King's Fund

Health in London: Powers and Responsibilities of the GLA

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Introduction

This paper deals with the distribution of powers and responsibilities for health at the London regional level. It focuses on the structures and processes at the interface of the new Greater London Authority and the developing health partnerships across the capital. Do they provide enough scope for the Mayor and Assembly to add value to health improvement in London?

The GLA about to be established is unique. It differs from its predecessor, the Greater London Council, from the Scottish Parliament, the Welsh Assembly and the governing body proposed for Northern Ireland; nor is it readily comparable to the system of government of any large city elsewhere in the world. Moreover, by vesting executive responsibility in a directly elected Mayor, it is importing an institution tried and tested abroad, but unknown here.

The size of London's population, over 7 million people, makes it difficult to compare with other UK cities. Other significant characteristics include the high proportion of ethnic minorities, the mobility and relative youthfulness of the population and the widening gap between the wealthiest and poorest. Twenty-four per cent of London's population is estimated to be living in poverty.[1]

The establishment of the GLA is also the first example of regional devolution in England. The legislation has been tailored to accommodate the complex governmental and administrative networks of a large metropolitan region and is unlikely to be replicated if devolution to other regions follows.

The GLA will be made up of a directly elected Mayor and an Assembly comprising 14 constituency members and 11 list members. The Mayor must produce strategies in eight key policy areas. Health will not be one of the strategies, but a general duty that must permeate GLA policy. The function of the Assembly is to scrutinise the actions and decisions of the Mayor.

In a typology of regional government, the new Authority is a version of executive devolution – a relatively weak form.[2] It will have executive responsibility, but not legislative powers; it will execute a range of strategic functions with a small overall budget determined by central government and raised by national taxation. The Authority will not provide services itself, nor will it be allowed to spend money on matters for which responsibility lies elsewhere, for example on schools or the delivery of health services.

Addressing the positive implications of this version of executive devolution, Stoker, Hogwood and Bullman suggest that such an assembly can provide a focus for democratic voice, collaboration and partnership, and be a more accessible and better-informed overseer of local authority activity (i.e. than central government). Part of the argument for giving the GLA a share of responsibility for health rests on the belief that it presents an opportunity to introduce a focus for 'democratic voice', which, in health, is largely confined to the national level, through a Secretary of State and junior ministers accountable to the public through Parliament. At the local level,

health authorities, of which there are 15 in London, are appointed by the Secretary of State.

The advantages of partnership and collaboration to which Stoker *et al.* refer are presently central to the Government's policy for all public services and are nowhere more important than in health improvement policy. This also points to a role for the GLA.

On the negative side, the same authors refer to:

... the fear of the establishment of an interventionist and meddling institution operating at a remote level to the public. Indeed a regional authority might squeeze out the established mechanisms for co-operation and partnership within regions. It could prove a weak check and influence on central government but a considerable threat to the autonomy of local government.

In the case of the GLA, prevailing concerns in the health sector and London boroughs are focused more on the possibility of the new Authority being interventionist and meddlesome, and less on the risk of its operation at a remote level from the public. In fact, the directly elected Mayor can claim to be mandated by and therefore in touch with the public, and the legislation includes a number of measures to ensure regular public consultation and accountability. It is unlikely that the new Authority could be perceived by the public as more remote than the Government Office for London (GOL), a branch of the DETR, from whom the new Authority will inherit several of its responsibilities.

Risks of encroachment on the autonomy of local government or health authorities have been addressed by statutory provision for certain powers to be reserved, and for the GLA to be barred from spending money on services for which responsibility lies elsewhere.

The task of identifying and instituting responsibilities to be devolved to the regional level is difficult, particularly within a system of government that has developed piecemeal, over centuries, under an unwritten constitution. The GLA is the first instance of English regional devolution and we are at the bottom of a very steep learning curve. There are signs that the enthusiasm with which the Government embraced devolution policies before and immediately following the 1997 election, is on the wane. Even so, it is important that the impact of the new Authority should be monitored and evaluated in order to inform the devolution process which may be developed for other English regions.

Devolution to Scotland and Wales has already raised some public health issues, for example, over the 'beef on the bone' issue (September/October 1999). The separate and conflicting pronouncements of the Chief Medical Officers for the three nations caused central government to exert considerable pressure to maintain UK conformity. The consequences of devolved responsibilities for public health and the development of decision-making and accountability at a new, sub-UK level are beginning to take hold.

Since the inception of the NHS there have been fluctuations in the way responsibilities for health are distributed between local democratic government and centralised bureaucracy. The emergence of a democratic regional tier will inevitably pose further questions about how the two should relate.

1. Powers

Greater London Authority Act 1999: Relevant Sections

In its passage through Parliament, the GLA Bill was considerably amended. It was enacted in November 1999. The relevant sections of the Act are as follows:

General and subsidiary powers

30 (1) The Authority shall have power to do anything which it considers will further any one or more of its principal purposes

(2) Any reference in this Act to the principal purposes of the Authority is a reference to the purposes of –

(a) promoting economic development and wealth creation in Greater London
(b) promoting social development in Greater London; and
(c) promoting the improvement of the environment in Greater London

(4) In determining whether or how to exercise the power conferred by subsection (1) above, the Authority shall have regard to the effect which the proposed exercise of the power would have on –

(a) the health of persons in Greater London
(b) the achievement of sustainable development in the United Kingdom

(5) Where the Authority exercises the power conferred by subsection (1) above it shall do so in the way which it considers best calculated –

(a) to promote improvements in the health of persons in Greater London, and
(b) to contribute towards the achievement of sustainable development in the United Kingdom

except to the extent that the Authority considers that any action that would need to be taken by virtue of paragraph (a) or (b) above is not reasonably practicable in all the circumstances of the case.

This exception was an amendment to the Bill.

(6) In subsection 5 (a) above, the reference to promoting improvements in health includes a reference to mitigating any detriment to health which would otherwise be occasioned by the exercise of the power

Other subsections give the Secretary of State powers to issue guidance concerning the Authority's exercise of its general power. Other important clauses in this context include:

Limits of the general power

31 (1) The Authority shall not by virtue of section 30 (1) above incur expenditure in doing anything which may be done by a functional body other than the London Development Agency

(3) The Authority shall not by virtue of section 30 (1) above incur expenditure in providing

(a) any housing,
(b) any education services,
(c) any social services
(d) any health services

in any case where the provision in question may be made by a London borough council, the Common Council or any other public body

(6) Nothing in subsections (1) to (5) above shall be taken to prevent the Authority incurring expenditure in co-operating with, or facilitating or co-ordinating the activities of, the bodies mentioned in those subsections.

'Any other public body' must, presumably, include health authorities of the NHS.

(7) The Secretary of State may by order amending this section make further provision for preventing the Authority from doing by virtue of section 30 (1) above anything –

(a) which may be done by a London borough council, the Common Council or a public body

Consultation

The Act requires the Authority to consult such bodies or persons, as it considers appropriate before exercising its power under section 30 (1). The bodies must include London boroughs, voluntary bodies with a London-wide remit, bodies representing racial, ethnic and national groups, different religious groups and business interests in Greater London. Health authorities are not included.

The same bodies must be consulted by the Mayor in preparing or revising any strategy (section 42).

General functions of the Assembly

59 (1) The Assembly shall keep under review the exercise by the Mayor of the statutory functions exercisable by him.

(2) For the purposes of subsection (1) above, the powers of the Assembly include in particular power to investigate, and prepare reports about –

(a) any actions and decisions of the Mayor,
(b) any actions and decisions of any member of staff of the Authority,
(c) matters relating to the principle purposes of the Authority
(d) matters in relation to which statutory functions are exercisable by the Mayor
(e) any other matters which the Assembly considers to be of importance to Greater London

60 (1) Where the Assembly decides to do so, the Assembly may submit a proposal to the Mayor

The power of the Assembly to require attendance at its meetings, and to produce documents (section 61) extends to staff of the Authority, members or chairmen of functional bodies, anyone who has held a contract with or received a grant from the Authority, Assembly members, and former Mayors within the previous three years. No one attending shall be required to give evidence or produce documents relating to advice given to the Mayor.

Mayor's strategies

The Act provides for eight strategies to be produced by the Mayor.

- transport strategy (section 142)
- London Development Agency strategy (section 306)
- London biodiversity action plan (section 352)
- municipal waste management strategy (section 353)
- London air quality strategy (section 362)
- London ambient noise strategy (section 370)
- culture strategy (section 376)
- spatial development strategy (section 334)

In preparing the strategies the Mayor shall have regard to the need to ensure that each strategy is consistent with national policy and with each other, and:

41 (4) In preparing or revising any strategy mentioned in (1) above the Mayor shall have regard to –
(a) the principal purposes of the Authority
(b) the effect which the proposed strategy or revision would have on
(i) the health of persons in Greater London; and
(ii) the achievement of sustainable development in the United Kingdom

The GLA's strategies will be implemented by various functional bodies and local authorities. The Authority will not provide any services direct. Transport for London and the London Development Agency are the main functional bodies under the Act, but a number of other bodies are specified, such as the Cultural Strategy Group (an unincorporated, advisory body) and the Metropolitan Police, in relation to which the Authority will exercise a number of powers. There are effectively five functional bodies whose relationships with the GLA are subject to provisions in the GLA Act:

- Transport for London
- The Metropolitan Police Authority
- The London Development Agency
- The London Fire and Emergency Planning Authority
- The Cultural Strategy Group

Other provisions

Other provisions that might be relevant to the GLA's health role include:

- the Mayor must appoint a Deputy Mayor from among the Assembly members. The Act contains powers for the functions of the Authority that are exercisable by the Mayor to be delegated to the Deputy Mayor, and members of staff of the Authority, to Transport for London, the London Development Agency, and also to any local authority.

- the Act confers powers of appointment to numerous posts in five functional bodies

- the Mayor must produce a state of the environment report every four years (section 351)

- the Mayor must produce an annual report, which must include a summary of information relating to the Authority's performance of its statutory functions as well as information that the Assembly requires to be included (section 46).

Strengthening Health Provisions

In an analysis of the responses to the GLA Green Paper that referred to health, the Health of Londoners Project (HOLP) reported that 80 per cent were of the view that the GLA should have some role in either assessing or prioritising the health needs of the people of London, or a strategic health planning role, or a public health role. This included the King's Fund who, following publication of the Bill in November 1998, recommended a number of amendments that would reinstate health measures outlined in the White Paper. They included a clear duty to promote improvement in the health of Londoners, and a duty to produce and publish reports on the health impact of the Mayor's strategies. Some relevant sections have been amended but arguably in more rather than less equivocal terms. There is no duty on the Authority to report on the health impact of its strategies.

Although the GLA White Paper had referred to the possibility of the appointment of a director of public health or an adviser on this issue, this was omitted from the Bill and has not been provided for in amendments. The King's Fund recommended that the Mayor appoint a public health adviser and that a duty of partnership should be extended to the new Authority,[3] but neither has been incorporated in the legislation.

In their comments on the Green Paper outlining the Government's plans for the GLA, the Health of Londoners Project identified four options for the health functions of the Authority:

1. *Status quo*, i.e. no role in health or public health. NHS to retain all its current responsibilities
2. Public health and scrutiny role
3. Public health strategy and scrutiny role
4. A more radical reorganisation of the public health function between the GLA, NHS and local authorities.[4]

What the Act has provided sits somewhere between options 1 and 2, with the NHS retaining all its current responsibilities and the GLA given a scrutiny power but no clear duty, and no responsibility for strategy. It is doubtful whether having regard to promoting health constitutes a public health role.

The health policy provisions in the Act may be summarised thus:

- the principal purposes of the GLA are concerned with economic development and wealth creation, social development and improvement of the environment
- improvement of health is not a principal purpose of the GLA
- the GLA has no statutory duties in relation to health strategy
- the GLA must exercise its powers in a way calculated to promote health improvement, but not if it considers that this is not reasonably practicable
- there is no statutory framework for the relationship between health partners and the GLA
- health authorities do not have to be consulted as other strategies are prepared or revised
- the Assembly cannot reject the Mayor's strategies
- the Assembly can investigate health issues, but does not have to
- health authorities may not be required to attend Assembly inquiries
- no GLA health official. An adviser remains optional but probably low priority.

This is not to say that none of these things will happen, simply that they are not required by statute. Health is implicitly a factor within the three areas that are the GLA's principal purposes – economic development and wealth creation, social development, and improvement of the environment. Health is important to all Londoners. The GLA's health role and the machinery to handle relationships with bodies not named in the Act will develop *de facto*. Much will depend on the role that health partners want the new Authority to play, and even more will depend on the way the GLA chooses to interpret its health role within the parameters of the statute.

An Alternative Approach: Wales

A different model of devolution has been adopted for Wales, where the health responsibilities already administratively devolved to the Welsh Office have been democratically devolved by empowering the Welsh Assembly to take them over. These are more limited powers than those allocated to the Scottish Parliament, but they are considerably more extensive than the powers vested in the GLA. The Welsh Assembly can:

- decide the size of health budget from within its overall budget
- monitor the health of the population of Wales

- promote health
- promote good practice in health services
- hold NHS bodies to account for their performance.[5]

This means that the Welsh Assembly has effectively taken responsibility for public health, the three essential functions of which are to survey the health of the population, to promote and maintain health and to ensure that the means are available to evaluate existing health services.[6]

Power without Responsibility

The provisions for health within the GLA Act are couched in terms of subsidiary powers. A power is a liberty to do *x*, whereas a duty is an obligation to do *x* and can be enforced through the legal remedy of *mandamus.* Even where the sections of the Bill dealing with health can be interpreted as a duty, they would be extremely difficult to enforce through the courts. The GLA could offer a defence that resources were not available to promote improvements in the health of Londoners, and it would be difficult to establish who would have legal standing to seek a remedy. Under section 30 (5) the Authority is given ample discretion to justify not exercising its power in the way it considers best calculated to promote improvements in the health of persons in Greater London.

The Act provides no statutory framework for joint working with the agency leading health improvement (the NHS), either with the Regional Office for London or the 16 health authorities in the capital, or with any of their health partners. It is striking that the Act makes no reference to the NHS or health authorities, in contrast with other policy areas where institutional relationships with functional bodies and other existing authorities are the subject of detailed provisions. Comparison with environmental functions is particularly instructive:

- it is a principal purpose of the Authority to promote the improvement of the environment in Greater London
- the Mayor must produce four environmental strategies (waste management, air quality, ambient noise, biodiversity action plan)
- each functional body shall have regard to these strategies
- a team will be at the Mayor's disposal
- a state of the environment report must be published every four years.

The failure to make similar provisions in relation to health policy means that the new Greater London Authority will have statutory powers in relation to health improvement, without any formal share of responsibility. The power of the Mayor and Assembly to publicly raise health issues, voice criticisms, attribute blame, and make recommendations can be exercised safe in the knowledge that the formulation and delivery of health improvement policies are matters for which they are free from statutory responsibility. Nor are they encumbered by the duty to work in partnership which underpins the inter-sectoral collaboration central to the development of health improvement strategy.

This can be interpreted as safeguarding the independence of the NHS to pursue its own nationally determined objectives, but it also gives a free hand to the Mayor to

intervene in health randomly and in a self-serving way. The perceived importance of keeping the GLA out of health *services* has obscured the advantages of constructively engaging the new Authority in health improvement.

The theoretical argument for giving the Mayor and Assembly clear responsibilities and a defined role in improving the health of Londoners rests on the perception of health as a basic human need or right, and the widespread understanding of health in terms of its social and economic determinants. The claim made by the authors of *Future Prospects for Public Health* has resonance in this context:

As far as the overall determinants of health are concerned, and in terms of what might be done to improve the health status of the people, less than ten per cent of the relevant determinants are to be found within the sphere of NHS activities. The remaining ninety per cent are dependent upon decisions made elsewhere in the economy ... it is these decisions which must be influenced by any public health policy which is to have meaningful outcomes[7]

This has been a missed opportunity to place a share of responsibility for specific public health functions within a multi-functional strategic authority, or to ensure that the strategies of that authority really do incorporate health measures.

The growing body of work by HOLP has shown the need for strategic action on health at the regional level and for an orchestrated, pan-London approach to health improvement. There is a regional health agenda and the London Regional Office has launched a number of London-wide initiatives to develop ways of delivering it, for example the London Health Strategy and the Public Health Network. The work of the proposed London public health 'observatory' may help in distinguishing the regional from the local agendas.

Why the GLA is well-placed to share strategic responsibility for public health

- London-wide
- a multi-functional, strategic body
- separate from service commissioning or service delivery
- democratically accountable
- subsidiarity: decentralises decisions from national to regional levels
- a new conduit to/from the public
- unique opportunity to trial civic leadership in health

This does not mean that strategic health powers should be taken up from the local level, only those public health functions delivered at the regional level, such as overseeing HImP development and the linkages between HImPs and Community Plans, integrating health with economic regeneration, and delivering the wider public health agenda across London through GLA strategies for transport or policing/crime. Some of these wider strategic functions could be delivered by continuing partnership between the London Regional Office and the GLA. Eventually it might become mutually beneficial to both partners, as well as in the public interest, for the GLA to take sole responsibility for some (e.g. issues relating to its strategies, or more broadly, those which demand high levels of public consultation and involvement)

while the LRO retains charge of others, and also the responsibility for delivering its service agenda.

A Framework for Partnership

In its submission on the GLA Green Paper, the Association of London Government (ALG) pointed out:

There is no proper statutory framework for the development of essential links between health services, local government, police, the private sector and non-statutory organisations.

Behind the legislation there appears to be an implicit assumption that partnership with the GLA will spontaneously develop. Speaking at the King's Fund Conference in December 1998, the Public Health Minister, Tessa Jowell referred to the relationship between the London Regional Office and the Mayor (together with his or her advisers) as crucial. She envisaged the Regional Office acting as a conduit between individual NHS organisations and the GLA and referred to:

... a natural and essential partnership between the Regional Office and the Mayor, who has a duty to promote improvements in health[8]

In fact, the Bill, which was published only days before the conference, did not provide a clear and unambiguous duty to promote improvements in health. The need to improve health was instead a matter to which the Mayor must have regard in producing his or her strategies. The Minister anticipated the Mayor working alongside the Regional Office, to help local authorities and NHS bodies work together more effectively:

Establishing effective partnerships will be crucial to the GLA in improving the health of Londoners. Partnerships must have a firm base in terms of relationships and trust.

Whether the GLA will play this kind of voluntary brokering role in health is uncertain. Lack of strategic powers over health has effectively relegated it to the bottom of the GLA agenda, well below transport and economic development, environment or culture. The trust to which the Minister referred will have to be built from a sub-zero position. Among health authorities and in local government there is considerable apprehension about the GLA, an echo of the strained relations that often existed between the former GLC and the boroughs. There is an underlying concern that power and influence will be drawn up from the local to the regional level, and that the new Authority will be meddlesome rather than constructive.

The regional health agenda to which the GLA will, at least theoretically, contribute is now being developed through the London-wide public health initiatives launched by the London Regional Office. But the part that the GLA will play remains a matter for speculation. Communications will become more complex, for example an intermediate organisation is now being developed by the ALG and other London groups, intended to enable them to speak with a stronger voice to the GLA.[9] A number of professional groupings may also provide some kind of collective negotiating role with the GLA on behalf of their constituents, for example chief

executives of health authorities, or London boroughs, directors of public health, chairs of health authorities or PCGs.

This reaction may have the effect of making dialogue with the GLA more tenuous and protracted. There will be issues where the bodies concerned will not be able to speak with one voice. The Mayor and his/her advisers will not feel constrained to use recommended channels of communication where more direct ones achieve the results they want. The relationships and trust envisaged by the Minister may prove elusive in the absence of more binding forces. It would be especially regrettable if the collaboration between health authorities and the boroughs which has been reinvigorated by the process of HImP development was to be undermined by the interventions of a GLA that played one off against the other.

The importance of getting the GLA to work with health partners is paramount. It will require a dual relationship, with the Authority's executive branch (the Mayor) to ensure that the GLA's London strategies incorporate effective health measures, and with the Assembly, which will have a scrutiny role but can also be an ally in exerting pressure on the Mayor. If health fails to materialise on the Mayor's agenda, there is a danger that the GLA's role in relation to health is reduced to one of scrutiny, and a rare opportunity will have been lost.

2. The Mayor

Politician

In May 2000, London will become the first English region/city to have a directly elected Mayor. With some 5 million people eligible to vote, it will be the biggest individual election in British political history. Across Europe, the mandate that delivers London's Mayor will be exceeded only by a few national presidents. This wholly foreign political institution is intended to have a radical effect. The White Paper which set out the Government's vision of the GLA states that the Mayor

... will have exceptional influence, going well beyond the specific statutory and financial powers of the Office, yet remain accountable to Londoners ... we expect the Mayor to become a high profile figure who will speak out on London's behalf and be listened to. Londoners will all know who their Mayor is and have an opinion on how he or she is doing. This will change the face of London politics[10]

The biggest lever at the Mayor's disposal is the legitimacy derived from the large electoral mandate, which makes the holder of the office a conspicuous public figure, and generates both power and pressure to succeed. The Mayor can only retain credibility and public support if the strategies for London produce tangible results and the GLA can be seen to make a difference. In areas such as health and education, in which there is an abiding public interest and therefore electoral mileage, the Mayor need not hesitate to draw attention to failures of policy for which others are responsible.

The most important relationships for the Mayor will be with the heads of the functional bodies who will, in effect, make up the Cabinet, and with the Assembly.

There will be issues on which the Mayor and Assembly are mutually supportive, and others where the distinct nature of their respective functions will place them at odds. The task of holding the Mayor to account is intended to produce a creative tension between the two.

The current policy initiative to move towards directly elected mayors and a cabinet style of local government is specifically intended to curtail the worst effects of a two-party system and restore public confidence in local democracy. The GLA has been designed with a similar objective and the impact of party politics on the working of the GLA will be radically different to the previous experience of local councils. The Mayor will be quite unlike the traditional mayors of local councils, selected from among their own number by majority parties following election.

The process of UK devolution in Scotland and Wales has already indicated how the traditional, two-party domination is weakened at the sub-central level. The overseas experience of directly elected Mayors cited by Clarke *et al.* suggests that once elected, distance from party opens up.[11] The Assembly, elected by PR will be characterised by coalitions and alliances, and smaller parties, even single-issue parties, will stand a greater chance of electoral success. Even under first-past-the-post elections to the GLC, no party won over 50 per cent of seats, except on one occasion.

Thus, for a variety of reasons, the London Mayor is unlikely to have the backing of a single majority party, a fact which will have a substantial impact on accountability, and on the whole *modus operandi* of the GLA. Over time, conventions will develop which govern the way the Mayor/Assembly relationship works. The standing orders adopted by the Assembly will be important in this respect, although, under the terms of the Bill, they cannot bind the Mayor.

Holding the GLA elections mid-term in the general election cycle is likely to increase the chances of opposition parties doing well. This may be more than just a protest vote, for example voting patterns in federal systems have been identified in which voters regularly support one party in federal elections, but another in state or local elections. This is unlikely to lead to any kind of gridlock between Westminster and the GLA, because the powers of the GLA are executive rather than legislative, and the Authority is delivering national policies with funds from national taxation. Differences will probably manifest themselves in the detail of policy, in the delivery of services, strategic priorities, etc.

Party allegiance will also be a factor in the relationship between the GLA and national government at Westminster. Party nomination procedures have caused considerable controversy and revealed the difficulties which may lie ahead. One candidate from an opposition party has already declared an intention, if elected Mayor, not to move into the planned GLA building – an interesting dilemma.[12]

The GLA, like any devolved authority, is potentially a locus of opposition to Government and Prime Minister, which is why important powers are retained at the centre. For example, the Secretary of State (DETR) has powers to issue guidance to the GLA as to whether it is exceeding its functions, and may make orders to amend relevant sections of the Bill in order to prevent the Authority from doing anything

... which may be done by a London borough council, the common Council or a public body (section 31 (7)).

This could apply to health authorities. The Secretary of State can also issue orders to impose limits on expenditure incurred by the Authority in exercising its general power.

Putting Health on the Mayor's Agenda

In the context of the limited health powers and duties described in the previous section, the best hope is that the Mayor can add value across the capital to the effectiveness of health improvement policies and strategies developed by health and local authorities and their partners. It is at the local or borough level that real responsibility for health lies, and where health policy is delivered. Through the policy of Health Improvement Programmes, still in its infancy, the framework for health authority expenditure and service commissioning is set out in terms of health improvement priorities and objectives. The contribution of the boroughs to health is now more fully acknowledged than at any time since public health was moved from local government into the NHS in 1974. A logical development of this trend is to involve the new regional authority, which will be responsible for key strategies to be delivered locally by the boroughs and other agencies (to this end the King's Fund recommended the new duty of partnership be extended to the GLA).

For this to happen, all partners in health improvement need to regard the Mayor as a powerful ally from the beginning. The way the first Mayor works will set an important precedent.

The Mayor's most coherent contribution to health in London will depend largely on appropriate measures being included in the eight strategies for which the Mayor is responsible. Can the Mayor be persuaded to take health seriously as an issue dependent on sustained, multi-functional, long-term strategies? This will depend on a number of factors:

- demonstrable benefit to electorate
- equation with manifesto pledges
- mutual interest in outcomes
- calibre and working style of Mayor
- access by the Mayor to information and expert advice on health
- development of dialogue and mutual trust with health partners.

Demonstrable benefit to electorate

The long-term nature of health improvement policies militates against the kind of solutions which politicians like to identify. However, an increasing number of other important policy issues are not amenable to the quick fix, for example crime reduction, traffic congestion, pollution, food safety. Politicians will increasingly have to find ways of sustaining dialogue, support and engagement from their electors if inroads are to be made into intractable problems.

Equation with manifesto pledges

In the run-up to the first elections in May 2000, health has so far been an insignificant element in the election manifestos of the candidates. This reflects the meagre health provisions in the Bill. The public is undoubtedly interested in health from both a personal and a collective standpoint. A growing concern with the food we eat, the quality of the air we breathe and personal fitness point to this. So does the popularity of any television programme concerned with health services, documentary or fictional. A survey for the King's Fund also showed that Londoners are well informed about the determinants of health.[13] It is also true that the public has views about the health services that it wants. Hospital closure decisions have been difficult to justify to constituents. Mayoral candidates in the future may seek to tap into electoral support by publicly pledging to work for short-term goals in health service issues

Mutual interest in outcomes

If the Mayor can claim no credit for improvement in the health of Londoners, there is obviously less incentive to get involved. There is no mileage to the Mayor if the Secretary of State for Health is able to claim that the health of Londoners is improving – thanks to the work of his Department, the NHS and their local partners. This is a pragmatic and compelling reason for bringing the GLA into established health structures and processes.

Calibre and working style of Mayor

Once elected Mayor, expectations will be high. The challenge is to build a record on which a reputation can be sustained. With no statutory duty to work with health partners, the individual qualities and working style of the Mayor will be important if s/he is to exercise influence and make a contribution. It is paramount that the first holder of the office is able to build the partnerships capable of developing into the conventional *modus operandi.*

Access to information and expert advice

For health to stay on the Mayor's agenda, s/he will need direct access to London's official health facts and statistics. This will generate an increased workload for the LRO and may require a dedicated liaison team to deal with GLA demands and ensure health information is made routinely available to them. Both the Mayor and the Assembly will seek information about health and its unavailability may be difficult to justify. For example, the Assembly may conduct an inquiry and call for evidence from 'persons and papers'. Inevitably, more information is going to enter the public arena as a result of GLA activity. (For analysis of health information and policy research, the Mayor will also have recourse to academic and specialist institutes, expert individuals and campaign groups.)

Development of dialogue and mutual trust with health partners

This will be crucial. Health will not be high on the Mayor's list of priorities. To keep it on the agenda at all may require sustained pressure from outside. Notwithstanding the capacity of the Mayor and Assembly to make life difficult for all players in

London's health economy it is important that they are not seen purely as critics and scrutinisers of health policy. The Mayor, Assembly members and chiefs of the functional bodies must be regarded as health allies.

Health Roles

Assuming the Mayor will sooner or later become involved in health, s/he could play any of a number of roles ranging from the co-operative to the oppositional. They are not mutually exclusive and the Mayor could play several of these roles in relation to different issues, at any one time. Each role will involve a different set of relationships that may be adversarial in one policy context and harmonious and co-operative in another. Negotiation will be a key skill.

Convenor/negotiator

Broadly supportive of agreed policies. Uses influence to 'knock heads together', to tackle barriers to health improvement and extend partnerships. Helps deliver joined-up government. Incorporates national health priorities into Mayoral strategies.

Examples:

- supports HImPs
- public backing for specific health campaigns such as screening, take-up of immunisation, reducing pollution, accident prevention, tobacco policy, healthy schools, healthy living centres
- secures input by functional bodies

Health ambassador

Represents the health interests of London to national government, to other regions, and to foreign cities in Europe and worldwide.

Examples:

- pressing for a new regional distribution formula which would bring more NHS funds into London compared with other regions
- signing up to international initiatives such as Healthy Cities

Critic/auditor

Takes a detached view of health policy. Voices criticisms. Publicly endorses critical reports resulting from Assembly inquiries. Scrutiny role. Interested in London health services, the Mayor may forge links with the CHC movement and take a view on complaints against health authorities and trusts.

Examples:

- service-related issues, e.g. waiting lists, hospital closures, winter crisis
- performances of provider trusts

Oppositionalist

Mayor tries to take health leadership role – publicly challenges national or local priorities, seeks to change agreed strategic direction, pursues own agenda, publicly presses HAs and boroughs into specific courses of action inconsistent with agreed health improvement policies. This could come about as a result of political convictions, personal priorities, whims, an antagonistic or abrasive style, and a poor relationship with health authorities and partners.

Examples:
- ideological issues, e.g. health inequalities, private finance initiative, rationing
- intervenes in rationalisation of services, e.g. hospital closures

Advocate/campaigner

Espouses causes, either specific health issues or special interest groups. The Mayor's support will be a prize worth having for an organisation seeking political influence, fundraising or publicity. The Mayor will welcome opportunities to be associated with good causes – and to score quick wins.

Examples:
- issues – tobacco, asthma, fluoridation
- groups – asylum seekers, the homeless, patient groups, pensioners, young people

Strategic leader

Goes beyond the convenor/negotiator role supporting existing strategic aims and initiates own strategic health agenda. Responds to London's health needs as s/he sees them. Substitutes personal vision for health strategy *status quo*.

Examples:
- any health issues, new priorities

3. The Assembly

Power over the Executive

The general function of the Assembly, as set out in sections 59 and 60, is to keep under review the exercise by the Mayor of the statutory functions exercisable in his or her role. In doing so it has power to investigate and prepare reports about any actions and decisions of the Mayor or member of staff of the Authority, as well as:

59 (2) (c) matters relating to the principal purposes of the Authority
(d) matters in relation to which statutory functions are exercisable by the Mayor, or
(e) any other matters which the Assembly considers to be of importance to Greater London

Thus the Assembly may influence the health policy process by scrutinising the Mayor's actions, i.e. the delivery of his/her health functions, or by scrutinising health issues *per se*.

The Assembly can delegate any of its functions to a committee or to a single Assembly member, without preventing the Assembly from exercising those functions. With eight strategies to approve as well as the annual budget, the Assembly may refer each one to a Committee for detailed scrutiny.

In terms of overall control of the Executive, the powers of the Assembly are weak. It has, for example, no powers of veto or amendment over the Mayor's strategies. The Act provides that in preparing or revising his/her strategies, the Mayor must consult the Assembly and the functional bodies before consulting a number of other bodies such as London borough councils. The Mayor does not have to take any advice given; consequently the Assembly can criticise strategies for failing to take adequate account of health issues but can do nothing to enforce amendments.

Like any representative parliament, the Assembly will be open to pressure/pleas from its constituents. During consultations about the Mayor's strategies health partners will need to lobby GLA members to ensure measures to improve health are included. There is little the Assembly can do if they are excluded, except to draw public attention to the fact.

The Assembly's powers to overturn the Mayor's annual budget are also severely limited and depend on a two-thirds majority vote to approve an alternative proposal.

The Assembly has no powers of veto over the appointments within the Mayor's gift.

Inquiries

The Assembly has virtually unlimited scope for its inquiries in terms of subject. The possibility of an Assembly inquiry is a powerful weapon, simply by virtue of public exposure. However, much of the effectiveness of the power of inquiry depends on accompanying powers, which determine whether reports can be acted upon. At Westminster, the weakness of the House of Commons in holding the executive to account is manifest in the way select committees operate. Restricted opportunity even to have select committee reports debated in the House severely reduces their effectiveness. The impact of Assembly inquiries will also be confined to publicising issues rather than having recommendations implemented.

It is unclear whether health authority representatives could be compelled to give evidence before Assembly inquiries; they are not included in the bodies listed in section 61, such as members of functional bodies, GLA staff, former Mayors and Assembly members. In the event they would, of course, be under a considerable public obligation to attend. Over time, and as a collaborative relationship develops, the NHS London Regional Office may increasingly be regarded as having a comparable relationship with the new Authority as other functional bodies – still managerially accountable to the NHS but interconnected with the GLA.

In general terms, how far the writ of the Assembly will run is a matter for experience.

It might take an interest in issues which verge on the boundaries of its remit: for example, it could review the effectiveness of its emergency services and decide to include the ambulance service although the GLA is not responsible for it. An outbreak of some rare disease might lead it to inquire into communicable disease arrangements in the capital, notwithstanding responsibility lies within the NHS.

Representation and Advocacy

As representatives of their constituents, GLA members will have to carve out a new role in relation to those of local councillor, Member of Parliament and Member of European Parliament. In order to differentiate, the pressure will be on to maintain a London-wide focus, although inevitably their support will be sought in relation to purely local issues. Like any elected representative they will have to respond to a wide range of issues and will be expected to act as advocates for their constituents. Health issues are bound to be raised in this context. The role of the 11 list members may develop differently, with less constituency work than the other 14 members.

Attention has been drawn to the need for constituency casework to find its proper level in the UK. In Germany, for example, national government members do not handle cases directly, but pass them to members of regional Parliaments and local councillors, freeing MPs to develop a more strategic or effective scrutiny role.[14] In the context of London this would mean GLA members taking some cases from Westminster MPs and passing some down to councillors.

4. GLA Health Unit

Health Information

The GLA can only become a valuable partner in health if it has ready access to reliable health-related regional data. The Mayor will need expert advice, from someone who can sustain dialogue with other health partners and speak on the Mayor's behalf. Without this, health is likely to drop further down the Authority's agenda. The White Paper made reference to the possibility of a Mayoral appointment of a director of public health or an adviser but no provision was included in the Bill.

The Mayor can appoint up to 12 advisers to be based in the Mayor's Office (the other two branches of the GLA staff structure are the Assembly secretariat, and shared services, which include the chief executive). It is entirely a matter for the Mayor to decide whether to appoint an adviser on health. In theory at least, there would be nothing to prevent a Mayor who views health as sufficiently important appointing a public health expert to the cabinet.

Realistically, and given the demands on the Mayor in policy areas where there are substantial strategic and budgetary responsibilities, it is unlikely that s/he will devote more than a minimum of expert resources or time to health improvement. The worst scenario is that there may be none at all

In the provisions made for environmental policy, where the Mayor has a duty to ensure that all the policies s/he pursues are sustainable in the longer term, the White

Paper specified that a team will be at the mayor's disposal *'to ensure that environmental initiatives are integrated with other strategies'*. In health, where the general duty is similarly intended to underpin other strategies, a comparable resource is needed. Presumably the assumption behind this omission is that public health expertise will be made available by the NHS or commissioned independently from academic departments, research institutes or the London health observatory.

The Mayor and Assembly will need the following information as a minimum:

- baseline information about London health to inform strategies
- information to allow comparisons over time, between boroughs/areas, with other cities
- health service-related data, e.g. access, take-up rates, etc.
- Londoners' views, perceptions, concerns.

Health Expertise

As well as access to data, a senior level health expert is needed for a number of reasons:

- to keep health on the political agenda. The Mayor will have little time to pursue health issues. There is no responsibility to produce a health strategy, hence its low priority
- to liaise with the functional bodies responsible for delivering the Mayor's strategies which must take health of Londoners into account, e.g. Transport for London, the LDA
- to present and interpret public health information to the Mayor. Public health issues require a long-term approach and are often not voter-friendly. A strong steer may be needed to prevent the Mayor from confining any interest in health to health services
- to maintain dialogue with organisations and individuals active in public health. This may involve representing the Mayor, e.g. in health partnerships.

Providing public health advice to the Assembly raises issues relating to separation of powers. In the event of an Assembly inquiry into health aspects of the Mayor's strategies, or generally when scrutinising the actions and decisions of the Mayor, as the Assembly is required to do, the possibility of a conflict of interest means that a different source of advice will be needed. The Assembly's standing orders will need to take this into account. One solution would be for the Assembly to appoint its own advisers for the duration of each inquiry as with Parliamentary select committees. (It would be unrealistic to expect the GLA's small establishment to maintain two separate health policy advisers). Alternatively, a GLA 'health team' could be housed in the Assembly secretariat, or be part of shared services providing data to both branches of the Authority, leaving the Mayor to bring in health advisers on an ad hoc basis as and when needed. This arrangement would be less likely to keep up the necessary dialogue between the GLA and health partners at the official level. For this reason a senior health adviser in the Mayor's office is needed.

A pragmatic argument against providing the GLA with its own independent public health unit is one of duplication: why replicate the office of DPH for London when the

Regional Office of the NHS already has one? This raises the question of the form the institutional relationship might take between the GLA and the office of DPH for London. Under the former regional health authorities, DPHs continued the tradition of professional independence, which had evolved at the local level through the office of the former medical officers of health within local government. When the RHAs were abolished, to be replaced by Regional Offices of the NHSE, their directors of public health lost their independent status and became civil servants. This was a departure from long established practice, which attracted some criticism.[15] Regional directors of public health are now managerially accountable to the Regional Office's Chief Executive and professionally to the Medical Director of the NHS Executive and to the CMO.

It is difficult to see how, thus placed, the same office holder could serve both the NHS and the GLA. The requirements of the two organisations will be different, and the new Authority will need an independent public health expert.

At the local level, independent status for DPHs has been retained, at least for the purpose of producing their annual public health reports, and is now being reinforced by a small but growing number of DPHs who are jointly appointed by health and local authorities.[16]

Other options open to the GLA include:

- developing the capacity of the London Research Centre (which is being brought into the GLA) to include a GLA health division

- commissioning public health input on an ad hoc contractual basis from academic departments, research institutes, or the 'public health observatories' (an as yet loosely defined concept referred to in the recent public health White Paper)

- the Mayor will have the option of bringing outsiders into the Cabinet and could obtain the services of a public health expert in this way

- the Mayor will have powers to supplement core staff by secondments and cross-cutting working arrangements with the new London bodies and authorities. The 1999 King's Fund report referred to the possibility of the London Regional Office making a secondment of a senior public health post, but this would not obviate the need for independence and, unless personally chosen or approved by the Mayor, may not be the preferred option

- if the Mayor makes no health appointments it would benefit the London health authorities to continue to fund salaried convenors for key groups such as chief executives, DPHs or chairs, or for specific subject areas. Their remit could be extended to provide advice to the GLA and assist in the development of collaborative mechanisms.

5. Resources

The funding of the new Greater London Authority is a specialist area beyond the remit of this working paper, but a few points should be made. First, the GLA will be modestly funded; it will also be barred by the Act from spending money in areas for which responsibility lies elsewhere. This raises the question of how any new regional health activities generated by the GLA will be funded.

Boroughs and health authorities could continue to top-slice budgets to fund regional initiatives or contribute towards salaries of convenors.

Regional health promotion activity – which is likely to appeal to the Mayor – can be more cost-effective regionally than at the local level. Advertising costs, which for district health authorities and boroughs would be prohibitive, can be met by pooled budgets across a region – which might also correspond with a television catchment area.

In so far as the Mayor's priorities can be predicted, it is almost certain that he or she will publicly press for more central government funds for London, in any area of public spending, but particularly NHS funding, where it is widely perceived that London lost out to other regions as a result of RAWP,[17] and that the capital's special circumstances are not reflected in the way funds are distributed.

There is a growing body of academic and political opinion that changes are needed in the way territorial expenditure is allocated. The Barnett Formula, which governs changes in public spending allocation to the regions, has been in operation since 1978, and is updated annually on the basis, not of needs, but of population changes. The results are widely held to be inequitable. For example, public spending in Scotland is 16 per cent higher than the UK average. However, block grants to Scotland and Wales have traditionally allowed greater scope to vire funds between budget heads than in England. This is a subject of the utmost complexity and taken out of context, comparisons can be invidious; one Mayoral candidate has already implied that Scotland is responsible for the poor state of London's public transport.[18]

Although, in the process of devolution to Scotland and Wales, the Government pledged to maintain the Barnett Formula, the arrival of devolution means far more transparency, as Heald & Geaughan have pointed out:

... the real numbers will increasingly be in the public domain and it will be much more difficult to fudge them[19]

They suggest the Government should reassess its commitment to maintain the Barnett Formula and should announce its intention to conduct a needs assessment for, say, the year 2002 (following the next election). The London Mayor is likely to generate more support for change, and in doing so will provide further impetus for other English regions to have a voice.

The Mayor may also be instrumental in levering funding from private or charitable sources for initiatives that may contain health components, or specifically for health promotion campaigns (an extension of the public–private partnership principle). More

fundamentally, it is one of the GLA's principal purposes to promote wealth creation in Greater London.

6. Future Development

The GLA Bill will received the Royal Assent two days before Parliament was prorogued on Friday 12 November. Its enactment and the inaugural elections in May 2000 mark the beginning of a devolution process. The way the Authority will actually work, and the scope of its activities will be a matter for interpretation. There are three important factors in this context: the *modus operandi* of the Authority as a body, which will be influenced by the standing orders it adopts; the working practices and tone set by the first Mayor; and the role of the courts.

In relation to a health role for the GLA, reference has already been made to the importance of the first Mayor being prepared to build and sustain partnerships. This will depend not only on the NHS and existing health partners actively enlisting the support of the new Authority, but also on the priorities and personality of the Mayor. A conciliatory rather than oppositional style is needed at the start, when convention and practice is being established, as well as a constructive interest in issues of health strategy.

The legislation, like Scottish and Welsh devolution Acts, says little about the machinery for conducting relations with Westminster, for example the role of GOL in relation to the GLA, and in particular, the handling of the public health brief relating to liaison and the oversight of Health Improvement Programmes (HImPs). Where competencies overlap between Westminster and the Welsh Assembly, a series of concordats are in the process of development; presumably something similar will be needed for London. These are intended to be purely political documents and not legally enforceable. Machinery will also need to be developed to resolve disputes between regional and national governments.

The courts will also play a part in defining the way the Authority works and the exact nature of its remit. It has been argued that devolution, and the way it builds on the Union structure is for the UK what federalism is for Australia, Canada and the USA: it provides a constitutional framework only. The courts, and ultimately the Privy Council, will have a central role in interpreting the devolution settlement and in adjusting it in the light of changing circumstances:

This may go further than purely marginal adjustment: in the first century of the Canadian federation a series of decisions by the Privy Council in London turned the intended division of powers between the federal and provincial governments on its head[20]

Cornes also points out that the European Court of Justice has jurisdiction in relation to Community law in every part of a member state, including devolved constituent elements. The demarcation of responsibilities between the GLA and national government, and between the boroughs and the GLA will become clearer as it is tested, and will continue to be susceptible to interpretation and change.

7. Policy Proposals

Key Opportunities

In order to inform and influence the GLA on health issues, interested bodies and individuals need to take advantage of key opportunities to submit recommendations, publicise issues, elicit support:

- the drafting and subsequent revision of the eight Mayoral strategies
- comment by the Assembly on the draft strategies
- Assembly meetings including questions to Mayor and employees*
- the preparation and publication of the Mayor's annual report†
- consideration by the Assembly of the annual spending plan/budget
- publication of four yearly state of the environment reports
- annual 'state of London' debate open to public
- twice yearly 'People's Question Time' open to public
- response by GLA to national policy initiatives (e.g. Green Papers).

Policy Objectives

In the context of relatively weak powers over health and the absence of a statutory framework or processes through which the GLA can contribute to health improvement in London, the challenge is to stimulate the development of good collaborative practice from the beginning. Institutions of co-operation must develop *de facto* and it will be in all parties' interests to ensure that their interests converge and they find a common health agenda. The NHS and its health partners will need to:

- reduce the risk of the GLA confining its health brief to one of scrutiny and ad hoc interventions
- encourage the GLA to participate in development of regional public health strategy
- maximise opportunities to bring the new Authority into existing health partnerships
- take all necessary measures to ensure health improvement is written into the eight GLA strategies
- ensure the GLA has direct access to health information and expertise
- continue to adapt NHS regional structure, processes and culture to facilitate communication with the GLA
- respond constructively to Assembly inquiries and reports.

A number of measures could be taken by the GLA to develop a more strategic health role and by the NHS to adapt its regional structures in order to accommodate the new Authority as a strategic partner:

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* Ten times a year the Mayor must submit a report to the Assembly (section 45) and attend a meeting of the Assembly to answer written and oral questions, which may also be put to employees of the Authority (section 52).

† The Mayor's annual report must include a summary of information relating to the Authority's performance of its statutory functions as well as any information that the Assembly has notified to the Mayor at the start of the year that it wishes to be included (section 46 (2)).

Cross Membership of a Strategic Health Body

The regional tier of the NHS as presently arranged is a conduit from the centre to the district, rather than a vehicle for lateral collaboration. Regional health authorities have been replaced by Regional Offices of the National Health Service Executive (although regional chairs have been retained).

At the same time, an increasing number of Government policies demand inter-sectoral collaboration at the regional level. The public health observatories described in *Saving Lives*: *Our Healthier Nation* (paragraph 11.31) are intended to link NHS Regional Offices with the Government Offices for the Regions, the RDAs and others to form a national network of *'knowledge, information and surveillance in public health'*. Government policy on Health Improvement Programmes (HImPs) also requires NHS Regional Offices to work with Government Offices for the Regions to monitor the progress of health authorities and their local health partners (paragraph 29 HSC 1998/167).

Outside London, regional development agencies have been set up, possibly leading in the long term, to the establishment of regional assemblies, which would have a strategic remit comparable to the GLA. Although public health is not one of the core functions of the RDAs it is named as a policy area in which they have a consultative advisory role.

These policy requirements have not been specifically extended to cover the partnership between the GLA and the London Regional Office. Although GOL will continue to exist alongside the GLA (retaining responsibility for some two-thirds of its present budget), it may seek to delegate its public health monitoring roles to the new Authority – another reason to develop a GLA health unit.

The 1998 King's Fund report made the point that a more open, collaborative and strategic public health function is needed at the regional level.[21] Hazell and Jervis make a similar point:

We expect that the NHS will come under increasing pressure from the RDAs to engage fully in the regional development agenda. The objectives of the public health Green Paper are likely to be furthered if the NHS is an active participant in the development of regional regeneration and economic development strategies[22]

Some kind of regional health strategy group in London could provide a vehicle to extend existing partnerships to the GLA by allowing for cross membership with the Greater London Assembly. Provisions in the GLA Act for other functional bodies indicate feasibility, for example, the Fire & Emergency Planning Authority will have 17 members, of whom nine will be Assembly members appointed by the Mayor. The other eight will be members of London borough councils, appointed by the Mayor on the nomination of the boroughs acting jointly. Twelve of the 23 members of the Metropolitan Police Authority will be Assembly members – including the Deputy Mayor. Also appointed by the Mayor, their numbers must reflect the balance of the parties in the Assembly.

As an advisory group, the Cultural Strategy Group is a useful model. It will have between ten and 25 members, appointed by the Mayor, '*who are representatives of such bodies concerned with relevant matters as the Mayor considers appropriate, or who have knowledge, experience or expertise which is relevant to the functions of the Cultural Strategy Group for London'* (schedule 30). The function of the Group is to draft the cultural strategy and advise the Mayor on its implementation.

Taking the Cultural Strategy Group as a model, an informally constituted regional health strategy group could include people nominated by the NHS Regional Office, the GLA, boroughs, health authorities and the functional bodies, together with representatives of other appropriate London-wide agencies. The chair could rotate between the GLA and the London Regional Office. For the GLA the chair could be the Deputy Mayor or an Assembly member with a special interest in health policy. Under section 38 of the GLA Act, the Mayor could delegate the necessary powers to the Deputy Mayor without obviating his own involvement.

The Group could carry out a number of functions:

- advise the Mayor
- develop a broad-based regional health agenda
- co-ordinate health input to GLA strategies
- make recommendations
- commission work, e.g. overviews of London HImPs
- initiate regional health promotion campaigns.

Such a body could succeed the London Health Strategy Group recently set up by the LRO. Eventually, regional collaboration of this kind could be instituted formally, through Ministerial directions or amendments to legislation, as necessary, but it could start by informal voluntary arrangements which the NHS Regional Office will be free to initiate.

Functional Bodies: Health Strategy Officers

The Mayor could, under section 38, delegate the Authority's health-related duties to a named health strategy officer in each of the functional bodies: London Development Agency, Transport for London, Metropolitan Police, London Fire and Emergency Planning. This would provide someone to champion health in the GLA's main policy arenas. An informal arrangement could be made to provide the same sort of facility to the Cultural Strategy Group, which is advisory but whose remit includes recreation and sport in the capital.

These officers would have two main functions: to ensure that each strategy takes into account the duty to consider improvement in the health of Londoners, and to act as a point of liaison on health-related issues with the Mayor and advisers, with the Assembly, the NHS Regional Office and other functional bodies within the GLA's remit. They could meet regularly under the aegis of the proposed regional health strategy group, or report direct to the Assembly.

These appointments could be on secondment from the London Regional Office or health authorities.

Delegation by the Assembly

It is inevitable that Assembly members will develop special interests and expertise. The Assembly could, under section 54 of the Act, delegate specific health-related functions to one of its members, who would keep a watching brief and act as a point of liaison with health bodies. This person would be well-placed to chair any Assembly committee conducting an inquiry into health-related subjects.

Publication of a London Health Report

This would be a health version of the duty on the Mayor to produce an environmental report every four years, and would build on the work begun by the Health of Londoners Project. The report could be drafted by a health adviser to the Mayor, or the proposed regional health strategy group, or it could be commissioned from an independent source by the Mayor.

The Assembly may deliver the GLA's health remit by periodically commissioning retrospective health impact assessments of the Mayor's strategies. These could be published, along with the reports of any other Assembly inquiries into health. These publications might acquire considerable status as independent assessments or audits.

Devolved Powers of Appointment

The Act provides for extensive powers of appointment to functional bodies to be exercised by the Mayor. Even in the politically sensitive area of policing, the Mayor must be allowed to make representations to the Secretary of State concerning the applicants to fill the vacancy of 'the Commissioner of Police of the Metropolis'.

In contrast the considerable number of health appointments, including the regional chair, health authority chairs, and non-executive members as well as numerous trust appointments, have all been retained at the national level by the Secretary of State for Health who acts on advice, principally from the regional chair. Giving the Mayor a say in this process, if only a right to be consulted, would provide further incentive for the GLA to find common cause with health authorities and trusts.

8. Monitoring/Evaluation

Looking to the future, once the GLA is operational, its impact will be a subject for monitoring and evaluation, which will inform the debate about devolution in other English regions. Hazell and Jervis recommend appropriate investment in tracking studies in order to address health-related issues as devolution to Scotland and Wales gets under way.[23] The same must be true of London, even though the GLA's health remit is more narrowly defined.

The point has already been made that one effect of the GLA is likely to be increased pressure from other English regions for their own assemblies:

The template to watch is London, and the extent to which political progress on assemblies is made with trepidation or confidence hinges on the success of the GLA/LDA relationship[24]

In health policy, as in economic development, institutional relationships should be a key subject for evaluation. The results of evaluation may make a case for organising health at the regional level differently. Although the Greater London government structure is unlikely to be adopted for other English regions, it is important that as much as possible is understood if certain elements are to be replicated (or avoided) elsewhere. One approach would institute a longitudinal study to compare the performance of the Welsh and Greater London models of devolution in relation to health improvement.

The ways in which the GLA can work with health authorities and boroughs will, over time, become clearer and the demarcation of functions more firmly entrenched in working practices and conventions. Demonstrable achievements of the GLA in health may make a case for further delegation of powers from the national to the regional tier, or for the absorption of powers currently exercised by appointed bodies.

Evaluation would need to focus on process as well as outcome. Assessing the impact of an institution in the complex processes of policy development is difficult, particularly when the process is characterised by partnership with a wide range of other bodies.

The following questions might be pursued:

- is the health of people of London improving relative to other English regions?
- are inequalities in the health of Londoners lessening?
- how is the GLA influencing the processes of partnership in health improvement?
- does the GLA perceive itself as a partner in the health economy?
- is its health role strategic or one of scrutiny/monitoring, or both?
- has health improvement become integral to the GLA's strategies?
- have these strategies led to measurable health improvement?
- has the GLA produced reliable health impact assessments?
- have they led to action?
- has the Mayor become publicly involved in health issues (not services)?
- has the regional allocation of health funds to London changed?
- have health-related bodies changed their organisation or ways of working to adapt to the GLA?
- do people in London perceive the GLA to have some responsibility for their health?
- has debate about health issues widened to increase the involvement of the London public?
- has the GLA increased public accountability of health?
- is more/better information about London's health in the public arena?
- do partners in the health economy perceive benefit from the GLA?

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