When is subnational, supra-local tobacco control 'just right'? A qualitative study in England

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ABSTRACT

Introduction

Subnational, supra-local (or “regional”) approaches to tobacco control are often central federal nation tobacco control and can be superfluous for very small nations. However, their relevance to countries with weak intermediate tiers of governance are less clear. This study explores expert and policymaker perceptions on the function, form, footprint and funding of regional tobacco control in England.

Methods

One-to-one semi-structured interviews (n=16) and four focus groups (n=26) exploring knowledge and perceptions of the past, present and future of regional tobacco control in England were conducted with public health leaders, clinicians, tobacco control practitioners, civil servants and politicians. Interviews were audio-recorded, transcribed verbatim and analysed thematically.

Results

Participants reported several key functions for regional tobacco control, including illicit tobacco control, media campaigns, advocacy, policy development and network facilitation for local actors. A small minority of participants reported little role for regional tobacco control. Broader perceived features of effective regional tobacco control included subject expertise, strong regional ties, systems leadership, and a distinctive programme of work. Views varied on whether regional programmes should be developed nationally or locally, and their optimal footprint. Participants

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generally agreed stable funding was a prerequisite for success, although there was lesser agreement on funding sources.

Conclusions

Pooling resources at the regional level in countries with weak intermediate tiers of governance may increase reach, cost-effectiveness and impact of campaigns, policy interventions and advocacy, whilst retaining the ability to tailor approaches to regional populations.

IMPLICATIONS

There are likely to be greater funding and governance challenges associated with introducing or strengthening regional tobacco control in countries with weak intermediate tiers of governance.

Despite this, evidence from England shows it is possible to develop regional tobacco control approaches reported as effective by key stakeholders. Possible benefits of regional approaches in this context include cost-effective delivery of illicit tobacco control, media campaigns, advocacy, research, policy development, and co-ordinated support for local action on tobacco.

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INTRODUCTION

The subnational, supra-local level (known variously as states, regions and provinces) has been the default footprint for large-scale tobacco control activity in many countries with federal governance structures. For example, in Argentina, the province of Santa Fe was the first in South America to enact smoke-free laws,[1] subsequently implemented in regions of Brazil[2] and Mexico.[3] The Centers for Disease Control and Prevention's State Tobacco Activities Tracking and Evaluation System (STATE) highlights the US state role in determining tobacco control laws, funding, policy, research and cessation services.[4]

For small nations with only one or two tiers of governance, an intermediate tier for tobacco control may be unnecessary. However, its relevance for countries such as England, described as having a "missing middle" of sub-national governance,[5] is less clear. England's heterogonous regional structure operates through diverse "devolution deals" to smaller subregions, in which some, but not all, partnerships of local authorities are delegated variable powers and funding.[6] In healthcare, there are seven management regions, but, in the future, subregional planning and delivery will take place through 42 Integrated Care Systems (ICSs), supralocal partnerships of health and care organisations.[7]

Relating to tobacco, the arms-length national body Public Health England (PHE) has provided advice to Government on tobacco policy, carried out evidence reviews and run communications campaigns, and provide support at regional level. On 1 October 2021 it was split into separate organisations. Overall responsibility for national and

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regional tobacco control moved to the Office for Health Improvement and Disparities, which is fully integrated with the government health ministry. [15]

Advocates of regional tobacco control (RTC) approaches in England argue they bridge national and local organisations and reduce duplication, achieve economies of scale, tackle under-prioritisation of tobacco issues and enhance population reach.[8,9] Fresh, a longstanding RTC office in England set up in 2005 in the North East of England, now funded by local authorities and hosted by a local healthcare organisation, has been described as an exemplar for RTC in England. [10,11,12] However, regional delivery across England is sparse and several other semi-autonomous programmes of work have ceased or contracted in scope.[13]

Here we use the term regional tobacco control to mean co-ordinated tobacco control action taken at the sub-national, supra-local level. Our aim was to identify expert and policymaker perceptions on the function, footprint and funding of RTC in England. The findings have relevance for countries with similar intermediate governance structures.

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METHODS

Design

A qualitative study was conducted using a mixture of semi-structured one-to-one interviews and focus groups. The study was underpinned by a constructionist research paradigm.[14] The research was approved by the University of Nottingham's Faculty of Medicine and Health Sciences Research Ethics Committee in June 2021. The COREQ checklist for qualitative research was used in design and reporting. [15]

Participant recruitment and sampling

Stakeholders representing public health leadership, tobacco control practitioners, national civil servants, clinicians and politicians were purposively identified and approached by the authors. Individuals from each group were purposively sampled based on their expertise or influence in tobacco control.[16,17] Between July and September 2021, potential interviewees and focus group participants were individually approached via e-mails sent by DA, HC and ND. Those interested in participating were asked to contact the lead researcher (ND), who provided a detailed information sheet and online consent form and answered questions. ND arranged appointments for one-to-one semi-structured interviews. Focus groups were organised for roles where numerous interviewees were available at once (local politicians, local tobacco control, regional tobacco control).

Interview guide and procedure

A semi-structured interview/focus group guide was developed by the research team, in collaboration with ASH. The guide began with a brief introduction and summary of

the purpose of the interview or focus group. Data management, confidentiality and consent was reaffirmed. Participants were reminded that they were free to withdraw at any point. No incentive was provided.

The interview schedule (supplementary material 1) was developed and updated after the first two interviews. Topics explored past and current perceptions of regional tobacco control in England, and views on the future focus of regional tobacco control with respect to structures, funding, evaluation, and links with other programmes. Single interviews were recorded via video call on MS Teams with a median duration of 25 minutes (IQR 23-33). Online focus groups were conducted similarly with a median duration of 73 minutes (IQR 52 – 83). All were conducted between July and September 2021 by a trained interviewer (ND).

Analysis

Interviews and focus groups were transcribed verbatim by a professional transcription service. ND verified transcripts and anonymised identifying information. Data were analysed using thematic analysis.[18] Each transcript was read several times and 113 initial codes generated using NVivo 12.[19] Five transcripts in total were double-coded by MB and LP to triangulate findings and assess saturation.[20] Latent level analysis of findings led to merging of initial descriptive codes into broader themes and subthemes, which were reviewed and discussed between the research team. Findings were double-checked with some participants.[21]

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RESULTS

Participant characteristics from interviews (n=16) and four focus groups (n=26) are presented in Table 1.

Three main themes, each with associated sub-themes, are presented in Table 2. Quotes have been provided to illustrate both common and less typical perspectives.

Theme 1: Key functions of RTC

Participants discussed key TC activities they perceived should involve regional working, and activities perceived to be better delivered locally or nationally.

Illicit tobacco

There was strong agreement that tackling illicit tobacco was appropriate at supra-local footprint, given the large yet geographically specific nature of activity. Many participants reported local enforcement lacked resources, resulting in ad-hoc supply-side tactics. Participants reported regions could take broader approaches to reducing demand and supply, such as interventions that highlight harms of illicit tobacco to communities, but barriers to regional work included a lack of co-ordination and resources.

"Criminals don't stop at local authority borders, they certainly don't care about local authority borders, so if we're tackling criminals you have to tackle at that bigger footprint." (regional regulatory services)

Advocating for national action

Many participants described a role for RTC in advocating for action best taken nationally. Several cited how Fresh, an RTC office in the North East region,

stimulated local support to advocate for an English smoking ban that would not exempt “wet pubs” (pubs not serving food) from smoke-free legislation. Many participants believed that advocacy could be strengthened across other regions. A minority, noticeably some local politicians, felt advocacy should be left to those in a political role.

“There’s always been a really strong (regional) advocacy role…we need our public health people and our politicians to speak up, and our population to speak up. We need… smokers and non-smokers and ex-smokers.” (subregional TC lead)

Communications and campaigns

Some participants reported the regional level was an effective place to run communications campaigns to change attitudes, norms, and behaviour. Participants reported benefits of pooling local authority funds for bigger campaigns on footprints mirroring regional news outlets. Some local authority participants reported insufficient budget to run effective local campaigns.

“So mass media campaigns is probably the big one, that have a local and a regional feel.” (clinician)

A minority of participants believed communications campaigns were better at national or local level, reporting local campaigns enabled hyperlocal targeting of populations and national campaigns were most cost-effective and far-reaching.

“I just think in terms of cost-effectiveness I think (national) would be the most useful in terms of getting the message across. It also helps ensure that there’s a universal provision or a universal offer around campaigns.” (RTC lead)

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Policy and intervention development

Many participants discussed using regional tobacco control expertise to develop policies to be adopted across a region – "doing once, doing well". Examples given included joint position statements on electronic cigarettes, smoke-free hospital policies and training materials for hospital-based smoking cessation services.

Conversely, participants raised the risk of regions creating a culture of *"death by update"* (local authority participant*)* where regions organise meetings for local participants to share best practice and updates, but have no practical role overseeing policy development and delivery. A small number of participants did not feel regions should spend time on policymaking that could be done locally or nationally, as it introduced bureaucracy and opportunity cost.

"Well, a local authority doesn't need to speak to anybody else in a region to introduce a smoke-free policy, neither does any NHS organisation." (local director of public health)

Facilitating and developing local approaches

Participants discussed the benefits and drawbacks to regional involvement in smoking cessation services, which are usually commissioned locally, and local tobacco control. Some participants were concerned about a narrow regional focus on smoking cessation services.

"The other thing to note I think about the regional element is that for [place 4] it mainly seems to be focused on smoking cessation and not really the wider tobacco control agenda." (RTC lead)

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Some participants advised against regional teams taking on the role of performance management in scrutinising delivery of local services, citing negative impacts on relationships between regional and local teams.

"The bit that they didn't like previously through that network was the degree of scrutiny and stuff around performance that came very strongly from the NHS kind of leadership of that." (RTC lead)

Some participants advocated for a greater role for regions in a supportive "performance development" function gathering, analysing and disseminating data on service delivery and wider tobacco control from local areas. One participant described this tension as *"a bit of a fine line between data collection evaluation and performance monitoring".* (local director of public health)

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Theme 2: Wider features of effective RTC

Expertise in tobacco control

Participants generally agreed regional teams should possess up-to-date expertise on tobacco control. Local stakeholders who reported trusting and valuing regional teams discussed their extensive expertise in tobacco control and stability in post.

"(Name's) always been the linchpin of that and has done so exceptionally ably over many, many, many years. (Name's) the go-to… on all things tobacco control for the region." (local director of public health)

Some participants reported that when regional teams possess only generic skillsets, local partners could feel like they are working with people who only *"tell you what you already know"* (local director of public health) at the cost of spending time engaging with a regional office.

Some participants described an optimal RTC workforce. This included those with project management skills, linked to the view that RTC should directly deliver programmes. Those who identified multimedia campaigns as an important RTC function made the case for communications professionals. Data analysis and evaluation skills were discussed, with some reporting these skills could be drawn upon from external teams when needed.

"You need communications and PR expertise to create noise and to have those skills … you'll probably need a sort of data skill somehow to understand the data and present that data back to local areas". (regional tobacco control)

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Many participants felt RTC requires leadership who care deeply about the impact of tobacco, which drives leaders to influence others by *"a sense of…social justice in terms of the impact that tobacco has on families and communities"* (subregional lead). This was linked to a view that effective regional tobacco control was a clear, well-evidenced method of reducing health inequalities.

Relationships with local and national partners

Participants reflected that RTC teams should build strong relationships with public health teams, local authorities, politicians, health leaders and national organisational teams. RTC teams are likely to be small, participants reported, so the ability to bring together a coalition of wider partners with greater collective influence around a shared vision for tobacco control would result in better outcomes.

"The office approach has been able to address (wider networks) better... I remember [name] and I speaking to the Clinical Director of the Maternity Network who at the time didn't really appreciate how effective and cost-effective interventions for smoking cessation were in pregnancy." (local director of public health)

Distinctive programme of work

Many participants reported that RTC programmes should make links with other strategies and programmes, like clinical priorities such as cancer and respiratory disease. There was less support for links with other public health priorities; some participants felt this could lead to a loss of focus on tobacco control, although others felt would benefit from the attention given to risk factors such as diet. However, many

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participants reported benefits of developing an identity as an independent office or programme.

"*It needs to be at the forefront of the agenda and we need to link it with things like CVD, obesity and all the other things that we know it links to, but make sure it's the number one priority still."* (local TC lead)

Theme 3: Funding and governance of RTC

Footprint of RTC

Participants considered size of population, geographical size, strength of regional identity and stability of the geographical footprint when considering the optimum RTC footprint. A shared footprint with partner agencies was reported to be an important factor to enable consistency across a region. Areas with consistently coterminous regulatory authorities, directors of public health networks, healthcare catchment areas and media outlets, such as the North East, were described as having optimal conditions for regional work. Some participants identified frequently shifting geographical boundaries and organisational change as a barrier to regional working.

"So there's no ideal and the least bad for me would be [government region] because it's not broken... I wouldn't organise it around [healthcare] boundaries because they come, they go, they come, they go, and you can't keep up." (local director of public health)

Consistency of RTC

Many participants felt that their area or region would benefit from a stronger regional approach to tobacco control. Often citing the Fresh model in the North East and a subregional model in Greater Manchester as exemplars, these participants argued for a more consistent approach to regional tobacco control across the country.

"It is not uniform enough. So having worked in [government region 1] and [government region 2], we don't have equivalents and that's a real gap … how could we get some of that infrastructure capability back in place and how do we resource

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… and build it back in on a kind of more universal footprint, you know, universal coverage across the country really." (local director of public health)

A minority of participants felt regional tobacco approaches would not necessarily be welcomed in their area, because of desires to focus solely on the local population, and/or perceived lack of regional identity. Some local politicians in particular reported fears that local influence could be lost to regional work, although this was not a majority view.

"If you start building a whole structure around a region, we don't react well to that regional influence." (local politician)

Participant views on how regional programmes should be instigated were varied. On the one hand, some participants stated regional collaboration should be organically determined by local areas. On the other, participants felt that without clear national action to kickstart consistent regional working, the English status quo of generally weak RTC would persist.

"I think until we get… commitment from a high level to say yes… have a regional output, these are going to be the regional areas and this is how we're going to do it, I think we'll struggle potentially to get buy-in in those places that don't see the value, whereas others will continue to thrive." (RTC lead)

Funding RTC

Participants articulated a need for longer-term regional funding to build stability in networks and activity. Some described the difficulty of short-term contracts that

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initially galvanised action but ultimately led to malaise as local partners were left to deal with a sudden withdrawal of support and activity.

Views on how regional tobacco control should be funded were mixed. Many participants described how precarious financial situations for public health departments would continue to be a barrier to funding regional tobacco control work.

One idea proposed in different forms by multiple participants was a shared funding model, in which central government, local authorities and health service partners contribute funding to a regional approach. The benefits articulated included shared ownership and securing commitment from those who would otherwise struggle to contribute.

"It's important local authorities contribute. I think it's important (healthcare) contributes. I think it's important…national government contributes. I think that way you get better buy-in because everyone feels it's their money. Nothing like your own money to give you some focus and attention to a problem." (regional director of public health)

DISCUSSION

The reported views of a purposive sample of experts and policymakers show general support for a subnational, supra-local tier of tobacco control in England delivering specific functions such as tackling illicit tobacco, running multimedia campaigns, advocacy and leading strategy and policy development. A small minority opposed developing RTC in their area as being too large an opportunity cost. In many parts of England, this would substantially develop the role of the region in tobacco control, which often currently plays a limited facilitative role in hosting networks and sharing of best practice.

Limitations

These findings relate to the English context, although there is some transferability to nations with a similarly weak-to-middling regional tier of government. The purposive sampling frame used captured a wide range of participants from all regions and there was a high acceptance rate, although it is possible the views of participants differ from those who declined to participate. The lead interviewer was a male public health registrar, which may have affected responses given a shared professional background with some interviewees.

Comparison with existing literature

Existing studies have shown that regional approaches in England can be effective in tackling illicit tobacco [22] [23], developing regional interventions like maternal smoking pathways [22,23] campaigns for driving quit attempts,[24] campaigns changing attitudes to electronic cigarettes, [25] in generating public engagement with tobacco control issues [26] and in galvanising local advocacy on matters of national tobacco

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control policy. [12] Stronger international evidence exists of subnational impact of campaigns on smoking prevalence[27] and in introducing major new tobacco control policies such as smoke-free legislation.[1,2,28]

Our findings show experts and policymakers generally believe that there should be a stronger role for RTC in regions which traditionally have had lesser involvement in tobacco control delivery.

Those interviewed often reported that regional approaches offered a cost-effective approach to tobacco control, as has been shown in an economic evaluation of RTC in England.[29] Importantly, we found that emphasis on cost-effectiveness and reach should be combined with an approach that retains the advantages of personal relationships, readily available expertise and strategies tailored to regional populations, otherwise regional advantages over national programmes are lost. This supports and expands upon the findings of an ethnographic study of one particular regional office in England, where staff were described as “sparkplugs”, “visionaries” and “movement builders”. [12]

CONCLUSION

Whilst most participants broadly agreed on basic features and function of effective RTC, views were mixed on proposed funding and its form in the context of transformation of health governance. There were opposing views on whether RTC should be mandated nationally or developed by coming together of local areas; however, there was general agreement that a convening role was needed to drive regional work forward. The English experience suggests that national exhortation and local will alone is not enough to overcome the governance barriers to setting up

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RTC approaches. The 2011 national Tobacco Control Plan encouraged regional working [30], yet its publication was followed by a decrease in the number of regional tobacco programmes. Existing independent regional programmes also have their roots in regional offices set up by the national Department of Health. [13]

Participants also largely agreed that funding concerns are substantial barriers to local authorities and health services supporting regional approaches. One way of overcoming structural and funding barriers in countries with weak intermediate tiers of governance may be for the responsible national department to set out a clear direction for RTC, providing funding over the long-term duration of a national tobacco control plan. New or existing national tobacco taxes and levies could be potential funding sources. Conditions could include partial contribution from local authorities and/or healthcare systems collaborating on a supra-local basis. Each RTC footprint would be determined in collaboration between local areas and national government to ensure it meets existing local governance arrangements and partnerships. This could help ensure that regional programmes complement national and local tobacco control functions.

The degree to which tobacco control takes place at the subnational level will be strongly dependent on the governance structures of individual nations. We found perceived funding, governance and stakeholder management challenges associated with introducing or strengthening RTC in England, and approaches to overcome these will need to be context specific. Despite this challenge, nations with weaker regional approaches should consider the benefits of pooling resources regionally for delivery of illicit tobacco control, media campaigns, advocacy, policy implementation

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and supporting improvement and learning for local tobacco control and service delivery.

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Table 1: Participant characteristics

Characteristic	Number of interviewees
Gender	
Female	20
Male	22
Role	
Clinician	1
Health service leader	1
Local director of public health	6
Local tobacco control	7
National public health leader	1
Local politician with responsibility for public health	7
Regional director of public health	3
Regional regulatory services	1
Regional tobacco control	8
Regional tobacco dependence treatment lead	5
Subregional tobacco control	2
Region	
National	1
East Midlands	3
East of England	4
London	4
North East	5
North West	6
South East	3
South West	3
West Midlands	2
Yorkshire and the Humber	5

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Table 2: Themes and sub-themes

Themes	Sub-themes
1. Key functions of RTC	Illicit tobacco
	Advocating for national action
	Communications and campaigns
	Policy and intervention development
	Facilitating and developing local approaches
2. Wider features of effective RTC	Expertise in tobacco control
	Relationships with local and national partners
	Distinctive programme of work
3. Funding and governance of RTC	Footprint of RTC
	Consistency of RTC
	Initiating and developing RTC
	Funding RCT

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