The Road to Healthcare Devolution

Anticipating dangers and opportunities

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Executive Summary

- If healthcare provision is to be devolved, the opportunity should be used to also devolve revenue collection to the local level and require local authorities to finance acute care in collaboration with their neighbours. This would provide the strongest possible incentives for local authorities, who also commission social care, public health and primary care, to avoid every acute admission they can; a sure way to save the NHS considerable sums of money.

- Additionally, if citizens see the majority of their new local health taxes (excluding adjustment measures) going to health and social services in their area, they may support increases in taxation, if earmarked for this purpose.

- Devolving health budget responsibility to other large metropolitan areas such as West Yorkshire has the potential to work well and is something that this report recommends so long as results from the Greater Manchester pilot look promising. However, as we gradually give powers to such regions, we need to consider how expertise for commissioning responsibilities can be shared over larger areas in the more rural parts of the country.

- Devolution has the potential to make healthcare an extremely prominent issue in local elections. It would be likely to become the largest issue debated during campaigns. Subsequently, the turnout for local elections could significantly increase with local populations feeling that they have far more say in healthcare decisions than at present (when voting in general elections for national health policies).

- There is widespread consensus among health professionals that another top-down reorganisation of the NHS is not the answer to its problems, despite how vulnerable its future sustainability is. Devolution offers real hope by potentially reducing demand for healthcare as well as making it more efficient without requiring a radical, top-down reorganisation. We can gradually evolve into devolved healthcare in a cautious and controlled manner while causing minimal disruption.

- Finland shows us that devolved healthcare is not a luxury for health systems with few fiscal worries. Instead it is a legitimate means of providing highly efficient and effective healthcare when funds are limited.

Local authorities who have patients wishing to take their treatment elsewhere due to poor service quality, a lack of a particular services' existence or unreasonable waiting times should be required to finance all costs of the patients' treatment to be transferred to a neighboring locality (including the travel and administrative costs). This would act as an incentive to keep standards high in each area and thus prevent a postcode lottery.

Some degree of political devolution in relation to UK healthcare has already been experienced. Since 1999, England, Scotland, Wales and Northern Ireland have each taken individual control of healthcare governance through pursuing different regional policies.[1] A recent announcement from NHS England, made at the end of February 2015, suggests the possibility of further devolution within England.[2] From April next year, 12 Clinical Commissioning Groups (CCGs), 15 NHS providers and most importantly ten local authorities will together become responsible for Greater Manchester's £6 billion share of the NHS budget.[3] Many have seen this as a pilot scheme for general semi-devolved healthcare throughout England, where local areas will become free to choose and commission service provision. Indeed, the BBC's health editor described the NHS England's announcement as marking 'a potentially momentous week for the NHS and the future of regional government in England'.[4] Additionally, Chancellor George Osborne has said that '(devolution) is a model that other parts of the country can take forward if they would like to'[5].

Decentralisation has been lauded by some as being potentially highly advantageous; allowing local people to engage in and influence the local decision-making process and enabling local authorities to respond effectively to local need. It may also increase overall efficiency with local decision makers having greater opportunities to reduce costs than centralised management.[6] Local managers might also have increased freedom to innovate their sourcing of alternative service provision.[7] Critics of decentralisation however point to certain dangers, especially regarding a potential resultant inequality between regions. They also voice concerns that decentralisation might lead to the excessive fragmentation of some services which would hinder the integration of care.[8] Further, local government might not be able to achieve the economies of scale that national or major regional areas can achieve when procuring equipment or commissioning services.[9]

This report investigates the possible future consequences for our healthcare, and specifically for the NHS, should England become more localised in its approach to

health system management. It examines Denmark and Finland, where healthcare is currently managed locally, in order to see what aspects might be relevant to the situation in England. For example, what advantages could be expected and what dangers may lie on the road to decentralisation? The report will further consider the 'centralised decentralisation'[10] phenomenon in those countries where, even though some responsibilities of local governments have been returned to central government, regional and local politicians still play a highly significant role in running health and care services. It is expected that local councillors in Greater Manchester will soon wield similar influence.[11]

The UK situation

The devolved countries of the UK

Since 1999 each country within the UK has been able to regulate its own healthcare system. Substantial differences in policy are consequently now being observed between them.[12] In Northern Ireland policy variation from that of England is not as marked as that of Wales and Scotland. This is probably because Northern Irish devolution was paused for half a decade from 2002, when its assembly was suspended until 2007. Perhaps the main policy difference between England and the other nations is that in England the purchaser/provider split has been maintained, whereas in Scotland and Wales it has been abolished. Another major difference is that in Wales, Scotland and Northern Ireland prescription charges have been ended while in England they have been maintained. Scotland also now provides free personal care for the elderly which is not the case elsewhere.[13] There are currently different overall health budgets between the countries, with Scotland spending more than the others, who allocate roughly equal per capita sums. Staffing levels are also unequal, with more staff being provided per thousand of population (including GPs in Scotland only) in Scotland and Northern Ireland than in England and Wales.[14] In terms of functioning however, regarding outpatient appointments offered, England offers greater patient accessibility (North East England is here evidenced as being more easily comparable statistically than are other areas). Despite these differences, a report from the Nuffield Trust concluded in 2014 that there was little evidence of one home country's health system moving consistently ahead of any other with regard to established health indicators.[15] It is also relevant to state here that each country has different demographic profiles making them therefore difficult to correlate in terms of healthcare provision measures.[16] Devolution has arguably given rise to increasing heterogeneity in terms of the measures used for data collection, making it harder to readily make comparisons between providers.[17] What can be ascertained from some markers however, is that differences in the range and quality of services certainly exist between the countries. Nevertheless, it is difficult to be sure of the overall outcomes these differences may generate. If such differences were to be replicated on the local level as a result of the devolution of NHS control, this may be seen by critics as leading to unequal care quality around the country, effectively worsening the 'postcode lottery' for care in England.[18]

Greater Manchester: a pilot scheme for devolution

From 2016, the complete £6 billion health services budget for Greater Manchester (an area with 2.7 million inhabitants[19]) will become the responsibility of its ten local councils, 12 CCGs and 15 NHS providers, all working with NHS England and under the auspices of a newly elected mayor. These authorities will engage with a broad range of issues, especially integrated care, and thereby attempt to promote physical, mental and social wellbeing amongst the citizens for whom they have responsibility.[20] NHS England claims its new plans will put the people of Greater Manchester 'in the driving seat' to direct the services for their area.[21] The scheme accords well with Chancellor George Osborne's vision of a semi-autonomous 'northern powerhouse'[22] with a possible full devolution of public spending to it in the near future.[23] The devolved entity's responsibility will, in addition to the entire health and social care system for the region, include future public health initiatives.[24] Simon Stevens, chief executive of NHS England has described the move as having the 'potential to be the greatest act of devolution there has ever been in the history of the NHS'.[25] However, council leaders have expressed caution, stressing the importance of all other stakeholders in decision-making. They hold that the move to devolution does not represent a 'town hall takeover' but rather an opportunity to facilitate joint decisions between health and social care organisations.[26]

One great advantage of local council involvement in decisions on healthcare is that although they are currently responsible for commissioning social care in England,[27] they will, under the new arrangement, be making joint decisions concerning *both* health and social care with all other stakeholders. Separate responsibilities for health and social care budgets currently lead to inefficiency and can be dangerous for patients due to health and social care authorities sometimes offloading patients from one to the other in an effort to conserve their limited funds.[28] The result is that patients are not always situated appropriately for their treatment needs.[29] In addition, unwillingness of social care providers to take back patients from acute hospitals, again to save their budgets, means that patients often remain in hospital longer than necessary.[30] It is hoped that when a single body is commissioning both health and social resources, even if the amount they are allowed to spend on each remains the same, that this could result in better integrated care for patients.

Although better integrated care, especially with regard to social care, is anticipated to result from the new measures, their principle objective remains that of enhancing

general physical mental and social wellbeing.[31] The King's Fund expresses excitement at the prospect of the new partnership shifting the emphasis of healthcare even beyond the integration of care to focus on general population health; thus preventing the occurrence of disease.[32] It is encouraging to observe disease prevention and management measures being stressed on the Greater Manchester Combined Authority Website. Here it is claimed that people with long-term conditions, such as heart conditions, will be treated as much as possible in the community, thereby avoiding frequent trips to hospital.[33] Nevertheless, although it is claimed that devolution will 'put local people in the driving seat for deciding on health and social care services',[34] only time will tell how much freedom the region will have in reality to depart from national health policies.[35]

What can the NHS in England learn?

Choice, local involvement and feasibility

If devolution of healthcare were to expand across other regions of England, other metropolitan areas with large populations such as that of Greater Manchester could be given similar control over their health and social care budgets. A typical example is West Yorkshire, a metropolitan county with a population of around 2.2 million[36] divided into five metropolitan boroughs.[37] West Yorkshire's ten CCGs could function within the boroughs and source local providers as in Greater Manchester. Similar metropolitan districts around the country could conveniently provide hubs for leadership, and ensure that services are provided efficiently in these densely populated areas. However, in more sparsely populated and rural parts of the country, where CCGs are geographically positioned further apart from one another, and where there are no joint authorities such as those that exist in many large cities, there could be problems regarding the establishment of strong leadership and in recruiting professionals with the level of expertise needed to commission services effectively. Further, with the broadening of regional administrative boundaries, it could be envisaged that the benefits of effective executive control might be reduced, as civil servants and commissioners become less immediately connected with local areas, and thus less familiar with their population's health needs.

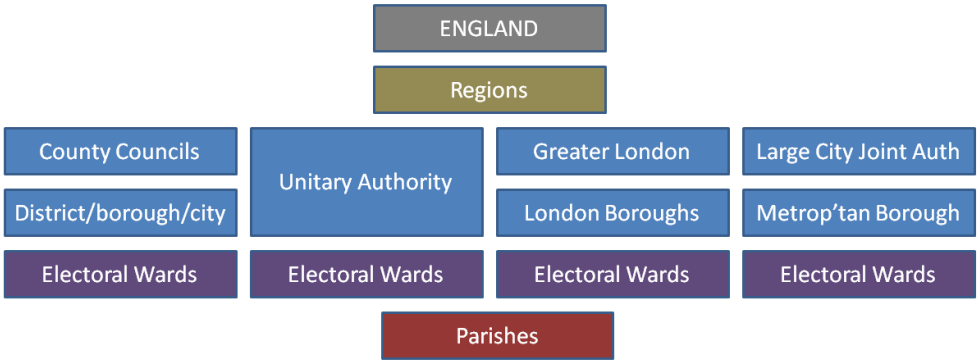
The considerable heterogeneity of local government structure in England (see figure 1 and table 1) might make it difficult to establish a standard decentralised healthcare structure across England. As there presently exists no typical administrative blueprint, it could be that different areas around the country would have to introduce individual arrangements as to how services might be commissioned and managed. This situation might be seen as either promising – the whole point of devolution being to provide more tailored services to better suit local population need – or as being of concern in terms of equality of public access to services and executive accountability for their effective delivery. Current diversity in local administration could further make any clear standard specification of what services are mandatory for each area much more difficult to produce. The present lack of any standardised local structure could easily result, after devolution, in ambiguities as to who might be ultimately responsible for the viability of any locality's services. It might therefore be envisaged that in order to monitor, regulate

and even correspond effectively with each devolved area, extra central administration would be required at considerable cost to the taxpayer.

Table 1: The designated responsibilities of different bodies of local government in England

Arrangement	Upper Tier Authority	Lower Tier Authority
Country Councils / District, borough or city councils	education transport planning fire and public safety social care libraries waste management trading standards	rubbish collection recycling council tax collections housing planning applications
Unitary Authorities in shire areas		education transport planning fire and public safety social care libraries waste management trading standards rubbish collection recycling council tax collections housing planning applications
Greater London / London boroughs	police fire services public transport	education transport planning fire and public safety social care libraries waste management trading standards rubbish collection recycling council tax collections housing planning applications
Other large cities' joint authorities/metropolitan boroughs	police fire services public transport	education transport planning fire and public safety social care libraries waste management trading standards rubbish collection recycling council tax collections housing planning applications

Figure 1: Structure of local government in England



Considered in isolation, it is unlikely that devolution would directly enhance healthcare choice for the English public, for example, by allowing enhanced choice of treatment provider. However, depending on the powers granted to each locality, devolution could give local citizens more influence over which services are commissioned, and from whom, in their locality. However, due to the variations in local administration as noted above, any degree of public influence might vary considerably between regions, as might the fact that the populations subject to individual local administrations vary widely (from over one million to under 40,000, although most are above 150,000 and below 300,000).[38]

Further, the devolution of services to local administrations would imply that, to a greater or lesser extent, healthcare will become a local political issue. Citizens may well vote in local elections for whichever candidate promises the services which seem most immediately appealing. With the turnout at the most recent (2014) local elections estimated at only 35.3 per cent,[39] public interest in local government does not currently seem high. However, the issue of local healthcare might stimulate increased interest in the future. Unlike in general elections where healthcare, though a prominent issue, is one amongst many, and where particular regional policy receives little attention, the empowerment of citizens with regard to influencing their regional healthcare in local elections might prove politically energising. Health and social care might become the main issue debated during campaigns, and prove to be the issue upon which parties win or loose. Nevertheless, it should be remembered that apolitical CCGs would still be fundamentally involved in health service provision as would large in-house NHS

providers. Consequently, local administrations would still only have a certain proportion of influence within the context of a much larger collaborative responsibility to plan and provide health services for any particular area.

Efficiency

One fundamental issue to be addressed is whether or not devolution might help English healthcare to become more efficient. That it should do so is vitally important if the NHS is to achieve the (highly optimistic) two to three per cent annual efficiency gains that have been predicted as necessary to keep the service financially sustainable within the level of funding promised by the government during its current term of office.[40]

Of particular interest in this respect is the example of Finland (see appendix for country profile), which the Health Consumer Powerhouse's Euro Health Consumer Index Report of 2014 described as the leader in value-for-money healthcare.[41] When we think of Scandinavian countries, we tend to think of rich nations with ample financial resources available to enable their healthcare systems to enjoy far less fiscal restraint. In fact, Finland spends slightly less per capita on healthcare than does England, however, despite its lower per capita expenditure Finland performs consistently well in all the quality care indicators listed earlier in this report. The identification of what specific factors underlie Finland's success could help us to improve the NHS with our own severely limited resources. If high standards of care for moderate expenditure have been achieved through devolution and not through another mechanism, it would support the case for similar devolution in England also. However, as stated above, Finland has a much smaller population than does England; more akin to that of Scotland. It could be that a small population makes healthcare easier to manage, or that less clinical and management errors are made amongst a small population than when providing healthcare for over 50 million people. Such errors reduce efficiency and drive up costs.

Further, the average annual income is higher in the UK than Finland, ($41,192 compared to $40,060 in 2013, at 2013 USD PPP: purchasing power parity)[42] but Finland as a country has a lower rate of income inequality (with a Gini coefficient of 0.265 compared to 0.344 in the United Kingdom).[43] It is possible that this higher income inequality in England could contribute to worse healthcare performance as low paid English citizens might have less easy access to healthcare. Stressful

social comparisons with those more successful in society have also been shown to affect health,[44] and it could be that those on the bottom feel less confident and indeed less welcome when utilizing services. Nevertheless, as the majority of healthcare is free at the point of use in both countries (almost entirely so in England), there is a limit to how much influence income inequalities can have in accessing healthcare once unwell. Also, the income factor cannot readily explain differences in treatment quality (and the frequency of errors) once healthcare has been accessed. Lastly, with reference to Finland's aforementioned high diabetes and heart disease morbidities, and the fact that both countries have similar proportions of elderly in their populations (16.1 per cent in the UK compared to 16.7 per cent in Finland), the case for demographic differences leading to differences in efficiency and care quality between the two countries can be largely discounted.

Following devolution, the fact that each English local authority would then be responsible for healthcare as well as social care and many environmental and social determinants that affect health, might result in a stronger emphasis being placed on preventative health measures and care in the community. Such a policy shift might create the conditions necessary to stop excessive numbers of often unnecessary hospital admissions as occur at present. Authorities would have a powerful incentive to do so if they now had to fund that excessive acute care, which results from a lack of adequate social or community care, from their own resources. In Finland, where local authorities largely finance their 21 hospital regions, a strong emphasis is thus laid on prevention rather than acute care, resulting in efficient service provision. Finnish local authorities will try to avoid expensive hospital treatment that they must directly pay for by utilising primary care, social care and public health measures as effectively as possible. There can be no greater incentive to avoid patient hospitalisation than making those who handle the majority of primary care and many other health determinants pay for it.

Healthcare efficiency following devolution in England might also be enhanced by following the Finnish example where patients can easily choose to transfer their treatment to approved providers anywhere in the country, thus spreading demand and reducing bottlenecks in the system when specific local providers become overburdened. If pressure on the system was similarly lessened in England by allowing the same freedom of choice, this might reduce the likelihood of errors due to overwork in certain specialisms and allow less pressured staff the opportunity to

maximise efficiency. The fact that there exist differences in the level of expenditure on specific specialisms between different local authorities in Finland in response to varying population demographics, as presumably will be the case in England after devolution, [45] means that necessary treatments are always available to individuals as they can exercise their right to choice of provision outside their locality.

One factor that should not be overlooked when considering Finnish healthcare efficiency is that user charges are required from patients when accessing both in and outpatient services, though these are subject to daily and annual maximums. Superficially, such user charges appear to reduce overall government expenditure on healthcare and they may even deter some unnecessary utilisation of services from individuals who do not wish to incur charges without good reason. However, global studies have revealed that user charges can cause a 'squeezed balloon effect', where people simply forego necessary treatment to avoid initial expense only to consequently require more urgent care later; thus drastically increasing expenditure on more acute intervention services.[46] Researchers from the London School of Economics and Political Science who have investigated this issue have concluded that, far from making health systems more efficient, user charges for health services actually undermine efficiency and 'make little economic sense'.[47] They cite examples from middle income countries such as South Africa where, after user charges are abolished, patients flock to health centres, revealing a large degree of unmet and very real need.[48] These considerations as to the ultimate economic viability of user charges must introduce doubt as to their usefulness in increasing healthcare efficiency but also shows that they are unlikely to be the cause of Finland's better-value healthcare.

Also worthy of note is the fact that in Finland there are few, if any, repercussions when hospital districts exceed their budgets. Possibly, instead of being seen as an indication of hospital inefficiency, local authorities hold themselves to be responsible for such overspending by not sufficiently reducing demand on hospitals through preventative and social measures. Finnish local authority cost projections are also frequently lower than is actually required in practice, and thus are often revised during a financial year without blame being attributed to hospitals. In effect this practice of semi-conscious under-budgeting operates as a pay-as-you-go method of financing acute care, and could possibly help to contain costs although with some fiscal hardship for hospitals. Lastly, with regard to the efficiency of Finnish healthcare, it should be noted that Finnish local government operates with

a permanent deficit of around seven per cent of GDP, and this is possibly due to significant increasing demand for healthcare. So, even if Finland appears to be providing healthcare at a lower per capita cost than England, these lower levels of funding are obviously not adequate to fully meet the requirements of its population.

The issue of efficiency cannot be divorced from that of economies of scale. Concerns have been raised earlier in this report regarding commissioning groups such as local authorities procuring medical goods and services for small populations. In this context they cannot hope to achieve the same cost advantage as can national or regional bodies. It might also be hard for small local commissioning bodies to recruit executives with sufficient levels of experience and expertise, especially with many other local authorities competing for their services. Both these issues could affect the equity of healthcare provision across the country, with larger local authorities able to provide better managed and consequently cheaper healthcare. If devolution occurs in England, it must be ensured that inequalities in procurement and recruitment do not perpetuate the 'postcode lottery' which presently exists in some areas of England. To avoid it, the procurement of goods and services might have to be effectuated by partnerships of multiple local authorities.[49] Devolution might nonetheless provide a means of empowering local management who are best placed to identify possible savings. Increasing local executive powers of local managers to organise, provide and commission local health services might well make it easier for them to take the necessary measures to increase efficiency. As an illustration, simply increasing the size of local authorities, as has happened in some Nordic countries has not been shown to necessarily enhance efficiency. In the Finnish context, no great efficiency gains have been observed, and international studies of administrative expansion and related efficiency have proved inconclusive.[50]

As a final consideration, if devolution were to be implemented in England, job security must be ensured for existing staff for a substantial period of time after any reorganisation, despite thereby incurring some additional cost. By this means support will be gained and maintained for the new system. Failure to do so might undermine any possible efficiency gains due to low morale.

Recentralisation in Nordic countries

Concerns around the quality of healthcare and equality of access to it, especially with regard to variations between regions, have been cited as the principle reasons

for initiating some administrative recentralisation in Nordic countries.[51] There is also the issue that, after many years of decentralised governance, central state regulation is somewhat resented as an intrusion into local policy-making. This has made it increasingly hard to exercise central control on some localities.[52] Thirdly, in more remote areas it was extremely difficult to organise viable local services due to the small populations requiring them. It was simply not feasible to recruit and finance all the administrative expertise required to provide effective services for so few citizens. In consequence, it was realised that larger administrative units were more able to make economies of scale, and, as a result, in recent years, these economic factors have led to the re-imposition of some degree of central control.[53] It appears reasonable to conclude therefore that when demographic and geographic factors hinder efforts to improve efficiency and equality, central government may decide that it is necessary to merge some of the very smallest localities together. The feasibility of providing cost-effective healthcare services to small remote communities is made all the more difficult by the cost of modern technical treatment facilities which the population in general have come to expect.[54]

Equality

The greatest challenge to equality of healthcare provision which arises from devolution is that of differing levels of effective specialist treatments between regions (the aforementioned postcode lottery). To minimise this factor it is essential, especially if considerable autonomy is devolved to each local authority, that there is a rigorous national specification regarding exactly which services, and at what level, each local administration must provide. These specifications should be met everywhere without default. Further, legislation should be enacted to give patients the right to access providers in other areas of the country should they so wish, as is the case in Denmark and Finland. This measure would act as a safeguard so that patients would never be left without recourse should a prescribed service be unavailable in their locality. Such a policy might also reduce waiting times by spreading demand across the country's providers. Local authorities might be made financially responsible for transfers to non-local providers as an incentive to maintain their own high quality comprehensive services and reduce local waiting times. The fact that patients could choose to transfer their treatment to another municipality at their own municipality's expense might well thereby contribute to

keeping local standards high, as is arguably the case in Denmark (for country profile see appendix).

It is also important to determine whether devolution might help or hinder efforts to eradicate socioeconomic inequalities in disease susceptibility and in access to healthcare. England has the worst income inequality of the three countries with a Gini coefficient of 0.344 as compared to Denmark's 0.253 and Finland's 0.265. Despite this, if we look at absolute inequalities in all-cause mortality between those citizens with the lowest and highest levels of education (deaths/100,000 persons/year) the UK performs the best (662), Denmark next, (669.5) and Finland the worst (869). As stated previously, in terms of difficulty of access to specialist doctors and medical examinations the UK also performs better than both other countries. It is possible that this may be the result of the UK's (including England's) more centralised structure, however it could be that user charges in Denmark and Finland act as a disincentive to seeking treatment. It is worth noting that both Denmark and Finland responded to the 2008 financial crisis by increasing user charges for some treatments, whereas the UK did not[55], and user charges are known to discourage poorer groups from accessing treatment.[56] It seems likely that the UK's continuing commitment to healthcare that is 'free at the point of delivery'[57] helps access to services remain equal between all socioeconomic groups in society. It may also be the case that the British GP's role as gatekeeper to more specialised services stops the more confident and articulate middle classes from using their influence to directly consult specialists, as occurs, albeit unofficially, in Denmark.

Though it seems obvious that devolution will affect the geographical and demographic factors of healthcare, it would appear that user charges are a truly crucial issue affecting equality of access in centralised and decentralised health systems alike. The fact that we see moderate levels of pro-rich bias amongst those accessing care in all three countries shows that no health system has managed to create a system where access to healthcare is fully equitable for all. Poorer people remain more likely to become ill than do richer for a variety of reasons.[58] The attempted analysis of any country's health patterns involving the consideration of many often confounding factors, makes it difficult to arrive at any firm conclusion as to the beneficial or harmful effect of devolution on equality of healthcare access.

Transition to local authority autonomy

A contentious issue concerns just how much responsibility devolved authorities should have. To effectively implement devolution, central government obviously needs to relinquish a proportion of its power. However, every signatory government, including that of the UK and England, has a responsibility to uphold article 25 of the Universal Declaration of Human Rights, specifically '...the right to a standard of living adequate for the health and wellbeing of himself and his family including medical care'.[59] Local authorities, especially in the period of transition, would presumably have to operate under provisional organisational arrangements, perhaps, even if only temporarily, to the detriment of residents in any given locality. Therefore, to comply with its responsibility under the Declaration, central government would need to specify exactly which powers were to be devolved and make available the resources to oversee each devolved administration's activity. Central government should also have emergency funding available to rescue any administration which fails in its duty as a healthcare provider or experiences financial difficulty due to mismanagement. It might also prove necessary to introduce sanctions to impose on authorities that underperform, and thereby discourage risk-taking and encourage innovation. Possibly, local authorities that perform well could receive extra funding to devise improvement strategies for those underachieving. At the launch of NHS England's recent Five Year Forward View, Chief Executive Simon Stevens stated, 'England is too big for a one-size-fits-all plan, nor is the answer to simply let a thousand flowers bloom'. Despite the caution expressed in this statement, the nation could certainly nurture a large bouquet of such flowers, the most spectacular of which could serve as model solutions for localities where successful devolution has proved difficult to achieve.

In Denmark, municipalities, regions and the national government hold meetings in May and June to plan strategies for the coming year. At this time, they assess rates of and limits to municipal taxation, and discuss expenditure in relation to the size of block grants from central government for the coming year.[60] This annual meeting seems effective as indicated by Denmark's success in comparative studies of international healthcare. A similar extended meeting period could be introduced in England. Nevertheless, while local authorities are in the process of transition to devolution, it is likely that much more regular meetings would be required until each locality became stable in its new administrative form.

As regards the role of providers, large hospitals are likely to want to be consulted over many issues arising from the introduction of a decentralised system to which they will act as a principle resource. Hospitals consist of a body of expert administrators and clinical staff with extensive experience of any local community's needs and the logistics of meeting them. Local hospitals would need to work closely with newly devolved authorities in the commissioning and procurement of goods and services for both health and social care in relation to ensure they match with local demand. As is the case in Greater Manchester it seems wise therefore to have health services collaboratively administered by local authorities, CCGs and providers on a continuing basis.

Devolution without a top-down reorganisation

Despite the less than ideal fiscal condition of the NHS at present, the consensus amongst health experts is that another top-down reorganisation will not solve its problems and that the large scale reforms introduced under the recent coalition government were both 'damaging and distracting'.[61] Although devolution is frequently argued to be more of a bottom-up reorganisation, it would still represent large scale change and introduce much uncertainty amongst all involved not least clinical staff and patients. Instead, following the example of Greater Manchester, high-achieving confident devolved administrations should lead the way, with competent and experienced managers from those administrations acting as advisors both to central government and to newly devolved local authorities. Nevertheless, it would be unwise to embark on a further programme of devolution until Greater Manchester has been given time enough to make an appraisal of its successes and failures possible, and decide whether or not its prospects of sustaining its initial successes seems likely. Given that this is the case, after a period of several years' observation, it might then be thought appropriate to devolve similar levels of autonomy to other interested and competent authorities throughout the country. Instead of throwing caution to the wind and restructuring our health system in one go, as has been the case in the past, devolution could help us gradually evolve into a newly structured health system in a cautious and controlled manner.

The aggregation of services

Finnish authorities have recently decided that, as attempting to provide every service at every hospital often proves inefficient, they will begin a process of merging services, even to the national level. Similarly, in the English context, it has

been suggested by Norman Warner and Jack O'Sullivan of the think tank Reform, that merging services, especially in the acute hospital sector to produce fewer centres of excellence, increases efficiency and produces better outcomes.[62] Finland's efforts to merge acute care facilities, while keeping primary care and health service management highly decentralised, even though local authorities must still finance this acute care, gives those authorities a powerful incentive to prevent acute illness from occurring. The Finnish combination of specialised central services with access to them largely financed by local administration could be the most important contributing factor in enabling Finland to provide high quality efficient healthcare.

In England the process of aggregating some services has already begun, for example stroke care services in London. Now, instead of 31 hospitals offering these services there are eight. The superior expertise and technical facilities available in these fewer centres is estimated to have saved over 400 lives in the two years since their establishment.[63] Such aggregated centres can more easily be fully staffed 24 hours a day and seven days a week, thereby ensuring that expensive equipment is available to the maximum amount of patients at all times. Similar increases in efficiency with comparable results have been observed in other aggregated specialisms.

Devolution might however mean that efforts to achieve aggregation might become subject to political considerations. It is possible that local authorities might, following devolution, be unwilling to relinquish some specialist services at local hospitals, especially if this was thought likely to affect their prospects of being re-elected. Such local opposition might thwart any central government initiatives in favour of aggregation, assuming that is, that local authorities, in devolution, are granted increased control of both primary and secondary healthcare services. It is nevertheless possible, that if English hospitals were to become largely financed, as in Finland, by local authorities, this might actually make administrators more amenable to service aggregation, as such a policy might be perceived as a politically astute tactical rearrangement, an initiative of the local administration in the interests of local people. Denmark has already succeeded in aggregating a large number of its services, however this is possibly easier in a small country such as Denmark with good transportation links between the population centres where aggregated specialist units are established.[64] Much Danish secondary care still

also takes place at the regional level, where nevertheless central government still has a reasonable level of influence.

Raising revenue

The devolution of healthcare services presents the possibility of raising healthcare revenue at the municipal level. The greater part of Finland's healthcare budget is raised from local taxation. Following possible English healthcare devolution, healthcare funding could be altered or augmented by a similar earmarked local tax raised proportionally to income. If citizens understand that their local taxes pay for health and social services in *their* area, they may be willing to support increased payments overall. The introduction of such earmarked local taxation would however, need to incorporate adjustment measures, such as exist in both Denmark and Finland, to equalise budgets in relation to demand between different localities. Such a measure is necessary as general population health can vary between different regions for a variety of factors known to influence demand for healthcare; these include the concentration of inhabitants, number of single parent families, rates of tenancy and unemployment, education levels, and numbers of immigrants and of elderly persons living alone. Of course, the tax base, and therefore the possible amount of revenue that might be raised, also differs between regions, thus an adjustment strategy can ensure that wealthy areas, where demand for health services is often lower can support poorer areas where healthcare demand may be higher. Finland employs such an adjustment strategy to top up the revenue of any local administration with less than 92 per cent of the national average, and reduces the budget of those authorities who have more than the average. Whatever local revenue raising strategy might be adopted in England after devolution, similar adjustment measures should protect the NHS's guiding principle of healthcare provided in response to 'need and not ability to pay'[65], and also avoid the need for the introduction of user charges, which on the evidence of Denmark and Finland, might prove problematic.

It should be noted that whichever of local administrations or central government provide the bulk of revenue supporting healthcare, that body is likely to have the greater influence over healthcare policy and provision arrangements. Central funding might therefore represent a constraint to local initiative for good or ill, and it seems evident that if local authorities collect the majority of healthcare revenue through local taxation, they will feel less obliged to conform to central government initiatives apart from those required by law. Similarly, whichever administrative

level provides the larger proportion of the funding for secondary and tertiary care services (whether aggregated or not) they will have the greatest influence on the management of those services. Funding issues might therefore easily have unforeseen effects on efficiency, for example if hospital and specialist care is funded by central government, local authorities may feel less obliged to reduce demand for such services than if they were required to finance this level of care themselves.

Merging health and social care

The possible combination of budgets for health and social care has become the focus of much recent healthcare policy debate. Opponents of the merging of these services emphasise the difficulty of combining means-tested social care provision with a free-at-the-point-of-use healthcare budget, claiming that the disparity between the two could lead to patients being means tested for services that had formerly been free for everybody. However, advocates of the combination of budgets hold the present separation of the two results in problems when transfers between health and social care need to take place. Restricted budgets for both health and social care leads to situations where neither wishes to take financial responsibility for patients unless clearly defined within their remit. Discharges from hospital can become delayed, putting pressure on acute hospital services and hampering the health and social care system as a whole. This can inhibit efforts to shift the NHS's emphasis from acute treatment towards prevention and disease management in the community. With a shared budget it would be in both specialisms' interest to transfer money from acute healthcare towards the social care sector in order to reduce hospital admissions. In September 2014, the Independent Commission on the Future of Health and Social Care in England concluded that it would be advisable to adopt a single ring-fenced budget for NHS and social care services, with a single commissioner responsible for its implementation at the local level.[66]

Denmark and Finland's social care budgets are administered locally. Both countries' services assess need before benefit is provided. Denmark has a means testing structure similar to that of England demonstrating that devolution in England need not necessarily force a change to the existing system, though change might be advisable for the reasons cited above. In fact, in England, integrating health and social care budgets has become one of the government's objectives. Their commitment is demonstrated by the Better Care Fund of £5.3 billion which

specifically aims to facilitate better integrated health and social care.[67] The fund is hoped to improve the management of hospital discharges into social care, enhance data collection and promote the planning of future strategy based on that data. However, the fund operates independently of any possible merging of health and social care budgets. As regards devolution, it is not clear whether or not local authorities would have the power to merge budgets on their own authority. Professor Chris Ham of the King's Fund claims that devolution in Manchester will not so much focus on health and social care integration but focus more on health and wellbeing in the population and particularly related to disease prevention.[68] Nevertheless, with the English population ageing and the consequent desirability of moving care away from acute sector care into the community, it would seem advisable to try even if initially at an experimental pilot level, to merge health and social care services and their budgets whenever possible. Devolution of healthcare in England would surely create an exciting opportunity for this to occur.

Public health

Care must be taken during the process of devolution that national public health initiatives such as screening and vaccination programmes are not disrupted. Such disruption is unlikely to pose a major problem. Local authorities could be mandated to facilitate whatever programmes central government has deemed necessary. It is generally held that carefully devised screening and vaccination programmes pay for themselves by preventing serious disease requiring expensive treatment at a later date. Consequently any dissent from local authorities against carrying out such programmes is not to be expected.

Data collection

A further danger of devolution might be the disruption of national data collection systems. It would be advisable to specify before the process of devolution began, exactly on what health performance indicators and statistics of disease incidence each local authority is required to collect data. To ensure equal performance of services across regions it will be necessary to compare data which is collected in exactly the same way in precisely the same categories. By so doing, any underperforming or overperforming localities will be easily identifiable. Localities in England must not be allowed to suffer the same data collection fragmentation as occurred between the countries of the United Kingdom. This fragmentation has, in recent years, led to difficulties in comparing healthcare performance between these countries as the indicators addressed by their statistics have become increasingly

individualistic. Accurate data to be used in comparison is always extremely useful; it is often the only means to identify dangerous underachievement.[69]

Caveats for devolution

Chris Ham, Chief Executive of the King's Fund, warns that one of the main risks of implementing devolution while the NHS is in its current precarious financial state is that it will distract attention from current efforts to close the funding gap facing the NHS.[70] By 2020/21 it is predicted that the NHS could be operating with an annual budget deficit of as much as £30 billion. Extraordinary efficiency savings will be necessary to avoid this regrettable situation.[71] As such draconian efficiency gains seem unrealistic compared to the NHS's current performance, critics of devolution fear a further diminution of efficiency. Nevertheless, Gwyn Bevan, professor of policy analysis at the London School of Economics and Political Science, holds that in reality we have had so many large recent reorganisations of the NHS that it is hard to assess the system's performance potential under whatever form of administration.[72] As a consequence, it is extremely hard to predict if implementing yet more change will be beneficial or damaging, especially as change runs the risk of introducing further complexity to the existing system. However, the scale of the current funding problem means that taking some risks might be justified. Another aspect of the complexity issue is that even inside the Greater Manchester locality each of the constituent ten local authorities might still want to regulate in favour of their immediate area to the detriment of the region as a whole.[73] Were such discrimination to occur, it might again result in an aforementioned postcode lottery: where better or different services are available in one area than in another.[74]

Conclusion

Will devolution work for England?

Overall, the case for effecting an improvement in healthcare quality and efficiency by administrative devolution in England seems compelling. As stated above, it is almost universally recognised that care needs to be increasingly based in the community with greater attention given to non-clinical factors. Local authorities have specific detailed knowledge of their communities and thus have the potential to work constructively with other key local stakeholders to improve general public health and manage chronic disease outside hospitals.

The NHS's current and continuing efficiency initiatives mean that resources must be allocated as effectively as possible. Between 1995 and 2008 central government funding for hospital and community health services increased by 4.3 per cent each year. However, during this same period productivity in terms of successful patient and client outcome actually fell by 2.4 per cent annually, though the demand for healthcare increased by only 2.8 per cent each year. These statistics suggest that the NHS in its current form tends to consume any increase in resources without a matching increase in productivity being observed,[75] and that the NHS's current structure may therefore be inherently inefficient, reducing the potential benefit from simply further increasing its budget. A study undertaken by the Nuffield Trust has revealed that in times of high healthcare demand, where increased fiscal input is not possible, crude productivity can actually increase.[76] Empowered local management, no longer subject to command-and-control directives from central government, may be able to achieve increases in crude productivity that are impossible in centralized systems. These local managers will be able to work in cooperation with local providers and patient groups and use their detailed knowledge of the population they serve to commission precisely the services that each locality requires. It is to be hoped that pilot devolution schemes, such as that of Greater Manchester will, in time, provide solid evidence as to whether local leadership can indeed improve the efficiency and cost-effectiveness that the NHS sorely needs. Any measurable improvement would obviously give impetus to further devolution. With particular regard to Finland, it is evident that decentralised healthcare does not simply operate as a luxury style of provision for countries with an abundance of fiscal resources, but is instead a viable way of

offering efficient, value for money healthcare at a less per capita cost than currently is the case in England.

How localised should England become?

If England were to devolve its healthcare, it would be necessary to decide to what extent. Existing models vary. Denmark has three distinct levels of administration whereas Finland more closely resembles two, with its additional hospital regions formed simply via collaboration between local authorities. Greater Manchester's devolution model most closely resembles that of Denmark, with Manchester's ten Borough and City Councils and 12 CCGs able to bridge the administrative gap between local provision and central government in the commissioning of services. It seems likely that the granting of independent budget control to large metropolitan districts like Greater Manchester will be the form English devolution takes, at least in its initial phase. However, in imitation of the Finnish model, it seems logical that in large rural areas numerous local authorities might, with devolution, combine to manage and commission many services.

Healthcare devolution in England could include change to its funding base. England could become like Finland and collect earmarked contributions at the local level, with local authorities combining to fund regional hospitals or, as is the case in Denmark, funds could continue to be granted by central government. This report supports the view that it would be preferable to have local authorities themselves financing acute care, thus incentivising them to focus on holistic, community measures to prevent hospital admissions.

As detailed above, revenue collection and distribution mechanisms can greatly affect the viability of health services and also the balance of influence between central and local government regarding policy. Local revenue sourcing may also give local citizens more influence regarding healthcare issues, as their voting in local elections might theoretically affect healthcare as much or more than voting in national ones.

It seems safe to say that devolution works in both Denmark and Finland. Although both countries have experienced some degree of recentralisation, in essence their health systems are likely to remain relatively devolved for the foreseeable future. Although there is generally better health system performance in the two Nordic countries (see appendix), especially in Denmark, than in England, large variation between many aspects of the three countries' systems makes it almost impossible

to conclude whether this can be attributed to the effects of devolution or if it is due to other factors. The Health Consumer Powerhouse's index rated both Finland and Denmark as being better than England in its comprehensive evaluation of each country's healthcare system. Their report, however, attributes high importance to non-clinical markers such as a 'culture of openness' and 'responsibility, trust and accountability' and that 'empowered patients and consumers themselves can do great things'. The Consumer Powerhouse further highlights its identification of a surprisingly small correlation between financial resource and high quality care. Essentially, they hold that non-clinical criteria matter as much as more technical material factors when assessing the quality of healthcare.[77] The fact that these devolved Nordic systems tend to score better than England's could therefore lead to the conclusion that devolution provides a means to achieve more 'patient-centred' and therefore possibly superior healthcare.

Promoting healthy lifestyle

Any scheme for devolution must incorporate public health measures. Local authorities are extremely well placed to take a holistic view of healthcare similar to that proposed by the Alma Ata Declaration of 1974.[78] This declaration urged nations to regard healthcare in terms of 'a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity'[79] as had been the objective stated previously by the World Health Organisation. Promoting such well-being must, the declaration says, improve general population health by ameliorating harmful environmental and social factors. Such factors must assume more importance in the minds of healthcare policy-makers and the public alike when defining what constitutes good healthcare. The aim of both national and local healthcare strategy must therefore become the prevention of illness or its management in the community before crisis points requiring acute care are reached. This can best be achieved by encouraging healthy lifestyles and managing chronic conditions locally in an effective way. Limited resources and common sense increasingly suggest that lifestyle and condition management might prove more effective in maintaining good health in a population than reliance on shiny new hospitals brimming with state of the art technology. In the English context, Greater Manchester's proposed emphasis on general public health might, if successful, provide a model that other devolved authorities might and indeed should follow.

Population size

It must be remembered that although much can be learned from the consideration of healthcare in Denmark and Finland, with, according to the previously cited studies, both countries equalling if not surpassing the quality and efficiency of healthcare in England; the disparity between organising and providing care for England's 53 million citizens as compared to Denmark and Finland's five million, must make any firm conclusions as to the certain benefits of devolution beyond the scope of one single report.

What needs to be done to devolve healthcare?

No immediate action needs to be taken. The consensus amongst healthcare stakeholders is that another sudden and radical top down reorganisation of the NHS will do far more harm than good. For this reason, it is probably advisable to scrutinise the progress and effects of devolution in Greater Manchester which is functioning as a pilot study. If good results are achieved there in terms of healthcare quality, overall efficiency and especially in terms of local patient satisfaction, then this report recommends that other large metropolitan areas should be allowed to follow Manchester's lead. Subsequently, if further success is observed, it may indicate the advisability of extending devolution to more remote, rural districts.

Where next?

This report has painted a picture of devolution that is introduced into large metropolitan regions first. At the top will remain central government, in the middle these large metropolitan districts would work with CCGs and large providers while at the bottom level, local councils would provide tailored services to their areas. In rural areas however, achieving devolution could be more problematic. Here, local authorities would have to work in partnerships over much larger geographical areas, sharing expertise to achieve effective service provision, and thus would lack any obvious coherent unifying identity such as is enjoyed in metropolitan entities such as Greater Manchester.

As discussed earlier, as part of the devolution process, it is essential that a definitive directive of required services that each devolved locality must provide is produced. This directive should be strictly adhered to if healthcare is to remain equitable in terms of quality and access across England. As this report has discussed, it is likely that some districts will have greater demand for certain

specific services than others. For example, an area whose population includes more elderly citizens will obviously require more geriatric-orientated services, and thus, as in the Finnish model, arrangements between neighbouring districts must be established to transfer patients between those regional facilities most suitable for the treatment of particular individuals, while at the same time ensuring that the distances involved are not too great. It would also be advisable to direct local authorities to combine whenever possible in the procurement of medical products to achieve economies of scale.

For reasons of financial and clinical efficiency, Finland has recentralised some of its acute care while keeping primary care and health service management in the community. However, Finnish more centralised acute care is still largely joint-financed by the devolved localities. This report supports this Finnish initiative, in that if local authorities have to finance acute care, this responsibility will give them a powerful motivation to prevent health crises requiring hospital admission by focusing on preventative and community health measures which they also commission. This report suggests that the Finnish devolved healthcare model could be adapted for introduction in England. Its success suggests that similar organization has the potential to help the NHS become more efficient and sustainable, thereby ensuring its survival and adaption to a rapidly changing society.

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