DEVO-HEALTH

What & why?

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This booklet sets out the context for IPPR's research on devo-health and the questions which we would like this programme of work to address. We also set out some initial hypotheses about devo-health which we will look to test as we proceed.

KEY FINDINGS

1. **At the moment, 'devo-health' is more akin to delegation than devolution.** In Manchester, the health secretary rather than the newly elected mayor will remain ultimately accountable for health and care. Going forward, this may need to change, with local mayors given clearly defined roles in the NHS and the centre stepping away from its responsibilities, in order to give local leaders 'skin in the game' and enable local communities to hold them to account.
2. Devo-health has the potential to drive improvements in health from both within and outside of the NHS. **Devo-health can catalyse reform within the NHS (particularly integration) and can drive improvements in the social determinants of health through the creation of place-based public services.** The latter has particular potential given that health devolution is likely to be part of broader decentralisation deals.
3. **The potential benefits of devo-health do not imply that every area in the UK should take on powers over the NHS**, but rather that it should be considered as one option in looking to drive reform going forward. **There is a better case for proceeding with devo-health in urban areas with clearly established geographic boundaries and with a strong history of joint working between the NHS and local government.**
   All future devolution deals should adhere to the decentralisation principles set out in IPPR North's report *Decentralisation decade* (see Cox et al 2014): they must have a clear purpose; be joined up across silos; be given time to bed in; have cross-party support; and will necessarily be asymmetrical.
4. **There are risks involved in health devolution.** Rather than simplifying the post-Lansley landscape, devo-health in Manchester has so far just created a new level of bureaucracy; rhetoric appears to be running ahead of reality, given that history shows structural changes rarely deliver in terms of efficiency or heath outcomes; and **there are very real concerns that 'devo-health' will ultimately lead to finger-pointing between central and local government as the next round of public sector cuts hit.**
5. Having said that, **the most commonly cited concern – that we will lose the 'N' in the NHS – has been exaggerated.** Significant variation in the quality of care and the health outcomes achieved already exists across England under our more centralised system. While it is feasible that devo-health could make this worse, that seems unlikely, especially as the NHS Mandate and NHS Constitution will remain in place.
6. **A huge number of unanswered questions remain.** How much freedom should local areas have to differ from national policy? Should full devolution follow delegation? Is there a role for fiscal devolution? How can local areas unlock the potential benefits of devo-health, and what should local areas do with their devolved powers? How do we keep the 'N' in the NHS while also delivering place-based public services? Will the funding pressures on the NHS and local government ultimately undermine efforts at reform? Our programme will look to address these questions and more over the coming months.

For the full report, including all references, data sources and notes on methodology, see: www.ippr.org/publications/devo-health

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