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Commentary

# Can Devolution Change Health and Social Care Spending Decisions? Lessons From Greater Manchester

## Comment on "The Impact of Devolution on Local Health System Financing: A Synthetic Difference-in-Differences Study of Greater Manchester, England"

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**Abstract**

Greater Manchester's devolution deal aimed to improve the alignment of health and social care with local needs and shift resources towards prevention. Moss et al find higher overall expenditure after devolution, driven initially by spending by local National Health Service (NHS) commissioners and later by local authority (LA) spending, with limited changes across most broad expenditure categories. This commentary argues that these findings should be interpreted in the context of a complex, multi-stage devolution process, including the 2017/2018 100% Business Rates Retention Scheme (BRRS) pilot, which may partly explain later increases in LA adult social care (ASC) spending. Future research could make greater use of individual-level data to examine how activity changed across patient groups within at least some of the broad expenditure categories analysed. Where more detailed aggregate data are available, the analysis of finer expenditure sub-categories may reveal whether resources were redirected in line with the stated policy goals.

**Keywords:** Devolution, Fiscal Devolution, Greater Manchester, Health and Social Care, Expenditure

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## Introduction

Devolution is the process of decentralising central government responsibilities to local governments. Its advocates emphasise that devolution can increase local discretion over resource allocation and political accountability, facilitate the alignment of public services with local needs and, in turn, lead to better outcomes.[1-3] On the other hand, greater decentralisation may weaken redistributive mechanisms and exacerbate inequalities across local areas.[4]

This commentary discusses the study by Moss et al which focuses on the devolution of health and social care planning and budgeting powers in the Greater Manchester area since 2016/2017.[5] This devolution deal was designed to enhance the coordination between National Health Service (NHS) Clinical Commissioning Groups (CCGs), responsible for commissioning healthcare, and local authorities (LAs) responsible for public health and social care. Two key aims were to better align health and social care services with local community needs and to shift resources from treatment towards prevention.

Moss et al investigate whether this policy changed the level and composition of health and social care expenditure, providing evidence on whether local resource allocation changed in line with the policy goals. Their analysis focuses on CCG expenditure on acute care, primary care, community care, mental health, Continuing Healthcare (which incorporates the small amount of CCG expenditure on adult social care [ASC] services), and other services, and on LA expenditure on ASC, children's social care, and public health. The analysis uses synthetic difference-in-differences over the seven-year period from 2013/2014 to 2019/2020 – three pre-policy years and four post-policy years.

## Key Findings

The key findings (Table 2 in Moss et al) suggest that the policy increased total CCG and LA expenditure per capita, defined as the sum of all analysed expenditure categories, by £66.58. On average across the post-devolution period, this increase was primarily driven by a £36.39 increase in total LA expenditure per capita, while the increase in total CCG expenditure was not statistically significant. The event-study analysis, however, shows that the increase in total CCG and LA expenditure initially reflected higher total CCG expenditure in 2016/2017 and 2017/2018, while higher total LA expenditure emerged in 2018/2019 and 2019/2020 (Figure 2 in Moss et al).

The temporary increase in total CCG expenditure was primarily driven by higher expenditure on other services in 2016/2017, 2017/2018 and 2018/2019, together with

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an increase in expenditure on acute care in 2017/2018. Conversely, CCG expenditure on Continuing Healthcare decreased in 2016/2017. The later increase in total LA expenditure was mainly explained by higher expenditure on ASC in 2018/2019 and 2019/2020 and on children's social care in 2018/2019.

The authors also examine changes in expenditure composition (Figure 3 in Moss et al). As a share of total CCG and LA expenditure, CCG expenditure on other services increased in 2016/2017 and 2017/2018, while the share devoted to Continuing Healthcare decreased in those same years. The share devoted to LA ASC increased in 2019/2020.

## A Complex Devolution Deal and Its Studied Effects

The Greater Manchester devolution deal was complex, involving changes in both decision-making powers and available resources in multiple stages. The November 2014 deal increased local decision-making and budgetary powers over services potentially affecting wider determinants of health, including housing, employment, transport, adult education, policing, strategic planning, and business support.

The health and social care devolution came into effect in April 2016. A Greater Manchester Health and Social Care Strategic Partnership Board brought together CCGs, NHS providers, and the ten LAs, providing a region-wide structure for coordinating decisions across health and social care. In addition to new arrangements for coordination, Greater Manchester received a five-year £450 million fund to support health-system transformation, which was allocated across the ten local areas at the discretion of the Partnership. Therefore, this health and social care deal introduced additional discretionary resources as well as greater discretion over existing budgets.

Nevertheless, the deal has been described as a relatively "soft" form of devolution. CCGs and LAs remained subject to existing accountability arrangements and the same national rules, targets and financial arrangements as elsewhere in England. Core NHS funding and much of LA funding remained determined by existing national arrangements, and the deal did not devolve additional revenue-raising powers. A separate change in local financing occurred from 2017/2018, when the ten LAs in Greater Manchester and other LAs moved from the standard 50% Business Rates Retention Scheme (BRRS) to the 100% BRRS pilot. This provided LAs with greater incentives to stimulate their local economies by allowing them to retain 100% rather than up to 50% of real-terms growth in business rates revenues. In addition to the greater fiscal incentives, the pilot also allowed LAs to benefit from 100%, rather than 50%, of the real-terms growth accumulated since the introduction of the 50% BRRS in 2013/2014. Therefore, although intended to be cost neutral for the central government at the point of delivery by offsetting the additional retained business rates with reductions in central government grants, which in Greater Manchester included the Public Health Grant, the policy generated the possibility of an immediate financial gain.

Evaluations prior to Moss et al capture different, although overlapping, stages and aspects of this complex process. Britteon et al investigate the effect of the devolution policy on life expectancy using November 2014 as the intervention date.[6] They estimate higher life expectancy following devolution, and the authors interpret their findings as reflecting the combined effects of devolution across sectors rather than the November 2014 deal alone. A follow-up study by Britteon et al explores the effect of the health and social care devolution deal on 98 measures across the health system, using April 2016 as the intervention date.[7] They find that devolution increased acute-care staffing and primary care access, improved several emergency and inpatient outcomes, cancer screening, and some ASC outcomes. Mixed effects were found on mental health outcomes. Their findings also indicate increased acute-care expenditure, while expenditure on mental health, public health and community care did not significantly change. The subsequent findings from Moss et al, discussed earlier, are broadly consistent with these earlier findings. They complement previous findings by showing that the increase in CCG acute-care expenditure was temporary, that primary care expenditure did not change, and that LA ASC expenditure increased in 2018/2019 and 2019/2020.

## A Recent Study on Fiscal Devolution in England

A recent study by Longo et al may help further explain findings on LA ASC spending decisions after the Greater Manchester devolution deal.[8] This study investigates some of the effects of the 100% BRRS on the first cohort of LAs that joined the pilot scheme in 2017/2018 including those in Greater Manchester, Liverpool City Region, West of England, West Midlands, and Cornwall. The study focuses on whether the new fiscal policy impacted local income, LA ASC expenditure and ASC-related outcomes between 2013/2014 and 2019/2020.

Interestingly, the two studies find similar effects: both estimate an increase in LA ASC expenditure per capita of around £18 over their respective post-policy periods (Table 2 in Moss et al and Table 2, panel (i), in Longo et al). Some differences, however, arise in the event-study results. Moss et al suggest that LA ASC expenditure increases are statistically significant only in 2018/2019 (£28) and 2019/2020 (£40), their third and fourth post-policy years (Table S4 in Moss and colleagues' supporting material), while Longo et al show that statistically significant increases start in 2017/2018 (£13), their first post-policy year, and continue in 2018/2019 (£17) and 2019/2020 (£25). These results from Longo et al are robust to controlling for the 2016/2017 health and social care devolution deal in Greater Manchester. This comparison of findings supports the possibility anticipated by Moss et al: the increase in LA ASC expenditure estimated by Moss et al in 2018/2019 and 2019/2020 cannot necessarily be attributed solely to greater coordination between CCGs and LAs following health and social care devolution. It may partly reflect the 100% BRRS. The allocation of some of these additional resources to ASC may also help explain some of the improvements in ASC and population outcomes after 2017/2018 observed in previous studies.[6,7]

In addition, Longo et al estimate the effect on LA ASC expenditure for the first cohort of the 100% BRRS pilot as a whole, including Greater Manchester LAs as well as other

non-London pilot LAs that contributed to the synthetic control group used by Moss et al (Table S1 in Moss and colleagues' supporting material). The contamination of the synthetic control group may translate into lower or noisier estimates of the true effect on LA ASC expenditure, since part of the comparison group was itself exposed to a policy that increased ASC expenditure. This might explain the finding in Moss et al of a statistically insignificant estimated effect in 2017/2018, although the magnitude of this effect (£12) remains close to that estimated by Longo et al in the same year (£13). A more direct assessment for Greater Manchester would require an analysis that explicitly treats the 100% BRRS as a second intervention and uses comparison areas not exposed to the pilot.

Finally, another potential inferential issue hampering the interpretation of these estimates in Moss et al is that the weights used to construct the synthetic controls appear to be estimated in a first stage but subsequently treated as fixed. The reported cluster-robust standard errors therefore do not appear to account for uncertainty arising from the estimation of these weights, which could potentially be addressed by a bootstrap procedure that re-estimates the weights in each replication.

## Final Considerations

Investigating the effect of the Greater Manchester devolution deal with a limited number of independent treated units remains a difficult task for analysts. However, the study by Moss et al raises important questions about how to shape future research in this area. Two main avenues might be worth pursuing further. The analysis of individual-level data may improve precision and allow a much richer analysis of how activity changed across patient groups within at least some of the expenditure categories analysed in Moss et al. For example, Hospital Episode Statistics and Clinical Practice Research Datalink provide patient-level data on hospital and primary-care activity, respectively, during the period of interest. Clinical Practice Research Datalink data can also be linked to Hospital Episode Statistics to investigate whether changes in hospital and primary-care activity were concentrated among particular patient groups. Although this seems a promising step forward, developing individual-level analyses may take time because of constraints on data availability and the development and implementation of suitable methods.

In the meantime, currently available aggregated data may still help improve understanding of the effects of devolution, particularly if analyses focus directly on the dimensions specifically targeted by the policy. For example, Greater Manchester Combined Authority set out specific policy goals, including reducing cancer, cardiovascular and respiratory mortality, reducing fall-related injuries among vulnerable and older people, and reducing low birth weight.[9] Expenditure directed to these goals (and others) may cut across several of the categories used by Moss et al, or involve reallocations within them. Limited changes in broad expenditure categories might mask the redirection of resources towards the stated priorities. For example, from 2014/2015, the Adult Social Care Finance Return provides breakdowns of ASC expenditure by age, primary support reason, support type, and, for long-term support, by care setting. These data may allow a test of whether LAs redirected resources towards specific groups of ASC clients. Therefore, where available, the analysis of expenditure sub-categories may reveal whether resources were redirected in line with the identified goals. That said, changes in expenditure do not themselves demonstrate improvements in outcomes, efficiency or equity, and better use of existing resources may also substitute for higher spending.

Furthermore, Greater Manchester offers a useful case study of a complex and multifaceted devolution process. Disentangling the effects of each stage of a devolution deal that evolves over multiple years is difficult but crucial. This has direct relevance for current policy. The Greater Manchester partnership has been regarded as a prototype for integrated care systems, introduced in England in 2022. Within these systems, integrated care boards work alongside LAs and other partners, although the institutional arrangements differ from those in Greater Manchester in terms of funding, powers, and the role of local government. Better evidence on which elements of the Greater Manchester model worked, how resources were reallocated, and how these changes translated into outcomes could therefore inform the development of integrated care systems and integrated care boards, as well as the design of future devolution policies. Greater Manchester may therefore help answer a more policy-relevant question than simply whether devolution works: which combination of powers, resources and institutional arrangements enables local systems to translate greater autonomy into improved outcomes?

In conclusion, further research is required to establish more clearly whether and how devolution in Greater Manchester achieved its stated goals. This evidence would help move the debate beyond the question of whether devolution works and towards identifying the conditions under which it can improve population health and reduce inequalities.

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### Disclosure of artificial intelligence (AI) use

ChatGPT was used to improve grammar.

### Ethical issues

Not applicable.

### Conflicts of interest

Author declares that he has no conflicts of interest.

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