Regional Leadership in Public Health: Fragmented London and the London Health Commission

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Introduction

Much of what ensures good health has nothing to do with health care services (Fox 2003, Hunter 2004). It has to do with good nutrition, employment, good housing, good sanitation, food inspection and environmental pollution. And that means that many of the levers required to improve population health and reduce inequalities are not in the hands of organizations that, structurally, have been given the job of promoting health or reducing inequalities. Transport, education, housing and other policy fields have a role to play, and yet they have their own politics and agendas that mean they may operate quite separately from health or health care services and not make the contribution to health that they could. They might often have been established in the nineteenth or twentieth centuries with the explicit goal of improving health1, but have since then become

This structural problem dogs public health policy. But it has also led to much creative work, formal and informal, to try and overcome it, or at least ameliorate its effects. One such innovation is the London Health Commission.

This paper describes the development of the LHC and what it seeks to do, based on interviews with members and stakeholders. It explores how the LHC interacts with the new governance arrangements for London introduced by the Greater London Authority Act, 1999. We argue that the LHC represents a new model for addressing the challenges facing such strategic, light touch government. It is a semi-formal coalition of major London actors and agencies, with a small staff team located in City Hall, dedicated to tackling the determinants of health in the capital by influencing policy makers and practitioners, focusing on particular issues and supporting local action In this paper, we seek to describe the key features of this model and determine its applicability to the different roles that the LHC has taken on.

Although media interest has focused on the new post of Mayor of London (and the character of its current incumbent), the GLA is a new type of government - one that seeks to govern London not through direct control and large scale public spending, but through networking, persuasion

1 Consider the number of Victorian and Edwardian buildings, in London and elsewhere, that bear the Latin legend "the health of the people is the highest law." Many of them are now what we consider local government facilities, as distinct as a library on Walworth road and a swimming baths in Hackney. But those legends are there for a reason, and underscore that appreciate of the wider determinants of health is not new, but is rather constantly forgotten and rediscovered.

and influence2. This is of interest for two reasons. First, networks of all sorts are how diverse organisations are increasingly knitted together in an effort to produce "governance without government"3. Second, academic appreciation of the role of networks and semi-formal networks such as the LHC has filtered into policy; regardless of the quality of the evidence behind theories of network government, they underpin policies as diverse as New Deal for Communities, the activities of the Greater London Authority and the EU's social policy framework.

In this context it is valuable to have an empirical understanding of 'strategic government', a phrase much used in reference to GLA and regional governance elsewhere in England but which has never been either adequately defined or researched. The new type of government represented by the GLA can be seen as emerging in other areas, with the development of regional chambers and policy forums, equally designed to address the problem of governing a range of actors without a formal organization or spending powers. While these lack significant budgets and formal powers with which to advocate regionally-specific priorities in health (or any other policy area), the LHC offers potential ideas and policies on how to do much with little. It also suffers from all the problems of an organisation- or network- that fundamentally controls little and to which almost nobody must pay attention. Its sharing this problem with other networks- whether formal or informal, government-sponsored or not- is what makes it interesting to those outside London.

This paper starts by describing the fluid nature of London government and health services and the development of the LHC. It then discusses the new type of government represented by the GLA, the LHC model as we have developed it, its successes and weaknesses, and its applicability to other areas. It concludes by asking what the LHC is doing and where its organizational "fit" with its activities is obviously best.

We argue that the LHC is interesting for what it can teach us as a case of the network-dependent public policy that the government favours, and as a case of the networks that bulk so large in policy analysis of governance. It has developed solutions to some of their problems, largely through its semi-formal nature. With staff and a

Its semi-formalization builds credibility and a public persona- rather than being a network of friends, it can take an authoritative public stance. But this means that in addition to the interest of the way it structures its activities, it also carries lessons about what sorts of activities are as useful for networks as current policy thinking suggests. Its forte, so far, has been in building credibility as a focal point for health in London- by contributing to the development of a sense that there is a London health policy network, and by speaking for health in that. The LHC packages a credible statement of what health requires, and finds some listeners. Some groups are required, however loosely, to listen to health, and the LHC provides a way for them to do it

[2] It its flyer "What is the London Health Commission" (n.d.) the LHC states its task as "Influencing key policy makers and practitioners; supporting Local Action; and Driving on specific, priority issues through joint programmes of work" and its core principles as "active engagement and inclusion of citizens, communities, and key constituencies; promoting partnership working that is inclusive, sharing, visible and committed; expanding and sharing information, ideas and learning about health, the determinants of health and other areas; commitment to equity and diversity" www.londonshealth.gov.uk

3 The phrase is from Rosenau and Czempiel 1992.

without too much extra costs. The Mayor of London, for example, has a legal obligation to take health into account. Others *want* or are willing to listen to a health perspective, whether because they are designing an Olympic bid with a focus on social inclusion and regeneration, or whether because they are servants of a government that has an interest, however weak sometimes, in mainstreaming health and reducing health inequalities.

In other words, because of its powerful backing, consistent profile, inclusive membership and fixed staff the LHC has been able to become a credible representative of parts of the London health policy network and an important factor in specialist debates about London health issues such as workforce or smoking. We found much less evidence, though, that it is successful in influencing big organisations such as the London NHS or boroughs- its efforts to diffuse good practice, while still recent and therefore too early to evaluate, are competing with other networks.

The research

This report is the culmination of a research project funded by the King's Fund, as part of its *Putting Health First* programme. The research was carried out between January and September 2004. The information presented here is based on an analysis of websites and documents, attendance at various LHC events, and a range of semi-structured interviews. These started with interviews with the 9 members of the LHC executive. A 'snowball' technique was then used to identify further interviewees: the executive members were asked for names of actors who should be interviewed and these were followed up. Most actors identified in this way were individuals from non-health organizations: for instance, environment, voluntary, black and minority ethnic group representatives. Unattributed quotes from interviewees are used in this report.

We adopted an approach of respectful scepticism to the data obtained from respondents. In our experience, actors within governance networks have a tendency to mix optimism with a positive evaluation of progress so far. We are not suggesting that any of our respondents were insincere or aimed to mislead; positive thinking results from networking with 'like minds' and is a vital and understated ingredient in keeping networks alive. Given this, however, to obtain a more objective assessment of the progress of a network, it is necessary to analyse the standpoints of sources and complement interviews with desk-based research (Yin 2002, Strauss 1998).

London's health

Greater London is a complex world city, with a diverse, mobile, and rapidly changing population, extremes of wealth and poverty, and a varied economy. But it is also an English city and it shares both many of its problems and its organizational structures with the rest of the United Kingdom and its experiences of dealing with the problems of urban governance, local government and NHS fragmentation, and the complex interlocking nature of health problems.

By UK standards, Greater London's health status is not so much bad as complex. If we exclude the City of London, with its small and atypical population, then London's standardised mortality

ratios4 range from 71 in Westminster to 116 in Newham (the SMR reflects the likelihood of death in a given year against a UK norm of 100). This compares relatively favourably to SMRs of 127 in Manchester, 144 in Glasgow and 125 of Merthyr Tydfil (see Appendix 1). But there are serious inequalities and complex problems that are hidden by the headline figures.

First, there are problems of economic inequality and exclusion, which are strongly linked to life expectancy and morbidity (LHC 2004:89). Newham, Tower Hamlets and Hackney have the highest unemployment rates of all the England and Wales local authorities (LHC 2004:44), while, despite the large concentration of highly educated individuals in London, only 35.4% of 15 year old boys in Inner London manage five or more A*-C grades in their GCSEs (LHC 2004:64-6). There are also sizeable percentages of houses that are unfit for habitation in some boroughs and areas, including more than 12% in Hammersmith and Fulham (which often sit cheek by jowl with some very expensive housing) (LHC 2004: 89)

Second, there is the ethnic diversity that makes addressing the needs of Londoners very complex. Many of the problems that directly influence health afflict some ethnic groups more than others; the unemployment rate, for example, is 20.5% for Bangladeshis, 12.3% for people of Black Caribbean ethnicity, and 5% for those of White British ethnicity (LHC 2004:50), while educational attainment shows sharp variation by ethnic group. Discrimination undoubtedly contributes to problems such as unemployment, and, in doing so, contributes to poor health. There are also a wide variety of problems of intercultural communication that make it difficult to work with people and groups from different ethnic backgrounds (LHC 2004:56). Issues such as drug and alcohol abuse, domestic violence, mental health and final-stages care all have very different meanings to different ethnic and religious groups.

So while London might look wealthy and passably healthy overall, that masks geographic inequality and pockets of serious, often complex, deprivation that produce poor living conditions and poor health. While the way these different factors come together in London makes the city unique, inequality, diversity, social exclusion and poor health are shared with other parts of the UK. This makes attempts to deal with them in London of wider interest and applicability.

The government of London

In 1994 the great historian of London Roy Porter wrote:

> "London's basic and ever-present fault line- the anomaly of its government- has come out into the open. Because of niggling petty jealousies and a failure of will, the predicament of London's governance is now further than ever from being solved…Over the centuries London's government was bumble and bungle: internal confusion on a day-to-day basis, and paralysis at times of crisis- the Plague, the Fire, the Gordon Riots, even the Blitz. In the past, the failures- structural and personal- of London's government have been neutralized by the socially redemptive power of its trading position and the cohesiveness

[4] SMRs give the likelihood of death in a given year against a UK-wide norm of 100. The higher the number, the more prone an area's population is to die relative to the rest of the country. Low is therefore better and higher worse. It is an indicator not of overall health status, but rather of inequalities in health outcomes.

> of its population. It is hard to feel confident that this good fortune will continue." (388-89).

Between the abolition of the Greater London Council in 1986 and the arrival of the Greater London Authority in 2000, there was no tier of government covering the territory of Greater London. The 32 boroughs and the City of London ran all local government services alongside a range of joint boards and central government-controlled agencies. These included bodies such as the Metropolitan Police and London Transport, which were later to become part of the GLA 'family' (see below), and agencies such as the Housing Corporation and London Arts Board, which did not.

In the run-up to the 1997 general election, the Labour Party had a long-standing commitment to restore London-wide government, though this was not particularly well argued or thought through (Travers 2004:46-47). Rather vague arguments were made about the need for London to 'speak with one voice' and to co-ordinate policy over a range of fields. Inter-borough co-ordination had not been a disaster, and New Labour was keen to avoid reminders of its past through charges of wanting to create a 'GLC mark II'.[5] Labour, in its late-1990s pragmatism, was strongly in favour of 'working with the grain of London'. The main added value of a London-wide authority was to be land-use and transport planning and co-ordination of a range of policy, rather than in the creation of a new, powerful executive government with a wide range of new or transferred functions. There was very little support from any quarter, in the run-up to 2000, for a stronger form of devolution along the lines of the Scottish or Welsh models. The following paragraph from the Green Paper on the GLA sums up the prevailing view:

> "Well-judged co-ordination of action, in line with agreed strategies, will pay dividends for London... We do not consider that the mayor needs powers over and above these [appointments and executive functions] to secure compliance with his or her strategic objectives – the mandate from the electorate will give the mayor considerable authority and we see him or her working with the assembly and with a wide range of organizations to create a consensus."[6]

Little thought was given, however, to how this new form of governance would work in practice. The unusual aspiration towards 'light-touch' strategic government set out in the Greater London Authority Act 1999, and in the powers it gave to the GLA, begged many questions as to how it would influence, make, or direct many of the policies for which it was responsible.[7] This was the subject of earlier research funded by the King's Fund (Davies and Kendall 1998 **BIB**),

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[5] Department of the Environment, Transport and the Regions, *A Mayor and Assembly for London* (London: The Stationery Office, 1999), p. 8. The Greater London Council (GLC) covered the same geographical area as the GLA. It existed from 1964 to 1986, when it was abolished by the Conservative government following increasingly vocal political opposition to Conservative central government policies. The last leader of the GLC was Ken Livingstone, who became the first Mayor in 2000. Livingstone's tenure at the GLC was an embarrassing part of the Labour Party's past which New Labour has wanted to forget.

[6] DETR, 1998, p. 6

[7] *New Leadership for London*, HMSO, London, 1997, Cm 3724; *A Mayor and Assembly for London*, HMSO, London, 1998, Cm 3897

examining the potential role for the Mayor and a 'strategic' government in the area of public health. This research looked at the roles played by other mayoral authorities in Europe and North America.

The GLA was created with a separately-constituted executive Mayor and a scrutinising Assembly. The Mayor of London holds all the executive powers in the GLA, but most of them are carried out at one remove through four 'functional bodies', which are essentially quangos. These are: Transport for London (TfL), the London Development Agency, the Metropolitan Police Authority and London Fire and Emergency Planning Authority. The Assembly, meanwhile, has a limited scrutiny and budget-approving role which has little influence on the day-to-day work of the Mayor.

The GLA has 'responsibility' for matters such as culture and arts, the environment, and health, but it was not to run public services in those policy fields. It is obliged to write a number of strategy documents on matters such as ambient noise, air quality, biodiversity and waste (see Table 1), though it would have few powers and sanctions to ensure that they were implemented (consider the problems of improving air quality and reducing noise pollution in London without being able to touch Heathrow). The Mayor therefore relies upon goodwill, partnership and his electoral mandate to take them forward.

Table 1: Mayoral powers and strategies

Executive powers	**Strategy documents**
Metropolitan Police Authority	
Transport for London	Transport
London Fire and Emergency Planning Authority	
London Development Agency	Economic Development
	Air Quality Ambient Noise Biodiversity Waste Management
	Culture
Planning	London Plan

London's health and public health structures

London's health services, like those in the rest of the UK, have undergone a number of reorganisations in recent years. Until 2001, it had an NHS region which sat atop its district health authorities, with trusts and GPs beneath them. In 2001 it became one of the four, giant English regions with a Director of Health and Social Care, while its strategic public health function moved from the NHS regional office to the regional Government Office for London. The Regional Director of Health and Social Care has since been abolished, but the strategic public health teams stayed in regional Government Offices. Since 2001 Greater London has had five

strategic health authorities, each responsible for co-ordination and performance management in its patch. Their heads meet and are sometimes known as the "London NHS Cabinet."

Below the SHAs are Primary Care Trusts responsible for providing or commissioning care for a set population, and acute trusts including more autonomous "foundation hospitals", plus specialist services such as ambulances and mental health and some private providers). A variety of regulators, presently being reorganized, try to prevent bad outcomes and make special interventions in services. This structure is recent and history does not encourage faith in the stability of internal NHS structures; there have been a large number of NHS reorganisations over time, including among recent ones 1991, 1998, and 2001. Currently, London's health services consist of 32 Primary Care Trusts, which are co-terminous with borough boundaries and tasked with commissioning for specific populations; and thirty trusts providing acute, community and mental health services. The only component of the London health system that is formally organized with a Greater London remit is the regional public health team, headed by the Regional Director of Public Health, Dr Sue Atkinson, who is also an LHC member and the Mayor's public health advisor.

In summary, the public health role within Greater London is spread over a number of different organisations, not all of which are obliged to relate to one another. For a strategic government, which was obliged to achieve outputs by working with partners (the phrase 'banging heads together' was frequently used when the proposals for the GLA were under development), this represented an opportunity to add value. Simply bringing together these disparate actors to discuss their policy aims would cost the GLA little in terms of time and money and could potentially achieve very useful outcomes.

Health and the GLA

Where does health fit into this model of government? At first glance there is little in the structure of London government to suggest that we should expect a Greater London health policy. It has a toehold in the GLA Act, one that advocates of a London public health policy had to lobby hard to insert. The Mayor is obliged to have regard to "the health of persons in Greater London; and the achievement of sustainable development in the United Kingdom" (GLA Act s30 (5)) - again without specified power or budgets. This could be merely hortatory and could be a dead letter if the Mayor wanted it to be so. It has not been so, we will argue, for three reasons:

- Because advocates for regional work on the wider determinants of health had an organizational strategy, focused on the creation of the London Health Commission (LHC), to induce and allow the GLA to create a health policy;
- Because the LHC and the Mayor have found areas of health policy in which to work that are poorly served by other bodies;
- Because a focus on wider determinants fitted with the concepts of 'strategic', light-touch government that emerged in the GLA Act. Policy on the wider determinants of health, to be effective, requires policies in other fields to harmonise with its aims. It is not a potential government department or policy field in itself, but an *approach* to policy that consists of ensuring that other policies - crime, transport, housing, arts and culture, fire

and safety, and employment, for example - promote health rather than obstructing it.

The London Health Commission represents a bottom-up attempt to engage health advocates with Mayoral policy. It predates the establishment of the GLA and the election of the Mayor, and hence has an independent existence from the Mayor. At the same time, it is dependent upon Mayoral and Kings Fund largesse for most of its effectiveness – providing office space and some funding, and the opportunity to network. Conversely, the LHC is not the Mayor's only 'health policy'. He set up the Greater London Alcohol and Drug Alliance (GLADA) in early 2001, with a membership including the ALG, probation, the London NHS, the prison service, the Metropolitan Police and the Social Services Inspectorate. The high-level aims of this group resemble those of the LHC. They include being "a voice for London" and "providing a mechanism for tackling Londonwide problems" (GLA website). An eight-point plan of action was produced for the first year, which included producing a 'policy for London' on alcohol, research, involvement of users, and impact on Mayoral strategies. Besides this, a campaign entitled "Saving Londoners' Lives" was run jointly with the London NHS and a range of voluntary organizations (including the British Heart Foundation, the Red Cross, St John Ambulance and Under Pressure). This was an advertising campaign publicising ways to recognise when a heart attack is happening, in order to increase the likelihood of help being called from emergency services. A wide-ranging survey of disabled people's experience was undertaken through 2003 and the results launched at a conference in December 2003 (the Disability Capital conference).

Each of these policies involves Mayoral intervention in areas which are perceived to be under-served by action within the NHS mainstream. They differ from the LHC, however, in that networking does not appear to be the main process through which they operate and that they are closely identified with the Mayor himself. They are far less driven by the concerns of a professional membership than the LHC is.

The LHC: a brief history

Formation and influence on the GLA Act

The LHC itself first appeared in 1999, when a group of self-appointed 'concerned organizations' came together informally, and produced to produce a *London Health Strategy* in March 2000 (LHC 2001). The strategy was the descendent of what one interviewee then involved some "fairly crude" work produced by the NHS public health team in the early 1990s, and subsequently developed to a much more sophisticated level. It identified health-related targets based factors known to contribute to morbidity, rather than on health outcomes, noted areas in which London performed poorly, and suggested some mechanisms to overcome them.

The LHC at this point had only an informal structure, and little in the way of stable funding (and no staff, being run out of the King's Fund's offices). It was, however, able to gain commitments from all of the mayoral candidates for the first elections in 2000 to include health concerns in their manifestos. Ken Livingstone, after his election victory, appointed Dr Sue Atkinson as his health advisor. As noted above, Atkinson was and is a serving civil servant (as Regional Director of Public Health) and one of the founding members of the LHC. This formalises important lines of communication.

Neither boroughs nor the Department of Health had been positive about a GLA role in health, while leading pro- GLA politicians (including Ken Livingstone) were prone to suggest that they thought the GLA should control the London NHS - a stance that was unlikely to win friends in the DH or London NHS organizations. Two interviewees who had been involved in this entire period both suggested that the breakthrough was to divert the GLA from this (probably hopeless) goal and to identify an attractive and important set of health issues that would sidestep conflict while giving Greater London a health role. Interviewees reflected on how politically-charged innovations such as the LHC were at this period:

> "There was a lot of politics- it seems amazing [now] that people got so worried about their prerogatives." [LHC official]
>
> "People were so nervous then- everybody was safeguarding their positions" [Member of a 'GLA family' organisation].
>
> "The boroughs worried that the GLA would take over health policy, so they got interested… even though nobody was sure it was the right way to go" [Member of the LHC steering committee]

Expansion, 2000 - 2003

Following the 2000 election, a number of organizations contributed money towards the establishment of a secretarial function in City Hall. These were the GLA, the King's Fund, Government Office for London, Association of London Government, the Social Services

Inspectorate, the NHS Executive London, the Metropolitan Police Authority and the London Development Agency (the latter two joining after the LHC's formation). Some, though not all, of the funders took a seat on the LHC, including:

- Dr Sue Atkinson (as above);
- a representative from Government Office for London;
- a representative from the King's Fund;
- a representative of the London Health Observatory;
- a representative of London Health Link.

The LHC has never been open only to financial contributors, however. Already in 2000 it numbered 43 members, including health authorities, academia, local government, business, black and minority ethnic groups and the London Development Agency. Only one London Assembly member, Trevor Phillips (then Assembly Chair) sat on the Commission, and his presence does not appear to have been significant for relationships between the LHC and the Assembly.

Through 2002 and 2003 the LHC grew incrementally, largely by invitation. When an institutional viewpoint or attribute was known to be lacking (for instance, small business, disabled Londoners), LHC members tried to bring a representative of those interests on to the LHC. This took place through entirely informal processes: new members would be suggested and assented to by existing members. The Commission was also open to being approached 'cold' by potential new members. By mid-2003 the LHC had a membership of some 75. This made it hard to make decisions or pass resolutions, and some of our interviewees felt that senior actors had begun to stay away, believing that it was not a good use of their time.

Formalising structures

Through 2003, a review was conducted to streamline the activities of the LHC, and at the same time its structures were formalised. A new Executive Board of 10 members was established (see box), and issue-based working groups were gradually set up.[8] This change was welcomed by most members interviewed:

> "I think it's leaner and therefore going towards a more focused body. There were lots of people sitting around the table before who weren't quite sure why we were there … it sometimes felt like it was three or four hours that would be better spent elsewhere." [Executive member]

Most of the members of the new executive had already been 'leading lights' in the LHC – indeed, one interviewee referred to the Executive "being formalised". The most significant change was the appointment of Len Duvall (a leading Labour member of the London Assembly) as chair of the LHC. Although the LHC is an independent organisation, and the Mayor cannot

[8] The pressures of expanding membership, and the solution found of an executive group with a pyramid structure of forums for specific aspects of policy, are familiar in policy forums in the other English regions. Rural affairs, housing, health and various other issue-based forums have undergone very similar processes to the one described here.

therefore formally appoint its chair, in practice this is what happened. Indeed, GLA literature sometimes claims that the Mayor set the LHC up (GLA website). Whatever the exact details, Len Duvall was a high-profile chair who could raise the profile of the LHC, both with the Mayor's office and with the public (he was replaced by Jennette Arnold, a fellow Labour assembly member, in December 2004).

Other LHC members, and newly interested groups, now contribute to three 'priority groups' on black and minority ethnic communities, children and young people, and disabled Londoners. The first has been established for 12 months, and is building towards 25-30 regular members. The second group is in its infancy, and the third has yet to be established. Each group is chaired - or will be chaired - by a member of the Executive, to enable the groups' opinions to move directly into the Executive. These networks, it is expected, should extend further the reach of the LHC by serving as connections to groups interested in particular topics.

The LHC has approximately three permanent members of staff: a secondee from the Health Development Agency (via the public health team in the Government Office), a staffer paid for by the Kings Fund to work on London Works for Better Health (see below), and two administrators (one temporary), supported by the GLA and DH. They operate from a bank of desks within City Hall, the GLA building, and therefore have access to GLA staff and to the news and information facilities of the GLA. Close relationships have been built with the Mayor's own (separate) health policy team.

Funding for the Commission currently comes from a range of sources (see table 2, which is consolidated from LHC documents and gives an indication of its range of support). The GLA also provides in-kind support (through housing the staff team), as does the London Health Observatory.

Table 2: LHC funding streams

Sources	**£000**	**Destination**
Department of Health / Health Development Agency	90 *20* *45* ***155***	LHC Co-ordinator post and Assistant post Communications post HDA 'programme support'
GLA	25 25 **50**	Health In London Report General funding
Kings Fund	100 *20* ***120***	'London Works for Better Health; Communications post
ALG	***51***	Community Development and Voluntary Sector Involvement

Reserves	***20***	
Total	**396**	

Interestingly, although the total funding available for 2004-05 is £396,000, the LHC set a budget of £581,000. This indicates the range of work it would like to pursue. Some of the un-funded programmes included in LHC documents include a review of race equality schemes, promoting National black and minority ethnic mental health strategy, supporting the ALG Fair Funding London Campaign, promoting the Disability Discrimination Act, and Developing tracking of implementation of Mayoral strategies. Health inequalities stand out as a recurring theme in this list.

What does the LHC do?

The LHC's website describes it as "an independent, high level, strategic partnership that seeks to improve the well-being of all Londoners and reduce inequalities in health." It claims to do so by "influencing key policy makers and practitioners; supporting local action; [and] driving on specific priority issues through joint programmes of work". To achieve this two political aims are important: ensuring that 'the key partners' are Commission members, and getting the attention of the Mayor of London. One interviewee emphasised the importance of this political positioning:

> "I think it has put health on the agenda for a number of partners who otherwise might not think about it...If we'd not got the LHC, the Mayor would give less attention to health. That's something you could never prove, but because he does not have a direct responsibility for health, I think less attention would be given if there wasn't a health commission and one of his senior members chairing it." [LHC executive member]

Nevertheless, our interviewees found it hard to define 'key partners.' The actual membership of the LHC executive indicates they are large governmental organizations, executive agencies and London wide interest groups. However, the actual *individuals* on the LHC executive are mostly those people who had been involved in establishing it: they tend to be individuals with particularly strong personal interest in the work, and experience in pre-existing networks, as much as representatives of their organizations. This led to a certain vagueness about the formal structures of the LHC: one interviewee said "I think technically I'm not a member of the executive, but I think everybody's forgotten that". Another interviewee, long involved, expressed relief at no longer needing to turn up at meetings- but turned up at subsequent general or executive meetings nonetheless.

The activity of the LHC falls into the following broad categories:

- Collecting, structuring and disseminating **data** that focuses on London's health and solutions to its problems.
- Getting involved in the development of other regional policies by providing **advice and assessment** and acting as a **representative of health**.
- **Diffusing ideas** by coming up with concrete policy ideas and building networks.
- **Stimulating debates** and trying to raise the profile of issues.

The particular focus of its activity tends to change with changing circumstances. The LHC's advice and assessment role came to the fore when it had the opportunity to advise on Mayoral strategies, but there is now more time and reason to look at other issues, including London's Olympic bid.

Data

The LHC's very first activity was the production of the London Health Strategy. The Strategy

identified health-related targets based on known factors contributing to morbidity, rather than health outcomes; of the ten indicators only three are specifically about health. The rest were about risk factors that contribute to poor health[9]. It noted particular areas in which London performed poorly, and suggested some mechanisms to overcome them

The LHC also publishes updates on health indicators in the form of the *Health in London* reports. These show progress on its chosen indicators and give London a regional data bank with visibility. The London Health Observatory, one of a network of regional health data producers established by the Department of Health, helps produce the data, but the LHC does much of the commissioning and editorial work on the document.

There is no equivalent series of publications for any other part of England. The result is that thanks to the LHC it is possible to understand the challenges facing London- and think coherently about its health and heath problems. It also probably therefore contributes to wider understanding of the broad nature of London's distinctiveness in health. Judging by interviews, it is the most appreciated and widely used LHC output.

Advice and Assessment

A major focus of the LHC's work in 2002-3 was the production of a guide to Health Impact Assessment (HIA) and conducting HIAs on the eight statutory strategies of the Mayor. Health Impact Assessment is what its name suggests: an effort to assess the likely impact of a given policy idea on health (this links health policy up with the wider determinants of health). The LHC has produced a short guide to how to carry out a health impact assessment, for the benefit of any group in London wishing to either develop policy, plan future development, allocate resources, commission services, prepare funding bids, or undertake community development. The guide emphasises: fairness, especially between disadvantaged groups; sustainable development; participation; and the use of qualitative evidence (LHC 2000). Like public health, these are policy approaches rather than policies in their own right.

The HIAs of the Mayor's strategies consisted, in each case, of a rapid review of evidence, followed by a half-day seminar (the London Plan HIA held a full day seminar, due to the complexity of the issues discussed). The LHC's team provided initial presentations focusing on the main points of the relevant strategy and the evidence available for rapid review. The focus of the day, however, was on participants' discussion groups, where they were asked to assess how parts of mayoral strategies would impact on health outcomes. ('Facilitators' were available to supply factual detail). The outcome of this process was a series of quite detailed reports, four of which (those on Air Quality, Noise, Waste and Biodiversity) were presented to the London

[9].They are: Unemployment; Unemployment among Black and minority ethnic groups; Educational attainment: percentage of pupils achieving 5 GCSE grades A*-C; Proportion of homes judged unfit to live in; Burglary rate per 1000 resident population; Air quality indicators; Road traffic casualty rate per 1000 resident population; Life expectancy at birth; Infant mortality rate; Proportion of people with self-assessed fair, poor, or bad health. The last three are good indicators of population health status, crime (burglaries) seems to covary with ill health as well as contributing to ill health; and the rest are major explanatory factors for ill health.

Assembly's Environment Committee.[10]

An assessment of the HIA process itself was carried out by Opinion Leader Research in 2003, commissioned by the GLA.[11] The assessment found that a wide range of stakeholders had been engaged in the HIA process, which had had the effect of raising awareness of HIA. But it also identified "limitations" including "a lack of agreed methods, time-scales and gaps in the evidence base for health impacts" (p6). A number of our respondents also suggested that the HIAs had been too reliant on the opinion of seminar participants, rather than on research and analysis and they questioned how much difference the process had made on the ground, although the OLR report quotes GLA officers who claimed they had taken the HIAs into account when finalising strategies (Opinion Leader Research 2003:43).

Through 2004 the LHC contributed to London's Olympic bid. There are two reasons to "drop everything and focus on the Games," as one interviewee in GOL put it. First, such a bid can unleash strategically directed public action (to regenerate areas or improve transport, for example) that might be harnessed to healthy ends. Second, it presented opportunities to convince payers and the International Olympic Committee that the Games will have a social impact beyond entertainment and sports facilities. London's bid, for example, intends to use the games to change the face of the area around Stratford and Hackney; it was designed to produce beneficial regeneration.

An interviewee on the LHC executive said the LHC had been "the obvious way to speak about health" and influence the bid "both because it could coordinate, and because it could speak for all the different stakeholders". In other words, the LHC's role in the bid is an example of it representing upwards; using its relatively comprehensive membership and information to speak for the health sector in a situation in which a health input was called for.

Diffusing ideas

The most comprehensive effort to diffuse ideas and promote change in behaviour has been *London Works for Better Health*. This programme began with a broad mission to identify some actual policies to attack poor health through employment policy, both public and private (the NHS is a major employer). The novelty of the agenda meant that the first year of LWBH was spent building networks and looking for good ideas or little-noticed good policies at work. At least in principle, this networking process could be valuable in itself.

Over 2004, LWBH identified three major areas in which to work and some policies. The first area is individuals and skills. A LWBH interviewee explained that in any analysis of London's dynamic labour market, one of the major causes of unemployment is lack of skills, including

[10] During the 2000-04 term the Environment Committee was unusually proactive for an Assembly scrutiny committee, thanks mainly to the leadership of its chair.
[11] Opinion Leader Research, *Report on the qualitative evaluation of four health impact assessments on draft mayoral strategies for London*, London, 2003

basic skills such as literacy.[12] The LHC's response has been a series of "learning events" that try to bring together the different skills and employment agencies to "raise awareness of the health issues" and good practice. The second is keeping people in work and finding ways to stop people leaving work for incapacity benefit. The third is work at the community level, focusing, above all on the role of the NHS. This means diffusing, for example, the lessons from Barts and the London trust, which is rebuilding the biggest A&E department in Europe and which has appointed a regeneration director for the project. LWBH is the LHC's support of an effort to identify solutions to intractable problems at the interface of health and the labour market. Much of its work, in other words, consists of building networks, identifying concrete problems, and ferrying solutions from one place to another. A project at the vast St Mary's hospital trust was featured at one LWBH event; the trust had developed a scheme to recruit and train staff from its neighbourhood, thereby both creating local jobs and solving the hospital's inability to recruit semi-skilled labour on the open market.[13]

Starting debates: Smoking

The LHC participated in a debate through late 2003 and early 2004 about smoking in the capital - "the Big Smoke" which contributed to the sense that a given issue – banning smoking in public places – was on the agenda. The representation of London was far from complete, and the LHC's networks far from encompassing. But in questions of representation and influence on political agendas, the important thing is not to represent a group perfectly; it is to represent it better than any alternative. The importance of its contribution was not so much in ensuring that all possible health bodies were represented, but using its profile to turn what was then a New York novelty, (and later an Irish novelty), into a London policy proposal. It took place at the same time as Northern Irish, Scottish and Welsh moves to ban smoking in public places, and contributed to a general surge of interest in the issue and pressure on the Government (one might wonder, the United Kingdom being what it is, whether a debate in central London has more impact on UK policy than radical legislation in Scotland). The upshot may actually have been a UK-wide ban on smoking in certain kinds of public places (Department of Health 2004).

The LHC approach

What these different activities and the history of the LHC itself have in common is a basic *modus operandi.* This involves building and using networks to shape information and idea flows to organizations around London. Leaders of organizations, whether they are boroughs, NHS trusts, quangos, or local groups, are problem-solvers by definition. Therefore, one way to get them to act on a given issue is to create a problem for them for them to solve. This is a tactic used by Whitehall target setters, direct action protesters and, indeed, anybody who tries to use a combination of analysis, media, and personal contact to convince a politician that a problem

[12] This "skills mismatch" argument is ubiquitous in analyses of the British economy. It weaves together Britain's weak vocational training system, its employers' reluctance to train employees, its flexible labour market and its overall good employment performance in an explanation of both its pockets of structural unemployment and the difficulty employers have filling some high-skill jobs. See Hall and Soskice (2001) for the background.

[13] "There are only two kinds of people who will ever work in the London NHS for more than five years" generalized a manager in a NHS agency; "native Londoners and immigrants whose alternative back home is worse."

exists, even if all that leads to is a seminar tied to a press release (Kingdon 1995; Baumgartner and Jones 1993).

Another way to get them to focus on a given issue, and one that policymakers are more likely to appreciate, is to identify how a policy or approach can help with problems that they have already. There is not just a dearth of time, money, and attention in politics: very often there is also a dearth of policy. Recurring problems, such as minority health or large populations on incapacity benefit, have resisted many interventions so far, so new or repackaged ideas always have a chance, if policy advocates can get them to decision makers when they need them. The business of being that policy advocate is aided by:

- Forming a credible organisation with credible people;
- Identifying useful ideas, ones a policymaker will want;
- Forming networks that further enhance reputation and encourage information;
- Finding and deploying slack resources.

Much of what the LHC does is to make sure it is in that position. Its general approach is to solve other people's problems, through its position and status as a network and through the quality of information that it disseminates.

Networks and advocacy coalitions: the location of the LHC in policy theory

Most of the public sector bodies which have responsibility for health or health related matters within London are represented on the LHC. The LHC seeks to influence or direct public policy, and it is physically located within the GLA. But it is not a conventional form of government. It is a membership organization; it aims to deliver its desired outcomes through other organizations. Being a new and unconventional form of government, what it should or can try to achieve is not self-evident. On a theoretical level, the LHC can be viewed in two complementary ways. Firstly, it is an example of a policy network. Secondly, it is an innovative solution to a specific policy issue, public health/wider determinants of health, which is quintessentially cross-cutting, and to the problems faced by all forms of "strategic government" when they are called upon to turn academic insights into network governance into actual policy outputs.

Governance and policy networks

Scholars have coined the term "governance" to encapsulate a perception that, over the last 25-30 years, states around the world have withdrawn from a previous hegemony of control over various areas of public policy. (Rhodes 1997, Marsh 1998, Jordan and Richardson 1979). Privatisation, "new public management", innovations such as the NHS internal market, Next Steps agencies and public-private partnerships, the fragmentation of central government and the devolution of power to regional and local levels, have created a situation in which the formerly centralised state has less control over outcomes. However, the withdrawal of the state from direct action produces not chaos but governance. This term has come to refer to government not through a single, accountable state but through a web of actors with different resources, interests, and interconnections.

One result of the fragmentation of government is "the development of governing styles in which boundaries between and within public and private sectors have become blurred" (Stoker 1998:17). Governance implies an increasing focus on private or voluntary stakeholders, who may form a partnership to deliver a particular public service or investment programme. The most common stakeholder partnerships in the UK in the 1990s were urban regeneration programmes funded by the European Union (see Haughton 1995, Fordham et al 1998, Bridges et al 2001). Although the development of partnership working was somewhat uneven in these programmes, it was perceived as a useful means of improving the quality of policy and of relationships with those to whom policy had traditionally been 'done':

> "Partnerships encourage co-ordination of activity and policies across organisations. This can reduce duplication of effort. It can also instil synergy as the integrated activities of partners may amount tom ore than the impacts of each working in relative isolation." (Alcock et al 1998:30)

Another effect has been the organic development, or deliberate establishment, of co-ordination mechanisms between institutions, either at the same tier of government or between different tiers. These have often taken the form of multi-lateral policy forums or networks, which may

serve to link between tiers of government and to link across policy areas at a single fragmented tier of government. Forums and networks normally lack institutional permanence, but their influence comes through the activities they pursue, not through their status in the hierarchy of formal institutions – "governance is to some extent more about process than institution: hence managing multi-level governance becomes a matter of integrating processes at different institutional levels." (Pierre and Peters 2002:78).

The idea of governance appears to suggest that the state has lost the ability to control policy fields. A state which presides over a fragmented public sphere and which relies increasingly on partnerships with other actors to achieve policy outcomes would reasonably be thought to have lost powers. Another view, however, is that transformation, not retrenchment, more accurately grasps what has happened. The state may only be *primus inter pares*, as Pierre & Peters suggest, but it certainly remains *primus*. Indeed, these authors suggest that "the emergence of governance could well in fact increase public control over society instead of decreasing it" (2000:78).

The confluence of changing governance and developing interest in networks mean that networks are increasingly being seen not just as a fact of political analysis but also as a useful policy tool. The LHC can be understood as a form of policy network which has achieved an unusual degree of formalisation. The concept of the policy network was first developed by Heclo and Wildavsky in 1974. It has been refined by contributions from Jordan and Richardson (1979) and voluminous work by Marsh and Rhodes throughout the 1990s.

Rhodes produced a typology of five different types of policy network, on a continuum from "policy communities", with strong influence on government and tightly-organised membership, to "issue networks" with fluid and unstable memberships largely concentrated on discussions (see Table 3).

Table 3: Rhodes's network typology (source: Rhodes 1997:38)

Type of network	**Characteristics of network**
Policy community/territorial community	Stability, highly restricted membership, vertical interdependence, limited horizontal articulation
Professional network	Stability, highly restricted membership, vertical interdependence, limited horizontal articulation, serves interest of profession
Intergovernmental network	Limited membership, limited vertical interdependence, extensive horizontal articulation
Producer network	Fluctuating memberships, limited vertical interdependence, serves interest of producer
Issue network	Unstable, large number of members, limited vertical interdependence

In this terminology, the LHC conforms most closely to the 'issue network', given its large and fluctuating membership. But it contains characteristics from other categories. It has some degree

of vertical interdependence, in that, although it does not rely on the GLA for its existence, its work would be severely compromised without its support. Also, having obtained GLA support in kind and a relatively stable set of funding streams, it can no longer be described as 'unstable'. Further, the LHC has a formalised membership structure in that, although members do not pay to join, it restricts membership to individuals representative of 'relevant' health and related bodies. It also has a small staff team, which makes a substantial difference between a mere network of interested individuals and a more organised and sustained discussion forum.

The LHC, then, represents a form of 'network governance' as described by Rhodes (1997) and Marsh (1998). It differs, however, from their descriptions of national policy networks, which have direct links to central government. The LHC is a self-established, semi-formalised network developed as a political strategy and tool in itself. It has been able to seek influence with the main political players within a particular territory through its manipulation of the constant networking that surrounds all government. Its breadth and organisational profile at least in principle allow it to be easy to join- with its website and staff, it is more than a group of people, and it can therefore accumulate more connections (Granovetter 1973).

This point is worth underscoring for it points directly to what the LHC does and does not tend to do with vigor. Its semi-formalisation means that it is visible and credible; it routinely interacts with a good number of policymakers, has credible members, and can be joined and referred to thanks to its coherence and public presence. That means it can speak, better than any other organisation, as the voice of those interested in London's population health (as against health services).

Public health and networks: a good match?

The literature on policy networks developed out of the empirical study of policymaking as analysts identified and realized the importance of individuals in government, academia, and private organizations who shared a common engagement with a given policy area. They seem to be ubiquitous and entrenched. Heclo states that "very few policies ever seem to drop off the public agenda as more are added" (1978:97). But it is possible that networks are more than a fact of political life. It is possible that the *form* of organisation of policy networks is particularly suited to issues which cross traditional departmental boundaries. Policy networks open up spaces for policy-making and policy-discussion which do not rely on the existence of departmental boundaries. Could public health policy in particular benefit from such an approach?

The fact that the LHC is a network and not a large bureaucracy has two impacts. Firstly, it means that the whole of its attention can be focused on public health matters. Large organizations (such as London boroughs) have enormous commitments, limited room to manoeuvre, core tasks they must fulfil, and accountability to fulfil certain tasks. They already have standard operating procedures, core tasks and values, cultures, and forms of accountability. This is an effect of the 'silo mentality', where policy areas remain 'self-sufficient' and isolated from one another.

The second impact of the LHC is that, paradoxically, when the LHC's only resources are influence, talk, and networking events, it becomes easier to interest other organizations in their

priorities. This is because there are a number of organisations that for one reason or another want to incorporate health, or at least fend off challenges that they are ignoring health. Working with the LHC suits their interests as well as those of the LHC; it can supply a credible idea and connections to other important backers, while its credibility and coherence make it difficult to challenge work with it. The result is that it is able to have some influence over debates in which health must participate but in which it has traditionally been ignored.

The LHC "model"

If we were to write a description of the London Health Commission, to make it transferable to other regions or cities, what would be its chief characteristics? The LHC is not simply an issue network but a *semi-formalised issue network*. It is an intentional effort to create a form of sustainable network governance. The LHC, in other words, is a new development in policy networks, occasioned by the introduction of strategic government in London.

The LHC's structure as a semi-formalised issue network cannot be understood apart from the institutional context in which it exists – that of London under the GLA. The GLA is a unique form of government in the UK, in that its entire approach depends, for any effectiveness, on engagement with outside interests: stakeholders, officers of other tiers of government, private organisations. The Commission model is an efficient quasi-institutional response to this new form of governance. It engages stakeholders; it is engaged with, but not dependent on, political structures; and it has its own institutional presence, which enables it to set and pursue agendas and not merely follow those of other actors.

We have identified six[14] characteristics that differentiate the LHC from the *ad hoc* partnerships and established local networks that characterise local and regional joint working. These are:

- Stable core participants with resources
- An underlying network of known individuals
- A measure of autonomy from politics
- A measure of political support
- Staff
- An identity

Stable core participants with resources

The LHC was created and sustained by a small number of major organisations. It does not merely serve their 'interests': its membership is wider, mixing public and private actors. It is not a lobbyist in any familiar sense: its task is as much working with its own members to change behaviour as working with politicians to change policy. It could not thrive without them in the

[14].During the time of our research, there was substantial debate about whether to legally constitute the LHC as a formal, registered organization. At present it is semi-formal: it looks like an ordinary formal organization, with a logo, office space, coherent staff, and several years of history, but it is very small, made up entirely of staff on secondment or limited contracts, and it has no corporate legal personality of its own. Our analysis of its key characteristics suggest that this lack of legal personality has very little impact on its ability (or inability) to create change– none of these characteristics would necessarily be changed much by making it independent. If, for example, the Kings Fund, Government Office (regional public health team), or GLA were to decide it was not valuable and cease to support it, the impact of that would outweigh any change in its legal status. In fact, a change in the individuals at the core of the Commission would have more influence.

form it takes, since they pay for it and staff the core steering group. They also give it a sense of importance (because they are all important) and permanence.

The UK is “full of partnerships that last as long as the grant application they came together to write” according to one interviewee in local government. The relative permanence and resources of the founding organisations means the LHC can do some medium-term planning in security. However, because a coalition of these organisations sustains the LHC, it is not seen as the creature of any one.

A*n underlying network of known individuals:*

It should be clear from the short history and description of the LHC that it is in many ways an extension and formalization of pre-existing networks based on specific individuals with a given worldview. This should be no surprise. If there is anything consistent about public health working at the local and regional level in the UK, it is the importance of personal trust-based networks. London, in common with other areas of the UK (Wales, the North West of England, Greater Glasgow), has had a relatively stable group of local actors for many years who exchange information and act together.

Overcoming problems of organisational integration - of establishing enough trust to deviate from organisational mandates and accountabilities – takes trust in other members of the network (Behn 2001). It is this trust, formed in a stable issue network that was fundamental in forming the LHC into the ‘commission model’. But it goes beyond ordinary organisations- in the same way other partnerships could and have done- by being public enough, and coherent enough over time, to be joinable. It pools their credibility and is a formal vehicle for adding credible newcomers, whether from neighbourhood groups or big organisations.

A *measure of autonomy from politics*

London has a London-wide, democratically elected body, the GLA, a Mayor, 32 boroughs and the City of London, all of which are involved in a range of health activities. What value can the LHC add to this range of political actors? The answer is that being one step removed from all these political actors allows the LHC to maintain a more technocratic profile and to be a better “policy broker”. One effect of policy networks is that they tend to devolve policy knowledge and solutions from elected politicians to advocates and experts. Policy can be depoliticised and presented as the result of expert advice. Governments may find it hard to build or lead partnerships because politicians operate in ways that can be irritating or dangerous to other groups; the LHC can bring in a range of actors because it is not dominated by elected politicians. It offers the GLA and others a credible health policy (which the GLA is required to have) without much cost.

A *measure of political support*

At the same time, the LHC has the support of important London politicians, above all the Mayor,

who needs to carry out his responsibility for health[15]. It has representation from the boroughs (in the form of the Association of London Government representative), and from Government Office for London, which gives the LHC access and influence. These 'big beasts' benefit from a forum which can provide them with access to expertise and to stakeholder opinion.

Staff

The LHC at the time of writing had a secondee from the Health Development Agency (via the public health team in the Government Office), a staffer paid for by the Kings Fund to work on London Works for Better Health, and two administrators (one temporary), supported by the GLA and DH. Having a staff team is important both for simply getting things done and for establishing the independent, cross-boundary nature of the Commission. A representative of a particular organisation on the LHC will always have a comparatively hard time speaking "just" as a commissioner; most of the audience will also know what that person's "day job" is, and presume that those interests are at work as well. LHC staff do not have this problem.

Having reasonably stable staffing also allows the LHC to develop a consistent identity and set of connections. And it provides the energy and capacity to get things done: London Works for Better Health, for instance, simply could not happen without a dedicated staffer. The LHC was founded on the enthusiasm of individuals, but the existence of the staff team means it does not have to rely just on those individuals for continued momentum. A degree of formalisation of structure and process takes the pressure off those individuals and allows the network to remain functional if and when they move on to new challenges.

An identity

Finally, the LHC has a distinctive identity, with its own logo (based on the LOND/ON logo used by the Mayor and GLA) and series of events. The effects of such an identity are difficult to estimate, but they lend it a sense of fixity and continuity, as well as an impression of independence.

All of these characteristics are further reasons why the LHC is more than an issue network and has been able to become a more permanent fixture in the structure of governance, despite its paradoxically open membership structure. However, they all relate to structures and processes. They say nothing about what the LHC should do, or what it does do, and whether this is effective. This is the subject of the next chapter.

Benefits and drawbacks of the LHC model

The LHC may be a new form of governance, but in which areas is it most likely to succeed in influencing outcomes? And what types of activity should it focus on to achieve them? In which areas is it most likely to succeed in influencing outcomes? The activities of the LHC do not give us a clear answer to this question since they are extremely eclectic. That eclecticism is hardly

[15] On the GLA website, if one clicks on "What is the Mayor doing" the first thing to appear is a disclaimer of any role in the NHS- followed by a link to the LHC. www.london.gov.uk/mayor/health/index.jsp.

surprising. The LHC's flexibility - its fundamental opportunism - does not lead to particularly consistent agendas. Influencing organisations must take at least part of their cue from the opportunities to influence.

The activities of the LHC can be discussed from the perspective of its level of organization. The LHC is a *regional* organization. It operates on a level between Whitehall and the boroughs. It is closer to Whitehall than the boroughs, and it is closer to the boroughs than Whitehall. That means, we argue, that it engages in all directions- up, down, and sideways. Its greatest successes, and its greatest use of its semi-formal nature, appear to date to have been in representing upwards.

Representing upwards

The LHC has a claim to be the best representative of London in public health. It has the support of the key public health organisations, the key local governments, articulate policy analysts, and (more nebulously) groups focused on local upstream policies. The London SHAs and trust chief executives, without a NHS London region, band together to speak for health services and the NHS in London; the LHC can speak for broader public health. This reflects the fact that almost all of the levers of power needed to influence public health remain, in the last instance, with central government. Regional networking will often run up against legislation, programmes that cannot be modified without the consent of Whitehall, or lack of money. Influencing, and maintaining a good relationship with central government, are vital tools if those impediments are to be removed. Examples of its attempts to influence upwards include its response to the government's 2004 consultation on public health or its efforts to supply ideas for making the Olympics healthy.

Discussing sideways

London, thanks to the presence of the GLA, has a much stronger regional level than the rest of England. The GLA's creation prompted the creation of the LHC in its current form. The presence of the GLA also gave the LHC its first real role, as producer of HIAs. There is a confluence of interests: the GLA needs some sort of health policy (and shows no reluctance to have one) and the organisations in the LHC want to use any opportunity to influence policy. Structurally, "the GLA needs some way to develop its interest in health and the LHC does much of that" (interview data, LHC executive member).

A notable feature of our research was the lack of engagement revealed between the LHC and the London Assembly's Health Scrutiny Committee (merged since June 2004 into the Health and Public Services Committee). The LHC and the scrutiny secretariat share the same open-plan office and the (former) chair of the HSC, Elizabeth Howlett, sits on the LHC, but we found no evidence of actual joint working between the two. Interviewees agreed that LHC relationships are stronger with the 'Mayoral side' of the GLA staff.[16] One LHC respondent expressed surprise that the committee had never tried to scrutinise the LHC, though another stated that this would

[16] Reflecting the divide between the executive Mayor and the scrutinising Assembly, there is quite a sharp divide within the GLA between executive staff and the scrutiny secretariat.

be inappropriate.

A majority of core, repeat participants in the LHC appear to be from non-health organisations (based on the attendance lists from the various events held by the LHC during 2004) and very few are from the high-profile power centres of the London NHS. While a few senior staff from PCTs, hospital trusts, and GP practices do attend LHC events, they are in the minority. Indeed, in the course of this research we came across some PCT directors of public health who had no involvement from the LHC and were, indeed, unsure what it was. This suggests that in practice the LHC's priorities did appeal more to health than to non-health-services bodies.

Discussing downwards

It is not just Whitehall and Westminster that have problems and need to solve them. There are many problems that stay on the local level and many policymakers looking for solutions to local versions of national issues such as social exclusion or sexual health problems. LHC networks extend outward to key groups such as those interested in black and minority ethnic issues or children's issues. However, judging by the membership of those groups the LHC tends to reach organisations at the London-wide or sub-regional level rather than local activist groups.

Interviews suggested different viewpoints within the Commission as to its priorities. Two of our interviewees felt that the LHC needed to engage more strongly with local groups across London to take account of this. Others felt this was not its role. Our judgment is that local engagement is unlikely to be practicable for an organisation with three members of staff in a city of seven million people. This is also not really something that a cross-organisational network at the regional level is well-placed to do. The LHC might provide an entry point into wider networks for local organisations, but it is unlikely to have the resources to provide local actors themselves with substantial advice or information – simply because of the scale of London. There is also a concern in some interviews that trying to develop strong local connections would require a large number of networks nested inside each other, which might become hard to manage, or a damagingly large bureaucracy.

Some respondents had alternative suggestions about the best use, for them, of a strategic-level health body. One suggested that the LHC could provide an e-bulletin service giving examples of best practice in a number of different sectors, a benefit he received from membership of the Future Health Care Network. This respondent said that invitations to LHC events were sent out comparatively late, making attendance difficult. Two other respondents stated that they were unsure of what the remit of the LHC actually was: a problem shared by one executive member, who said "It wasn't tripping off my tongue, and I was involved in developing it". Another respondent suggested "I think [in many areas] we're on the cusp of doing something useful, rather than actually having achieved very much".

Lessons for the rest of the UK

The problems of integration in London after the demise of the GLC, and the new networks and opportunities they created, may appear unique, but were shared to some extent by all the former Metropolitan counties. Policy makers in Strathclyde, Greater Manchester, South Yorkshire and the West Midlands felt the need to reassign some regional services and replace others with networks. Indeed, such networks have grown up with greater or lesser success and permanence around the UK; even in the most poisonous local government politics there are overwhelming reasons to work together on some issues. Therefore, it may appear that the LHC has a lot to offer other areas, and that its key characteristics should be studied by them. We believe there are some reasons to be sceptical about this.

First, the LHC was lucky to have, from the outset, players with a local commitment and significant resources - not just money, but premises and a reputation for neutrality in intergovernmental relations. In particular, the King's Fund's ability to provide sufficient resources to enable London networks to start to look institutionalised, to provide information, and to run events that promoted London-wide thinking were vital in building some of the capacity that led to the establishment of the LHC in the first place. Some London universities also took an interest in the city's governance, including the Greater London Group at the LSE. Their contribution in resources was less, but they could both contribute to thinking about London as a meaningful shared space for policy and politics, and could start and sustain discussions about the politics and policies of London governments.

Secondly, London was lucky in getting the GLA. The GLA created a focus for London activity, a reference point for London networks, and a pool of resources for regional working. Its very existence means that organisations feel they need to monitor what it is doing and that there is a London arena in which they act. Its existence also offers the prospect of reducing the costs of interaction with the London regional institutions. Furthermore, London has a Mayor who can raise a standard other players might be willing and able to follow. Just as important, City Hall provides a base and resources: it has proved an ideal environment for the LHC to develop a degree of institutional permanence. Policy networks have come and gone routinely within UK politics, but one with three full-time staff and a range of funding commitments has a good chance of enduring through political and policy shifts.

Therefore, we suspect that in practice the GLA is crucial for the success of the commission model, because it provides a focus for policy making and space for the establishment of a permanent resource to do it. To influence public policy, both the institutional weight of the GLA *and* the networking of a range of interested organisations are needed. Note that the fact that the Mayor and London Assembly have democratic legitimacy does not appear to be a major issue. Interviewees hardly ever mentioned the Mayor as an important actor in the health field. His importance to the commission model appears to be symbolic, endorsing the activities of the LHC at regular intervals by dint of his importance to London governance. Interviews did not suggest that his electoral mandate provided the LHC with democratic legitimacy, or indeed that greater involvement on his part was desirable.

Other regions in England have been putting in place structures that slightly resemble anaemic forms of the Commission. For example, there is a North-East Forum for Health and Regeneration, which operates from the North-East Assembly (i.e. the voluntary, un-elected regional chamber – see Sandford 2002). It has a wide-ranging membership, including the Government office, the Regional Development Agency, Health Development Agency, Public Health Observatory, SHAs, PCTs and local government. It is chaired by the Health representative on the Assembly, and holds an annual Health Summit, at which a wide range of stakeholders discuss public health issues. In the South-East, the Regional Assembly runs a Healthy Region forum which meets three times per year. This is supplemented by an annual Health Summit, where presentations on matters of importance to health in the region are given.

These represent valiant efforts from fragmented regional authorities, but they are not on the same scale as the LHC. Though small amounts of office space, officer time and cash are available, there is far less of these things in the un-elected Regional Chambers. These have 30-50 staff members and total budgets of £2m per annum, overwhelmingly programme-related. By contrast, the GLA has some 675 staff and costs £73 million per annum, a sum raised through precepting powers on London's boroughs. It is unlikely that Regional Chambers could have the time or resources to animate regional networks to the same extent. They also lack access to political heavyweights. This suggests that the Commission model is limited to London, if and until elected assemblies are resurrected in the other regions of England following the North-East referendum defeat of 4 November 2004.

Conclusion

Networks are a fact of life in government. They are the way policymaking happens in almost any system. The London Health Commission has its roots in such networks - the governments developed by organisations and individuals interested in the wider determinants of health and population health in London. But the LHC is distinctive above and beyond those networks. It is an effort to consciously use and give a formal label to networks- to develop networks that will enable not just coherent governance but also to pursue complex policy ideas such as employment policy that contributes to health. It has been most successful in representing the broader public health of London to national government and in talking on behalf of London about health issues in debates that are primarily about other topics (such as the Olympics). It has also carved out a role with London policy makers, for example through its Health Impact Assessment of mayoral strategies and the Big Smoke debate. As a regional organization, it seems to work most often and most effectively on the regional level.

Like other regional actors in the UK, it has had more difficulty in influencing downward, although we have argued that it has the potential to have a downward impact, for example by identifying and connecting examples of good practice from around London. Its highest profile programme, London Works for Better Health, already collects examples of NHS staff recruitment and retention schemes that both expand local employment and help solve the nightmarish staffing difficulties of London's acute trusts.

The LHC is not just a policy network. Its *organizational* distinctiveness, and distinct advantages, are to do with the characteristics described above that distinguish it from the networks maintained by any good Regional Director of Public Health. They are: a stable core of organisations; good personal networks, at least at start; some autonomy from politics; some political support; staff; and an identity. These features, presumably, allow it to solve other people's problems in ways that also improve health. Their virtues largely amount to a high, consistent, status- a good position for an influencing organization. The combination of relative neutrality with a Greater London remit and political backing (in the small p sense, including actors like GOL) gives it an aura of importance. The combination of an identity, staff, consistent support and ancillary resources such as the website gives it an appearance of seriousness and, over time, a record of activity while the presence of staff means that it can target and promote a few ideas that would otherwise be ignored for lack of dedicated budget lines.

It is not surprising to find that other regions of the country, facing similar 'wicked problems', and the need to find solutions that can be applied in an era of fragmenting public services, are trying to establish their own networks along similar lines. However, our study of the LHC raises questions about how successful these are likely to be, outside the unique political, organisational and academic community of London. If the commission model is to work in other regions (or other cities), it needs the support of substantial funding. It also needs the political clout of an organization that is central to regional administration – this might be a Regional Chamber, or a regional development agency or Government Office for the Region.

A further effect of the LHC has been the expansion of London-oriented territorial policy networks (see Keating and Loughlin 2002). As the capital of the UK, London has always been a major location of national policy networks, but those relating to the territorial governance of London have been underdeveloped by comparison. Such a development might contribute to the embedding of the concept of Greater London as a region of England. The LHC indisputably has created something of a network beyond the initial group of a few activists. Its precarious status means that it has to keep doing something to attract the support of organisations that have more than enough other demands on their time and resources. It is a regional organization and that is where it almost seems, judging by its work, to have found its own added value. There is no other organization that can address the GLA, London policymakers, or Whitehall with such a base and such a claim to representation.[17] The LHC partially creates and partially represents a technically skilled, representative group of London health policy players. Its coherence and credibility- and ability to expand- mean that it can speak for London's health in a relatively consensual, technically competent way and propose solutions that ideas that will solve policymakers' problems as well as advancing ideas.

The commission model is therefore a representation of one of the ways in which the new 'strategic' government can work. Using minimal hard resources (cash and executive powers) and substantial amounts of goodwill and trust, it can establish small but effective interventions in policy areas which are neglected by more established parts of the public sector. Its importance should not be overestimated: it is neither a new form of government nor a replacement for executive power as we know it. But it is an important part of the story of the changing shape of the public sector in the UK.

[17] Its base might not be wide, but it is wider than any alternative that might claim to speak for those concerned with London's overall health and wellbeing. One need not be good to be better.

Bibliography

Peter Alcock, Gary Craig, Paul Lawless, Sarah Pearson, David Robinson, *Inclusive Regeneration: Local Authorities' corporate strategies for tackling disadvantage,* Sheffield Hallam University, 1998

Baumgartner, F. R. and B. D. Jones. 1993. *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.

Behn, Robert D. 2001. *Rethinking Democratic Accountability*. Washington, D. C.: Brookings.

Clews, Graham. 2004. Slow-burning strategies see London drag behind in smoking cessation. *Health Service Journal* 114 (5910):10-11.

Coote, Anna. 2004. *Prevention rather than cure: Making the case for choosing health*. London: Kings Fund.

Department of Health 2001. *Shifting the Balance of Power: Securing Delivery.* London: TSO

---. 2004. *Choosing Health*. London: TSO.

Fox, Daniel M. 2003. Population and the Law: The Changing Scope of Health Policy. *Journal of Law, Medicine and Ethics* 31:607-14.

Granovetter, Mark. 1973. The Strength of Weak Ties. *American Journal of Sociology* 78 (6):1360-1380.

Greer, S. L., and M. Sandford. 2003. *Fixing London*. London: The Constitution Unit.

Greer, Scott L. 2001. *The Real Regional Health Agenda: Networks, Soft Money, and the Wider Determinants of Health in the East Midlands*. London: The Constitution Unit.

———. 2004. *Territorial Politics and Health Policy: UK Health Politics in Comparative Perspective*. Manchester: Manchester University Press.

Greer, Scott L., and M. Sandford. 2001. *Regional Government and Public Health*. London: The Constitution Unit.

Hall, P. H. and Soskice, D. 2001. *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage.* Oxford: Oxford University Press.

Heclo H., "Issue Networks and the Executive Establishment", in King A., ed. *The New American Political System* (Washington DC, 1978)

Hunter, David J. 2003. *Public Health Policy*. Cambridge: Polity.

Keating, Michael, and John Loughlin. 2002. *Territorial Policy Communities and Devolution in the United Kingdom*. Vol. 2002/1. Florence: European University Institute EUI Working Papers.

Kingdon, John W. 1995. *Agendas, Alternatives, and Public Policies*. New York: HarperCollins.

LHC (London Health Commission) 2000. *A Short Guide to Health Impact Assessment: Informing Healthy Decisions.* London: London Health Commission. www.londonshealth.gov.uk.

---. 2001. *London Health Strategy.* London: London Health Commission. www.londonshealth.gov.uk

---. 2004. *Health in London: Review of the London Health Strategy High Level Indicators.* London: GLA. www.londonshealth.gov.uk

Marsh, David, *Comparing Policy Networks*, Open University Press, Philadelphia, 1998

Pierre, J, and Peters, B.G, *Governance, Politics and the State*, Macmillan, Basingstoke, 2000

Pimlott, Ben, and Rao, Nirmala, 2002. *Governing London*. Oxford: Oxford University Press.

Porter, Roy. 1994. *London: A Social History*. London: Penguin.

Research, Opinion Leader. 2003. Report on the qualitative evaluation of four health impact

assessments on draft Mayoral strategies for London. London: Mayor of London/ London Health Observatory/ London Health Commission.
Rhodes R, *Understanding Governance: policy networks, governance, reflexivity and accountability*, Open University Press, Buckingham, 1997
Rosenau, James N. and Ernst-Otto Czempiel. 1992. *Governance Without Government: Order and Change in World Politics*. Cambridge: Cambridge University Press.
Sandford, Mark, 2002. *Inclusiveness of Regional Chambers*, Constitution Unit, London, 2002
Sandford, Mark. 2004. The Governance of London: Strategic Governance and Policy Divergence. In *Has Devolution Made a Difference? The State of the Nations 2004*, edited by A. Trench. Exeter: Imprint.
Strauss, Anselm. 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* London: Sage.
Sturm, Roland. forthcoming. The Adventure of Divergence: Political Origins of Policy Divergence. In *Territory, Justice, and Democracy*, edited by S. L. Greer. Basingstoke: Palgrave Macmillan.
Subirats, Joan. forthcoming. Governance in Multi-level politics: Is there a Spanish way? In *Territory, Justice, and Democracy*, edited by S. L. Greer. Basingstoke: Palgrave Macmillan.
Travers, Tony. 2004. *The Politics of London: Governing an Ungovernable City*. Basingstoke: Palgrave Macmillan.
Wood, Robert C. 1961. *1400 Governments*. Cambridge, MA: Harvard University Press.
Yin, R. K. 2002. *Case Study Research: Design and Methods*. 3rd edition. London: Sage.

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Appendix 1: London's health situation in the UK

London Borough (+City)	**SMR**	**Local authority**	**SMR**
Camden	91	Newcastle-upon-Tyne	110
City of London	60	Manchester	127
Hammersmith and Fulham	95	Liverpool	126
Kensington and Chelsea	80	Sedgefield	121
Wandsworth	97	Middlesbrough	103
Westminster	71	Derbyshire Dales	90
Hackney	102	Burnley	117
Haringey	94	Leeds	98
Islington	100	Doncaster	111
Lambeth	96	Nottingham	107
Lewisham	108	Rutland	81
Newham	116	Norwich	88
Southwark	100	Birmingham	105
Tower Hamlets	106	Wolverhampton	109
Barking and Dagenham	114	City of Bristol	85
Bexley	93	East Dorset	75
Enfield	95	Merthyr Tydfil	125
Greenwich	103	Blaenau Gwent	115
Havering	97	Cardiff	100
Redbridge	89	Swansea	98
Waltham Forest	106	Glasgow City	144
Bromley	88	Scottish Borders	99
Croydon	96	West Lothian	136
Kingston upon Thames	93	Falkirk	123
Merton	93	Belfast	104
Sutton	95	Derry	111
Barnet	86	Cookstown	85
Brent	95	**UK**	100
Ealing	97	England	98
Harrow	86	Northern Ireland	100
Hillingdon	90	Scotland	118
Hounslow	95	Wales	104
Richmond-upon-Thames	79	London	95

Source: *Regional Trends* 36 (2001)

Appendix 2 : Chronology of Events 1999 – 2004

Date	London Health Commission	London political events
2000 March	Launch of London Health Strategy	
4 May		Ken Livingstone elected as Mayor of London
12 October	Formal launch of LHC by Mayor and first formal meeting	
10 October		Robert Kiley appointed Transport Commissioner by Ken Livingstone
14 November	Transport Strategy HIA workshop	
2001 2 February	Econ Dev Strategy HIA workshop	
Early 2001	Formation of Greater London Alcohol and Drug Alliance (GLADA)	
12 March	Air Quality Strategy HIA workshop Biodiversity	
5 April	Presentation of HIAs to Environment Committee	
6 June		UK General Election
30 July		Mayor and Transport Commissioner lose first court case against UK Government over PPP for London Underground
10 October	Waste Strategy HIA workshop	
2002 6 June	Energy Strategy HIA workshop	
21 June		Launch of Draft London Plan (Sustainable Development Strategy)
26 July		Mayor and Transport Commissioner withdraw second court case opposing Underground PPP against Government
4 September	London Plan HIA workshop	
18 September	Ambient Noise Strategy HIA workshop	
6 November		Nicky Gavron selected as Labour Mayoral candidate for 2004
14 November	2nd anniversary conference focusing on health	

	inequalities	
30 December		First contracts signed for London Underground PPP
2003 18 January	Trevor Phillips also relinquishes LHC role	Trevor Phillips, first chair of London Assembly, resigns to become head of the Commission for Racial Equality
5 February		Mayor agrees terms of transfer of London Underground with UK Government
17 February	Culture Strategy HIA workshop	Congestion charging introduced
12 March	Submission of Culture Strategy HIA	
15 May		Government agrees to back a London bid for the 2012 Olympics
18 July	Children & Young People strategy HIA seminar	
2004 6 January		Ken Livingstone rejoins the Labour Party
February	Scoping event for "London Works for Better Health"	
29 April	Crack cocaine strategy launched with GLADA	
10 June		Ken Livingstone re-elected as mayor

The New LHC Executive, established autumn 2003:

Dr Sue Atkinson	Regional Public Health Group
Mark Brangwyn	Association of London Government
Anna Coote	King's Fund
Helen Davies	Greater London Authority
Len Duvall	Greater London Authority (Labour Assembly Member)
Gail Findlay	London Health Commission
Judith Hunt	London Health Observatory
Marion Kerr	Government Office for London
Melba Wilson	PCT chair

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