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Regional Government and Public Health

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Executive Summary

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Introduction

Why devolve anything at all? Before advocating the devolution of new powers, it pays to recall the reasons for devolution. Regardless of where they are, devolved governments offer the integration of public services, the development of innovative regional strategies, the democratisation of policy and the adaptation of policy to place. Devolution to the English regions offers all of these advantages. The question for policymakers is how to design an English regional settlement that gains these advantages. We argue that one policy field in which regions can demonstrate their advantages is that of public health, and that public health competencies should be devolved to elected regional assemblies in England.

English regional devolution cannot be a process like we saw in Northern Ireland, Scotland or Wales. Devolution until now has been about creating legislative bodies in pre-existing territorial administrations—the Scottish Parliament and the Welsh and Northern Irish assemblies each inherited most of their competencies from the pre-existing Scottish, Welsh, and Northern Ireland Offices and the Northern Ireland Civil Service. The reach and resources of the administrations barely changed; it was the structure of accountability that changed. The borders of the devolution settlement were largely settled before the arrival of the elected bodies.

By contrast, devolution within England has no previously fixed map of regional powers. There is no clear layer of regional administration, akin to the Scottish Office or Northern Ireland Civil Service, that could have a democratically-elected assembly attached. Thus the process of political devolution must go with the process of constructing the region as a political unit. In other words, devolution to English regions must come with the definition of English regions as real political units. Given that England is a highly centralised political unit, designing regional governments will require careful thought it the regions are to neither damage the workings of public administration nor be pointless.

We propose that public health be a function of elected regional assemblies. Turning over extensive public health powers to the regions would:

- build on the existing successful regional working in public health, working which has already demonstrated the value of a regional public health focus
- fit with the growing role of regions in coordinating, integrating, and adapting economic and social policies
- fill in a gap in British social provision by integrating health with other policies
- fit with the developing structure of public health in the NHS.

The rest of this study documents the extent of current regional working and its virtues; the way public health working interacts with its institutional environment; and the mechanisms necessary to integrate public health with ongoing regional activities in social and economic development and inclusion.

Background

This paper brings together two longstanding interests of the Constitution Unit, which have both been very active in 2001. The first is the Unit's work on regional government in England, now led by Mark Sandford. This has resulted in two major reports this year, the first on elected regional assemblies, *Unexplored Territory: Regional Assemblies in England* (July 2001); and the second on regional chambers, *Further Steps for Regional Chambers* (December 2001). The second longstanding field of interest is our work on Devolution and Health, funded by the Nuffield Trust. In May 2001 Scott Greer joined us to work full time on additional projects on devolution and health, funded by the Leverhulme Trust. He soon found that his interest in the devolution of health policy in England overlapped with Mark Sandford's interests in r

the ‘fear of the unknown’ which must inevitably dog the development of the regional White Paper.

Making health work

Despite the lack of serious regionalism in England, regional public health joint working has emerged—something that testifies both to its intrinsic virtues as a channel for social and economic policy, and to the commitment of activists from across different institutions who see ways to incorporate public health outcomes into their own agendas, to general benefit. From the mid-1990s onward, public health professionals, policymakers, and decision makers in other areas began to formulate and push an agenda in which public health and the wider determinants of health would be serious issues for policy outside the NHS.

The intellectual basis for these theses is simple and nearly irrefutable. Most great improvements in morbidity and mortality in the modern world have been attributable to work outside acute care. Sewers and clean drinking water, public transport and air quality regulation, immunisations and screening, jobs and training, education and healthy habits all have effects on quality and length of life that are rivalled only by a few of history’s medical breakthroughs. Thus, the best and cheapest way to solve many of England’s serious health problems is not through more investment in expensive acute services that will take years to come on line; it is through preventive programmes that reduce the need for such services now and in the future.

This agenda faces three obstacles. First, there is a strong cultural sentiment that health is “what the NHS does.” On one side, those inside the Service face a medical professional culture that exalts the academic and hospital specialists who work with some of the toughest diagnostic and treatment issues rather than those who grapple with disease vector analysis or dietary education. On the other side, much of local government and the state remains oblivious to the health consequences of their strategies—not realising that decisions about bus services, business parks, school curricula or domestic abuse plans have major health consequences and might not achieve their goals without major health inputs.

Second, in many cases there is overlaid on this divide an atmosphere of deep suspicion and dislike in relations between the NHS and other parts of local and national government. The NHS began by taking over hospitals once owned by local governments, and as a centralised, professional organisation has long had problems dealing with democratic local government. Furthermore, the core of the NHS is in health services, not public health. Until recently, there was little institutional support for attention to health beyond the health service. Meanwhile, every other policy field already has bureaucracies at work, with their own ways of planning policy. Thus, bringing health into their concerns requires that they change in order to achieve a goal they used to think was not their responsibility.

Third, every government agency remains subject to demands for delivery, which often means transferring resources and energy from policies with major long-run consequences to policies with smaller but more visible short-run consequences. Thus, waiting lists for the

The Labour Party came to power in 1997 with a clear commitment to reintroducing London-wide government. But it was anxious to avoid comparisons with the embarrassing past of Livingstone's GLC: especially as it had become clear by 1999 that Livingstone, by then an MP, would want to run for the new position of Mayor of London. Thus, the Greater London Authority was explicitly a very different body, bringing together a number of experiments in governmental practice.

GLA Structures

The GLA has Britain's first directly-elected mayor with sole executive power. The Mayor is elected by the Supplementary Vote. He or she may appoint an advisory cabinet, but takes all the GLA executive decisions (with one exception below).

The majority (90%, or £3.3bn) of the Mayor's budget passes to the four 'functional bodies': the Metropolitan Police Authority, the London Development Agency, Transport for London and the L.0(g)-520.1(to)2.3(g)12.4(eth.ueTw /F30F)itlectxtpmThy, Tr.2(t)0cento rftoge.1(m1(o)2.4(r)3.6(i)(L

The Mayor has no direct powers over health services. However, he or she does have a duty, according to the GLA act, “to promote improvements in the health of persons in Greater London”.[3] Originally, the act had no health responsibilities for the mayor, as the NHS and others were fearful that the mayor would try to take on a role in direct governance of health services. As the discussions leading to the act progressed, however, public health specialists at a number of key London institutions were able to persuade the NHS that the Mayor could help with public health (that once again, public health could provide a common ground between political forces that mistrust each other) and to persuade the London politicians that

London governance bodies outside the GLA

As stated, the salient attribute of the GLA is the absence of executive power. The Mayor must govern through influence and negotiation. Most executive power in London continues to lie in similar places to where it did before the GLA's arrival. For the purposes of public health, the important players are:

The Government Office for London.
This is one of the nine Government Offices, initially set up in 1994. For most respondents it has had a shadowy existence. Briefly before the setup of the GLA, one individual within GOL took a lead on public health, and built up some effective relationships. This individual retired, and nobody took his place. Health is not a Government Office responsibility, so it was very vulnerable to the personalisation of policy initiation and the current instability of

has done little to reduce this ignorance. One organisation, however, deserves pride of place in the structure of London health policy: the London Health Commission. In a fragmented policy arena riven by distrust and uncertainty about powers and alliances, it provides a space for education and policy coordination and is creating a London health policy community.

The London Health Commission

In a polity which functions through influence and negotiation, a natural means of working is through the advocacy coalition.[5] This is an informal group of as wide a range of experts in the field as possible, which meets to discuss and advocate policies (the concept constantly reappears under different names in political science, as researchers encounter it across countries, policies, and epochs). What has happened in London public health (and to a lesser extent in the other regions) is that the advocacy coalition has been semi-formalised. This semi-formal advocacy coalition is the London Health Commission.

The London Health Commission grew initially from the Turnberg Review of 1999, which created, for the first time, a London NHS region on the Greater London boundaries. Several organisations—the King's Fund, Government Office for London, Association of London Government, Metropolitan Police, the NHS, the London Development Agency, Health Development Agency and others—provided sponsorship for the Commission (it appears that the NHS London region leadership and the King's Fund were the organisations that provided the initial bases for the idea champions).

The Commission was also able to influence the GLA's health policy, though not that of London as a whole, by dint of having been set up earlier than the GLA. In that sense it was able to occupy the 'empty chair' of Mayoral health policy[6]. The Commission had a health strategy in place by the time of the Mayoralh-465.8(r)3.6(a)1q BT 0 0 0 v in(y)-357.12000(.)-480.0(A)

the existence of effective networks through which to carry out policy extremely tenuous. Some good relationships exist, but respondents are very aware that these may not last due to circumstances outside their control: naturally, this limits the energy that actors are willing to give to building effective working.

Personal relationships predominate in the absence of substantial budgets or powers for public health. The corollary of this state of affairs is that literally the only way open to public health professionals to secure effec

identity in the regions of England. It has no history of joint working; several boundaries which might easily be disputed (but have not been), and it has no one clear centre of power. There are five counties and four unitary authorities. Lincolnshire is highly rural and remote, with many associated problems; Northamptonshire, in the south, looks as much to London as to the Midlands; the three major cities, Leicester, Derby and Nottingham (each of about 250,000 people) are unitary authorities surrounded by shire counties, with the small unitary county of Rutland completing the picture. The region contains former mining areas and the tourism-oriented south part of the Peak District. The total population is some 4.2 million.

The lack of regional identity or joint working, and the consequent lack of past disputes, may be a factor in the East Midlands emerging as the most effective of the English regions in terms of joint working. It certainly illustrates that regional identity is not a necessary condition of effective regional joint working. Another factor, however, was undoubtedly good management. The East Midlands Regional Assembly made the construction of an Integrated Regional Strategy (IRS) a priority early on in its life, with the result that much less effort has been spent dovetailing different plans and working at cross-purposes since then. The IRS had input from, and consequently enjoys ownership by, all the important regional stakeholders.

Regional structures

The interest of the East Midlands is in its advanced degree of regional working and innovation. In each case, the good luck of the region appears to be in the degree to which its institutions are "fit-for-purpose:" they are mostly fairly new, and all are in the hands of entrepreneurial leaders who see how public health policy can benefit their institutions, the regional level on which they have staked their efforts, and their particular institutions.

The East Midlands contains the same regional structures as the other seven non-London regions of England. There is a Government Office for the Region, originally set up in 1994 with civil servants from four departments relocated to the region. In the last two years these four departments have been joined by representatives from Culture Media & Sport, the Home Office, and the former MAFF. GOEM has a unified directorate but no ability to vire between projects; its 2001-2002 budget of £391.61 million is confined within strict limits. Like the other Government Offices, it is an experiment to see how much benefit can come from putting civil servants together in an environment that limits departmental concerns. In the case of GOEM, it took the mission to heart, including extensive participation in regional working teams and a secondee from the NHS.

emda

The Regional Development Agency, emda (East Midlands Development Agency), was set up in 1999 from an agglomeration of previous national development bodies. Its budget is £91.23m; from April 2002 the budget will be subject to full virement across project heads. It

was tasked to produce a Regional Economic Development Strategy, which was also required to take account of environmentaled

The actual character of the work falls into two categories: bringing together those already making policy in a region to coordinate them and squeeze out extra value—such as bringing th

Secondments

The use of secondees is a common feature of the public health agenda. It represents a creation of soft money where it was thought not to exist—that is, a secondment is a

threatened in London than elsewhere. The London regional office will be the only region to survive unscathed. Underneath it will be five strategic health authorities, in place of the current 16 health authorities. Staff faces in the new system will often be familiar from the old one: relationships will be disrupted, but not fatally. None of this, however, should disguise the almost fatalistic tedium of yet more reorganisation expressed by the respondents. A further advantage for London is that most Primary Care Trusts are, or will soon be, coterminous with borough boundaries. This makes joint working at borough level (in principle) much easier.

The sheer size and legacy of disjointed working in London has meant that the construction of

organisations. There is very little possibility of shielding for London as a result, and, perhaps in turn, few of the large organisations attempt it.

In the East Midlands, distance from London, the metropolitan preoccupations of media and politicians, and the leadership of a few powerful individuals in the NHS and government have been able to shield regional health work, thereby making possible the achievements to date. Shielding is the crucial reason for giving public health to the regions. Public health involves integrating health concerns into a host of different activities. If it were a regional activity, it would be a centre of a broad integrated agenda. Without a regional shield to defend public health, as one interviewee put it, "it gets kicked off every time by waiting lists". Safely within the regional body, public health can be disconnected from statistics on waiting lists.

Why Devolve Public Health?

Devolution to the regions of England is a problematic subject for this government. A proliferation of performance indicators, close interest in local government affairs and tight discipline have been hallmarks of the Blair governments. In particular, the second Blair government stressed its commitment to improvement of public services: it would be very surprising if the regional White Paper advocated the decentralisation of those services and the consequent loss of control over them by central government. On the other hand, the same government has brought devolution to Scotland and Wales, and has long promised unspecified forms of elected government for England's regions. And it has always specified that elected regional government would need to be approved by referendum.

Thus the White Paper will necessarily tread a thin line between producing a model of regional government strong enough to attract support in a referendum, and a model which is not so strong as to strip central government of responsibility for public services. Therefore, it will have to draw up a list of powers which could reasonably be devolved to elected assemblies. Public health is a leading candidate.

In the Introduction, we mentioned four reasons why public health would function better as part of a range of powers enjoyed by regional assemblies. The rest of this section details why public health is an excellent candidate for devolution.

1. Regional public health would build on existing success

Devolving public health to the regions would build on the existing regional successes studied in this report. Regional public health, almost entirely on the backs of activists and idea champions in and outside of the NHS, has begun to show local results and, perhaps more importantly, change the way policymakers think about public health and the regions. As we have argued above, much of this is because of the development of strong regional policy networks and webs of secondments with slack resources and shielding from central

pressure. An elected regional assembly could enhance all of the above. Furthermore, it would have incentives to throw its weight behind public health, given the opportunity public health offers to bring together different regional players and the prominence it would have among the likely powers of elected assemblies. This would all be further reinforced by the regions' competencies, as public health would for them be a major responsibility, and it would be disconnected from the constant pressure on waiting lists that damages NHS public health working.

There is one fundamental reason that public health is such a good candidate to move into the regions. As we have said, public health is an inherently interstitial, entrepreneurial, viscous policy field. As such, it works to overcome departmental and functional divisions, creating neutral spaces for new thinking and eroding old barriers. It brings policymakers from different fields together to discuss topics that they had not discussed before—and therefore can give them a common cause in many cases where they previously had none. It thus depends on smaller policy communities and more trust than national policies. It also depends on local conditions that allow actors to forge partnerships that would seem far to specialised to national policymakers: programmes we studied such as a bus improvement programme in rural Lincolnshire or integration of mental health services and disability benefits for a troubled population in London can be identified and can create new networks far more easily in a region than in the central policy departments. Thus, for its adaptability, small size, and high trust, the region is an effective level on which to promote public health.

2. Regional public health would fit with a broader role for regions

Most of the conversation about what regions might or might not do is about the way they can give shape, coherence, and democratic accountability to existing policies. Nobody

focus on shaping policy regimes to suit their voters and that add great value by integrating concerns and goals across policy domains.

Also, it is likely that elected regional assemblies will have full, or at least some, freedom of virement over their budgets. Without that freedom, regional assemblies' reach will be extremely limited. With that freedom will come the advantages of 'soft money' set out above—along with the potential to integrate public health initiatives with transport,

4. Regional public health would fit with the developing structure of public health in the NHS

With the upcoming abolition of the NHS executive, Regional Directors of Public Health will be transferred to the Government Offices for the Regions, cutting across the new regional structures proposed for the NHS. The rest of the reorganisation pushes powers down to the local level with Primary Care Trusts doing most work and commissioning, and up to the level of three giant new Health and Social Care regions (plus London) and the centre, which wants a "clear line of sight" to the frontlines. Public Health will in this case be the odd one out, the only part of the NHS on the regional level.

This reorganisation means that many of the criticisms of regional public health have already been met. Critics can charge that by dividing public health into regional policy teams and the gritty work of public health specialists in the PCTs, the field will be split and distorted. If these charges are likely be proved right, then it is already too late. On the other hand, the integrative function of public health could be carried out even better as a major, professional, high-status part of a regional assembly's work rather than as another, small, component of the work of the Government Offices. Also, one major worry is that small, pressured, and GP-dominated PCTs will forget public health, and the Department of Health and Secretary of State will let them. Having a strong regional lobby to support public health funding and to work with PCTs—and regional politicians who would perforce have to make a mark in public health—could easily be a boon to public health in the local areas that outweighs any disadvantages of splitting the profession.

Blueprints

The goals of any regionalisation of public health should be:

- To facilitate regional joint working by bringing decisions down to a more flexible and accountable level of government;
- To raise the profile of public health and build on its success by making it a key part of the assemblies' powers;
- To make the most of—and build up—the assemblies by giving them a field that combines real issues (cancer, heart disease, teen pregnancy) with ample need for strategic thinking;
- To use the fact that both public health and regions work best when they can bring resources to bear on promoting, through networks, policy integration and new ideas that more effectively use existing resources and institutions.

The basic outline for a regionalisation of public health competencies is relatively simple, given the changes in regional and health system design in the last year. We propose:

- That the integrated public health teams currently being formed for transfer to the Government Offices be transferred to the elected regional assemblies upon their constitution;
- That the budgets of these teams be transferred as well as the available funds for regional public health promotion within the Department of Health and NHS Executive;
- That the regional assemblies have funds that can be vired between purposes and used as seen money or grants, and that they have a responsibility to use them to promote public health as well as their other goals;
- That the regional assemblies have additional soft money funds available as part of their start-

build their activities. The regional public health observatories are likewise a growing core of skills and knowledge. They and their staff and budgets should likewise be devolved to the regions where they can have the most impact.

More importantly, the government should devolve granting authority for public health to the regions: funds from HAZs, grants associated with HIMPs, social inclusion grants with an important health component, including New Deal for Communities and Single Regeneration Budget funds should be transferred as a block grant to the regions. This budget, combined

Instead, the important matter is that the design of the regional assemblies create something akin to the equality that the present devolved bodies have when facing Whitehall. The regional governments should have veto power over central public health spending in their regions; otherwise nobody need listen to them and they will not be able to fulfil their democratic or technical goals. Whitehall should not be able to run parallel programs in regional public health competencies; the experience of devolution in Northern Ireland, Scotland and Wales demonstrates that these kinds of clashes can be avoided or resolved, and that devolved and central governments can negotiate the exact divisions of powers. What is necessary to establish a basis for an amicable division of labour, however, is an obligation for Whitehall to listen to the devolved governments. Given that the NHS will retain extensive public health competencies in the PCTs and in the national level, the worry is that regions will be squeezed out. That is why we propose that the regions have, effectively, a veto power over public health projects directed from the centre. It is unlikely that regional governments would object to greater resources in their public health systems, but they must have some way to prevent their being sidelined by the centre. Furthermore, policy will work better if there is integration, and since it would be a regional core competency and optional for Whitehall, it is the region that must take pride of place.

As a route to making the most of policies in general, and to specify what will need to be in the concordats, regions could produce public health plans in line with their other competencies, but this (while very likely) need not be obligatory. They might also develop closer links with the new strategic health authorities to ensure co-ordination of activity, possibly including a more general health strategy for the region which the NHS would sign up to.

Ideas for the regions

The core of regional public health will be in its ability to shield and promote entrepreneurs by creating a core around which networks form, and funding worthwhile policies. However, there are other opportunities in the regional devolution of public health. There should be a distinct scrutiny / policy development committee for public health. This would be another

It is also likely that regional assemblies would be able to make innovative use, if they so chose, of special advisors, possibly of co-opting members of scrutiny / policy committees. There might be a useful role here for a body resembling the London Health Commission. That body has been somewhat frustrated in its work, according to some respondents, because of its large size (40+) making it unwieldy. It is also not clear whether its role is to advise on existing policy or to adopt a more proactive role. The latter could only be a beneficial means to bringing expertise on board. A slimmed-down version of the London Health Commission, with perhaps a dozen members, and with Assembly secretarial support, could provide a more focused source of advice. It would also be a vital means by which NHS senior management would maintain relationships with the regional assembly: it would be painfully easy for the two to arrive at loggerheads very early on.

A clear way of reintroducing links between the region and the sub-region—and at the same time increasing the democratic accountability of the NHS—would be to oblige some of the board members of each SHA to be drawn from the members of both the relevant regional assembly and the relevant local authorities. In the case of the regional assembly, the members could also be drawn from the public health policy / scrutiny committee (though, together with the proposal above, this might lead to overload): and in the case of local government, from any health scrutiny committee that had been set up by local authorities. An early useful task for the Public Health directorate would be establishing relations with any existing scrutiny committees, and feeding their findings into an archive available for the

The proposals for elected members to sit on SHAs might still be implemented, though probably fewer members would be able to do so.

In regions which have not voted for elected assemblies there would still be a role for public health. We suggest that the existing Regional Assemblies be charged with a public health planning and scrutiny function.

The objectives of this activity would be:

- to ensure that the development of regional political networks includes health, both as public health and the NHS services proper, and on a voluntary basis from the start rather than as a later imposition on the health service;
- to ensure that public health takes an appropriate place in all regional activities by both writing it into regional plans and creating awareness of how and why health concerns matter;
- to take full advantage of the transfer of public health into Government Offices by both solidifying older links into the NHS and creating new ones in the Government Offices;
- to thereby build the networks and consensus necessary to incorporate full regional public health powers into any later elected regional assembly.

The specific obligations would be:

- The regional assemblies, in consultation with all of their partners, but specifically the

Conclusion

The regional government agenda of the Labour Party, perhaps contrperto379.8(er)x.1(7)3.1(er)ct1.6(ab)t-2

Related publications by the Constitution Unit

The Constitution Unit's publications have proved and invaluable source of information for policy makers, practitioners, academics and students. All our work has a sharply practical focus, is concise and clearly written, timely and relevant to policy makers and practitioners. Further publications linked our regional government and devolution and health programme are listed below.

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- Devolution and Health: First Annual Report, February 2000 £10

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- Devolution and Health: Second Annual Report, June 2001 Free on line

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- Unexplored Territory: Elected Regional Assemblies in England, July 2001 £10

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- The Real Regional Health Agenda: Networks, Soft Money, and the Wider Determinants of Health in the East Midlands Free on line

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