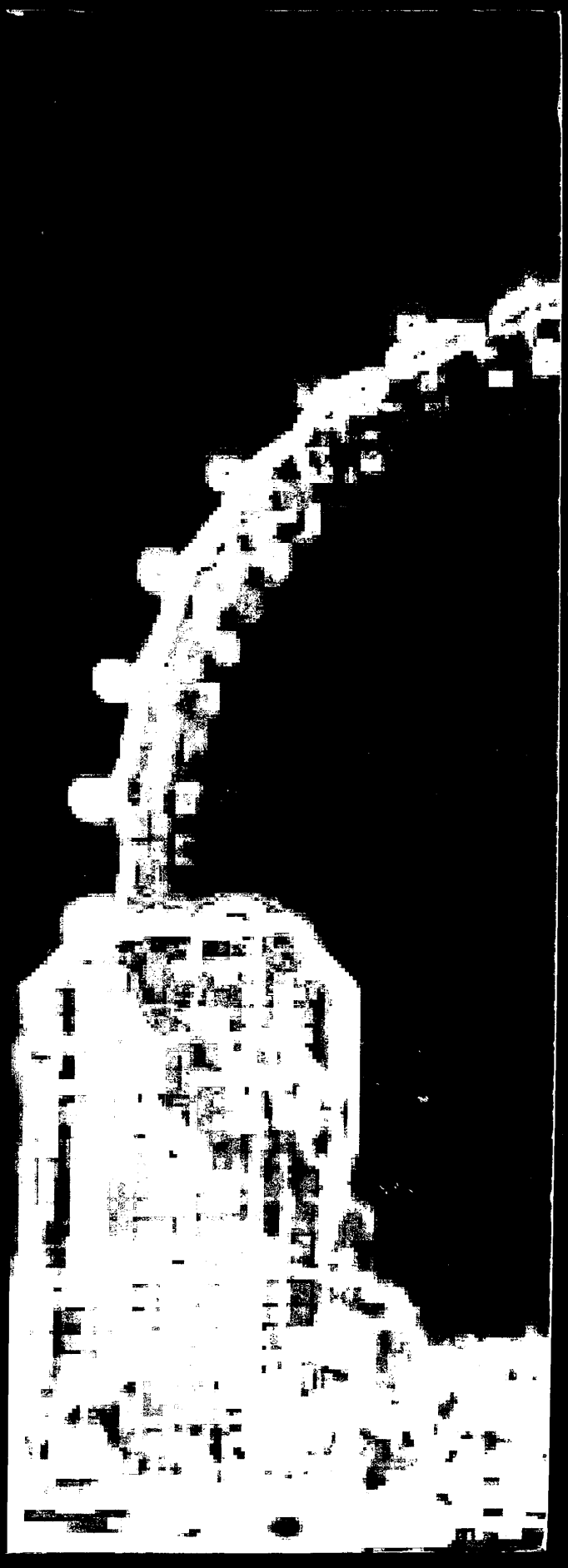
King's Fund

Improving London's Health

The role of the Greater London Authority

Anne Davies
Elizabeth Kendall



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Contents

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The views expressed in this document are those of the King's Fund and do not necessarily reflect those of individuals named above, or the London Regional Officer of the NHS.

Executive Summary

The Greater London Authority, which provides London with its first directly elected Mayor, has important strategic powers and responsibilities that include a duty to improve the health of Londoners. This report considers how the GLA can best contribute to health improvement and to reducing health inequalities across the capital. It examines the powers and responsibilities of the Mayor and Assembly, the main health issues affecting Londoners, and the experiences of other city-wide authorities in the UK, North America and Europe. It analyses policy options and sets out recommendations for developing the role of the GLA in improving London's health.

Powers and responsibilities of the GLA

The GLA has a general power to do anything it considers will further one or more of its three 'principal purposes': economic development and wealth creation, social development, and improvement of the environment.

Although health is not a principal focus of the GLA, the new Authority has powers and a discretionary duty to improve the health of Londoners where it exercises its general power. The Mayor must produce eight strategies – on transport, development, bio-diversity, waste management, air quality, ambient noise, culture and spatial development – and must 'have regard' to the effect these will have on the health of Londoners. He may choose to have a health strategy for London, but is not obliged to do so.

Although the GLA is barred from spending money on health services, it can incur expenditure in co-ordinating and facilitating public bodies, which include health authorities as well as London boroughs.

The 25-member strong Assembly cannot legislate or raise taxes, and has no powers to reject or force amendments to the Mayor's strategies. Its main role is to scrutinise the

work of the Mayor and hold him to account for the exercise of his statutory powers and duties. It can also inquire into any matters it considers important to London, which could include health.

The Mayor may play a range of roles in the health policy arena, from constructive to oppositional, or may confine his attentions to health services and take no active interest in health improvement. Though neither the Mayor nor the Assembly have significant powers in relation to health, they may exercise considerable influence by means of leadership, advocacy, negotiation, media relations and other indirect routes.

The GLA Act provides a framework for the relationship between the new Authority and the functional bodies that are associated with it (Transport for London, the Metropolitan Policy Authority, the London Development Agency, the London Fire and Emergency Planning Authority), as well as the Cultural Strategy Group and the London boroughs that will help to deliver its strategies. The Act says nothing about liaison with health authorities at regional or local level. How these relationships develop is a matter of importance, capable of influencing the way the GLA interprets its health role.

London's health

Key health issues have been identified where a pan-London approach is required and where the GLA may therefore have a significant role to play.

- Inequality is a defining characteristic of health in London. The gap between rich and poor is growing. The chances of dying before 75 are almost twice as high for those in the most deprived areas of London as for those in the wealthiest neighbourhoods
- London has a high proportion of children and young people. Some of the capital's most important health issues are more common among younger people, including acute mental illness, HIV/AIDS, unplanned pregnancy and substance misuse
- London is Britain's most ethnically diverse city. Black and minority ethnic groups, who make up a quarter of its population, tend to be more disadvantaged in

terms of key factors influencing health (e.g. income, education, employment and housing). Equality of access and cultural appropriateness of health services are matters of particular concern

- Poor housing, traffic congestion and high levels of crime and fear of crime are significant problems in London. All are known to have a detrimental effect on health

A profile of health and social indicators for the GLA electoral areas has been prepared by the Health of Londoners Project and is available separately from the King's Fund (contact Pat Tawn on 020 7307 2672 for more information).

Learning from other cities

To inform the development of the GLA's role, lessons may be drawn from the way other city-wide authorities deal with health issues. The WHO's Healthy Cities Project has demonstrated the importance of organisations and individuals investing significant time and effort in the development of city-wide health strategies, and the need for a keen understanding of political processes. The King's Fund conducted a study of nine cities: Barcelona, Berlin, Birmingham, Chicago, Glasgow, New York, Paris, Rome and Toronto. There were more differences than similarities between the cities and all other authorities had more extensive formal powers than the GLA. Key findings include:

- the personality of the mayor and the political context in which he or she operates are as likely to determine whether action is taken to improve health as formal powers and institutional arrangements
- a mayor is more likely to take action to improve health if it fits in with plans to pursue other major political objectives
- a mayor with few (or no) direct powers to improve health can nevertheless contribute significantly to health improvement through political influence, media campaigning, financial leverage and other, indirect means

- though there are few direct points of comparison, other cities provide a source from which the London Mayor may draw ideas and insights to inform a strategy to improve the health of Londoners.

Practical examples of how other city-wide authorities have taken action to improve health are set out in the report.

Developing the GLA's health role

The GLA is well placed to play a strategic role in health because:

- health is a key element in the policy areas for which it has strategic responsibility
- as a democratically elected, representative body, the GLA will be as concerned with health improvement as it is with economic, social and environmental improvement: health is important to all Londoners
- the new Authority offers a conduit of consultation and accountability to the London public.

In order to play a strategic health role, the Mayor and Assembly will need to work with the NHS and its partners in taking forward the London Health Strategy and developing the health improvement policies initiated by the London Coalition for Health and Regeneration.

Options for the Mayor

The biggest lever at the Mayor's command is the legitimacy and high profile derived from a large, direct electoral mandate. A number of factors will influence the priority he gives to health:

- the Mayor's election manifesto pledges
- alignment of health with other policy priorities
- access by the Mayor to health information and advice

- development of dialogue and mutual trust with NHS and health partners
- how the Assembly exercises its scrutiny role on health issues
- perceived impact on voter opinion.

Added to these five factors is the critical question of the Mayor's personal values, ability and leadership style. Observation of mayors in other city-wide authorities suggests six broad interpretations of the role:

- convenor/negotiator
- ambassador
- visionary/educator
- advocate/champion of causes
- critic/auditor
- opposition/confrontation.

These roles are not mutually exclusive. The Mayor can be a negotiator in one context while being oppositionalist in another. In the UK, current health policy places emphasis on the need for partnership to address wider health determinants in a coherent and sustained way. The six roles may thus be perceived on a spectrum of preference, which places the highest value on convening and negotiating and the lowest on confrontation. The report gives illustrations of each category from other cities.

Funding levels for London, including London's NHS, are likely to be challenged by the Mayor, who will seek a greater share of national public expenditure for the capital. This may, in turn, prompt other cities and regions in England to press for a high-profile, elected Mayor and more regional autonomy.

The GLA will be audited by the Audit Commission, which, in the absence of precedents or comparators, is developing a range of new performance indicators. These will include quality of life and public health indicators.

Recommendations

The interests of Londoners would best be served by:

- reducing the risk of the GLA confining its health brief to one of scrutiny and *ad hoc* interventions
- encouraging the GLA to adopt a health strategy for London
- ensuring that health improvement is written into the eight GLA strategies
- providing the GLA with direct access to health information and expertise.

A GLA Health Strategy Group

Taking the Cultural Strategy Group as a model, the Mayor could develop and co-ordinate a Health Strategy Group. This could oversee the regional health agenda, advise the Mayor, co-ordinate health input to GLA strategies, make recommendations, commission work (e.g. to review the relationship between London's Health Improvement Programmes and Community Plans), and initiate regional health promotion campaigns. The Group could include representatives of the London Regional Office of the NHS and the GLA, at either the political or official level, together with other representatives of London boroughs and health authorities and voluntary sector organisations. The Group would sustain a constructive dialogue, taking health measures into GLA strategies and giving the GLA input into regional public health.

Health strategy officers in GLA functional bodies

The Mayor could delegate health-related duties to a named official in each of the four functional bodies (the London Development Agency, Transport for London, the Metropolitan Police and London Fire and Emergency Planning Authority) and the Cultural Strategy Group. They would have two functions: to take health into other policy areas by ensuring the relevant strategies included health-improving measures,

and to act as a point of liaison on health matters, linking the Mayor, Assembly and functional bodies with other appropriate agencies such as health authorities.

Access to health information

The GLA must have ready access to reliable health data for London – either from its own research and information division (formerly the London Research Centre) or from the new regional Public Health Observatory, or the London Regional Office of the NHS.

Health adviser/director

A senior level health expert is needed at the GLA, either at the official level or as health adviser to the Mayor. The appointment would have the following functions:

- to present and interpret public health information to the Mayor
- to maintain dialogue with the NHS and its partners in the new London Coalition for Health and Regeneration
- to liaise with the GLA's functional bodies
- to keep health on the Mayor's agenda.

If no specialist appointment is made, the GLA may consider accepting secondments to advise the Mayor and/or Assembly.

Devolved powers of appointment

The Mayor could be consulted, or otherwise participate, in key London health appointments currently made by the Secretary of State.

Publication of a London health report

The GLA should give account of its progress in improving the health of Londoners by publishing a regular review of London's health. This would be comparable to the statutory duty the GLA has to produce a state of the environment report every four years. Progress towards health targets should also be included in the Mayor's annual report.

Long-term evaluation

The experience of the GLA will inform the debate about devolution to other English regions. It would be useful to compare, over time, the Welsh and Greater London models of devolution in relation to health policy to see what impact a democratically elected Assembly has on the delivery of public health functions, and how this compares with the impact of the GLA operating within a different framework of powers and responsibilities.

Introduction

This report examines the potential for the new Mayor and Greater London Assembly to improve the health of Londoners. It looks first at the powers and responsibilities for health provided in the Greater London Authority Act 1999, and focuses on the structures and processes at the interface between the Greater London Authority, the NHS and the developing health partnerships across the capital. It investigates the roles that the Mayor and Assembly can undertake to make a significant contribution towards health improvement in London.

Other major cities in the world have powerful mayors and city-wide authorities, and lessons may be learned from their experience in relation to health improvement. This report describes the different ways in which mayors, in a sample of city-wide authorities, have worked to affect change. It examines a number of initiatives to improve health in other cities, and strategies in other policy areas that have incorporated health measures. Our research methods are set out in Appendix 1.

One key finding from our work in other cities is that as much depends upon the personality of the mayor and on the political context in which he or she operates as on the formal powers and duties invested in the mayoral office. There are very few points of direct comparison between the cities we have studied. There is no significant documented evidence about the impact on health of any interventions by the city-wide authorities described in this report. Furthermore, there is no precedent for what is happening in London, nor any means of predicting how events will unfold. It would be futile, in our view, to attempt to 'read across' from the disparate experiences of other cities, or to draw from this part of our research any systematic conclusions about what could or should happen in London. We have, however, gathered a range of insights and ideas, which have helped us to analyse the possibilities for London and to develop our recommendations. These are based on research and analysis of current institutional developments in London and the UK, on our review of health issues in London and on a critical appraisal of policy options, as well as on the insights drawn from our field research in other cities.

1. A new form of city government

The new form of government for London is unique in the UK. It differs from its predecessor, the Greater London Council, from the Scottish Parliament, the Welsh Assembly and the governing body proposed for Northern Ireland. By vesting executive responsibility in a directly elected Mayor, London is importing an institution familiar abroad, but unknown in the UK.

The establishment of the GLA is also the first example of 'regional' devolution in England; it is the first elected authority to occupy the tier between national and local government. The legislation has been tailored to accommodate the complex governmental and administrative networks of a large metropolitan region and is unlikely to be exactly replicated if devolution to English regions follows.

The GLA is made up of a directly elected Mayor and an Assembly comprising 14 constituency members and 11 list members. The function of the Assembly is to scrutinise the actions and decisions of the Mayor. The Mayor must produce strategies in eight key policy areas. Health is not one of the strategies, nor is it a principal purpose of the Authority, but it is covered by a subsidiary power that must, in effect, permeate GLA policy.

According to a typology of regional government provided by Stoker, Hogwood and Bullman, the new Authority is a version of executive devolution – a relatively weak form.[1] It has executive responsibility, but not legislative powers; it executes a range of strategic functions with a small overall budget determined by central government and raised mainly by national taxation. The Authority cannot provide services itself, nor is it 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 (put forward by the King's Fund and others) 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 – a Secretary of State and junior ministers accountable to the public through Parliament. At the local level, health authorities, of which there are 16 in London, are appointed by the Secretary of State, as is the Chair of the London Regional Office of the NHS Executive.

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. The NHS and its health partners in London are in the process of developing health strategies on a London-wide basis. This also points to a health 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 have 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 DETR, from whom the new Authority has inherited 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 the 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 already 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 that 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.

The difficulties of carving out a new tier of democratic government are accentuated at the intersection with the vertical bureaucratic structure of the NHS. Since its inception, 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 inevitably poses further questions about how the two should relate.

2. Powers of the GLA

The Greater London Authority Act 1999 implemented the broad recommendations of the White Paper *A Mayor and Assembly for London* (Cm. 3897), which was published in March 1998, prior to a referendum held in Greater London in May that year. A majority of those voting in the referendum answered 'yes' to the question 'Do you agree with the Government's proposals for a Mayor and Assembly for London?'

The Act establishes the new Authority, comprising a directly elected Mayor and separately elected Assembly, as well as a number of functional bodies, including Transport for London, the London Development Agency, the Metropolitan Police Authority and the London Fire and Emergency Planning Authority. The Act also defines the GLA's planning, environmental and cultural responsibilities and establishes a Cultural Strategy Group, which is an unincorporated advisory body.

The GLA has a general power to further its principal purposes within stated limits. It also has various subsidiary powers, among which is the duty to take the effect on health into account when exercising its general power and in producing its strategies.

Box 1

General and subsidiary powers of the GLA

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.

(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

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 Mayor in preparing or revising any strategy must consult the same bodies *(section 42)*.

Box 2

Limits of the general power of the GLA

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 cooperating with, or facilitating or coordinating the activities of, the bodies mentioned in those subsections.

(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

2.1 The Mayor

The function of the GLA is strategic. It will not deliver services. The Mayor is the sole executive and must develop strategies for transport, planning and environment and approve strategies for economic development and culture (to be drafted by the London Development Agency and the Cultural Strategy Group respectively). The Act provides for eight strategies:

- transport strategy *(section 142)*
- London Development Agency strategy *(section 306)*
- London bio-diversity 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 or revising the strategies, the Mayor *must have regard* to the need to ensure that each strategy is consistent with national policy and with each other and *'the effect which the proposed strategy or revision would have on the health of persons in Greater London' (section 40 (4)(a)(I)).*

In addition to responsibilities for GLA strategies, the Mayor will be responsible for setting a budget for the GLA and its four functional bodies and will also make appointments to the boards of the functional bodies and to other London organisations.

2.2 The Assembly

The function of the Assembly is to comment on the Mayoral strategies and budget, scrutinise the exercise of the Mayor's functions and conduct investigations into London issues.

Box 3

Powers 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

The Assembly has no powers to amend the Mayor's strategies – it can only '*submit a proposal to the Mayor' (section 60 (1))*. Its powers to amend the budget are also limited.

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 from the previous three years. No one attending shall be required to give evidence or produce documents relating to advice given to the Mayor.

2.3 Other statutory provisions

Other elements in the Act that might be relevant to the GLA's health role include provisions for delegation of powers, appointment powers and duties to make regular reports, i.e.:

- the Mayor must appoint a Deputy Mayor from among the Assembly members. The Deputy Mayor will be appointed as a member of the Metropolitan Police Authority and will become Acting Mayor when the Mayor is temporarily unable to act. The Mayor is able to delegate functions to the Deputy Mayor. The Act also contains powers for the functions of the Authority, which are exercisable by the Mayor to be delegated to members of staff of the Authority, to Transport for London, the London Development Agency, and also to any local authority
- the GLA Act confers on the Mayor powers of appointment to numerous posts in the functional bodies. No powers of appointment to London health authorities or trusts are included
- the Mayor must produce a state of the environment report every four years, but is not required to report on health in the capital. However, 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)*.

The policy proposals at the end of this report suggest how these opportunities could be used to further action on health improvement by the GLA.

3. Interpreting the GLA Act

The GLA Bill received the Royal Assent two days before Parliament was prorogued on Friday 12 November 1999. Its enactment and the inaugural elections in May 2000 mark the beginning of a regional 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.

If the GLA is to play a strategic role, the Mayor must be prepared to build and sustain partnerships. This will depend not only on NHS and existing health partners actively enlisting the support of the new Authority, but also on the priorities and personality of the Mayor. A sustainable interest in issues of health strategy, as well as a conciliatory rather than oppositional style are needed at the start, when conventions and working practices are established.

The legislation, like the Scottish and Welsh devolution Acts, says little about the machinery for conducting relations with Westminster. The role of the Government Office for London (GOL) in relation to the GLA will need clear demarcation. All Government Regional Offices have liaison responsibilities in relation to public health. Machinery will also need to be developed to resolve disputes between regional and national governments. 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 Concordats are intended to be purely political documents and not legally enforceable.

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.[2]

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 over time, and will continue to be susceptible to interpretation and change.

The provisions for health within the GLA Act are expressed 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 health-related sections of the Act 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.

3.1 Health powers without responsibilities

The improvement of the health of the people of London is not a principal purpose of the GLA. Nevertheless, health is inherently 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.

The provisions under the Act for the discharge of the Authority's environmental powers provide a contrast:

- 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, bio-diversity action plan)
- each functional body shall have regard to these strategies
- a team will be at the Mayor's disposal (White Paper recommendation)
- a state of the environment report must be published every four years.

Another comparison may usefully be made with the way health has been devolved in Wales. There, 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 the 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.[3]

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.[4]

The lack of similar provisions in relation to health policy in London means that the new Greater London Authority will have statutory powers in relation to health improvement without any formal share of strategic responsibility. The power of the Mayor and Assembly publicly to 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 that underpins the inter-sectoral collaboration central to the development of present 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. In drafting the legislation, the perceived importance of keeping the GLA out of health *services* would appear to have obscured the advantages of constructively engaging the new Authority in health improvement.

Equally significant is the absence of a statutory framework for joint working between the GLA and 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.

The GLA's health role and the machinery to handle relationships with bodies not named in the Act will therefore 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 Mayor and Assembly choose to interpret their health roles. For example, although the Act makes no provision for a public health director for London, or even an adviser as suggested in the White Paper, several Mayoral candidates included in their manifestos a pledge to appoint a health director or medical officer of health (MOH) within the GLA, independent of the NHS.

3.2 Scrutiny or strategy?

The theoretical argument for giving the Mayor and Assembly clear responsibilities and a defined strategic role in improving the health of Londoners rests on the perception of health as a basic human need or right, and on 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.*[5]

It might be argued that the establishment of the GLA offered an unprecedented opportunity to place a share of responsibility for specific public health functions within a multi-functional strategic authority, and to ensure that the other strategies of that Authority incorporate health measures. The GLA is a London-wide, strategic and multi-functional body. It is separate from service commissioning and service delivery and it is democratically accountable. The principle of subsidiarity would be served by decentralised decisions from national to regional levels. The GLA would provide a new conduit to/from the public, and a unique opportunity to trial civic leadership in public health.

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 of respondees were of the view that the GLA should have some role in either assessing or prioritising the health needs of the people of London, a strategic health planning role, or a public health role.[6] HOLP 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[7]

What the Act has provided sits somewhere between the first and second options, with the NHS retaining all its current responsibilities and the GLA given a scrutiny power and no responsibility for strategy. This raises the question of whether such scrutiny is needed. The emergence of an additional source of scrutiny at the regional level is anticipated in an analysis of Labour's proposals for devolution in England by Brian Hogwood,[8] who suggests they would lead to *'multiple sources of demands for reporting and scrutiny rather than providing a simple solution to concerns about accountability'*.

The growing body of work initiated by HOLP, and now being taken forward by the London Regional Office of the NHS, 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 recognised regional health agenda and the London Regional Office has worked with a wide range of partner organisations to develop a regional strategy for London's health and a new Coalition for Health and Regeneration. The work of the new London Public Health Observatory may help in establishing a distinctive regional agenda.

This is, arguably, an appropriate time to reconsider the distribution of public health tasks between regional and local levels across NHS and elected government boundaries. In addition to meeting the demands of devolution, the NHS structure is undergoing another round of change as primary care groups (PCGs) take over commissioning from health authorities. Public health professionals are thus being pulled in all directions, informing commissioning of services and advising on health improvement at PCG level and, at health authority level, serving as advocates of the

public interest and as key players in the development of Health Improvement Programmes (HImPs).

Assuming access to a proper level of public health expertise and advice, the GLA is well placed to share responsibility for developing some public health functions at the regional level. This might include overseeing the linkages between Health Improvement Programmes and Community Plans, integrating health with economic regeneration, and helping to deliver the wider public health agenda across London, through GLA strategies for transport, regeneration or crime.

An increasing number of Government policies demand inter-sectoral collaboration at the regional level. Firstly, although public health is not one of the core functions of the Regional Development Agencies (RDAs), it is named as a policy area in which they have a consultative advisory role. Secondly, the Public Health Observatories, described in *Saving Lives*: O*ur Healthier Nation*, 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'*.[9] Thirdly, Government policy on HImPs requires NHS Regional Offices to work with Government Offices for the Regions to monitor the progress of health authorities and their local health partners.[10] This responsibility must, presumably, belong to the Government Office for London, in which case some clarification may be needed as to whether the GOL should pass it on to the GLA.

3.3 Partnership challenge

Behind the legislation, there appears to be an implicit assumption that partnership with the GLA will spontaneously develop. Speaking at a 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.[11]

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 is, 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 partner role in health is uncertain. The absence of strategic powers over health is likely to mean that health will have a lower priority on the GLA agenda than transport and economic development, environment or culture. The trust to which the Minister referred may take time to build. Among London boroughs and health authorities there was, initially, considerable apprehension when the GLA was proposed in a White Paper. This was an echo of the strained relations that had often existed between the former GLC and the boroughs. There was an underlying concern that power and influence might be drawn up from the local to the regional level, and that the new Authority would be meddlesome rather than constructive.

Getting the GLA to work alongside the NHS and its health partners in delivering London's health strategy is of paramount importance. The new London Coalition for Health and Regeneration will need to forge alliances with both the Authority's executive branch, i.e. the Mayor and Mayoral bodies, to ensure that the GLA's London strategies incorporate effective health measures, and with the Assembly, which will hold the Mayor to account and conduct inquiries, and which can be an ally in exerting pressure for health improvement.

4. The role of the Mayor

In May 2000, London became the first English region/city to have a Mayor who has been directly elected. With some 5 million people eligible to vote, it was the biggest individual election in British political history. Across Europe, the mandate that delivers London's Mayor is exceeded only by the Presidents of France and Germany. This new political institution was intended to have a radical effect; the White Paper that set out the Government's vision of the GLA stated 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.*[12]

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. However, 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 has a strong incentive to draw attention to failures of policy for which others are responsible and to take credit, where possible, for developments that attract popular support.

The most important relationships for the Mayor (apart from that with the electorate) will be with the heads of the functional bodies 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 could place them at odds. The task of holding the Mayor to account is intended to produce a creative tension between the two:

Proportional representation of Assembly members and the separate election of the Mayor means that the impact of party politics on the working of the GLA differs radically from the experience of local councils.[13]

Over time, conventions will develop to 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 Act, 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, in federal systems such as the USA, voting patterns have been identified in which voters regularly support one party in federal elections but another in state or local elections. However, 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 central government has retained important levers of control.

In other cities

In Paris, the conflicts between Mayor Jean Tiberi and the Prefect of Paris are mainly due to the fact that the Prefect represents France's national government, which is controlled by a different political party from the Mayor's. In New York, Mayor Rudi Giuliani's opposition to the City Council is partly a consequence of politics (45 of the 51 members of the City Council are Democrats whereas Giuliani is a Republican), although the Mayor is also well known for his generally forthright and outspoken personality.[14] However, mayors can and do form constructive relationships with members of different political parties. Mayor Richard Daley of Chicago has a constructive relationship with Governor Ryan of Illinois, even through Ryan is a Republican.[15] In Toronto, an important reason why Mayor Mel Lastman has to negotiate and broker agreements with individual City Councillors is that the Council does not have a party political system in the sense that we have in the UK. Individual Councillors can be, and are, members of Canada's main political parties. However, there is no Party Whip in the City Council. This means that Lastman must secure each individual Councillor's vote, and build consensus, in order to be effective.[16]

In Italy, the party political structure is weak (there are currently more than 40 parties in the national parliament). National government is perceived by many as ineffective[17] while individual cities have, historically, played a strong role in Italian politics. MP allegiances are primarily local, and successful reform depends on bringing together a wide range of disparate interests without an effective system of Party Whip. The weakness of central government, coupled with a new breed of strong, managerialist city mayors, has meant that Italian cities and regions are increasingly seen as the level where effective action takes place. A new Mayor's Party (*Partito dei Sindaci*) to lobby central government for more power at the city level is under discussion.

Our research indicates that mayors frequently put their city above their political party.[18] Mayors have to deliver, and be seen to deliver, for their city in order to be re-elected. This often means working in partnership with the key players at every government level, whatever their political affiliation. The former Mayor of Chicago, Harold Washington, was in frequent conflict with the City Council, even though Councillors were predominantly from the same party (Democrat). In his first election campaign, Richard Daley promised to work with the Council to end this deadlock.[19] It has been argued that, constitutionally, Chicago has a 'weak' Mayor and a 'strong' Council.[20] However, the current Mayor is arguably in a stronger position than his predecessor, partly because of his reputation and political heritage (his father was Richard J Daley, Mayor of Chicago during in the 1960s), and partly because of strong public support for his commitment to end the deadlock with the City Council.

4.1 Health action by the Mayor

At this stage, it is possible only to speculate how successive incumbents of the office will interpret the role. However, the potential for Mayoral action on health may be divided into three broad categories:

- *ad hoc interventions.* Actions in response to events. The Mayor, as elected representative of the whole city, will act individually and not feel constrained to act only in concert with others. Interventions on health service issues are most likely to fall in this category. Opportunities to enhance reputation and build

political support will be taken. The challenge facing the public health lobby is to exploit those opportunities to promote health

- *GLA strategies.* 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. This would focus on the wider determinants of health. The experience of other cities indicates the feasibility of incorporating health-improving initiatives in other policy areas (see Section 11). The effectiveness of this approach may be measurable only in the long term
- *health strategies.* The third category refers to the role of the Mayor (and Assembly) in specific health strategies, for example those being developed by the NHS London Regional Office in partnership with health authorities, London boroughs and others. For this to happen, all partners in health improvement need to regard the Mayor as a powerful ally from the beginning. Mayoral support for, and participation in, London's health partnerships must be sought and developed if the Mayor is not to become an outsider to the process of health improvement. (Section 11 describes health strategies in other cities.)

Whether the Mayor takes health seriously, as an issue requiring sustained, multi-functional, long-term strategies, must depend on a number of factors:

- perceived benefit to the electorate
- equation with Mayoral manifesto pledges
- shared interest in outcomes
- access by the Mayor to information and expert advice
- development of dialogue and mutual trust with health partners.

Perceived benefit to the electorate

The long-term nature of health improvement policies militates against the kind of solutions that politicians like to identify. However, other important policy issues are no more amenable to the quick fix, for example crime reduction, traffic congestion, pollution, food safety. Politicians must find ways of sustaining dialogue, support and engagement from their electors if they want to make inroads into intractable problems.

A Mayor who has ready access to the media could make a valuable contribution towards educating the public about the need for long-term policies to improve health.

Equation with Mayoral manifesto pledges

A cynical view holds that candidates say one thing in an election campaign and something different when in office. Realistically, mayors, like any politician, must seek to deliver the main elements of their manifesto commitments if they are to retain integrity with voters. The performance of the NHS and health have traditionally been of great interest to the electorate and all the frontrunners in the first Mayoral election in May 2000 included health policy proposals in their manifestos. Public interest in health is a powerful incentive, and this is no longer confined to health services. A survey for the King's Fund has shown that Londoners are well informed about the determinants of health.[21]

Shared interest in outcomes

Evidence from other cities suggests that mayors may take credit that is undeserved. In New York and Chicago, for example, the Mayor's logo is attached to a whole range of city-wide initiatives without the Mayor necessarily being actively involved. Mayoral support is obviously a prize worth having, particularly where the mayor has a high profile. Conversely, mayors are politicians and need public approval. If the Mayor of London can share some of the credit for improvement in the health of his or her city, there will be an incentive to get involved and support the NHS and its partners. This is the pragmatic and compelling argument for bringing the GLA into established health structures and processes, such as the London Coalition for Health and Regeneration.

Access by the Mayor to information and expert advice

For the Mayor to play a useful role in health, he or she will need direct access to London's official health facts and statistics. This may generate extra work for the

LRO and may require a dedicated liaison team to deal with information demands from both the Mayor and Assembly, and ensure health information is made routinely available to them. The Assembly may conduct an inquiry and call for evidence from the NHS. 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 the new London Public Health Observatory, to academic and specialist institutes, expert individuals and pressure groups.

Development of dialogue and mutual trust with health partners

If health is not high on the Mayor's list of priorities, sustained pressure from outside may be required to keep it on the agenda. It is important that the Mayor and Assembly are not seen purely as critics and auditors of health policy. The Mayor, Assembly members and chiefs of the functional bodies must be regarded as health allies.

Added to these five factors are the all-important issues of the Mayor's personal values, ability and leadership style.

4.2 Interpretations of leadership

The way the Mayor interprets the health powers vested in the GLA will be a matter for individual interpretation and development, a process that is open to influence. It is paramount that the first holder of the office perceives the health role as important, and one where Mayoral involvement can make a difference. Conventions may be laid down which come to be accepted – more or less – as the *modus operandi* for successive mayors.

The way the Mayor interprets the role is inextricably linked to personality and style. It hardly needs saying that mayors are leaders, not followers. Current health improvement policy is predicated on partnership and cross-sectoral working and the

aim is to develop a sense of shared 'ownership', which assumes a partnership of equals. This may be difficult to reconcile with the strong leadership of a directly elected individual leader.

The GLA Act requires the Mayor to take health into account when pursuing the principle purposes of the GLA. Powers of scrutiny vested in the Assembly – and also the Audit Commission – ensure that the Mayor is held to account for the discharge of all his or her statutory functions. So the Mayor must do something to improve health, but in doing so must operate within highly restrictive parameters – no responsibility for health strategy *per se*, no responsibility for any service delivery and no health budget. What kind of leadership role does this suggest, and how have mayors in other cities interpreted their role?

In his analysis of leadership,[22] Charles Handy identifies three broad theoretical categories: *trait theories*, which assume the individual is more important than the situation; *style theories*, which recognise the importance of managerial style ranging from the authoritarian to the democratic; and *contingency theories*, which take account of the other variables involved in the leadership situation, such as the nature of the task and the position of the leader within the wider grouping. Handy concludes that a hybrid of all three, *the best fit approach*, is preferable to any one type. The way the fit is achieved will depend on the organisational setting, which includes:

- the power or position of the leader
- the relationship with his or her group
- the organisational norms
- the structure and technology
- the variety of tasks
- the variety of subordinates.

Apart from the first factor, each of the remaining five factors indicates the significance of the role which other individuals and institutions will play in determining the nature of the Mayor's leadership. Key internal relationships will involve the Cabinet, the private office and the Assembly. External relationships

involve the NHS and its partners in the Coalition for Health and Regeneration. Organisational norms will be influenced by the standing orders that the Assembly adopts for itself and the conventions that develop across the Authority as a whole.

Of the five categories of power identified by Handy, London's Mayor will have at least one, *position power*, derived from the legitimacy of the office of Mayor, and possibly two or three – *expert power* and *personal power* or *charisma*. Two other categories, *physical power* and *resource power*, we may assume to be irrelevant in this context, although the sixth, *negative power*, may conceivably be deployed. The point to be extrapolated is, simply, that some mayors will, in some circumstances, be more powerful than others, but all will, if only by virtue of their position, want to be regarded as leaders.

In his exploration of leadership for health,[23] John Catford points to the paucity of research of what makes good public health leaders and how leadership can be strengthened. He makes the point that the public health scenario is unlike the management environment of the business sector to which most leadership theory relates: *'the practice of public health is not typified by vast armies of subservient employees; indeed the line management role in public health or health promotion departments is minimal. Winning political support, inter-sectoral action and community participation is the major challenge'*. This raises all kinds of questions about who should play a leadership role in health. Traditionally the role has been the preserve of professionals or experts, not elected representatives, although the former location of responsibility for public health within local government meant that the professionals were once answerable, in some measure, to local electorates. Although public health practitioners increasingly work across the NHS/local government divide, and some are now jointly employed or seconded from one sector to the other, this is a long way from an elected representative assuming any kind of health leadership role.

It is important to distinguish here between the kind of leadership that might be appropriate at the local level and what is needed at the pan-London or regional level in an Authority that is purely strategic. It would clearly not be advisable to have a Mayor, or anyone else, playing a leadership role in health without recourse to expert

advice and information. Arguably, what is needed is not so much leadership as 'shared ownership' and partnership.

Our observations of city-wide authorities in the UK and elsewhere have suggested that the roles that might be played by the Mayor in the health policy arena may fall into one or more of the following categories:

- convenor/negotiator
- ambassador
- visionary/educator
- advocate/champion of causes
- critic/auditor
- oppositionalist.

These roles are not mutually exclusive and the Mayor could play several roles in relation to different issues at any one time. Each role will involve a different set of relationships, which may be adversarial in one policy context and harmonious and co-operative in another. Because current policy places such emphasis on partnership (to address wider health determinants) and because it is argued here that it is preferable to have the Mayor involved in health improvement strategy rather than remaining detached from it, the roles may be perceived on a spectrum of preference that places the highest value on negotiation and the lowest on confrontation. Experience of other cities are included in each category.

a) The convenor/negotiator

Characteristics: The Mayor is broadly supportive of agreed policies and participates either directly or via delegates in established health partnerships. The Mayor ensures access to expert information and advice, and uses influence to 'knock heads together', to tackle institutional barriers to health improvement and extend partnerships. National health priorities are incorporated into Mayoral strategies. The Mayor publicly supports or spearheads health promotion initiatives in the capital.

Examples: The Mayor supports the HImP priorities of boroughs and health authorities and works closely with the Regional Office of the NHS to develop and deliver its London health strategy. The Mayor publicly endorses specific health campaigns such as screening, take up of immunisation, reducing pollution, accident prevention, tobacco policy, healthy schools,[a] healthy living centres. The Mayor actively seeks health input to GLA strategies.

Experience of other cities

In Rome, Mayor Francesco Rutelli aims to build bridges with the city's boroughs (or *circoscrizioni*), which are an important delivery mechanism for many of his policies, particularly social provision.[b] There is clear potential for conflict between the Mayor and the boroughs, particularly because the City Council (or *Commune*) allocates money to the boroughs, but the boroughs can choose spend this money on their own priorities. Mayor Rutelli has tried to build agreement on social care standards in the city by bringing the boroughs together with voluntary and private sector providers to sign up to a voluntary code. The City Council holds quarterly meetings with borough presidents to help co-ordinate the quality of locally provided health services. These meetings are an important opportunity for the city to address the regional Lazio government with a single voice about the health needs of the city's population. It also enables the City Council to improve its understanding of health needs across the city.[24] Some boroughs have public offices in the Council's buildings. The Council often pilots policies in the most co-operative boroughs, such as a new way to code noise pollution which has subsequently been extended across the city (for more details of action on noise pollution, see below). Mayor Rutelli has also worked to build agreement amongst the city's Councillors. A member of the Green Party, he is supported by a cross-party coalition in Rome's City Council that includes Greens, socialists and communists. This group represents approximately 60 per cent of the city's 60 Councillors and was formed when Rutelli stood for re-election in 1997 and members of the coalition were elected from a list bearing Rutelli's name. Although

[a] The GLA has no education function.

[b] Rome is part of the region of Lazio, with the city covering around 54 per cent of the region's population. In the Italian constitution, Rome is both a province and a commune. The Mayor of Rome, Francesco Rutelli, has jurisdiction over the commune of Rome. The commune is divided into 19 boroughs or *circoscrizioni*, each of which is run by a directly elected president.

much of the Council's power lies with its 15 strong cabinet (or *giunta*), the lack of cohesive party structure in the city, and across Italy as a whole, means that the onus is on Rutelli to sustain a strong coalition of Councillors.[25]

However, the picture in Rome is not uniform. Rutelli has a strained relationship with the city centre's borough (the first *circoscrizione*, otherwise know as *Monti*), ruled by a right wing coalition which recently put up posters in the city centre denouncing Rutelli. There is also conflict with the 40 per cent of City Councillors who make up Rutelli's opposition. This group is a coalition of Christian Democrats and right wing parties such as Forza Italia and Alleanza Nazionale. The group takes an anti-regulation, anti-state intervention stance and makes regular attempts to block any new city-wide legislation. As a consequence of its opposition to Rutelli's policies, this group has been dubbed *uomini contro* – 'the men who say no'. The coalition introduced 300 amendments to a recent Millennium Bill that would have given the *Commune* the power to fine illegally parked buses, including the large number of tourist buses visiting the city over the Millennium. Other issues the opposition has attempted to block include setting up a privatised tourist bus service in the city to help keep large tourist coaches out of the city centre, and environmental protection.[26]

In Chicago, building consensus for change with Chicago's Aldermen has been a critical element of Mayor Daley's working style, particularly over service delivery issues.[27] The citizens of Chicago have traditionally contacted their local Alderman when concerned about services in their neighbourhood, even though most services are delivered by the City Council. Mayor Daley has worked closely with the Aldermen to ensure that people can contact either their Alderman or the City Council to address their concerns. Daley has dedicated one unit of staff exclusively to liaising with Chicago's Aldermen and another to working solely on federal government issues. He has also worked to build consensus with the State of Illinois, for example in brokering agreements to devolve further power and responsibility to the city. Illinois has a 'Home Rule' ordinance, which allows the State to give a degree of freedom to particular municipalities over certain issues, and one of these municipalities is Chicago. Responsibility for education in the USA usually rests with the State, but Illinois has devolved this responsibility to Chicago under the 'Home Rule' ordinance.

One view is that it was only because the State had been subject to considerable criticism over the poor standards of education in Chicago that it was willing to relinquish responsibility.[28] In addition to education, Daley would like to have full responsibility for running public housing, which is currently a federal government responsibility. The Housing and Urban Development Agency (a federal body) has given the city a degree of responsibility for this issue, through new powers to appoint members of the Agency's board. However, the HUD has so far refused to give the city the direct fiscal or day-to-day control that Mayor Daley argues is necessary to secure effective improvements in the city's housing.[29]

Toronto has recently undergone a major re-organisation of its administration.[c] Many of the Council's 58 members are new and have never worked together before. Negotiating and brokering agreements has characterised the working style of Mayor Lastman. Working closely with individual City Councillors to understand their specific needs, issues and priorities is seen by city officials as crucial in securing support for the new city's programme.[30]

In Barcelona, the regeneration of the deprived Ciutat Vella district in the centre of Barcelona has required Mayor Joan Clos, his predecessor Pasqual Maragall and the City Council to work closely with the regional government of Catalonia (or *Generalitat*). The *Generalitat* has responsibility (or the 'competence') for building work in Barcelona, whereas the City Council is responsible for managing the city's land. The regeneration of Ciutat Vella has involved widening streets and building public squares and new housing. An effective partnership between the City Council, Mayor and the *Generalitat*, which has lasted for over a decade, has been critical to the success of the programme.[31]

An important mechanism used by the Mayor of Berlin, Eberhard Diepgen, to build agreement between the state and the district administrations in Berlin[d] is the Council

[c] Seven municipalities – Metropolitan Toronto, the cities of Toronto, North York, Scarborough, Etobicoke and York and the Borough of East York – were amalgamated into the new city of Toronto in January 1998.

[d] Berlin also has two levels of government. Berlin is both a city and a federal state (*bundesland*). The second tier of government in Berlin is the local or district level. There are 21 districts in Berlin, although in 2002 this number will be reduced to 12. Districts have their own mayor and town council

of the Mayors (*Rat der Bürgermeister*). Currently, there are 21 district mayors, plus the City Mayor, who heads the Council. The Council's role is to make decisions on basic questions of administration and legislation at the level of the city district, although the Mayor of Berlin can bring forward issues that concern the city as a whole, such as how the Reichstag should be renovated or how the Potsdamer Platz will be built.

Mayor Giuliani has used his high profile and strategic leadership to build the consensus needed to tackle domestic violence in New York, through the Mayor's Commission to Combat Family Violence. Bringing together the police with hospitals and other health care providers in the Mayor of New York's Commission to Combat Family Violence has highlighted the need for health services to play an increased role in identifying victims of domestic violence and linking them to the services they need. It has been argued that the Commission has helped to generate new and innovative approaches to tackling domestic violence, such as the Alternative to Shelter project and the Adopt a School programme (for further details, see below), by bringing together different organisations to discuss how best to tackle the issue.[32]

In Toronto, Mayor Lastman has helped co-ordinate the work of a range of public, private and voluntary organisations to address homelessness in the city through his Task Force on Homelessness.

In 1994, the Mayor of Paris, Jacques Chirac, established a multi-agency group to tackle homelessness across the city. Members of the group include RATP, which runs the Paris Metro, and SNCF, responsible for national railway stations. Since homeless people often congregate around stations, SNCF and RATP have an important role to play in helping to identify and link homeless people to appropriate services elsewhere in the city.

(*bezirksamt*). Each district also has eight departments to mirror the eight federal ministries (outlined above) at the district level, run by a chairperson or *stradträte*.

b) Ambassador

Characteristics: The Mayor represents London on the world and European stage and advances the claims of London in relation to other regions of the UK.

Examples: The Mayor signs up to international initiatives such as WHO's Healthy Cities Project. The Mayor publicly presses for more health spending in the capital and calls for a new regional distribution formula, which would bring more public funds into London compared with other regions (see Section 6, 'Funding issues').

Experience of other cities

Mayors have been ambassadors for their city, both abroad and within their own country. In Europe, the successful interpretation of this role can lead to European funds and encourages many cities and regions to look beyond their national boundaries. In Birmingham, the coterminous City Council and Health Authority have worked to secure significant European Union funding for their initiatives.[33]

For Mayor Mel Lastman, being Toronto's ambassador to the Province of Ontario and to the federal government in Ottawa has been especially important. Ontario Province[e] is run by the Progressive Conservative Party, who were elected on a promise to downsize government and cut taxes. The re-organisation of the city of Toronto was an important element of this strategy. The Province is cutting the services the provincial government provides and devolving increasing responsibility for other services they used to provide to the municipal level, without transferring the corresponding resources.[f] It has been argued that these cuts will be particularly keenly felt in Toronto

[e] Canada has a federal system of government. In addition to the national government, there are three layers: two territories, ten provinces and various municipalities. The City of Toronto is the major municipality in the Province of Ontario. The federal or national government is responsible for areas such as foreign policy, taxation, currency and banking, immigration, criminal law and procedure, defence, citizenship, postal services and national economic policies. The provincial government of Ontario is responsible for areas such as health services, natural resources, highways, hospitals and education. Municipal government has no status within the Canadian constitution as an order of government.

[f] Two years ago the Province devolved responsibility for running the public transit system to the city of Toronto, including the requirement to fund it. One hundred per cent of the public transit system now has to be paid for by the city, which has had to raise the extra funds required from increased property

because the city contains a higher proportion of disadvantaged groups than elsewhere in the Province.[34] An additional problem for the Mayor and City Council is that the federal government and Ontario Province often work together on particular issues of concern in Toronto, such as immigration policy, without any input from the city.

Mayor Lastman frequently campaigns for both the provincial and federal government to take greater responsibility for the issues faced by the city, although his success has been limited. A key theme of the Action Plan produced by the Mayor's Taskforce on Homelessness[35] is that all three levels of government should to take ownership of the issue and responsibility for solving it. The Task Force argued that the Province should fund 100 per cent of new supportive housing built in the city and reassume responsibility for funding any supportive housing that has already been devolved to the municipal level. The Task Force also called for the federal government to work with the city to address immigration and refugee policy and ensure that municipalities outside Toronto provide emergency shelter for some immigrants and refugees to reduce the pressure on Toronto's hostel system.

c) The visionary/public educator

Characteristics: The Mayor articulates a broad vision of the city's future, which is then used as a means of inspiring support and participation, and delivering public messages.

Examples: A Mayor is elected on the basis of a vision of London that seeks city-wide economic regeneration, the eradication of poverty and substantial reduction in inequalities. There would be health benefits. This kind of Mayor could be successful in health promotion and changing public attitudes.

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taxes. The Premier of Ontario Province, Mike Harris, has also proposed two tranches of cuts in the services it provides, worth approximately $1 billion in total.

Experience of other cities

Some mayors have articulated a clear vision of their city and used it as a means of engaging the public. The regeneration of Ciutat Vella by successive mayors of Barcelona consists of two elements: the physical regeneration of the district and the human regeneration of the population through social programmes. The Ciutat Vella programme is a practical example of the former Mayor Pasqual Maragall's vision of the city, a vision that has continued to drive his successor, Mayor Joan Clos. This vision is perhaps best encapsulated by the message of a major public education campaign that Maragall ran when he was Mayor: *Barcelona: posa't guapa.* This translates somewhat crudely as 'Barcelona: make yourself beautiful'. The phrase has two meanings. The first is the need to improve the physical infrastructure of Barcelona, particularly the facades of many of the city's buildings, which had fallen into disrepair. This part of the message emphasises Barcelona's rich architectural heritage, and the new buildings for Barcelona's Olympics can be seen in this context. The second meaning of *Barcelona: posa't guapa* is the need for the people of Barcelona to 'make themselves beautiful', to care for and be proud of themselves, because they are as important to the city's life as the buildings they live and work in.[36]

Mayors who have a high political and media profile are well placed to transmit strong messages and help change attitudes on a wide variety of topics, including health and health-related issues. In New York, Mayor Giuliani has argued that attitudes towards domestic violence must be changed so that it is considered as much a crime as burglary or homicide. The Mayor's Commission to Combat Family Violence cites drunk driving as a prime example of how an education campaign, launched in combination with a strong criminal justice response, can significantly change society's attitudes. A key aim of the Commission is to achieve the same change in attitudes in relation to domestic violence.[37]

In Rome, Mayor Rutelli has used his high political and media profile to attempt to change public attitudes towards transport. Rutelli uses two key arguments to persuade Romans to get out of their cars and onto the city's public transport system. Firstly, he has appealed to their sense of pride in their city. He has stressed the detrimental effect that pollution has on Rome's historic monuments by publishing details of how

particular pollutants cause damage to different types of building material. Secondly, Rutelli has emphasised the links between traffic, pollution and the health and well-being of people living and working in the city.[38]

d) The advocate/campaigner

Characteristics: In this scenario, the Mayor is willing to espouse 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. Some may get involved in individual cases or grievances.

Examples: One or more health campaign issues, e.g. tobacco, asthma, fluoridation, drugs, or groups such as pensioners, the homeless and young people, receive active support or leadership from the Mayor.

Examples from other cities

In Chicago, Mayor Daley has championed the needs of older people.[39] Last year the city's Department of Ageing conducted a 'Health Needs Assessment' to help determine how best to address the needs of current and future seniors in the city.[40] The Assessment was carried out through a combination of telephone and face-to-face surveys, focus groups and individual interviews. It found that the 'next generation' of seniors were more interested in receiving help and information on managing their finances and in using the city's cultural and health facilities than current seniors. The 'next generation' of seniors were also more likely to want to continue living in Chicago, unlike current seniors who were more likely to want to move out of the city. Perhaps unsurprisingly, the overall theme of the Health Needs Assessment was that current seniors are more likely to expect the state to provide for them in retirement, whereas the 'next generation' of seniors tend to want more choice, both financially and socially, than their predecessors. The results of the Assessment will be used to assist in the planning of services and programmes for Chicago Seniors in the future.

e) The critic/auditor

Characteristics: The Mayor takes a detached view of health policy and sees health as someone else's responsibility. He or she voices criticisms on behalf of the electorate and may publicly endorse critical reports resulting from scrutinies. This kind of detached view could apply to health services as much as to public health.

Examples: Service-related issues such as waiting lists, hospital closures, winter crises or the performances of provider trusts. The Mayor in this scenario becomes a natural ally of patients and user groups, and takes a view on complaints against health authorities and trusts. There could be public pressure for the Mayor to deliver this kind of health role.

Examples from other cities

Like the GLA, the *Commune* of Rome does not run health services in the city. This is the responsibility of the Lazio health region. However, the city has managed to influence some aspects of health service management in the city. The City Council put pressure on the region to change the system of hospital visiting hours, an issue that had been raised with the *Commune* by the city's boroughs. The region has now agreed to introduce morning, lunchtime and evening sessions so that Romans have more opportunities to visit their friends and relatives in hospital.[41]

A further example of how Rome works to influence health services in the city is the establishment of a special committee to investigate a hospital where unsanitary conditions in a maternity unit led to a number of babies contracting gastro-enteritis. The committee is made up of City Councillors as well as external experts.[42]

f) The oppositionalist

Characteristics: This is a more extreme version of the critic/auditor role, and likely to be opportunistic and even 'maverick'. In this scenario, the Mayor takes no sustained

or consistent interest in the health improvement policies in which others are engaged. He or she pursues his or her own agenda. This could come about as a result of political convictions, personal values, whims, an antagonistic or abrasive style, or a poor relationship with health authorities and partners. An oppositional stance is likely to be deployed when it will enhance Mayoral popularity and bring political advantage.

Examples: The Mayor is from a different party to the Government; he or she may publicly challenge national or local health priorities, seek to change agreed strategic direction, publicly press health authorities and boroughs into specific courses of action regardless of agreed health improvement priorities. Likely issues would be ideological, such as tackling health inequalities, the NHS Private Finance Initiative, rationing of services. Rationalisation of services, which involve hospital closures, are a likely target.

Examples from other cities

The Mayor of Paris, Jean Tiberi, is involved in frequent conflicts with the state (or national) government of France, whose centrally appointed representative in the capital is the Prefect (*Prefet*).[8] Tiberi regularly opposes national government policy by highlighting issues in Paris and claiming that a lack of action by the state, via the Prefect, is a major cause of the problem.

[8] In addition to national government, France has three directly elected tiers of government. There are 22 regions, 95 departments and around 36,500 municipalities in France. Regions are run by directly elected assemblies which are responsible for planning and investment across the region. Paris has both departmental and municipal status. Departments are the main levels of government responsible for implementing policy and delivering services. Each department has a prefect – the state's representative who oversees the services for which the state is responsible within the department. Departments are run by a directly elected council. The Paris City Council (*Conseil de Paris*) runs both the departmental and municipal responsibilities of the city, rather like unitary authorities in the UK. It consists of 163 councillors representing the city's 20 *arrondissements*. These councillors also sit on the individual *arrondissement* councils along with other councillors who only represent their local area (there are 354 *arrondissement* councillors in total). The City Council elects the Mayor of Paris for a six-year term.

Conflict also characterises the relationship between Rudy Giuliani and the New York City Council. For example, the Council wanted to establish an Independent Police Board to review allegations of corruption in the New York Police Department, with members appointed by both the Council and the Mayor. The Council passed legislation to establish the Board but Giuliani opposed the move, arguing that the only way to secure lasting change would be for NYPD itself to take action. This dispute is currently going through legal proceedings.[43]

Mayor Giuliani often attempts to influence decisions about issues for which he has no formal responsibility by making his views known to the general public via the media[44] – a tactic known as 'the bully pulpit'. When Giuliani wanted a new train link from La Guardia airport to New York's downtown financial district, the project was initially excluded from the Metropolitan Transport Authority's capital budget. The Mayor of New York has no formal responsibility for transport in the city. However, Giuliani argued the MTA's capital budget would be failing to meet the needs and interests of New Yorkers if it did not include the La Guardia rail link. The proposal was subsequently incorporated into the MTA's plans.

All mayors aim to build support from the general public via the media. This is an especially important tactic used by the oppositionalist. Both the Mayor of New York, Rudolph Giuliani, and the Mayor of Paris, Jean Tiberi, hold daily press conferences. Tiberi has used opinion surveys to help build support for his activities. In 1999, he conducted an opinion poll of 1500 Parisians to find out what they thought the key issues were affecting their health and the health of their city. It has been argued that this survey was part of Tiberi's strategy to gain greater responsibility for health issues in the city, particularly health promotion and protection.[45] The survey found that 60 per cent of Parisians were worried about their health, particularly women aged under 60 years, and that they thought the main factors influencing their general quality of life were stress, pollution and the quality of food. The majority of Parisians said they wanted the Mayor to have a stronger role in health issues in the city. In response to this survey, Tiberi held a week-long conference for health professionals to look at the impact of urban life on health and organised a public 'Health in the City' event to which all Parisians were invited.

5. The role of the Assembly

5.1 Power over the executive

The general function of the Assembly, as set out in *sections 59* and *60* of the GLA Act, is to keep under review the statutory functions exercised by the Mayor. 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 any matters relating to the principal purposes of the Authority (these do not include health), matters in relation to which statutory functions are exercisable by the Mayor (these might be interpreted as including health), and *'any other matters which the Assembly considers to be of importance to Greater London' (section 59 (2)).*

Thus, the Assembly may influence the health policy process by scrutinising the Mayor's actions, i.e. the implementation of his or her health powers, 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 itself. 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 or 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 is open to pressure and pleas from its constituents. During consultations about the Mayor's strategies, health partners

may need to lobby GLA members to ensure measures to improve health are included. Although in practical terms there is little the Assembly can do if such measures are excluded, Assembly members can, like the Mayor, extend influence through the media and draw public attention to the omission.

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 must be consulted on the draft budget, which it can amend before returning to the Mayor, who, if he or she rejects the amendments, is required to give reasons.

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

5.2 Inquiries

The Assembly has virtually unlimited scope for its inquiries in terms of subject matter. 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 may also be confined to publicising issues rather than having their own recommendations implemented.

Under the terms of the GLA Act, health authority representatives may not be compelled to give evidence before Assembly inquiries – they are not included in the bodies listed in *section 61*, which includes 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. Eventually, if a collaborative relationship develops, it may become conventional to regard the NHS London Regional Office as having a relationship with the GLA that is comparable with that of a functional body such as the Metropolitan Police. In other words, the LRO remains formally

accountable to the NHS and Parliament, but *de facto* interconnected and answerable to the GLA. London's public might consider the NHS to be oddly unco-operative if it were to decline to appear before GLA Assembly inquiries.

In general terms, how far the writ of the Assembly will run is a matter for experience. It might take an interest in issues that verge on the boundaries of its remit, for example it could review the effectiveness of the GLA's emergency services (fire and police) 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, even though responsibility lies within the NHS.

5.3 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' selected on the basis of votes cast for each party may develop differently, with less constituency work than the 14 constituency-based 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.[46] In the context of London this could mean GLA members taking some cases from Westminster MPs and passing some down to local councillors.

In Toronto, Councillors often lead the work of the city's task forces. For example, Councillors Rob Davis and Brad Duguid chair Toronto's Task Force on Community

Safety. Inevitably, one reason councillors are keen to lead work on particular issues is that it helps raise their personal profile in the city.[47] In Berlin, the links between poverty, deprivation and ill health were highlighted not by the Mayor but the head of Berlin's Ministry for Health and Social Affairs.[h] The Ministry produced a report showing major differences in mortality rates between different districts in Berlin.[48] The report found particularly high levels of ill health and social deprivation in areas near the centre of the city, which had a higher proportion of welfare recipients, unemployed people and citizens from countries other than Germany. In response to this report, the Mayor of Berlin, Eberhard Diepgen, held several conferences to discuss the issues raised and to develop practical solutions to the problems. These 'inner city conferences' are chaired by the Mayor and include members of a number of different government ministries (including education, health and social affairs and city planning) as well as representatives from industry, the unions and the local mayors from the districts involved. The first 'inner city conference' was held in April 1998 and focused on improving Berlin's schools. The second, in June 1998, focused on the economy and employment in Berlin's deprived districts. The links between poor health and deprivation in Berlin's inner city areas have featured in these debates.

[h] Berlin's Senate is elected through a system of proportional representation. Three of the current Senators are members of the SPD. The other four, plus Mayor Eberhard Diepgen, are Christian Democrats.

6. Funding issues

The funding of the new Greater London Authority is a specialist area beyond the remit of this working paper, but certain points are relevant to this discussion. Firstly, the GLA will be modestly funded. As noted, it is also barred by the Act from spending money in areas for which responsibility lies with other public bodies. It is explicitly prevented from incurring expenditure on housing, education, social services or health services. This raises the question of how any new regional health activities generated by the GLA will be funded.

The Mayor will be able to use the power in *section 30* to co-operate with, co-ordinate or facilitate the activities of bodies on a London-wide basis. According to the Explanatory Notes accompanying the GLA Act, *'This might include, with the agreement of such authorities or bodies, providing a related specialist service which would be of benefit to London as a whole'*. One example may be health promotion activity – likely to appeal to the Mayor – which 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.

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

In so far as the Mayor's priorities can be predicted, it is almost certain that the Mayor will publicly press for more central government funds for London in any area of public spending, but particularly NHS funding, where it is often argued 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 than in England to vire funds between budget heads. This is a subject of the utmost complexity and, taken out of context, comparisons can be invidious: London's Mayor has already implied that disproportionate funding for Scotland is responsible for the poor state of London's public transport.[49]

Although the Government pledged to maintain the Barnett Formula during the process of devolution in Scotland and Wales, the arrival of devolution means far more transparency. As Heald and Geaughan have pointed out: *'the real numbers will increasingly be in the public domain and it will be much more difficult to fudge them'*.[50] They suggest that the Government should reassess its commitment to maintaining 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 may provide further impetus for other English regions to have a voice.

It is fair to say that every mayor or city-wide authority in this study has sought to increase funds, usually from national and regional governments. In Toronto, Mayor Lastman has criticised both federal and provincial governments for failing to provide sufficient funds to tackle homelessness in the city and has pressed (so far unsuccessfully) for additional resources: *'This cheapens and demeans our cities. It is a national emergency and a national embarrassment. The federal government has downloaded all its responsibilities to the municipalities of Canada'*.[51]

The Mayor of Rome, Francesco Rutelli, is generally on good terms with Italy's national government but tensions have arisen over the amount of money distributed to different cities. Mayor Rutelli has responded to claims from the Mayor of Milan (a member of the separatist Northern League) that Southern Italy, including Rome, is draining resources from the North by arguing that Rome is getting an unfairly low proportion of funding from central government in comparison with Milan. Per capita transfers from central government are about £149 per head in Milan and £97 in

Rome.[52] Rutelli has so far been unsuccessful in persuading the central government to change the way it distributes resources between cities.

The GLA will not be in a position to fund projects, make grants or provide services directly. However, the Mayor may be able to lever-in 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, and the regeneration agenda may provide strong opportunities to improve health in parts of the capital.

In New York, Mayor Giuliani secured private sector funds to pay for substantial elements of his domestic violence strategy (for example the public education campaign) and uses the city's funds to pilot innovative projects such as the Alternative to Shelter and Adopt a School programmes.[53]

Barcelona City Council lacked sufficient funds to support the regeneration of Ciutat Vella, so established a public/private organisation called PROCIVESCA to enable the City Council to generate additional funds for the programme.[54] The city has also encouraged the improvement of private properties through low interest loans and subsidies funded jointly by the City Council and the regional government (the *Generalitat*).

Some mayors have used city funds to supplement central government funding for particular programmes.

Chicago City Council distributes 2.8 million meals on wheels for the city's seniors every year. This project is partly funded by the federal government, but Mayor Daley has added city funds to ensure that no senior is on a waiting list for the service.[55]

The Mayor of Paris, Jean Tiberi, has been highly critical about the levels of spending awarded by the national government's Ministry of Health to hospitals in Paris. These hospitals have had cuts made to their budgets which, Tiberi argues, will lead to a drop

in the general quality of care provided as well as limiting access to emergency services.[56] Tiberi has reached an agreement with the city's hospitals whereby the city hall subsidises a number of projects that both sides agree are a priority. Some City Councillors oppose Tiberi and have accused him of acting *ultra vires*. However, a formal legal challenge has yet to be mounted.

7. London's health

A profile of health and social indicators for the GLA electoral areas has been prepared as part of this project by the Health of Londoners Project,[57] and is available separately from the King's Fund. This takes account of a new classification of areas within London in the form of 14 GLA constituencies and summarises some key features of health in those constituencies. These include measures of health status, health service use and determinants of health.

About 7 million people live in Greater London. It has a high proportion of younger people, particularly children and those aged 25–35 years. There are also proportionately fewer people of retirement age. London's young population has an important effect on health in the capital: *'Many of the most important health issues in the capital are more common among younger people. These include the higher levels of acute mental illness, HIV/AIDS, unplanned pregnancy and substance misuse'.*[58]

London is Britain's most ethnically diverse city. Nearly half of the UK's total black and minority ethnic population live in London and these groups now make up a quarter of the capital's population. London's diversity has an important effect on health in the capital. Black and minority ethnic groups tend to be more disadvantaged in terms of the key determinants of health in the capital and some health problems are associated with particular black and minority ethnic communities. Ethnic diversity is also important in terms of the accessibility and cultural appropriateness of health and related services.[59]

London's population shows a widening gap between the wealthiest and poorest. Twenty four per cent of London's population is estimated to be living in poverty.[60] The chances of dying before reaching the age of 75 are almost twice as high in the most deprived areas of London as in the least deprived. It has been convincingly argued that inequality is one of the defining characteristics of health in London.[61]

Housing is a key health determinant.[62] London has a significant number of homes that lack basic amenities and more than twice the national average proportion of

overcrowded homes. Poor quality housing, including overcrowding, damp and cold, is linked with accidents in the home, infectious diseases, stress and mental health problems and respiratory disease. London also has high levels of homelessness. Homelessness is linked with mental illness, alcohol and drug problems, poor access to all types of health service, and respiratory and infectious diseases.

Transport effects the health of Londoners in a number of different ways.[63] Although mortality rates from road traffic accidents are relatively low in London compared with the rest of the country (due to lower speeds in the capital), there are still nearly 300 deaths and 46,000 injuries every year from road traffic accidents. Whilst it is unlikely that poor air quality is a direct cause of asthma, it may exacerbate the symptoms of some people who already have respiratory problems. Exercise from walking or cycling instead of using a car or public transport to get around can have a beneficial impact on an individual's health. However, the most common form of transport in London for trips over 200 metres is the car. Transport can also affect local communities' access to work, food outlets and key services, such as health services.[64]

There is growing evidence that crime and fear of crime have a significant impact on health in the capital.[65] Crime can and often does damage the physical and mental health of victims, and fear of crime is a very real and debilitating factor in many people's lives, limiting their lifestyles in ways that are detrimental to health.

In addition to these 'upstream' causes of ill health, factors relating to individual behaviour are associated with poor health. Smoking rates in London are similar to those for England as a whole (around 32 per cent). Reductions in the proportion of people who smoke in London over the past few years have been greatest in more affluent social groups, as is true elsewhere in the country. A relatively high proportion of adult Londoners take no exercise. This lack of exercise, combined with a poor diet, may be an important cause of the relatively high rate of obesity in London compared with other European cities.[66]

Mortality rates for cardiovascular disease and cancer rates are significantly higher in Inner than in Outer London. Other key health characteristics in the capital include

higher mortality rates for respiratory disease, in particular for pneumonia and for infectious disease such as TB and HIV/AIDS. Suicide rates in Inner London are particularly high.[67]

8. Putting health on the city agenda

In the UK, it is at the local level that real responsibility for health lies, and where health policy is delivered. Through the policy of Health Improvement Programmes, now in its second year, 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 to the NHS in 1974. When making any interventions in health improvement or health strategy in the capital, the GLA would be well advised to respect the primacy of local Health Improvement Programmes.

Below are summarised key recommendations for strategic health action in London, put forward by The Health of Londoners Project (HOLP), the King's Fund and the London Coalition for Health and Regeneration.

The Health of Londoners Project has outlined the following ways in which the GLA strategies could be used to improve health:[68]

Transport

- Promote walking and cycling
- Reduce car use (to improve air quality and minimise noise)
- Introduce road and transport safety measures to reduce accidents
- Make planning decisions on road/rail location to maintain local communities
- Support real employment opportunities within the transport infrastructure
- Maximise public transport access to health care facilities

London Development Agency strategy

- Develop local economies to reduce poverty
- Generate employment
- Prioritise areas or minority groups to reduce inequalities

Spatial development strategy

This provides the context for the boroughs' Unitary Development Plans and the Mayor's own policies, and HOLP anticipates a potential impact on levels of social isolation, community involvement, general mental health and, by ensuring access to food retailers, on diet.

Environmental strategies

These include the air quality, waste management, ambient noise and bio-diversity action plans, all of which can improve health through overall quality of life and stress reduction and, more specifically, by reducing respiratory and cardiovascular disease and levels of infection/infestation related to waste.

Culture strategy

This incorporates culture, media and sport and can therefore play a key part in:

- shaping Londoners' perceptions of health and key health issues, e.g. smoking, substance misuse, obesity-related problems, accident prevention
- promoting physical exercise.

Crime

The GLA has no statutory duty to produce a crime strategy, but the Metropolitan Police Authority is a functional body of the Authority and a crime strategy remains an option. In any case, the work of the police can have an impact on health through:

- joint work on drug misuse and harm reduction strategies
- community safety initiatives to improve the environment and reduce social exclusion
- reducing injury and violence.

Fire and emergency planning

There is no statutory GLA fire and emergency planning strategy. The ambulance service remains the responsibility of the NHS. However, the new functional body, the Fire and Emergency Planning Authority, could have an impact on health through:

- preventive strategies to reduce accidents and injuries
- providing an optimum service, in collaboration with other emergency services, to minimise the severity and effects of accidents.

A Millennium Declaration

The King's Fund has drawn up a Millennium Declaration, which sets out five priorities for the Mayor and GLA:

1. Tackle health inequalities
2. Regenerate London's deprived areas
3. Create a healthy transport strategy
4. Cut crime and improve community safety
5. Involve Londoners and establish effective partnerships

A Coalition for Health and Regeneration

At the instigation of the London Regional Office of the NHS, more than 300 organisations across the capital have contributed to the formation of a Coalition for Health and Regeneration, which has produced the first strategy for London's health. This is based on three underlying principles – involving citizens, sharing intelligence and working in partnership. The Coalition has identified four priority areas for action:

- regeneration
- inequalities
- black and minority ethnic health
- transport.

A number of broad aims are specified under these headings. The Coalition intends to develop them into action plans for review in the autumn 2000. It anticipates that the London Health Observatory will provide analysis and research and publish reports. It will develop a number of high level indicators into a monitoring programme. They are:

- overall unemployment rates
- GCSE attainment rates
- the proportion of homes judged unfit to live in
- burglary rates
- air quality
- traffic accident rates
- black and minority ethnic groups' unemployment rates
- life expectancy at birth
- infant death rate
- the proportion of population self-assessing with fair, poor or bad health.

The Coalition recognises *'that health is affected by all the policies that are the Mayor and GLA's responsibility'* and stands ready to work in partnership with the new Authority.[69]

Securing a place for health improvement on any political agenda is not easy – a fact supported by evidence from the second phase evaluation of the World Health Organisation's Healthy Cities Project.[70] Strategic, city-wide action on health *per se* is relatively unusual, although individual projects on health issues have been established. Other priorities dominate cities' political agendas, but in many cases these have led to the adoption of strategies with substantive health-improving components. For example, Mayor Giuliani's top priority in New York has been to reduce crime.[71] In Chicago, Mayor Daley's drive has been to improve basic services and develop a more family-friendly city.[72] Mayor Rutelli's three key priorities for Rome are 'Traffic, traffic and traffic'.[73] The resultant strategies have incorporated health objectives (discussed below).

As the WHO has argued: *'The concept of health in itself has little intrinsic value for policy-making. Successful Healthy Cities have been able to translate health into values closely related to urban planning (zoning exercises), local economy (employment and schooling schemes), and ecology (sustainable development)'.*[74] The Healthy Cities Project has demonstrated that much time and effort from organisations and individuals promoting policies to improve health are fundamental to the development of city-wide health strategies.[75] Moreover, these organisations and individuals have needed to show a high degree of understanding of political processes in order to be successful. The process of developing Health Improvement Programmes at the local level in the UK has demonstrated the demanding nature of the partnership building that is essential to any health improvement strategy.

A basic difficulty lies in the general lack of understanding amongst elected politicians about the meaning of 'public health' or 'health improvement' or even 'health'. This is particularly true in the UK where public health and responsibility for health improvement are integrated within the wider NHS and are obscured from public view by the voracious spending requirements of acute health services. When most politicians talk about 'health' they mean health services.

There is considerable debate about the value of city-wide strategies, including strategies for health. Some city authorities take the view that all-encompassing plans are necessarily so broad that they lack focus and direction, and that the time and effort required to develop a plan for the city would be better spent on taking action.[76] Others point to the benefits of producing city-wide plans: *'It is generally recognised that the social and organisational process of developing health plans is of tremendous impact on the survival of the Project'.*[77] The actual process of producing a city-wide health plan is thought to help organisations develop a common understanding of the issues as well as the means of addressing them, and to be a crucial stage in the process of securing sustainable and successful improvements in health.

The size of the city concerned is bound to be a factor. What has proved beneficial (if only as a learning experience) in such UK cities as Glasgow, Birmingham – which has a coterminous health and city authority – Liverpool and Sheffield must be harder to

achieve in London where there are 33 boroughs, 16 health authorities and a population of 7 million.

Another difficulty, when putting health on the agenda, is the 'short-termism' that dominates political action. Politicians need to demonstrate to the electorate that measurable improvements are being made before the next election. As the WHO has argued: *'Measuring this outcome [i.e. the health of city population] is difficult, especially in the short term, and ascribing cause and effect is even more difficult'.*[78]

The experience of other cities suggests that putting action to improve health on to the city-wide agenda has been easier when it has contributed to the Mayor's core political priorities. In New York, one of Mayor Giuliani's key objectives has been to reduce crime, and tackling domestic violence forms a key part of the Mayor's strategy. Giuliani has argued that domestic violence is not only a crime issue, but a major public health issue: *'Domestic violence is a widespread public health epidemic that directly affects millions of American women and children every year, without regard to race, class or sexual orientation'.*[79] The Mayor's Commission to Combat Family Violence has established important links between the police and a range of different agencies responsible for improving health in the city.

New York's 'Mental Health Treatment is Working' campaign is another example of how action on health has gained Mayor Giuliani's support because it resonates with one of his key political priorities, which is to help people move off welfare benefits and into work. The campaign, which is run by the New York City Department of Health, aims to address the stigma associated with people with mental health problems and to encourage employers to offer them jobs. Giuliani's support for this campaign may seem surprising to those who are more familiar with the Mayor's strategy of cleaning up the streets of New York, which many have argued simply shifts vulnerable groups, including people with mental health problems, out of Manhattan into surrounding districts. The Mayor has used his high profile to help bring about a change in attitudes, particularly of employers, in the city: *'I urge New Yorkers to set aside prejudices and stereotypes about people with mental illness ... Our campaign sends an important message that most individuals who are mentally ill*

are law-abiding, tax-paying and employable citizens. We want the public, particularly employers and the business community, to see that a significant number of those with a psychiatric disability want to work and – with treatment – can work successfully'.[80]

9. Providing an evidence base for city health improvement

It has been argued that it is difficult to assess the effectiveness of many forms of public health activity, especially those relating to the underlying causes of health and health inequalities.[81] This analysis is supported by our research. City-wide authorities have outlined a range of problems associated with providing evidence that initiatives to improve health have been effective. Evaluating projects takes time and resources that may be lacking, particularly in departments that focus on the needs of deprived communities.[82]

The mobility of city populations is another factor that makes evaluation difficult. It has been argued that once people gain the skills they need to find employment they may move out of deprived city areas, and that more disadvantaged groups move in to take their place.[83] This 'revolving door' makes measuring the effectiveness of health improvement programmes, particularly those that focus on inequalities, highly problematic.

It can also be difficult to attribute changes in health to specific causes. Barcelona City Council has argued that there is some evidence that child health in Ciutat Vella has improved. The proportion of premature births is not significantly different from the city as a whole and the proportion of low birth weight babies is only slightly higher. *'These indicators are some of those that are influenced by the quality of care during pregnancy, and it is possible that the programme of mother-child health initiated in 1986 in Ciutat Vella has had some impact on these aspects'.*[84]

Evidence of health improvement attributable to specific programmes can be masked by the emergence of new problems. For example, in Barcelona the emergence of AIDS and drug misuse during the late 1980s made it difficult, if not impossible, to know whether the City Council's regeneration policy in Ciutat Vella had begun to improve morbidity and mortality rates in the area. However, it could be argued that without the programme of regeneration in Ciutat Vella, the situation would have been significantly worse.

In the light of these difficulties, city-wide authorities have used a range of indicators of progress. The longevity of programmes and sustained political commitment to their objectives can be regarded as indicators of success. The same is true of material outcomes such as new buildings or services.[85] Establishing effective partnerships or successfully securing project funding are, arguably, indicators of a project's success, although there are dangers in taking this argument too far.[86]

The need to develop new indicators of progress towards improving health and tackling inequalities has been acknowledged.[87] Birmingham Health Authority is seeking to develop new indicators to help assess the effectiveness of its Family Support Strategy, such as the links between increased social capacity and improved health and well-being.[88] Barcelona City Council's Health Interview Survey in 2000 [i] will focus on gender inequalities in order to help assess the impact that women's work – both inside and outside the home – has on their health. The survey aims to analyse the links between the degree of social support within local communities and the effect on mental health.[89]

Any Mayor will need to establish a balance between long-term goals to tackle the key underlying determinants of health and the 'quick wins' that will be crucial in building and sustaining confidence and support for the GLA's activities in the short and medium term. This raises the question of access by the Mayor to health information and expertise.

[i] The survey will include 10,000 face-to-face interviews and questionnaires. One thousand will take place in each health district.

10. Public health – crossing boundaries

Only by ensuring politicians have access to health information and expert interpretation and advice, can it be realistically expected that health improvement will appear on any political agenda to good effect. This has been a subject for criticism of the GLA Act, which, despite intentions expressed in the White Paper, makes no provision for a health unit at the GLA or for a health adviser for the Mayor.[90] In the first Mayoral election campaign, however, three candidates pledged to appoint an 'MOH'[j] for London, and one of them, Frank Dobson (a former Secretary of State for Health), intended this appointment to be *'independent of the NHS'*.

This revives the issue of where to situate public health, which has been a subject for debate since the abolition of the local government MOH in 1974, and assumed a new significance following the 'purchaser/provider' split, which caused a substantial proportion of public health personnel to become advisers in the process of commissioning services. Arguably, another branch of public health is needed within multi-functional bodies, such as the GLA, which have leverage over policy areas that include the wider health determinants, such as transport, environment and regeneration.

All the cities in this study have different political and bureaucratic structures (see Appendix 2). None of them separate responsibility for health and health expertise from elected city governments so rigidly as in London. However, this distinction may be ameliorated by another finding – that the formal, statutory framework of powers and responsibilities for health does not prevent health-improving partnerships and policies developing informally.

In Barcelona, it has been argued that locating the Health Information Centre within the City Council, rather than in the Department of Public Health, has encouraged the Council to become more involved in improving health in its broadest sense.[91] Barcelona's Health Information Centre provides information on health indicators for

[j] Medical officer of health.

each of the ten health/municipal districts in the city, as well as for smaller geographical areas. It presents a 'Health in the City' report to the Mayor and Council once a year. This information is used by the city to help define priorities for each district and small area.

Paris City Council's Hygiene Laboratory is responsible for providing the Council with evidence about the links between the environment and health to help guide policy-making and to ensure the public and media have access to information on the environment. It is arguable that the Laboratory's work has also encouraged more effective cross-boundary working in the city.[92]

A case can also be made for locating public health on neutral or independent territory, neither in health services nor in elected government. It has been suggested that the independence of Toronto's Board of Health has had a significant effect on the relationship between health agencies and the City Council.[93] The Board of Health, led by Toronto's Medical Officer for Health, reports to the City Council. However, the Board is not subject to the Council's authority and has the power to publicly oppose any of the Council's decisions that it believes may be detrimental to the health of people living in the city. The Board rarely uses this power, but its existence gives the Board greater influence and leverage over the city's decisions than if it were under the direct authority of the Council. The London Health Observatory is intended to be independent and to serve as a valuable public health resource for all.

Independence is a recognised tradition in public health in the UK, dating back to the presence of the MOH in local government as an independent professional acting as advocate of the public interest. Since 1974, the successor to the MOH – the Director of Public Health (DPH) has preserved that advocacy role by making an annual report on the population's health from an independent position. But the DPH is also an executive member of the health authority (which in the annual report he or she must be free to criticise). This is sometimes a difficult balancing act.

The new duty on local authorities to work in partnership with health authorities, combined with their role in producing and delivering HImPs, is leading to renewed

demand for public health capacity in local government to inform their policies. Some Directors of Public Health are now being employed jointly by health and local authorities and, in order to further the development of HImPs, secondments have been made from health to the local government sector.

The GLA Act says nothing about how the Authority will relate to London's health authorities, which have responsibility for leading health improvement, or the London Regional Office (LRO) of the NHS. Just as, at the local level, London's health authorities work closely with the boroughs and readily acknowledge that they cannot deliver their objectives without them, so the LRO will have to institute ways of working with the GLA. The election manifesto of London's Mayor stated that he would: *'set up arrangements for the London Region of the NHS to report regularly to the Mayor and Assembly on progress in meeting targets for health improvement in London'*.[94] Such arrangements allow for a two-way process, would provide the necessary opportunity for the LRO to inform the Mayor of appropriate health measures for inclusion in his or her strategies and generally advise on how to fulfil his or her duties regarding the health of Londoners (see Section 13, 'Recommendations').

11. Health action in other cities

In an earlier section, 'The role of the Mayor', it was suggested that Mayoral action on health may be perceived in three contexts: firstly, *ad hoc* interventions that are essentially non-strategic, individualist and responsive to events, likely to be critical of the policy *status quo* and politically opportunist. Secondly, within strategies in other policy areas – such as environment, transport or regeneration (which in the case of London are required by statute) – and which may be perceived as 'health by another name'; and thirdly in any health-specific strategic action which the Mayor may choose to engage in.

This section outlines some initiatives taken by other cities to improve health. Most of them fall within the second category, in that health improvement was a secondary rather than a primary objective. However, some initiatives are specifically health-related, and focus on the health needs of particular groups, the risk factors associated with ill health and on specific diseases.

No other city is entirely comparable with London, either in terms of the health needs of the population, the structure of local health and related services, or the responsibilities the city-wide authority holds in relation to health. Although the Mayor of London's formal powers and responsibilities are different, and on the whole weaker, than those of other city-wide authorities, there is a wide range of initiatives that have been pursued in other cities that might be adapted to the London context.

11.1 Health initiatives in wider strategies

Transport

Reducing traffic and improving the environment in Rome

The Mayor of Rome, Francesco Rutelli, has identified two strategies for reducing traffic in the city. The first is to reduce levels of car ownership (there are nearly two cars and one scooter for every adult in Rome). The second is to shift the balance

between the proportion of journeys made by private and public transport from the current level of 60 per cent private: 40 per cent public to 40 per cent private: 60 per cent public.

Mayor Rutelli has used his high political and media profile to argue that Romans should leave their cars and scooters at home. He has appealed to their sense of pride in the city by highlighting the effect pollution has on Rome's historic monuments and has also stressed the detrimental impact pollution has on the health and well-being of people living and working in the city.

The Mayor and City Council have adopted an incremental approach to reducing traffic in Rome. Initially, a 'Clean Wednesday' programme was established to prohibit vehicles without catalytic converters from entering the city centre between 3 p.m. and 9 p.m. on designated days. This initiative was then extended to prevent cars without converters from entering a wider section known as the 'Green strip'. From August 2000, all cars belonging to non-residents of the city centre will be prevented from entering the strip and from January 2002, cars belonging to city centre residents will also be banned. Limited Traffic Zones are also being implemented. These areas are surrounded by electronic barriers that prevent non-residents and those without special permits (costing the equivalent of £300) from entering. Later this year, the Council plans to restrict permits to residents who have cars with catalytic converters.

Additional action includes holding weekend events to encourage car owners to leave their vehicles at home, such as Sunday concerts in squares that are normally open to traffic. Tourist coaches are prohibited from entering the city centre; visitors are transported to attractions on specially designated buses instead. The Council is currently considering the use of incentives to encourage shared car use by people working in the city centre.

In order to reduce levels of car ownership, a range of programmes is being pursued to improve public transport and the links between the suburbs and city centre. Two metro lines are being extended and plans are being developed to build an additional line. Nine new park-and-ride car parks containing approximately 12,500 free parking

spaces are being built. The use of electric scooters is also being encouraged. The Council provides a 30 per cent subsidy to the cost of buying a new electric scooter and has negotiated a 15 per cent discount from Rome's major scooter manufacturers. Together, these subsidies have reduced the cost of purchasing an electric scooter from approximately £2000 to £1150.

Paris's City-wide Cycle Plan

The Mayor of Paris, Jean Tiberi, launched the City-wide Cycle Plan in 1996. One hundred and thirty kilometres of cycle routes and more than 8500 bicycle parking places have since been established. The Plan has been developed in close collaboration with the city's 20 local councils (or *arrondissements*). The City Council has laid out the major cycle routes across the city centre whilst the mayors of individual *arrondissements* have developed local tracks to link into the major routes.

Raising public awareness about the impact traffic has on life in Paris has been an important element of the Cycle Plan. The Mayor and City Council held an 'In town without my car' day in September 1999. Designated areas were closed to traffic from 7 a.m. to 9 p.m. and 1500 bicycles were hired to the general public free of charge. Forty five thousand people took part in the initiative and pollution levels in Paris dropped by 5 per cent.[95]

Crime

The Mayor of New York's Commission to Combat Family Violence

The Mayor of New York, Rudolph Giuliani, has made reducing crime a top priority in the city. Tackling domestic violence forms a key part of this strategy. As has already been outlined, Mayor Giuliani regards domestic violence as a key public health issue in the city.[96] New York City's Police Department made over 26,000 family-related arrests in 1998. Almost half of all homicide victims in New York City are killed by an intimate partner or family member. In addition, it is estimated that up to 25 per cent of all women visiting hospital emergency rooms in New York's public hospitals do so as

a result of domestic violence. This accounts for approximately $77.5 million of annual emergency room costs in the city.[97]

Mayor Giuliani established the Mayor's Commission to Combat Family Violence in April 1994 to tackle the issue. The Commission includes experts in health care, social services, policing, the law, education and housing. One of the Commission's key objectives is to change public attitudes towards domestic violence so that it is considered as much a crime as burglary or homicide. The Commission cites drunk driving as an example of how an education campaign launched in combination with a strong criminal justice response can significantly change the way society views an issue.[98]

The Commission has established links between a range of public services, particularly the health service and organisations involved with domestic violence in the city, notably the police. An important mechanism for identifying victims of domestic violence is through their contact with a doctor or hospital emergency room. Domestic violence co-ordinators have been appointed in each of the 11 acute care facilities of the Health and Hospitals Corporation (the body that runs public hospitals in New York). These co-ordinators help train hospital staff to identify, counsel and refer victims of domestic violence to appropriate services. The Commission has also established links between health programmes and domestic violence. In the past, substance abuse projects have often failed to recognise the correlation between domestic violence and drug or alcohol abuse. Women who have overcome their substance or alcohol addictions may be put at greater risk of being attacked if they re-enter an environment where the key factor in their addiction (a violent partner) has not been addressed. A pilot programme has been established to enhance existing substance abuse treatment services with domestic violence screening, assessment, counselling and treatment.

A central element of Mayor Giuliani's strategy to tackle domestic violence has been implementing an aggressive, pro-arrest policy for domestic violence-related crimes. Each of New York City's 76 police precincts contains specially trained domestic violence prevention officers and investigators (there are currently over 300). A

domestic violence unit in Police Head Quarters oversees the Department's efforts in this area. In future, the police aim to move their focus towards preventive action, offering outreach to those considered at risk of being a victim or offender of domestic violence.

It has been argued that the Commission has encouraged the development of a number of innovative programmes by bringing together different organisations to discuss issues of common concern.[99] The Alternative to Shelter Project allows victims of domestic violence to remain in their homes through a combination of alarm and communications technology and a co-ordinated community response. (The project is not used in every situation and risk assessments are therefore carried out for each woman involved.) The Adopt-a-School programme links public schools with domestic violence organisations that provide a range of services including information on how to prevent family violence, counselling for students, community outreach work with parents and training for staff.

A number of initiatives aim to raise awareness of domestic violence issues in the city. These include public education campaigns and an annual National Work to End Domestic Violence Day. The City Council has also imprinted pay cheque stubs with messages about domestic violence and distributed letters from Mayor Giuliani highlighting the problem. In addition, a 24-hour, toll-free Domestic Violence Hotline has been established. This is run by trained counsellors from Victim Services (a voluntary organisation), who provide information and crisis counselling, give advice about safety planning and refer victims to the city's emergency shelter system.

Toronto's Community Safety strategy

Toronto is a relatively safe city with lower crime rates than other Canadian cities like Montreal, Ottawa and Vancouver. However, fear of crime in the city is high. Forty three per cent of Toronto citizens believe that crime has gone up in the past two years. Women, people aged 55 years and over, and those on low incomes are particularly concerned about crime rates in the city.

Community safety was made a top priority of the new city of Toronto at its inaugural meeting in January 1998. The Mayor of Toronto, Mel Lastman, established a Task Force to address the issue, chaired by two of the city's Councillors. The Task Force includes members of Toronto's police service, school boards, businesses, youth organisations, local crime prevention organisations, agencies working to prevent family violence, and organisations representing people with disabilities and black and minority ethnic groups. The work of the Task Force is being co-ordinated by Toronto's Healthy Cities Office, which is based in the Chief Executive's office to help ensure action is co-ordinated across a range of city departments.[100]

The Task Force has produced a series of recommendations that are currently being implemented. The main themes of the recommendations are strengthening neighbourhoods, improving the safety of children, young people and families, better co-ordination and provision of information, and shifting the focus of community safety interventions towards prevention. A key recommendation of the Task Force is that the City Council should set a target of designating 1 per cent of its police service funds to expand crime prevention programmes, focusing on groups vulnerable to committing or being victims of crime. The Task Force recommends that the provincial and federal governments should match this fund. The strategy is referred to as 'One Percent for Prevention'.

The links between health, crime and fear of crime are made throughout the Task Force's proposals. Toronto's Department of Public Health has been given a lead role in working to ensure resources are directed mainly towards children and their caregivers, from pregnancy through to the end of secondary school. Specifically, the Department has been given responsibility for expanding parenting skills and education amongst high-risk families and developing the 'One on One' school mentoring programme where city staff work to form supportive personal relationships with at-risk children and young people.

The Task Force has called for a number of other initiatives to make the links between crime and health. It recommends that a drug abuse committee be established by Toronto's Public Health Department to address the impact of illicit drugs and other

harmful substances on vulnerable communities. Initiatives such as the Walking School Bus programme are cited as examples of 'joined-up' projects that can help to both increase pedestrian safety and improve health through exercise. The Task Force stresses the need for good practice on community safety to be promoted and disseminated between communities. It recommends establishing a database on crime prevention and community safety projects, which can be accessed through a range of public outlets including the health service.

Regeneration

Regenerating Ciutat Vella, Barcelona

Barcelona City Council's programme to regenerate Ciutat Vella, the oldest and most deprived district in the city, has been established for more than a decade. Ciutat Vella suffers from a number of physical, social and economic problems. The dilapidated physical infrastructure of the district is a result of the city being prohibited from expanding beyond its medieval city walls until 1852. Consequently, Ciutat Vella's streets are narrow, there is a lack of open space for people to congregate and housing is old and run down. Buildings are high and often cramped because homes have been continually partitioned to increase the number of people housed.

When Barcelona was finally allowed to expand beyond its city walls, younger families and those who could afford to moved into new houses built in 'the Enlargement' (or *L'Eixample*). Approximately 84,000 people currently live in Ciutat Vella (Barcelona's total population is 1.6 million). A high proportion of the population is elderly: one in every five people living in the district is over 65-years-old. The district also contains many of the city's most deprived communities, including refugees and people from black and minority ethnic groups who have recently moved to the city. These groups mainly live in the Raval area of Ciutat Vella.

Health indicators in Ciutat Vella are worse than those elsewhere in the city. Men are likely to live 5.3 years less than men in Barcelona as a whole. In Raval South, this figure rises to 11.7 years. Men are also between two and five times more likely to

suffer from AIDS than those in Barcelona as a whole, and between four and seven times more likely to suffer from TB. Fertility rates in Ciutat Vella are high, as are rates of teenage pregnancy.[101] There are few public services in the area, particularly schools and health services, and unemployment is high. Crime and other indicators of social exclusion, such as drug use, are also prevalent.

However, Ciutat Vella also has many positive features. The area is in the heart of the city, just off *las Ramblas*, and is *'absolutely identified with the political, urban, cultural and social life of Barcelona'*.[102] In regenerating the area, the objective of the Mayor and Council has been to preserve and improve the historic and cultural nature of the district rather than to change it.[103]

The 'Comprehensive Plan of Transformation of Ciutat Vella' was introduced in 1987 when the current Mayor of Barcelona, Joan Clos, was president of the district. The main focus of the plan has been on improving the physical infrastructure of Ciutat Vella. New open spaces have been created for people to congregate and children to play in, and pedestrianised areas have been expanded and improved. Old houses have been rehabilitated and new homes built. Residents are given the choice of moving out of the area into other housing provided by the Council or remaining in Ciutat Vella in newly renovated homes. Barcelona City Council has encouraged the improvement of private properties through low interest loans and subsidies jointly provided with the regional Catalan government.

New public buildings have also been built in the area, including the Museum of Contemporary Art and the Centre of Contemporary Culture, in order to bring tourists and investment to the area. The Council is also trying to encourage more young people to live in the district by increasing leisure activities (e.g. by developing sports facilities) and by bringing the Pompeu Fabra University to the district. Plans are currently being developed to build a further university, the Ramon Llull, in Ciutat Vella in the future.

In addition to regenerating the physical environment, the City Council has also focused on tackling the health and other social inequalities that have contributed to the

district's decline. Health indicators have been used to argue for a redistribution of resources to the area and to introduce specific health initiatives.[104] A mother and child programme was established in the late 1980s to improve pre- and post-natal services, and an initiative to control and treat TB has also been implemented. The success of the latter has lead to similar programmes being implemented elsewhere by the Catalan government (which is responsible for health services in the region). Ciutat Vella's primary health care services have also been reformed to develop outreach work to raise awareness of the services available and to increase access, particularly amongst the district's black and minority ethnic communities.

Action to encourage people to adopt healthier lifestyles has also been pursued. The 'Walking on the Raval' programme aims to increase exercise among school children as well as improve their knowledge of the neighbourhood and encourage feelings of pride in the area as part of the strategy to reduce crime. School sports facilities have also been opened up out of school hours to encourage pupils and other residents, including older people, to lead lives that are more active.

Birmingham's 'Family Support Strategy'

One of the key priorities of Birmingham Health Authority's Health Improvement Programme is improving the health of the city's children. Birmingham has the second highest peri-natal mortality rate in the country, with 13.4 deaths per 1000 live births. More children die before, at, or shortly after birth in Birmingham than children in other cities with similar or worse levels of social deprivation. Many babies in Birmingham also weigh less than they should at birth, which increases the risk that they will not survive or will suffer from ill health during their early years. One in every ten babies born in Birmingham has a low birth weight (less than 2500g) and there has been little improvement in the situation over the past 15 years.[105]

Birmingham's Family Support Strategy forms a key element of the city's response to the problem. It is a multi-agency programme involving housing, education, social services, the NHS and the voluntary sector. The strategy's aim is to give the city's most deprived children a healthier start in life by tackling the poverty and disadvantage experienced by families as a whole. It focuses on improving the lives of

parents as the key to improving the lives of children, because most of a child's life is spent within the family environment. The strategy brings together a range of professionals, both at the city-wide and local level. Local people have been involved in developing the programme through Health Needs Assessments conducted in each of the participating communities as a first stage to the programme.

The Family Support Strategy trains local people as community parents to provide help and support for first time parents who are referred by health visitors. Each child receives 'Book start', a package of books which helps to encourage parents to read with their children. Community parents give advice about healthy diets and cooking on a low income. Parents also get help with affordable, high quality child care. Information about parenting and giving infants and children a healthier start in life is provided through radio programmes, newsletters and by working with community groups. Community parents also encourage parents to go into schools with their children, for example to help them work with or play on their computers. This in turn helps improve parents' own skills and employment prospects and therefore increases the chance of improving the family's income.

The Robert Taylor Initiative, Chicago

The Robert Taylor Initiative is run by Chicago's Department of Public Health. It aims to improve the overall health of public housing residents by breaking the poor health experiences of several generations through early intervention, prevention and seamless care throughout an individual's lifetime. Programmes range from primary health care to literacy, and from violence prevention to job training. They are delivered through primary care centres, home visiting, mentoring, and individual and family counselling.

The Initiative focuses on the health needs of 1900 people living in five Robert Taylor Homes in Grand Boulevard, one of the largest public housing developments in the USA. Ninety nine per cent of the population of Grand Boulevard are African-American, with Hispanics and Whites constituting the remaining 1 per cent. Sixty per cent of the residents are female. The population is also young: just over half of the residents are younger than 15-years-old and 20 per cent are less than five-years-old.

Sixty six per cent of the project areas residents aged 16 and over are unemployed. Consequently, 86 per cent of the project area's residents lives below the poverty level – four times greater than the city as a whole.[106] As might be expected, the health of residents living in Grand Boulevard is also poor. The community has the third highest age-adjusted mortality rate in Chicago. Rates for heart disease, cancer, homicide, sexually transmitted diseases and teenage pregnancy are particularly high.[107]

The Robert Taylor Initiative includes a wide range of programmes designed to address the underlying causes of ill health. There is a particular focus on providing education, skills and training as the key route out of poverty and ill health. The Home Instruction Programme for Pre-school Youngsters (HIPPY) aims to improve school readiness through parental support for pre-school youngsters. The Chicago Public Schools Satellite High School Programme provides high school diplomas and job readiness skills to students with poor educational performance. There are also basic skills and work experience programmes to provide educational and job readiness skills for adults. In addition, the 'Beyond Expectations' violence prevention programme uses adult mentors to guide children and young people aged eight to 18 years to choose non-violent options for growth and development.

Other initiatives focus on addressing more 'downstream' health issues. The Robert Taylor Girls Athletic Programme for girls aged six to 14 years aims to reduce the likelihood of teenage pregnancy. The HEROIC Programme (Health Education Reaching Out Into the Community) educates community peer leaders to become leaders in the prevention and education of HIV, sexually transmitted diseases and other health issues.

11.2 Action to address the health needs of particular groups

New York's Mental Health Treatment is Working initiative

The Mental Health Treatment is Working campaign is run by New York City's Department of Mental Health and was launched by the Mayor of New York, Rudolph Giuliani, in June 1999. The campaign aims to address the stigma associated with people with mental health problems and to encourage employers to offer them jobs. Advertisements on the public transport system and in local newspapers promote the message that, with the right treatment, people with mental illness can work and be productive members of their communities. The advertisements include a referral telephone number to encourage New Yorkers with mental health problems to access treatment, employment and support services.

New York's Department of Mental Health has also established an initiative to encourage partnerships between businesses and non-profit organisations to employ people with mental illness. The Department has launched a city-wide Employment Center to offer employment and educational resources to organisations that provide mental health services in order to make employment an integral part of their mental health treatment programmes.

Toronto's Task Force on Community Access and Equity

Toronto's programme to address diversity and tackle racism is remarkable for the breadth of its ambition. Toronto is a particularly diverse city. It has more foreign-born residents than any other city in the world. Over 70,000 immigrants come to Toronto every year. The city includes people from 169 countries and over 100 languages are spoken. Forty two per cent of new immigrants speak neither English nor French. The Mayor of Toronto, Mel Lastman, has called on Toronto's citizens to embrace the benefits of the city's diversity: *'In Toronto diversity is our strength ... to achieve a healthy, inclusive public culture, we must understand that embracing diversity is always the product of positive action, not simply the absence of discrimination ... Rather than being a "cost", diversity strategies are an investment. Investing in diversity releases human potential measurable on the bottom line.'*[108]

However, racism and inequality are still significant problems in the city. The City Council has established a Task Force on Community Access and Equity to identify the policies, structures, priorities and methods of evaluation that are necessary to tackle these problems. The Task Force aims to both build on the city's previous work and achievements and address the areas where weaknesses still persist.

The Task Force's draft report, *Diversity Our Strength: Access and Equity Our Goal*, was produced in January 1999. The health needs of different groups in the city are integral to the report. For example, the report highlights that Aboriginal women live on average ten years less than non-Aboriginal women: 66 years compared to 76 years. The poor life expectancy of Aboriginals is not only effected by a lack of access to health services, because of language and other communication barriers, but crucially to poverty, unemployment, lack of skills and training and inadequate housing. These issues have a direct impact on the health of Toronto's Aboriginal community, including increased rates of substance abuse, mental health problems and homelessness.

Chicago's action for older people

Chicago City Council's Department of Ageing takes a broad and holistic approach to improving the health and well-being of the city's seniors. In addition to receiving almost 3 million meals on wheels every year, Chicago seniors are given advice on different aspects of their health, such as blood pressure and diabetes, from 'wellness nurses'. The 'wellness programme' is provided in five regional senior centres in the city. Exercise classes are also available through these centres (and in churches and other community centres), as are specially trained personal trainers for seniors. A cultural centre has been established in 'Renaissance Court', where artists, musicians and other creative people give talks and run workshops for the city's seniors.

The Mayor of Chicago, Richard Daley, aims to integrate the needs of seniors in all aspects of the city's work. For example, as part of the Mayor's transport strategy for Chicago, a 'senior's shuttle service' takes older people shopping once a week to large local stores, which have cheaper, more nutritional food than smaller shops.[109]

In 1999, the Department of Ageing conducted a 'Health Needs Assessment' to help determine how best to address the needs of current and future seniors.[110] The Assessment was carried out through a combination of telephone and face-to-face surveys, focus groups and individual interviews. It found that the 'next generation' of seniors were more interested in receiving help and information on managing their finances, and more interested in using the city's cultural and health facilities than current seniors. The 'next generation' of seniors was also more likely to want to continue living in Chicago, unlike current seniors who were more likely to want to move out of the city. Perhaps unsurprisingly, the overall theme of the 'Health Needs Assessment' was that current seniors are more likely to expect the state to provide for them in retirement, whereas the 'next generation' of seniors tend to want more choice, both financially and socially, than their predecessors. The results of the Assessment will be used to assist in the planning of services and programmes for Chicago seniors in the future.

The Mayor of Toronto's Task Force on Homelessness

During the campaign to elect the first Mayor of the new city of Toronto, Mel Lastman (who subsequently won) claimed that homelessness was not a problem in North York, the area where he used to be Mayor. During the following week, a homeless person in North York died from exposure to the cold and Toronto's media attacked Lastman for his mistake. Lastman subsequently attempted to turn the issue to his advantage. He put tackling homelessness high on his personal agenda and promised that, if elected, he would ensure action was taken.

It has been argued that Mayor Lastman has been true to his word and has indeed driven forward action on the problem.[111] Shortly after being elected, he established the Mayor's Homelessness Action Task Force to recommend ways to stop the growth of homelessness and respond to the public's concern about the growing number of homeless people on the streets of Toronto. The Task Force's definition of homelessness includes visibly homeless people on the streets or in hostels, hidden homeless people living in illegal or temporary accommodation, and those at risk of becoming homeless.

The Task Force's report, *Taking Responsibility for Homelessness: An Action Plan for Toronto*, has two main themes. The first is the need for preventive, long-term approaches to replace the reactive, emergency responses to homelessness that have previously been taken by the city. The second is for all three levels of government – at city, provincial and federal levels – to take ownership of the problem and responsibility for solving it.

A key recommendation of the Action Plan is establishing a comprehensive health strategy for homeless people in Toronto. Proposals include establishing a kiosk in downtown Toronto to enable homeless people to register for health cards (these are required to access health services in the city) and ensuring a staff person skilled in working with homeless people is available to every hospital emergency room when required. The Action Plan proposes establishing a pharmacy pilot project so that homeless people can obtain prescription drugs free of charge. A three-year pilot project to improve the oral health needs of Toronto's homeless population is also recommended.

In addition to recommendations focusing on the health needs of homeless people, the Action Plan places a strong emphasis on the need for simplification and better co-ordination of the system. It calls for a Facilitator for Action on Homelessness to be appointed to implement the Taskforce's recommendations and to report regularly to the Mayor and Council on progress, a 24-hour Homeless Services Information System for staff in agencies servicing the homeless to be established, and a central hostels bed registry to bet set up to provide up-to-date information on hostel bed availability on a 24-hour basis.

A number of specific strategies for high-risk sub-groups are proposed. These include treatment programmes for young parents with substance abuse problems, dedicated support for young homeless mothers, supportive housing units with special safety features for abused women and their children, and proper housing and support for the Aboriginal homeless population (to be funded by the federal government in partnership with the Province).

The need to shift policy towards prevention of homelessness is a central theme of the Action Plan. The Task Force recommends developing a new shelter allowance targeted at low income working families and a city-wide rent bank to help individuals and families deal with short-term rent arrears. Policies aimed at creating more affordable housing in Toronto are also stressed. These include implementing a 'housing first' policy on municipal lands to make sites available for affordable housing, establishing a tax rate for multi-resident properties at a level comparable to that for single family dwellings, and waiving development charges, land use application fees and other charges for developments that meet affordable housing criteria. The Action Plan also calls on the federal government to provide up to $300 million in capital support for new low income housing in the city.

11.3 Action addressing specific health issues

Birmingham's strategy to tackle heart disease and stroke

Heart attacks and stroke are the biggest cause of death and disability for people in Birmingham in middle or old age. There have been improvements in some groups over the past decade, but there are still major differences between men and women, ethnic communities and socio-economic groups. Birmingham Health Authority's approach to the problem is set out in its Health Improvement Programme (HImP). This stresses the need to improve living standards in order to tackle the high incidence of heart disease and stroke amongst the city's most deprived communities, by helping families with no earned income get work through help with training and child care.

The HIMP sets out the city's strategy to tackle the risk factors associated with heart disease and stroke, including reducing smoking, increasing exercise and promoting healthy diets. Initiatives to help people stop smoking include providing nicotine replacement therapy, training more health service staff to give advice about how to give up smoking – and stay stopped – and exploring new methods to encourage young people not to smoke. A range of initiatives is being implemented to help people become more active. The 'Walk 2000' programme provides Birmingham's primary care groups with information about a series of two kilometre walks around the city

that can be passed onto patients with coronary heart disease. Three 'walking officers' have been appointed in Birmingham City Council's Leisure Department to help champion the programme. The 'Exercise on Prescription' scheme refers people who are at high risk of heart disease on to the city's leisure facilities and provides follow-up from the doctor to help patients maintain their change of lifestyle. The 'Safer Routes to School' initiative aims to show parents how they and their children can walk or cycle to school instead of going by car. Action to encourage people to eat more healthily includes promoting healthy eating in schools through School Nutrition Action Groups and maintaining minimum nutritional standards for school meals under the Fair Funding regime.

The final strand of Birmingham's strategy to tackle heart disease and stroke focuses on ensuring that patients receive prompt, effective treatment. Objectives include ensuring all patients have an equal chance of getting high quality treatment, providing more information about how to recognise the early symptoms of a heart attack, and cutting the time between calling an ambulance and receiving clot-busting drugs.

Paris's action to reduce tobacco use

In July 1999, Paris City Council established a multi-agency committee to develop a two-year strategy to reduce the number of young, female smokers in the city. The target group for the programme is women aged 20 to 30 years. Smoking amongst this group has increased over recent years. The City Council's main role has been to act as a catalyst for change by bringing together more than 20 different organisations across the city to address the issue. Members of the committee include representatives from Paris's hospitals, universities, pharmacists, doctors associations and chambers of commerce. Each organisation finances the particular element of the initiative for which they are responsible and a special sub-group has been established to evaluate the programme.

The first stage, which began in September 1999, alerted doctors in Paris to the rise in smoking amongst young women and provided advice on how best to encourage and support women who want to give up. The Paris Medical Association is now running sessions to train one doctor in each of the city's 20 local councils (or

arrondissements) about the programme. This doctor will then act as a trainer for other doctors in the area. The aim is, firstly, to increase awareness of the campaign amongst the city's medics and, secondly, to create a network of doctors across the capital to help evaluate the programme alongside a team of researchers. A team of female health professionals is also being established to give advice to other female colleagues who smoke, in order to help them quit.

In addition to encouraging work amongst the medical profession, the City Council has also established a pilot programme in a small number of schools to identify the most effective forms of intervention for this age group. The pilot is currently being evaluated by a Paris-wide anti-smoking charity. Anti-smoking information is also being distributed to everyone under 50-years-old that leaves hospital. Leaflets and posters are being made available in crèches, schools and taxis, and lists of products that help people quit, such as nicotine patches, are being distributed to pharmacies. The city aims to launch a much wider public information campaign in the future, for example by distributing leaflets to cafés, hotels and restaurants.

Glasgow Alliance's strategy to tackle poor health

Glasgow has a long history of working across boundaries to tackle the underlying determinants of health and to reduce health inequalities, for example through its status as a WHO Healthy City. The need to redouble the city's effort in this area was given new purpose in 1997 when the then Secretary of State for Scotland, Donald Dewar, called for urgent priority to be given to drawing up *'a comprehensive, rigorous and authoritative forward strategy for the city ... [to] provide a framework for the Council and other agencies to shape their investment decisions'*.[112]

Glasgow Alliance's strategy for the city, 'Creating Tomorrow's Glasgow', was published in March 1999 as a response to this request. The strategy is a significant attempt to ensure genuinely 'joined-up', holistic government at the city-wide level. Glasgow Alliance is a coalition of organisations from the public, private, voluntary and community sectors, which works at the city-wide and local level. Members include Glasgow City Council, Glasgow Development Agency, Greater Glasgow

Health Board, Scottish Homes, Glasgow Council for the Voluntary Sector, the Scottish Office and Scottish Business in the Community.

The Alliance's strategy has four main objectives: greater access to jobs, making Glasgow more attractive for development, improving housing choice and tackling poor health. These objectives have been chosen on the basis of the potential for the Alliance to make a difference, the scale of benefit to the population as a whole, the potential for spin-off benefits for other issues (for example addressing tobacco as an entry route to wider drug use), and the policy contexts within which city organisations are already working. The strategy aims to demonstrate how the Alliance will play a strong and active role in the city's existing partnerships, and how it will make a difference by 'adding value' to work already taking place.

The aim of the programme to tackle poor health is that: *'By the year 2010 Glasgow will be a city where all citizens have the knowledge, services and support to live a safe, active and healthy life'*.[113] Four key issues have been identified: child health, mental health, reducing tobacco consumption and encouraging physical activity. The strategy acknowledges that there are other pressing health priorities for the city – especially drug misuse, the health needs of women and the increasingly elderly population. However, there are already strong partnerships in place to address each of these issues.[114]

Programmes to improve child health in the city include providing parents support with education and skills, improving child care, implementing a community safety strategy with a particular focus on children, working towards fluoridating Glasgow's water supply to help improve oral health and developing a food policy for the city.

In order to address the city's mental health problems, the Alliance emphasises the need to co-ordinate inter-agency support for people with chronic and debilitating mental illness. This means addressing people's employment and housing needs, as well as their health and social care needs. The importance of reducing the stigma associated with mental illness is also stressed. Other initiatives include: establishing a programme to prevent domestic violence and support its victims, working to ensure

stronger, community-based networks and self-help and support groups in key areas of the city; implementing mental health policies in all Glasgow's schools, and supporting race equality and tackling racism throughout the city.

The Alliance aims to reduce the overall prevalence of smoking and increase the number of smoke-free environments in the city. Tobacco is the single largest preventable cause of mortality in Glasgow. Each year, nearly 2000 people die from smoking and almost 6000 people are admitted to hospital due to smoking-related illnesses. Initiatives outlined in the strategy include establishing a 'Smoke-free Kids' programme, increasing the number of smoke-free environments in the city and strengthening local control of tobacco advertising and promotion. The need to establish a comprehensive and accessible smoking cessation programme is also outlined, including providing better smoking cessation support within communities and key care settings and exploring the potential for a central cessation centre. The strategy recommends that all members involved with the Alliance 'lead by example' by taking forward anti-smoking strategies aimed at their own employees.

The strategy aims to ensure regular, moderate levels of physical activity are the norm at all ages of life in Glasgow. Short-term goals include reducing the barriers to physical activity, particularly for children, and improving and promoting cycling and walking networks. Medium-term goals include increasing public and professional knowledge of the benefits of physical activity and ensuring new neighbourhoods are designed in ways that encourage safe and active living for all age groups.

11.4 Summary of key findings from other city-wide authorities

- There are many more substantial differences between the cities in this study than there are similarities. For the purposes of this inquiry, there are few useful points of direct comparison to be made between London and any of the other cities
- In general, the Greater London Authority has more limited formal powers and responsibilities than any of the other city-wide authorities and, where health is concerned, its formal remit is negligible

- The experiences of other cities suggest that the personality of the mayor and the political context in which he or she operates are more likely to determine whether action is taken to improve health, than the formal powers and institutional arrangements that pertain
- A mayor is more likely to take action to improve health if it fits in with plans to pursue other major political objectives
- A mayor with few (or no) direct powers to improve health can nevertheless contribute to health improvement through political influence, media campaigning, financial leverage and other, indirect, means
- Though there are few direct points of comparison, other cities provide a source from which the London Mayor may draw ideas and insights to inform a strategy to improve the health of Londoners
- None of the health-related initiatives described in this study has been systematically evaluated for its impact on health (although some evaluations may be underway)

12. Developing the GLA's health role

In Section 3, we argued that the GLA is well placed to play a strategic role in health for three reasons. Firstly, health is a key element in the policy areas for which the GLA has strategic responsibility. Secondly, as a democratically elected, representative body, the GLA is likely to be as concerned with health improvement as with economic, social and environmental improvement, because health is important to all Londoners. Thirdly, the new Authority offers a conduit of consultation and accountability to the London public.

In the context of relatively weak powers over health and the absence of a statutory framework or processes through which the GLA must contribute to health improvement in London, the challenge is to stimulate the informal development of policy-making processes that allow for health input. This will depend on good collaborative practice between the NHS and its health partners and the new Authority. It will be in all parties' interests to ensure that their policy objectives converge and they find a common health agenda.

Developments at the GLA also need to be viewed in the context of a (possibly) continuing programme of devolution from Westminster to a regional tier. The NHS regional structure may need to adapt to demands from elected authorities in other regions to participate in the formulation of health strategy – particularly if, as in London, the remit of those emerging regional authorities is essentially strategic. Regional Development Agencies are already developing relationships with other NHS Regional Offices. As Hazell and Jervis observe:

> *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.*[115]

London's Coalition for Health and Regeneration, launched on 30 March 2000, was an important first step in developing a co-ordinated approach to improving health across

London. It provides the essential basis of a regional partnership, which may be built on and taken forward by the GLA. The Coalition's strategy anticipates considerable impact from the new Authority:

> *London's new Mayor has the potential to be a major force for improving health in the capital ... We are hoping that the new Mayor, Greater London Authority Members and all other organisations with an interest in health will join us.*[116]

The stated intention in the first Mayor's manifesto to set up a London Health Commission may mesh with the process of partnership building and agenda development that the Coalition has started. The Coalition has engaged the necessary support and participation of a large number of statutory and non-statutory organisations.

A number of measures have been included in the GLA Act to ensure openness and to guarantee public access to the processes of policy development and public accountability. To inform and influence the GLA on health issues, the NHS and its health partners can take advantage of opportunities in the GLA's annual cycle, to submit recommendations, publicise issues and elicit political support. These opportunities include:

- the drafting and revising of the eight Mayoral strategies (the Assembly must comment on the draft strategies)
- Assembly meetings including questions to the Mayor and employees[k]
- the preparation and publication of the Mayor's annual report[l]
- consideration and approval of the Mayor's annual budget by the Assembly
- publication of the four-yearly state of the environment report (which will closely overlap with health)

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[k] 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)*.

[l] 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 which the Assembly has notified to the Mayor at the start of the year that it wishes to be included *(section 46 (2))*.

- the annual 'state of London' debate open to the public
- the twice-yearly People's Question Time, also open to the public
- responses by the Mayor and the Assembly to national Government policy initiatives, such as Green Papers.

Recognising the limitations of the GLA's statutory health functions, and the need to take forward the regional health agenda set out by the London Coalition, the recommendations set out in the next section share the following objectives:

- to reduce the risk of the GLA confining its health brief to one of scrutiny by the Assembly and *ad hoc* interventions from the Mayor
- to reinforce the distinction between health, in relation to which the GLA has powers, and health services
- to maximise opportunities to involve the new Authority in the new Coalition for Health and Regeneration
- to ensure health improvement is written into the eight GLA strategies
- to provide the GLA with direct access to health information and expertise.

13. Recommendations

The recommendations set out below have been developed from the King's Fund's analysis of the formal powers and responsibilities of the Greater London Authority, and the political and constitutional context in which they have evolved. That analysis is based on a review of relevant literature, interviews with key informants, advice from the project's Reference Group and a series of conferences, seminars and workshops that have taken place at the King's Fund between 1998 and 2000. They are also informed by the insights and ideas drawn from our study of other city-wide authorities and of the wider devolution programme in the UK.

The focus of the recommendations is on the development of a strategic health role for the GLA and effective co-operation and partnership between the GLA, the NHS and its many health partners in London.

13.1 GLA Health Strategy Group

The GLA Act does not require the Authority to produce a health strategy, nor does it institute any source of health advice or expertise. This report has suggested that both may develop informally. As an advisory group, the GLA's Cultural Strategy Group (set up under the GLA Act) is a useful model. It has 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 GLA's cultural strategy and advise the Mayor on its implementation.

An informally constituted GLA Health Strategy Group (the precise title may not be important) could include individuals nominated by the NHS Regional Office, the Assembly, boroughs, health authorities and the functional bodies together with representatives of other appropriate London-wide agencies. Its chief function would be to advise the GLA in carrying out its statutory duties in relation to health. Like the

Cultural Strategy Group, it would be advisory; it would recommend and draft issues for the Mayor to take forward. It would ensure genuine two-way dialogue, taking health measures into GLA strategies and giving the GLA input into regional public health functions for which the NHS has retained responsibility.

The Group could:

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

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 to whom the Mayor delegates specific functions.

The Health Strategy Group could be seen as the core of London's new Coalition for Health and Regeneration and could operate alongside or serve instead of the Health Commission outlined in the Mayor's manifesto.

13.2 Functional bodies: health strategy officers

Incorporating health-improving measures into the GLA's strategies for transport, regeneration (both priorities for the Coalition's London health strategy) and environment is of paramount importance.

The Mayor could 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 with the Cultural Strategy Group, which is

advisory and not a functional body, but whose remit includes recreation and sport in the capital, and therefore overlaps with health.)

The officers would preferably be within the established staff of each body, taking on health as an additional duty. They would have two main health-related functions: firstly, to ensure that each strategy takes into account the duty to consider improvement in the health of Londoners and, secondly, to act as a point of liaison on health-related issues with the Mayor and advisers, the Assembly, the NHS Regional Office and other functional bodies within the GLA's remit.

It might be argued that special designations of this sort could enable others in the organisation to regard the subject as someone else's concern, and thus inhibit a broader sense of ownership across an organisation. Realistically, however, this has to be set against the risk of the issue failing to surface on the corporate agenda, if it is no one's responsibility to get it there.

13.3 Access to 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 and Assembly will need the following information as a minimum:

- baseline information about London's 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 and concerns.

In the provisions made for environmental policy, where the Mayor has a duty to ensure that all the policies he or she 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 proposed London Health Observatory. How that might happen is still unclear, and much may depend on the development of the London Observatory, its location and the form it acquires.

13.4 Health adviser/director

In addition to the supply of health data, London's Mayor will need expert advice, from someone who can build and 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 Act empowers the Mayor to delegate specified functions to staff or Assembly members. Although the possibility of a Mayoral appointment of a director of public health or an adviser was referred to in the GLA White Paper, no provision was made in the Bill. The options open to the GLA include:

- GLA in-house expertise and advice
- developing the capacity of the London Research Centre (which has been brought into the GLA) to include a GLA health division
- entering into an agreement with the Health of Londoners Project, currently funded by London health authorities
- commissioning public health input on an *ad hoc* contractual basis from academic departments and research institutes
- ensuring GLA access to the proposed London Health Observatory
- the Mayor can bring outsiders into the Cabinet and obtain the services of a public health expert in this way
- use of the Mayor's 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 health post. This has now happened and the Mayor will have an option to retain such secondments or fund appointments directly.

If the Mayor makes no health appointments, it would benefit the London health authorities to continue to fund salaried convenors for key regional groupings such as chief executives, Directors of Public Health (DsPH) 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.

The Mayor can appoint up to 12 advisers to be based in the Mayor's Office, which is one of three branches of the GLA staff structure, the other two being the Assembly secretariat and shared services, which include the Chief Executive. It is entirely a matter for the Mayor to decide whether, and how, to appoint an adviser on health.

By whatever title, a senior level health adviser to the Mayor would generate energy and commitment to improving London's health. Such an appointment could fulfil a variety of important functions:

- 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 NHS and health partners, including the new London Coalition for Health and Regeneration
- to liaise with the functional bodies responsible for delivering the Mayor's strategies that must take health of Londoners into account
- to keep health on the Mayor's political agenda. The Mayor may have little time to pursue health issues personally.

Providing public health advice to the Assembly raises other issues that concern the traditional 'separation of powers'. It is an historic function of elected representatives to hold the executive branch of government accountable; in the case of the GLA Assembly, which does not legislate, its sole functions are to hold the Mayor to account and investigate issues relevant to London.

When scrutinising the actions and decisions of the Mayor or conducting its inquiries, the possibility of a conflict of interest may mean 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.) A less likely alternative would see a GLA health expert or team housed in the Assembly secretariat, or in 'shared services', providing expertise to both branches of the Authority. This would leave the Mayor free to appoint his or her own health adviser or to bring in advice on an *ad hoc* basis as and when needed (e.g. when drafting or revising GLA strategies).

A pragmatic argument against providing the GLA with its own independent public health expertise 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 (RHAs), regional directors of public health 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.[117] 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, without changing the status of regional directors of public health, 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 DsPH has, to an extent, 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 DsPH who are jointly appointed by health and local authorities.[118]

13.5 Delegation by the Assembly

Assembly members will, as members of functional bodies, 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 an Assembly committee conducting an inquiry into health-related subjects (although not, as a delegatee of the Mayor, into the activities of the Mayor).

13.6 Assembly inquiries

The impact on health of the Assembly's powers of inquiry will be influenced by the way the Assembly chooses to organise. It may opt for traditional subject-based committees, the so-called 'policy silos', focusing on transport, environment, regeneration and culture, with health and sustainable development and equality, over which the GLA has overarching powers, providing three more subjects. Alternatively, it may pursue cross-cutting issues (to include health sustainability and equality) and base its committees on population groups such as older people, children, asylum seekers, or generic problem areas, such as unemployment, homelessness, inequalities.

The Assembly could use its powers of inquiry to commission retrospective health impact assessments of the Mayor's strategies. These could be published, as could the reports of any other Assembly inquiries into health. These publications might acquire considerable status as independent assessments.

The scope for prospective health impact assessments by the Assembly is more limited: the Assembly will not legislate and has powers only to influence the Mayor's strategies. Periods of consultation on draft strategies may not allow for full assessments to be made. On the other hand, if relations between Mayor and Assembly develop harmoniously, and if time allows, the Mayor may use the Assembly to inquire into the feasibility of certain aspects of his or her proposed strategies.[m]

[m] Both the Assembly and the Mayor could commission health impact assessments from independent sources, such as the London Health Observatory.

It may benefit the Assembly secretariat to have a seconded expert to provide health policy advice as it develops its scrutiny role. There would be additional benefit in that Assembly members are also members of the Mayor's cabinet and of the functional bodies that must incorporate health into their strategies.

13.7 Devolved powers of appointment

The Act provides for extensive powers of appointment to functional bodies to be exercised by the Mayor. This helps to ensure a shared strategic interest between the new Authority and its functional bodies. Assembly members will also be appointed to the functional bodies. Even in the politically sensitive area of policing, the Mayor must be given the opportunity 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, health appointments in the capital, including the Regional Chair, London 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 takes advice principally from the Regional Chair). Giving the Mayor a part in this process, if only a right to be consulted, could provide further incentive for the GLA to find common cause with health authorities and trusts.

The Mayor of New York appoints the President of the Health and Hospital Corporation, which runs New York's 17 public hospitals (but not the remaining 40 or so private hospitals). The Mayor of New York is also responsible for appointing the Commissioner of New York City's Department of Health (which runs health monitoring, protection and promotion activities in the city) and the Commissioner of the Department of Mental Health, Mental Retardation and Alcoholism Services.

In the UK, a critical report on NHS appointments by the Public Appointments Commissioner – Dame Renee Fritchie – indicates that there is room for improvement in the way health service appointments are made.[119]

13.8 Publication of a London health report

The Mayor has a duty to produce an environmental report every four years. A London health report could fulfil a similar function 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 commissioned from an independent source.

Another option would be to incorporate a report on the state of London's health within the annual report that the Mayor is required to publish. In New York, the 'Mayor's Management Report' (MMR) provides an illustration of the impact this can have.[120] It sets out a wide range of agency and city-wide indicators of progress towards the Mayor's key priorities, otherwise known as the 'Mayor's Major Missions'. Health and health-related indicators are included, as well as progress on key initiatives, for example the New York City Asthma Initiative and the Mayor's Commission to Combat Family Violence.

13.9 Monitoring/evaluation

Looking to the future, the impact of the GLA will be a subject for monitoring and evaluation, which will inform the debate about devolution to 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.[121] 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.*[122]

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 be to institute a longitudinal study to compare the performance of the Welsh and Greater London models of devolution in relation to health improvement, and to see what impact a democratically elected Assembly has on the delivery of public health functions and on reducing health inequalities.

Over time, the ways in which the GLA can work with health authorities and boroughs will 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 the people of London improving relative to other English regions?
- Are inequalities in the health of Londoners being reduced?
- 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 issues relating to health improvement, as distinct from health 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 involvement of the London public?
- Has the GLA increased public accountability of health policy?
- Is more/better information about London's health available in the public arena?
- Do partners in the health economy perceive that the GLA is helping them to achieve their health goals?

13.10 Improving performance/auditing the GLA

Auditing the new Greater London Authority presents a new challenge to the Audit Commission, the agency charged with the responsibility. There are, as the Commission has acknowledged, no comparators or precedents. The Commission is therefore conducting a consultation exercise with a wide range of interested parties, to develop new performance indicators to apply from April 2001. Included among them will be new quality of life and public health indicators.

The Commission will measure the success of the new Authority according to five criteria:[123]

1. Has it produced strategic solutions to London's problems?
2. How far are these user-focused and joined-up?
3. Has it achieved more effective partnership working?
4. Is there an improved economy (including efficiency and effectiveness of GLA functional bodies)?
5. Are Londoners more contented?

The reports from the Audit Commission are likely to be politically contentious, in so far as opponents of decentralisation and devolution will welcome any evidence that public money is not being well spent by the new Authority. Equally, the first Mayor and Assembly will want to demonstrate their worth and make the case for re-election. The Authority will need to take on board any recommendations from the Commission.

London's Coalition for Health and Regeneration intends its progress to be measured and assessed by the new Health Observatory, which will be another source of scrutiny and audit.

Appendix I

Research methods

There were four stages to this project:

1. A profile of London's health issues
2. An analysis of the functions, responsibilities and powers of the GLA in relation to health
3. An analysis of the experiences of other cities
4. A critical appraisal of policy options to inform the Mayor and the GLA

A Reference Group played an important role in helping to shape and monitor the project's work. The group was jointly chaired by Anna Coote, Director, Public Health Programme, King's Fund, and Dr Bobbie Jacobson, Chair, Health of Londoners Project. Other members included: Professor Tony Travers, Greater London Group, London School of Economics; Dr Agis Tsouros, Head, Centre for Urban Health, World Health Organisation; Lord Harris of Haringey, Chair, Association of London Government and Visiting Fellow, King's Fund; Professor Paul Jervis, The Constitution Unit, School of Public Policy, University College London; Professor Marshall Marinker, Guys and St Thomas' Hospital; Professor Margaret Whitehead, Department of Public Health, Liverpool University and Visiting Fellow, King's Fund; Dr Sue Atkinson, Director of Public Health, NHSE London Regional Office; and Dr Bob Chilton, Head of the GLA Transition Team, Government Office for London.

1. A profile of London's health issues

A profile was drawn up of the key health issues in the capital on which the Mayor and Assembly can take action. This profile built on work already carried out by the Health of Londoners Project and other organisations, including the London Regional Office of the NHS Executive. Additional data was commissioned from the Health of Londoners Project, including a breakdown of key data on health and health

determinants by GLA constituency and trends over time (available separately from the King's Fund: see Section 7, 'London's Health').

2. An analysis of the functions, responsibilities and powers of the GLA in relation to health

A watching brief on the GLA's remit on health was kept as the GLA Bill progressed through Parliament.

Key bodies with a role in improving health in the capital were identified. Their powers and functions and how these relate to the Mayor and GLA were assessed.

A sample of key informants was interviewed from the London Regional Office of the NHSE (including the public health function), London's health authorities and boroughs, the Government Office for London, the Association of London Government, the functional bodies of the GLA, academics in law and constitutional issues and the voluntary sector.

The potential for, and barriers to, collaboration between the GLA and other organisations with a role in improving health in the capital was assessed. The possible impact on the structures, functions and powers of these bodies was also identified.

An analysis of the functions, powers and responsibilities of the GLA in relation to health was then drawn up. A workshop was held to test the emerging analysis with key stakeholders from London's health service, local government and the voluntary and private sectors. The analysis was then refined in the light of expert feedback.

3. An analysis of the experiences of other cities

a) Selecting cities for research

The following cities were included in the study:

- Birmingham
- Glasgow
- New York
- Chicago
- Toronto
- Paris
- Rome
- Berlin
- Barcelona.

With a population of more than 7 million people, London is by far the largest city in the UK and bigger than any other Western European capital.[124] The sheer size of London means that the challenges it faces are different from those faced by other cities. Size also limits the choice of comparators. Nevertheless, a number of UK cities were included in the study because they share the same national policy environment within which people are working to improve health, and have similar structures of local health and related services.

The choice of cities outside the UK was constrained by pragmatic considerations of time and cost. A critical factor in the selection process was whether or not a Mayor or city authority had demonstrated an interest in improving health. We looked for evidence of strategic, city-wide action to improve health, and at specific initiatives with which the Mayor or authority had been directly involved. We did not attempt any assessment of the impact of those initiatives.[n]

[n] There is considerable debate about what constitutes evidence for the success of health improvement initiatives – see p.1.

The system of government and the powers and responsibilities held by different layers of government, as well as the organisation of health and related sectors, were taken into account. Several cities in the sample are located within a wider, regional level of government. For example, Rome is the main city in the Lazio region, Toronto is part of the Province of Ontario and Chicago is the main city in the State of Illinois. Berlin, like London, is itself a regional level of government. Local government exists at the tier below the city in Rome, Berlin, Paris and London.

The mayors of cities such as New York, Chicago and Rome are directly elected, while others, including the mayors of Barcelona and Paris, are elected by members of the City Council. Some cities do not have a Mayor and instead have a leader or chair of the council, including Glasgow and Birmingham. We were interested to find out how far the reputation and high media profile that some mayors have gained for providing strong leadership in their cities had influenced health improvement initiatives.

Another important variable factor is the funding and organisation of health and related public services. Berlin, Toronto and Barcelona have health services funded through a system of social insurance; New York and Chicago through a system of private insurance; and London, Birmingham and Glasgow through national taxation. Major differences in this complex area significantly qualify any lessons that may be extrapolated from other cities' experience.

Some cities in the sample have greater powers and responsibilities for health than those proposed for the Mayor of London. However, none has full responsibility for delivering and funding health services (see Appendix 2 for further details).

b) Systematic literature review

Once the cities had been selected, key policy documents and evidence were collected from the selected cities by a systematic literature review of published material. Unpublished material was also collected through personal contact with relevant agencies in the selected cities. The following databases were searched for the systematic literature review, using both thesaurus terms and free text searching in

order to cover as wide a field of references as possible: King's Fund Database, DHData, Helmis, HealthSTAR, Assia, Sociological Abstracts, Social Science Citation Index, Medline, Cochrane Library, Urbadisc, Healthpromis and WHOLIS.

A search of newspaper articles was also undertaken using the World Reporter and *Independent* newspaper databases. The literature search was restricted to material published from 1985 to the present day. Further references found from the bibliographies of the papers in the literature search were hand searched.

c) Semi-structured interviews

Questions were then drawn up for more detailed analysis of the selected cities. These questions formed the basis of semi-structured interviews with key officials with responsibility for health policy in the selected cities, by telephone, e-mail, and/or through face-to-face interviews, as appropriate and practicable.

d) Workshops

Two workshops were held to test the emerging analysis, bringing together key policy-makers and practitioners in London, from the NHS, local government and the voluntary and private sectors. The analysis was then refined in the light of expert feedback.

4. A critical appraisal of policy options

The original plan of investigation and methods for the project included a proposal to outline what a pan-London strategy could be for two or three test cases of major health issues in the capital. However, this work is already being taken forward by the London Regional Office of the NHS Executive and partner organisations through the London health strategy.

The critical appraisal of policy options for the Mayor and Assembly has therefore focused on identifying the potential for – and barriers to – the Mayor and GLA collaborating with other key bodies to improve health in London and examining the possible impact on the structures, functions and powers of these bodies. This appraisal is based on the first three stages of the project as outlined here. It is also informed by insights drawn from our field research into other city-wide authorities and from our observations of the emerging experience of devolution in the UK.

Appendix 2

Table comparing cities with London

CITY	POPULATION	KEY HEALTH ISSUES	MAYOR	STRUCTURE OF GOVERNMENT	HEALTH FUNCTION OF CITY	HEALTH SERVICE FUNDING
London	7 million	High proportion of children and people aged 25–35 yrs. 25% of population from BME communities. Health inequalities, e.g. infant mortality rates. Major causes of death and disease: CHD, stroke and cancer. Also mental ill health, HIV/AIDS and teenage pregnancy. Higher than average rates of unemployment, dependence on benefits, poor housing and homelessness, particularly in Inner London.	Yes. Directly elected (Mayor Ken Living-stone).	Greater London Authority is the regional tier responsible for strategy. 32 London boroughs (plus the Corporation of London) at local level.	Duty to improve the health of Londoners through Mayor's strategies. London Region NHSE responsible for health services.	General national taxation
Birming-ham	1 million	25% of population from BME communities. Health inequalities, e.g. infant mortality rates. High incidence of low birth weight babies. Major causes of death and disease: CHD, stroke and cancer. Higher than average rates of unemployment and dependence on benefits.	No. Leader of Council (Cllr Albert Bore).	Birmingham City Council is a metropolitan council.	City Council responsible for social services. Birmingham Health Authority responsible for planning health and public health services.	General national taxation

CITY	POPULATION	KEY HEALTH ISSUES	MAYOR	STRUCTURE OF GOVERNMENT	HEALTH FUNCTION OF CITY	HEALTH SERVICE FUNDING
Glasgow	616,000	Fall in birth rate over past 5 years, although now slowing. 3.5% of population from BME communities. Health inequalities, e.g. risk of death before 65 yrs 30% higher than rest of Scotland. Major causes of death and disease: lung cancer and CHD. High rates of smoking and poor diet. Also social deprivation, unemployment, dependence on benefits and poor housing.	No. Leader of Council (Cllr Charles Gordon).	Glasgow City Council. Established April 1999, amalgamating Glasgow District Council and Strathclyde Regional Council. Largest local authority in Scotland.	City Council responsible for social services. Greater Glasgow Health Board responsible for planning health and public health services. Member of WHO Healthy Cities Project.	General national taxation
Berlin	3.47 million	Higher proportion of older people: 18% of population aged 65yrs+. 13% of population from non-German background. High hospitalisation rates for cancer, mental health, circulatory disease, CHD, injury and poisoning. High rates of unemployment, dependence on benefits, social exclusion, poor housing and homelessness.	Yes. Elected by Council (Mayor Eberhard Diepgen).	Germany has a federal system of government. Berlin has both city and federal state status. There are currently 21 city districts, each with its own mayor and town council.	State of Berlin is responsible for health and health services through the Ministry for Work, Health and Social Affairs.	Social insurance system

CITY	POPULATION	KEY HEALTH ISSUES	MAYOR	STRUCTURE OF GOVERNMENT	HEALTH FUNCTION OF CITY	HEALTH SERVICE FUNDING
Barcelona	1.6 million	Ageing population. Major causes of death and disease: cancer (especially lung cancer and breast cancer) and CHD. Also TB, HIV/AIDS and drug misuse. High rates of unemployment, illiteracy, poor housing, drug misuse and smoking (particularly amongst men).	Yes. Elected by Council (Mayor Joan Clos i Mateu).	Barcelona City Council is within the regional government of Catalonia.	Municipal Institute for Public Health responsible for health protection, prevention and promotion services. (Institute became autonomous from City Council in 1998.) Catalonia regional government responsible for health services, although Council does have degree of responsibility for some hospitals in the city.	Social insurance system
New York	9 million	High proportion of population from BME groups. Major causes of death and disease: CHD and cancer. Also HIV/AIDS, mental health problems, teenage pregnancy, suicide and drug misuse. Poor housing and homelessness.	Yes. Directly elected (Mayor Rudolph Giuliani).	The USA has a federal system of government. New York City Council is within the State of New York.	New York City Department of Health is responsible for health monitoring, protection, prevention and promotion. Mayor also appoints President of Health and Hospitals Corporation (which runs 16 public hospitals in the city).	Private insurance system

CITY	POPULA-TION	KEY HEALTH ISSUES	MAYOR	STRUCTURE OF GOVERNMENT	HEALTH FUNCTION OF CITY	HEALTH SERVICE FUNDING
Chicago	2.5 million	38.6% of population African American, 19.6% Hispanic, 3.5% Asian. Major causes of death and disease: CHD and cancer. Also high rates of HIV/AIDS, STDs, teenage pregnancy and homicide among BME groups. Higher than average rates of unemployment, poverty, dependence on benefits and poor housing, particularly among BME groups.	Yes. Directly elected (Mayor Richard M Daley).	The USA has a federal system of government. Chicago City Council is a municipality within the State of Illinois.	Chicago Department of Public Health is responsible for health protection, prevention and promotion services.	Private insurance system
Toronto	2.4 million	30% of population non-white and 50% foreign born. Major causes of death and disease: CHD, stroke and respiratory disease. Higher than national average rates of injury, suicide and HIV/AIDS. Also unemployment, lack of affordable housing, homelessness and fear of crime.	Yes. Directly elected (Mayor Mel Lastman).	Canada has a federal system of government. Toronto City Council is a municipality within Ontario Province.	Toronto Department of Public Health provides health prevention, promotion and protection services on behalf of an independent Board of Health. Member of WHO Healthy Cities Project.	Social insurance system
Paris	2.12 million	58% of population aged between 20–59 yrs, compared with 54% nationally. 16% of population born in country other than France. Ille de France region has lowest levels of heart disease in France. Higher rates of breast cancer, lung cancer, infectious diseases, respiratory disease, accidents and suicide. Also HIV/AIDS.	Yes. Elected by Council (Mayor Jean Tiberi).	Paris has both departmental and municipal status. The city is within the Ille de France administrative region. The city has 20 *arrondissements*, each with their own mayor and council.	Paris City Council co-ordinates cancer services, pre-natal and infant care, school health, and public health services, including vaccination, monitoring and prevention. National government oversees the provision of health services.	Social insurance system

CITY	POPULATION	KEY HEALTH ISSUES	MAYOR	STRUCTURE OF GOVERNMENT	HEALTH FUNCTION OF CITY	HEALTH SERVICE FUNDING
Rome	2.65 million	Ageing population, declining birth rates. 5% of population born in country other than Italy. Major causes of death and disease: CHD, respiratory diseases, breast and testicular cancer. Also high rates of infectious diseases, including HIV/AIDS. High rates of unemployment, poor housing and homelessness.	Yes. Directly elected (Mayor Francesco Rutelli).	Rome is both a province and a commune within the Lazio administrative region. Rome is one of nine Italian cities with metropolitan status. The city has 19 boroughs at local level, each run by a directly elected president.	Rome City Council plans and co-ordinates community-based care for disabled and older people, although these services are delivered by the boroughs. The City Council also runs health promotion campaigns. Lazio health region is responsible for health services.	General national taxation

References

[1] Stoker G, Hogwood B and Bullman U. *Regionalism.* Luton: Local Government Management Board, 1996.

[2] Cornes R. Intergovernmental Relations. In: Hazell R, editor. *Constitutional Futures: A History of the Next Ten Years.* Oxford: OUP, 1999.

[3] Hazell R and Jervis P. Devolution and Health: dynamics of change in the post devolution health services. In: Harrison A, editor. *Health Care UK 1997/98: The King's Fund annual review of health policy.* London: King's Fund, 1998.

[4] The Committee of Inquiry Into The Future Development Of The Public Health Function. *Public Health In England* Cm. 289. London: HMSO, 1988.

[5] Armitage L, Birt C, Davis H and Smith P. *Future Prospects for Public Health: Local Authority and Health Authority Collaboration.* Occasional Paper 14. Birmingham: School of Public Policy, University of Birmingham, 1998.

[6] Kemp V, Bardsley M and Jacobson B. *New Leadership for London: The Government's proposals for a Greater London Authority – The Public Health Function: Some Proposals for the structure of the function in London.* London: The Health of Londoners Project, 1997.

[7] Kemp V, Bardsley M and Jacobson B. *op. cit.*

[8] Hogwood BW. Devolution: The English Dimension. *Public Money & Management* 1996; 16(4).

[9] Department of Health. *Saving Lives: Our Healthier Nation.* Cm. 4386. London: The Stationery Office, 1999, para. 11.31.

[10] Department of Health. *Health Improvement Programmes – Planning for Better Health and Health Care.* HSC 1998/167: LAC 23. London: DoH, 1998, para. 29.

[11] Davies A and Kendall L. *Health and the London Mayor.* London: King's Fund, 1999.

[12] DETR. *A Mayor and Assembly for London.* Cm. 3897. London: TSO, 1998.

[13] *ibid.*

[14] Interview with Anthony P Coles, Senior Adviser to the Mayor, Office of the Mayor, City of New York.

[15] Interview with Sarah Pang, Deputy Chief of Staff, Office of the Mayor, City of Chicago.

[16] Interview with Connie Clement, Director, Policy and Planning Division, Department of Public Health, Toronto.

[17] Hine D. *Governing Italy.* Oxford: OUP, 1993.

[18] Interview with Sarah Pang, Deputy Chief of Staff, Office of the Mayor, City of Chicago.

[19] *ibid.*

[20] Interview with Commissioner John Markowski, Department of Housing, City of Chicago.

[21] Davies A and Kendall L. *op. cit.*

[22] Handy C. *Understanding Organisations.* London: Penguin, 1986.

[23] Catford J. Developing Leadership for Health: Our Biggest Blindspot. *Health Promotion International* 1997; 12(1).

[24] Interview with official, Assesorato alle politiche per la promozione della salute.

[25] Interview with Profesor Robert Leonardi, Director, European Institute, London School of Economics.

[26] *ibid.*

[27] Interview with Sarah Pang, Deputy Chief of Staff, Office of the Mayor, Chicago.

[28] *ibid.*

[29] *ibid.*

[30] Interview with Lisa Salsberg, Acting Manger, Healthy City Office, City of Toronto.

[31] Interview with Pere Cabrera, Executive Director of the Department of Integrated Rehabilitation of Ciutat Vella.

[32] Interview with Reah Mallet, Executive Director, Mayor's Commission to Combat Family Violence, Office of the Mayor, City of New York.

[33] Interviews with Michael Lyons, Chief Executive, Birmingham City Council, and Bryan Stoten, Chair, Birmingham Health Authority.

[34] Interview with Connie Clement, Director, Policy and Planning Division, Department of Public Health, Toronto.

[35] Mayor's Message. *Mayor's Commission to Combat Family Violence.* New York City web site: www.ci.nyc.ny.us

[36] Interview with Gabinet de Relacions Internacionals, Ajuntament de Barcelona.

[37] Mayor's Commission to Combat Family Violence. *Public-Private Solutions to Combat Family Violence: Mayor Giuliani's Colloquim Group Report.* New York, 1996.

[38] 'Ora Roma Comincia a muoversi' ('Rome is starting to move'). Francesco Rutelli, electoral campaign publicity, 1997.

[39] Interview with Commissioner Anna L Willis, Department of Ageing, City of Chicago.

[40] Metro Chicago Information Center and Buehler Center on Ageing, Northwestern University. *Facing the Millennium: Chicago Elderly Needs Assessment.* Chicago: City of Chicago Department on Ageing, 1999.

[41] Commune di Roma. *Consuntivo della Giunta Rutelli 1993–1997. op. cit.*

[42] *Public Finance* 24–30 September 1999.

[43] Interview with Anthony P Coles, Senior Adviser to the Mayor, Office of the Mayor, City of New York.

[44] *ibid.*

[45] Interview with official, L'Action Sociale de l'Enfance et de la Santé.

[46] Hazell R, editor. *Constitutional Futures: A History of the Next Ten Years.* Oxford: OUP, 1999.

[47] Interview with Connie Clement, Director, Policy and Planning Division, Department of Public Health, Toronto.

[48] Senatsverwaltung für Gesundheit und Soziales. *Sozialstrukturatlas.* Berlin, 1997.

[49] McLean A. Spending on Scots blamed for tube trouble. *The Scotsman.* 21 March 1998.

[50] Heald D and Geaughan N. In: Norton P, editor. *The Consequences of Devolution.* London: The Hansard Society, 1998.

[51] Press release, 4 June 1999.

[52] *The Economist.* 15 March 1997.

[53] Mayor's Commission to Combat Family Violence, *Public-Private Soutions to Combat Family Violence: Mayor Giuliani's Colloquim Group Report. op. cit.*

[54] Interview with Pere Cabrera, Executive Director of the Department of Integrated Rehabilitation of Ciutat Vella.

[55] Interview with Commissioner Anna L Willis, Department of Ageing, City of Chicago.

[56] Mayor Jean Tiberi. Press statement, 18 November 1999.

[57] Morgan D and Bardsley M. *Health and the Greater London Authority.* London: The Health of Londoners Project, 1999.

[58] The Health of Londoners Project. *The Health of Londoners: A public health report for London.* London: King's Fund, 1998.

[59] *ibid.*

[60] *ibid.*

[61] *ibid.*

[62] Health of Londoners Project. *Housing and health in London: A review by the Health of Londoners Project.* London: King's Fund, 1998.

[63] Health of Londoners Project, *The Health of Londoners. op. cit.*

[64] *ibid.*

[65] Crime Concern. *Review to Support the Development of the Health Strategy for London: Crime and Disorder.* London: Crime Concern, 1999.

[66] Bardsley M. *Project Megapoles: Health in Europe's capitals.* Luxembourg: European Commission, 1999.

[67] Health of Londoners Project, *The Health of Londoners.* op. cit.

[68] Lowdell C, Morgan D and Bardsley M. *Health and the Greater London Authority: an overview of key public health issues for London.* London: Health of Londoners Project, 1999.

[69] London Regional Office of the NHS Executive, King's Fund, Government Office for London, Association of London Government and Social Services Inspectorate. *London's Health Strategy: Summary.* London: NHSE London Regional Office, 2000.

[70] De Leeuw E, Abberma E and Commers M. *Healthy Cities Project: Second Phase Policy Evaluation*, Maastricht: Universiteit Maastricht, 1998.

[71] Interview with Anthony P Coles, Senior Adviser to the Mayor, Office of the Mayor, City of New York.

[72] Interview with Sarah Pang, Deputy Chief of Staff, Office of the Mayor, Chicago.

[73] Davies A and Kendall L. *Health and the London Mayor.* London: King's Fund, 1999.

[74] *ibid.*

[75] De Leeuw E, Abberma E and Commers M. *Healthy Cities Project: Second Phase Policy Evaluation. op. cit.*

[76] Interviews with Sarah Pang, Deputy Chief of Staff, Office of the Mayor, City of Chicago; and Michael Lyons, Chief Executive, Birmingham City Council.

[77] De Leeuw E, Abberma E and Commers M. *Healthy Cities Project: Second Phase Policy Evaluation*. Maastricht: Universiteit Maastricht, 1998.

[78] Urban Health Centre, WHO Regional Office for Europe. *City health profiles: a review of progress*. Copenhagen: World Health Organisation, 1998.

[79] Mayor's Message. *Mayor's Commission to Combat Family Violence*. New York City web site: www.ci.nyc.ny.us

[80] New York City Department of Health and Department of Mental Health. Press release, 21 June 1999.

[81] Coote A and Gowman N. *Evidence and Public Health: Towards a common framework*. London: King's Fund, 2000. (Also available on the King's Fund web site: www.kingsfund.org.uk/publichealth)

[82] Interview with Shelia Lyne, Commissioner, Chicago Department of Public Health.

[83] Lambeth, Southwark and Lewisham Health Authority. *Past, Present and Future: 1997–1998 Annual Report of the Director of Public Health*. London: Lambeth, Southwark and Lewisham Health Authority, 1998.

[84] Ajundatment de Barcelona. *Revista d'informació i estudis socials. op. cit.*

[85] Casas X. *Reclaiming a deprived area in Barcelona: the case of Ciutat Vella. op. cit.*

[86] Interview with Dr Jackie Chambers, Director of Public Health, Birmingham Health Authority.

[87] Coote A and Gowman N. *Evidence and Public Health: Towards a common framework. op. cit.*

[88] Interview with Dr Jackie Chambers, Director of Public Health, Birmingham Health Authority.

[89] Interview with Carme Borrell, Head of Health Information Unit, Institut Municipal de Salut Publica, Ajuntament de Barcelona.

[90] Davies A and Kendall L. *Health and the London Mayor. op. cit.*

[91] Interview with Carme Borrell, Head of Health Information Unit, Institut Municipal de Salut Pública.

[92] Interview with official, Direction de l'Action Sociale de l'enfance et de la santé.

[93] Interview with Connie Clement, Director, Policy and Planning Division, Department of Public Health, Toronto.

[94] Livingstone K. *Manifesto for Mayor of London.* April 2000.

[95] Mayor of Paris. Press release, 6 September 1999.

[96] Mayor's Message. *Mayor's Commission to Combat Family Violence.* New York City web site: www.ci.nyc.ny.us

[97] Victim Services. *The Cost of Domestic Violence fact sheet.* New York: City of New York, 1998.

[98] Mayor's Commission to Combat Family Violence. *Public-Private Soutions to Combat Family Violence: Mayor Giuliani's Colloquim Group Report. op. cit.*

[99] Interview with Reah Mallett, Executive Director, Commission to Combat Family Violence, Office of the Mayor, City of New York.

[100] Interview, Lisa Salsberg, Acting Mangaer, Healthy City Office, City of Toronto.

[101] Ajundatment de Barcelona. *Revista d'informació i estudis socials.* Barcelona: Barcelona societat/9, 1999.

[102] Casas X. *Reclaiming a deprived area in Barcelona: the case of Ciutat Vella. op.cit.*

[103] Interview with Pere Cabrera, Executive Director of the Department of Integrated Rehabilitation of Ciutat Vella.

[104] Interview with Carme Borrell, Head of Health Information Unit, Institut Municipal de Salut Publica, Ajuntament de Barcelona.

[105] *A Better Start to Life: A Draft Action Plan for Improving the Health of Birmingham's Babies.*

[106] Chicago Department of Public Health. *The Robert Taylor Initiative: Working Paper.* Chicago: Chicago Department of Public Health, 1995.

[107] *ibid.*

[108] Speech and paper submitted to G8 Summit of the Cities, Birmingham, May 1998.

[109] Interview with Commissioner Anna L Willis, Chicago Department of Ageing.

[110] Metro Chicago Information Center and Buehler Center on Ageing, Northwestern University. *Facing the Millennium: Chicago Elderly Needs Assessment. op. cit.*

[111] Interview with Connie Clement, Director, Policy and Planning Division, Department of Public Health, Toronto.

[112] Glasgow Alliance. *Creating Tomorrow's Glasgow: the Glasgow Alliance Strategy.*

[113] *ibid.*

[114] *ibid.*

[115] Hazell R and Jervis P. *Devolution and Health.* Nuffield Trust Series No.3. London: Nuffield Trust, 1998.

[116] London Regional Office of the NHS Executive, King's Fund, Government Office for London, Association of London Government and Social Services Inspectorate. *London's Health Strategy: Summary.* London: NHSE London Regional Office, 2000.

[117] Public Health Advocacy: Unpalatable truths. Editorial. *The Lancet* 1995; 345.

[118] Solihull, Wolverhampton and Somerset.

[119] London, 22 March 2000.

[120] *Mayor's Management Report.* New York: City of New York, 1999.

[121] Hazell R and Jervis P. *op. cit.*

[122] Whitehead A. From Regional Development to Regional Devolution. In: Dungey J and Newman I. *The New Regional Agenda.* London: LGIU, 1999.

[123] Address by Dame Helena Shovelton, Chair of Audit Commission to conference. *The Audit Commission and the Greater London Authority.* London: Barbican Centre, 6 December 1999.

[124] Morgan D and Bardsley M. *Health and the Greater London Authority: A profile of health and social indicators for GLA Electoral Areas.* London: The Health of Londoners Project, 1999.

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