especially encouraging stakeholders (health care providers, local authorities and other public service providers) to look beyond

organisations, break down organisational barriers and the divide between commissioning and provision in order to truly work together.

- 35 Warren Heppollette explained that the health objectives set forth as part of the devolution process were ambitions which could not be delivered by one institution or sector. Health outcomes which necessarily related to the wider determinants of health: healthy life expectancy, school readiness, being economically active, levels of physical activity, etc. This is not to say that the constitutional standards on waiting lists for elective services or A&E were ignored but the success of joining up services as part of the devolution process would be measured according to more general social determinants of health. In many of those areas, the gap with England has been closed since devolution: on smoking prevalence, school readiness, physical activity, alcohol related admissions (see table 2 below). So there have been some successful results related to those specific objectives. These have been achieved through direct health initiatives but also working on other determinants such as poverty (the development of a work programme) and working with Greater Manchester housing to improve housing conditions. For example, reducing rough sleeping and homelessness. In addition to the initiatives mentioned above, a tri-partite agreement was thus set up with Greater Manchester's housing authority and the Combined Authority to work on the relationship between housing and health to end rough sleeping, to improve the quality and availability of housing in the region. Warren Heppollette pointed to the following collated evidence in relation to those wider objectives:

Table 2: Aims by 2021 and progress to date

Original aim	Latest data and comments
<ul style="list-style-type: none"> • 1,300 fewer people dying from cancer • 600 fewer people dying from cardiovascular disease • 580 fewer people dying from respiratory disease 	<p>The Greater Manchester Strategy (2017) contains revised/ redefined versions of these aims which identify annual reduction targets. The latest data available is from 2018, which is arguably too soon to see any impact post-devolution (2016), given the time that improvements in health take to impact on mortality rates. Improvements in smoking cessation will impact on these aims over time</p>
<ul style="list-style-type: none"> • 270 more babies being over 2,500g which makes a significant difference to their long-term health 	<p>Clinical guidance changed in 2015 which made this a less meaningful measure, so in its place the rate of stillbirths has been tracked.</p> <p>Latest data is from 2018 which shows reductions but not yet to the England average.</p> <p>The improvement in the number of smoke-free pregnancies will have also improved the health of babies being born.</p>
<ul style="list-style-type: none"> • More children reaching a good level of social and emotional development with 3,250 more children ready for the start of school at 5. 	<p>The GM Early Years programmes has shown particularly strong improvements for more disadvantaged children, with the gap in school readiness rates between Greater Manchester and England among children eligible for free school meals halving over the last 3 years and closing completely in 2018-9 (latest data available)</p>

<ul style="list-style-type: none"> • Supporting people to stay well and live at home for as long as possible, with 2,750 fewer people suffering serious falls. 	<p>'Serious falls' are defined as those that lead to an emergency admission but at present GM do not have the evidence needed to make a link between the work that has been done and the cases of emergency admissions due to falls.</p>
---	--

Source: GMHSCP 2018

- 36 A more complete analysis of concrete results can be found in the following document:
<https://zcs.sorbonne-universite.fr/service/home/~/?auth=co&loc=fr&id=119618&part=2>
- 37 However, the interviewees did recognise that it may take many more years to see the tangible effects of devolution on health outcomes. It is also very difficult to extrapolate and create the causality, something which has already been raised in the literature on devolution:
- I think some of it is quite difficult because there are two key things. One is that it takes a long time, it takes years and years to really see the improvements and outcomes of health and wellbeing and healthy life expectancy and the second thing is there is a big data lag as you'll know, so often we don't get the data. You know it might be two years in arrears so we often have to use proxy data (Mel Maguiness, personal communication 27 August 2021).
- 38 Moreover, the Coronavirus pandemic has created even greater challenges for the region. As Mel Maguiness underlines:
- It's hard because where we've started to see some positive shoots in terms of starting to tackle child obesity and physical activity, Covid's come along and it's really taking us backwards, for a lot of those areas as well so I think we've made really good progress and I think what we are going to have to do now is rebuild in light of Covid (Mel Maguiness, personal communication 27 August 2021).
- 39 Indeed, Covid hit the poorest localities with the lowest health performance. People living in these areas suffered the most from Covid infections and necessitated a high number of hospitalisations. To date, the North West has reported the highest rate of infections in the UK after London. According to Mel Maguiness, Brexit has also resulted in thwarting some of the progress made thanks to devolution. She contended that Brexit has come as an "unnecessary distraction" during difficult times. For her, it has worked against the philosophy of devolution which is about bringing people and systems together. More specifically, in terms of health outcomes, she argues that it has adversely affected the progress made to reduce poverty levels with some healthy foods becoming more difficult to obtain and costlier (Mel Maguiness, personal communication, 27 August 2021).
- 40 These challenges along with the historic health challenges have meant that the region is not delivering on its statutory obligations and NHS targets with long waiting lists. The region is also dealing with new challenges such as long Covid and an increase in mental health issues, especially among young people. In social care, there has been an increase in the number of children placed into care and a breakdown of placements. As Mel Maguiness, underlines:
- We're going to have to work together in the strongest possible way to be able to really address this because there's going to be an impact, not just a health impact but a much wider impact for generations to come. (Mel Maguiness, personal communication 27 August 2021).

- 41 Professor Donna Hall, Chair of Bolton NHS Foundation Trust, and one of the architects of the devolution bid, points out that while there have been deliverables in terms of improvements in cancer care and generally preventative health measures, little progress has been made in primary care owing to the focus on acute systems⁴: “we’ve got too many hospitals and they’re all trying to do the same thing in a local patch so I think we need fewer more specialist centres.” (Donna Hall, personal communication, 31 August 2021). The over reliance on hospital care and building of hospitals was also something Mike Barker raised. However, according to the health and social care partnership literature, devolution has enabled better coordination of GP practices and other services. It has thus become easier for people to get a GP appointment; with thousands more appointments being made available across Greater Manchester. (GMHSCP 2018). Although the increased use in software and digital advancements has also contributed to this process.
- 42 Jessica Williams, director of commissioning for Tameside and Glossop CCG, believes that the targets need to focus on more qualitative aspects of citizens’ lives such as healthy life expectancy, connectivity in the community and home support for the elderly and in the community. For her, there was a need for greater precision on health outcomes:
- I think we need real clarity on what the outcomes are, we’re striving for and then we have a need, a real clarity on the strategic direction to enable us to deliver that and I think that devolution possibly should have been sharper on that. (Jessica Williams, personal communication, 10 September 2021).
- 43 Will Blandamer, Executive Director of Strategic Commissioning for Bury admits that performance on key indicators of waiting times for cancer, A&E and ageing care had remained disappointing. Although he was still very positive about the potential of the region to reduce health inequalities thanks to the devolution deal because the commitment was there:
- 44 The most important dividend for me is that we’ve got very senior local authority political and officer leadership and indeed the mayor wholeheartedly committed to population health gain and health inequalities and also being prepared to back NHS reconfiguration ambitions as well. (Will Blandamer, personal communication, 11 August, 2021)

Linking health and wealth

- 45 It is clear that the link between health disparities and low health outcomes has had an impact on the economic performance in Greater Manchester, with the two being significantly connected in the bid to be awarded health devolution. As the Manchester Independent Economic Review (MIER) underlined, the region is performing below its potential because of ill health and social determinants of health (namely poverty) (McKillop *et al.* 2009). Warren Heppollette explained:
- We were recognising some of that intellectual argument that was saying Greater Manchester will punch below its weight economically because it does not organise itself as a single coherent economic geography and it will also punch below its weight because actually the health status of its population is too damaged to allow them to participate in the benefits of that economic growth. So there was a health improvement imperative as part of the wider devolution case that Greater Manchester was making so it felt rational and reasonable to include that in the

cases we were starting to make through the summer and autumn of 2014. (Warren Heppollette, personal communication, 16 August 2021)

- 46 Mike Barker also agreed that:

There is something really significant about connecting health and wealth and that's not a conversation I think that takes place enough, so the recognition that actually keeping people in work is good for the economy and vice versa." (Mike Barker, personal communication, 26 July 2021)

- 47 The key factor is improving health through wealth which might be reminiscent in some ways of New Labour's New Deal or "welfare to work" strategy:

I think we have to get to a place about being really serious about you know...if we want to make sure we have a thriving economy how to make sure that we get people quickly back to work, who are those people we need to get back to work, who are the most vulnerable, how do we get them seen? Effectively and I don't just mean clinical risk but you know societally vulnerable. How do we change our thought process so it is much more holistic and we are at the foothills of that conversation I think as a consequence of devolution. (Mike Barker, personal communication, 26 July 2021)

- 48 Linking health and work has been one of the major focuses of the health and social care devolution deal. A health and work programme has been established which recognises that long-term unemployment is not necessarily owing to lack of preparedness or issues with CV writing, but also related to severe mental and physical health issues (GMSCP 2019). The programme is therefore to help people find work and keep good work. The process also began earlier with support to children in full time education. A mental health and education strategy was created working with 125 schools, 15 further education colleges, the four universities and the Royal College of Music in the region. But a major concern is how efficient the process of devolution has been in providing the right services to the people who are really in need of those services (GMSCP 2019).
- 49 Despite the clear evidence on the link between wealth and health, there is always a danger with back to work policies that some individuals may be forced to work despite severe disabilities. This has been evident from the work programmes introduced by both New Labour and Conservative governments' in recent years. Such a back to work policy should therefore ensure first that people with severe health problems have the capacity to work and the process is not one of neoliberal rationalisation: work or perish.

Allocative efficiencies

- 50 Allocative efficiency refers to a situation in which production is aligned with consumer preferences so that each good or service is produced to bring marginal benefit to consumers. In the context of devolution to Greater Manchester, the aim is to align services, related to both health and social care, more efficiently. Mike Barker argued that devolution had enabled greater efficiency because it has allowed flexibility in the provision of services which fit local needs. He argued:

We are not just subject to a one size fits all national policy statement, we are able to really think a bit differently about them in our devolved world". (Mike Barker, personal communication, 26 July 2021)

- 51 Another way in which efficiency gains can be achieved through devolution is that the leaders in the region can come together in order to design pathways, policies,

initiatives and programmes which are run only once. Given the complexity of the place compared to other regions with ten different unitary authorities, allocative efficiency is very important for Greater Manchester. Mike Barker underlines how, thanks to devolution, Greater Manchester was able to manage its resources more independently to address the challenges of Coronavirus:

We can move PPE [personal protective equipment] around, we can buy our own PPE in a very different way than perhaps some of the places have been able to (...) I think our ability to respond quickly to the pandemic has been quite phenomenal.”
(Mike Barker, personal communication, 26 July 2021)

- 52 Mike Barker also mentioned a collective initiative which emerged from the Covid crisis as the provision of a vaccine bus. Thanks to collective working, it did not have to be replicated ten times but could have a central driver in the region in order to target specific communities.

- 53 Jessica Williams underlined how important it was to move quickly to provide digital health and social care during the pandemic. In particular GP practices moved from providing 7% of their services online prior to the pandemic to 88% in the region in the space of a few weeks. This achievement was down to collaboration and discussion that Greater Manchester had been having since devolution related to digital health and IT support across the region (Jessica Williams, personal communication, 10 September 2021).

- 54 Warren Heppollette was able to explain the history behind the importance of collaboration whether it be in responding to the pandemic in person or moving services online:

I think that the prehistory in particular of the having relationships together at senior levels across each of the organisations meant that the responses were rapid and they were already building on a degree of good will, historic relations might not be able to be taken for granted in other parts of the country. (Warren Heppollette, personal communication, 16 August 2021).

- 55 Will Blandemer noted how important the transformation funding as part of the devolution package has been to address significant health issues in the region. A Transformation Fund of £450m was granted to the region to help set up the devolved institutions. As far as he is concerned it filled gaps in services, discharge services, intermediate care services and rapid response and enabled to advance on the integrated care process.

- 56 Jessica Williams stated that devolution has enabled more effective financial management at a local level:

Devolution has provided real opportunities to have different conversations about what we want to do locally with our funds. (Jessica Williams, personal communication 10 September 2021).

- 57 Donna Hall, did however mention that given the scale of the problems facing Greater Manchester, the transformation funding was actually more about propping up a failing system in the transition to a devolved health and care system rather than full scale transformation (Donna Hall, personal communication, 31 August 2021).

- 58 It did emerge from the interviews that the idea was not necessarily to centralise or standardise services completely in the region because there were very diverse health outcomes across the localities. Mike Barker contends that nevertheless you can set a

number of expectations and some standards across the localities which could then be tailored or slightly adjusted:

You need to start getting to individual communities of 30,000 and have proper conversations about why is it that more people in part of a town are more likely to die, to suffer from heart failure than another part of the same borough, are more likely to live with diabetes for a long period of time, you don't need the same solutions for those two, you need the ability to be able to shift your emphasis at that level to make a difference. I don't believe you can do that with a population of 2.8 million at Greater Manchester, it's too big, much too big but what I think you can do is set a series of standards and expectations at Greater Manchester level. (Mike Barker, personal communication, 26 July 2016).

- 59 According to Mike Barker, it is also possible when services work well in one location to attempt to tailor them to the other localities whilst still taking into consideration the significant differences in poverty levels and health outcomes in those localities. However, the fact that true devolution has not taken place, that Greater Manchester is still subject to the national regulatory regime of health and social care, means that the room for manoeuvre is somewhat limited. It is thus questionable whether local regulatory bodies have enough power to regulate given that the devolution deal is closer to delegation than full scale devolution. Local authorities remained reluctant to disclose information on social care spending and insisted that spending should remain concentrated on their locality, despite the benefits of working across locality boundaries.
- 60 As Mike Barker argues:

You've still got organisations judging each other and in competition with each other which does not help in cooperation and collaboration terms. We are still subject to a regulatory regime which just has not caught up with the context of a place. (Mike Barker, personal communication, 26 July 2021)
- 61 Financial stability is also a major bottleneck given that local authority budgets have been reduced since 2010-11 in line with overall cuts in the UK. Under the Conservative-Liberal Democrat coalition government in 2010, an austerity budget was introduced which made significant cuts to departmental and local budgets. Between 2010/11 and 2015/16, local authorities in England lost on average 27% of their spending power. Social care saw cumulative cuts to the region of 45% (Joseph Rowntree Foundation, 2015). Within this context, any improvements to health outcomes with a lower budget appear to be overambitious. GMCA leaders have nevertheless argued that with more powers at regional level, they can act to make savings without undermining the health needs of the region.
- 62 Research conducted by the London School of Economics (LSE) suggested that Local Authorities and CCGs are still responsible for current funding flows and so the transition is long and costly. Moreover, whereas the NHS has seen its budget increase, local governments are under greater budgetary pressure with cuts to budgets and services (Hudson 2016). Local governments for example are not allowed to run a deficit in principle whereas NHS providers can. Moreover, budgets allocations are not the same. So any deficit in hospitals could unhinge the whole system. The differences in the two systems of health care (free at the point of use) and social care (means-tested) are significant and difficult to resolve.
- 63 The solutions provided have been very different across the health and social care sectors with social care providers cutting services and reducing the public availability

of services (National Audit Office 2014). The Department of Health upholds requests for extra cash support in the case of deficits of NHS institutions but not local authorities. Financial issues thus raise challenges for creating closer collaborations. While extra money nationwide was allocated to adult social care in the 2017 Spring Budget, this has led to greater tensions between health and social care providers (Quilter-Pinner and Gorsky 2017). Hospital leaders criticised local government for not speeding up transfers of care from hospital through these funds (Lintern 2017). Indeed, “bed blocking”⁵ in hospitals owing to the inability of local authorities to provide places outside hospital is a significant issue. A target was subsequently set at national level to free up to 3000 hospital beds through transfers. Budgets thus tend to create tensions and austerity has made integration very difficult (Douglas *et al.* 2016).

- 64 Moreover, with one budget, it is harder to identify costs for each differently funded system. Full autonomy is not possible, given that health care is still largely bound by central processes and statutory requirements of the central body NHS England. Even within the health domain, it has been noted that shifting investment across services is difficult because current tariff systems tend to reward activity more in the acute sector rather than the preventative health sector which is mainly administered by local authorities. There has also been an underestimation by Greater Manchester leaders of the amount of capital investment required to transform models of provision and support (LGA 2016). The interviews revealed that slow progress towards improving services in Greater Manchester is owing to national processes which thwart attempts to progress towards integrated care systems (ICSs). New structures are required to support a collaborative approach. Since there is no clear solution or budget agreement for social care, this limits Greater Manchester’s ability to make fundamental changes. As Warren Heppollette argues:
- 65 Integrating health and social care without a clear deal on the long term stable funding of long term care provision is a non-starter really. You’ve immediately weakened the argument. You’ve weakened the potential and you’ve destabilised the partnership whilst that feature of the system, which is significant, is still unresolved. And we’ve said that quite consistently through 2015 as well really. If one of the objectives of taking charge was to plot a path to clinical and financial sustainability across the health and care system, one of the key inputs to that was certainty around long term funding for adult social care. (Warren Heppollette, personal communication, 16 August 2021)
- 66 The overall consensus from the interviewees was that local governments and health providers were under significant financial pressure, which has deteriorated even further since the beginning of the Covid-19 pandemic. The lack of true fiscal devolution and plans to provide further financial sustainability have created real barriers to true devolution.

Democracy, transparency and accountability

- 67 According to Walshe *et al.* (2018), at the start of the devolution process, there were accusations of lack of transparency and appropriate scrutiny because the deal was made between Whitehall and Manchester town hall, and public consultations were considered to be poor. However, since then a number of public consultations have taken place.

- 68 Mike Barker argues that the devolution process is still not complete, but that devolution provides a real opportunity to link up democratic accountability with clinical and professional and community-based accountability in neighbourhood based structures:

We've still got an awful lot to do. You know some of that is about spatial level, so what services do we commission at what level, what services do we deliver at what level and how is that organised? What are the resources? Do we collect them all from individual localities and centralise them? Or do we federate them back down to localities and push the policy down as well? (Mike Barker, personal communication 26 July 2021)

- 69 Warren Heppollette argues that devolution provides a clear message of service providers working together and collaboration across the wider health and social systems.

It had a really clear statement of intent through taking charge for the five years which would drive both the changes in service delivery but also the changes in the way that we organised services at neighbourhood place and system level and created a sense of more public accountability I think for health and social care. (Warren Heppollette, personal communication, 16 August, 2021)

- 70 He explained that devolution has enabled the provision of more accountability on health and care in the region. Compared to the previous STPs which lacked transparency in their formulation, the plans for Greater Manchester are continually open to public debate through livestreamed meetings:

I think people did hook into that sense of more direct accountability, which I would see as a deliberate feature of devolution and change." (Warren Heppollette, personal communication 16 August 2021)

- 71 He explained that the direct accountability could be seen thanks to the Learning Disabilities strategy where self-advocates were invited into the room when the Partnership was agreeing on strategy.

- 72 Mike Barker underlined that:

Most localities in GM have been operating joint commissioning boards and elected politicians are core members. They bring their community with them to the discussion about allocative efficiency and resource deployment. There is also lay member involvement for community challenge along with VSCE inclusion in the conversation. Joining our the NHS with local government enables a sharing of approaches, and local government has historically been central to community development and engagement and they bring it to the table every day.

- 73 Jessica Williams was also very positive about the more transparent functioning and improved collaboration as a result of devolution:

Well it's given more visibility to what the NHS spend is on, but it has also done a large amount in terms of driving improved relationships." (Jessica Williams, personal communication, 10 September 2021)

- 74 Warren Heppollette admits that because genuine devolution did not take place, accountability is nevertheless mismatched, which limits the region's powers to go further (Warren Heppollette, personal communication 16 August 2021). This is because the local government and Combined Authority are democratically accountable to a defined population but they are also accountable to NHS structures and the Secretary of State, which creates a "vertical and horizontal mismatch of accountabilities".

- 75 Another major issue is the ability to unite various stakeholders in the region. There are complex layers at regional, sub-regional and local levels which divide commissioners

and providers (LSE). Providers were not signatories to the Memorandum of Understanding in Greater Manchester, so their implication would appear to be limited. GPs and frontline staff, for example, complained about exclusion. There is also an overall issue of democratic governance which has been identified. The devolution process gives powers to elected councils but NHS bodies are not accountable to tax payers. Service users (patients and carers) have not been able to air their opinions.

76 The Memorandum agreement and subsequent action for devolution was written and signed very rapidly. It would seem that the city region was not prepared for the changes implied by devolved power. It became confusing because political actors were part of decision-making for issues they had not previously been involved in, and notably the mayor of Manchester who had not been involved in decision-making relating to health before devolution. The new relationships imposed by devolution brought a significant degree of uncertainty as to whether stakeholders could work together. The result has been that various stakeholders have remained autonomous and kept individual financial arrangements. Statutory duties and decision-making processes remained the same, structured by individual boards. The co-production of decision-making was not in full process and described as limited because of competitive practices promoted by the Health and Social Care Act of 2012 (Walshe *et al.* 2018).

77 Mel Maguiness argues that the statutory requirements of the NHS prevent Greater Manchester from going further and this needs to change to allow for further flexibility:

Without changes to that accountability each organisation will still have to, because that's what they're held account for, deliver on their statutory obligations and finance plays a really key part." (Mel Maguiness, personal communication, 27 August 2021)

78 Donna Hall sees leadership ultimately as a problem. The health and care partnership is certainly more accountable and transparent but it has developed into a huge bureaucracy of 300 people who are indeed managing the system, but she believes that the tools of devolution need to be used to redesign the system.

79 Donna Hall regrets the reduced autonomy and also the lack of equality of partners. For her, the dominant voice is still the acute system. The overbearing focus on hospitals means that other parts of the system are neglected. She contends that more investment in the community is required to prevent hospitalisation:

The whole emphasis has been on provider, the provider aspect of the partnership rather than primary care and citizen engagement and community aspects of it. It's been very much about building bigger hospitals. And as Michael Marmot said when he came to Greater Manchester three months ago. You've got some of the worst health stats in the whole country and you've got a lot of brand new hospitals so you need to be doing something different. (Donna Hall, personal communication 31 August 2021)

Conclusion

80 While the literature on the devolution or decentralisation of health care to the regions is inconclusive on the overall benefits as opposed to centralised systems, there is no doubt that there is a future for making further progress with devolution process in the Greater Manchester region, thanks to a number of tangible benefits which have emerged from devolution of the health budget such as the ability of local authorities to manage the specific health needs of the localities and improve health outcomes.

Several of the interviews described the blueprint for the Health and Care act as being based on the region's experience, using Greater Manchester as a sort of prototype for the successful integration of health and social care. But the literature and the case study of the Manchester region also suggest that devolution is a long and complicated process. According to Donna Hall, one of the architects of the devolution bid, Greater Manchester still has far to go to move towards a truly integrated system: "If we're serious about devolution, it needs to be through the lens of public service reform and citizen engagement rather than just you know tinkering around the edges of an acute system" (Donna Hall, personal communication 31 August 2021).

- 81 Moreover, the standstill on devolution is clear at the time of writing under the current Conservative government. No new devolutionary powers for regions have been set forth in recent white papers. The much delayed devolution and recovery white paper has been replaced by a levelling up white paper. This replacement also involved a transfer of responsibility for drafting the paper from the Ministry of Housing, Communities & Local Government to the government and the Cabinet Office. There is clear lack of clarity on the meaning of levelling up and how the government intends to work with local government and devolved administrations to deliver such ambitions. So despite the enthusiasm of local leaders and health care executives to move health care governance from the centre and to embrace true devolution, national government does not seem to have the same commitments for such a process.

BIBLIOGRAPHY

- Abimbola, Seve, Leonard Baatiema, and Maryam Bigdeli. "The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence." *Health Policy Plan* 34(8), October 2019: 605-617.
- All Party Parliamentary Group. "Levelling-up Devo." APPG, March 2021. <https://connectpa.co.uk/wp-content/uploads/2021/03/Levelling-up-Devo-The-role-of-national-government-in-making-a-success-of-devolution-in-England.pdf>.
- Allen, Pauline. "New Localism in the English National Health Service. What is it for?" *Health Policy* 79, 2006: 244-252.
- Ayres, Sarah., Matthew Flinders and Sandford. Mark. "Territory, power and statecraft: Understanding English devolution." *Regional Studies* 52, 2018: 853-864. <https://doi.org/10.1080/00343404.2017.1360486>.
- Bankauskaite, Vaida and Richard B. Saltman "Central Issues in the Decentralisation Debate." In Richard B. Saltman, Vaida Banauskaite and Karsten Vranbaek, *Decentralisation in Health Care*. Berkshire: Open University Press, 2007: 9-21.
- Bossert, Thomas, Osvaldo Larranaga and Fernando Ruiz Meir. "Decentralization of Health Systems in Latin America." *Revista Panamericana de Salud Pública* (1-2) August 2008:84-92. DOI: 10.1590/S1020-49892000000700011.

- Buchanan, James M., and Gordon Tullock. *The Calculus of Consent*. Indianapolis: Liberty Fund, 1962.
- Cantarero Prieto and Pascual Saez. "Decentralisation and health care outcomes: An empirical analysis within the European Union." Working Paper FEDEA, 2006.
- Couttoulenc, Bernard, F. *Decentralization and Governance in the Ghana Health Sector*. World Bank Group, 2012.
- Dalingwater, Louise. *The NHS and Contemporary Health Challenges from a Multilevel Perspective*. Hershy P.A.: IGI Global, 2020.
- Devoconnect, "Is Devolution the future of health and social care?" file:///D:/V10866/Documents/Health%20devolution%20and%20cities/Final-Copy-Health-Devolution-Essaysread.pdf.
- Erens Bob, Gerald Wistow, Sandra Mounier-Jack, Nick Douglas, Lorelei Jones, Tommaso Manacorda and Nicholas Mays. "Early evaluation of the Integrated Care and Support Pioneers Programme: Final Report." Policy Innovation Research Unit, 2016.
- Doyle, Yvonne and Paul Johnstone. "Health benefits from devolution in England: international lessons." *Postgrad Med Journal*, 92(1087), May 2016: 282-5.
- GMCA. "Homeless Prevention Strategy." Manchester, 2021. <https://www.gmconsult.org/communications-and-engagement-team/homelessness-prevention-strategy/>.
- GMCA. "Taking Charge of our Health and Social Care." Manchester, 2015. file:///D:/V10866/Documents/Health%20devolution%20and%20cities/Taking-Charge-summary.pdf.
- GMHSCP. "The Devolution Difference." Manchester, 2018. <https://www.gmhsc.org.uk/wp-content/uploads/2018/05/FINAL-web-verison-Devolution-Difference-plain-english-leaflet.pdf>.
- GMHSCP. "Successful mental health programme for Greater Manchester schools and colleges doubles in size." 22 July 2019, <https://www.gmhsc.org.uk/news/successful-mental-health-programme-for-greater-manchester-schools-and-colleges-doubles-in-size/>.
- GMHSCP. "The Greater Manchester Story". Working Papers provided by Warren Heppollette. 2021.
- Görgeen Helmut Schmidt-Ehry Bergis. "The concept of the district health system." In Helmut Görgeen, Thomas Kirsch-Woik and Bergis Schmidt-Ehry (eds). *The District Health System: Experiences and Prospects in Africa*. 2nd ed. Schriftenreihe GTZ, Nr. 276. Wiesbaden: Universum Verlag, 2004: 27-50.
- Harrison John. "Life after regions? The evolution of city-regionalism in England." *Regional Studies*. 46(9): 1243-1259.
- Harrison John and Michael Hoyler. "Special issue editorial: City-region governance, 10 years on." *Urban Studies*, 51(11), 2014: 2249-2266. DOI: 10.1177/0042098013500699.
- Health Equity. "Greater Manchester Evaluation 2020." February 2020. <https://www.instituteoftheequity.org/resources-reports/greater-manchester-evaluation-2020>
- Hodson, Mike, Andrew McMeekin, Julie Froud and Michael Moran. "State-rescaling and re-designing the material city-region: Tensions of disruption and continuity in articulating the future of Greater Manchester." *Urban Studies* 57(1), 2020: 198-217. DOI: 10.1177/0042098018820181.

Hudson, Bob. "DevoManc and the NHS: Mind the gaps", *LSE Blog*, March 11 2015. <https://blogs.lse.ac.uk/politicsandpolicy/devomanc-and-the-nhs-mind-the-gaps/>.

Institute of Health Equity. "Greater Manchester Evaluation" 2020.

Jimenez, Dolores and Peter C. Smith. "Decentralisation of health care and its impact on health outcomes." *Discussion Papers in Economics*, 2005/10, York: The University of York, 2005.

Joseph Rowntree Foundation.(2015). The Cost of the Cuts: The Impact on the Local Government and Poorer Communities. <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/Summary-Final.pdf>

Kang, Youngju, Wonhyuk Cho and Kwangho Jung. "Does Decentralization Matter in Health Outcomes?" Evidence from 22 OECD Unbalanced Panel Data for 1995–2005. *International Review of Public Administration*, 17(1), 2012: 1-32.

Lee, Neil. "Powerhouse of cards? Understanding the 'Northern Powerhouse'." *Regional Studies*, 51, 2017: 478–489. <https://doi.org/10.1080/00343404.2016.1196289>.

LGA. *Charting Progress on the Health Devolution Journey. Early Lessons from Greater Manchester*. London: LGA, 2016.

<file:///D:/V10866/Documents/Health%20devolution%20and%20cities/charting-progress-health--d30read.pdf>.

Lintern Shaun. "Hospitals must be 'lippy' over use of increased social care funding." *HSJ*, 2017. <https://www.hsj.co.uk/topics/finance-and-efficiency/hospitals-must-be-lippy-over-use-of-increased-social-care-funding/7016330.article>.

Litvak Jennie, Junaaid Ahmad and Richard Bird. *Rethinking Decentralization in Developing Countries*. Sector Studies Series. Washington, DC: The World Bank, 1998.

Liwanag Harvy J. and Kaspar Wyss. "Assessing decentralisation is a challenging but necessary task if it should continue as a reform strategy: reflections from the systematic review by Sumah, Baatiema, and Abimbola." *Health Policy*, 121, 2017: 468–70.

Lorne, Colin, Anna Coleman, Ruth McDonald and Kieran Walshe. "Assembling the Healthopolis: Competitive city-regionalism and policy boosterism pushing Greater Manchester further, faster." *Transactions of the Institute of British Geographers*, 46, 2021:314–329.

McKenna, Helen and Phoebe Dunn, "Devolution: what it means for health and social care in England". *The King's Fund Briefing*, 2015. <file:///D:/V10866/Documents/Health%20devolution%20and%20cities/devolution-briefing-nov15read.pdf>

McKillop, Tom, Diane Coyle, Ed Glaeser, Jonathan Kestenbaum and Jim O'Neill. *Manchester Independent Economic Review*, 2009.

Mills Anne, Patrick J. Vaughan, Duane L. Smith, Tabibzadeh I. *Health System Decentralization: Concepts, Issues and Country Experience*. Geneva: World Health Organization, 1990.

Mitchell, Andrew and Thomas J. Bosser. "Decentralisation, Governance and Health System Performance: 'Where You Stand Depends on Where You Sit.'" *Development Policy Review*, 28 (6), 2010: 669–691.

National Audit Office. "The financial sustainability of NHS bodies. HC 722. Session 2014–15." London: National Audit Office, 2014. www.nao.org.uk/report/financialsustainability-nhs-bodies.

NHS England. "The five year forward view into action: NHS England and Greater Manchester announce shared plan for £6 billion health and social care funding." Press Release, 2015.

Available at: www.england.nhs.uk/2015/02/27/greater-manc-funding/.

Oates, Wallace. "An essay federal federalism." *J. Econ. Lit.*, 37, September 1999: 1120-1149.

Peckham, Stephen, Mark Exworthy, Martin Powell and Ian Greener. "Decentralizing health services in the UK: A new conceptual framework." *Public Administration*, 86(2), 2008: 559-580.

Quilter-Pinner, Harry and Gorsky, Martin. (eds) *Devos-Then, Devo-Now: What Can the History of the NHS Tell Us About Localism and Devolution in Health and Care?* Institute for Public Policy Research, London, 2017.

Regmi, Kristina, Jennie Naidoo, Alan Greer and Paul Pilkington. "Understanding the effect of decentralisation on health services: The Nepalese experience." *Journal of Health Organisation and Management* 24(4), August 2010:361-82. DOI:10.1108/14777261011064986.

Robalino, David A., Oscar F. Picazo and Albertus Voetberg. "Does fiscal decentralization improve health outcomes? Evidence from a cross-county analysis." *Policy Research Working Paper* 2565, Washington D.C.: World Bank, 2001.

Rodden, Jonathan. "Reviving Leviathan: Fiscal Federalism and the Growth of Government." *International Organization* 57, 2003: 695-729.

Rondinelli Dennis A. "Government Decentralization in Comparative Perspective: Theory and Practice in Developing Countries". *International Review of Administrative Sciences* 47 (2): 133-145, 1 June 1981.

<https://doi.org/10.1177/002085238004700205>.

Saltman, Richard,B, Vaida Bankauskaite and Karsten Vrangbaek. *Decentralization in health care*. European Observatory on Health Systems and Policies Series. Berkshire, England: Open University Press, 2007.

Sreeramareddy, Chandrashekhar and Tamysetty Sathyanarayana. "Decentralised versus centralised governance of health services." *Cochrane Database Syst Rev.* 9 September 19 2019. doi: 10.1002/14651858.CD010830.pub2PMCID: PMC6752685.

Sultaria, Shailen, Peter Roderick and Allyson Pollock. "Are radical changes to health and social care paving the way for fewer services and new user charges?" *BMJ Clinical Research* 358:j4279, September 2017. DOI:10.1136/bmj.j4279.

Sumah Anthony Mwinkaara, Leonard Baatiema and Seve Abimbola. "The impacts of decentralisation on health-related equity: A systematic review of the evidence." *Health Policy*, 120(10), October 2017: 1183-1192. Doi: 10.1016/j.healthpol.2016.09.003.

Walshe Kieran, Colin Lorne, Anna Coleman, Ruth McDonald and Alex Turner. "Devolving Health

and Social Care: Learning from Greater Manchester.” Alliance Manchester, The University of Manchester, 2018.

NOTES

1. The National Health Service and Community Care Act of 1990 led to the creation of an internal market within the NHS with the provision and commissioning (ie purchasing) of healthcare. The state had the powers to create NHS trusts which took over ownership and management of hospitals which had been previously managed by regional, district or other special health authorities. GPs also had the possibility of becoming fundholders and were thus able to manage their own budget, but also to choose where they purchased services. This led to furthering the marketization of the health service even though the NHS remained publicly owned and publicly financed.
 2. <https://www.greatermanchester-ca.gov.uk>
 3. The intention of the Health and Care Bill is to enact policies which were recommended in the 2019 NHS Long Term Plan to promote local collaboration in order to improve the provision of health and social care. It is expected to come into effect in April 2022.
 4. Acute systems tend to refer to hospitals. They are systems which provide treatment for a severe injury, period of illness, urgent medical condition, or recover from surgery. In the NHS, these are essentially services such as accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery.
 5. Bed blocking is the situation whereby elderly patients stay in hospital beds even though they no longer need further hospital care because there are not enough places in residential care in the community.
-

ABSTRACTS

The impetus to devolve power to regional health and social care partners is part of a general process towards devolution and decentralisation in the UK. Yet, for over a century or more, centralisation of power has been a key feature of UK regional policy. In 2015, on the eve of health budget devolution to Manchester, only 25% of public expenditure was allocated to local government. The NHS also followed a tradition of central control for much of the 20th century. From 1997 and the devolution process in Scotland, Wales and Northern Ireland, it was expected that transfer of power to the regions would be high on the political agenda, but initial attempts to create directly elected mayors failed to get much support. It was not until 2010 that a consensus emerged across political parties that power should be devolved to local communities on a much grander scale, which led to the Localism Act of 2011, the creation of Local Enterprise Partnerships and 26 City Deals. In 2014, George Osborne announced a major devolution of powers and the development of a ‘Northern Powerhouse’ in an effort to boost economic growth in the North of England. NHS England’s *Five Year Forward View* report of 2014 underlined the need to decentralise health policy stating that “England is too diverse for a ‘one size fits all’ care model to apply everywhere” (NHS England, 2015). It is within this context that Greater Manchester was chosen to be the first region to run its own health and social care budget.

This represents a significant move to improve health outcomes in the Northern region, given that the North West has comparatively poor health outcomes. Initial evaluations of the effectiveness of devolving health budgets to the regions have been rather inconclusive. Doyle and Johnston's (2016) review of international literature found that there was little evidence to suggest that devolution improved clinical outcomes or health status. As far as England is concerned, while there is much support for the decentralising and democratising process, there is concern that it is still largely driven at national level. Nevertheless, the Health Foundation (2017) has underlined the importance of this move. While it claims this may not bring significant changes to the way in which NHS services are run, it could well have a significant impact on overall health because devolution has also transferred more powers to the region over housing, employment and transport. However, the health deal has not led to an increase in the overall budget. The concern is that while regions may have innovative ideas to improve the health of their citizens, they may not have sufficient funding to implement such changes. This article thus seeks to assess whether six years after devolution of the health budget to Greater Manchester the ambitions to improve outcomes have been achieved. It will do so through analysis of secondary data (academic research, local government literature, publicly available minutes...) and original interviews with health and social care providers and principal stakeholders.

L'impulsion donnée à la dévolution de pouvoirs aux partenaires régionaux de la santé et de l'aide sociale fait partie d'un processus général de décentralisation au Royaume-Uni. Pourtant, depuis un siècle ou plus, la centralisation du pouvoir a été une caractéristique essentielle de la politique britannique. En 2015, à la veille de la dévolution du budget de la santé à Manchester, seuls 25% des dépenses publiques étaient alloués aux collectivités locales. Le système de santé britannique (le NHS) a également suivi une tradition de contrôle central pendant une grande partie du 20^e siècle. À partir de 1997 et du processus de *devolution* (décentralisation) en Écosse, au Pays de Galles et en Irlande du Nord, on s'attendait à ce que le transfert de pouvoir aux régions figure en bonne place dans l'agenda politique, mais les premières tentatives de créer des maires directement élus n'ont pas obtenu beaucoup de soutien. Ce n'est qu'en 2010 qu'un consensus s'est dégagé entre les partis politiques pour que le pouvoir soit dévolu aux communautés locales à une échelle beaucoup plus grande, ce qui a conduit à la Loi sur le localisme de 2011, à la création de partenariats d'entreprise locaux et à 26 *City Deals*. En 2014, George Osborne a annoncé un important transfert de pouvoirs et le développement d'une "Northern Powerhouse" dans le but de stimuler la croissance économique dans le nord de l'Angleterre. Le rapport Five Year Forward View de NHS England de 2014 a souligné la nécessité de décentraliser la politique de santé en déclarant que " l'Angleterre est trop diverse pour qu'un seul modèle puisse s'appliquer partout " (NHS England, 2015). C'est dans ce contexte que le Grand Manchester a été choisi pour être la première région à gérer son propre budget de santé et de soins sociaux.

Il s'agit d'une avancée significative pour améliorer les résultats en matière de santé dans la région du Nord, étant donné que le Nord-Ouest a des résultats relativement médiocres en matière de santé. Les premières évaluations de l'efficacité de la dévolution des budgets de santé aux régions ont été plutôt peu concluantes. Doyle et Johnston (2016) ont révélé qu'il y avait peu d'évidence pour montrer que la *devolution* améliore les résultats cliniques ou l'état de santé. En ce qui concerne l'Angleterre, si le processus de décentralisation et de démocratisation bénéficie d'un large soutien, on s'inquiète du fait qu'il soit encore largement piloté au niveau national. Néanmoins, la Health Foundation (2017) a souligné l'importance de cette évolution. Bien qu'elle affirme que cela n'apportera peut-être pas de changements significatifs dans la façon dont les services du NHS sont gérés, cela pourrait bien avoir globalement un impact important sur la santé, car la dévolution a également transféré plus de pouvoirs à la région en matière de logement, d'emploi et de transport. Toutefois, l'accord sur la santé ne s'est pas traduit par une augmentation du budget global. Le problème est que si les régions ont des idées novatrices pour

améliorer la santé de leurs citoyens, elles ne disposent pas des fonds suffisants pour mettre en œuvre ces changements. Cet article cherche donc à évaluer si, six ans après le transfert du budget de la santé à la région de Manchester, les ambitions d'amélioration des résultats ont été réalisées. Il le fera à travers l'analyse de données secondaires (recherche académique, littérature du gouvernement local, procès-verbaux accessibles au public, etc.) et d'entretiens originaux avec des prestataires de soins de santé et de soins sociaux et les principales parties prenantes.

INDEX

Keywords: NHS, devolution, Greater Manchester, health and social care

Mots-clés: NHS, dévolution, Greater Manchester, santé, assistance sociale

AUTHOR

LOUISE DALINGWATER

Louise Dalingwater is full professor of British politics at Sorbonne Université. Her current research focuses on health policy and healthcare delivery in the United Kingdom, with some comparative research on European health systems (notably France) and global health policy research. Recent publications include a monograph *The NHS and Contemporary Health Challenges* and several book chapters on healthcare. She has also authored articles in academic journals including in *Outre Terre* and *The International Journal of Health, Wellness and Society*. She is part of the Precision Health network (an international research project led by the Universities of Lund and Malmo in Sweden).