

Institute for Public Policy Research



DEVO-THEN, DEVO-NOW

WHAT CAN THE HISTORY OF THE NHS TELL
US ABOUT LOCALISM AND DEVOLUTION IN
HEALTH AND CARE?

**Edited by Harry Quilter-Pinner
and Professor Martin Gorsky**

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DEVO-THEN, DEVO-NOW

THE ROLE OF HISTORY AND HISTORIANS IN POLICY MAKING.

Professor Martin Gorsky and Harry Quilter-Pinner

Over the past few decades a recurrent theme in public policy discourse has been the desire to decentralise economic, public service and democratic power within the UK, and more recently within England. The latest incarnation of this movement has been the Northern Powerhouse agenda, launched by former Chancellor of Exchequer George Osborne in 2014, which promised to pass substantial powers down to newly created combined authorities and metro mayors (Osborne, 2014).

First in line for a devolution deal was Greater Manchester, gaining new powers over transport, housing, planning, policing, skills and employment support (HMT 2014). However, the most radical element of the regions deal was the inclusion of its £6 billion health and care budget (AGMA 2014). Up to this point it was widely believed that the NHS, as ‘the nearest thing the English have to a religion’, remained out of bounds.

This decision – made in the context of the government’s reforms plan, the Five Year Forward View (NHS, 2014), which prioritises the integration of services within and between health and care – was motivated in part by the view that making local leaders accountable, and empowering them to get on, would catalyse change. Other commentators have also suggested that decentralisation may lead to better local decision-making and engagement with the public, potentially winning support for difficult decisions (McKenna and Dunn 2015).

The decentralisation agenda within health and care, however, goes beyond Greater Manchester. A similar theory of change to that set out above – as well as an offer of more local autonomy – has underpinned the government’s wider health reform agenda, and, in particular, the much maligned Sustainability and Transformation Plans (STPs) (Quilter-Pinner and Antink 2017b), which are local health and care reform plans covering the whole country, designed to drive improvements in the efficiency and quality of care by 2021.

These initiatives – and in particular the devo-health ‘experiment’ in Greater Manchester – throw up a range of questions for policy makers and the public. How much power should be passed down to the local level within health and care? Who should it be passed down to? What should local leaders do with these new freedoms? Will this process lead to the democratisation of health and care decisions and speed up reform? Or, will it hinder the ability to deliver an efficient and effective health and care system?

“questions of how to reconcile the goals of a national service – fairness, efficient use of resources – with the benefits of devolved powers – democratic control, community integration – are not new”

Over the last year or so, IPPR has been looking to answer these questions from a contemporary perspective (Quilter-Pinner 2016, Quilter-Pinner and Antink 2017a, Quilter-Pinner and Antink 2017b). However, we also recognise

that historians of the British health system will likely feel a sense of déjà vu as they look at these developments. For questions of how to reconcile the goals of a national service (fairness, efficient use of resources) with the benefits of devolved powers (democratic control, community integration) are not new.

Indeed, they go right back to the creation of NHS in 1948. Prior to this momentous step in British political and social history, Britain could claim to have a localised system par excellence. Municipal authorities presided over networks of preventive and curative services and independent voluntary hospitals were strongly rooted. What has followed has been a long march away from this, empowering the central state, and creating new administrative bodies distinct from local government.

Let's take the 'money trail' as an example. Today, about 8 per cent of government income is supplied by local taxation, and only a minority of local spending (22 per cent) is self-financed (Pope and Waters 2015), but this stands in stark contrast the pre-1948 system. Originally, 73 per cent of social services spending – health, education housing and welfare benefits – was local in 1900, falling to 23 per cent in 1950, mainly as a result of the creation of the NHS and the replacement of the Poor Law by social security entitlements (Peacock and Wiseman 1961).

Meanwhile, the corollary of changing financial flows has been administrative centralisation. Direct state involvement in health began in 1911 when national health insurance for workers was introduced, but only in 1948 did the pluralist, localist health system disappear. Now most hospitals were brought within NHS control, under new boards run by appointees, and GPs, who were still independent, became centrally regulated. This left much-diminished local authorities' health work sidelined, with just social care and preventive duties, the latter to be (temporarily, as it transpired in 2012) taken away from them in the 1974 re-organisation.

Why did this change happen? The causes are, of course, too many and complex to address in any depth here, but at the highest level we can identify both societal and political drivers. An early suggestion, put forward by the welfare economists Peacock and Wiseman, attributed it to a change in 'social ideas', whereby the notion of welfare as dispensation of relief – a discretionary handout – was superseded by a positive notion of public benefits, delivered to a common standard: a right of citizenship (ibid).

“the notion of welfare as dispensation of relief – a discretionary handout – was superseded by a positive notion of public benefits, delivered to a common standard – a right of citizenship”

At a general level, this makes sense. The patchiness of local government resources meant some areas were 'too poor... too small... helpless', while others still relied on 'monstrous' Poor Law workhouses. Likewise, the 'caprice of charity' had situated the voluntary hospitals according to the whims of the 'well-to-do', not people's needs (Bevan 1946). Instead, the NHS would 'universalise the best', relying on redistributive direct taxation and national insurance, rather than local rates, philanthropy and voluntary insurance (ibid).

Meanwhile, others emphasise the battle of ideas and the competing interests within society when the NHS was conceived and created. After all, the marginalisation of local government was not inevitable in 1943–6 when the NHS was being planned. There were many, including civil servants, who argued that a local government-based NHS would be optimal. But objections came in particular from the British Medical Association, who feared doctors would become salaried employees bossed by bureaucrats. The sacrifice of the local

government interest was the price Bevan paid to reconcile this powerful faction.

“while we must recognise that human events never perfectly repeat themselves – there are no incontrovertible ‘lessons’ of history that we can all agree on – it is clear that an understanding of what has gone before can help inform the decisions policy makers shape what comes next”

In many respects, it was this process that resulted in the enduring tensions within the health system that continue to inform calls to revive localism today. As a result, understanding the history of health and care is an invaluable tool for policy makers today. In particular, while we must recognise that human events never perfectly repeat themselves – there are no incontrovertible ‘lessons’ of history that we can all agree on – it is clear that an understanding of what has gone before can help inform the decisions policy makers shape what comes next.

Firstly, history can help us to understand why and how we have got to where we are now. This is crucial because there is often an implicit assumption that our existing system has been designed by logic and evidence alone, and therefore has some specific ‘right to endure’. However, even a quick glance at the events of the last century shows us that health policy has always been a struggle between the ideas and interests of a diverse array of actors; from the state, both central and local, to the mainstream medical profession and the electorate. Separating out what, within our existing health and care system, is a quirk of history and what is a well-conceived driver of progress can help determine *where* reform is needed.

Secondly, history can also help us determine *what* reform may be needed. It can help us assess whether past solutions, similar to those discussed in the present, attained the desired outcomes, and if not, why they did not. There is a danger in health and care – indeed, across all areas of policy – that politicians attempt to ‘re-invent the wheel’, vaunting iterations of previous policies as the solution to today problems. History can help test these claims. Given the regularity with which reorganisations have been imposed on the NHS – ‘continuous revolution’ in the words of its official historian – we should attend carefully to institutional memory before advocating yet more.

It is therefore our hope that this set of essays, authored by leading historians of both the health and care system and the decentralisation of public services, will help shed light on some of these debates, feeding into the ongoing discussions at national and local level about the role of localism and centralisation within health and care. We hope you find them both interesting and informative.

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THE BIRTH OF THE NHS

WHY WASN'T IT LOCAL GOVERNMENT?

Professor John Stewart

Just over 70 years ago, as the allies drove Nazi forces back across Europe, leading thinkers in Britain turned their attention to the prospect of peace and reconstruction. Out of these discussions emerged a broad political consensus that some form of national health service – alongside wider reform of social security – was needed.

What was not obvious at that point was that, when the post-war Labour government passed its three National Health Service Acts (for England and Wales, Scotland, and Northern Ireland), the services would be centrally administered.

Indeed, many had assumed that the control and administration of any new service would remain largely in local authority hands. This had been the gist of the wartime coalition government's 1944 white paper *A National Health Service*, although in truth this was a rather confusing document, and open to interpretation (MoH 1944).

Nonetheless, the two main political parties were, in principle, committed to some form of local control. The Conservatives anticipated a service in which voluntary hospitals would, as their 1945 general election manifesto put it, work 'in friendly partnership with local authority hospitals'!

Meanwhile, the Labour Party – which, due to its landslide election victory in 1945, became the key player in the creation of the NHS – was also largely in favour of a localised service. Such was the influence of the local government faction of the party that this approach formed the basis of the party's health policy until 1945.

So, how did this come about and why was it ultimately a road not taken?

Here, the story of the NHS becomes the story of the Labour Party. After its general election defeat in 1931, the party was in a weak position for the rest of the decade, at least nationally. However, in 1934 it had a major success when it gained control of the London County Council (LCC).

“Here, the story of the NHS becomes the story of the Labour Party”

Under the previous administration of the Municipal Reform Party (effectively, the Conservatives) advantage had already been taken of the 1929 Local Government Act. This allowed – although crucially it did not compel – local authorities to 'appropriate' poor law hospitals and so bring them under local authority control.

One intention here was to remove the stigma associated with the poor law and, as far as the Labour LCC was concerned, to make health care a matter of London citizenship and so not associated with pauperism or charity. As Herbert

1 Historic party manifestos can be found online at, for example, <http://politicsresources.net/>

Morrison, London's Labour leader, put it, his aim was for the 'Hospitals and Medical Services of the county... [to be] improved and expanded, so as to give to our citizens a splendid civic service' (Morrison 1934).

Under Labour LCC, municipal health care was actively promoted with claims that it was, for instance, the largest single provider of hospital beds in the world. A later history of the LCC was therefore to claim that, by 1939, London probably had 'the finest municipal hospital service in the world' (Jackson 1965).

So influential in Labour policy making circles, the London health care 'model' was widely considered a blueprint for the nation as a whole. Such a system, it was argued, would have a range of benefits, including democratic control at a local level. However, the municipal model was not adopted for the NHS. Why?

For one thing, the most powerful doctors' organisation, the British Medical Association (BMA), was hostile to local authority control, or, if it came to that, any form of direct democratic governance. Famously, right up to the eleventh hour the BMA was opposed to socialised medicine and presented Labour ministers with a challenging series of negotiations.

More positively, the wartime Emergency Medical Service had provided an alternative, centralised model, and one which appeared to have been relatively successful. This struck a chord with those in the Labour movement who were less enamoured of the LCC model. The Trades Union Congress, for example, told the Beveridge Committee that the development of municipal hospitals was 'in the hands of local people with varying ideas of what is required, both in services and staffing' (Beveridge 1942).

Two related, and conflicting, issues were being raised here: the perceived need for uniform services across the country and the actual diversity of local authority approaches. And although only implicit in this passage, many were sceptical about the quality of local government personnel.

Such criticisms had already been raised by Dr Stephen Taylor, an increasingly influential figure in Labour's health policy-making. In 1939, Taylor had pointed out an irony of contemporary hospital provision: that the 'municipal needs of the poor areas are greater than those of the rich, so that rates (ie local taxation) fall heaviest on those least able to bear them' (Taylor 1939).

While affluent areas (of which London was one in the 1930s) could provide a good service, less advantaged areas could not. Such anomalies illustrated the need for 'hospital finance on a national basis' (ibid). In his autobiography, Taylor attributed his hostility to the local authority model to negative experiences working in an LCC hospital, and his encounters there with bad administrators and incompetent or even corrupt councillors (Taylor 1988).

But of course the most important Labour figure was the minister of health in the post-war government, Aneurin Bevan. Bevan was prepared to abandon aspects of party health policy, including local authority control, and to take his battle to Cabinet. Here he defeated advocates of the LCC model, most notably Morrison.

“Bevan understood that the local authority model could not provide what he saw as fundamental to socialised medicine, equal access and treatment irrespective of where one lived and irrespective of arbitrary historical boundaries”

Bevan's approach mixed pragmatism and ideology. He knew that he faced a difficult struggle with the BMA, who were noted firm opponents of local

authority control. Perhaps more importantly, Bevan understood that the local authority model could not provide what he saw as fundamental to socialised medicine: equal access and treatment irrespective of where one lived and irrespective of arbitrary historical boundaries.

Similarly, he believed in the primacy of parliament over local government. Ultimately, Bevan prioritised delivering a universal and comprehensive health service financed by general taxation, and was much less concerned about direct popular involvement in the administration and control of that service. Here, then, were the origins of the 'command and control' components of the NHS, much criticised in the 1990s in particular.

This rejection of the local authority model is not simply of historical interest. In the present era of actual or potentially devolved health care, whether to the United Kingdom's constituent nations or to various levels of local government, it highlights issues which are both pertinent and difficult to resolve.

So, for instance, how can equal provision and access be guaranteed nationally if governing authorities are to be allowed local discretion? Should health care be subject to direct democratic control or left in the hands of administrators? And, in the last resort, how is any service to be funded? Apparently resolved in the late 1940s, such challenging questions have, in fact, proved to have a long shelf-life.

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WHAT IS THE ‘N’ IN THE NHS?

Professor Roberta Bivins and Dr Jennifer Crane

Since 1948, the entire population of the United Kingdom has benefitted from universal and (mostly) comprehensive healthcare, free at the point of delivery. Conventionally, we refer to the provider of these benefits as the ‘National Health Service’. This name, used in Labour Party propaganda and political speeches since the 1930s, was chosen by its founders in part to reflect the changes in medical provision that the new system was intended to ensure.

Prior to this, services were fragmented, variable and often unequal – and they were reliant on a patchwork of charitable, philanthropic and governmental funding. In contrast, the new NHS was to be ‘an all-embracing comprehensive scheme to bring all that modern medicine can bring on the preventive and curative side within the reach of everyone’ (Griffiths 1942). With these words, Welsh MP James Griffiths described his vision of a national health service to Parliament in 1942, as the UK experimented with national medicine in response to the duress of World War Two.

“The NHS was to be more than just a service, however: a united system of healthcare – ‘a big comprehensive system’ – was explicitly intended to support Britain as a ‘united nation’ in the face of an existential threat”

The NHS was to be more than just a service, however: a united system of healthcare – ‘a big comprehensive system’ – was explicitly intended to support Britain as a ‘united nation’ in the face of an existential threat (Beveridge 1942). William Beveridge’s famous 1943 report, too, spoke of a national health service as a feature of his plan to ensure ‘social security’ for all (though he envisioned it rather differently). Either way, this vision of a universal comprehensive service was set out in the government’s white paper and the 1946 National Health Service Bill.

In reality, however, there has never been one single national health service in the United Kingdom. Even the primary legislation that established the health services between 1946 and 1948 distinguished Scotland and Northern Ireland from England and Wales, and in the succeeding seventy years, the medical and health services provided for and in the four home nations have diverged significantly, catalysed further by devolution in 1998.

Yet medical and health professionals, the media and the public still consistently speak of a singular ‘NHS’. This is not because commentators are unaware of the differences between the English NHS, NHS Wales/GIG Cymru, NHS Scotland, and the HSC in Northern Ireland, but because for most people there is one fundamental feature that all four health services share: they are intended to provide equal and universal access to health and to the care needed to maintain or restore it.

This idea of Britain’s health services as, in language of the day, ‘equalitarian’ – as a force for ensuring equality regardless of economic ability or geographic

location – have, since 1948, been at heart of not just of popular visions of the NHS, but of British national identity.

As that identity has waxed and waned in strength, so interpretations of diversity and difference in local and regional provision of NHS services have changed, at least in the eyes of politicians and policy makers. Indeed, the devolved nations – and more recently proponents of regional health devolution – have demanded the freedom to set local priorities, to fund (or, though rarely explicitly, de-fund) specific treatments, and to restructure provision based on knowledge gained closer to the communities served.

However, even prior to devolution to Scotland, Wales and Northern Ireland in 1998, and Greater Manchester in 2015, medical provision in the NHS has been sensitive to local and regional differences, not least because of the enduring role of local authorities in meditating or providing public health and what are now termed ‘social care’ services.

So what is in fact ‘national’ about the NHS?

It is perhaps easiest to identify deeply rooted expectations and understandings of the British health services as national and basically homogenous by looking at public reactions to regional variation, or – as they are most frequently described and reported in the media – to ‘post code lotteries’.

“From its inception in 1948, universal and comprehensive health provision in the UK was an aspiration rather than a reality”

From its inception in 1948, universal and comprehensive health provision in the UK was an aspiration rather than a reality. The founders of the health services were acutely aware that medical resources were unevenly spread across the country: large regions of the country were desperately ‘under-doctored’; specialist and teaching hospitals were heavily concentrated in urban areas and especially London; and general hospitals, while more evenly dispersed, were certainly unequal in terms of facilities and equipment.

In the first three decades of the NHS, the central health authorities – the Ministry of Health and its successors – and interested parties across the UK struggled mightily to redress these points, both formally through the Resource Allocation Working Party, and informally through a range of direct action health activist groups, regional lobbies, and professional pressure groups.

Thus, by the 30th anniversary of the NHS, stark inequalities in access to basic services had largely disappeared, though the same could not be said for specialist care, where ‘scandalous’ differences in waiting times for investigation and treatment still existed between the South East and the rest of the country. Here, hostile references to a ‘lottery’ in access to medical care, though rare, first appear in political rhetoric and daily life.²

Indeed, it was a point of near-consensus in UK politics that the remaining differences were unacceptable, and required amelioration – usually in the form of centralisation (Kilroy-Silk 1978) – rather than acceptance even in a period of budget-cutting. Variation was ‘discrimination’, and challenged the very idea of a ‘truly national health service’ – instead of ‘a series of regional health services in which there are huge discrepancies and enormous anomalies as between areas in the type and quality of service.’

² Intriguingly, it appears to describe regional variations in access to education and legal aid during exactly the same period.

With the 1980s, however, different forces came into play: the internal market, GP fundholding and devolution all played a role in shifting professional and political attitudes towards diversity in provision within the broad context of a universal health service. What these changes did not shift were public attitudes towards ‘inequality’ in access to health services.

By the 1990s, both parliamentary debates and the national press began to record significant public unease with exactly the local and regional variations that inevitably emerge from the turn towards local decision-making. The ‘post code lottery’ in healthcare became a familiar and well-recognised issue. As a result of this, campaigners started to mobilise on a national level, in defence of the whole NHS, rather than through small and fragmented local groups.

Intriguingly too, local intolerance of difference extended far beyond the sphere of life-threatening variability in access to expensive cancer drugs or cutting edge surgical treatments. Patients were, it seems, equally unwilling to accept differences in access to infertility treatment, specialist allergy advice, experimental flu drugs, non-emergency prostate operations, and mental health care. But these were exactly the areas – non-life threatening, affecting relatively small populations, and providing few directly quantifiable improvements in health outcomes – in which local diversity had been seen by experts as most acceptable.

“Whenever a national politician talks about local diversity, choice and decentralisation, it is usually humbug. Often the same politician will simultaneously deplore the ‘postcode lottery’ of the services. The contradiction does not occur to them”

Peter Riddell, 2000

As then-political commentator Peter Riddell complained in the *Times* in 2000: ‘Whenever a national politician talks about local diversity, choice and decentralisation, it is usually humbug. Often the same politician will simultaneously deplore the ‘postcode lottery’ of the services. The contradiction does not occur to them... As important is the belief in national equity and universal access to services.’ Moreover, Riddell argued, protests against what he called ‘postcode rationing’ were entirely understandable given that the NHS was funded through national taxes, and local authorities thus had ‘no real political or democratic legitimacy.’ The only ‘equitable’ solution was ‘the man in Whitehall’ (Ridell 2000).

What we have seen since the 2000s, especially as UK residents and citizens look across the borders between England and the devolved nations, is that even when local decision-makers have electoral mandates and direct and indirect fundraising powers, their constituents are no more tolerant of local variations that mean their neighbours can access services unavailable to themselves.

The emotional politics of NHS reform are important: indeed, Ed Smith, chairman of NHS Improvement, has argued that while implementing STPs locally, we must ask people, ‘how do you feel about the NHS?’, and see local populations themselves as STPs, or ‘Sensing Thinking People’ (Smith, 2017).

As we look towards greater health devolution, it is not at all clear that the central tension between the provision of locally responsive health services and of nationally equal ones has been resolved, or is even capable of resolution in a democracy where voters may support the localism of ‘more and closer’ in relation to healthcare, but show no signs at all of accepting that local decisions to provide one set of services, treatments or facilities may mean limitations to another.

What is national about the NHS – the egalitarian meaning with which we have imbued the health service since 1948, and on the basis of which it remains the most loved of UK institutions – may also prove to be the greatest cultural challenge to its successful devolution.

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RHETORIC AND REALITY

A BRUTALLY BRIEF HISTORY OF THE CENTRE-PERIPHERY RELATIONSHIP

Professor Rudolf Klein

The history of the National Health Service (England) reveals a curious paradox. Over the decades, successive Secretaries of State for Health have embraced the rhetoric of localism: in white paper after white paper the theme, with variations, has been power to the periphery. However, the same decades have seen an ever more assertive centre: an exhort and hope style of governance has been transformed, step by step, into a command and control system.

“in white paper after white paper the theme, with variations, has been power to the periphery. However, the same decades have seen an ever more assertive centre”

Rhetoric and reality have long since parted company. Why? In what follows, I argue that centralisation is built into the design of the NHS – the original sin of the founding fathers – and that what has really changed over the decades is that ineffective central control has been transformed by technology into effective, but arguably oppressive, control.

First, some illustrative, relatively recent examples of the rhetoric. Take the 1989 Conservative white paper, ‘Working for Patients’, introducing the NHS’s internal market (Roberts 1989). At the top of its proposed key changes was ‘to make the Health Service more responsive to the needs of patients, as much power as possible will be delegated to the local level’.

Next came Labour’s 1997 white paper, ‘The New NHS’ (Department of Health 1997), which largely repudiated the internal market but kept the language of localism. The delivery of health care against national standards was to be a local responsibility: ‘Local doctors and nurses who are in the best position to know what patients need will be in the driving seat’.

And in 2002, when market notions were in the ascendancy again, strengthening devolution was one of the main themes of ‘Delivering the NHS Plan’ (ibid 2002). ‘For fifty years the NHS has been subject to day to day running from Whitehall. A million strong service cannot be run in this way’, it declared. In future, ‘the real power and resources will move to the NHS frontline’.

But did power move to the frontline?

Not according to the 2010 white paper, ‘Equity and Excellence: Liberating the NHS’ (ibid 2010) whose subtitle suggested that the NHS was still in chains. ‘The headquarters of the NHS will not be in the Department of Health’, the white paper pronounced, ‘but instead power will be given to the front line clinicians and patients.... The government will liberate the NHS from excessive bureaucratic and political control’.

In the event, the liberation has been postponed. To take just one example: in November 2015, a mandatory ceiling on the employment of agency staff by

NHS providers was introduced, with specific year-by-year targets for reducing spending and a requirement to submit monthly returns reporting progress. To explain this gravitational pull of the centre, we must return to two crucial foundation principles of the NHS.

The first was that the NHS was to be tax financed. From this flowed Bevan's notorious, much quoted 'bedpan' doctrine: ministerial accountability to parliament meant, in turn, ministerial concern for how the NHS's budget was spent by those delivering the service. From the start, therefore, there could be little doubt that those running the NHS were the minister's 'agents', ultimately responsible to him or her alone.

The second principle was that of equity, both social and geographical: 'We shall promise every citizen in this country the same standard of service' (in Bevan's words). In other words, central government was committed not only to ensuring an equitable distribution of resources and defining standards, but also to overseeing their implementation.

The full implications of this were, however, slow to emerge. Initially, the Ministry of Health lacked the capacity to inform itself about – let alone control – what was happening at the coal face of the NHS. Bedpans might have been dropping all over the place without ministers knowing about it.

“Bedpans might have been dropping all over the place without Ministers knowing about it”

This was certainly the view of the Treasury in the 1950s, which complained about the ministry's 'lack of knowledge' and 'lack of people of adequate quality'. Similar criticisms were made by the Guillebaud Committee, which pointed to the Ministry's failure to develop measures of efficiency and the absence of statisticians from its staff.

The ministry's weakness in turn strengthened the role of Regional Hospital Boards, who saw themselves as representing the community and were closer to the action. 'Health service freedom lies in the fact that the centre is weak and the Regional Hospital Boards are strong', Richard Crossman concluded from his experience as Secretary of State at the turn of the 1960s (Edwards 1992). This judgement reflected the balance of knowledge in the NHS. To the extent that knowledge was defined to be experiential, judgemental and professional – too complex to be caught in crude statistics – so, inevitably, power leaned towards the periphery.

As departmental expertise improved in the 1970s, the balance began to change. Programme budgeting arrived. The department began to take an active role in defining priorities, with the aim of redistributing resources both geographically and between different services, and with a strong emphasis on moving care into the community.

There were two new forces at work from the 1980s onwards which were to transform the relationship between the department and the periphery in the coming decades. Neither were specific to the NHS, and both affected the centre-periphery relationship across other services.

The first was a change in the technology of government: 'new public management' (Exworthy 2015) introduced 'measurement culture': the specification of clear targets and the recording of progress towards their achievement, often with sanctions in case of failure. The second change – which made the first possible – was the introduction of IT, which by the end of the century had transformed the speed and scope of the information available to central government.

No longer was the Department of Health ‘flying blind’ as Sir Roy Griffiths put it in the mid-1980s, because data was so slow in being produced and analysed that it was largely irrelevant by the time it arrived on the ministerial desk. No longer did it have to rely on the regions to provide it with expenditure projections. For the first time in the NHS’s history, there was the managerial and analytic capacity to centralise effectively.

This led to a number of changes. Regional and other intermediary authorities were scrapped. Indicators and targets proliferated. Real time data prompted real time action: the ministerial telephone call of rebuke. While the Department of Health itself was hollowed out, new regulatory and inspection agencies proved powerful instruments of centralisation. The reality had changed while rhetoric continued to pay tribute to the long-lost world of localism.

The new devolution project – ‘Devo-Manc’ and, to a lesser extent, STPs – changes the terms of the historic centre-periphery debate in some respects. It involves new actors: local government. Its rationale is to challenge the existing distribution of resources and not just within the NHS. The traditional rhetoric of successive white papers, promising power to coal face professionals, now seems quaintly irrelevant.

Does this mean that the history of the centre-periphery relationship has also become irrelevant?

“While it remains the ambition that every citizen should have the same standard of service – an ambition still to be fulfilled – the scope for devolution will remain constrained”

On the contrary, I would suggest, it is crucial – in that it illustrates the likely limits of the devolution project. The forces that have driven centralisation – accountability for public funds and equity – have not changed. Neither has the capacity of the centre to define expectations and monitor performance at the periphery. While it remains the ambition that every citizen should have the same standard of service – an ambition still to be fulfilled – the scope for devolution will remain constrained.

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- For an extended discussion of the historic evidence, giving the sources, see Rudolf Klein 'The eternal; triangle: 60 years of the centre-periphery relationship in the National Health Service', *Social Policy & Administration*, Vol.14, No.3.
- For a contemporary analysis of devo-health today, see Harry Quilter-Pinner and Becca Antink *Devo-Health: Where next ?* IPPR 2017: <https://www.ippr.org/publications/devo-health-where-next>.

HOPE OVER EXPERIENCE

STILL TRYING TO BRIDGE THE DIVIDE IN HEALTH AND SOCIAL CARE

Professor Gerald Wistow

Few would argue that local government and the NHS are currently working well together. The current focus for division is finance and planning, and, in particular, the Better Care Fund (BCF) and the Sustainability and Transformation Plan (STP) initiatives. This situation is ironic, as the BCF was specifically designed to promote greater integration between the NHS and local government. STPs were also expected cover better integration with local authority services, including, but not limited to, prevention and social care.

Let's take a recent example: the allocation of a further £2 billion to adult social care (ASC) over three years in the 2017 Spring Budget. At first glance, this was in fact a victory for the relationship between local government and the NHS. After all, Simon Stevens, chief executive of NHS England, had actively called, before the budget, for any additional funding to go into local government – often seen as the junior partner in the health and care system – rather than into his own organisation.

However, in practice, the extra investment in local government seems to have aggravated relationships between the two sectors. For example, the *Health Service Journal* reported that a 'very senior NHS source' had told it that hospitals needed to be 'quite lippy' about ASC using the funds to reduce delayed transfers of care (DTOCs) (Lintern 2017). In response, the Local Government Association (LGA) argued for more flexibility over spending, emphasising that the role of social care was greater than that of 'easing the pressure on the NHS'.

In the event, the national guidance (NHS, DCLG and DoH 2017) said councils must help meet an NHS target of freeing up 2–3,000 hospital beds by reducing DTOCs. It also suggested removing funding from poorly performing councils. This resulted in the LGA withdrawing its support for the guidance (Bunn 2017), with leading local government figures accusing the NHS of being an 'inefficient' 'dinosaur' which 'resented' the allocation of funds to councils and wished 'to control how it is spent'.

“austerity is creating an ‘integration paradox’ – an environment in which the need for joint approaches is more necessary to sustain services but is simultaneously more difficult”

This kind of public exchange at the highest level of the NHS and local government is not uncommon. It appears consistent with the view that austerity is creating an 'integration paradox' – an environment in which the need for joint approaches is more necessary to sustain services, but is simultaneously more difficult, as budget constraints encourage agencies to place tighter boundaries around roles and responsibilities (Erens et al 2016).

Such tensions, however, are far from new. Austerity may be an immediate source of difference and dispute, but the underlying causes of the current shortcomings

of integration are much deeper and historically located. Indeed, the present day divisions have their roots way back in the Attlee government's decision to back Bevan's plan for nationalising hospitals over Herbert Morrison's proposal for a comprehensive local government service.

Since then, bridging the divide has been a persistent theme of local government and NHS politics and reform. The history of the term 'DTC' provides an instructive example of just how deep-rooted these tensions can be. Adopted only recently as a supposedly less pejorative description for 'bed blocking', 'the latter had been in use since the early fifties when such patients were also referred to (even more pejoratively) as 'frail ambulant' and 'disposal problems' (Gorsky and Mohan 2001).

Even then, such difficulties were laid at the feet of the now familiar combination of increasing numbers of older people seeking hospital care and the failure of local authorities to make sufficient provision outside hospital. Yet councils saw little reason to develop services to reduce demand on hospital services that had been removed from local government in 1948 (Parker 1965). Nonetheless, from 1957 the NHS went ahead with implementing a national target that implied reductions in bed numbers for older people but with 'little concern' for doing so 'in line with the development of... new... rehabilitation and home care services (Bridgen 2001).

The link between hospital bed numbers and the development of community services became explicit with the publication of the first national hospital plan of 1962, which was combined with a call for councils to align their plans with those for local hospitals (Sumner and Smith 1969). However, the findings of an independent evaluation of those local authority plans have a very contemporary feel, as the following examples demonstrate.

- 'The local authority associations... warned that if they were not able to meet the extra expenditure needed to expand their services, the minister's hospital plan would be imperilled.'
- 'The development of each service was usually considered in isolation, and it could not be said that there was an overall plan for the development of services for (older people) in any of the authorities studied' (ibid).

As the above account demonstrates, there are apparently strong parallels between the NHS and local authority relationships in the 1950s and 1960s and the situation today. Such parallels are the more striking when it is recalled that formal integration mechanisms were embryonic at best in the former period. Since the 1974 re-organisation, there has been a long procession of initiatives (Wistow 2012) to promote integrated working through statutory requirements, financial incentives, formal planning arrangements and service delivery based on multidisciplinary teamwork.

“Since the 1974 re-organisation there has been a long procession of initiatives to promote integrated working... Yet these initiatives have been followed by an equally long procession of academic studies and official reports charting their shortcomings”

Yet these initiatives have been followed by an equally long procession of academic studies and official reports charting their shortcomings. For example, early in the Coalition government, the Commons Health Committee concluded that 'little by way of integration has been achieved over this 40-year period' (House Of Commons Health Select Committee 2012). The Coalition's re-launch of integration has fared no better, with the National Audit Office concluding in 2017 that 'nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services'.

This view does not mean progress has been absent. Every period has had its poster children of good practice, such as Torbay in the recent past (Thistlethwaite 2011). But progress has been largely confined to such perceived islands of excellence, and has rarely been mainstreamed or sustained. Can the history of integration help us to understand some of the reasons for this apparently consistent failure to establish and universalise integrated care systems?

An examination of the different programmes for integration from 1974 onwards reveals that they are located within the same collaboration or partnership paradigm. The framework applied in 1974 has been re-worked in part or in whole on a number of occasions – and most recently reset in 2013 as part of the Lansley reforms. Common elements have included:

- exhortations reinforced by statutory duties to collaborate (but limited appetite for enforcement)
- shared geographical boundaries for NHS and local government (with varying degrees of (mis)alignment over time)
- local statutory forums for the coordination of planning and commissioning by individual agencies
- financial incentives and pooled budgets
- identification and spread of good practice, often through local pilot projects.

This approach is based on the compromise adopted in the design of the 1974 re-organisations. The then Secretary of State, Sir Keith Joseph, told parliament that while ‘in an ideal world, the answer would be to unify the NHS within local government’, he was proposing to get as near as possible to the advantages of unification by creating ‘two parallel but interacting structures’ (Joseph 1971).

The mechanisms identified above are, therefore, part of a partnership paradigm that has focussed on building bridges between siloed organisational structures rather than integrating their mainstream decision-making processes. The maintenance of separate outcomes and regulatory frameworks for CCGs, NHS providers, public health and adult social care are significant constraints on the extent to which commissioning and service delivery can be integrated locally, for example.

Moreover, more fundamental change has been resisted at the centre. For example, as part of the Lansley reforms, Health and Wellbeing Boards (HWBs) were established at the level of each ‘top tier’ local authority to promote integration but without decision making powers over commissioning plans. The government-appointed ‘Future Forum’ recommended that the HWBs should have such powers. This call was echoed by the Health Select Committee who argued for the creation of ‘a single commissioning process, with a single accounting officer, for older people’s health, care and housing services in their area’ (House of Commons 2012) – akin to what has since been put in place in Greater Manchester). However, the government did not agree that divided commissioning responsibilities were a barrier to integrated services (Secretary of State for Health 2012).

“The latest attempt to overcome these problems - STPs - demonstrate how little progress has been made, with local government critical of the whole approach”

This confidence now seems misplaced. The latest attempt to overcome these problems – STPs – demonstrates how little progress has been made. Local government is critical of the whole approach, seeing it as ‘all about NHS bodies and financial control, with local authorities a sort of optional add on... when

a whole system solution remains the answer' (Sinnot 2017). The Manchester devolution experiment may be the most far-reaching – and amicable – integration initiative in England so far (by some way). Its model of, in effect, combining the STP and devolution deal may merit wider consideration, but policy makers on all sides will have to work hard to overcome the long legacy of failure in this field.

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DEVO-HEALTH

SOME RESERVATIONS

Nicholas Timmins

I should start by declaring some prejudices. By and large, I share the view that England (and we're chiefly talking England for these purposes) is over-centralised. Local government has been excessively de-fenestrated over the years – something accelerated by the austerity agenda of the last seven years.

Meanwhile, one of the NHS's problems has been the requirement over the years for 'everything to be the same everywhere', in terms of managerial and administrative structures: for everywhere to have to have a region, and an area, and a district; or a strategic health authority with Primary Care Trusts beneath them constituted in exactly the same way across the country.

One of the great attractions of the Five Year Forward View (NHSE 2014) – the current governments' NHS reform strategy authored by the chief executive of NHS, Simon Stevens – was that it was the first NHS document that I can recall which said that NHS structures did not have to be the same everywhere.

“One of the great attractions of the Five Year Forward View... was that it was the first NHS document that I can recall which said that NHS structures did not have to be the same everywhere”

Instead, it allows for a powerful clinical commissioning group to effectively take over a struggling local hospital, or a powerful and effective hospital to take over struggling primary and community services, with the aim of providing more integrated care that might lead to something closer to an accountable care organisation (Addicot et al 2014).

Given this, it's no surprise that I approve of the inclusion of Greater Manchester's £6 billion health and social care commissioning in the 'Devo-Manc' project (AGMA 2014). It is a genuinely exciting and interesting attempt to tackle health and social care better – though one that I would desperately hope is being properly researched and monitored so that we can work out exactly what has happened and why when it proves either a success, a failure, or (more likely) something somewhere in between.

But that still leaves me with major reservations about heading all the way down the road that this path might lead to – handing health over to local government. Or to put it another way, heading for Herbert Morrison's solution for the NHS rather than Aneurin Bevan's. Of course, we are nowhere near that yet, but as Devo-Manc takes a small step down this road, it might still be worth thinking about the implications for the NHS further down the road.

My reservations come from a paradox and too much memory.

The paradox is one I once heard Tony Travers put eloquently in a quote I have long since lost. But it broadly went like this. If you ask the British (and indeed English) electorate, if they want more local control, the answer is almost always yes. But with that goes an almost Reithian belief in shared standards and equity.

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Moreover, this desire for equality stretches into many other areas of public life. Not just that access to social care should be equal for equal cases across the country, but that access to playing fields, libraries and much else should not differ spectacularly depending on where you live (obvious limitations of geography aside). So the desire for more local control is chiefly a desire to level up, not a desire to have less in the name of localism; a desire that does much to explain the centralisation of the British state.

The memories come from the seventies and eighties.

One of the effects of the 1974 reorganisation (National Health Service Reorganisation Act, 1973) was to put local authority members on health authorities – they made up a third of the membership. At the same time, the long forgotten Community Health Councils were created to give patients a voice. Both were conceived during a time of considerable financial stress in the NHS and fancied themselves as a ‘representative of the people’. The result was less an attempt to solve NHS problems locally, and much more a desire to blame central government for lack of resources.

I will never forget the results. For example, Patrick Jenkin in 1979, putting commissioners (illegally as it turned out) into the Lambeth, Southwark and Lewisham Area Health Authority when it refused to make the cuts needed to balance its budget. Or, Nina Talmage, the health authority chair up in Brent, and her officials, fleeing through the French windows to the courtyard outside in 1983 when the local health authority, faced with having to make 110 job cuts, faced such opposition – including opposition from the council members on the authority – that the meeting broke up in chaos.

“What the 1974 reorganisation provided was “representation without taxation” – a locally democratic voice with no direct responsibility for raising the money, which pitched itself against the body that did have that responsibility: central government”

Now that was then, and this is now. The political climate within local government is not so soured, even after seven years of austerity and cuts of 40 per cent of revenue expenditure. But these stories point to a key issue. What the 1974 reorganisation provided was ‘representation without taxation’ – a locally democratic voice with no direct responsibility for raising the money, which pitched itself against the body that did have that responsibility: central government. It is true that this has yet to happen in Greater Manchester, but that’s not to say it cannot happen again.

Meanwhile, the alternative – a move to ‘representation with taxation’ – would be an enormous shift. Local government expenditure in England sits at around £100 billion (NAO 2016). Most of that comes from central government, and one of local government’s problems remains the gearing effect when it tries to raise cash itself from the council tax.

True, we are going to go through a shift with more local government financing coming from local business rates. But, for obvious reasons of taxable capacity, this is going to require an equalisation mechanism between different areas

that is likely to be complex in the extreme – weakening the democratic link between voters and the providers of services.

Moreover, like business rates, NHS funding is also subject to a complex funding formula which, again, has occasionally been subject to accusations of political manipulation. But less so, in part because it is somewhat more hidden. Regardless, devising an equalisation formula for the additional £100 billion of health expenditure, in what would be a highly charged political environment, would be no easy task (although obviously not impossible).

More importantly, the change in business rates adds up to small change in comparison to the NHS. If the NHS budget were to completely devolved – which is unlikely, and verging on impossible – it would essentially double the size of local government over night.

So, while more localism in health and care should be welcomed, let's not pretend it doesn't throw up a huge range of challenges, that might ultimately limit where we end up. These are the questions that policy makers must look to answer now – at the start of the devolution journey – to ensure that we end up with a system that delivers high quality care for all, at the right time, and in the right place.

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