REFORM

CLOSE ENOUGH TO CARE

A new structure for the English health and care system

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After a decade of disruption, the country faces a moment of national reflection. For too long, Britain has been papering over the cracks in an outdated social and economic model, but while this may bring temporary respite, it doesn't fix the foundations. In 1942 Beveridge stated: "a revolutionary moment in the world's history is a time for revolutions, not for patching." 80 years on, and in the wake of a devastating national crisis, that statement once again rings true. Now is the time to fix Britain's foundations.

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Reimagining Health is one of the major work streams within this programme.

ABOUT REIMAGINING HEALTH

This paper is part of the *Reimagining Health* work stream. While the National Health Service was once visionary, as demand rises and outcomes deteriorate, a fundamental rethink is needed. The current model no longer works for patients, who too often struggle to access high-quality timely care; for medical staff, who feel disempowered, stressed, and burnt out; or for taxpayers, who foot an increasing bill for a service which is struggling to cope. In short, the structures and institutions designed to meet the challenges of the post-war world are not equipped to deal with our current and future health challenges.

'Reimagining Health' seeks to explore how to transform England's approach to health. It will consider how to move from a treatment-oriented model to one geared towards health creation, the changes necessary in healthcare to facilitate this, and how to build a fair and sustainable approach to funding. This paper is the first of several that seeks to fundamentally redesign the health and care system.

Reimagining Health Council

Reform is grateful to the expert members of the *Reimagining Health* Council who provide valuable insight and advise on the programme. Their involvement does not equal endorsement of every argument or recommendation put forward.

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The arguments and any errors that remain are the authors' and the authors' alone.

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Recommendations

Recommendation 1: The Government should commit to phasing out NHS England as quickly as possible. The Department of Health and Social Care should take on NHS England's remaining specialised commissioning functions, as well as responsibilities for setting core service entitlements, monitoring high level outcomes, determining resource allocation, and providing high level strategic support.

Recommendation 2: As devolution deals mature, the Government should commit to devolving all but a few specialist NHS services to an appropriate tier of local government. This should be achieved via a block grant lasting a minimum of five years. Local government should be free to decide their service model and how they wish to spend the grant, based on local needs, providing they meet a minimum service level set by the Department for Health and Social Care.

1. Introduction

In *Reimagining Health: a framing paper*, *Reform* set out the case for a radical new approach to health. *Reform* argued that institutions designed for the post-war era – centred on the provision of acute, episodic treatment – are ill-equipped to deal with the challenges of an ageing and multimorbid population. Such a one-size-fits-all model of health remains unsuited to the diverse and complex needs of England's communities, and multiple restructures of the healthcare system have failed to shift the dial on health outcomes.

To survive the challenges of the modern age, there is broad consensus that the health system must transition from a sickness service to a health creating service. The demand on the NHS must be reduced and diverted, not simply managed.

Figure 1 contrasts our current approach to health with *Reform*'s vision for a reimagined system.

Figure 1: *Reform*'s vision for a reimagined health system

Current approach	New approach
Produces a national conversation focused on healthcare	Produces a national conversation focused on health creation
Is increasingly unaffordable	Is fiscally sustainable
Takes a 'medical first' approach	Thinks holistically about health and its determinants
Reinforces patients as passive recipients of care	Is patient centred, treating people as co-creators of health
Is hierarchical and 'one size fits all'	Centralises only where necessary and localises wherever possible
Manages demand by rationing care	Intervenes early to prevent demand arising
Fails to take advantage of the power of communities and neighbourhoods	Sees communities as vital to health creation and actively seeks to maximise the benefits of community assets
Struggles to facilitate and adopt innovation	Proactively seeks and adopts innovation

Source: *Reform*, *Reimagining Health: a framing paper*, 2022.

There are many obstacles that undermine this transition – political will, financial capital, and the dominance of acute providers, among others – but structural incoherence in our health system sits at the heart of these. Services which treat illness are largely provided by the

NHS while those which boost health are largely provided by local government. This operational division affects both patients' experience of care and impedes the ability of decision makers to develop services suited to the needs of an ageing, multimorbid population.

The future of healthcare relies on health creating services and evidence indicates these are best situated at a local level. Despite numerous reforms in recent years to devolve and localise healthcare, it remains unusually centralised. That is because, while the conception of many of these reforms over the years is sound, the result is a system of delegation not devolution. So long as the centre is accountable for health outcomes, local systems are driven by meeting extensive centrally driven targets. These policies are not only divorced from health creation but also the distinct needs of demographically diverse communities.

In this paper, *Reform* proposes a model that radically shifts the centre of gravity in the health system to local decision makers in a way that has not been achieved by Integrated Care Systems (ICSs). Crucially, the paper addresses who should be empowered, and the incentives that are needed within the system in order to finally shift to a model that is preventative by default.

The logic of devolution is that smaller entities, properly structured, are more agile and accountable than larger ones. Progress already made in health devolution and place-based policy delivery demonstrates that it can improve outcomes at a reduced cost, improve integration between different services and increase innovation.[1] Indeed, by devolving healthcare, England would be catching up with many international comparators who have long accepted this logic, and are achieving better outcomes.[2]

This paper investigates the structural obstacles that will need to be overcome. It sets out an alternative vision designed to align incentives in the system to prioritise health creation, re-orient healthcare to focus on primary and community services, improve healthcare outcomes, and help achieve long-run fiscal sustainability.

It begins by describing the current structure of health and care provision in England, some core pathologies which afflict it, and past policy efforts to address them. It then sets out a case for change focused on developing a more devolved model of health and care, alongside an alternative approach to structuring our system to achieve the aims set out in *Reimagining Health: a framing paper.*

While structural reform is essential, it is nonetheless one constituent part of a wider programme of reform. This paper is one of many in the *Reimagining Health* workstream that will fundamentally rethink how to deliver health and care to meet the needs of modern society, as the NHS faces the most critical turning point since its inception.

[1] Chris Naylor and Dan Wellings, *A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal* (The King's Fund, 2019).
[2] Sebastian Rees, Patrick King, and Hashmath Hassan, *Looking Outward: International Lessons for Health System Reform* (Reform, 2023).

2. Where are we now and how did we get here?

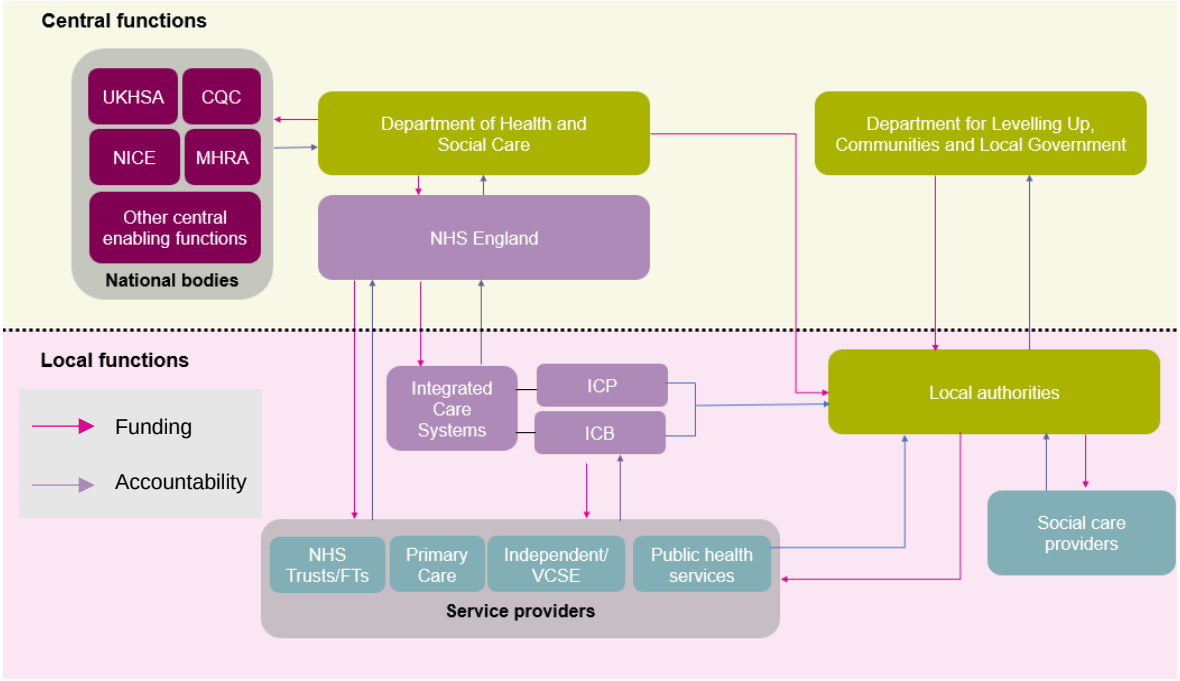
In order to describe the pathologies that face the English health system, it is important to briefly describe how the system is currently structured. This is not straightforward – decades of reorganisation and reform have left the English system with a complicated structural inheritance.

Though responsibility for health reaches far beyond the health and care system – and the recommendations put forward reflect that – this paper considers healthcare (largely the NHS), the public health system, and adult social care to be the three core components of England's health system.

2.1 The structure of England's health system

Understanding structure includes accountability and funding flows. Figure 2 provides a stylised structure of the system as a whole, but the sections below give a more comprehensive account of the structure of healthcare, social care and public health in England.

Figure 2: Stylised structure of England's health and care system



Source: Department of Health and Social Care, *Annual Reports and Accounts, 2021-2*, 2023.

2.1.1 The role of the centre

The departments

Ultimate responsibility for England's health and care system lies with the Secretary of State (SoS) for Health and Social Care, who heads up the Department of Health and Social Care (DHSC). The SoS, through DHSC, is responsible for overall policy for health, social care and public health.[3]

The Department is supported in its oversight role by several enabling agencies and arm's length bodies which shape national health and care policy. Figure 4 provides descriptions of a number of central bodies which help shape England's approach to health and care.

Figure 3: Selected central bodies

Body	Role
Care Quality Commission (CQC)	Regulates health and social care providers Monitors and inspects services and Integrated Care Systems
Medicine and Healthcare Products Regulatory Agency (MHRA)	Regulates medicines, medical devices and blood components for transfusion in the UK
National Institute for Health and Care Excellence (NICE)	Provides evidence-based guidance on whether medicines and other treatments represent a clinically cost-effective use of NHS resources
NHS Resolution	Manages negligence and other claims against the NHS in England
NHS Property Services	Manages the properties held across the NHS
NHS Business Services Authority	Provides central payment and administration services

Source: Department of Health and Social Care, *Annual Reports and Accounts, 2021-2*, 2023.

Alongside overseeing healthcare services, the Department is also responsible for public health and health protection policy. Two bodies oversee these functions in central government (following the disbanding of Public Health England in 2020).[4] The UK Health Security Agency (UKHSA), an executive agency, is responsible for protecting the UK against health threats and infectious diseases.[5]

[3] National Audit Office, *Departmental Overview 2020-21: Department of Health and Social Care*, 2022.
[4] Tom Powell, *The Structure of the NHS in England* (House of Commons Library, 2023).
[5] Niamh Foley, Bukky Balogun, and Thomas Powell, *Office for Health Improvement and Disparities and Health Inequalities* (House of Commons Library, 2022).

The Office for Health Improvement and Disparities (OHID) sits within the DHSC and is primarily responsible for improving population health and closing health inequalities. Its role includes, for example, work on obesity and nutrition, mental health, physical activity, tobacco and alcohol. OHID is responsible for cross-government working to address the wider determinants of health as well as developing England's specialist public health workforce, carrying out health surveillance (for instance, through its local area health profiles and oversight of the national cancer surveillance service), and overseeing the coverage of the public health grant (see below).

Responsibility for adult social care in central government is split between the DHSC and the Department for Levelling Up, Housing and Communities (DLUHC). The DHSC is responsible for adult social care policy, including improving integration between health and social care, supporting workforce development and monitoring and evaluating performance. Financial responsibility sits with DLUHC, which allocates resources and audits local authority spending on adult social care services.

This audit includes expenditure from core grant funding (the Social Care Grant) and revenue raised by local authorities (for example, the adult social care precept).[6] If local authorities fail to deliver services or cannot do so in a financially sustainable way, the Secretary of State for Levelling Up, Housing and Communities can intervene and run local services directly.

NHS England

Though the DHSC sets the NHS's Mandate (see below), day-to-day management of the health service sits with NHS England (NHSE), an arm's-length body. The vast majority of the Department's budget (86 per cent in 2023-24) is passed on directly to NHSE.[7] NHSE is responsible for commissioning some specialised health services, immunisation and screening programmes, and health services for those in secure settings. However, NHS England largely undertakes a performance management and agenda setting role for the system. This involves both managing overall healthcare expenditure, establishing, and holding Integrated Care Boards to account, and setting priorities and providing operational guidance to systems and providers.

Though NHSE was originally intended to be a commissioning and operational oversight body,[8] it has increasingly taken on a policy function of its own, developing plans for health service reform in the *Five Year Forward View* (2014) and the *Long Term Plan* (2019).

In recent years, the remit of NHSE has expanded significantly. In July 2022, NHSE took on NHS Improvement's role of monitoring and managing provider performance in the NHS. In

[6] Jonathan Holmes, 'Where Does the Buck Stop? Understanding Accountabilities and Structures in the National Health and Care System in England', *The King's Fund*, 18 August 2022.
[7] Stephen Rocks et al., *Health Care Funding* (Health Foundation, 2024).
[8] Nicholas Timmins, *'The World's Biggest Quango': The First Five Years of NHS England* (The King's Fund and Institute for Government, 2018).

February 2023, Health Education England and NHS Digital, responsible for workforce development and data/technology respectively, also merged into NHS England.[9]

NHS England is accountable to the Secretary of State for Health and Social Care and the DHSC for meeting its legal duties and fulfilling its mandate – accountability runs from NHSE's accountable officer (Chief Executive) to the Department's permanent secretary. NHSE's mandate is published and updated by the Secretary of State and sets out the objectives that the NHS is expected to deliver. This usually occurs annually, but under the terms of the 2022 Health and Care Act, the only requirement is that a mandate is always in place.[10]

2.1.2 Regions and systems

The regional level

Though considerable power sits centrally, both England's healthcare and public health systems have a regional tier.

NHS England has seven regional offices which have day-to-day oversight of Integrated Care Boards. They agree objectives with ICBs, hold them to account, support their development and intervene where necessary.[11]

OHID regional directors are members of NHS England's regional teams and therefore play a core assurance role in monitoring how the Public Health Grant is being spent by local authorities.

UKHSA has nine regional teams which provide support and expert advice to local authority DPHs and their teams on routine and acute health protection issues including outbreaks of communicable diseases, threats to health from environmental hazards and chemical, biological, radiological and nuclear threats and incidents.[12]

The 'system' level

Below the regions sit England's 42 Integrated Care Systems, bodies which bring together health and care organisations to plan services within their geographical area. ICSs vary in their size and structure – for instance in the number of upper tier local authorities within their

[9] NHS England, *NHS Oversight Framework*, 2022.
[10] Healthcare Financial Management Association, *Introductory Guide to NHS Finance*, 2023.
[11] NHS England, *Operating Framework for NHS England*, 2022.
[12] UK Health Security Agency, *Contacts: UKHSA Pan-Regional Local Health Protection Services*, 2021.

area and their overall population size (500,000 in Shropshire to 3.5 million in the North East and North Cumbria).[13]

ICSs are made up of two statutory bodies – the Integrated Care Board (ICBs) and the Integrated Care Partnership (ICP).

NHS England passes most of its commissioning resources (£107.8 billion in 2022-23) to ICBs who are responsible for the day-to-day running of NHS services within the NHS.[14] ICSs have taken on the assets, liabilities and commissioning functions which previously sat with clinical commissioning groups (CCGs).

The Health and Care Act (2022) and NHS England guidance set out minimum requirements for ICB membership.[15] Each ICB must have a chair, chief executive, finance director, medical director, and nursing director, two non-executive members, and at least three 'partner' members nominated by NHS trusts, primary medical services and local authorities in each area.[16] At least one member of the board must have expertise in mental health services.[17]

Beyond these statutory requirements, guidance on ICB membership is permissive. ICBs can choose to add additional roles reflecting local preference – for instance some areas include members of local Healthwatch or Directors of Public Health, on their boards.

Integrated Care Partnerships (ICPs) bring together other representatives from the NHS, local government, and the VCSE and independent sector to develop an integrated care strategy. This strategy sets out how the assessed needs of the ICS area should be met by the functions of the ICB.[18] The ICP draws on Joint Strategic Needs Assessments (prepared by local health and wellbeing boards) to inform the integrated care strategy.[19] In turn, ICBs are required to use the integrated care strategy to prepare a five-year joint forward plan with trusts and local authorities in their area.[20]

[13] Phoebe Dunn et al., *Integrated Care Systems: What Do They Look Like?* (The Health Foundation, 2022).
[14] Powell, *The Structure of the NHS in England*.
[15] NHS England, *Guidance to Clinical Commissioning Groups on Preparing Integrated Care Board Constitutions*, 2022.
[16] NHS England.
[17] Ibid.
[18] Department of Health and Social Care, *Guidance on the Preparation of Integrated Care Strategies*, 2022.
[19] Department of Health and Social Care.
[20] Department of Health and Social Care.

2.1.3 The local level

Place-based NHS partnerships

Beneath the bodies statutorily responsible for planning and commissioning health services (NHS England and Integrated Care Systems), 'place-based partnerships' are intended to join up services at a local level. These tend to match the areas covered by upper-tier or unitary local authorities. There are currently 175 place-based partnerships in England, covering populations of around 250,000 - 500,000.[21]

Although the Health and Care Act (2022) does not require ICSs to create place-based partnerships, 39 of 42 ICSs in England contain them and there is an expectation that ICBs delegate some of their budgets and responsibilities to this level (though, again, there is no formal requirement for them to do so).[22]

The role of place-based partnerships varies between ICSs – in some instances, most decision-making occurs at the place level and the ICS only makes decisions where planning for a larger population would lead to better outcomes. In West Yorkshire and Harrogate, for instance, the ICS has adopted a maximum delegation approach in which almost all of its £5 billion budget is being put under the control of five place committees, covering the same footprints as the CCGs responsible for local budgets.[23] In some Integrated Care Systems, efforts have been made to empower local authority leaders in decision-making. For instance, in Greater Manchester most of the constituent local authority chief executives also serve as Integrated Care System place-based leads.

Alongside these partnerships, providers of NHS services are also increasingly working together in alliances. 'Provider collaboratives' bring together NHS trusts to work at scale to deliver services, reduce variation in performance, and improve access. Primary Care Networks (PCN), groups of GP practices, work together with community, mental health, social care, pharmacy, hospital and voluntary services in their areas. There are around 1,250 PCNs covering populations of between 30,000 - 50,000.[24]

Though moves to delegate responsibility to this more local tier mark a welcome shift in direction, these partnerships remain non-statutory. Integrated Care Boards remain accountable to NHS England for any resources they delegate downwards. This clearly places limitations on how flexible local budgets can be to local needs, at risk of divergence from central requirements or targets.

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[21] Beccy Baird and Jake Beech, 'Primary Care Networks Explained', *The King's Fund*, 20 November 2020.
[22] Chris Naylor and Anna Charles, 'Place-Based Partnerships Explained', *The King's Fund*, 3 November 2022.
[23] Naylor and Charles.
[24] Baird and Beech, 'Primary Care Networks Explained'.

Public health and social care

For public health and social care, local authorities are both responsible and accountable for service provision.

The commissioning and delivery of most public health functions sit with upper-tier local authorities. Local authorities are responsible for commissioning some sexual health services, public mental health services, physical activity, obesity services, drug and alcohol misuse services and nutrition programmes. These statutory duties are overseen by local Directors of Public Health (DsPH) who are chief officers in their local authority and principal advisers on all health matters to elected members and officers.

DsPH have a range of statutory responsibilities for health improvement, health protection, and public healthcare (e.g., commissioned sexual health, drug and alcohol services). They also perform a number of non-statutory duties, such as health visiting and school nursing, children's weight management and oral health and sit on independent safeguarding boards.[25]

Most of the funding for public health services comes through the ring-fenced public health grant, via the Department of Health and Social Care (currently set at £3.529 billion).[26] Alongside the core public health grant, authorities have been provided with specific time-limited funding for certain public health services – for instance, £780 million has been granted to local authorities over the next three years to improve drug services in response to Dame Carol Black's review.[27]

Social care commissioning and delivery is also the responsibility of upper-tier local authorities (county councils, unitary authorities, London boroughs, and metropolitan districts). Local authorities are responsible for assessing people's needs and, if individuals are eligible, funding their care. Some local authorities also help organise care services for self-funding individuals who need assistance to do so.

Mechanisms for local accountability are stronger in social care than in the NHS. While the NHS is accountable to the public via NHS England, the Secretary of State, and ultimately Parliament, local authorities are directly accountable to the populations they serve in the case of adult social care.

New powers of intervention were introduced through the Health and Care Act 2022 enabling the Secretary of State to intervene when they are satisfied that local authorities have failed to discharge the functions outlined in the Care Act 2014. However, these are governed by strict guidance and are only "likely to be used in the most serious cases – for example,

[25] Department of Health and Social Care, *Directors of Public Health in Local Government: Roles, Responsibilities and Context*, 2023.
[26] Department of Health and Social Care, *Public Health Grants to Local Authorities: 2023 to 2024*, 2023.
[27] House of Commons Public Accounts Committee, *Alcohol Treatment Services*, 2023.

where a serious and persistent risk to people's safety has been identified, and other forms of support are insufficient to drive improvement."[28]

2.2 Structural pathologies in the health system

Based on the above, non-exhaustive, examination of the structure of England's health system, it is possible to discern its two key pathologies: a high degree of centralism and fragmentation between health creating and sickness services. These two features are closely linked – a top-down approach, particularly in the healthcare system, serves as a key barrier to driving the local flexibility necessary to truly integrate commissioning and delivery.

2.2.1 Centralism

While responsibilities for public health and social care sit locally, England's healthcare system remains deeply centralised. As Nigel Edwards, the former Chief Executive of the Nuffield Trust notes, it is in its degree of centralism that the NHS differs most markedly from comparable systems: "what is different about the NHS in England is that none of these systems attempt to run a single NHS for such a large population".[29] Figure 4 presents a matrix of functions which are centralised in the NHS.

[28] Department of Health and Social Care, *Operational Framework for Adult Social Care Intervention in Local Authorities*, 2023.
[29] Nigel Edwards, *Myth #2: 'The NHS is a "sacred cow" that evades reform, and its exceptionalism is its weakness'* (Nuffield Trust, 2022).

Figure 4: Centralism matrix

Function	Roles
Accountability	• Overall accountability for system performance sits with the Secretary of State for Health and Social Care • Prescribing the objectives and desired outcomes of the service via the Outcomes Framework, the NHS Mandates and annual planning guidance
Funding and payment	• Funding the majority of healthcare and public health services • Determining national tariffs – prices that healthcare providers should be paid for delivering specific services • Determining and allocating budgets between systems and services (e.g. capitated general practice budgets)
Workforce	• Strategic workforce planning including estimating the number of healthcare professionals needed in various specialities and regions • Overseeing training and education of healthcare professionals including coordinating the funding and distribution of training placements • Establishing standards, regulations and professional guidelines that healthcare professionals must adhere to • Negotiating pay scales and employment contracts for healthcare workers
Provider performance management	• Setting national clinical governance standards that all providers must adhere to, ensuring consistent patient care and outcomes • Monitoring and assessing performance on centrally determined indicators and metrics (both clinical and financial) • Mandating performance improvement standards • Direct intervention in case of severe performance issues
System strategy	• Issuing operational guidance to providers and systems • Setting out cross-cutting system level policy (e.g. through the *NHS Long Term Plan*)
Procurement	• Sourcing, negotiating contracts and purchasing a wide range of goods and services needed for healthcare delivery • Establishing national framework agreements outlining terms and conditions that NHS organisations must use when procuring goods

In many ways, centralism is encoded in the DNA of England's healthcare system. Despite contestation in the years leading up to its formation over the balance between centralised and localised control, the NHS was conceived as a centrally controlled and financed system, geared to offer a consistent and standardised service across the country.[30] This ambition for the health system is neatly encapsulated in the words of its founder Aneurin Bevan, who (perhaps apocryphally) announced that "if a bedpan is dropped in a hospital corridor in Tredegar, its reverberation should be heard around the Palace of Westminster".[31]

In the NHS's early decades, this centralising ambition proved difficult to realise. While governments were able to control total spend, with little meaningful data on the performance

[30] Socialist Health Association, 'Aneurin Bevan's Speech on the Second Reading of the NHS Bill', 30 April 1946.
[31] Timmins, *'The World's Biggest Quango': The First Five Years of NHS England*.

of providers and a recognition that Whitehall lacked the capability to centrally manage the system, responsibility for day-to-day management largely rested with regional hospital boards.[32]

However, from the 1970s onwards, top-down approaches to system management became more feasible and politically attractive. The rise of information technology and a significant increase in the amount of data available on system performance in real-time encouraged both more proactive steering from the centre and attracted more intense media scrutiny on performance. Drives to strengthen oversight through target setting, performance improvement regimes and national regulation became commonplace.[33]

Waves of reform since this time – whether through the development of primary care-led commissioning, the Foundation Trust model, or the emergence of 'partnership' working through Integrated Care Systems – have attempted to move away from a centralising model. However, none have been successful at fundamentally shifting power and responsibility to the local level.

The reasons for this are manifold but relate fundamentally to political and fiscal accountability. While functions and responsibilities have been *delegated* to local decision makers, accountability has continued to sit with central government through the DHSC, and in recent years through NHSE. Genuine devolution of accountability has not been attempted, even in areas with a higher degree of devolved spending power (such as Greater Manchester – see below).

England's peculiarly centralised approach to accountability in health is reflected in the activities of its central bodies. While NHS England's *Operating Framework* stresses the importance of empowering and supporting local systems and cites "devolution" as a major change in its ways of working, the health service remains tightly managed from the centre.[34]

Even where powers are formally delegated (to ICSs or NHS regions), the centre retains control over many aspects of service planning and provision. NHSE sets operational guidance and priorities for all NHS services and performance manages objectives through its Oversight Framework (containing 53 performance indicators for ICBs and 35 for trusts).[35] Top-down oversight leaves local systems with little room to design and deliver services to meet specific local needs. As one CCG Chief Executive told the NHS's strategy unit: "We list all the national 'must dos' and allocate money to them. Then we argue about the small amount that's left".[36]

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[32] Timmins, *'The World's Biggest Quango': The First Five Years of NHS England*.
[33] Rudolf Klein, 'The National Health Service (NHS) at 70: Bevan's Double-Edged Legacy', *Health Economics, Policy and Law* 14, no. 1 (January 2018): 1–10.
[34] NHSE, Operating framework, 2022
[35] NAO, *Introducing Integrated Care Systems: Joining up Local Services to Improve Health Outcomes*, 2022.
[36] Fraser Battye, 'Localism and the NHS: A Case in Four Stories', *The Strategy Unit*, 3 March 2021.

Centralised system oversight means that managerial capacity in the system is often expended on meeting the demands from above rather than meeting the needs of patients and communities. As the recent review into health and care leadership by General Sir Gordon Messenger noted, "The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user."[37]

Finally, while systems may wish to redesign services to meet the specific needs of their population – with their diverse geography, demography, infrastructure, assets and local civil society arrangements at neighbourhood and borough level – centralised approaches to payment limit their flexibility to do so. This is centralised through national contracts, pay settlements, and tariff rates for procedures. Siloed funding streams, set prices for services and rigid centralised contracting all act against transformative local approaches to health delivery.

Integrated care: one step forward or two steps back?

The latest round of NHS reorganisation, which involved the development of Integrated Care Systems has been heralded by some as a decisive break from past patterns of centralised control. In theory, ICSs should focus on developing horizontal partnerships in their area rather than looking up to the centre. However, in their current form, ICSs will struggle to make good on this promise.

As outlined above, Integrated Care Systems remain tightly managed by central government. Meeting NHS mandate targets and dealing with rigorous oversight arrangements takes precedence over addressing local priorities.[38] Given that accountability from ICSs flows upwards to NHSE (and in turn to the Department and Secretary of State), this makes sense. However, it means that the role of ICSs amounts to a form of *delegation* – "the transfer of government decision-making and administrative authority and/or responsibility for carefully spelled out tasks to institutions and organisations that are either under its indirect control or independent" – rather than genuine *devolution*.[39]

Breaking this cycle would involve embedding far more democratic accountability at the population level of ICSs, but progress here has been limited. In theory, local accountability is meant to be a core feature of ICSs, and local government leadership is wired into the structure of Integrated Care Systems in two ways.

Firstly, there is mandatory representation of local government on ICBs, the bodies responsible for managing and allocating the NHS's resources. While this is welcome, in

[37] Gordon Messenger and Linda Pollard, *Health and Social Care Review: Leadership for a Collaborative and Inclusive Future* (Department for Health and Social Care, 2022).
[38] NAO, *Introducing Integrated Care Systems: Joining up Local Services to Improve Health Outcomes*.
[39] Kieran Walshe et al., *Devolving Health and Social Care: Learning from Greater Manchester*, 2018.

practice Integrated Care Boards remain heavily NHS-dominated. Analysis by the County Councils Network found that of the 777 ICB members in England, 466 were NHS members, 220 were non-executives, 82 were Local Authority officers, and only 9 were elected councillors.[40]

Secondly, ICPs are meant to inform the strategic decision-making of the ICB and tend to be led by local government representatives. Helping shape an ICS's vision and strategy is a valuable duty, but ICPs are severely disempowered relative to ICBs. They lack control over budgets and resource allocation, the key enablers of system reform. As one Council leader in London notes, "You can't have a load of health people sitting in one room with all of the money, and local government people sat next door talking about how wonderful it is to work together".[41]

Finally, it is not clear what (if any) repercussions ICBs will face if they do not use ICP guidance to inform decisions around funding allocations, service design and commissioning. Though Integrated Care Partnerships are clearly informing decision-making in some parts of the country, worryingly in May 2023 (a year after the formation of ICSs) 6 ICPs had never held a public meeting and 9 had not published any minutes or papers.[42] The bodies responsible for injecting views on how to boost health still appear to be subservient to more powerful NHS-led boards.[43]

Health 'devolution': in name only?

Excepting the devolved nations, the most advanced move towards a decentralised approach to health and care in England has been seen in Greater Manchester. In 2015, the ten boroughs of Greater Manchester secured an agreement with NHS England to take "devolved control" over the £6 billion annual budget for health and social care for the 2.8 million people in the city region.[44] This occurred at the same time as the GMCA took responsibility for a range of other public services including transport, planning, skills and economic regeneration and the position of an elected Mayor for Greater Manchester was established.

This health 'devolution' agreement gave the Greater Manchester Health and Social Care Partnership, a new body, control over the joint commissioning of services. The partnership argued that taking on control of an integrated budget would allow it to radically advance population health, transform care in localities, standardise hospital and acute care, and standardise clinical support and back-office services.[45]

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[40] IMPOWER and County Councils Network, *The Evolving Role of County Authorities in Integrated Care Systems*, 2022.
[41] Future Care Capital, 'Councilors Fear Power Grab from NHS When ICSs Come into Force', 18 January 2022.
[42] Kate Bowie, 'The Integrated Care Partnerships with No Public Meetings or Minutes', *Health Services Journal*, 9 May 2023.
[43] Patricia Hewitt, *The Hewitt Review: An Independent Review of Integrated Care Systems*, 2023.
[44] Walshe et al., *Devolving Health and Social Care: Learning from Greater Manchester*.
[45] Walshe et al.

Emerging evidence finds that the Greater Manchester experiment has led to modest improvements in population health. A recent study in *The Lancet* found that two years after devolution life expectancy in Greater Manchester was 0.2 years higher than expected when compared with a synthetic control group with similar pre-devolution trends.[46] In that period, Greater Manchester bucked a broader trend of declining life expectancy experienced elsewhere in England.

However, whilst improvements in population health in Greater Manchester should be celebrated, the study does not point to a clear cause. It is therefore unclear to what extent the devolution of *health-specific* functions drove improved performance.

Further, the settlement achieved between the city-region and NHS England does not amount to genuine devolution. A recent academic evaluation on the process in Greater Manchester described it as "a constrained or soft form of devolution, enacted entirely within the existing legislative framework for the NHS in England".[47]

Rather than developing into a genuinely devolved system, Greater Manchester more closely resembles the governance model outlined in relation to Integrated Care Systems above. Accountability flows upwards to NHS England and the Department of Health and Social Care, rather than out to voters in the city region; system leaders must meet performance metrics, financial targets and service specifications, set centrally; and local NHS organisations are managed by NHS England rather than the local partnership. Without reforms to political accountability – and freedom – health devolution in Greater Manchester will therefore continue to exist in name only.

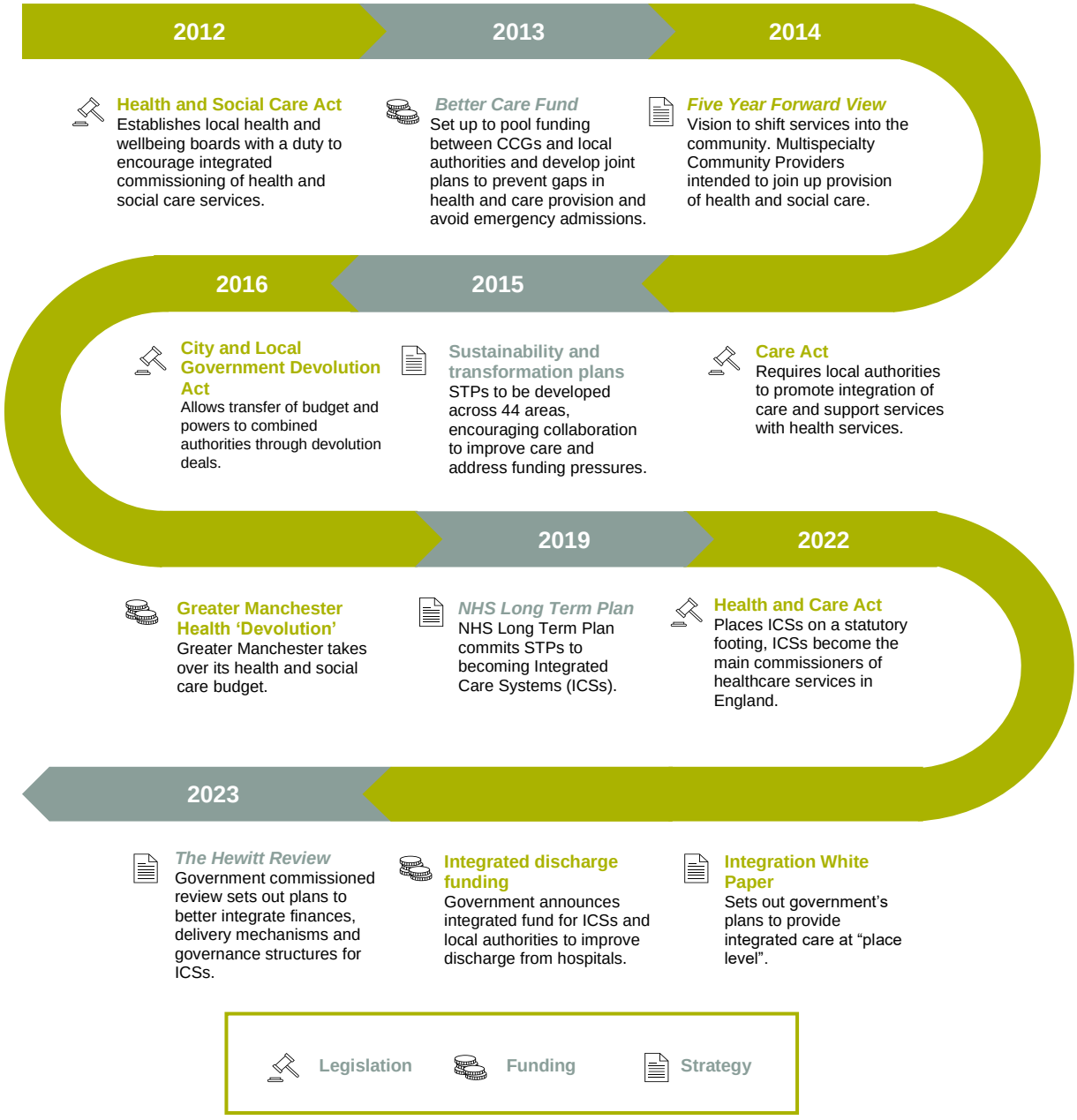
2.2.2 A fragmented approach

Alongside its high degree of centralisation, England's health and care system is also fragmented. Services which treat illness (largely provided by the NHS) and those which boost health (largely provided by local government) are structurally divided. This affects both patients' experience of care and the ability of decision makers and commissioners to develop holistic services suited to the needs of an ageing and multimorbid population.

For this reason, in recent years government, the NHS and providers have increasingly emphasised the need to collaborate to join up health and care services and shift towards an "integrated care" model. Figure 5 presents a timeline of initiatives to improve integration over the last decade.

[46] Philip Britteon et al., 'The Effect of Devolution on Health: A Generalised Synthetic Control Analysis of Greater Manchester, England', *The Lancet Public Health* 7, no. 10 (October 2022).
[47] Walshe et al., *Devolving Health and Social Care: Learning from Greater Manchester*.

Figure 5: Timeline of integration



However, integration efforts, spearheaded by ICSs are unlikely to succeed in their current form. As outlined above, ICSs are not true 'partners of equals' between the NHS and local government, either in their composition, decision-making and spending-related power, or in the metrics they are held to account on.

Closing gaps between services requires shared responsibility and accountability between healthcare, public health and social care, but control of these services currently sits with different tiers of government. While some steps have been taken to integrate payment mechanisms, funding for services still largely sits in siloed pots.

Governance models and approaches to funding therefore lead to separate services working towards their own sets of organisational priorities rather than a cross-cutting health creation mission.

3. The case for change

The section above described the structure of England's health and care system and examined its two chief pathologies – its top-down, centralised approach and its high level of fragmentation.

However, all complex systems possess structural flaws and there are significant challenges and trade-offs involved in moving towards a new system. Any further structural change must be justified by its potential to improve health and healthcare outcomes and financial sustainability.

3.1 The benefits of devolution

Internationally, the devolution of health governance from a national to a regional and local level has been advocated as a strategy to enhance efficiency and improve population health.[48] The logic of devolution is based on the presumption that "smaller organisations, properly structured and steered are inherently more agile and accountable than are larger organisations".[49]

The agility and accountability conferred by devolving responsibility for the health system to more local units can help improve outcomes, reduce cost, and transform our model of care.

3.1.1 Improved outcomes at reduced cost

Devolution has the potential to improve outcomes in our health system at a reduced cost.

In the first instance, devolution allows policymakers to plan services which are better tailored to the needs of their local population. Local decision makers have significant "informational advantages" over more distant central policy makers – they are closer to service users and can use local institutional and community knowledge to build more responsive approaches to health and care provision.[50] For instance, communities with a higher proportion of elderly or young people could develop service offers which better cater for their needs than a one-size-fits-all, nationally-led approach allows.

Secondly, strong accountability at a local level (particularly where some revenue is generated locally) provides incentives to improve quality and contain cost. Under the current model, accountability chains are long, and arrangements are convoluted. While healthcare

[48] Yao Wei et al., 'The Impact of Devolution on Experienced Health and Well-Being', *Social Science & Medicine* 333 (September 2023): 202, https://doi.org/10.1016/j.socscimed.2023.116139.
[49] Richard Saltman, Vaida Bankauskaite, and Karsten Vrangbaek, *Decentralization in Health Care* (European Observatory on Health Systems and Policies, 2007).
[50] OECD, *Decentralisation and Regionalisation in Portugal: What Reform Scenarios?*, 2020.

providers are *technically* accountable to local populations, in practice they look to the centre for guidance. Under a devolved system, lines of accountability to local communities would be far more direct – citizens would have a clearer say in who managed their local health economy.

Matching services to the needs of local populations and strengthening accountability at this level can in turn increase the efficiency of service provision. By better allocating resources to meet specific local demands, decision makers can decrease costs and be held to account over whether services are optimising value for money. Though savings will not be realised immediately, and devolution may require initial pump-priming investment, with the right support, shifting decision-making to a local level can improve allocative efficiency.

3.1.2 The innovation imperative

The NHS was set up on a principle of 'universalising the best' – a national system, so the argument goes, should be able to rapidly identify innovation and best practice and then scale it so that all citizens benefit.

There are some instances in which this is the case. The high level of focused expertise that can be marshalled centrally and the economies of scale that national bodies can generate can stimulate innovation. From funding high-cost, high-reward research to identifying and procuring new technologies to enhance care, centralised bodies play a vital role in system transformation.

However, nationally standardised systems, administered and regulated centrally may find it more difficult to spread innovation. In the first instance, top-down systems tend to centralise risk and raise the costs of reform. Unless all systems are in a position to make transformative change, innovation may be put off. More localised systems are better able to experiment – risks of failure are smaller, and systems can move at their own pace towards change, rather than a pace dictated by the centre.[51]

Secondly, while some forms of innovation – particularly those which require resource commitments that could not be sustained by a sub-unit within a system, like the application of advanced technologies – do benefit from scale, much of the potential for innovation in health and care comes from localised service redesign. This form of innovation is enabled by close collaboration between citizens, service users and decision makers.

This is far more easily facilitated at a smaller rather than larger scale. Existing relationships between individuals, organisations, and decision makers facilitate open communication and collaboration between partners, and a smaller number of stakeholders makes achieving consensus easier. In turn, smaller organisations can more quickly and flexibly adapt their approach than larger organisations.

[51] Simon Kaye, *Think Big, Act Small: Elinor Ostrom's Radical Vision for Community Power* (New Local, 2020).

While co-production with service users is key to the rhetoric of NHS England and the Department of Health and Social Care,[52] collaboration informed redesign will always be limited at the national level. New approaches must be developed in partnership with communities rather than imposed on them.

Finally, forms of productivity-enhancing process innovation may be more easily achieved in a system that grants higher levels of local autonomy. While some barriers to productivity – the slow adoption of technology, insufficient managerial and administrative investment, and undercapitalisation – exist across the system,[53] bottlenecks to boosting performance are often locally specific. Rigid adherence to central guidance and upward management on processes, not outcomes, stands in the way of achieving sustained improvements in productivity.

3.1.3 Improving integration

As discussed in Section 2.2.2, achieving better integration within healthcare, and between healthcare and other public services has been a key policy aim in recent decades. However, progress in this area has been limited.

A number of obstacles stand in the way of integrated service provision – the NHS, local government, and care providers have very different organisational cultures, are beholden to different regulatory regimes, and often face legal and technical difficulties when sharing information.[54]

However, one of the key barriers to transformation is structural. Different lines of accountability and funding models between healthcare, public health, and social care obstruct attempts at integration. The parcelling up of funding between these services – and, indeed, other services which create health – contributes to a siloed approach, ill-suited to the health challenges of our age.

There has been some progress in overcoming siloes and increasing flexibility in commissioning in recent years. The introduction of the Better Care Fund (BCF) in 2015, which pools funding for health and social care, has allowed commissioners to plan more integrated services. However, with a projected budget of just over £7.2 billion, the BCF represents only a small fraction of overall NHS and social care expenditure.[55] Further, given it can only be used to integrate health and care services, its potential as a vehicle for wider health creation is limited.

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[52] NHS England, *Co-Production: An Introduction*, 2023.
[53] Tim Horton, Anita Mehay, and Will Warburton, *Agility: The Missing Ingredient for NHS Productivity* (The Health Foundation, 2021).
[54] Sarah Reed et al., *Integrating Health and Social Care: A Comparison of Policy and Progress across the Four Countries of the UK* (Nuffield Trust, 2021).
[55] Department for Levelling Up, Housing & Communities and Department for Health and Social Care, *2022 to 2023 Better Care Fund Policy Framework*, 2022.

The delegation of Greater Manchester's health and care budget exhibits similar characteristics. Budgetary integration across health and care can aid commissioners in developing a more holistic approach to support. However, flexibility – and the potential of a localised model – remains curtailed by a failure to join up accountability and funding streams between healthcare and the wider determinants of population health.[56]

True integration requires bringing together budgets and accountability for healthcare and local government-provided services across a geographic area. This would provide local decision makers with a high degree of flexibility to shift resources into those areas most likely to boost population health. For instance, given the close link between worklessness and poor health, an integrated commissioner could choose to prioritise investment in work coaching over formal mental health provision to achieve a superior outcome.[57]

3.2 Unfulfilled promises

Although the theoretical benefits of a more devolved approach are often recognised, proponents of the current model argue that a centralised model has a number of distinct advantages. These relate chiefly to equity and efficiency.

However, it is clear that the current system is not meeting these expectations. Despite the aspirations of its founders, three quarters of a century on, our centralised system has not succeeded in either closing growing health gaps between communities or standardising high-quality care.

3.2.1 A postcode lottery

Arguments for centralism in England's approach to health are premised on an assumption that a universal, national offer reduces inequalities between areas. A centrally driven approach to performance monitoring, resource distribution, and provider management, the argument runs, should help prevent variation in care quality and health outcomes across the system. Proponents of this view argue that removing elements of central control would lead to a 'postcode lottery' in our health system.

Yet England's centralised approach has not prevented the emergence of wide variations in access to and the quality of care, nor in health outcomes. Though some variation in care quality and access can be expected in any health system, the extent of disparities between regions of England on key indicators is difficult to square with the vision of a 'national' health service.

[56] Walshe et al., *Devolving Health and Social Care: Learning from Greater Manchester*.
[57] Lord Michael Farmer, *The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime*, 2017.

The percentage of cancers diagnosed in stage 1 or 2 is twice as high in West Suffolk as it is in Slough, whilst those admitted to hospital for a stroke in East Staffordshire are more than twice as likely to die after 30 days than in neighbouring North Staffordshire.[58]

Variations in access are also considerable – patients in the Birmingham and Solihull Integrated Care System are almost twice as likely to be on a wait list for elective treatment as those in Frimley. In Gloucestershire, Sheffield, and Derby and Derbyshire nearly one in ten GP appointments take place more than a month after they are booked, whereas this number drops to one in fifty in Liverpool or North Central London.[59] Most concerningly, there is a large variation in health outcomes throughout England as Figure 6 shows.

Figure 6: Health outcomes by region

[58] NHS Right Care and Public Health England, *NHS Atlas of Variation in Healthcare*, 2015.
[59] NHS Right Care and Public Health England.

Source: Office for Health Improvement and Disparities, *Public Health Outcomes Framework*, 2023.[60]

Even within regions, variations in outcomes are stark. For instance, in London, women born in Wandsworth can expect to live more than a decade longer in good health than those born in Tower Hamlets.[61] In the North West, people aged under 75 in Blackpool are three times more likely to die of preventable causes than those living in Cheshire East.[62]

Determining the causes of divergent health outcomes, and differentiated levels of care quality and access is difficult. In some instances, variation relates to local and regional demography and underlying population health – for instance, given the close association between deprivation and morbidity, areas in which a higher proportion of the population live in poverty are likely to experience poorer health outcomes (see below).[63]

Nonetheless, an examination of health and healthcare related outcomes reveals that a centrally-managed, 'standardised' service offer has been unable to close persistent health gaps between regions and points to a clear conclusion: sizeable variations in population health require differentiated, locally specific solutions.

3.2.2 Differentiated service needs

The challenge of closing gaps in access, quality, and outcomes is accentuated by trying to make a standardised model fit the needs of very different populations throughout England. Different demographic profiles, levels and types of morbidity, and health behaviours lead to highly divergent requirements for health services.

[60] Office for Health Improvement and Disparities, *Public Health Outcomes Framework*, 2023.
[61] Office for Health Improvement and Disparities.
[62] Office for Health Improvement and Disparities.
[63] Evangelos Kontopantelis et al., 'Chronic Morbidity, Deprivation and Primary Medical Care Spending in England in 2015-16: A Cross-Sectional Spatial Analysis', *BMC Medicine* 16, no. 1 (14 February 2018): 19, https://doi.org/10.1186/s12916-017-0996-0.

29.6 per cent of Dorset's population is over the age of 65, whereas only 11.9 per cent of Londoners are in this age category. 85.6 per cent of working-age adults in West Berkshire are in employment, whereas that number drops to just 62.9 per cent of working-age adults in Middlesbrough. The percentage of adults reporting a long-term Musculoskeletal (MSK) problem in Redcar and Cleveland (25.9 per cent) is more than double that reported in Reading (11.7 per cent).[64]

Although allocations of health spending in England (for instance, funding allocated to Integrated Care Boards, funding for general practice and the core public health grant) are weighted according to factors including demography, morbidity, and deprivation, rigid centrally imposed service specifications and regulation make genuine innovation to meet needs difficult.[65]

[64] Office for Health Improvement and Disparities, *Public Health Outcomes Framework*.
[65] NHS England, *Technical Guide to Allocation Formulae and Convergence For 2022/23 to 2024/25 Revenue Allocations*, 2022.

4. Making change happen

The above section demonstrates the value of moving towards a far more devolved and integrated model of health. This chapter considers how to make change happen and focuses on two necessary transformations: shifting the role of central government and devolving power and responsibility to regional decision makers.

4.1 Radically shift the role of the centre

Despite a long-term rhetorical commitment to move responsibility and resources out of the centre and into local systems, England's health system has grown increasingly top-heavy in recent years.

Between March 2018 and October 2023, the number of full-time equivalent staff working in central bodies increased by 25 per cent.[66] The number of staff working for NHS England alone almost tripled in this period – from 5,776 to 15,630, whilst the number working for the core department over doubled – from 1,462 to 3,237.[67]

Though an increase in staffing to meet the operational requirements of the COVID-19 pandemic is understandable, a rapid growth of central functions is not in line with developing an operating model based on empowering local decision makers.

Redefining and slimming the role of the centre is a crucial first step in shifting this approach. This section outlines what a revamped, and slimmed down, centre should do.

4.1.1 What should sit at the centre?

The above chapters have outlined why a future model of health should be based on an assumption of subsidiarity – that accountability and decision-making responsibilities should sit as close to patients and communities as possible.

However, decision makers should be aware of 'the fantasy of optimum scale' – attempting to determine the ideal scale at which *all* functions should sit.[68] Instead, they should consider what scale works best for the function in question.

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[66] These central bodies include: DHSC, CQC, NHS Digital, Health Education England, Health Research Authority, Human Fertilisation and Embryology Authority, Human Tissue Authority, MHRA, NICE, NHS B&T, NHSBSA, NHS England, NHS Resolution, UKHSA (and previously PHE).

[67] Department of Health and Social Care, *DHSC Workforce Information: March 2018*, 2019; Department of Health and Social Care, *DHSC: Workforce Management Information October 2023*, 2023.

[68] Michiel De Vries, 'The Rise and Fall of Decentralization: A Comparative Analysis of Arguments and Practices in European Countries', *European Journal of Political Research* 38, no. 2 (October 2000).

Even in highly devolved health systems, national level bodies retain an important role and there are a number of areas where a centralised approach adds genuine value. These functions tend to exhibit a number of common characteristics:

- they benefit from the economies of scale that can only be achieved centrally;
- they require a high degree of specialist input;
- they facilitate necessary standardisation across the system; and/or
- they require a high level of interface with other national functions.

Core regulatory functions

As is the case in almost all health systems, there is a strong rationale for retaining a number of core regulatory functions at the centre.

The regulation of medical treatments on both safety (through the MHRA) and clinical/cost effectiveness grounds (through NICE) should continue as a central function. The complexities involved in carrying out health technology assessment and the high degree of duplication of responsibilities likely to emerge between regional bodies, make moving away from a centralised approach undesirable.

Though comprehensive devolution should involve granting more powers over workforce planning (see below), the centre should also retain its role in professional regulation and accreditation, including maintaining the medical register (via the GMC) and setting standards for training and development. These functions benefit from a high level of standardisation and ensure flexibility for professionals working across systems.

Though responsibilities for provider inspection could theoretically be devolved to a regional tier (as is the case in Spain), a standardised national approach to service assessment through the CQC should continue (albeit with a higher degree of sensitivity to local planning decisions).

The regulation of specialised services such as human embryo, in-vitro fertilisation and donor insemination clinics and research establishments (through the Human Fertilisation and Embryology Authority) and the removal, disposal and storage of human bodies, organs and tissues (through the Human Tissue Authority) should continue to sit centrally.

Core commercial functions

In general, commercial decision-making (including management of capital budgets) best sits with regional and local systems. However, there are instances in which the economies of scale that can be achieved centrally justify a national approach.

For instance, NHS England’s Commercial Medicines Director, as the chief purchaser of pharmaceuticals in England, can achieve better value for money in procurement than systems or trusts acting in isolation.

This same logic applies in the case of major, cross-cutting infrastructure projects such as the acquisition of comprehensive data architecture and patient record systems. Centralised purchasing helps drive down costs and reduces unnecessary duplication in the system, as well as ensuring greater interoperability across systems.

Core clinical functions

The centre should also retain a select number of clinical functions – most notably the commissioning of highly specialised care.

Much of NHS England's specialised commissioning budget – which covers 154 services accessed by people with rare and complex health needs – is currently being delegated to multi-ICB collaborations. However, for extremely rare conditions (such as Alström syndrome or pseudomyxoma peritonei) and/or for services which can only be carried out at a small number of trusts (such as proton beam therapy or heart and lung transplantation), there are few benefits to be gained from devolution.

Core data and digital functions

While improving digital capability is vital across the health system, the centre has an important role to play in developing a full national health data infrastructure, bringing together disparate sets of data generated both in healthcare and across the wider determinants of health. The centre should also continue to be responsible for developing interoperable, electronic health records to help providers and systems plan care and individuals manage their own health and care needs.

Core public health functions

Finally, the centre has a vital role to play in carrying out core public health duties. Functions which require a high level of specialist input and require significant interfacing with other central bodies such as monitoring and responding to future infectious diseases or dealing with biological, nuclear, chemical, and radiological threats all benefit from a high level of central oversight.

However, as noted in recent *Reform* research, in the case of national health emergencies, central bodies should confine their remit to providing information, guidance and support to local and regional systems rather than attempting to centrally manage their response.[69]

In addition to its central role in health protection, the centre should retain responsibilities for a small number of health improvement duties.

[69] James Sweetland and Hashmath Hassan, *Health Security from the Ground up: 5 Lessons for the Future of UKHSA* (Reform, 2023).

Firstly, in line with arguments made above, the centre should retain responsibility for compiling comprehensive population health datasets. OHID's existing 'Fingertips' dataset, which collates a wide range of public health data serves as a vital tool for policymakers nationally and locally to track variation in need, target resources and interventions, and evaluate policy. Further development of this data infrastructure nationally will continue to drive improvement.

Secondly, while most efforts at behaviour change and prevention are best organised locally, the centre should play a role in organising public health campaigns which affect the nation as a whole. For instance, national media campaigns in areas such as alcohol risk reduction, smoking cessation and sexual health awareness have all proved highly cost-effective when overseen centrally.

4.1.2 What should change at the centre?

The major shifts required at the centre involve the Department of Health and Social Care and NHS England. As noted above, it is these bodies which have grown most quickly in recent years and whose functions should be streamlined or devolved.

Going forward, the centre should move away from being a system 'controller' and towards being an enabler of a regional approach. This would require it to focus on four responsibilities: setting core service entitlements, monitoring overall system performance, determining resource allocations, and strategic coordination. The centre should also reserve extraordinary powers for intervention in the event of service failure.

Setting core entitlements

A revamped centre would define a comprehensive package of benefits available to patients across the entire system and minimum universal service standards. The national approach to entitlement setting could be based on the existing NHS constitution which provides for seven principles that set out the rights and responsibilities of patients and staff. The constitution guarantees a comprehensive, universal service on the basis of clinical need not ability to pay and sets out a range of national service entitlements.
Central policymakers could also make use of international examples of centrally determined benefits packages. In Italy, for instance, while health responsibilities are devolved to the regions, the central Ministry of Health is responsible for setting out a basic benefits package – the LEA (*Livelli essenziali di assistenza).*[70] Benefits covered include pharmaceuticals, inpatient care, preventive medicine, outpatient specialist care, maternity care, home care, primary care and hospice care. Regions can offer services not included in the national scheme but must finance those services themselves.

[70] Ministera della Saluto, 'National Health Service: The LEAs', Web Page, 30 January 2019.

Monitoring high-level outcomes

Local systems are best placed to set outcomes for services designed to meet the needs of their communities. However, the centre has an important role to play in monitoring performance against a small number of high-level national targets.

These targets should be based on a range of population health and healthcare related outcomes such as improvements to healthy life expectancy, reductions in preventable mortality, and survival rates for high-incidence conditions such as cancer and stroke rather than outputs (such as the number of procedures carried out).

A number of relevant measures are already collated in the NHS Outcomes Framework, the Public Health Outcomes Framework, and the Adult Social Care Outcomes Framework. Existing arrangements (which already overlap) could therefore be amalgamated and slimmed to develop an overall performance framework.

Resource allocation

In a more decentralised model, the centre would necessarily take on the role of effectively and equitably allocating resources between regional systems. Under a more devolved governance model, regions would ideally partly fund their own health and care services with central government playing an equalising role.

Similarly, as part of a wider approach to public service devolution, central government should move away from allocating specific resources for specific areas (health, skills, justice for instance). This would mirror the settlements struck with the devolved nations who are able to decide on their own spending allocations.

However, before wider devolutionary arrangements emerge in England's regions, central health and care bodies will play a role in allocating resources. NHS England's allocation of resources to ICBs which weights funding according to demographic and service user profiles in regions provides a useful basis for a future approach.

High-level strategic support

While the centre's role as a *manager* of performance should be limited, national bodies should continue to provide high-level strategic support to regional systems and providers. Developing a comprehensive and interoperable data infrastructure has been a core aim of policymaking in recent years and this could aid the development of national advisory programmes to improve care quality and outcomes.

Existing national programmes such as Getting It Right First Time (GIRFT) show the potential of a high-level centralised support function. GIRFT uses data and clinical input to identify unwarranted variation in the way services are delivered across the NHS. Findings on unwarranted variation are used to design strategies to improve care and deliver efficiencies.

GIRFT teams are able to support trusts, commissioners and integrated care systems to deliver the improvements recommended and best practice guidance is shared across the system to promote transformation.

Alongside providing strategic support at a national level, the centre should also play a role as a coordinator and manager of inter-jurisdictional relationships – for instance, where care for complex patients must be co-ordinated across a number of different areas. Systems may choose to pool resources to provide care for patients with highly specialised needs and central government facilitation may be necessary to advise in this area.

4.1.3 A reformed centre

Devolution would not see sweeping changes to the role of a number of core national bodies – as explained above, national health technology assessment functions (through NICE and the MHRA), high level health protection and promotion responsibilities (through UKHSA and OHID), and core regulatory duties all benefit from centralisation.

However, there is a strong case for the devolution of many of the *healthcare* specific functions currently carried out centrally. A devolved settlement would have significant implications for NHS England and the core department, whose roles would be slimmed, or become largely redundant.

Devolution of core commissioning and planning functions would catalyse a significant reduction in headcount in national bodies. Progress is already being made in this area. The merger of NHS Digital, Health Education and NHS England in 2023 provides opportunities to reduce duplication and it is expected that by 2023-4, the new organisation will be 30-40 per cent smaller than the current combined size of the three bodies.[71]

However, under this assumption, the new organisation would still have around 10,000 central staff. To fulfil the roles outlined above would require substantially fewer staff and a redistribution of managerial and administrative capacity to the regional level.

With a reduction in headcount, a streamlining of central roles, and extensive devolution to local systems, the existence of an independent, central commissioning board, NHS England, would become redundant. NHS England's specialised commissioning responsibilities would

Recommendation 1: The Government should commit to phasing out NHS England as quickly as possible. The Department of Health and Social Care should take on NHS England's remaining specialised commissioning functions, as well as responsibilities for setting core service entitlements, monitoring high level outcomes, determining resource allocation, and providing high level strategic support.

[71] NHS England, 'Health Education England and NHS England Complete Merger', Press release, 3 April 2023.

be integrated into the Department of Health and Social Care alongside the other, high-level strategic functions outlined above.

4.2 Genuine devolution

In Section 2, this paper described existing reforms to decentralise power – through Integrated Care Systems and health 'devolution' to Greater Manchester. Though both of these reform efforts mark a move towards a new approach, they will not in and of themselves shift the dial.

Making change requires the devolution of political accountability and a far higher degree of financial and strategic flexibility than the current system allows. It is these that can in turn drive behaviour change.

If services are directly accountable to local people via a democratic mechanism, decisions taken by those running them must satisfy the needs and priorities of that specific population. This then complements the technocratic accountability outlined in the previous section on the role of the centre. Currently the system leans too hard on the latter, exacerbating its centralised tendencies.

While political devolution should be the direction of travel, a number of barriers must be overcome to make this a reality.

4.2.1 Barriers to devolution

Diversity in local authorities

Moving towards a devolved model of health and care is made difficult by the complicated and often confusing administrative landscape of local government in England.[72]

In most countries with a more devolved approach to health and care, sub-national units of administration are (largely) standardised.

All parts of Spain, for instance, are covered by a regional authority (autonomous community (AC)) and a municipal government (*ayuntamiento*). These units have distinct responsibilities – the ACs are responsible for planning and managing health services, while the municipalities have responsibility for environmental health and certain health protection duties.[73] In Norway, primary, preventive and nursing care responsibilities sit with the country's 428 municipalities, while the national government is responsible for hospital and specialty care (managed through four Regional Health Authorities).[74]

[72] Jack Newman and Michael Kenny, *Devolving English Government* (Institute for Government, 2023).
[73] Gobierno de Espana, *National Health System Spain*, 2008.
[74] Ingrid Sperre Saunes, Marina Karanikolos, and Anna Sagan, *Norway: Health System Review* (European Observatory on Health Systems and Policies, 2020).

In England, the structure of local government varies from area to area. There are five different types of local authority in England (county councils, district councils, and 'single-tier' authorities including unitaries, metropolitan districts, and London boroughs) each with their own responsibilities.[75] Additionally, the Greater London Authority and, over the last decade, the emergence of combined authorities, that bring together councils to plan services on a larger footprint has added to this complicated landscape.[76]

If health devolution is to become the norm across England, either a higher degree of standardisation in models of local governance must emerge, or policymakers will need to be comfortable with devolution taking different forms in different parts of the country.[77]

Wider lack of coterminosity

Various efforts at public service decentralisation and delegation have also left England with a range of other statutory and non-statutory bodies with mismatched geographic boundaries.[78] Though there has been an ambition to develop joined-up public services across regions and places, the boundaries of NHS regions and integrated care boards, school commissioners, and fire and police force areas are not coterminous.

A lack of coterminosity between boundaries affects the ability to plan and deliver integrated public services. Shared accountability, communication between commissioners and decision makers, and collaboration with communities and service users are all made more difficult where governance boundaries do not match. Moving to a more integrated model will require ensuring a higher degree of coterminosity between services that create health and treat illness.

Limited fiscal devolution

One driver of England's centralised approach to accountability in healthcare is its limited approach to fiscal devolution. Where revenue is largely collected by central government, national political leaders are likely to be held more strongly to account for spending (even where responsibility for service commissioning is delegated to a sub-national area).[79]

Countries with more devolved approaches to health tend to raise a higher proportion of total tax revenue at a local and regional level. More than a third of all tax revenues in Sweden and

[75] Department for Levelling Up, Housing and Communities, *Guidance: Local Government Structure and Elections*, 2023.
[76] National Audit Office, *Progress in Setting up Combined Authorities*, 2017.
[77] Health Devolution Commission, *Levelling Up Health: Report and Recommendations of the Health Devolution Commission on the Government's Proposed Health and Care Bill*, 2021.
[78] British Academy, *Governing England: Devolution and Mayors in England*, 2017.
[79] Jessica Studdert, *Fiscal Devolution: Why We Need It and How to Make It Work* (New Local, 2023).

Norway are collected sub-nationally.[80] This compares with around 5 per cent of tax revenue in the UK.[81]

Fiscal devolution is not a precondition for health devolution – in both Spain and Italy, financing for devolved systems is largely drawn from central government tax revenue. However, an ability to raise revenue to meet local priorities can be a core enabler of system transformation, and reduce the requirements for financial oversight required in centralised states.

4.3 Navigating the road ahead

Over the last decade, a number of proposals have been put forward to facilitate the devolution of health and care responsibilities in England.[82]. However, these proposals have not sufficiently mapped out the structural changes necessary to carry out devolution. The remainder of this paper seeks to fill in this gap, setting out some proposals for a new system. In the examples explored above and the models proposed below, the location of accountability and budgets is key. This is because to deliver a health system based on maximising the health of the population, decisions about health priorities and services must be taken at a smaller scale. To achieve this, the system must be devolved, and to create the conditions for effective devolution, international evidence suggests both budgets and accountability must be devolved.[83]

That means that careful consideration must be given to where power lies within, and how money flows through, the system. Decisions about these will determine, to a large extent, what services are incentivised. One of the keys issues within the current system – helping to explain why it has consistently failed to make the shift away from acute towards more preventative services – is the siloed funding model. This lacks the incentive for resource to be shifted downstream. By seeking greater integration between primary and secondary care, the ICS model is attempting to tackle this, but as discussed above, there is no requirement to pool budgets and the funding models for each remain separate.

This paper presents two options for devolution of healthcare which experiment with different incentives, based on a variety of international approaches.

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[80] OECD, *Tax Autonomy of State and Local Government*, 2018.

[81] OECD.

[82] Harry Quilter-Pinner and Becca Antink, *Devo-Health: Where Next?* (IPPR, 2017); Ian Smith, Stephen Smith, and Phillip Blond, *How to Improve the Health and Wellbeing of the UK Population: Devolution and Reform of Health and Social Care* (Respublica, 2020); New Local Government Network and Collaborate, *Get Well Soon: Reimagining Place-Based Health*, 2016.

[83] Dolorez Jimenez-Rubio and Pilar Garcia-Gomez, 'Decentralization of Health Care Systems and Health Outcomes: Evidence from a Natural Experiment', *Social Science & Medicine* 188 (September 2017): 69–81.; Rees, King, and Hassan, *Looking Outward: International Lessons for Health System Reform*. (Reform, 2023).

Further analysis as part of the *Reimagining Health* – and in conjunction with *Reform's Reimagining the Local State* programme – will seek to identify the most effective model for the England's healthcare system.

4.3.1 Combined authority as ACO

Accountable Care Organisations (ACOs) are alliances of care providers that are collectively accountable for quality and costs across all care, and originally inspired what are now known as Integrated Care Systems in the UK.

ACOs are predicated on the idea that integrating care creates stronger incentives for cost savings – and therefore prevention – than healthcare models that pay per procedure carried out. This is because, generally, ACOs develop a care management approach targeting patients at risk of avoidable hospital admission or A&E attendance in order to reduce overall costs.[84]

In the context of ageing populations and increasing chronic illness, it is therefore considered a more appropriate healthcare model than one which does not explicitly disincentivise patients from entering secondary care.

ACOs have three core characteristics. First, they involve a provider or group of providers that collaborate to meet the needs of a defined population. Second, these providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population. Third, ACOs work under a contract that specifies the outcomes and other objectives they are required to achieve within the budget extending over a number of years.[85]

ACOs were designed so that providers share in the overall savings or suffer from cost over-runs. This incentivises outcomes rather than activity. It also incentivises cost saving as they can keep the savings to spend how they wish. In turn, by incentivising cost reduction across the system, the model incentivises prevention as the most cost-effective way to provide care.[86] This overcomes the challenge of a non-integrated system in which each organisational silo faces a different set of constraints and incentives.

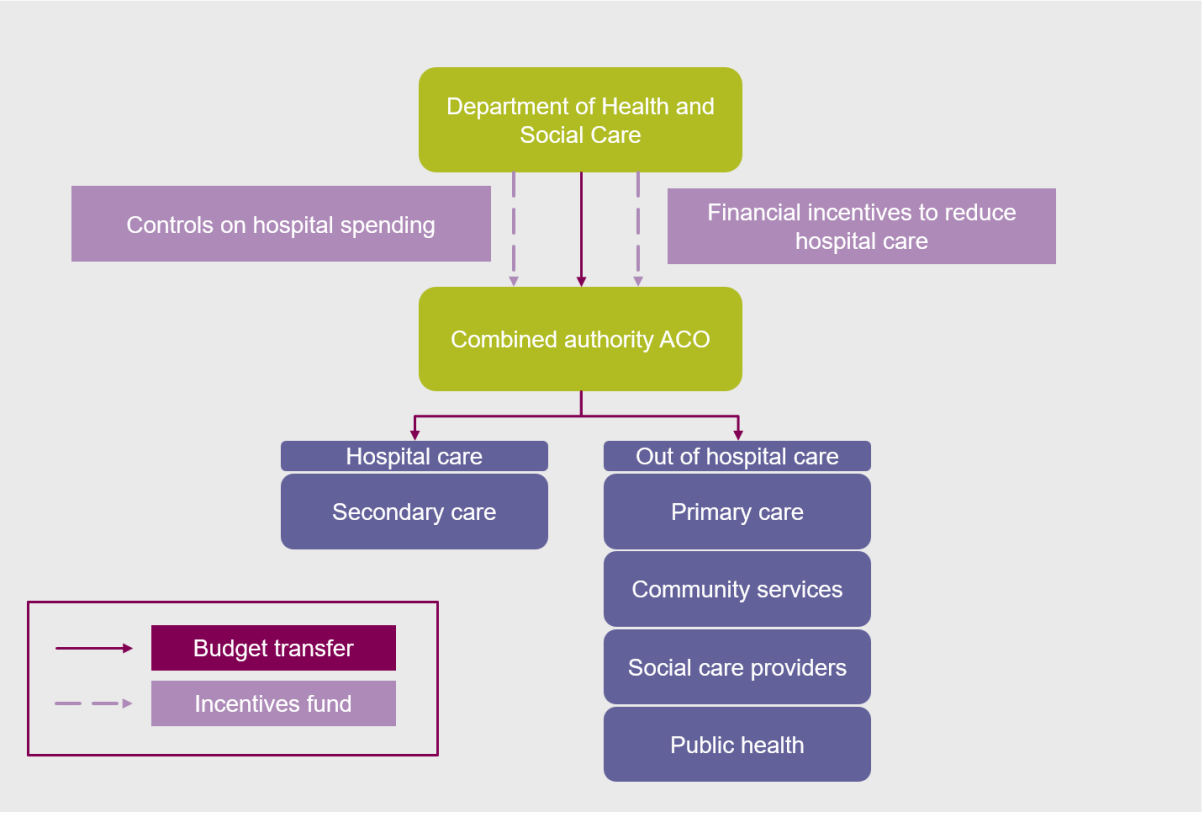
A model for England

In England, combined authorities would act as the ACO, responsible for a single budget and able to retain savings, but also responsible for overspends. This would incentivise a shift away from the NHS's current hospital-centric model, towards a more community- and primary care-dominant model. The incentive would be for the system to invest in lower cost health and social care interventions upstream, and as savings are secured from reduced

[84] Stephen Shortell et al., *Accountable Care Organisations in the United States and England: Testing, Evaluating and Learning What Works* (The King's Fund, 2014).
[85] Steven Wyatt, *Risk and Reward Sharing for NHS Integrated Care Systems* (Strategy Unit, 2018).
[86] Shortell et al., *Accountable Care Organisations in the United States and England: Testing, Evaluating and Learning What Works*.

acute demand, authorities could increasingly invest in health *creation* initiatives (i.e. pooling healthcare and other public service budgets).

Figure 8: Simplified model with combined authority as ACO



The role of the combined authority

Traditionally, ACOs have been an alliance of providers rather than a government. However, as previously outlined, it is precisely this division between local government (responsible for public health and other health creating services) and NHS providers (responsible for treating illness) that continues to undermine the shift to prevention. In addition, a combined authority is directly accountable to its local population via its elected leader(s).

The combined authority would be the optimal vehicle for the ACO model as it offers the advantage of being more decentralised than the current approach, but still provides the benefits of scale when it comes to planning services.

This is in line with other decentralised models, including Spain and Sweden. In Spain, 17 autonomous communities are responsible for overseeing and commissioning all health services, while in Sweden, 21 regional 'counties' are responsible for financing and delivering

health services to residents.[87] In both instances, regions may delegate functions to lower tiers of government (municipalities) but retain ultimate accountability for spending and performance.

Currently, devolved mayoral regions cover around 41 per cent of England's population, a number which will rise to 60 per cent if the five deals concluded in 2022 are implemented, meaning the majority of England's population will have a mayor for the first time.[88]

A regional devolution model in England would go with the grain of these developments – a single, non-ringfenced health and care budget including funding for secondary care, primary care, public health and social care could be devolved to the combined authority level. Combined authorities would be responsible for commissioning all healthcare services in their region and meeting centrally set minimum service specifications and targets. Combined authorities could choose to delegate responsibility to their constituent local authorities, but would remain ultimately accountable for system performance.

The potential drawback of a single regional ACO model is that the benefits of place-based commissioning and service co-design with local communities require smaller populations than those of city regions. Realising the benefits of much more localised service design – remembering that need can look very different even from ward to ward – would require combined authorities to delegate community service commissioning to local authorities.

Nonetheless, the case for moving towards a combined authority-led model is clear – combined authorities are the main institutional vehicle established to drive the devolution agenda, they have clear and visible democratic leadership via their mayors, and, as collective organisations with cabinets made up of leaders from their constituent local authorities, they are able to pool the knowledge and resources of local areas to plan more tailored services.

Funding settlement

A critical element of this system would be a longer term funding settlement. In the current system, despite the decentralisation of budgets to ICBs, national tariffs and contracting lock resources into existing ways of working. Current financial models are valuable in driving activity in particular areas (for instance, activity-based hospital payment models incentivise reducing treatment backlogs) but do little to help reorient our health system around the principles of population health management.

Moving to a new approach would involve granting each regional ACO a single block of funding and financial freedoms to design payment models to meet their local needs. This

[87] Enrique Bernal-Delgado et al., *Spain: Health System Review* (European Observatory on Health Systems and Policies, 2018); Anders Anell, Anna Glenngard, and Sherry Merkur, *Sweden: Health System Review* (European Observatory on Health Systems and Policies, 2012).
[88] Department for Levelling Up, Housing & Communities, *60% of England Now Covered by Historic Devolution Deals*, 2024.

makes it easier to make longer term decisions and plan effectively, in turn providing better value for money. ACOs would ideally be free to move away from centrally imposed arrangements such as the national tariff (for secondary care payment) or nationally determined contracts in General Practice. These block grants should be allocated for a minimum of five years in order to provide confidence to areas to invest for the longer-term and to allow for the benefits of doing so to emerge.

Integrating funding pools between primary and secondary care is paramount. Local areas should have the flexibility to spend this money in ways best suited to boosting population health in their area. Given their control of many of the services which act as core levers for improving population health, including housing, children's services, leisure and cultural services, planning and local transport, local authorities may choose to prioritise non-healthcare spending to boost outcomes.

There is a risk that integrating funding pools between primary and secondary care may see the latter prioritised over the former. However, as below, incentives can be explicitly designed into the system to prevent this.

Additional incentives

In addition to the inherent incentives noted above, additional financial incentives can be applied to further drive the desired shift towards early intervention and prevention.

The first measure relates to controls on hospital spending, based on those used in Israel.

Israel has a mandatory insurance-based system with all Israelis required to be a member of one of four competing non-profit health plans known as Health Maintenance Organisations (HMOs). HMOs provide a state mandated benefit package which includes hospital, primary, speciality and mental healthcare (primary care and GP visits are free of charge within the plans, but specialist care attracts a small co-payment).[89]

HMOs are naturally incentivised to invest resources upstream as while hospitals are not owned by HMOs, they are reimbursed by them for delivering care. It is therefore more affordable for HMOs to prevent patients requiring hospital care, and where specialist care is needed, to deliver it outside of a hospital setting.[90]

This has resulted in investment in specialist and emergency care outside hospitals and home hospitalisation. In 2018, there was an expansion in the use of home hospitalisation by HMOs, as a cost reducing and clinically beneficial alternative to treating patients in hospital

[89] Roosa Tikkanen et al., *International Health Care System Profiles: Israel* (The Commonwealth Fund, 2020).
[90] Bruce Rosen, Ruth Waitzberg, and Sherry Merkur, *Israel: Health System Review* (European Observatory on Health Systems and Policies, 2015).

wards.[91] The Ministry of Health now also provides specific financial incentives for HMOs to develop their capacity to support home hospitalisations.[92]

This drive to keep people out of expensive hospital settings is furthered by central government controls over hospital resource expenditure and resources. There are rigorous controls on key inputs such as hospital beds and expensive medical equipment, and caps on physician and nurse positions in hospitals. This, again, is designed to free resources to invest in comprehensive primary and community care services.[93] The result is a significant proportion of speciality care provided in community settings. Many surgical and diagnostic procedures, specialist follow-up care, and complex chronic care management takes place in integrated multi-speciality clinics provided by the health plans.

The second measure relates to incentives for reductions in hospital use, based on those used in Denmark.

While this is still relatively small in scale and empirical evidence of its effectiveness is limited, creating financial incentives for preventative interventions would be worth testing in an English ACO model.

In Denmark, while 77 per cent of the funding for health still comes from block grants that are adjusted for demographic and social differences, a small portion of state funding for regional and municipal services is tied to specific priority areas and targets.

In 2019, Denmark introduced a new scheme for national funding which is contingent on five general criteria: fewer hospital admissions per citizen, less in-hospital treatment for chronic care patients, fewer unnecessary readmissions within 30 days, increased use of telemedicine, and better integration of IT across regional and municipal sectors.[94] A similar fund in England could be sufficiently broad to allow combined authorities to tailor solutions to their specific demographic needs, but specific enough to further incentivise prevention.

4.3.2 Split devolution co-financing model

An alternative to the regional ACO is a split devolution model with a co-financing mechanism. Earlier, this paper argued that decision makers should avoid the ‘fantasy of the optimum scale’, instead recognising that different functions in a health system benefit from being situated at different levels of governance. Under a split model of devolution, functions could be separated based on the scale at which they are best organised.

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[91] Rees, King, and Hassan, *Looking Outward: International Lessons for Health System Reform*.
[92] Iris Megido, Avichai Soudri, and Adriana Prodan, ‘Management of Community-Based Home Hospitalization (CBHH) in Israeli Public Health System’, *International Journal of Comparative Management* 20, no. 5 (December 2019): 544–56.
[93] Tikkanen et al., *International Health Care System Profiles: Israel*.
[94]Roosa Tikkanen et al., *International Health Care System Profiles: Denmark* (The Commonwealth Fund, 2020).

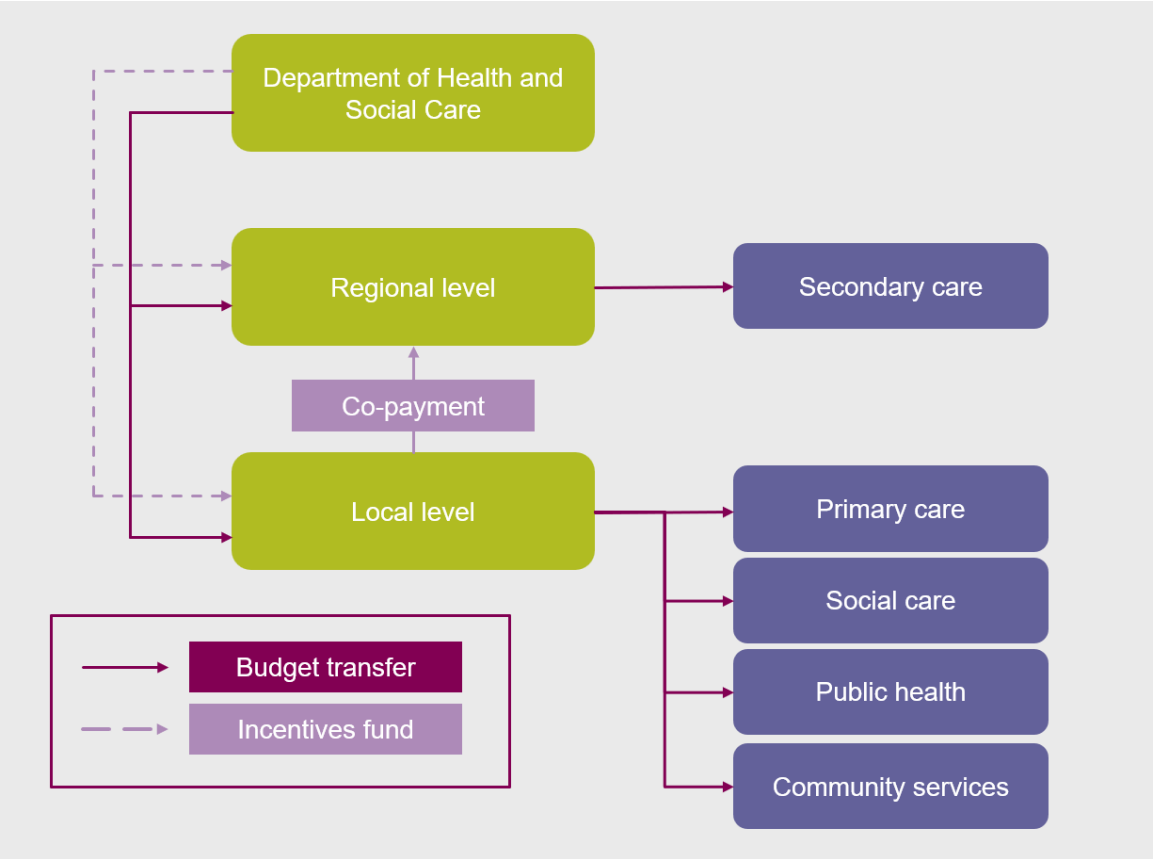
In this model, those functions that require a higher degree of centralism (commissioning secondary care, comprehensive workforce planning) would sit with a regional tier, whilst those which benefit from specific tailoring to local need (out-of-hospital care, health improvement) would sit with a more local tier of government.

However, this governance split, which would also require a budget split, risks losing the inbuilt incentive towards prevention that a single budget provides. To address this, co-financing for hospitals between different tiers of government has started to emerge as an incentive to reduce hospital admissions and drive investment upstream. An incentives fund, similar to the ACO model, can further reinforce a shift to prevention.

A model for England

In England, the combined authority would provide the regional tier, while upper-tier local authorities would provide the local tier.

Figure 9: Split devolution co-financing model



The split devolution model

Currently, responsibility for 'out-of-hospital' care sits with a range of bodies and commissioners. Social care services are commissioned by local government, whilst most

primary and community care is commissioned by the NHS. However, given the interdependencies between these services, under the proposed model, primary, community, and social care services would be brought into a single commissioning system.

Local authorities would become the core commissioner of out-of-hospital services, allowing them to design approaches best suited to their local circumstances. For instance, some local areas may choose to invest in services which directly integrate health and social care responsibilities, others may choose to develop community hub models for integrated care.

Existing bodies can also provide institutions to effectively commission and oversee services. Integrated commissioning could be carried out by joint Health and Wellbeing Boards (HWBs), which already exist as statutory bodies in every upper-tier local authority and are responsible for approving spending of the Better Care Fund. HWBs in some parts of the country have already taken on responsibilities for joint commissioning – in Wigan, for instance, health and care budgets have been brought together in a Section 75 pooled and aligned budget arrangement and extended to include housing and leisure services.[95] In Newham, services for children with chronic illnesses such as diabetes, asthma and epilepsy are jointly commissioned by the NHS and local authority.[96]

Combined authorities would then be responsible for the provision of hospital and specialist care, which is better suited to a larger population scale.

Funding

Similar to the ACO model, central government should provide a combination of block funding to both regional and local government over a longer term funding settlement period of at least five years.

Over time, as activity in community and primary care settings is increased – whether via successful prevention or increases in non-hospital based secondary care – the block grants would be adjusted, with more going to the local tier.

Additional incentives

There are two ways to incentivise prevention in this model. The first measure is co-financing. In Denmark, the regions are responsible for hospital and other specialised care, while the municipalities are responsible for a majority of out-of-hospital care, as well as prevention, health promotion and rehabilitation outside of hospitals. In order to incentivise preventive services and reduce hospitalisation, a system of municipal co-financing, where municipalities must pay a share of the costs each time an individual is admitted to a regional hospital, was implemented.

[95] Local Government Association, 'Wigan Health and Wellbeing Board', 3 July 2019.
[96] Office for Health Improvement and Disparities, *Public Health Outcomes Framework*.

There has been limited research on the effectiveness of co-financing, but the empirical evidence that does exist is tentatively optimistic. Research in 2013 showed that 48 per cent of local authorities estimate that the local co-financing has had an impact on their health strategy to some extent, while 22 per cent estimate that it has had a substantial impact on their health strategy. This is matched by growing expenditures on public health among the municipalities – overall it appears that the municipalities increased their public health efforts after the reform.[97]

In order to further incentivise a reduction in hospitalisation, and ensure local areas are able to make the co-payments, the block grant allocation should, at least in the early settlements, reflect this – i.e. a proportion of the hospital funding should be allocated to the local tier. This would help smooth the transition.

The second measure is, as in the above ACO model, funding tied to specific priority areas and targets. In this model, such incentives are likely even more important given the risks of a split budget, and they would need to be applied to both the regional and local level separately, and therefore require specific incentives for secondary and primary care.

Figure 10: Evaluating options for reform

	Advantages	Disadvantages
Combined authority ACO model	• Provides appropriate scale for integrated commissioning between primary and secondary care • Follows the direction of travel of existing public service devolution	• Sub-optimal scale for organising services which benefit from high level of local tailoring (primary and community care) • Roll out to all regions across England delayed due to lack of devolution settlements
Split devolution model with co-payment	• Local government infrastructure already exists • Situates commissioning responsibility for integrated services closest to population • Provides appropriate scale for integrated commissioning between public health, social care and primary care	• Risk of split budget reducing likelihood of shift to community-based care • Risk of fragmenting patient care pathway

[97]Karsten Vrangbaek and Laerke Mette Sorensen, 'Does Municipal Co-Financing Reduce Hospitalisation Rates in Denmark?', *Scandinavian Journal of Public Health* 41, no. 6 (2013).

Recommendation 2: As devolution deals mature, the Government should commit to devolving all but a few specialist NHS services to an appropriate tier of local government. This should be achieved via a block grant lasting a minimum of five years. Local government should be free to decide their service model and how they wish to spend the grant, based on local needs, providing they meet a minimum service level set by the Department for Health and Social Care.

5. Conclusion

Changes to the governance, accountability and funding model will not be a panacea for current health woes – serious attention must be paid to developing new models for healthcare delivery, driving increased productivity across the system, and building a workforce equipped for the challenges of the 21st century. However, transforming England's approach to health will require confronting a number of deep-seated structural obstacles.

Shifting the location of power and accountability so that the health system looks out to service users and citizens rather than up to national government; dissolving the artificial divide between those institutions responsible for creating health and those responsible for dealing with illness; and developing an approach to funding and resource allocation which incentivises health maximising investment are all vital elements of a genuine programme for reform.

This paper has set out an alternative vision for England's health system in which local systems rather than national government become the key agents of change. Bringing all out-of-hospital care services and public health into one commissioning body can help catalyse a shift towards a more integrated, place-based model.

Moving towards a devolved model will require detailed and careful planning by policymakers, and will necessarily involve confronting difficult trade-offs. Though local authorities already possess the capacity to commission and deliver essential care and public health services, capability and capacity building will be required to ensure that the local state is equipped to take on a much broader set of responsibilities.

While many of the changes envisaged in this paper could be carried out under current legislation, as a more devolved approach to health and care provision develops, there may emerge a need to pass comprehensive legislation. Finally, given the high level of public and political sensitivity tied up with health system reform, it is clear that a new model would face significant challenge from existing interests.

However, in spite of these challenges, exploring a more devolved settlement is vital. Without fundamental change, our centralised health system will prove unable to withstand the challenges of the future.

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