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“…within a stone’s throw of prosperous, money-making Liverpool – of clubs, cafés, banks, commercial places; the Reform Club, the Conservative Club, places of wealth and ambition…one could imagine no darker face of squalor, no deeper fringe of suffering, of helpless, hopeless poverty, so near to hope, comfort and activity…”

Liverpool Daily Post report on Scotland Road, 1855
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Chair’s Foreword
Susan Woodward OBE

Liverpool, my home city, is a City synonymous with change.

The ebb and flow of a river-City whose port has both welcomed and waved goodbye to so many; a City of changing fortunes – from its prominence in the Empire, to four lads who shook the world, to hard times and social unrest, to a European cultural capital; and perhaps most famously, the changing dynamics of its iconic and spectacular skyline.

In the few short months since the Commission published its Interim Report, we have seen a dramatic change in the economic and political landscape, a change which has seen the whole nation thrown into a period of increasing economic uncertainty.

As we present this, our Final Report, we do so in the knowledge that for so many of our local citizens, just keeping on top of things has become a daily struggle, with already stretched budgets facing peak petrol prices, rising fuel bills, mortgage arrears and the threat of repossessions.

Once again, as we look at ways in which we might somehow contribute to improving the quality of people’s lives across the City-region, I find myself reminded of the Commission’s adopted mantra: Doing nothing is not an option.

This report marks the culmination of eighteen months hard work from Commissioners, our research partners and scores of witnesses, who have generously given up their valuable time and have poured incredible energy, commitment and enthusiasm into the project. Sincere thanks for all of your efforts.

During our investigations, the Commission has faced some incredibly tough questions and has heard sometimes harrowing, often controversial, and always no-holds-barred evidence. Luckily, our involvement in the project has not only allowed us to understand that there are certainly problems, but also to recognise that there are solutions – that behind the bleak headlines, there are beacons of hope.

At the outset, Commissioners promised each other that we would be radical, honest and bold in our thinking. In making our recommendations, we have also tried to keep some sense of realism. We know that our proposals are achievable; we know that they can be delivered, and we know that we can – and do – believe in them.

The Commission recognises that many of the answers might lie in self-help, and we have committed ourselves to making positive and enabling recommendations – not simply saying ‘Government should do this’, but looking at what we as a City-region can do to help ourselves.

We hope that we have met all of these challenges, but at the same time recognise that this is very much work-in-progress.

We have sometimes needed to rein in our own passion and enthusiasm for the project; to recognise that it would be a simply impossible task to ‘fix everything’ in eighteen months.

In presenting the results of our work to partners and stakeholders, who have already shown such dedication and commitment to making a difference, we hope that they can go forward to build on what we have achieved.

Liverpool’s successful bid to become European Capital of Culture in 2008 showed just how much can be achieved by working together in true partnership. In winning that bid, I am proud to say that Liverpool and its City-region not only found a new confidence, but also found the
strength to take an honest look at itself and face its toughest challenges head-on.

As we draw towards the end of Liverpool’s Capital of Culture year, we hope that partners and stakeholders will come together once again in the same spirit to support our call for a celebration of 2010 as our Year of Wellbeing: a definitive and public statement of the City-region’s commitment to health, to wealth and to wellness.

Officially, the Commission’s work stops here, but I am confident that in our different walks of life, Commissioners, contributors and everybody who has been part of the ‘Health is Wealth’ project will continue to promote its findings and foster a widespread awareness and understanding of its work.

Liverpool is a City of change.

Believe that we can change things for the better.

Susan Woodward OBE
About the Commission

Originally conceived within the Liverpool City-region Development Plan, the Commission has been operational since March 2007, and has been charged with identifying those factors contributing to the divergence of the City-region’s public health against its economic growth.

There are four core questions against which the Commission has been asked to make recommendations. They are:

• What more can be done to achieve measurably greater aspiration and commitment to improving health and wellbeing amongst local people, communities and businesses?

• How can the region reduce the current health inequalities that exist across the region and better exploit the diverse assets and talents that lie underused as a result?

• How can the region strengthen its presence as an internationally renowned centre for health science and better exploit those assets for the benefit of local people?

• What more can be done to maximise the economic benefit of the health services sector to the region through, for example, procurement, recruitment and enlightened corporate social responsibility?

Building on the City-region’s acknowledged strength in health, sports, science and research and development, the Commission’s aim is to address these questions through examine the specific links between health and productivity, identifying knowledge gaps, seeking innovative solutions and encouraging a more focused and collaborative alignment between the business, research and public health agendas.
Within these terms of reference, the Commission has sought to:

- Identify key areas in which intervention can achieve the most sustainable impact
- Arrive at evidence-based recommendations that are both innovative and deliverable
- Focus on facilitating positive behavioural change and enablement

Over the past eighteen months, the Commission has met monthly to hear from key witnesses on a range of topics, supported by research and analysis from colleagues at the Northwest Public Health Observatory and the University of Liverpool’s IMPACT team. It has also commissioned its own research project – the ‘Street’ project – where residents of seven streets across the City-region were interviewed to gain an in-depth insight into people’s health and lifestyle.

The Commission published its interim conclusions as a report for discussion in April 2008, and following a widespread consultation process, has worked closely with partners and stakeholders over the last few months in enhancing and refining those recommendations for inclusion within this, its final report.
Commissioners

Commissioners have been drawn from diverse professional backgrounds, specialisms and interests with the aim of creating a broad-based body, committed to an inclusive and imaginative process of engagement and evidence gathering. They are:

Larry Neild
Journalist & Broadcaster

Robin Currie
CEO, Liverpool PSS and Senior Research Fellow in Health and Social Care, Liverpool Hope University

Ole Petersen CBE
Professor of Physiology, University of Liverpool

Claire Dove MBE
CEO of Blackburne House

Cynthia Pine CBE
Dean of Dentistry, University of Liverpool

Cllr Beatrice Fraenkel
Chair, RENEW and Cosmopolitan Housing
Sue Woodward OBE (Chair)

Evelyn Asante-Mensah OBE
Head of Equality & Diversity,
NWDA

Cllr Gideon Ben-Tovim
Chair, Liverpool PCT
(Liverpool City Councillor
until May 2008)

Dr Katy Gardner
GP, Marybone Health Centre

Bernard Hogan-Howe
Chief Constable,
Merseyside Police

Anthony McGuirk
Chief Fire Officer, Merseyside
Fire & Rescue Service

Sheena Ramsey
CEO, Knowsley Metropolitan
Borough Council

Frances Street JP
Chair, Wirral PCT

Mark Turner
Head of Sustainability, Morgan
Professional Services
The City-region has a lot to boast about…

Its economy is one of the fastest growing in the UK, and has recently seen a number of high-profile projects to regenerate Liverpool’s City Centre including the £920m Grosvenor scheme and the flagship King’s Dock development.

The City-region boasts seven teaching hospitals, one of the largest Children’s hospitals in Europe, and nationally and internationally renowned centres for ophthalmology, breast and lung cancer, cardiothoracic services, public health research, vaccine manufacturing and neuroscience.

The Liverpool School of Tropical Medicine was recently awarded £25.5 million from the Gates Foundation to aid Malaria research.
But, at the same time…

Life expectancy for residents of the Liverpool City-region is typically 3 years less than the England average, and 7 years less than some parts of the South-East.

People are almost a third more likely to die from cancer and more than twice as likely to die from chronic liver disease, than in England as a whole.

Incapacity Benefit levels are almost 75% higher than the British average, with 12% of the working age population claiming IB.¹

92% of the areas of North Liverpool are in amongst the 10% most deprived nationally, in terms of education, health, income, living standards, and crime.

The annual cost of ill-health (supporting IB and lost wage income) to the City-region’s economy is approximately £2 billion.

¹ PHO
Introduction

The Health is Wealth Commission has been established to investigate health-related and economic issues across the Liverpool City-region, to examine ways in which local productivity might be driven forward through improved health, and specifically to address the outwardly contradictory relationship between the City-region’s continued economic growth and its disproportionately poor public health status.

Its work builds on a long history of investigation into the co-relation between ‘health’ and ‘wealth’. Indeed, the effect of economic status on the health of the ‘labouring population’ formed the basis of Liverpool-born Dr. William Duncan’s arguments in his 1847 Report on Sanitation, which went on to influence Sir Edwin Chadwick’s celebrated report and, in turn, Government’s first foray into ‘public health’.

The Commission’s investigation comes, however, at a time when the relationship between the two concepts has become increasingly complex.

Historically, there has perhaps been a working assumption that the most effective way to improve health and ‘quality of life’ is through increased wealth and raised material living standards. In fact, although economic growth remains critically important for the very poorest countries in the world, evidence suggests that amongst the richer countries, there is no comparative tendency for health or social issues to be necessarily improved with increased affluence.2 In its report published just last month, the World Health Organisation (WHO)’s Commission on Social Determinants of Health states:

“…Increasingly the nature of the health problems rich and poor countries have to solve are converging. The development of a society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.”3

It is simply no longer enough to assume that economic growth and increased affluence will improve health, happiness or well-being.

Instead, there is a growing focus on and acknowledgement of the effects of inequality on health; of how relative deprivation and poverty within societies and of how differences in income within social structures – be they countries, cities or more local communities relate directly to a number of social measures including health, crime and educational achievement. The WHO report recognises that:

“…Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces…”4

Social inequalities and the individual’s perception of social status have been shown to have a profound effect on health and wellbeing; where greater inequality exists, so the individual’s perception of status within that hierarchy is affected. Increased income inequality has led to less social mobility and in many areas ‘residential segregation’,5 with less social and geographical mixing and low or no sense of community. The Commission

2  ‘The Impact of Inequality’, Professor Richard Wilkinson, 2005
4  As above
5  ‘The Impact of Inequality’, Professor Richard Wilkinson, 2005
recognises that much of this inequality cannot be addressed at a City-region level and must be tackled by central government. Its brief, however, was to focus specifically on actions and interventions that can be delivered at a local level, and it has therefore endeavoured to address these issues as far as possible within that brief.

The Commission’s work also takes place at a time when there is an increasingly global economic focus, and when global issues around the environment, climate change and sustainability are taking social and political precedence. The conservation of depleting resources sits squarely against the very ‘over-consumption’ which is acknowledged as contributing so much to the ‘higher end’ of the inequality gap. The changes which governments will need to make in response to these issues will undoubtedly have a profound impact worldwide, but the impact is likely to be significantly differential, and it is likely that those with the lowest incomes, least social capital or least material wealth will be worst hit. Already, the UK has experienced the effects of peak oil prices and figures released earlier this year by the consumer watchdog Energywatch show one in six UK households living in ‘fuel poverty’, spending over a tenth of total income on heating and utility bills. As might be expected, vulnerable groups have been the most exposed with figures from Age Concern estimating the current average annual fuel bill for 65 to 74-year-olds as £1000, a rise of 15% for a single pensioner. Liverpool has the highest rate in the country of people over 65 living without central heating (29%) and the Commission welcomes Liverpool PCT’s commitment to tackling the City’s problems with fuel poverty in its recently published three-year strategy, working in partnership with Liverpool City Council’s Housing team.

Throughout its investigations, the Commission has been keenly aware of the importance of education, both in terms of its relationship with inequality and deprivation, but also in terms of its critical role in personal and social development, of raising aspiration, encouraging social mobility and creating life opportunities. Approximately 1 in 3 children in the UK are currently living below the poverty line (where the household income is lower than 60% or less of the UK average, with adjustments for family size) and recent research from the Child Poverty Action Group show that by 3 years old, poorer children may be up to a year behind children from wealthier homes in terms of cognitive development and ‘school readiness’. This early inequality continues as evidenced by statistics released last month by the Department for Children, Schools and Families revealing that 45% of children eligible for free school meals failed to get a GCSE at grade C or better in 2006/07, compared to just 24% of pupils generally.

The Commission recognises that ‘education’ must go beyond literacy, skills and qualifications, and that through strengthening the City-region’s commitment to quality and equality in education, there is a real opportunity to influence the experience of every individual in terms of foundational upbringing, self-perception, cultural awareness and social understanding. It hopes that implementation of its recommendations as set out in this report can contribute to creating an environment in which this can happen, but within its limited timeframe has focussed primarily on skills and training development, encouraging social enterprise and improving links between the City-region’s academic institutions and the local community.

Despite its significant economic growth over recent years, substantial European investment, Liverpool’s status as this year’s European Capital of Culture and

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6 Energywatch, January 2008
7 Age Concern, August 2008
8 DCSF, August 2008
major physical developments such as Grosvenor’s ‘Liverpool One’ project, it is clear that not all of the City-region’s population are benefiting from its economic progress. A third of our population continue to live in the top 10 most deprived of the country, according to their placing in the 2007 Index of Multiple Deprivation, which also ranks Liverpool as the most deprived district in England. In its ‘Cities Outlook 2008’ report, the Centre for Cities describes Liverpool as a ‘city of contrasts’, highlighting its disproportionately high rate of benefit claimancy against its position as best annual earnings growth rate (up 5.6% since 2002), and ranking Liverpool as the 3rd most ‘unequal’ City in the country.

It is this contradiction in economic performance and health status on which the Health is Wealth project is predicated. During its investigations, it has been necessary for the Commission to keep firmly in mind how major projects in Liverpool City Centre might certainly make a significant contribution to the City-region’s economic wealth, employment and its growing retail and tourism industries, but always to consider the conflicting impact projects such as these might have on sub-urban centres across the City-region, and subsequently their potential to widen the inequality gap.

The Commission recognises that it would be an impossible task to have tackled all of these significant issues within its short lifetime, and based on the evidence and research presented to it, has therefore made recommendations within six specific themes as detailed in this report. It welcomes the commitment of its partners and stakeholders to progress these recommendations, and has assigned lead Commissioners and lead partner organisations to each theme.

The Commission gratefully acknowledges the input and support of all of its sponsors, partners, stakeholders and contributors, and hopes that its proposals will go forward to contribute toward a healthier and better skilled population, tackling the blight of deprivation and inequality, driving forward productivity and making the most of all that this great modern-day European City and its regional partners have to offer.

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9 NW Public Health Observatory
10 Centre for Cities ‘Cities Outlook 2008 report’, December 2007
Note on IMPACT

The Commission is confident that implementation of the recommendations it sets out within this report can and will make a significant and positive contribution towards achieving its objectives, but recognises that this point marks only the first step in delivery. In order to maximise impact and stimulate further complementary research and action, the Commission has worked closely with the University of Liverpool’s IMPACT team in undertaking a detailed assessment of its recommendations and in developing proposals to take specific recommendations within each theme forward.

Summaries of IMPACT’s assessment and proposals are included within each theme, and its full analysis is attached as an appendix to this report.
Alcohol, Smoking and Obesity

Every five minutes a new bar opens in the City Centre, and I really think the City Council has a responsibility to think about the health impacts of their policies which allow these sorts of places to open up.

Robin Ireland, Heart of Mersey

Interim Conclusions

Supporting and improving the health and well-being of the City-region’s residents, and enhancing future health prospects for its children, is central to the Health is Wealth initiative. The prevalence of preventable illness and mortality in the City-region – and by virtue of its preventability, the significance of contributory lifestyle factors such as alcohol, smoking, diet and physical activity – has been a cross-cutting theme throughout the Commission’s investigations.

Smoking prevalence in the City-region remains well above the national average, despite the success of Knowsley’s smoking cessation programme, which saw more people give up smoking last year than in any other PCT area in the country, despite Liverpool PCT’s remarkable efforts in reducing smoking prevalence in the City itself from 35% to 28% over the last 3 years, and despite the significant achievements of the ‘SmokeFree Liverpool’ campaign.

Evidence presented to the Commission also highlighted increasing levels of obesity within the City-region as a key issue, with research estimating the economic cost to Liverpool alone in terms of extra health services and lost work days as £23m. The ‘Taste for Health’ project found that nearly one in five of 10 and 11 year-olds in Liverpool can currently be classified as obese; and that 95% of the sample survey had a daily saturated fat intake above the medically recommended level.

By far and above the most critical area of concern pinpointed by evidence and research has been alcohol-misuse and its associated health and social impacts. The Commission’s launch last year coincided with the publication of a national profiling exercise which placed Liverpool as second in England for hazardous alcohol consumption levels, and earlier this year the NWPHO’s ‘Risky Drinking’ report calculated that around 30% of 15 and 16 year olds in the Northwest binge-drink at least weekly (drinking five or more drinks in each session). Data presented to the Commission by its colleagues at the Northwest Public Health Observatory showed that, on average, 16 months of life is lost for men due to alcohol misuse and almost a year for women, 85% above the England average. Over 900 people are dying each year in the City-region due to alcohol-related conditions, of which around 1 in 3 are directly attributable to alcohol, and 1 in 3 due to chronic liver disease. Our region’s hospitals deal with over 16,000 men and women admitted to hospital due to alcohol-related casuies, with half of those admitted directly due to the effects of alcohol every year.

Price, availability and promotion were identified as key drivers of consumption by a number of witnesses. As Dr Ruth Hussey, Northwest Regional Director of Public Health said in her evidence:

“...If it’s readily available and you can afford it there are no barriers to wanting to do it, to executing your choice... If you look at tobacco, I think you’ve got a case study in terms of how price in particular did work and did drive down consumption overall. It was the trigger that people said ‘right, I’m going to give up’…”

Building on this concept, the Commission largely focussed its thoughts on ways in which it might

11 “Risky Drinking in North West schoolchildren and its consequences”, NWPHO March 2008
influence or affect rates of alcohol consumption at a local level. The Commission was particularly interested to note the work by the Scottish Executive and the Scottish CMO in applying public health principles as part of Scotland’s licensing application process. The outcome of this initiative has led to the inclusion of a fifth licensing objective in “The Licensing (Scotland) Act 2005” – that of “protecting and improving public health”, and has also seen the formation of area-based Statutory Licensing Forums, whose function is to advise Licensing Boards on relevant health, crime and social implications within designated local areas.

In considering the Scottish model, the Commission understands that licensing laws in England and Wales are specific in not allowing ‘Public Health’ considerations. It was encouraged, however, on a local level by a call from the latest Liverpool City Council Overview and Scrutiny Committee for “…the development of joint strategies, including the use of the licensing powers of the Council, to curb excessive behaviour, reduce public costs and, above all, assist the improvement in levels of health of people in the City…”12, and nationally by a recommendation in the Government’s ‘Safe, Sensible, Social’ strategy for: “…A new programme that will help local partnerships and communities tackle alcohol-related crime and disorder – encouraging more and stronger local partnerships and industry participation…”13

Using these principles as a foundation, the Commission used its Interim Report to set out its proposal to introduce area-based Health Impact Assessment (HIA) processes into licensing applications. It proposed a two-level approach – firstly, working with its partners to establish area-based non-statutory Licensing Advisory Forums, and secondly lobbying for the introduction of more formal structures to enable the consideration of health impacts in planning and licensing policies.

Moving on

Following the publication of its interim conclusions, the Commission was pleased to find strong support for its Licensing Advisory Forums proposal in both consultation feedback and in its Alcohol, Smoking and Obesity (ASO) Syndicate Session. Colleagues at that session stressed that it would be important to build an alliance between consumers, brewers and trade representatives, supermarkets and other stockists and health organisations in order to develop an effective response to the problem. The Commission was also pleased to note a positive response from industry representatives to its call for more positive engagement and collaboration.

The Commission was alarmed to hear evidence in its ASO syndicate session around the growing ‘illegal tobacco’ trade, found to be prevalent in more deprived areas, and as part of which counterfeit cigarettes have been found to contain dangerously high levels of toxic substances including arsenic, rat poison, 60% more tar and up to 130% more carbon monoxide. The Commission welcomes and supports Liverpool PCT’s collaboration with HM Revenue and Customs and Trading Standards in establishing a dedicated Unit to tackle this problem.

Contributors to the session felt that the scale of the City-region’s struggle with obesity called for a much greater emphasis within the Commission’s thinking, and in particular that consideration should be given to the potential impacts of targeted promotion and increased availability of healthier foods, of exploiting links with the tourism industry and of taxing or legislating against the use of trans-fats, for example in fast food outlets. Group members echoed feedback around the Interim Report in highlighting the specific issue of public sector food procurement practices, and in particular the need for Local Authorities, PCTs and other public organisations to strengthen the message by employing healthier catering practices.
The Big Idea

The Commission recommends development of a ‘Health Improvement Plan’ for the City-region, supports the introduction of area-based non-statutory Licensing Advisory Forums, and proposes a ‘healthy food’ award and accreditation scheme.

The Commission will take its recommendation to establish area-based Licensing Advisory Forums to its partners at the PCTs, and to other local partners and stakeholders including City and Borough Councils, the Police, the Fire Service and industry representatives. It also proposes to add its voice in lobbying Government to adopt a more formal consideration of the implications to ‘Public Health’ within licensing legislation, so that local authorities are enabled – on an optional basis – to include a requirement for HIAs as part of their individual Statements of Licensing Policy.

The Commission is keenly aware that the City-region faces a growing problem with obesity levels, and is confident that a similar model of area-based advisory bodies could also be used in assessing planning applications for fast-food premises.

The Commission wishes to see the implementation of healthy food procurement in the public sector, and hopes that its proposals set out under the ‘Procurement’ theme will go some way toward achieving this.

The Commission strongly believes that steps should be taken to encourage ‘healthy’ practices at trade level and to empower consumers in making healthy choices. It recommends, therefore, that businesses that produce and prepare foods ‘healthily’, or who provide healthy food options for their employees, are rewarded and promoted. The Commission will take this proposal to its partners at The Mersey Partnership, whom it believes would be well placed to take this forward as part of its work with its tourism-industry members, perhaps under the auspices of its well established annual Tourism Awards, or as part of a new ‘kite mark’ scheme for good practice.

The relationship between all three issues – alcohol consumption, smoking and obesity – with economic inequality remains a particular concern to the Commission. The Commission strongly believes that all three must be targeted as priorities if future health prospects for the City-region are to improve.

The Commission has been pleased to note that there is already a huge amount of good work being undertaken to encourage individuals to pursue healthier lifestyles in general, such as the Liverpool ‘Health Trainers’ programme which provides personalised support and advice, and specifically in tackling the City-region’s obesity problem by colleagues at Heart of Mersey, by the Liverpool Active City partnership, which is encouraging a range of enhanced physical activity across the city, and by the work of the Healthy Schools programme across the City-region, amongst others.

The Commission has, however, also recognised three key characteristics which may have mitigated against sustained improvements. Firstly, some excellent work has been undertaken on a short-term project basis, but has then faded away because a particular initiative in a specific locality has come to an end. Secondly, that there has historically been a lack of co-ordination within and between different agencies running programmes that can impact on health and health-related behaviour. Thirdly, that evaluation of the effectiveness of programmes on changing health has not always been undertaken. These three areas could be remedied by developing a joint common approach and delivery plan across all agencies within the region.

The Commission believes that there are some stark and startling messages emerging from the evidence and feedback it has heard, to which the City-region must urgently respond. It therefore recommends that its partners at the City-region’s PCTs, the SHA and the Directors of Public Health develop a high profile City-region ‘Health Improvement Plan’, working in close partnership with local Councils, focussed on delivering a unified and targeted strategy against the increasingly negative health impacts of alcohol, smoking, poor diet and lack of physical activity across the City-region.
Recommendations

The Commission recommends that a co-ordinated ‘Health Improvement Plan’ for the City-region be developed, through which resources can be specifically focused on delivering and evaluating a unified and targeted strategy against the health impacts of alcohol, smoking, poor diet and lack of physical activity across the City-region.

The Commission recommends the introduction of area-based non-statutory Licensing Advisory Forums, designed to assess local health and social impacts of licence applications. The Commission advocates the introduction of more formal structures to enable the consideration of health impacts in planning and licensing policies and calls upon partners to raise this issue in their communications with Government.

The Commission believes that this model could potentially be rolled out to include planning applications for fast-food establishments.

The Commission recommends that businesses that produce and prepare foods ‘healthily’, or who provide healthy food options for their employees, are rewarded and promoted, perhaps through tourism-industry awards, or as part of a new ‘kite mark’ accreditation scheme.

**Lead Commissioners:** Robin Currie
Frances Street JP

**Lead Co-ordinating Partners:** Wirral Primary Care Trust
Wirral Metropolitan Borough Council
Extracts from the IMPACT Assessment – Licensing Advisory Forums

Alcohol consumption and harm is an extremely dynamic and complex area of considerable public health and societal relevance and concern at international, national and local levels.

Whist there is a welcome and growing coherence between evidence and policy, there is some lack of congruence between the most recently published evidence on alcohol-related harm and the policy arena at European and national levels, reflecting a lack of clarity around responsibility for alcohol policy. This seems principally to be around promoting as good practice interventions that are effective but resource intensive, or for which there is a less than robust evidence base, particularly at population level. The eventual overall costs of promulgating such an approach have yet to be estimated.

There is evidence of significant gaps in the evidence base concerning the effectiveness of interventions on health inequalities and vulnerable groups (including women and families) and the cost effectiveness of interventions for children and young people, disadvantaged and vulnerable groups.

There is consensus in the difficulty in estimating the economic burden of alcohol. This was clearly reinforced in both this HIA and in the Equality Impact Assessment undertaken simultaneously on the 2007 Alcohol Strategy, ‘Safe, Sensible, Social’, where social identity groups/equality target groups were identified as an appropriate level of analysis to properly differentiate between population subgroups. It was noted that the focus of the strategy was crime, health and cost, not health inequalities and promoting health.

In order to maximise the potential impacts on health of the Commission’s proposal, and particularly to increase the focus on reduction of health inequalities, delivery partners should consider the following recommendations:

- Establish systems to gather evidence from implementation, in order to strengthen the overall evidence-base for using HIA approaches in making planning applications for all licensed premises.

- Establish a means of benchmarking the evidence gathered and experience of implementation against policy advice and development from other sources, particularly Scotland (where the Licensing Act 2005 does have an objective to ‘protect and improve public health’ unlike in the English Licensing Act 2003)

- Lobby government for adoption of common bye laws, to harmonise as far as possible legislative policy across the Liverpool City-region; creating a more consistent “level playing field” for those making applications to the area-based licensing forums and assisting in uniform evaluation

- Continue the Commission’s advocacy (as set out in its Interim Report) for a consistent and common response across the City-region to the current Department of Health consultation, ‘Safe, Sensible, Social – consultation on further action’.
Wellbeing at Work

Workplace policy should move from just keeping people from harming themselves at work to something which actually uses the workplace to improve people's health.

Professor Mark Bellis, Centre for Public Health

Interim conclusions

The 'Health is Wealth' project is predicated on the belief that a flourishing and wealthy society depends on having a healthy population – and that a strong and dynamic economy is driven by a healthy and productive labour market. The Commission's task is to promote public policy that will have a beneficial effect on health and the economy, and thus health at work is an issue of considerable importance.

Earlier this year, the potential social and economic impacts of improved occupational and work-based health were reviewed in Dame Carol Black's national policy report 'Working for a Healthier Tomorrow'. The report states that approximately 175 million working dates were lost to illness in the UK in 2006, that an average of 3% of the workforce are off work sick at any one time, and that the annual cost of sickness absence and worklessness to the national economy is over £100 billion – greater than the current annual budget for the NHS.  

Evidence presented to the Commission from both Professor Cary Cooper and the front line experience of the Merseyside-based charitable agency Health@Work underscored the extent to which poor management and communication contributes to ill-health in the workplace. The Commission concluded that there was a need not only to give occupational health a much higher priority, but also for a cultural shift to promote the potential health benefits of work.

The Commission welcomed the revisions to Director's Duties through the Companies Act 2006 and a renewed focus on good management practice, training and positive development, and advocated more widespread dissemination of information to employers in the City-region about the potential returns from investments in employees' health. Commissioners acknowledged and applauded the pioneering and innovative work of Health@Work, particularly in enabling SMEs to develop and employ effective work-based health policies.

The Commission proposed to respond to the challenge set out by Dame Carol's report by pro-actively positioning the Liverpool City-region at the forefront of the work-related health agenda. In what Professor Cary Cooper called a "UK first", it outlined its recommendation to develop a ground-breaking and comprehensive 'Health at Work Charter' for the City-region, promoting health at work, flexible working arrangements, positive equality and diversity policies, environmental awareness and work-life balance.

The Commission committed itself to working closely with its key partners and stakeholders in developing the proposed Charter, examining current work-based health policies and practices, and establishing which elements of support or enablement partners felt were missing or needed strengthening, so that the Charter might make the most effective and positive impact.

14 "Working for a Healthier Tomorrow", Dame Carol Black 2008
Moving on

Following the publication of its Interim Report, the Commission sought advice and guidance from colleagues working in this area at its ‘Health at Work’ Task Group session (April 2008). Contributors to the session were broadly supportive of the concept of the Charter, but set out a number of challenges for the Commission to consider in its development, including:

- Developing the wording and focus of the Charter to avoid being overly bureaucratic
- Setting out clear, positive and focused objectives – making sure the Charter is about more than reducing absenteeism
- Identifying effective means of measurement and evaluation
- Identifying international examples of ‘best practice’ and incorporating these into a working model
- Convincing employers and organisations that adopting the Charter – and investing in workplace health and wellbeing – is worthwhile

Colleagues at the session felt that, rather than formatting the Charter as ‘a list of rules’, it should instead be a statement about the way the Liverpool City-region supports its workforce and its employers; setting out an underlying philosophy for the way in which we conduct business.

One important development from the session was a shift in focus away from ‘Health at Work’ as a theme, and instead toward a broader concept of ‘Wellbeing at Work’. The group felt the need to recognise a wider agenda, beyond the management of absenteeism and the prevention of sickness, moving more towards promoting the Liverpool City-region as a place where entrepreneurialism and initiative are encouraged and rewarded, where skills are developed and potential is realised, where good management and communication are fostered, and where workplace culture is predicated on respect.

The group echoed plenary evidence and feedback to the Interim Report in enabling SMEs and social enterprises to participate in the Charter, and emphasised the need to strengthen its viability with the development of a high-quality and easily-accessible occupational health (OH) service provision, particularly for those SMEs and social enterprises that may otherwise struggle to provide OH services.

Contributors to the session also felt that consideration should be given to flexible working practices, and the Commission heard from the Northwest Flexible Working Group, already commended by Government, about its work in using advances in technology to developing ‘home-working’ schemes and progressive solutions to redressing the life/work balance.
The Big Idea

The Commission recommends the development of a City-region ‘Wellbeing at Work Charter’ – a statement about the way the Liverpool City-region supports its workforce and its employers, the creation of a shared Occupational Health Service scheme and a City Region-wide ‘Wellbeing at Work’ accreditation programme to recognise and commend good practice in promoting work-based health and well-being.

The Commission was encouraged to find a broad support for the concept of the Charter amongst colleagues, and pleased that its intention that it should be used as a basis for establishing an underlying set of principles for how business is conducted in the City-region was well received.

The Commission believes that the Charter must proceed with a clear message that a healthier workforce will improve the productivity of businesses and, therefore, the prosperity of the City-region. The impetus to act on the philosophy set out within the Charter will largely be with employers, and so the Commission welcomes the Government’s ‘Health, Work, Wellbeing’ initiative which, building on the outcomes of the Dame Carol Black report, has launched an online evaluation tool to help employers assess the cost of ill-health to their business and the potential impact of wellness programmes on their bottom-line. The tool adapts to the size and sector, and is designed to turn health and well-being into management information on which businesses can act (http://www.workingforhealth.gov.uk/Employers/Tool).

The Commission envisages that implementation of the Charter will strengthen and promote its proposals under other themes of investigation. It should assist, for example, in bringing more people back into employment by creating a more supportive and positive workplace environment, and in enabling employers and employees to better address lifestyle issues such as alcohol dependency within the workplace.

The Commission also believes that it is important that the Charter embraces examples of good practice, and is modelled on the values of those companies established in the City-region who have won national recognition for their progressive policies in this area. Notably, the John Lewis Partnership has developed an agenda that goes beyond wellbeing and explicitly aims to promote “the happiness of all its members” (staff). Their approach focuses on five core principles:

- Work/life balance
- Competitive pay and benefits
- Fulfilling potential
- Fair treatment
- Powered by principles (shared values and positive communication)

Another company with an established local presence who has won national plaudits and a place in The Sunday Times newspaper’s “100 Best Companies to Work For” is the Dutch-owned building consultancy Royal Haskoning. Not surprisingly many of their policies overlap with those of John Lewis including commitments to flexible working, professional development and personal growth.

The Commission is also pleased to note the recent publication of ‘Top Tips for Healthier Workplaces’ by The Cheshire and Merseyside Public Health Network (CHAMPS), which offers a wide range of useful and practical suggestions on health promoting developments in the workplace. (http://www.nwph.net/champs/Publications)15

It is vital that small private businesses are enabled to participate in the Charter, and companies such as John Lewis, Royal Haskoning and others could potentially work in helping to mentor other local companies and SMEs. In its Interim Report, the Commission quoted from Health@Work’s WHISQ survey16, which found that employees of larger firms were far more likely to have

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15 CHAMPS, August 2008
16 Health@Work Workplace Health Information and Support Questionnaire, 2007
access to Occupational Health services than those in smaller firms – with 50% of respondents in firms with over 50 employees compared to just 8% in firms with less than 10 employees. The Commission therefore strongly supports the creation of a shared occupational health service scheme – as a social enterprise, funded through membership and possibly subsidised through public monies – that can be accessed on demand or as necessary by its members.

It may be that a similar scheme could be employed by larger organisations, sharing resources to support ‘health visitor’ schemes to deliver incidental health services to employees in the workplace. These could operate in the same vein as school health visitors, chiropodists and school nurses, therefore not only saving on leave for appointments, but also accessing those more at-risk groups who are less likely to attend preventative health checks.

The Commission once again acknowledges and applauds the pioneering and innovative work that has already been delivered in this area by Health@Work, and hopes that it will accept its invitation to work with its partners and stakeholders in the coming months in developing the Charter. The Commission recognises that the successful development of the Charter will require significant enhancement of capacity in order to provide appropriate support to workplaces and organisations, and welcomes a commitment from its partners at Liverpool PCT and Liverpool City Council to take an active part in the Charter’s production and the commissioning process.

The Commission envisages that monitoring and evaluation of the Charter might be delivered under the auspices of its proposed research institute facility into local wellbeing, linked to a City Region-wide accreditation programme to recognise and commend good practice. Within the NHS, this could also link to the World Health Organisation “Health Promoting Hospital” standard currently being aspired to or achieved by several local hospitals and already covering some strands of the proposed Charter.

The organisations represented on the Commission itself, who include some of the key public-sector bodies in the City-region, have pledged to take a leadership role in the process and, along with other key stakeholders, to be the first signatories to the Charter, as well as using their collective influence to engage the support of other key partners.

**Recommendations**

The Commission recommends the development of a City-region ‘Wellbeing at Work Charter’ - a statement about the way the Liverpool City-region supports its workforce and its employers; setting out an underlying philosophy for the way in which the City-region conducts business.

The Charter will build on good practice and will promote the Liverpool City-region as a place where entrepreneurialism and initiative are encouraged and rewarded, where skills are developed and potential is realised, where good management and communication are fostered, and where workplace culture is predicated on respect.

The Commission strongly supports the creation of a shared Occupational Health Service scheme – as a social enterprise, funded through membership and possibly subsidised through public monies – that can be accessed on demand or as necessary by its members, particularly for those SMEs and social enterprises that may otherwise struggle to provide OH services.

The Commission supports a City Region-wide accreditation programme to recognise and commend good practice in promoting work-based health and well-being, linked within the NHS to the WHO “Health Promoting Hospitals” standard.

**Lead Commissioner:** Cllr Gideon Ben-Tovim

**Lead Partners:**
- Health@Work
- Liverpool City Council
- Liverpool Primary Care Trust
Extracts from the IMPACT Assessment – ‘Wellbeing at Work’ Charter

There is a plethora of national and European-derived legislation/policies on improving and protecting the health of workers, with recent renewed attempts to re-focus and invigorate health at work nationally. There is general congruence between European and national health at work policy developments, although England is lagging behind on acknowledging and addressing emerging risk factors associated with psychosocial working conditions, e.g., ‘flexicurity’ and quality jobs.

In general, being in work is better for health than having no job and is the main determinant of health; mechanisms include providing income/material resources essential for life, social interaction/inclusion, social roles and status.

However there are exceptions to this rule, e.g., workers in poor quality, low paid and precarious (insecure) jobs have work characteristics as damaging to health as unemployment; women, BME groups and people with low or no qualifications are more likely to be in poor quality jobs.

Some health at work interventions have been effective in improving health outcomes, e.g., lifestyle change, mental and physical health and wellbeing, and improving other outcome measures, e.g., reductions in sickness absence, improvements in employee performance and effectiveness; however other interventions have not.

There have been very few quality ‘evidence of effectiveness’ studies and there are gaps in interventions at organisational systems and structure level, as well as for specific population groups, e.g., older people.

The Commission’s attention on health and wellbeing at work is entirely appropriate – an LCR ‘Wellbeing at Work’ Charter particularly focusing on the psychosocial work environment may contribute to existing measures to improve worker health and wellbeing, whilst also reducing sickness absence and improving organisational performance. In order to maximise impact and effectiveness, partners progressing development of the Charter should consider its potential role in:

- Enabling ‘health promoting’ employment policy – adopt the work and health model and target action at all levels of the model; work with regional and national agencies to develop ‘health enhancing’ employment policy;
- Enhancing data availability and accessibility – analyse existing data on work-related ill-health and psychosocial working conditions, including equality and diversity at work, and commission new research to extend the psychosocial working conditions dataset to include data on ‘flexicurity’ and job quality in the City-region;
- Developing effective occupational health systems and services (OHSS) – work with the HSE/LAs to define OHSS coverage and local OHSS models for the LCR, reflecting industry sector, type and size, and based on ILO/WHO guidelines;
- Implementing ‘Wellbeing at Work’ interventions – auditing interventions at individual, work environment or organisational systems/structures, and piloting innovative interventions, e.g., to improve job quality, or targeted at specific employee groups, e.g., older people, part-time workers;
- Ensuring contractors’ health at work – designing protocols for procurement contracts that ensure a joint liability on the principal contractor for the sub-contractors’ obligations towards their workers, linking with the Commission’s proposals under the ‘Procurement’ theme;
- Commissioning ‘evidence of effectiveness’ studies – high quality prospective studies to assess the effects of the ‘Wellbeing at Work’ pilot interventions.
Interim Conclusions

The City-region’s worklessness profile, and in particular its claimant rate for Incapacity Benefit (IB), was quickly identified as a key concern for the Commission at an early stage in its tenure, and has continued as a strong theme throughout its investigations. IB is not only a key marker of poor health in the City-region but also, in the context of regeneration and development, something which the City-region currently has an opportunity to address.

Latest figures show 107,660 of the City-region’s working age population claiming IB/Severe Disablement Allowance, representing a staggering 11% of the City-region’s working age population – accounting for over a quarter of claimants in the Northwest and 5% of the England total. Four of our six local authorities rank in the country’s top 20 for highest levels of IB claimants, and long-term dependency remains a particular issue with over two-thirds of those claimants profiled in 2007 being in receipt of benefits for over 5 years.

In recognition of the acuteness of the problem within the City-region, and furthermore of the Northwest region’s position within the national profile (32 of the top 100 areas for IB claimants in England are within the Northwest, with approximately 400,000 people in the region claiming IB), the Commission set out its vision for a “Northwest Worklessness Task Force” in its Interim Report earlier this year.

Plenary evidence presented to the Commission highlighted wider impacts such as inter-generational dependency, links with chronic depression and mental health problems. Research evidence revealed wider issues with the 2006/7 Annual Population Survey showing only 43,700 people in the City-region as ‘unemployed and wanting a job’, against an IB claimant figure of over 107,000. In proposing the ‘Task Force’ approach, the Commission sought to acknowledge not only that there are huge social, cultural and individual psychological barriers that must be overcome in tackling the IB issue, but that the sheer scale of the problem means that it will require a strong, unified and long-term commitment.

In recent months, state welfare and benefits provision have seen an increased priority in the national political agenda with all of the major parties addressing the issue with renewed vigour, publishing detailed, high-profile and often controversial policy proposals. Following its announcement that from 2009, Jobseeker’s Allowance will be replaced with Employment and Support Allowance, and all IB claimants will be reassessed using the Work Capability Assessment (WCA), Government has recently published a green paper ‘No one written off: reforming welfare to reward responsibility’. The paper, profiled by DWP as the most radical reform to the welfare-state system since its inception, proposes a number of measures including:

- Giving private and voluntary providers the right to bid for any back-to-work service
- Requiring jobseekers to do more the longer they claim, including working full-time in return for benefit at any stage where this might be deemed effective
- Using legislative powers to require those with skills...
barriers to undertake relevant training

- Sanctions for those who fail to take steps to get back into work or refuse to take a job
- A requirement for certain categories of drugs-users to take action to stabilise their habit and take pro-active steps towards employment\(^\text{18}\)

The paper is subject to public consultation until October 2008. The Commission will certainly share its research and findings with DWP as part of that consultation process, and hopes that this will assist in positioning the City-region and its Northwest partners at the forefront of Government thinking as this agenda continues to be developed.

**Moving On**

Following the publication of its Interim Report, the Commission took its proposal to establish a regional Task Force to its IB Syndicate Session (May 2008), at which it heard from colleagues working in the ‘front-line’ of delivery. Commissioners were encouraged to hear about the success of individual projects within the City-region, particularly ‘Knowsley Works’, a Northern Way funded initiative which is working to help 3,000 people in Knowsley move from incapacity benefit into employment, and Liverpool’s ‘Step Closer 2 Work’ programme, which in its first year of operation has supported 262 people back into work and 225 into vocational training, achieving a 12 month plus work-retention rate of 83%.

Contributors to this session were generally positive about policy proposals emerging from Government, but were on the whole sceptical about the introduction of private sector delivery (as supported by the green paper), expressing concern that a more commercial ‘results-led’ approach might only result in softer targets being pursued or prioritised to generate easier results.

Participants also considered that the public sector would remain better placed to deliver a more holistic family and community-based solution rather than an isolated focus on the individual, in order to recognise the difficulties of breaking free from ‘inter-generational’ cycles of dependency and the potential for stimulating longer-term cultural change through working with family units.

A strong message emerging from the group was the need to recognise the importance of voluntary work as an effective ‘first step’ in many cases on the route back into employment. The Commission, therefore, notes with interest the green paper’s inclusion of voluntary work in its proposed ‘back to work plans’. The group also supported ‘recycling budgets’ – pumping a percentage of the state savings from previous IB claims back into programmes to support other IB beneficiaries. Again, the Commission notes with interest that this idea has come through strongly in the green paper, which proposes that “… providers will be paid by results on the basis of outcomes, out of the benefit savings they achieve…” \(^\text{19}\)

Contributors echoed plenary evidence and feedback around the Interim Report in emphasising the importance of creating specific opportunities for employment and training within areas of particular deprivation in order to avoid a simple ‘shift’ in those areas from high IB dependency to high Jobseeker’s or Employment and Support Allowance claims.

The group welcomed the Commission’s proposals for a regional Task Force, and in particular supported an audit of the ‘plethora’ of schemes already being delivered. It was felt that development of a more streamlined approach might be one area in which public sector delivery could learn from private sector models such as ‘America Works’ – the first for-profit ‘welfare-to-work’ company, set up in the late 1980s – which utilises a simple and powerful message behind a simple and powerful brand.

Contributors to the session suggested that the Task Force might be able to build on the work of the Liverpool/ Merseyside City Employment Strategy (CES) Board as a basis for its proposed Task Force. Established in 2007 by Government as part of its Pathfinder programme, the CES Board includes representation from all six Local Authorities, Job Centre Plus, Learning & Skills Council, GONW, NWDA, The Mersey Partnership and Health at Work, It was set up to co-ordinate sub-regional employment and social inclusion activity, focusing particularly on skills and employer engagement, and is currently in the second year of its six year programme.

\(^{18}\) In 2007, there were 1220 IB/SDA claimants across the Liverpool City-region whose main stated medical reason was drug abuse.

\(^{19}\) ‘No one written off: reforming welfare to reward responsibility’ – DWP, 2008
The Big Idea

The Commission recommends the establishment of a ‘Northwest Works Task Force’ to examine the causes of and contributors to IB claims and worklessness, to audit current schemes and projects across the region and identify areas of best practice, and to determine positive routes for change.

The Commission welcomes the renewed public, media and political awareness around the worklessness agenda, but is also very much aware that in the current poor national economic climate and forecasted downturn, and with existing and new jobs under increasing pressure, it may very well be those most in need who find themselves left even further behind.

Indeed, the Commission notes with interest the recent publication of findings from the Social Marketing Foundation within its ‘Flexible New Deal – Making it Work’ report, which questions how effective the Government’s green paper can be in its current format. It warns that the regulatory procedures currently proposed might struggle to drive good performance from private contractors and that, because the system is based on a single payment for placing a person in work, irrespective of their personal profile, there will be no incentive for contractors to work with those who may require more help to overcome disadvantages. The report states: s

“…Those furthest from the labour market will inevitably not be offered services appropriate to their needs - they will be ‘parked’. This will occur because the design of the payment system sets the profit motive of contractors in tension with the aim to help all clients...” 20

The Commission considers that there remains a need for a broader approach to the issues, centred on positive action and improvements to health, wellbeing and quality of life, rather than focusing simply on ‘getting a job’. It has been encouraged to find a broad support for its regional Task Force proposal from both the consultation feedback and the IB Syndicate Session; and in particular a strong appetite for strengthening working partnerships and sharing best-practice across the region.

Having listened to feedback and input from colleagues, the Commission continues to advocate an in-depth investigation of IB, worklessness and associated issues, but recommends that the investigation should ‘go beyond the benefits’ themselves and focus instead on stimulating positive action: identifying opportunities for employment, skills, training and voluntary work, locating and addressing gaps in provision, supporting both individuals and communities and ultimately improving quality of life.

The Commission therefore recommends the establishment of a ‘Northwest Works Task Force’, the primary objectives of which will be to:

- Audit current IB/worklessness projects and services across the region – assessing what is working and what is not, identifying areas of best practice, exploring possibilities for effective partnership working, and supporting and ‘rolling out’ successful models
- Undertake a robust and evidence-based examination of the determinants of worklessness, looking particularly at causatory and contributory health and social factors
- Determine positive routes for change – looking at the best ways for deliverers to encourage and support individuals in their development (through voluntary work or placements, for example) and reinforcing this development through positive locally based support structures

The Commission recommends the establishment of a ‘Northwest Works Task Force’ to examine the causes of and contributors to IB claims and worklessness, to audit current schemes and projects across the region and identify areas of best practice, and to determine positive routes for change.

20 Social Marketing Foundation, September 2008
The commission wishes to stress that, particularly in the current economic climate, the focus should very much be on enablement and support; creating the conditions to support people, whether they take up employment training, volunteering, or other social activities. People on IB must not be penalised by moving into the job market and at every stage the impact on health inequalities must be monitored.  

It is crucially important to achieving the Commission’s vision for the Task Force that it avoids being ‘just another counting exercise’ and instead – in keeping with the Commission’s own principles – maintains a qualitative, participatory and creative approach, designed to stimulate open lines of communication and thereby create an opportunity for deliverers and end-users to contribute throughout. Any research or exploratory work undertaken on behalf of the Task Force must – as far as is possible – avoid perpetuating the perception of ‘them and us, ‘the doers and the done to’ – and must instead seek to stimulate an inclusive exchange of thoughts and ideas.


The Commission hopes that exploring IB and worklessness within a wider context might lead to some more radical thinking around how communities and neighbourhoods are developed, how leisure and cultural opportunities might be improved, how public spaces can be better utilised and how education and skills support is delivered. It wishes to highlight the potential for working across its own core themes, and the opportunities that might be presented in this case by, for example, the recommendations it has put forward in this report within its ‘Beyond the Built Environment’ and ‘Knowledge Capital’ proposals.

The Commission will present this recommendation to its partners and stakeholders, and in particular to its colleagues at Knowsley MBC as lead for the Merseyside CES Board, and its colleagues at NWDA, whom the Commission hopes will champion development of the Task Force and use its unique position within the region to move the proposal forward.

Recommendations

The Commission recommends the establishment of a ‘Northwest Works Task Force’ to examine the causes of and contributors to IB claims and worklessness, to audit current provision across the region and identify areas of best practice, and to determine positive routes for change.

The Commission hopes that exploration of these issues within a wider context might stimulate more radical thinking around how communities and neighbourhoods are developed, how leisure and cultural opportunities might be improved, how public spaces can be better utilised and how education and skills support is delivered

The Commission feels strongly that the focus of the Task Forces should be to stimulate positive action and that it should as far as possible be delivered in a qualitative, participatory and creative way.

**Lead Commissioners:** Evelyn Asante-Mensah OBE
Sheena Ramsey

**Lead Co-ordinating Partners:** Northwest Development Agency
Knowsley Metropolitan Borough Council
Extracts from IMPACT Assessment – ‘Northwest Works’

Worklessness is a very sensitive area with public debate often being polarised. There is strong evidence showing economic conditions are the main determinant of worklessness. Worklessness is detrimental to the physical and mental health of not only the individual affected but the whole family. ‘Welfare to work’ interventions show variable levels of effectiveness for increasing employment for people with disabilities and chronic health conditions. Moving from benefit to work has positive effects on health when household income increases.

The Commission’s ‘Northwest Works’ Task Force (NWWTF) is welcome and will provide important input to the Government’s recent welfare benefit reform Green Paper. To maximise impacts, it is recommended that the NWWTF adopts the employment, worklessness and health model described below and directs action at different structural levels of the model:

• Enabling favourable labour market conditions – support and collaborate with national and regional agencies to stimulate economic growth in the North West, e.g., through local procurement collaboratives.
• Changing employer attitudes – develop campaigns with local industry and commerce champions to addresses the Labour Market Inequalities that exist – the marginalisation of certain groups from the labour market – and that perpetuate health inequalities.
• Developing workplace health – work with national and regional agencies to raise awareness and develop innovative approaches to improving health and wellbeing at work, linked with the Commission’s proposals under its ‘Wellbeing at Work’ theme.
• Developing responsive health services – work with the local NHS to identify ‘bottle necks’ in local health care provision which may impede return to work from sickness or incapacity, e.g., support from mental health or therapy services.
• Understanding local IB claimant needs – in recognition of the heterogeneity of IB claimants and their labour market attachment, lobby for and/or commission an analysis of a sample of existing claimants in the NW to define individual and household characteristics, including health status, LMA and where appropriate what support is needed for transition from inactivity/unemployment to employment.
• Commissioning ‘evidence of effectiveness’ studies – lobby for and/or commission high quality prospective research to assess the effects of W2W interventions for people with disabilities or chronic conditions with different levels of LMA on, e.g., employment, earnings, job quality, health outcomes; include assessment of employer-related interventions and differential impacts.
• Modelling in-work benefit needs – to ensure employment is financially rewarded, household income increases and health is not detrimentally affected; commission economic analyses to estimate the potential in-work benefit needs of former claimants in low paid employment.
Beyond the Built Environment: Designing for Health

Overall the evidence strongly points to the importance to human health and well-being of incorporating trees and greenery in residential settings, as well as means to access them physically and visually.

Professor Tim Blackman, Durham University

Interim Conclusions

The Commission’s Interim Report focused heavily on the important link between health and the built environment. It acknowledged the extent to which the pioneering public health work of Dr William Duncan was a direct response to the appalling housing and environmental conditions that prevailed in Liverpool in the mid 19th Century.

The Commission continues to believe that the planning and design of new buildings and new transport infrastructure has a very significant impact on human health and wellbeing, and in particular acknowledges the need to ensure that disadvantaged groups can easily access opportunities for employment and learning. It wishes to reaffirm the principle conclusions and recommendations outlined in the Interim Report, including:

Planning to reduce global warming and environmental pollution – There is a clear opportunity to improve integration between transport and land use planning in order to reduce the need for travel and promote the use of more sustainable transport modes. The Liverpool City-region must improve the quality and diversity of its public transport system if it is to provide travellers with viable and attractive alternatives to the car. It must therefore be willing to respond positively to all potential sources of new investment including the Government’s “Transport Improvement Fund” initiative which ties new capital investment to consideration of road user charges. A strong commitment by local authorities and civic partners to make Liverpool City-region the UK’s “greenest” could be an attractive message to investors and entrepreneurs.

Designing for Health and Wellbeing – The Commission was hugely impressed by the design of the new proposed Children’s Hospital at Alder Hey – The “Health Park” model – which acknowledges that specific design features and elements can have a directly beneficial impact on health and well-being. In its Interim Report, The Commission called for a City-region ‘Design for Health and Wellbeing” initiative, building on some of the interesting work already being explored by CABE (The Commission for Architecture and The Built Environment), RIBA (Royal Institute of British Architects) at a regional level by RENEW Northwest and its ‘Places Matter’ programme. The Commission would like to see the development of a Designing for Health and Wellbeing good practice guide that would inform the approach to all new development and design across the City-region. These principles could ultimately be incorporated into Supplementary Planning Drafts (SPD) in a similar approach to that taken with respect to access and sustainability standards.

Putting health at the heart of planning – For health to be at the heart of policy-making in the areas of transport and urban design, the health sector must itself be directly engaged in the policy process. The Commission proposed that there should be a forum for the City-region engaged in the formulation of transport and planning policy with senior public health professionals and the PCTs represented alongside planning, transport and regeneration professionals from the local authorities, the private sector and Merseytravel. In the immediate short term, the established Health, Environment and Transport Forum established as part of the Local Transport Plan’s consultative structures, could be given a wider and more prominent role in taking this agenda forward.
Following the publication of its Interim Report, the Commission has been made increasingly aware that people’s sense of place and their relationship with their living environment cannot be analysed purely in terms of the built environment. There is a growing emphasis on the need to rebuild “neighbourhoods” rather than simply renew or refurbish housing units. Whilst sustainability in building has been identified as a significant growth-area, there is also a widespread recognition of the importance of the environmental context in which buildings sit. Evidence presented to the Commission at its ‘Built Environment’ Task Group session (May 2008), suggests that local authorities are seeking to devolve more services to the area or neighbourhood level, whilst LSPs are trying to focus the efforts of other key service providers at a similarly local level.

In his contribution to the Task Group session, Professor Tim Blackman, Professor of Sociology and Social Policy at Durham University, suggested that the Liverpool City-region should consider one simple intervention aimed at creating a physical environment that would foster improved health and well-being. His proposal to “green” the City-region recognised that economic and demographic decline has bequeathed an urban environment with more than its fair share of derelict and desolate spaces. As the property bonanza stalls, perhaps an initiative to extend and enhance the green environment is both sensible and timely.

The Commission has been impressed and encouraged by a number of individual projects that demonstrate how the involvement of local people in the design and management of their local neighbourhood can deliver a wide range of immediate and longer term benefits. In the Interim Report, The Commission specifically commended some of the innovative work that was being pioneered by the INES (Include Environmental Services) regeneration partnership in the L8 area of Liverpool. By introducing an environmental maintenance approach that employed local people through a new social business structure, there had been a dramatic improvement in the quality of the service and a discernable change in public attitudes toward the local environment.

The Task Group session heard about the Liverpool-based “Community Roots” project being delivered in partnership by the Al-Ghazali Multicultural Centre and the HeaL8 healthy living project, through which derelict building sites are converted into community allotments where local people can learn how to grow healthy organic food. From the Commission’s perspective these are paradigm projects that foster outdoor activity, positive social interaction and the promotion of healthy eating. The projects have modest aims, but again provide an example of local enterprise that could encourage similar initiatives in other parts of the City-region.

The Commission’s Interim Report noted that the City-region boasts some of the UK’s finest and best designed Victorian Parks, and that Wirral’s Birkenhead Park, opened in 1847, is acknowledged as the first civic public park in Britain. For the Victorians there was an obvious synergy between the reforms of Dr. Duncan and the impetus to create these great amenities for the promotion of public health and enjoyment. The Commission was therefore saddened to hear evidence from Liverpool John Moores University’s report “Returning Urban Parks to their Public Health Roots” which sets out how our parks have become an enormous and under-utilised resource. Parks are free and accessible opportunities for recreation, contemplation and social interaction, yet for many decades have simply been left in decline. It was recognised that a key issue around under-utilisation related to how safe people perceived public parks to

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22 Liverpool JMU Centre for Public Health, 2007
be. If they are to be fully utilised, it is essential that they become visibly safe for all to enjoy.

Whilst the Commission believes that local Councils are committed to maintaining and improving their urban parks and green spaces, and applauds those Councils that have facilitated the formation of “friends groups” to encourage a greater sense of community ownership and involvement, survey data reveals that 5 of the 6 local authorities in the City-region are spending less on parks maintenance today than they were 10 years ago. Councils such as Wirral, Halton and Liverpool have been successful in securing external funding from agencies such as the Heritage Lottery Fund and the RDA for specific renovation projects, but overall public investment in the maintenance and development of our parks has been starved.

CIWEM’s “Parks for People” report (2001) discovered many instances of innovation and good practice, but also discovered management and maintenance regimes that were fractured and under-resourced. It seems anomalous that even the smallest community and leisure centres have dedicated managers whilst vastly more complex facilities are managed by off-site teams – often employed in different Council directorates – with parallel responsibilities for other parks and green spaces. The report found that Wirral’s Birkenhead Park is virtually unique in that it has a dedicated park manager who is actually based on site.

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23 The Chartered Institution of Water and Environmental Management “Parks for People”, 2001
The Big Idea

The Commission recommends a ‘Design for Health and Wellbeing’ initiative to guide the approach to new development and design across the City-region, and the establishment of a Parks Task Group to investigate the management, maintenance and marketing of urban parks and lead a high-profile public debate on their future.

The neighbourhood agenda is challenging and complex. It requires public policymakers to abandon the presumption that there are common structural approaches and templates that can be applied across the board. Artificially defined communities and convoluted structures for local partnership working may represent a change in organisational vocabulary but do not always signify the profound philosophical shift that is required to deliver the renewal of neighbourhoods. The Commission believes that the most important and beneficial initiatives are as likely to be bottom-up and improvised as they are planned and structured, and commends the Neighbourhood ‘Walkabout’ approach, as employed in Dingle, where agencies, local councilors and residents walk together regularly around the neighbourhood to discuss problems and generate solutions.

The Commission wishes to encourage a similar bottom-up approach in recommending a public debate about the future of parks across the City-region. At a time when our leisure activities are becoming increasingly virtual, and the pursuit of fitness increasingly confined to the air-conditioned interiors of private gyms, we need original and creative approaches to promote greater public use and enjoyment of our parks and green spaces. At a fundamental level we seem to be unclear about what parks are for and therefore what the objectives of park policy should be. As Liverpool JMU’s “Returning Urban Parks to their Public Health roots” described, good parks are not just pristine environments, they must be living places and an essential part of the infrastructure of a healthy and sustainable City-region.

The Commission feels that there are many instances of good practice that could be promoted and shared, but believes that there are structural and cultural issues that need to be resolved if our parks are to experience a genuine renaissance. The City-region can look to international examples to see how declining urban parks have been revived and transformed. In the early 1980’s New York Mayor Ed Koch unveiled a bold initiative to stem the decline in the city’s famed Central Park. The establishment of The Central Park Conservancy created a not-for-profit company to administer the park on behalf of the city. The company continues to fulfil this contract and had demonstrated over nearly three decades the benefits of having a dedicated management regime with integrated responsibilities for maintenance and conservation, development, marketing, fundraising, public engagement, security and the operation of commercial franchises and concessions. The Conservancy has been successful in dramatically increasing capital investment in the park and raises, through franchising income, a sum equivalent to 30% of the annual maintenance budget. The arms length arrangement with The Conservancy and the injection of a more commercial approach has not compromised the park’s public ethos or feel. Conversely it has made the park a more attractive and safer environment for public enjoyment.

It is surprising that even in circumstances where public revenue funding for park maintenance is under such pressure that there is still a reluctance to consider opportunities for generating revenue through the introduction of more commercial concessions. In continental Europe where there is arguably an even stronger tradition of public provision it is commonplace for civic parks to contain good quality privately operated restaurants and cafes, boats for hire, children’s rides and other commercial concessions that help to animate...
the park and complement its essential function as a public amenity.

The Commission is not advocating privatisation or commercialisation, but is proposing the need for dedicated on site management of large urban parks. These are important and complex amenities that fulfil a diverse range of recreational, social and cultural needs. Parks are, or have the potential to be, community centres, sports clubs, theatres, health centres, museums and education facilities rolled into one.

The Commission envisages an integrated management structure for parks that would give a dedicated management team direct responsibility for:

- The delivery of effective maintenance and security services.
- The formulation of long-term investment plans for both conservation and new capital infrastructure.
- Community engagement activity, including the creation of “friends” and user groups, public consultation programmes and outreach activity aimed at local groups and those who do not traditionally use parks.
- Wider marketing activity and the formulation of an inclusive events programme.
- A commercial strategy that would identify additional sources of public and private investment as well as revenue income from concessions and complementary commercial activity.

The Commission recognises that for this approach to be successful, local parks and spaces must be integrated into the ‘neighborhood’ approach. This approach has already been employed in the regeneration of a number of green spaces across the City-region including Great George Square and Belle Vale Park. The Commission strongly supports:

- Involving local residents in the redesign of green spaces, as demonstrated in the improvements to Great George Square;
- An enhanced role for social enterprise employing local labour to carry out maintenance, for example INES (Include Environmental Services)

The key to the new parks management philosophy would be a new relationship with the community based on open and inclusive engagement. Development plans, animation strategies, events programmes and proposals for new concessions and amenities should be developed through consultation and dialogue with park users and communities. If our urban parks are going to be core elements in the revival of neighbourhoods then they must be owned, valued and cherished by the people of those neighbourhoods.

The Commission strongly advocates the need for local authorities in the City Region to consider a new approach to the management and marketing of large urban parks. We recommend that a Parks Task Group is established with a broad membership from local government, established “friends” groups, community organisations, urban design / heritage interests and business to lead a high profile public debate on the future of our parks and the establishment of new management models and approaches.
Recommendations

The Commission calls for a City-region ‘Design for Health and Wellbeing’ initiative, and would like to see the development of a Designing for Health and Wellbeing good practice guide that would inform the approach to all new development and design across the City-region.

The Commission recognises the importance of ‘neighbourhoods’ in local development, and wholly supports those programmes which encourage local social enterprise, positive social interaction and an open and inclusive community-based approach in taking this agenda forward.

As part of its commitment to healthier and more sustainable ‘neighbourhoods’, the Commission strongly advocates a new approach to the management, maintenance and marketing of urban parks. The Commission recommends that a Parks Task Group is established with a broad membership from local government, established “friends” groups, community organisations, urban design / heritage interests and business.

The Commission proposes that, once established, the Parks Task Group leads a high-profile public debate on the future of our parks and the establishment of new management models and approaches.

Lead Commissioners: Dr Katy Gardner  
Cllr Beatrice Fraenkel

Lead Co-ordinating Partners: Knowsley Metropolitan Borough Council  
Liverpool Alder Hey Children's Hospital
The Commission’s proposed ‘Designing for Health and Wellbeing’ approach will help health to be considered in the planning and development control process - placing health at the centre of urban planning.

The existing evidence shows clear links between urban planning, the built environment and health with a number of key themes emerging from the evidence; including physical activity; transport and social interaction/capital; air, light and noise pollution, crime/ fear of crime; inclusivity and accessibility.

The quality of public spaces and in particular access to appropriate, high quality green space is crucially important for health and wellbeing. Regeneration projects, however, that relocate and displace people in an insensitive manner may have negative impacts that counteract the positive effects of regeneration.

Some aspects of the quality of the built environment are controlled by policies and actors that operate outside the planning and development control system, and it must be remembered that the built environment needs of rural areas and their populations within the City-region differ from urban areas.

In order to maximise the potential impacts on health and, in particular, to target health inequalities, it is recommended that partners progressing the Commission’s proposals consider the following:

• Engage a wider group of stakeholders in establishing and maintaining standards of quality of the built environment, e.g., building control officers and registered social landlords, and ‘piggy backing’ onto existing initiatives, e.g., ‘Healthy Cities’ healthy urban planning.

• Consider widening the geographical scope of proposals to include rural areas within the Liverpool City-region
• Commission research to identify and explore the relationship between the built and natural environment.
• Examine existing approaches to development in areas designated as ‘brownfield’ sites.
• Recognise and address the limitations of planning tools, e.g., Supplementary Planning Statements in the context of other material considerations, e.g., economic impacts.
• Show support for and raise the profile of Liverpool’s HIA Planning officer in assessing the health impacts of development proposals, urban and architectural design quality, and a means by which enhancements to development proposals will be progressed through the development control process.
• Reiterate the historical and contemporary links between the planning, public health and related sectors.
Procurement

If we need to go out and we need to buy pens and you as an organisation can offer us pens at the same price but you can deliver a whole load of added value in the background why wouldn't we come to you?

Shaun Doran, FRC Group Ltd

Interim Conclusions

Throughout its deliberations, ‘The Power of the Public Purse’ has been of particular interest to the Commission. Given that the public sector accounts for approximately 39% of the City-region’s employment, that the NHS itself is the second largest direct employer within the City-region and that there are imminent large-scale construction programmes scheduled for its two major hospitals (£400m at Royal Liverpool Hospital and £120m at Alder Hey Children’s Hospital), it is perhaps hardly surprising that looking at innovative ways to achieve a ‘multiple bottom line’ effect, maximising the potential social and economic benefits of large-scale public sector spend to the City-region, has presented itself as a priority.

Despite a growing awareness of the sustainable procurement debate within the private sector and on a national policy level, the majority of plenary evidence presented to the Commission suggested that all too often, public sector procurement decisions on the ground remain governed by narrowly commercial considerations, with procurement targets set nationally and decisions determined largely by price.

Witnesses to the Commission identified widespread uncertainty amongst both purchasers and suppliers as to the legality of incorporating social clauses into procurement contracts, particularly in relation to EU regulations. On further investigation, it has become clear to the Commission that this lack of clarity, particularly within large public sector organisations, is acting as a barrier to small businesses, local entrepreneurs, social enterprises and the third sector in general, and furthermore that it is in fact entirely feasible to develop procurement processes that can generate social benefits and still operate within all relevant regulations.

Witnesses also pointed to a confusion caused by the growing amount of legislation and policy surrounding the procurement agenda. ‘The Gershon Review’ and its impacts on procurement practice was cited in several plenary sessions, and appears to be subject to interpretation, with ‘efficiency’ often linked directly to ‘price’.

Despite the excellent work being delivered in a number of individual schemes across the City-region, and at a regional level by the NHS Northwest Procurement Hub, the Commission strongly believes that only a fraction of the potential social value that could be manifested through public sector procurement practices is being realised. The Commission heard from several witnesses who described the difficult terrain in which individual schemes often operate as SMEs and social enterprises, constrained by ‘value for money’ targets, limiting qualification criteria, and “…having to tick the boxes…”.

The Commission was interested to note Sir Neville Simms’ call for a collective and determined effort in driving forward sustainable procurement in the Government’s Sustainable Development Task Force Report (commissioned jointly by DEFRA and the Treasury):

“…Sustainable procurement – in short using procurement to support wider social, economic and environmental objectives, in ways that offer real long-term benefits, is how the public sector should be spending tax-payers’ money. It will require determined effort from the top down throughout both central and
local government, the NHS, indeed everyone who either spends money from the public purse or on behalf of the public. It does not mean that the public sector should act as a monolith – that is neither efficient nor desirable. But it does mean a sense of common purpose.”

In its Interim Report, the Commission set out its proposal for the City-region to take up that challenge, by taking a national lead in bringing together all public agencies (and, ideally, significant private sector employers) to agree a common ‘Procurement Concordat’, designed to stimulate, develop and adopt best practice – specifically in creating employment and training opportunities, supporting social enterprise and engaging those citizens who have been in receipt of long-term Incapacity Benefit, another of its key themes.

Moving On

Following the publication of its Interim Report, the Commission sought advice and guidance from colleagues working in this area in finessing the idea of the Concordat and refining its terms. Contributors to that session were broadly supportive of the Concordat approach, and felt that it would represent a clear and positive step towards consolidating efforts across the City-region, supporting a cultural shift towards the prioritising of social objectives, and maximising what might be achieved through improved procurement practice.

Colleagues at the session echoed the urgent need for clarification as to what is possible within both EU directives and UK legislation, and felt that the Concordat might prove a useful tool in removing ambiguity and simplifying processes.

Interestingly, the group questioned whether cost is in fact still the primary driver in procurement decisions, and many contributors felt that – despite the acknowledged uncertainty around policy and regulation – there is actually a growing awareness amongst decision makers of the importance of generating wider social benefits, which is already being put into practice. Figures presented by The Merseyside Authorities Procurement Collaboration to the session showed that of £788 million combined local authority procurement spend, 27% of the value of those invoices was spent within local postcode areas (compared to national average of 23%).

The group felt that development of the supplier base should be a priority – whether featured explicitly in the Concordat or pursued separately. It was proposed that in order to secure a commitment to local procurement, skills and capacity issues must first be more effectively addressed, with specialist and targeted support for SMEs and social enterprises in becoming better equipped to deliver large public sector contracts.
The Big Idea

The Commission recommends the adoption of a common ‘Procurement Concordat’, designed to stimulate, develop and adopt best practice – specifically in creating employment and training opportunities, supporting social enterprise and engaging those citizens who have been in receipt of long-term Incapacity Benefit.

The Commission was encouraged to find a broad support for the concept of the Concordat amongst colleagues, and pleased that its intention for its use as a basis for establishing a common purpose and stimulating a unified approach toward that purpose was well received.

Much of the consultation feedback and syndicate discussion mirrored the Commission’s own findings, certainly in highlighting a widespread ambiguity and uncertainty regarding legislation, and in the importance of balancing improved procurement practices with the development of the ‘supply-side’.

In its investigations, the Commission discovered that EC Procurement directives do not actually apply to ‘under-threshold’ contracts (currently £3.86 million for works and £154,477 for most supplies and services) and that the obligation not to ‘disadvantage non-local contractors’ can be met through using general categories of beneficiary (e.g. unemployed people, trainees, young people) and then targeting the benefits locally through supply-side activities (e.g. training and job-matching services).

The Commission recommends, therefore, that the implementation of the Concordat is supported by a programme of robust and targeted supply-side actions – particularly in providing training, advice and support for local SMEs and social enterprises, but also in targeting promotion of contracts and opportunities to particular individuals and sectors of the community.

Given the broad support for the proposed approach amongst colleagues, and the strength of appetite for its implementation, the Commission has worked closely with its partners, stakeholders and legal advisors over the last few months in drafting a ‘Procurement Concordat’ for the City-region, which will launch concurrently with this report in September 2008.

The Commission recognises that implementation of the Concordat will require a period of transition, particularly in order for suppliers, SMEs and social enterprises, but is confident that as the Concordat develops, it will continue to attract widespread support, certainly amongst public sector colleagues, but also from the private sector.

The organisations represented on the Commission itself, who include some of the key public sector bodies in the City-region, will take a leadership role in the process and, along with other key stakeholders including the Royal Liverpool University Hospital have pledged to be the first signatories to the Concordat, as well as using their collective influence to engage the support of other key partners.
Recommendations

The Commission recommends the City-region takes a national lead in bringing together all public agencies (and, ideally, significant private sector employers) to agree a common ‘Procurement Concordat’, designed to stimulate, develop and adopt best practice – specifically in creating employment and training opportunities, supporting social enterprise and engaging those citizens who have been in receipt of long-term Incapacity Benefit.

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The Commission recommends that the implementation of the Concordat is supported by a programme of robust and targeted supply-side actions – particularly in providing training, advice and support for local SMEs and social enterprises, but also in targeting promotion of contracts and opportunities to particular individuals and sectors of the community.

Lead Commissioners: Claire Dove MBE
Anthony McGuirk

Lead Co-ordinating Partners: NHS Northwest Procurement Hub
Merseyside Fire & Rescue Services
Royal Liverpool University Hospital
The Commission has identified sustainable procurement (SP) as a way to address inequalities within the LCR. There are three main components of SP; environment, social and economic, and there are strong policy and political drivers for SP at international, national and local level. i.e. Agenda 21 (1992), World Summit of Sustainable Development (2002), EU Sustainable Development Strategy, National Procurement Strategy for Local Government (2003), UK Sustainable Development Strategy (2005), SP Taskforce (2005), NWDA (2007), LCC Procurement Strategy, LCC Small Business Friendly Concordat.

All public bodies are required to apply the EC Procurement Directives. The concepts of sustainable procurement do not contravene these directives as long as it complies with the principles of non-discrimination, equal treatment, free movement of goods and services and transparency.

Although there is a relatively well-developed body of research investigating aspects of SP in private sector organisations, there is limited research on SP in the public sector. Studies have mainly focused on environmental issues in procurement, with the social aspects of SP being under-researched to date. There is limited evidence available on the effectiveness of SP.

SP potentially impacts on a range of health determinants and health inequalities. These include employment, local economy, environment, environmental justice, transport, food and the built environment.

The commission’s proposal to establish a Procurement Concordat (PC) in its current form could potentially impact positively on determinants of health such as employment and economic benefits. It could provide a valuable contribution to the development of SP at City-region and national level.

In order to maximise the potential impacts on health and, in particular, to target health inequalities, it is recommended that partners progressing the ‘Procurement Concordat’ consider the following:

- Ensure that the PC has a clear remit to address all three elements of SP – environment, social and economic.
- Use SP as a tool to explicitly address inequalities. This should extend beyond the labour market and economy (gender, ethnicity, environment etc.)
- Use the PC to address issues of social justice including environmental justice and human rights.
- Commission research into identifying how SP can be used to promote health and target health inequalities in the LCR.
- Commission a scoping exercise to identify examples of good practice to build on.
- Consider impacts on health beyond LCR (e.g. climate change, health staff migration).
- Utilise the involvement of the public sector in the PC to engage with the private sector.
- Ensure that the promotion of SP clauses is balanced with actions to address ‘supply side’ issues such as providing support to local businesses to be able to compete.
Knowledge Capital

I would like to see the region put a big marker down that says we’re going to do this big-time and we’re going to get everybody working together to do it

Dr Janet Hemingway, Liverpool School of Tropical Medicine

Interim Conclusions

The third of the four core questions set for the Commission asks both how the City-region can strengthen its presence as an internationally renowned centre for health science, but also – importantly – how those assets might be better exploited for the benefit of local people.

As noted in the Commission’s Interim Report, the Liverpool City-region unquestionably boasts an extraordinary wealth and concentration of world-class health and bioscience institutions. The Royal Liverpool University Hospital, Liverpool Women’s Hospital, Alder Hey Children’s Hospital, Clatterbridge Centre for Oncology, The Liverpool Heart and Chest Hospital and the Walton Centre for Neurology and Neurosurgery all have national reputations for innovation and excellence. The University of Liverpool is unique in its clinical education offer, being the only UK University with Schools of Clinical Medicine, Health Sciences, Dentistry and Veterinary Science, and Liverpool John Moores University is widely acknowledged for the strength of its health research capacity. The Liverpool School of Tropical Medicine is a world-renowned centre for research and development, and the City-region also attracts significant investment in Bio-manufacturing, including the development of the £30m National Bio-manufacturing Centre at Speke, Liverpool.

The Life Sciences sector is internationally acknowledged as a fast-growing and dynamic global industry, with global annual growth of 30%, and the strength of the sector in Merseyside is demonstrated by its position as the largest employment sector in the City-region accounting for 40,000 jobs (MER 2007). This potential for growth for those knowledge-based assets in Liverpool City Centre has already been recognised by the Universities and other key stakeholders, who are supporting the development and promotion of those assets through the ‘Knowledge Quarter’ initiative.

In terms of what more can be done toward securing a better position on the international stage, plenary evidence presented to the Commission called strongly for a ‘think big’ approach, and suggested that perhaps the vision and drive expressed by key leaders in the sector has to date failed to be matched by the wider public sector and main regeneration agencies. In terms of how our knowledge-based assets might better serve the interests of local people, witnesses expressed disappointment and frustration that the strength of the City’s academic offer is not acknowledged as widely as its cultural, sporting and historical legacies, and suggested that the international focus of those assets and a perceived lack of local employment opportunities might have contributed to a lack of positive engagement and connection between the sector and local residents. As Dr Janet Hemingway from the Liverpool School of Tropical Medicine observed:

“…it’s about a sense of pride... having local people thinking, yes I can do that and then when they come in to the school, at whatever level they come in, then fostering a feeling that there is an upwards to get to here, and that it’s something everybody can be part of…”

In its Interim Report, the Commission set out its proposals to work with the City-region’s Universities and NHS organisations to identify more effective collaborative structures, so that local policy and decision makers are able to better utilise the world-class
research capabilities so readily available to them. It also set out its vision for the establishment of a research institute to study local health and wellbeing issues, to be delivered in partnership with the University of Liverpool and Liverpool PCT.

**Moving On**

At its Knowledge Capital Syndicate Session (April 2008) the Commission heard supporting statements from the University that in establishing the Institute, it hoped to showcase Liverpool as a benchmark for how academic institutions and NHS organisations can work together, and from Derek Campbell, Chief Executive of Liverpool PCT who expressed an urgent need for his organisation to have access to a specialist ‘public health’ research facility to assist the PCT in its delivery and assessment of its new 3-year strategy, and who indicated that the PCT was committed to making a significant financial investment to help launch the Institute.

 Commissioners were encouraged to hear contributors to the session express a positive commitment to supporting the Institute in its pursuit of excellence and a collective endorsement for ‘thinking big’ in its delivery – looking to international examples of best practice such as Boston’s Institute for Healthcare Improvement (IHI) and the Harvard-MIT led Translational Health Science and Technology Institute (THSTI) in India.

The Commission was also encouraged to hear from Jim Gill at the syndicate session in his new role as Chief Executive of Liverpool’s newly formed inward investment agency, Liverpool PLC, who not only expressed support for the Commission’s overarching objective to drive forward productivity through improving public health, but also acknowledged that achieving a healthier, more productive and better skilled workforce could not only improve Liverpool’s image as a location for inward investment, but also contribute to its growing international reputation as a 21st Century ‘knowledge economy’.

A strong message emerging from both the session and consultation feedback has been the importance of ensuring that the ‘big idea’ of the Institute is delivered within the context of creating direct social benefits for the local community, particularly through providing employment and skills development opportunities. Establishing stronger connections with local businesses, SMEs and entrepreneurs, and undertaking pro-active outreach activity with schools and colleges were also put forward as priorities.
The Big Idea

The Commission recommends the establishment of a dedicated research Institute to study local health and wellbeing issues, with a particular focus on those conditions and illnesses which are caused through or accelerated by inequality and deprivation, working with local people and creating direct social benefits for the local community.

The Commission recognises and applauds the excellence of the City-region’s research capacity within health and social science, but feels that there remains limited opportunity for this academic excellence to be applied practically or for it to exert any tangible influence on local policy or practice. It is strongly committed to ensuring that the City-region’s research and teaching institutions find effective ways of sharing their expertise and skills with the local community, and particularly ways to bring their unique skills and combined knowledge towards tackling the blight of ill-health and deprivation in Merseyside.

The Commission therefore, recommends a dedicated research Institute be established to study local health and wellbeing issues, with a particular focus on those conditions and illnesses which are caused through or accelerated by inequality and deprivation.

It welcomes the broad support it has received to date for this proposal, and gratefully acknowledges the invaluable input from partners and stakeholders in refining the initial concept so that it is now better aligned with the latest global and European health and social science trends, and better placed to both complement the City-region’s existing research capacity and to develop its own niche area of specialist study.

The Commission’s primary objective in establishing the Institute is that it will be able to take a lead in identifying and combating the negative impacts of health inequalities and deprivation across the City-region. It aspires that the Institute will become a centre of excellence in its field and that, in doing so, will assist Liverpool PLC, The Mersey Partnership and other key stakeholders in improving the global positioning of the City-region and in attracting international inward investment. It envisages that the Institute will work locally with local people and local conditions, but will aim to share results internationally in a spirit of co-operation and partnership, equally bringing that international perspective back to the City-region to further develop its knowledge economy.

Having listened to thoughts and feedback on how the Institute might contribute directly to the local economy, the Commission urges its delivery partners that as the concept is developed further, it should be used wherever possible to stimulate employment, skills and training opportunities for local people, to support graduate retention and to encourage positive engagement with local businesses, schools and colleges, and public delivery agencies.

In all of its recommendations, the Commission has endeavoured to support and stimulate co-operation and partnership working towards a common goal. In this instance, its aim is that the Institute will help to establish and strengthen links between existing research programmes and will act as an interface for collaboration between the City-region’s universities and public health organisations. Although the Institute is being championed by colleagues at the University of Liverpool and Liverpool PCT, the Commission hopes that colleagues at Liverpool John Moores, Liverpool Hope and Edge Hill and all of the City-region’s PCTs will accept its invitation to work together to contribute to its successful development and delivery.
Recommendations

The Commission recommends a dedicated research Institute be established to study local health and wellbeing issues, with a particular focus on those conditions and illnesses which are caused through or accelerated by inequality and deprivation.

It envisages that the Institute will work locally with local people and investigate local issues, but will aim to share results internationally in a spirit of co-operation and partnership, equally bringing that international perspective back to the City-region to further develop its knowledge economy.

The Commission recommends that the Institute is delivered within the context of creating direct social benefits for the local community, particularly through providing employment and skills development opportunities, but also in establishing stronger connections with local businesses, SMEs and entrepreneurs, and undertaking pro-active outreach activity with local schools and colleges.

Lead Commissioners: Sue Woodward OBE  
Professor Ole Petersen CBE

Lead Co-ordinating Partners: Liverpool Primary Care Trust  
University of Liverpool
Notes on Further Research

The Commission envisages that there will be a key role for the proposed Institute in the delivery, development and evaluation of its ‘Big Ideas’, as they are progressed by its delivery partners.

The Commission gratefully acknowledges and welcomes the additional research and analysis undertaken by the University of Liverpool’s IMPACT team in identifying how its proposals might be most effectively taken forward in order to maximise effectiveness, and hopes that where the IMPACT team has identified gaps in research and analysis, there might also be a role for the proposed Institute in undertaking these pieces of work.

This might include, for example:

- Action research to test out and evaluate interventions, particularly those proposals under Beyond the Built Environment and Wellbeing at Work

- Analysis of existing data on work-related ill-health and psychosocial working conditions, including equality and diversity at work, and new research to extend the psychosocial working conditions dataset to include data on ‘flexicurity’ and job quality in the City-region (Wellbeing at Work)

- Analysis of a sample of existing claimants in the NW to define individual and household characteristics, including health status, LMA and where appropriate what support is needed for transition from inactivity/unemployment to employment (IB)

- Research to assess the effects of interventions for people with disabilities or chronic conditions with different levels of LMA on, e.g., employment, earnings, job quality, health outcomes; include assessment of employer-related interventions and differential impacts (IB)

- Modelling in-work benefit needs – to ensure employment is financially rewarded, household income increases and health is not detrimentally affected, commission economic analyses to estimate the potential in-work benefit needs of former claimants in low paid employment (IB)

- Gathering evidence from implementation of its ‘Licensing Advisory Forums’ proposal and benchmarking the evidence gathered and experience of implementation against policy advice and development from other sources (Alcohol, Smoking & Obesity)
Final Recommendations

1. That a co-ordinated ‘Health Improvement Plan’ for the City-region be developed, through which resources can be specifically focused on delivering and evaluating a unified and targeted strategy against the health impacts of alcohol, smoking, poor diet and lack of physical activity across the City-region.

2. The introduction of area-based non-statutory Licensing Advisory Forums, designed to assess local health and social impacts of licence applications. The Commission advocates the introduction of more formal structures to enable the consideration of health impacts in planning and licensing policies and calls upon partners to raise this issue in their communications with Government.

3. A “healthy food” award and accreditation scheme, through which businesses that produce and prepare foods ‘healthily’, or who provide healthy food options for their employees, are rewarded and promoted, perhaps through tourism industry awards, or as part of a new ‘kite mark’ accreditation scheme.

4. The development of a City-region ‘Wellbeing at Work Charter’ – a statement about the way the Liverpool City-region supports its workforce and its employers; setting out an underlying philosophy for the way in which the City-region conducts business.

5. The Commission supports a City Region-wide ‘Wellbeing at Work’ accreditation programme to recognise and commend good practice in promoting work-based health and well-being, linked within the NHS to the WHO “Health Promoting Hospitals” standard.

6. The creation of a shared Occupational Health Service scheme – as a social enterprise, funded through membership and possibly subsidised through public monies – that can be accessed on demand or as necessary by its members, particularly for those SMEs and social enterprises that may otherwise struggle to provide OH services.
7. The establishment of a ‘Northwest Works Task Force’ to examine the causes of and contributors to IB claims and worklessness, to audit current schemes and projects across the region and identify areas of best practice, and to determine positive routes for change.

8. A ‘Design for Health and Wellbeing’ initiative, led by the development of a Designing for Health and Wellbeing good practice guide to inform the approach to all new development and design across the City-region.

9. The establishment of a Parks Task Group, to investigate a new approach to the management, maintenance and marketing of urban parks, and to include a broad membership from local government, established “friends” groups, community organisations, urban design / heritage interests and business.

10. That, once established, the Parks Task Group leads a high-profile public debate on the future of our parks and the establishment of new management models and approaches.

11. The adoption of a common ‘Procurement Concordat’, designed to stimulate, develop and adopt best practice – specifically in creating employment and training opportunities, supporting social enterprise and engaging those citizens who have been in receipt of long-term Incapacity Benefit.

12. The establishment of a dedicated research Institute to study local health and wellbeing issues, with a particular focus on those conditions and illnesses which are caused through or accelerated by inequality and deprivation, working with local people and creating direct social benefits for the local community.
Conclusion

Over the past eighteen months, Commissioners have heard and considered a wide range of plenary, written and research-based evidence.

Much of that evidence sets out a stark and worrying picture of the City-region’s health profile. Colleagues at the PHO reported life expectancy for residents of the City-region as typically 3 years less than the England average, and 7 years less than some parts of the South-East. A growing problem with alcohol misuse, disproportionate levels of benefit dependency and huge inequalities in terms of health, education and living standards emerged as areas of particular concern.

These findings were also mirrored in the results of the Commission’s ‘Street’ research project, which in a detailed examination of seven street-based communities across the City-region found high levels of benefit claims, significant percentages of household income spent on cigarettes and alcohol, poor diet and poor environmental conditions.

More positively, throughout its investigations, the Commission was encouraged to find evidence of individual projects and programmes successfully bringing neighbourhoods and communities together across the City-region in creating positive change. The Commission was struck in particular by the number of progressive and lateral schemes that have been piloted across the City-region to promote local employment, to support the role of social businesses and to provide work and training to the long term unemployed or incapacitated.

It hopes that the auditing and evaluation processes it has recommended within this report might highlight these and other individually successful projects to enable good practice to be rolled-out on a wider scale.

As the scale of its task became clear, the Commission recognised that it would not be able to tackle every issue in its short lifetime. As such, based on its first year of investigations and building on the four core questions it was asked to consider, the Commission identified six key themes on which to focus: Alcohol, Smoking & Obesity, Incapacity Benefit, Built Environment, Wellbeing at Work, Procurement and Knowledge Capital. Following the publication of its Interim Report, the Commission worked closely with colleagues experienced in these fields to refine its early proposals and to determine where interventions might best be made. Building on this feedback, it has developed twelve ‘Big Idea’ recommendations within the six key themes, as set out in this report.

In making these recommendations, the Commission hopes that it has identified clear routes through which the fundamental health and economic issues that sit behind its four core questions might be addressed. It also hopes that it has successfully met its own challenge: to make innovative, deliverable and evidence-based recommendations that will enable positive change and achieve sustainable impact.

The Commission recognises that whilst the publication of this report marks the end of its investigations, it also marks just the beginning of the delivery process. It hopes that its partners and stakeholders will now continue to progress its proposals in the same spirit of openness and positive engagement with which it has endeavoured to work, and that the recommendations made within the IMPACT analysis will assist them in determining the most effective next steps.
The level of passion and commitment it has seen from partners and contributors to delivering positive change makes the Commission confident that this will happen. In handing over its recommendations to its partners, the Commission reminds them of its own adopted mantra:

**Doing nothing is not an option.**

The Commission welcomes the publication of the WHO’s recently published findings on the Social Determinants of Health and in particular its recommendations to improve living conditions, to protect workers, to ‘place health and health equity at the heart of urban governance and planning’, and to ‘invest in the global sharing of evidence on social determinants of health and health equity’. 26

Whilst recognising that by their nature, these issues will require co-operative global action from central government, the Commission hopes that its own proposals under Wellbeing at Work, Beyond the Built Environment and Knowledge Capital can contribute towards the WHO’s objectives, and go some way to addressing those inequalities that have such a real and significant impact on the lives of local people.

By taking action on these issues now, the Commission very much hopes that its work might help to once again position the Liverpool City-region as a pioneer in innovative approaches to public health.

One of the principles behind establishing the Commission was for the City-region to create and take an opportunity to ‘sort out its own problems’ – finding local solutions to local issues, in an investigation funded and supported entirely from within the City-region.


In the same spirit, and as we draw near to the end of Liverpool’s European Capital of Culture year, the Commission hopes that its partners and stakeholders will re-affirm their commitment to the future health, prosperity and wellbeing of all of our citizens by supporting its call for a celebration of 2010 as **The Year of Wellbeing** – a year in which we can come together in a positive, unified and public statement of the Liverpool City-region’s continued commitment to health, to wealth and to wellness.
Appendix 1
List of Witnesses to the Commission

(in alphabetical order)

The Commission gratefully acknowledges the invaluable contribution of those individuals and organisations that gave plenary evidence during its investigations, submitted written evidence or took part in its Away Days and themed task group sessions.

Peter Aikid
Chief Executive, NHS Northwest Collaborative Procurement Hub

George Allen
Step Up to Supply, Sefton MBC

Tony Baldwinson
Knowledge Management & Innovation, RENEW Northwest

Geoffrey Barnes
Senior Practitioner in Public Health, Liverpool PCT

Peter Bates
Merseyside Disability Federation

Tony Bell OBE
Chief Executive, The Royal Liverpool and Broadgreen University Hospital Trust

Professor Mark Bellis
Director, Centre for Public Health

Sir Howard Bernstein
Chief Executive, Manchester City Council

Professor Tim Blackman
Professor of Sociology and Social Policy, Durham University

Paul Blackmore
Policy & Programmes Team, Regeneration, Liverpool City Council

Pat Broster
Supply Chain Initiatives Manager, Groundwork Merseyside

Paul Brown
Community Investment Officer, Clean Slate

Karen Brownbill
Director, Greater Merseyside Learning & Skills Council

Dr Paula Byrne
University of Liverpool, Division of Primary Care

Professor John Caldwell
Pro Vice Chancellor & Dean of Medicine, University of Liverpool

Derek Campbell
Chief Executive, Liverpool PCT

Bob Caton
Procurement Director, Merseyside Fire & Rescue Services

Peter Connor
BT/Chair, NW Flexible Working Group

Professor Cary Cooper CBE
Professor of Organisational Psychology and Health, University of Lancaster

Alan Cunningham
Voluntary Public Community Health Worker

Sarah Dewar
Merseytravel Co-ordinator, Merseyside TravelWise

Shaun Doran
Commercial Director, FRC Group

Dr Stuart Eglin
Director of Research & Development, NHS Northwest

Tracy Fishwick
Head of Employment, Knowsley MBC

Peter Flynn
Communications & Consultation Manager, New Heartlands

Andy Frith
Economic & Development Manager, Learning & Skills Council

Dr Cathy Garner
CEO, Manchester Knowledge Capital
Jim Gill OBE
Chief Executive, Liverpool PLC

Dr Alison Giles
Director of ‘Our Life’, NHS Northwest

Professor Ian Gilmore
President, Royal College of Physicians

Keith Gorman
Programme Manager, Health@Work

Murray Grant
Head of LTP Support Unit, Merseytravel

Professor Janet Hemingway
Director, Liverpool School of Tropical Medicine

Sir David Henshaw
Chairman, NHS Northwest

Alison Holbourne
Merseyside Single Procurement Vision

David Houghton
Estates Manager, Alder Hey

Andy Hull
Head of Public Protection, Liverpool City Council

Dr Ruth Hussey OBE
Regional Director of Public Health/SHA Medical Director at NHS North West

Robin Ireland
Chief Executive, Heart of Mersey

Chris Jones
Operations Manager for Merseyside, Tomorrows People

Rosemary Kay
Merseyside Single Procurement Vision

John Kelly
Executive Director of Regeneration, Liverpool City Council

Paulo Lauria
Centre for Public Health, Environmental Research

Lee Le Clerq
Regional Secretary, British Beer and Pub Association

Nichola Lee
‘Food’ Special Projects Manager, Liverpool City Council

Anita Marsland MBE
Chief Executive, Knowsley PCT

Kevin McGlone
Chair, Merseyside Authorities Procurement Partnership

Jim McVeigh
Head of Substance Use, Centre for Public Health

Frances Molloy
Executive Director, Health@Work

Dave Moorcroft
Director of Economic Development, The Mersey Partnership

Modi Mtswama
Food and Health Programme Manager, Heart of Mersey

Councillor Steve Munby
Liverpool City Council

Anne Mylie
Community Support Contracts, Liverpool City Council

Peter Norman
Purchasing Executive, NHS Purchasing and Supply Agency

Neil Perris
Manager, Conditions Management Programme Liverpool & Wirral PCT

Carol Perry
Director, Liverpool First

Ken Perry
Group Chief Executive, Plus Housing Limited

Tony Rednall
Scottish Criminal Justice Directorate

Councillor Kiron Reid
University of Liverpool School of Law

Lawrence Santangeli
Chief Executive, The Eldonian Group
Neil Scales OBE
Chief Executive and Director General, Merseytravel

Dr Alex Scott-Samuel
EQUAL, Division of Public Health, University of Liverpool

Danny Sharples
Step Closer 2 Work, Liverpool First

John Staples
Step Closer 2 Work, Liverpool First

Jerry Spencer
Social Enterprise Programmes, Business Liverpool

Professor Peter Stoney
Senior Fellow, University of Liverpool Management School

Jack Stopforth
CEO, Liverpool Chamber of Commerce & Industry

Mark Turner
Head of Sustainability, Morgan Professional Services

Councillor Paul Twigger
Chair, Liverpool Childhood Obesity Scrutiny Group

Dr. Geoff Wainwright
Director, 2Bio Ltd.

Val Walsh
Chair, The Duncan Society

Professor Jonathan Watson
Executive Director, HealthclusterNET

Simon Weston OBE
Vice-President and Co-Founder, Weston Spirit

Peter Williams
Merseyside IOSH

Terry Windle
Acting Chief Executive, Alder Hey

Ruth Woodall
Project Manager, Responsibility Northwest

Stuart Wright
Step Closer 2 Work, Liverpool First
A Health Impact Assessment of the Health is Wealth Commission’s ‘Big Ideas’

1. Introduction

‘Health is the greatest wealth’
Virgil (70-19 BC)

1.1 IMPACT – the International Impact Assessment Consortium – based in the division of Public Health, a WHO Collaborating Centre at the University of Liverpool, was commissioned by the Health is Wealth (HiW) Commission (the Commission) to undertake a Health Impact Assessment (HIA) of the Commission’s proposals to improve health and wealth in the Liverpool City Region (LCR), their ‘Big Ideas’. HIA is concerned with improving health and reducing health inequalities. The aim of HIA is to inform and influence policy decision-making by enabling decision-makers to consider the health implications of their policies – in this case the ‘Big Ideas’ – during the policy planning process. HIA involves collecting and analysing evidence of the effects of the policy on key health determinants and in turn their effect on health outcomes.

1.2 The scope of the HIA was limited to undertaking a descriptive analysis of the evidence of the potential effects of five of the six ‘Big Ideas’ published in the Commission’s April discussion document (HiW Commission, 2008) – alcohol, incapacity benefit, health at work, built environment and procurement – on the health and wellbeing of people living in the LCR, and to making recommendations to help shape the Commission’s final proposals, maximising their positive impacts on health and reducing inequalities. The evidence was synthesised from secondary data collected from a range of sources, although some primary data was collected from key informants; further details of the methods used and their limitations are available from the authors. This work was undertaken during July and August 2008.

1.3 This report describes the context for the ‘Big Ideas’, e.g., existing policies and data, the analyses of evidence, and the recommendations. There is a summary of key points for each of the ‘Big Ideas’.

2. Summary of the ‘Big Ideas’

2.1 The ‘Big Ideas’ analysed in this HIA are as follows:

2.1.2 Alcohol
- Introduce HIA procedures via the licensing and planning system to address problems related to alcohol, smoking and diet.
- Establish Area Based Licensing Forums, initially non-statutory, to potentially be rolled out to include fast food.
- Lobby for more formal structures to enable local authorities to consider health impacts in planning and licensing policies and include public health within licensing legislation.

2.1.3 Incapacity Benefit
- Establish a North West Worklessness Task Force (NWWTF) that will help ease people disengaged from a working life back into mainstream employment
- The Commission to lead a regional response to the ‘IB question’
- Include IB as key element of the NWWTF’s remit

Appendix 2
Impact - The International Health Impact Assessment Consortium
Debbie Abrahams, Hilary Dreaves, Fiona Haigh, Andy Pennington and Alex Scott-Samuel
• NWWTF to scrutinise current provision and proposed policy to examine the determinants of worklessness and benefit dependency, to realistically determine what proportion of claimants might be brought back into workforce, encourage effective partnership working, mainstreaming successful programmes and sharing best practice across region.

2.1.4 Health at work
• Develop a Health at Work Charter to promote a complete work-based set of rules for employees and employers
• Promote widespread understanding of business case for improved work-based health policies
• Develop and secure public and private sector commitment to ‘Health at Work’ charter, promoting flexible working arrangements, anti-bullying support, positive equality and diversity policies, environmental awareness, stress-management and work-life balance
• Secure public sector commitment, bring private sector partners on board and roll out across Merseyside
• Examine work-based health policies and practices to ensure they are effective and have positive impacts

2.1.5 Built environment
• Taking a national lead in putting health and well-being at the centre of urban planning
• Develop an LCR ‘Design for Health and Wellbeing’ initiative
• Establish a joint working group bringing together specialists in planning, health, education and housing sectors alongside CABE and RIBA
• Identify key objectives relating to impact of built environment on health
• Develop ‘Design for Health and Wellbeing’ good practice guide that would inform approach to all new development and design across city region
• Include ‘Design for Health’ principles in Supplementary Planning Guidance

2.1.6 Procurement
• Develop a procurement Concordat that will see major public and private bodies signing up to buy goods and services from local sources
• LCR to take national lead in bringing together all public agencies (and ideally significant private sector employers) to agree ‘procurement concordat’
• Stimulate, develop and adopt best practice
• Encourage ambitious and imaginative procurement policies featuring community benefit clauses designed to stimulate job-creation, training opportunities and social enterprise that could be used to engage long-term IB claimants

3. Background

3.1 Life expectancy has increased and key disease mortality rates have decreased in the UK during the 20th Century. For example, life expectancy at birth, early death rates from heart disease, stroke and cancer all show improvements (ONS, 2005). However, although there are clear improvements in total quantity of life, trends in morbidity show a different pattern. For example, longstanding illness and limiting long-standing illness have been increasing since the early 1970s (GHS, 2005). In addition, there are significant geographical variations in both mortality and morbidity. The north/south divide in health identified in the 1980s persists today. In particular women in the North East and North West live over 2 years less than their counterparts in the South East and South West, and men over 2.5 years less (DH, 2007). Similarly, the old Strategic Health Authority areas of Northumberland, Tyne & Wear, County Durham & Tees Valley and South Yorkshire had the highest levels of limiting long-standing illness (DH, 2004). Healthy life expectancy (HLE) at birth, the number of years a person is expected to live in good health and an important measure in relation to the future age limits of the working population, shows similar regional patterns with the lowest levels of HLE in the North East followed by the North West (ONS, 2004).

3.2 Across the LCR there are also variations in mortality and morbidity, with Liverpool having the lowest life expectancy for men (73.4 years) and women (78.1 years) and Sefton the highest (75.9 years for men and 80.4 years for women) (DH, 2007); similarly Liverpool has the highest percentage of people feeling in ‘poor health’ (13.1%) and Sefton the least (9.2%). There are also differences in health outcomes between population groups reflecting socio-economic circumstances. These social inequalities in health (or health inequalities) exist between rich and poor
areas (countries and regions), and between affluent and disadvantaged groups within these. Moreover in the last two decades the social gradient in mortality has increased and there is no evidence that it will recede in the near future (Makenbach, 2005; Drever & Whitehead, 1997). Inequalities in self-reported health are even more pronounced.

3.3 It is generally acknowledged that the health of a population is determined by exposure to different risk factors, e.g., smoking, and risk conditions, e.g., hazards at work, as well as positive health factors, e.g., being in control over life outcomes, good relationships at home, economic security, and protective factors, e.g., a healthy diet, social support. However, the burden of disease – key causes of death and ill health/disability – and their risk, positive and protective factors is specific for each population (Dahlgren & Whitehead, 2006); in addition this analysis needs to go beyond easy-to-measure behavioural risk factors ('downstream'), e.g., alcohol consumption, to more distal and broader risks to health ('upstream'), e.g., economic growth strategies. Finally, in order to address health inequalities, this analysis also needs to identify the factors affecting different socio-economic groups which may be different from those affecting the population as a whole.

3.4 These health patterns reflect the industrial legacy of these areas with different population groups having differential exposure to risk, protective and positive factors.

4. Summary of key points

Alcohol
• Alcohol consumption and harm is an extremely dynamic and complex area of considerable public health and societal relevance and concern at international, national and local levels.
• The content of the Licensing Act 2003 (essentially a reactive dispute resolution process) is varied within the UK, with Scotland having an objective relating to public health that is absent in the English legislation.
• It is clear that the alcohol industry makes a significant contribution to the global and UK economies and is a significant partner in alcohol harm reduction, but the challenges regarding competition law and guidance for business and enterprise make this an extremely sensitive area in the prevailing economic climate.
• The new European Alcohol Strategy while most welcome, does not advocate the harmonisation of legislation, shown to be the most cost-effective intervention at population level.
• While there is a welcome and growing coherence between evidence and policy, there is some lack of congruence between the most recently published evidence on alcohol-related harm and the policy arena at European and national levels, reflecting a lack of clarity for responsibility for alcohol policy. This seems principally to be around promoting as good practice interventions that are effective but resource intensive, or for which there is a less than robust evidence base, particularly at population level. The eventual overall costs of promulgating such an approach have yet to be estimated.
• There is evidence in the literature of significant gaps in the evidence base concerning the effectiveness of interventions on health inequalities and vulnerable groups (including women and families) and the cost effectiveness of interventions for children and young people, disadvantaged and vulnerable groups.
• There is consensus in the difficulty in estimating the economic burden of alcohol.
• This was clearly reinforced in both the HIA and Equality Impact Assessment undertaken simultaneously on the 2007 Alcohol Strategy, ‘Safe, Sensible, Social’, where social identity groups/equality target groups were identified as an appropriate level of analysis to properly differentiate between population subgroups. It was noted that the focus of the strategy was crime, health and cost, not health inequalities and promoting health.
• National policy continues to target “the worst”, with a policy of “cracking down” using existing legislative powers and greater enforcement. It is unclear how this will impact upon health, especially health inequalities in the longer term, although it may bring further improvements in proxy measures and indicators used in the field.
• Key informants have identified that the proposal made by the Commission might be similarly challenged, but commend the Commission for their timely recommendation to bring a consistent approach across a wider LCR geographical footprint, intended to “bring health into planning”; if implemented, this has the potential to contribute to alcohol harm reduction.
In order to maximise the potential impacts on health and particularly to increase the focus on reduction of health inequalities, the Commission should consider the following recommendations:

- Establish systems to gather evidence from implementation of their proposal in order to strengthen the overall evidence-base for using HIA approaches in making planning applications for all licensed premises.
- Establish a means of benchmarking the evidence gathered and experience of implementation against policy advice and development from other sources, particularly Scotland (where the Licensing Act 2005 does have an objective to protect and improve public health unlike in the English Licensing Act 2003) http://tinyurl.com/5mao36 and http://tinyurl.com/5d9b4s and for example, the BMA http://tinyurl.com/636uaf.
- Advocate that relevant agencies lobby for adoption of common byelaws, to harmonise as far as possible legislative policy across the LCR; create a more consistent “level playing field” for those making applications to the area-based licensing forums; assist in evaluation across the LCR.
- Strongly advocate for consistent and common responses across the LCR to the current Department of Health consultation, ‘Safe, Sensible, Social – consultation on further action’.

Incacity Benefit

- Worklessness – unemployment and incapacity – varies regionally and sub-regionally with the North East followed by the North West having the highest levels; in the LCR, Liverpool has the highest unemployment and Knowsley the highest Incapacity Benefit (IB) rates.
- Unemployment levels also vary in different population groups – regardless of qualifications you are less likely to be in work if you are disabled, chronically ill or from certain ethnic minorities.
- Although some suggest IB rates do not reflect deteriorating population health, there is evidence that IB is a legitimate population health indicator.
- There are key IB claimant characteristics for men with some local variations.
- Economic performance drives demand for labour – London and the South East have had the highest growth and the lowest levels of worklessness; only when there are sustained high periods of growth do IB levels fall (employers need to draw on expanded labour supply including people with disabilities or chronic conditions).
- Worklessness affects physical and mental health and is a major determinant of morbidity and mortality; mechanisms include poverty, social exclusion, unemployment as a stressful life event, health-related behaviour changes, disrupting employment (worklessness/employment transitions).
- Worklessness impacts on the Exchequer through welfare benefits and services, but inactivity through incapacity also affects competitiveness through wage demands.
- Decommodifying liberal welfare systems including the UK and US have the poorest health outcomes and are more likely to have intergenerational transmission of welfare dependency on economic grounds – children inherit their parents’ poverty.
- Welfare benefit systems can affect labour market attachment (LMA) and the probability of moving back into employment.
- UK evaluations of ‘welfare to work’ (W2W) programmes show variable effectiveness in increasing employment for people with disabilities or chronic conditions (11-50%); however there are concerns about the reliability and validity of these results, the limited studies on employer-related interventions and lack of data on differential impacts, e.g., by condition, gender, ethnicity.
- Studies on longer-running W2W programmes in the US also indicate that it is difficult to attribute the transition from welfare assistance to employment to these interventions rather than favourable economic and labour market conditions; in addition increases in employment were usually into low paid, poor quality jobs with limited earnings growth potential or employment retention prospects.
- Positive effects from these programmes include self-reported increases in confidence and motivation, and reduced anxiety.
- There is evidence that moving from benefit to employment with no improvement in household income results in adverse outcomes for children; other negative effects relating to leaving welfare assistance (time-limited financial support) without employment include food insecurity, increased hospitalisation of children, rent arrears and living in over-crowded accommodation.
- The Commission’s proposal that a North West Worklessness Task Force (NWWTF) should be established to consider specific regional determinants and interventions to address worklessness is welcome.
and will provide important input to the Government’s welfare benefit reform Green Paper ‘No one written off’, potentially contributing to reducing worklessness and its effects

- However, to maximise the impacts and ensure worklessness is addressed, population health is improved and most importantly inequalities are reduced, it is recommended that the NWWTF adopt the employment, worklessness and health model described below and direct action at different structural levels of the model

Specific action recommended includes:

- Enabling favourable labour market conditions – support and collaborate with national and regional agencies to stimulate economic growth in the North West, e.g., through local procurement collaboratives (section 9)
- Changing employer attitudes – develop campaigns with local industry and commerce champions to address the Labour Market Inequalities that exist – the marginalisation of certain groups from the labour market – and that perpetuate health inequalities
- Developing workplace health – work with national and regional agencies to raise awareness and develop innovative approaches to improving health at work, e.g., ‘health at work’ collaboratives for SMEs, job quality indicators (section 6)
- Developing responsive health services – work with the local NHS to identify ‘bottle necks’ in local health care provision which may impede return to work from sickness or incapacity, e.g., support from mental health or therapy services
- Understanding local IB claimant needs – in recognition of the heterogeneity of IB claimants and their labour market attachment, lobby for and/or commission an analysis of a sample of existing claimants in the NW to define individual and household characteristics, including health status, LMA and where appropriate what support is needed for transition from inactivity/unemployment to employment
- Commissioning ‘evidence of effectiveness’ studies – lobby for and/or commission high quality prospective research to assess the effects of W2W interventions for people with disabilities or chronic conditions with different levels of LMA on, e.g., employment, earnings, job quality, health outcomes; include assessment of employer-related interventions and differential impacts
- Modelling in-work benefit needs – to ensure employment is financially rewarded, household income increases and health is not detrimentally affected, commission economic analyses to estimate the potential in-work benefit needs of former claimants in low-paid employment

Health at work

- Trends in work-related injuries, ill-health and death have changed over the last 30 years reflecting changes in employment and occupation patterns; incidences of ‘traditional’ occupational diseases are unlikely to decline soon because of their long latencies
- The UK has the 12th highest rate of fatal and serious injuries amongst the EU-27
- The most common work-related health problems in the UK are psychological disorders (stress, depression, anxiety), musculoskeletal disorders (MSDs), and injuries
- The North West has injury rates above national levels and self-reported ill-health rates attributed to past or current work similar to the national average (no data was available on illness type)
- The LCR has 3 local authority areas in the highest 25% of all authorities for reported injury rates; no data was accessed on work-related ill-health
- There were 36 million working days lost in Britain and 3.8 million in the North West 1.5 days per worker, similar to the national average; no data was accessed on working days lost in the LCR
- Patterns of injuries, ill-health and death reflect the employment, industrial and occupational mix of regions; however, physical and psychosocial working conditions – their determinants – have changed little in Britain or Europe over the last few years
- There are a plethora of national and European-derived legislation/policies on improving and protecting the health of workers with recent renewed attempts to re-focus and invigorate health at work nationally
- There is general congruence between European and national health at work policy developments, although England is lagging behind on acknowledging and addressing emerging risk factors associated with psychosocial working conditions, e.g., ‘flexicurity’ and quality jobs
- In general being in work is better for health than having no job and is the main determinant of health; mechanisms include providing income/material resources essential for life, social interaction/inclusion, social roles and status
• However there are exceptions to this rule, e.g., workers in poor quality, low paid and precarious (insecure) jobs have work characteristics as damaging to health as unemployment; women, BME groups and people with low or no qualifications are more likely to be in poor quality jobs
• Employment and socio-economic status are the main drivers of the social gradient in health
• There is extensive evidence of the risks to health of physical, chemical and physiological hazards in the workplace; these vary with industry, occupation, gender, ethnicity and age
• Risk factors associated with psychosocial working conditions transcend occupations and industries and affect MSD, anxiety and depression, as well as diseases such as CVD; risk factors include job insecurity or perceived insecurity, high effort/low reward work, work-life balance issues, high demand/low control jobs, support
• Some health at work interventions have been effective in improving health outcomes, e.g., lifestyle change, mental and physical health and wellbeing, and improving other outcome measures, e.g., reductions in sickness absence, improvements in employee performance and effectiveness; however other interventions have not
• There have been very few quality ‘evidence of effectiveness’ studies and there are gaps in interventions at organisational systems and structure level, as well as for specific population groups, e.g., older people
• The Commission’s attention on health at work is entirely appropriate – an LCR ‘Health at Work’ Charter particularly focusing on the psychosocial work environment may contribute to existing measures to improve worker health and wellbeing while also reducing sickness absence and improving organisational performance; however it will be important to distinguish the ‘flexible working arrangements’ which the Commission would wish to promote as this covers a wide range of working practices with both positive and negative health effects. Related to this is the need to consider health issues associated with ‘flexicurity’ and ‘decent work’/quality jobs, a major impact on inequalities.

Specific recommendations are as follows:

• Enabling ‘health promoting’ employment policy – adopt the work and health model and target action at all levels of the model; work with regional and national agencies to develop ‘health promoting’ employment policy;
• Enhancing data availability and accessibility – analyse existing data on work-related ill-health and psychosocial working conditions, including equality and diversity at work in the LCR; commission new research to extend the psychosocial working conditions dataset to include data on ‘flexicurity’ and job quality in the LCR;
• Changing employer attitudes to ‘Health at Work’ – identify ‘Health at Work’ leaders and champions from the public and private sector (including SMEs) to lead the ‘Health at Work’ campaign; work with the NWDA to resurrect the regional multiagency ‘Health at Work’ task group;
• Developing effective occupational health systems and services (OHSS) – work with the HSE/LAs to define OHSS coverage and local OHSS models for the LCR, reflecting industry sector, type and size, and based on ILO/WHO guidelines;
• Implementing ‘Health at Work’ interventions – audit interventions at individual, work environment or organisational systems/structures; pilot innovative interventions, e.g., to improve job quality, or targeted at specific employee groups, e.g., older people, part-time workers;
• Ensuring contractors’ health at Work – design protocols for procurement contracts that ensure a joint liability on the principal contractor for the sub-contractors’ obligations towards their workers;
• Commissioning ‘evidence of effectiveness’ studies – commission high quality prospective studies to assess the effects ‘Health at Work’ pilots.

Built environment
• The Commission’s approach will help health to be considered in the planning and development control process placing health at the centre of urban planning.
• The existing evidence shows clear links between urban planning, the built environment and health with a number of key themes emerging from the evidence; these include:
  • Strong associations between the built environment and physical activity including the relationships between urban design, transport use and
physical activity;
• Associations between urban design, transport and social interaction/capital;
• There are a range of risk factors associated with car dominated transport;
• The built environment, directly and indirectly, exposes human populations to air, light and noise pollution with a wide range of potential negative health outcomes;
• The relationship between urban design and crime/fear of crime is widely recognised;
• Inclusivity of design has important health implications to a range of groups;
• Access to appropriate, high quality green space is important for health and wellbeing;
• The quality of public spaces link to levels of health, crime and wellbeing;
• Regeneration projects that relocate and displace people in an insensitive manner may have negative impacts that counteract the positive effects of regeneration;
• Gaps exist in this growing body of evidence.
• Some aspects of the quality of the built environment are controlled by policies and actors that operate outside the planning and development control system.
• The built environment needs of rural areas, and their populations, within the LCR differ from urban areas.

In order to maximise the potential impacts on health and, in particular, to target health inequalities, it is recommended that the Commission consider the following:

• Consider a wider group of stakeholders in establishing and maintaining standards of quality of the built environment, e.g., building control officers and registered social landlords, and ‘piggy backing’ onto existing initiatives, e.g., Healthy Cities’ healthy urban planning.
• Consider widening the geographical scope to include rural areas within the LCR.
• Commission research to identify and explore the relationship between the built and natural environment.
• Examine existing approaches to development in areas designated as ‘brownfield’ sites.
• Recognise and address the limitations of planning tools, e.g., Supplementary Planning Statements in the context of other material considerations, e.g., economic impacts.
• Support for and raise the profile of Liverpool’s HIA Planning officer to assess the health impacts of development proposals urban and architectural design quality, and a means by which enhancements to development proposals will be progressed through the development control process.
• Reiterate the historical and contemporary links between the planning, public health and related sectors.

Procurement
• The Commission has identified sustainable procurement (SP) as a way to address inequalities within the LCR.
• There are three main components of SP; environment, social and economic.
• All public bodies have to apply the EC Procurement Directives. The concepts of sustainable procurement do not contravene these directives as long as it complies with the principles of non-discrimination, equal treatment, free movement of goods and services and transparency.
• Although there is a relatively well-developed body of research investigating aspects of SP in private sector organisations, there is limited research on SP in the public sector. Studies have mainly focused on environmental issues in procurement, with the social aspects of SP being under-researched to date. There is limited evidence available on the effectiveness of SP.
• SP potentially impacts on a range of health determinants and health inequalities. These include employment, local economy, environment, environmental justice, transport, food and the built environment.
• The commission’s proposal to establish a Procurement Concordat (PC) in its current form could potentially impact positively on determinants of health such as employment and economic benefits. It could provide a valuable contribution to the development of SP at LCR and national level.
In order to maximise the potential impacts on health and, in particular, to target health inequalities, it is recommended that the commission consider the following:

- Ensure that the PC has a clear remit to address all three elements of SP – environment, social and economic.
- Use SP as a tool to explicitly address inequalities. This should extend beyond the labour market and economy (gender, ethnicity, environment etc.)
- Use the PC to address issues of social justice including environmental justice and human rights.
- Commission research into identifying how SP can be used to promote health and target health inequalities in the LCR.
- Commission a scoping exercise to identify examples of good practice to build on.
- Consider impacts on health beyond LCR (e.g. climate change, health staff migration).
- Utilise the involvement of the public sector in the PC to engage with the private sector.
- Ensure that the promotion/use of SP clauses is balanced with actions to address ‘supply side’ issues such as providing support to local businesses to be able to compete.

5. Alcohol

Background

5.1 The publication of the first ever ‘EU Strategy on Alcohol’ in 2006 http://tinyurl.com/ynb5hn is widely welcomed, but viewed by some expert commentators as somewhat weakened, as the European Community do not intend to harmonise EU legislation in the field of the prevention of alcohol related harm.

5.2 At national level, there has been considerable policy development since the first ‘Alcohol Harm Reduction Strategy’ in 2004 http://tinyurl.com/5qxj62 in a number of government departments, demonstrating the importance of the subject, but resulting in nuances of use and interpretation of the scientific evidence according to their remit.


5.4 In an evaluation of the impact of the new Licensing Act http://tinyurl.com/5njt4a, the Department of Culture, Media and Sport (2008) concluded that there were no widespread problems and that while the freedoms of the Act were being utilised, there was greater opportunity for enforcement powers to be used to “crack down” on irresponsible behaviour. Their view has subsequently been contested by the Local Government Association http://tinyurl.com/64agyl.

5.5 Among other 2008 policy publications, the Department of Health has described in ‘Health Inequalities – progress and next steps’ http://tinyurl.com/5t3795 how it intends to accelerate progress in reducing health inequalities by targeting areas of highest numbers of hospital admissions for alcohol-related illnesses and promoting effective interventions, with expansion of alcohol treatment services. The Department of Children, Schools and Families have published a ‘Youth Alcohol Action Plan’ http://tinyurl.com/6djd7w and particularly significantly, the Department of Health has launched a consultation, ‘Safe, Sensible, Social – consultation on further action’ http://tinyurl.com/66n4a9.

5.6 This consultation invites consideration of options to strengthen the currently voluntary retailing code of practice; whether that should be made mandatory; what more can be done by the NHS and how the government might respond if labelling initiatives are not implemented. The British Beer and Pub Association has advised that in light of guidance from the Department of Business and Enterprise and legal advice on competition law the voluntary retailing code of practice is now withdrawn http://tinyurl.com/69v98r

5.7 At LCR level, the focus of the Commission’s work is the Urban Core, where progress in the development
of Alcohol Harm Reduction Strategies is variable, although there is a clear infrastructure, mapped recently by the North West Public Health Group, of those engaged in alcohol-related work across the North West. A focus on the Urban Core may present challenges in reaching an inclusive City-Region-wide policy consensus when there is a timely opportunity for the Commission to develop a cohesive understanding of their “vicinity”, currently variously defined at local level across the country.

5.8 In a complex and volatile policy context, the proposal made by the Commission is both positive and timely, seeking as it does to introduce local Licensing Advisory Forums and HIA approaches into planning applications for licensed premises. There is an opportunity to benchmark activity and progress against policy developments in Scotland, where the new Licensing Act does include an objective to protect and improve public health, unlike England.

Evidence

5.9 In a review of the effectiveness of treatment for alcohol treatment, Raistrick et al (2006) http://tinyurl.com/2uxdb4 noted that the majority of the population move in and out of different drinking patterns, sometimes problem drinking, without going anywhere near treatment services. Public health and preventive measures act as modulators of alcohol consumption, which together with local cultures determine the overall prevalence of problem drinking. Many people move out of problem drinking by responding to support and direction from family and friends or by responding to self-appraisal of the problem drinking. People with more severe problems are more likely to act to achieve stable abstinence, which confers long-term benefits, compared to those moving in and out of problem drinking episodes.

5.10 Evidence on both the population effectiveness and population cost-effectiveness of interventions to reduce the burden of disease as a result of alcohol, that is chronic disease and disability (excluding foetal alcohol syndrome), was drawn together in the 2nd edition of Disease Control in Developing Countries (2006) http://tinyurl.com/6agxce. Estimates made took no account of the social harms or harm to people other than the drinker. As a result of this, the estimates given may constitute half or less of the total burden of alcohol, making the burden of social problems at least as significant as the health burden.

5.11 They concluded that the most efficient strategies for reducing high-risk alcohol use in global regions such as Europe with high prevalence (in rank order) are:

1. Tax increases
2. Introduction or escalation of comprehensive advertising bans on alcohol products
3. Reduced access to retail outlets
4. Brief physician advice

Multi-faceted strategies combining increases in taxation with full implementation of the other interventions also have a favourable ratio of costs to health benefits. Mass-media campaigns were omitted as the evidence was weak with regard to methodological quality and effect on consumption.

5.12 The difficulties of estimating the economic burden of alcohol were discussed by Baumberg in 2006 http://tinyurl.com/6quimt, who observed that premature deaths cannot morally be regarded as cost savings, with attempts to value pain, suffering and human life itself, although contentious, indicating that in Europe, such intangible costs are between one and seven times the value of “real money” costs. Few studies have evaluated (economically) the benefits of alcohol. He suggests that policy-makers should adopt a more generic methodology for cost effective analysis, such as the World Health Organisation (WHO) CHOICE model, discussed by Chisholm, Doran, Shibuya and Rehm (2006) http://tinyurl.com/6fq6e3, who stress that while estimations at regional and global levels may “mask” population subgroups that are at particular risk, such as adolescents and indigenous populations, the only barriers to working at these lower levels are epidemiology and intervention effectiveness literature for these selected groups. Governments should continue to develop cost-effective repression strategies, including prevention and harm reduction, in order to contribute to the body of empirical evidence (including non-health outcomes), as the most cost-effective strategies are linked to government action, are potentially unpopular and can create considerable resistance from industry and lobby groups, often mitigated by the implementation of less cost-effective measures, such as mass-media campaigns.
5.13 The evidence of both effectiveness and cost-effectiveness of interventions to reduce consumption of alcohol and minimise alcohol-related harm are comprehensively dealt with by Anderson and Baumberg in their 2006 report for the European Commission, ‘Alcohol in Europe – A Public Health Perspective’ http://tinyurl.com/657tym. These authors have commented in similar vein to Chisholm et al elsewhere in the literature on government action and the relationship with industry.

5.14 Alcohol is recognised as one of the key health determinants in the European Community, an important contributor to health inequalities between and within member states that risks damaging social cohesion throughout the Union. The burden brought by alcohol and how it places a strain on the viable, socially responsible and productive Europe envisaged in the Lisbon Strategy is described. The report finds that alcohol policy, which is a global public good and an integral part of the health and well-being of European citizens, can enhance social cohesion and social capital and improve health and safety in the living environment, so contributing to higher productivity and sustainable economic development.

5.15 In a UK context, in their 2005 evidence briefing, Mulvihill et al http://tinyurl.com/6c95fn presented the evidence available for a range of interventions, the most effective and cost-effective of which have already been cited here, but found a number of significant gaps in the evidence-base. Most importantly for addressing health inequalities and vulnerable groups, they found a complete lack of evidence on the effectiveness of interventions targeting socio-economic, ethnic or vulnerable groups. The interventions identified did not address the differential effectiveness of interventions among these groups, or how the different components affected them. Primary research was identified as urgently needed to examine the cost-effectiveness of interventions to prevent misuse in both the general population and disadvantaged and vulnerable groups.

5.16 Other gaps included research on the effectiveness of screening and brief advice as part of routine healthcare practice and in the hospital setting, together with evidence of possible cost savings and cost-effectiveness. Few studies demonstrate why some interventions work and others do not when implemented. Further research is needed for multi-component programmes and outreach versus non-outreach programmes in different settings. Research is needed to establish which outcome variables are the most appropriate for youth drinking behaviour, particularly as predictors of alcohol misuse, morbidity and mortality in later life and there is a need to update the evidence on interventions to reduce alcohol consumption in pregnancy. As the workplace captures many of the heavier drinking groups (16-24 year olds, employed professional women, occupational groups at greater risk of developing alcohol related problems), development of workplace alcohol policies should be encouraged.

5.17 The evidence-briefing goes on to suggest that fiscal measures, other forms of legislation, safer drinking environments, education and mass media should all be investigated as to their impacts upon the prevention of both alcohol misuse and related harms.

5.18 The lack of robust cost-effectiveness studies relating to harm reduction was identified by the WHO Expert Committee on problems related to alcohol consumption (2007) http://tinyurl.com/5snwzs

5.19 Both the HIA of the review of the Alcohol Harm Reduction Strategy for England (2007) http://tinyurl.com/5glwvf and the Equality Impact Assessment undertaken simultaneously http://tinyurl.com/59xd3s note that the potential for health improvement or reducing health inequalities did not appear to be a focus of the Strategy, identifying reduction in social incivilities and anti-social behaviour associated with binge-drinking as the short term focus, while seeking to increase social responsibility and change in British culture in the long term.

5.20 These assessments found that successful delivery and implementation of a range of other government strategies was essential to achieving many of the outcomes important to health, but noted that having a largely medical interpretation of health, there were for example, no explicit links to either ‘Choosing Health’ (2004) http://tinyurl.com/5vqijw or the Wanless Report (2004) http://tinyurl.com/54gbs, both key to public health policy.
5.21 The HIA created a conceptual model of alcohol consumption and harm (Figure 1) that demonstrates clearly the links between demand and supply of alcohol, consumption by underage groups, harmful drinkers and binge drinkers aged 18-24 years and several of the wider determinants of health.

5.22 A number of recommendations were made in the HIA to the Government some of which were considered in the final Strategy. Others appear to have been picked up in more recent policy initiatives, but not in so far as re-focussing the Strategy on improving health and reducing health inequalities.

5.23 The statutory Equality Impact Assessment makes a number of observations about the need to focus and properly consult with population subgroups most likely to suffer alcohol harms. It is unclear how the Strategy has met the legal requirement of consultation, particularly with social identity groups and equality target groups relevant to alcohol (women, young women, those with a mental health problem, young women and men not usually routinely consulted by government, people from lower socio-economic groups). It concludes that more subtle differentiation of population target groups is required; wider consultation of vulnerable groups necessary; accurate monitoring by social identity group needed to inform service planning and evaluation; that local partnerships at every opportunity tease out hidden harms; that examples of good practice be widely and effectively shared.

5.24 Two independent reports published after the work of the Commission was concluded provide evidence that supports the proposal of the Commission. ‘Are We Choosing Health?’ (July 2008) http://tinyurl.com/5cnpva calls for renewed drive and focus from the Government, particularly as although improvements have been made, inequalities continue and are changing. Their seven recommendations concern clear, consistent, ambitious and measurable targets; relevant, reliable and up-to-date information; consistent focus across government (all policies to have impacts on health assessed early, that is HIA, but not by name); putting the evidence of “what works” into practice; resources, capability and capacity (economic incentives); commissioning for local need and clear accountability for commissioning and delivery.
5.25 ‘Unequal Partners: A Report into the Limitations of the Alcohol Regulatory Regime’ (July 2008) http://tinyurl.com/5nxwcu makes six recommendations to Government to support accountability for licensee practice and create a level playing field for industry benefit. These are to establish a new, independent watchdog; establish in the first instance a national alcohol enforcement team; make the development of harm reduction policies a condition of applying for a premises (or club) license; review the fee setting system; promote the establishment of local residents’ pressure groups among councils and raise more awareness among residents of their rights; fast track licensing appeals.

5.26 Several evidence reports were simultaneously published on 23 July with the Department of Health policy consultation document ‘Safe, Sensible, Social – consultation on further action’ http://tinyurl.com/5g35zb. These included a substantial review of the alcohol industry’s social responsibility standards document; updated costs of alcohol harm to England (comparative to 2003, so still “service”-oriented, not “health”); an independent review of pricing and promotions; a report on the alcohol labelling regime; hospital admissions data.

5.27 In the absence of harmonising legislation, this recent evidence brings clear coherence with current public policy and offers support to the Commission’s proposal, for example options for strengthening licensing powers and several recommendations from both Alcohol Concern and Audit Commission reports.

5.28 A panel of six key informants was identified to reflect local expertise from the Urban Core of the City Region and also wider expertise from the published literature. All were contacted prior to the most recent “July publications”, so could not comment on these developments.

5.29 All the key informants described broadly the status of their local alcohol harm reduction strategy and related activity, which reflects the variation found in the brief local policy review. All welcomed the intent of the Commission to work at City-region level “[develop a helicopter view]” and intention to lobby upwards. This was identified as an opportunity to influence ministerial thinking as a forerunner to potential changes in legislation and was commended. However, without a strong and clear mandate to act at City-region level, it was unclear how this might be uniformly implemented and as a result the impact of the proposal in regard to alcohol may not be as they anticipate.

5.30 In the absence of harmonising of legislation at European and national levels and in an extremely dynamic global policy arena, not uninfluenced by a strongly lobbying industry, key informants felt that while the proposal might improve local drinking environments, crime and disorder and so on, as evidenced in the literature, without unified approaches there remained potential for simply displacing alcohol related activity elsewhere in or beyond the City-region, with effects unlikely to impact upon health inequalities in the short to medium term. That is to say, monitoring may well demonstrate some quantitative changes relative to improvements in, for example, access to services or reductions relative to current targets, but overall, these are unlikely to significantly impact on health inequalities.

5.31 Other practical suggestions mentioned by key informants included:

- Formal training and development for the proposed forums to guard against the use of competition law to negate the need for HIA approaches in local licensing applications.
- In adopting HIA approaches in licensing applications for all types of licensed outlets, consideration should also be given to local transport infrastructure and initiatives to safely disperse users of alcohol.
- The advantages of co-location of officers leading to shared understanding at local authority level, for example in the forming of local enforcement protocols and development of local authority licensing policy. This also aids working with local trade.
- The proposal would clearly demonstrate participation and partnership for the local authorities, giving them an opportunity to inform the public, address concerns and show responses have been listened to.
• There needs to be some marrying of sub-City Region initiatives, i.e., existing efforts to develop a larger footprint for harm reduction initiatives, with the proposal, perhaps leading to the development of Regional guidance

Analysis, conclusion and recommendations

5.32 There is a growing coherence, but some lack of congruence between policy and evidence, not always helped by the complexity of drinking careers, variations in terminology and interpretation of the evidence. There are gaps identified in the evidence from the literature particularly with regard to impacts upon health inequalities, vulnerable population groups and equality target groups that the work of the Commission could usefully contribute to.

5.33 The new and welcome European alcohol strategy identifies the major impact of alcohol on public health, economic development and society in general, recognising that the level of harm, especially among young people, on roads and at workplaces, remains unacceptably high in all Member States. In accordance with the principle of subsidiarity, it does not propose to develop harmonised legislation in the field of the prevention of alcohol-related harm (shown in the literature to be the most cost-effective intervention) but through an Alcohol and Health Forum to support and complement already implemented national strategies and dissemination of good practice.

5.34 Nationally, policy is developing rapidly, but perhaps with a narrowing of focus. For example, in the health policy arena, preventive interventions shown to be effective (but not cost-effective at population level) are to be advocated to accelerate progress, together with expansion of treatment services (welcome to achieve stable abstinence, rather than address upstream the cultural and societal moderators of alcohol misuse). Interventions, some of which are evidence-based (but not all cost-effective at population level) such as those relating to drink-driving, moderating the drinking environment and others with a less robust evidence-base such as education and media campaigns are to be further advocated at local levels and strengthened through the criminal justice and education systems. Progress in policy-making at local level is apparently variable across the Urban Core of the LCR.

5.35 The withdrawal of the industry’s 2005 voluntary code regarding alcohol promotions demonstrates the complexity and sensitivity of the legislative and policy arenas in the prevailing economic climate. It is as yet unclear how this will impact on health.

5.36 In the absence of legislative policy, the proposal of the Commission to suggest HIA approaches be adopted for planning-related area-based licensing forums is a welcome starting point from which it may be possible to modify local drinking environments and access through retail outlets, for which there is some evidence of effectiveness, but less evidence of either cost-effectiveness at a population level or of impact upon health inequalities, particularly for vulnerable and equality target groups.

5.37 In order to maximise the potential impacts on health and particularly to increase the focus on reduction of health inequalities, the Commission should consider the following recommendations:

• Establish systems to gather evidence from implementation of their proposal in order to strengthen the overall evidence-base for using HIA approaches in making planning applications for all licensed premises.
• Establish a means of benchmarking the evidence gathered and experience of implementation against policy advice and development from other sources, particularly Scotland (where the Licensing Act 2005 does have an objective to protect and improve public health unlike in the English Licensing Act 2003) http://tinyurl.com/5mao36 and http://tinyurl.com/5d9b4s and for example, the BMA http://tinyurl.com/636uaf.
• Advocate that relevant agencies lobby for adoption of common byelaws, to harmonise as far as possible legislative policy across the LCR; create a more consistent “level playing field” for those making applications to the area-based licensing forums; assist in evaluation across the LCR.
• Strongly advocate for consistent and common responses across the LCR to the current Department of Health consultation, Safe, Sensible, Social – consultation on further action.
6. Incapacity Benefit

Background

6.1 After a prolonged fall in unemployment rates in the UK from nearly 11% in 1992 to less than 5% in 2005, this rose by nearly a percentage point by the middle of 2006; subsequently the rate has been relatively stable to the middle of 2007 (5.6% May 2006 to 5.4% October 2007) with a fairly flat trend (5.3, 5.4%) since November 2007 (ONS, 2007).

6.2 The LCR, like many of the former industrial centres of the UK, has higher than average levels of worklessness in the working age population. Although there are different definitions, for this purpose worklessness includes unemployment (people out of work, but available and looking for work) and incapacity (people not able to work through ill health or disability).

6.3 There have been regional variations in unemployment across England for many years with the North East, West Midlands and the North West having the highest rates in 1993 and in 2007 (with some gender variation). There have also been historical sub-regional variations in unemployment which still exist. For example, in 2007, the West Midlands had unemployment rates ranging from 2.8% (Stratford-on-Avon) to 9.2% (Birmingham); the North West had an unemployment rate range of 2.5% (Ribble Valley) to 8.6% (Liverpool) and the North East 3.5% (Durham) to 8.6% (Hartlepool).

6.4 In the LCR the 2007 unemployment rate range was 6.1% (St Helens) to 8.6% (Liverpool) with an average rate equivalent to that for the 27 countries of the European Union (EU) (Eurostat, 2007; DWP, 2007).

6.5 In addition, there is evidence in England of differential levels of unemployment across population groups; in the following order, disabled people, including people with chronic ill health conditions, Black and ethnic minority groups (particularly people from Bangladeshi and Pakistani origins), lone parents, people with no qualifications, older people (50+) and women are more likely to be unemployed (Abrahams et al, 2004).

6.6 Using Incapacity Benefit (IB) claimants as an indicator of incapacity, there has been a marginal decline in England over the last 9 years from 7.0% in 1999 to 6.7% in 2007 (DWP, 2007).

6.7 Regional variations in IB claimant rates have shown some similarities to the unemployment patterns. In August 2007, the North East was the local authority (LA) area (Easington) with the highest IB claimant rate at 17.7%, the largest proportion of LA areas (86.9%) above the England IB claimant average and has five LAs in the top 10 IB claimant rate LA areas (Easington, Hartlepool, Wear Valley, Sedgefield and Sunderland).

6.8 The North West was the region with the second highest IB claimant rate at 13.6% (Knowsley) and the second largest proportion of LA districts (76.7%) above the England IB average; in addition the region had three LA areas in the top 10 LA areas (Knowsley, Liverpool and Barrow). Time series data shows the North West's IB claimant rate has fallen by 2.2% between 1999 and 2007, with areas such as Liverpool and Knowsley falling even lower, by 3.2% and 3.5%, respectively (ONS, 2007).

6.9 At a national level IB claimant characteristics are emerging particularly for men (Fothergill, 2005):

- Aged 50-64 years
- Two-thirds are former manual workers
- Significant work experience, often for long periods with one employer
- Ill health/injury accounted for 50% job losses
- About a half want a full-time job
- Around 25% say they couldn’t work at all
- Less than 10% are looking for work
- About a quarter moved onto IB from unemployment benefits
- Many have been on long term IB claimants – about half for more than 5 years
- A significant minority draw on a company or personal pension as well as IB (IB not means-tested)
- Health problems by prevalence – mental and behavioural disorders, musculoskeletal diseases, other diseases, circulatory diseases, diseases of the nervous system, injuries

6.10 The characteristics for women are less clear. However, there are regional variations of these
general characteristics and heterogeneity in relation to labour market attachment. For example, in a recent survey in Northern Ireland (Shuttleworth et al., 2008) 75% said they had lost their job through ill health and the main health problems were musculoskeletal (37%), coronary and circulatory diseases (19%), allergies (14%) and mental health problems (depression) (7%). In the LCR, the health problems of IB claimants reflect the national pattern (NWPHO, 2007). There is also evidence of heterogeneity.

6.11 Economic indicators show that there has been sustained growth across the UK since the late 1990s; in England, Gross Value Added (GVA) per head of population increased by 47% from £12,313 in 1997 to £18,097 in 2005. However, there are regional variations in economic performance with the West Midlands (40.5%), followed by Yorkshire and Humber (42.1%); the highest growth was in London (52.3%) followed by the South East (49.8%). Between 1997 and 2004, productivity patterns showed different regional trends: an increase across England (31%), with the North West having the lowest growth in productivity per workforce job (20%), followed by the North East (24%) and the South East having the highest growth (34.6%), followed by London (30.3%) (ONS, 2006).

6.12 With increases in economic growth and more favourable labour market conditions, there have been associated reductions in unemployment for the ‘job ready’; the propagation of ‘welfare to work’ programmes and ‘work first’ approaches reflecting liberal welfare state types (Epsing-Andersen, 1990) has accelerated this transition into work (Abrahams et al, 2004).

6.13 However, the relatively flat unemployment trend (5%) over the last 3 years suggests that there are fewer ‘job ready’ claimants remaining with a ‘core’ of long term, older, less skilled, unemployed remaining. The regional and sub-regional unemployment variations tend to reflect the industrial legacy of these areas and the local labour supply.

6.14 There are different interpretations of the rise and slow decline in incapacity (IB) rates. Some suggest that this is not to do with deteriorating population ill health (although recognising that IB claimants have to be independently assessed by doctors), but more to do with the benefit system itself – once an IB claimant, there is no requirement to look for work and because as IB claimants they are better off financially than as JSA claimants, they give up looking (Beatty et al, 2007; Fothergill, 2005).

6.15 Others are more cautious (Little, 2006); based on comparative analysis between IB claimant data and self-reported health, illness and mortality data, it is evidenced that IB claimant data is a legitimate and useful annual population health indicator (Norman & Bambra, 2007; 2006).

6.16 In addition the plentiful supply of labour and the reluctance of employers to engage workers with ill health or disability have contributed to this marginalisation of less healthy workers; this is particularly so in those areas where there is a low demand for labour, e.g., North East and North West. Only when there are sustained, high levels of growth do IB numbers fall, reflecting fewer new IB claimants rather than an outflow of existing claimants. The concept of ‘hidden unemployment’ has been used to describe those IB claimants who in genuinely full employment could be reasonably expected to be in work (Beatty et al, 2002; Fothergill, 2005; Beatty et al, 2007).

Evidence
Effects of worklessness
6.17 There is strong evidence that worklessness affects physical and mental health; it is a major determinant of morbidity and mortality (e.g., Lawless, 1998; Bethune, 1997). It has been estimated that for every 2000 unemployed men, there are 3 excess deaths (BMA, 1998). Various studies have shown that unemployment has an independent effect on mortality. One study has indicated up to a 10-year lag in increased all-cause mortality associated with unemployment (Brenner, 2002). In addition to the impacts on unemployed men and women, family members including children are also affected. Unemployment is a key determinant of health inequalities, with people further down the social scale being hit hardest.
6.18 Explanations for the mechanisms by which unemployment leads to poorer health focus on the following factors:
- Poverty and poor living conditions
- Unemployment as a stressful life event
- Social exclusion
- Health-related behaviour changes
- Disrupting employment

6.19 The links between poverty and poor health are well established. People in poverty live in less healthy environments and are less likely to have healthy lifestyles. Many studies link the effects of unemployment (and low paid work) directly to financial strain. For example studies show that unemployed people who borrow are twice as prone to depression as those who do not. Psychological health and wellbeing falls most sharply immediately after unemployment; this includes depression, lower self efficacy, alienation and cynicism. This plateaus after 12-18 months as individuals adapt to their financial and social circumstances. The scarring and stigma effects associated with unemployment may also be experienced with inactivity.

6.20 The concept of unemployment as a stressful life event is based on the non-financial benefits associated with work; self esteem, status, social interaction, and personal achievement. There are many studies that show the link between low self esteem and depression which can lead to the activation of biological stress mechanisms that increase the risk of CHD.

6.21 There is some evidence that unemployment is associated with some forms of health-damaging behaviour, such as excessive alcohol consumption and cigarette smoking, although it is not clear if the behaviour or job loss comes first. Employment-related weight gain and loss has also been reported, increasing the risk of future cardiovascular episodes. There are also impacts on family relationships.

6.22 The effects of unemployment may go beyond a single spell of worklessness. There is evidence that unemployment can become a recurring event. Once again people from lower socio-economic groups are disproportionately affected. The repetitive nature of unemployment may lead to chronic job insecurity, higher than normal exposure to poor quality jobs and a lack of control over working life.

6.23 As already described there is strong evidence showing clear labour market inequalities (LMI) for certain population groups; people with disabilities and chronic health conditions, ethnic minority groups, lone parents, people with no qualifications, older people and women have lower employment rates than the working age population as a whole (ranging from 4.2%-32.8%, 2002 data). Some of these groups have poorer health than the population as a whole according to a number of health measures, e.g., people who are chronically sick or disabled, Bangladeshis and Pakistanis. As such there is a double disadvantage for these groups. In addition, there is some evidence that these disadvantaged groups tend to be recruited into poor quality jobs – low pay, low skills, poor psychosocial and physical work environments, as well as being insecure.

6.24 There are also economic effects associated with worklessness. Firstly there is a financial cost to the Exchequer; IB/SDA claims are estimated at nearly £6 billion per annum for England and £290 million for the LCR (NWPHO, 2007), which some would argue could be spent elsewhere or on possible tax cuts. Secondly, there is a cost to the economy through lost growth and productivity; however as has been discussed above those areas with a high demand for labour have high employment rates and low unemployment and incapacity rates anyway, the former driving the latter not the other way round. Thirdly a larger labour supply is said to put a downward pressure on wages and is less inflationary (Barrell et al, 2003); this reduces unit costs and export prices whilst increasing competitiveness and ultimately creating jobs.

Effects of welfare systems and services

6.25 There is evidence to suggest that those welfare regimes with highly decommodifying state packages, i.e., where the economically inactive or unemployed are reliant on state income to maintain ‘normal and socially acceptable standards of living’ (Epsing-Andersen, 1987; 1990) have less stark class and income inequalities and also have better national health outcomes as measured by Infant Mortality Rates (IMR) (Bambra, 2005) and IMR and low birth weight rates (LBWR) (Chung & Muntaner, 2006).
6.26 Both studies analysed 18 OECD countries and indicated that the social democratic welfare system-type of the Scandinavian countries had the highest decommodification scores and performed best in terms of their health outcomes, with the UK in the liberal welfare system category with the lowest decommodification scores and the poorest health outcomes. Chung & Muntaner analysed this trend over 39 years, showed this to be independent of GDP per capita and that the effect widened over the 1990s; they calculated that 20% of the country differences in IMR and 10% of LBWR could be accounted for by welfare state types.

6.27 There is also some evidence from analysis of European Social Survey data that self-reported health, mental and physical, is also associated with welfare system type (Eikemo et al, 2008). Thus it appears some welfare systems are better for population health than others.

6.28 Investigation into the intergenerational effects of welfare recipiency indicates that there is no single or straightforward explanation for this (Stenberg, 2000). Some evidence from Liberal (US) and Social Democratic (Sweden) welfare systems suggests both systems have intergenerational transmission effects, but whereas in the US this appears to be economic – ‘poverty heredity’ is the main driver – in Sweden there is a ‘social heredity’ effect – family circumstances, adjustment problems, parental criminality, and poverty all play a part.

6.29 Within the UK, there is evidence of benefit system effects on labour market attachment (LMA) (Shuttleworth et al, 2008; Little, 2006). Short term IB claimants (less than 2 years) are less likely to be detached from employment, valuing work most and those short term claimants who also ‘felt in control’ were more likely to expect to be working within 2 years.

6.30 Longer-term claimants, however, suffer from the highest degree of detachment. Related to this is the de-skilling of these claimants. As such there is heterogeneity of claimants by duration of claim and LMA, which may also affect job search behaviour.

6.31 There is some evidence indicating that the probability of moving back into employment is associated with active job search behaviour and willingness to work (Little, 2006). In addition there is a suggestion that how benefit systems operate can also affect LMA and so transition from inactivity to unemployment or employment.

6.32 ‘Welfare-to-work’ programmes have been in operation in the US and Europe including the UK for many years (Gregg et al, 2007; Bambra et al, 2005; Abrahams et al, 2004). In the UK there are a wide range of ‘welfare-to-work’ interventions, including ‘work first’, skills programmes, advice/support, in-work benefits, and employer incentives.

6.33 There have been a number of studies examining the effectiveness of those programmes targeted at people with disabilities or chronic ill health (Hasluck & Green, 2007; Bambra et al, 2005); these have shown variable results. For example, success in gaining employment ranged from 11-50% depending on age, disability-type and ‘job readiness’ as well as the wider labour market and social context.

6.34 Concerns about the quality of these studies, e.g., the lack of controls in most, have made it difficult to say if the interventions themselves increased employment, and, in particular if they would work in unfavourable labour market conditions.

6.35 There was also very little experimental evidence on certain interventions, e.g., on employer incentives, and on differential impacts by condition, gender, ethnicity, lone parents or social group. Finally the estimated 4-year lag between policy reform and change in employment behaviour has added to the practical difficulties in evaluating their effectiveness.

6.36 Evaluation studies from the longer-running US ‘welfare-to-work’ programmes also have difficulty attributing the increase in employment to specific interventions rather than economic performance; however, results of ‘work first’ approaches outperformed skills, education or training programmes, with a transition for most welfare recipients from welfare benefit/assistance to employment.

6.37 These results were undermined by most jobs typically being low paid and poor quality, with
limited earnings growth over time, or employment retention prospects (Gregg et al, 2007; Huston, 2002). In addition although absolute child poverty was reduced, if a parent’s move from benefit to employment meant no increase in household income, child wellbeing did not improve (e.g., Proctor and Dalacker, 2002; Morris et al, 2001).

6.38 Unlike the current UK incapacity system the US funding regime meant compulsion and time limits for financial assistance were imposed; there were a number of other impacts associated with leaving welfare support, e.g., food insecurity/hunger, rent arrears, living in overcrowded accommodation (Polit et al, 2001), hospitalisation of children (Scalicky & Cook, 2000).

Analysis, conclusion and recommendations

6.39 Based on this evidence a model of the relationship between employment, worklessness and health (Figure 2) has been constructed; this includes the transition between incapacity, unemployment and employment and the health effects of this.

6.40 Worklessness is high in the LCR compared with many areas in England, but in the economic and ill health context this is to be expected. It is important to acknowledge that IB is a legitimate population health measure and to refute arguments that further stigmatise an already disadvantaged and discriminated group of people. Having said that there is clear evidence that the UK welfare system itself is associated with poor population health outcomes, fails to adequately support IB claimants who wish to enter or return to work and that welfare interventions that are in place have questionable effectiveness.

6.41 The Commission’s focus on worklessness as a major determinant of ill health and inequalities in the region is highly appropriate. It is also timely in view of the Government’s recent launch of their consultation on welfare reform of worklessness (DWP, July, 2008). As such establishing a North West Worklessness Task Force (NWWTF) to work with existing statutory, business and voluntary sector agencies to identify determinants and interventions to address regional worklessness is welcome; it is likely that this regional attention will ensure locally-sensitive and so more appropriate solutions adding value to the national agenda.

6.42 Although it is recognised that detailed proposals are to be developed, to maximise the positive impacts and ensure worklessness is addressed, population health is improved and most importantly inequalities are reduced, it is recommended that the NWWTF adopt the work, worklessness and health model (reflects the evidence of the dynamic inter-relationship between the economy, employment/worklessness and health) and direct action at different structural levels of the model. As part of this it will be important to have a better understanding of worklessness, including incapacity in the region; however care should be taken with quantifying a so-called ‘hidden unemployment’ figure.

6.43 Specific action recommended includes:

- Enabling favourable labour market conditions – support and collaborate with national and regional agencies to stimulate economic growth in the North West, e.g., through local procurement collaboratives
- Changing employer attitudes – develop campaigns with local industry and commerce champions to addresses the Labour Market Inequalities that exits – the marginalisation of certain groups from the labour market – and that perpetuate health inequalities
- Developing workplace health – work with national and regional agencies to raise awareness and develop innovative approaches to improving health at work, e.g., ‘health at work’ collaboratives for SMEs, job quality indicators
- Developing responsive health services – work with the local NHS to identify ‘bottle necks’ in local health care provision which may impede return to work from sickness or incapacity, e.g., support from mental health or therapy services
- Understanding local IB claimant needs – in recognition of the heterogeneity of IB claimants and their labour market attachment, lobby for and/or commission an analysis of a sample of existing claimants in the NW to define individual and household characteristics, including health status, LMA and where appropriate what support is needed for transition from inactivity/unemployment to employment
- Commissioning ‘evidence of effectiveness’ studies – lobby for and/or commission high quality prospective
research to assess the effects of W2W interventions for people with disabilities or chronic conditions with different levels of LMA on, e.g., employment, earnings, job quality, health outcomes; include assessment of employer-related interventions and differential impacts

- Modelling in-work benefit needs – to ensure employment is financially rewarded, household income increases and health is not detrimentally affected commission economic analyses to estimate the potential in-work benefit needs of former claimants in low paid employment

7. Health at Work

Background

7.1 Trends in work-related injuries, illnesses and deaths in the UK have changed over the last 30 years or so with changing employment and occupation patterns (Davies & Jones, 2005; Drever, 1995). The shift from male-dominated primary and heavy manufacturing towards the service sector has had generally positive impacts on workplace health and safety. This trend of improvements in occupational health is generally reflected across Europe although there is significant variance between member states (Eurofound, 2008).

7.2 However, with the nature of risks faced by employees changing as the economy alters new or previously ignored workplace injuries and illnesses are emerging. It is also important to note that the long latency of many ‘traditional’ occupational illnesses means that their incidence levels are unlikely to decline soon; in Great Britain over 2000 people died from mesothelioma and thousands more from other occupational cancers and lung diseases during 2005 (HSE, 2007a).

7.3 Most recent occupational health data indicates over 2 million people believe they suffer from an illness caused or made worse by their current or past work (HSE, 2007a). During 2006/07 241 people were killed at work, with over 140,000 reportable injuries under RIDDOR and 274,000 reportable self-reported injuries according to the Labour Force Survey (LFS). The construction and agriculture industries have the highest rates for fatal and non-fatal injuries, and health & social care, extraction and agriculture sectors have the highest prevalence of self-reported ill-health. In the EU-27 the UK was 12th highest for fatal and serious injury rates (Eurofound, 2008).

7.4 Currently, the most common health problems associated with work in the UK are psychological disorders (stress, depression and anxiety),
musculoskeletal disorders (MSD), and injuries from slips and trips at work with 36 million working days lost in 2006.

7.5 In the North West in 2006/07, there were 33 fatal injuries, over 3,400 major injuries and 14,000 over 3-day injuries; these rates were all above national levels with rates not changing much over the last 5 years. The pattern of injuries and ill-health reflects the employment, industry and occupational mix in the region, e.g., the Services industries accounted for 55-64% of fatal and major injuries over a six-year period to 2006/07.

7.6 In the LCR, St Helens, Knowsley, Halton and Wirral had injury rates in the highest 25% of all local authorities (HSE, 2007b). Over 3.8 million working days were lost in the North West during 2006/07 a similar rate per worker to the national rate of 1.5 days.

7.7 From British workers' perspective working conditions have changed little between 2005 and 2006, with 50% reporting their jobs involved manual handling and handling harmful substances (HSE, 2007a); interestingly risk controls for manual handling and handling harmful substances were also thought to have decreased in the same period. In addition there has been little change in psychosocial working conditions – demand, control, managerial support, peer support, role, relationships and change – between 2004 and 2007, when these conditions first started to be monitored.

7.8 At European level, women report lifting people and handling infectious materials more than men. Similarly to the UK, psychosocial working conditions appear fairly stable, although men report being more exposed to psychosocial factors.

7.9 In addition to the statutory duty of employers to consider the health, safety and welfare of their employees under the Health & Safety at Work Act (HMSO, 1974) there are numerous national policies and strategies, many originating from the EC, designed to protect and promote the health of British workers. For example, Working Time Regulations (TSO, 1998), Part Time Workers Regulations (TSO, 2000), Employment Act (TSO, 2002), Employment Equality Regulations (TSO, 2003), and Balancing work and family life (HMT/DTI, 2003).

7.10 The Health and Safety Executive's 'Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond' (HSE, 2004) which builds on 'Revitalising Health and Safety' (HSE, 2000) targets and ‘Securing Health Together’ (HSE, 2001) aims to achieve workplace health and safety that leads the world. However targets for reducing work-related ill-health incidences and working days lost are not on track. In addition the Management Standards launched by the HSE in 2004 as an approach to improve psychosocial working conditions and tackle work-related stress are not expected to take effect before 2008; both job-stressfulness and stress-related ill health are already said to be decreasing but the Management Standards initiative is not thought to have directly contributed to these reductions (HSE, 2007c).

7.11 The most recent proposals from Dame Carol Black reinforce the economic benefits to employers of an holistic approach to improving workplace health and wellbeing and the impact of the psychosocial work environment on health and performance (Black, 2008).

7.12 The LCR has historically championed health in the workplace with projects such as the Liverpool Occupational Health Project and Knowsley’s Workplace Health Development project. Similarly specific industry sectors have introduced their own programmes, e.g., the NHS’ ‘Improving Working Lives’ scheme (DH, 2002) combining healthy workplaces with flexible working practices.

7.13 Although there is general congruence with these national occupational health policy developments with those in the EC, e.g., ‘Improving quality and productivity at work: Community strategy on health and safety at work’ (EC, 2007a) and ‘Together for health: A strategic approach for the EU’ (EC, 2007b), there is a wider policy debate on ‘quality jobs’ (EC, 2002; 2001; 2000) or ‘Decent Work for All’ (EC, 2008; ETUC, 2007) and ‘flexicurity’ (EC, 2007c) which is absent in the UK.

7.14 The Lisbon Strategy’s focus on developing a knowledge economy and the European Employment Strategy’s drive for increasing labour market flexibility – flexible (non-standard) contract types, flexible functionality (adapting jobs task) and
numerical flexibility (‘downsizing’) – have associated, new occupational health effects. These strategies and their occupational health effects also apply to the UK but have not yet featured in national policy.

Evidence
Effects of work on health
7.15 There is a body of knowledge that shows higher levels of employment leads to better health of the population. For example, a study on the impact of unemployment rates on mortality in European Union (EU) countries showed a clear decline in mortality with increases in employment (Brenner, 2002). Work is generally the means of obtaining adequate economic resources to meet the material needs to live in today’s society. Employment also benefits mental health, e.g., through social interactions and involvement in a collective effort, as well as providing identity and status. Employment and socio-economic status are the main drivers of social gradients in health. In general being in work is better for health than having no job.

7.16 However there do seem to be exceptions to this rule (Waddell & Burton, 2006). Some work characteristics can be as damaging to health as unemployment. Workers in jobs that are poor quality, low paid and precarious (insecure) have similar health scores to the unemployed; the social context needs to be considered; a small group of people may experience contrary health effects from work(lessness). Women, ethnic minority groups and those with no or low qualifications are more likely to be in poor quality jobs (IER, 2007).

7.17 There is an extensive evidence-base which shows the relationship between different occupations, exposure to physical and chemical work hazards and risks to health (Drever, 1995). For example, physicochemical exposures to noise, vibration, and dust injuries, as well as working at height are hazards associated with the construction industry. Physiological and ergonomic factors are associated with occupations involving heavy lifting, e.g., health and social care, and repetitive movements, e.g., assembly work.

7.18 There is also evidence of the differential distribution of exposure to these hazards according to skill level, contract type, hours worked, gender, age and ethnicity. Interestingly, some evidence shows a relationship with workplace injuries and the business cycle; across all sectors a 1% increase in GDP above trend is associated with a 1.4% increase in the rate of major accidents (Davies & Jones, 2005). This is thought to be due to the hiring of new staff (newer workers are more at risk of injury) and an increased worker effort.

7.19 In addition to specific occupational risk factors, there is also a growing literature on the relationship between the psychosocial work environment and employee health which transcends occupations. Research has shown the psychosocial work factors that affect health include:

- High demand, low control jobs – increased risk of cardiovascular disease in people with jobs characterised by low control
- High effort, low reward jobs – Increased risk of cardiovascular disease
- Anticipation of job loss or job insecurity – increase in psychological disorders (especially anxiety, depression), self-reported ill-health, cardiovascular disease and associated risk factors
- High levels of worker support – offset some negative effects of job insecurity

7.20 In general working conditions that are low control and make high psychological demands on workers (‘job strain’ model) (Marmot et al, 1997) have an increased risk of:

- Coronary Heart Disease (CHD)
- MSD
- Psychological disorders
- Sickness absence

7.21 These risks have been shown to be independent of individual psychological characteristics; high demand, low control work is more common with less skilled jobs and lower socio-economic groups. It is believed that psychological factors at work may play an important part in the social gradient in ill health.
7.22 Specific ‘job strain’ work characteristics associated with health-related problems at work includes:

- Changing nature of work, e.g., labour market flexibility
- High levels of repetitive, stressful work
- Increased time pressures
- Increased work intensification
- Increased multi-skilling demands

7.23 There is evidence that when there is a perceived imbalance between individual effort and reward this results in emotional distress or ‘active coping’ characterised by feelings of anger, frustration and dissatisfaction; this in turn is associated with changes in the nervous and hormone systems (neuro-hormonal response) (Siegrist, 1996). Studies have shown a two to six times increase in relative risk of cardiovascular disease and a 2.6 and 1.7 times increase in psychiatric risk for men and women, respectively (Stansfield, 1998). Other health effects include:

- MSD
- Gastrointestinal disorders
- Fatigue
- Sleep disturbance
- Sickness absence
- Coronary restenosis (re-blocking of coronary arteries)

7.24 As described above recent trends in employment in Europe including the UK show an increase in demand for labour market flexibility, e.g., ‘hiring and firing’, part-time hours and fixed term contracts. There are physical and psychological health effects associated with both ‘actual’ job insecurity, e.g., temporary/fixed term contracts, and ‘perceived’ job insecurity, e.g., loss of valued features of a job (Ferrie et al, 2002). An increased use of health services has also been reported.

7.25 Some recent work indicates that the most acute deterioration in health status occurs when employees move from secure to insecure jobs; these health effects are not mediated by the normal ‘job strain’ main psychosocial work characteristics such as low control suggesting that during organisational change a different type of ‘job strain’ model applies compared with a stable state organisation. In addition to the health effects of ‘flexicurity’, there are other emerging psychosocial health risks including job quality/decent work, ageing workforce, work intensification, high emotional demands, low pay/working poverty, work-life balance issues (OHSA, 2007; EWCO, 2007).

7.26 Research indicates that the negative impacts on health from working conditions and organisational change can be offset when workers are provided with information and given the opportunity to discuss possible changes. However there is also inequity in these opportunities with unskilled workers being least engaged in these exchanges. It has also been found that social support in the workplace ameliorates the effects of job strain.

**Effects of health at work interventions**

7.27 There is strong evidence of the effectiveness of workplace health promotions interventions, i.e., measures and programmes aimed at promoting health (or reducing ill-health) at work. However their effectiveness varied according to their focus. For example, comprehensive workplace health promotion programmes, including needs assessment, lifestyle change, screening and risk reduction, health education targeted at individual and workplace levels were evaluated as effective (Kallestal et al, 2004). Outcome measures included reductions in health-related care costs (US programmes) and sickness absence, enhanced employee performance/effectiveness, as well as improvements in health behaviour, physical and mental health.

7.28 Reviews of programmes focused on reducing musculoskeletal problems including neck and back problems indicate that training in preventing back pain is effective, but preventing other musculoskeletal symptoms is inconclusive (Kallestal et al, 2004); another review indicates that success in improving musculoskeletal health at work is most likely when there is an organisational culture with high commitment to stakeholders, utilising multiple interventions to reduce risk factors and modifier interventions involving and targeting workers at high risk (Westgaard & Winkel, 1997). Evidence of the effectiveness of programmes aimed at reducing workplace accidents and injuries is also limited (Kallestal et al, 2004); one meta analysis
on the effectiveness of behaviour-based safety interventions (Tuncel et al 2006) indicates that the poor quality of studies to evaluate this means reported reductions in workplace accidents and injuries should be treated with caution.

7.29 Lifestyle programmes and programmes designed to reduce the risk of cardiovascular disease showed some success. Programmes promoting and supporting employees to be more physically active had positive results; however positive effects on health outcomes such as lower blood lipid levels, hypertension and reduced fatigue were less evident (Kallestal et al, 2004). There is some evidence of a positive, albeit limited effect of worksite physical activity on absenteeism, but inconclusive evidence on the effects on job stress and satisfaction (Proper et al, 2002). Guidance on promoting physical activity in the workplace has also been developed by NICE (2008).

7.30 Regarding preventing cardiovascular disease, the evidence suggests cautious optimism especially when individual counselling is part of the programme (Kallestal et al, 2004). However, weight reduction programmes do not point to any lasting effects. No-smoking workplaces were shown to be effective in reducing smoking in employees (Kallestal et al, 2004); this is further enhanced when smoking cessation support is provided (NICE, 2007). There is some, although limited, evidence that substance abuse programmes – alcohol and drugs – when integrated into wellness programmes may be effective in reducing heavy and binge drinking (Deitz et al, 2005).

7.31 Evidence of the effectiveness on promoting mental health and wellbeing at work is mixed. Stress management programmes used various methods and as such it is difficult to evaluate their effectiveness (Kallestal et al, 2004). Reviews of US interventions examining the cost-effectiveness of enhanced depression care for employees (Wang et al, 2006) suggests some marginal benefits in Quality Adjusted Life Years (QALYs) and although an initial cost to the employer a cumulative saving over a 5-year period.

7.32 However there is paucity in interventions at organisational level to improve psychosocial working conditions and employee mental wellbeing. The HSE’s Management Standards programme is one relatively new example which has yet to yield results (HSE, 2007) and NICE is due to report on a comprehensive review of the effects of work and working conditions on employee mental health and wellbeing in June 2009.

7.33 Other specific interventions include ‘health circles’ – employee/employer participation groups responsible for identifying problems at work and solutions to address them; a review of these in Germany suggested some success in terms of reduced sickness absence and improvements in physical and psychosocial working conditions, although because of the quality of the study advised further research (Aust & Ducki, 2004).

7.34 In spite of the support for the development of Occupational Health and Safety Systems and Services from, e.g., WHO, the EC and Dame Black, and an intuitive belief that this will improve health and safety of workers, there is limited evidence to support this; the findings from a systematic review of thirteen high quality or moderate studies report that there was insufficient evidence to say if they were effective or not mainly due to the studies’ limitations (Robson et al, 2007).

7.35 No studies were accessed on interventions targeted at specific population groups, e.g., women; it is also acknowledged that some workers, e.g., those on temporary contracts do not often have access to these services.

Analysis, conclusion and recommendations
7.36 The evidence described above has been used to construct a ‘work and health’ model (Figure 3) describing the relationship between the physical and psychosocial work environment and health.
7.37 Work is generally better for health than having no job. However, there are exceptions to this rule; e.g., poor quality, insecure and low-paid jobs have similar health scores to the unemployed. Women, BME groups, and people with low or no qualifications are more likely to be in poor quality jobs.

7.38 Work-related injuries of some areas in the LCR are amongst the highest 25% of all local authorities in Britain; however, these rates reflect the employment, industry, and occupational mix of the area. Interestingly, working days lost per worker due to ill-health are similar to the national average. It is important that with the increase in physical regeneration of the area, e.g., Housing Market Renewal, Capital of Culture, Universities campi, that the health and safety of workers remains paramount. No data was accessed on work-related ill-health in the LCR.

7.39 The emerging occupational health risk factors that have been identified relate to psychosocial working conditions. No data were accessed regarding psychosocial working conditions of workplaces in the LCR; as such it is difficult to comment on their effects on the health of the local working population. However, if it is assumed that these conditions are equivalent to the average in Britain, there is unlikely to have been much improvement in these over the last few years. In addition, at a national level there is a lack of debate about key psychosocial working conditions known to affect health, e.g., ‘flexicurity’. The trends in outsourcing, temporary/contract work and other flexible working arrangements should bring this into sharp focus.

7.40 The variable evidence of effectiveness of different workplace health programmes indicates a cautious approach to interventions is needed. Certain occupational/workplace health programmes have been shown to have positive impacts on employee performance and absenteeism, as well as on health and wellbeing. However, others have not; this is especially so regarding changing psychosocial working conditions and reducing work-related stress. In addition, there is a gap in evidence of interventions aimed at organisational systems and structures rather than at individuals and their specific work environment.

7.41 The Commission’s attention on health at work is entirely appropriate; work, including the work environment, can have both positive and negative effects on worker health, and in turn, organisational performance. However, the effectiveness of health at work interventions varies. As such, a LCR ‘Health
at Work’ Charter particularly focusing on the psychosocial work environment may contribute to existing measures to improve worker health and wellbeing. It will be important to distinguish the ‘flexible working arrangements’ which the Commission would wish to promote as this covers a wide range of working practices with both positive and negative health effects. Related to this is the need to consider health issues associated with ‘flexicurity’ and ‘decent work’/quality jobs, a major impact on health inequalities.

7.42 Specific recommendations are as follows:

- Enabling ‘health promoting’ employment policy – adopt the work and health model and target action at all levels of the model; work with regional and national agencies to develop ‘health enhancing’ employment policy;
- Enhancing data availability and accessibility – analyse existing data on work-related ill-health and psychosocial working conditions, including equality and diversity at work in the LCR; commission new research to extend the psychosocial working conditions dataset to include data on ‘flexicurity’ and job quality in the LCR;
- Changing employer attitudes to ‘Health at work’ – working with the NW Workplace Health Network identify ‘Health at work’ leaders and champions from the public and private sector (including SMEs) to lead the ‘Health at work’ campaign;
- Developing effective occupational health systems and services (OHSS) – work with the HSE/LAs to define OHSS coverage and local OHSS models for the LCR, reflecting industry sector, type and size, and based on ILO/WHO guidelines;
- Implementing ‘Health at work’ interventions – audit interventions at individual, work environment or organisational systems/structures; pilot innovative interventions, e.g., to improve job quality, or targeted at specific employee groups, e.g., older people, part-time workers;
- Ensuring contractors’ health at work – design protocols for procurement contracts that ensure a joint liability on the principal contractor for the subcontractors’ obligations towards their workers;
- Commissioning ‘evidence of effectiveness’ studies – commission high quality prospective studies to assess the effects of ‘Health at work’ pilots.

8. Built environment

Background

8.1 There are a range of policies at European, national and regional levels which recognise and emphasise the importance of the built environment as a determinant of health. The WHO’s Healthy Cities programme, which includes Liverpool as a Healthy City, has healthy urban planning as one of its key objectives in Phase IV (WHO, 2004).

8.2 The EC’s Strategic Environment Assessment Directive (EC, 2001) specifically included spatial strategies as strategies to consider their effects on the environment and population health. In the North West, the Regional Spatial Strategy (NWDA, 2004) and its recent review (2008) has been informed by a HIA.

8.3 The recent Local Government and Public Involvement in Health Act (2007) placed new duties on PCT’s and Local Authorities to ensure that their areas’ sustainable communities strategy were underpinned by a Joint Strategic Needs Assessment of their health and social care needs.

8.4 Within Liverpool City Council a HIA officer (2005) works alongside planning officers to ensure that at strategic and development levels health is integrated into planning decisions, e.g., the Local Development Framework, housing developments. In addition, a HIA capacity building programme across both the PCT and City Council is developing a culture where health considerations are integrated into planning decisions affecting the built environment and more widely.

Evidence

8.5 Although it is a relatively new direction for contemporary public health research, the associations between the built environment and health have been widely recognised in the UK since the infancy of town planning and public health over a century ago. There is a growing body of evidence to support the assertion that certain characteristics of the built environment have an impact on key determinants of health such as physical activity and health outcomes such as obesity. Figure 4 shows a model of the associations between components of the built environment, health determinants and health outcomes with examples of the existing evidence.
8.6 Some aspects of the quality of the built environment are controlled by policies and actors that operate outside the planning and development control system. Three areas have been identified.

8.7 Firstly, the quality and maintenance of the existing built environment, e.g., public spaces, green spaces and housing. These standards are controlled by mechanisms (e.g. legislation, policies and guidance) that operate outside the planning and development control system. The existing built environment is maintained by public bodies and private individuals/bodies, for example housing under the control of individuals and private and registered social landlords.

8.8 Secondly, the standards of construction and materials are in part controlled through the building control system which operates outside the planning and development control system.

8.9 Thirdly, new developments (defined as operational and change of use) operate within the planning and development control system and the building control system. These developments include new builds and alteration to existing properties and the change of use of buildings, for example residential properties changing to commercial uses.

8.10 However those aspects of the built environment that are controlled by the planning and development control system are as follows:

**Physical activity**

8.11 There are associations between the built environment and physical activity including the relationships between urban design, transport use and physical activity (e.g. Frank et al, undated; Saelens et al, 2003; Swinburn, 2001).

**Social Interaction and Transport**

8.12 Transport can contribute to social interaction by increasing access to people and places, including work and services. However, road traffic volume can also affect social interactions Appleyard (1981).

**Social interaction and urban design**

8.13 The quality of urban design has a key role in determining social interaction. High quality urban design can facilitate connections between people, neighbourhoods, facilities and public spaces; poor quality urban design creates both physical
and psychological barriers to human interaction. The associations between the urban design of neighbourhoods and children's patterns of physical activity should also be noted.

**Risk factors associated with car dominated travel**

8.14 A range of significant risk factors are associated with car dominated transportation. These include pollution (air and noise) and injuries from road traffic accidents.

**Pollution (air, light, noise)**

8.15 The built environment may, both directly (e.g. industrial pollution, indoor air pollution and pollution from cars) and indirectly (e.g. urban design promoting car dominance), generate air, light and noise pollution. There are a wide range of associations between pollution and negative health outcomes such as depression, fatigue and respiratory disease. Lack of adequate daylight may also lead to negative health outcomes (Rao, 2007).

**Crime and safety**

8.16 The relationship between the built environment/urban design and crime/fear of crime is widely recognised within the literature (e.g. Carmona, 2001; Colquhoun, 2004) and by government policy and guidance (e.g. Department of the Environment Circular 5/94 “Planning Out Crime”, Crime and Disorder Act 1998, PPS1, PPS3, PPS7, PPS12, PPS13, PPS15, PPS17). Crime poses substantial risks to the health of victims and perpetrators. Health impacts can be physical and psychological (Robinson & Keithley, 2000).

**Inclusivity of design and access**

8.17 The difficulties that people with disabilities have experienced when accessing facilities and services often relates, not to an individual’s disability, but to the lack of thought and lack of awareness of society when designing the built environment around us and when establishing how services are provided (BFBC, 2007). Inclusivity of design relates to other groups such as the elderly and parents with young children/pushchairs. Poor design may limit access to goods, and services and to social and community networks with negative impacts on social, psychological and physical health.

**Ability to access appropriate, high quality green space**

8.18 Surveys repeatedly show how much the public values green spaces while research reveals how closely the quality of public spaces links to levels of health, crime and the quality of life in every neighbourhood (CABE Space, 2003).

**Regeneration, relocated and displacement**

8.19 Moving house is considered to be a health damaging life-event (Hooper & Ineichen, 1979 in Douglas, Thomson, & Gaughan, 2003). This is particularly so when there is a perceived lack of control in the decision to move (Allen, 2000 in Douglas, Thomson, & Gaughan, 2003). Housing relocation has been associated with loss of social networks (Fried, 1966 in Douglas, Thomson, & Gaughan, 2003) and social aspirations (Yuchtman & Spiro, 1979 in Douglas, Thomson, & Gaughan, 2003) that may counteract satisfaction with improved housing conditions. The impacts of forced relocation and displacement may be more severe.

**Gaps in the existing evidence**

8.20 Although there is a growing body of evidence on the associations between the built environment and health, gaps still exist, e.g., evidence on the health impacts of the loss of green space, the loss of built heritage and aspects of the regeneration process are scarce. Evidence on the effectiveness of interventions on improving health is limited e.g., housing. Further research is required in these areas.

**Analysis, conclusions and recommendations**

8.21 The existing evidence shows clear links between the urban planning, the built environment and health. The Commission’s aim to address issues of health through the planning and development control process is appropriate and commendable. The LCR is well-placed to build on the momentum already underway in Liverpool through the current HIA and healthy urban planning work. It is speculated that if the Commission’s aim can be translated into a specific strategy it may have large scale positive impacts on the health and wellbeing of the population of the City Region. However, there are fallibilities in some of the proposed mechanisms for achieving this, e.g., Supplementary Planning Guidance, as described.
8.22 The Commission should consider a broader range of policies and actors in establishing and maintaining standards of quality of the built environment, e.g., building control officers and registered social landlords.

8.23 Similarly the relationship between the built and natural environment is not explicit and should be identified in the proposals.

8.24 The Commission’s focus on urban areas within the LCR may be too limited. Populations within rural areas are also impacted upon by the built environment and they have issues specific to the built environment in rural areas. For example, difficulties in accessing affordable housing and services for groups including the young, the elderly, disabled and people on fixed and low incomes. The impacts may be widespread and include problems relating to the breakdown of traditional communities where young people and lower paid traditional (e.g. farm workers) and key workers (nurses etc) cannot afford to buy properties and services in their local areas. Problems in rural areas are particularly apparent in times of high land and property prices and when fuel prices are high (both heating and petrol etc). It is important to note that cars are not a luxury in remote rural areas but often a necessity; measures specific to rural areas may need to be developed. The Commission should consider widening the geographical scope to include rural areas within the Liverpool City Region.

8.25 Some ‘brownfield’ site designations have been criticised on health grounds. Development within former green spaces that include residential gardens and public allotments have potential negative impacts to the quality of the built environment and subsequently health and wellbeing, particularly in times of rising food prices and falling physical activity. Existing approaches to development in areas designated as ‘brownfield’ sites should be examined.

8.26 The Commission draw an interesting historical parallel to the aspirations of Dr Duncan and refer to the creation of the first department of public health in Liverpool. They could also identify that the Department of Civic Design in the University of Liverpool was the first department of town planning in the world and cite Duncan’s close working relationships with the town planners of his day. For example, the city engineer James Newland played a key role in improving public health through measures such as new building regulations, provision of parks, an efficient refuse collection system and street cleaning, improved access to clean drinking water and facilities such as public bath houses. This tradition is reflected in modern day working relationships between planners, public health and related specialists should also be emphasised, such as the HIA officer working within Liverpool City Council/Central Liverpool PCT. Experience from this approach could be usefully applied across the LCR and further afield.

8.27 The creation of a multisectoral ‘joint working group’ to address the issues of health and the built environment is appropriate. However, this would benefit from a wider group of stakeholders and a clear remit. Similarly the role some proposed members may be able to play is likely to be limited, e.g., CABE is a consultee on major developments.

8.28 There are potential benefits but as already mentioned there are also limitations to the proposal for Supplementary Planning Guidance being developed. The assessment of the quality of a development proposal is just one piece of information within a wide body of legislation, policy, guidance and information that must be considered by development control officers. The discretionary nature of the town planning system may favour some considerations, e.g. economic, over others, e.g., design quality.

8.29 There are similar potential issues surrounding the weight given to Statements, e.g., Environment Statements, within the development control decision-making process. In addition, CABE’s assessment reports may currently come too late in the development control process to allow for the fundamental changes to development proposals that may be needed to promote health. These obstacles in the current planning processes need to be considered when framing the Commission’s final proposals.

8.30 The Commission may wish to consider endorsing proposals of the HIA planning officer to develop guidance based on CABE’s urban and architectural
design assessments methodology and HIA methodology which will integrate design solutions into planning applications in a timely fashion as part of the development control process.

8.31 In order to maximise the potential impacts on health and, in particular, to target health inequalities, it is recommended that the Commission consider the following:

- Consider a wider group of stakeholders in establishing and maintaining standards of quality of the built environment, e.g., building control officers and registered social landlords, and ‘piggy backing’ onto existing initiatives, e.g., Healthy Cities’ healthy urban planning.
- Consider widening the geographical scope to include rural areas within the LCR.
- Commission research to identify and explore the relationship between the built and natural environment.
- Examine existing approaches to development in areas designated as ‘brownfield’ sites.
- Recognise and address the limitations of planning tools, e.g., Supplementary Planning Statements in the context of other material considerations, e.g., economic impacts.
- Support for and raise the profile of Liverpool’s HIA Planning officer to assess the health impacts of development proposals urban and architectural design quality, and a means by which enhancements to development proposals will be progressed through the development control process.
- Reiterate the historical and contemporary links between the planning, public health and related sectors.

9. Procurement

Background

9.1 The Commission has identified sustainable procurement as a way to address inequalities and promote economic growth within the LCR. The UK government has defined sustainable development as ‘development which meets the needs of the present without compromising the ability of future generations to meet their own needs’. Sustainable procurement (SP) is procurement that is consistent with the principles of sustainable development. There are three main components of sustainable procurement; environment, social and economic (Defra 2006).

9.2 Procurement in the public sector has been identified as a lever to deliver broader government objectives, such as stimulating innovation in supply markets, using public money to support environmental or social objectives, and for supporting domestic markets (McCruden 2004). McCruden also notes that sustainable procurement places the public sector in two roles by “participating in the market as purchaser and at the same time regulating it through the use of its purchasing power to advance conceptions of social justice” (McCruden 2004).

International context

9.3 In 1992 Agenda 21, a global plan of action on sustainable development, was adopted by countries attending the United Nations Conference on Environment and Development in Rio de Janeiro. Ten years later at the World Summit in Johannesburg countries reaffirmed their commitment to the Agenda 21 goals and called for countries to “promote public procurement policies that encourage development and diffusion of environmentally sound goods and services” (WSSD 2002).

9.4 A crucial milestone for the development of SP in Europe was the Gothenburg European Council (European Council 2001) and the adoption of the EU Sustainable Development Strategy (Commission of the European Councils 2001). The philosophy of this strategy is that economic, social and environmental objectives could be pursued simultaneously adding an environmental dimension to the Lisbon Process (European Commission 2000). At EU level there has been a particular focus on the development of ‘green’ procurement.

9.5 All public bodies have to apply the EC Procurement Directives, which include detailed requirements for advertisement, specifications, selection of tenderers and award of contracts (European Parliament 2004). The concepts of sustainable procurement do not contravene these directives as long as it complies with the principles of non-discrimination, equal treatment, free movement of goods and services and transparency. The EU has produced specific guidance on ‘green’ procurement (European Commission 2004).
National and local context

9.6 At national level there are strong policy drivers for sustainable procurement. In response to the World Summit on Sustainable Development (2002), the UK government stated its goal to be amongst the leaders in Europe on sustainable procurement by 2009 (HM Government 2005). The UK sustainable development strategy makes specific references to the use of public procurement as a tool to help achieve sustainable development objectives (HM Government 2005).

9.7 The government’s sustainable consumption and production framework stresses the need for public sector purchasing decisions to promote sustainable development, as well as contributing to objectives for sustainable communities, public health, employment, transport, waste and energy (Defra 2003). The strategy defines sustainable procurement as ‘embedding sustainable development considerations into spending and investment decisions across the public sector’.

9.8 The National Procurement Strategy for Local Government requires local authorities to “use procurement to help deliver corporate objectives including the economic, social and environmental objectives set out in the community plan” (ODPM 2003).

9.9 The Sustainable Procurement Task Force was established in May 2005, charged with drawing up an action plan to bring about a step-change in sustainable public procurement so that the UK is among the leaders in the EU by 2009. The action plan was launched on 12 June 2006 (Defra 2007).

9.10 In addition to work being carried out by the NWDA on sustainable procurement (Chamber of Commerce East Lancashire 2007) there is also action at a more local level. For example, Liverpool City Council committed itself to sustainable procurement and local sustainability in its 2007–2010 Procurement Strategy (LCC 2006). It has also signed up to the Small Business Friendly Concordat (ODPM 2005).

NHS

9.11 NHS organisations are now required to use their role as powerful corporate bodies to act as a good corporate citizen and contribute to public health through their procurement practices (NICE 2005). The NHS has become very active in the area of sustainable development and SP (NHS 2006). NHS Trusts and PCTs Human Resources strategy should focus on continually improving recruitment opportunities for local, disadvantaged and long-term unemployed people, as well as other marginalised groups. Under the new system for assessing whether NHS organisations are meeting the national healthcare standards, the Healthcare Commission will eventually take account of trusts’ performance as ‘good corporate citizens’ – including their procurement activities – in deciding on the annual rating they should be awarded.

9.12 In the Northwest a new project called In:tend will focus on the needs of NHS procurement within the North West with the aim to assist the development of a sustainable procurement policy that will benefit the NHS, help regenerate the North West and improve standards for local businesses and their employees.

Evidence

Procurement and health

9.13 Sustainable procurement potentially impacts on a range of determinants of health and on health inequalities. The Wanless Report pointed to a number of connections between healthy economies and healthy people, specifically, the link between socio-economic inequality and health inequality (Wanless, 2002). The Report ‘Claiming the Health Dividend’ published by the Kings Fund in 2002 described the relationship between sustainable development and health and identified how the NHS could improve health through procurement. Areas identified included, employment, purchasing policy, procurement of child care services and food, management of waste, travel and energy, and commissioning new buildings (Coote, 2002).

9.14 By using targeted recruitment and training SP can improve levels of employment in groups that have difficulty accessing employment (e.g., people belonging to ethnic minority groups, long term unemployed, IB claimants, and people with low skills). These are groups that also tend to experience poor health. Targeting groups such as these could potentially lead to improvements in health for those people and also a reduction in
health inequalities. But as described in section 7, not all employment is good for health. SP can, however, also be used to ensure employment conditions are conducive to health.

9.15 SP can be used to specify environmental conditions such as: use of low emission vehicles; recycled materials in the delivery of services or products; requirement to recycle materials produced as part of the contract, transport related emissions, minimisation of carbon footprint (Anthony Collins Solicitors, 2007). Improvement and minimisation of harm to the environment impacts on health in a variety of ways including; health outcomes such as pollution related respiratory problems, mental wellbeing, and weather related health impacts through climate change.

9.16 Many of the environmental impacts that can be addressed by sustainable procurement are felt locally: cleaner public transport, for example, would improve local air quality; a reduced use of toxic chemicals in cleaning provides a healthier working environment and so on. Sustainable procurement can also act as a useful channel for raising environmental awareness within the local community by introducing greener products to the community and providing information about the benefits of sustainable procurement (Procura+, 2008). Some of these potential impacts are immediate whereas as others involve a time lag that could extend to future generations.

9.17 Of particular interest and relevance to LCR and the Commission’s focus on inequalities is the issue of environmental justice. Participants of the Central and Eastern European Workshop on Environmental Justice (CEU Center for Environmental Policy and Law, 2003) defined environmental injustice in the following way:

“An environmental injustice exists when members of disadvantaged, ethnic, minority or other groups suffer disproportionately ... from environmental risks or hazards, and/or suffer disproportionately from violations of fundamental human rights as a result of environmental factors, and/or denied access to environmental investments, benefits, and/or natural resources, and/or are denied access to information; and/or participation in decision making; and/or access to justice in environment-related matters.”

9.18 A Friends of the Earth study correlated the Environment Agency’s factory emissions data with the Government’s ‘Index of Multiple Deprivation’ and found that of 11,400 tonnes of carcinogenic chemicals emitted to the air from large factories in England in 1999, 82 per cent were from factories located in the most deprived 20 per cent of local authority wards (Friends of the Earth, 2001).

9.19 The Government’s inquiry into ‘Inequalities in Health’ noted that ‘The burden of air pollution tends to fall on people experiencing disadvantage, who do not enjoy the benefits of the private motorised transport which causes the pollution... it is easily forgotten by policy-makers that 30 per cent of households do not have access to a car (Acheson, 1998). BME groups are also more likely to live in areas with higher exposure to pollution (Stephens, Bullock, & Scott, 2001).

9.20 It is possible to link procurement to human rights norms. For example, the procurement policies of the United Nations Children’s Fund (UNICEF) refer to the Convention on the Rights of the Child and draws the attention of potential suppliers to Article 32 of the Convention that requires that a child shall be protected from performing any work that is likely to be hazardous or to interfere with the child’s education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development. UNICEF reserves the right to terminate any contract unconditionally and without liability in the event that the supplier is discovered to be in non-compliance with the national labour laws and regulations with respect to child employment.

9.21 SP can also be used to influence transport. Road traffic is a significant cause of ill health through injuries resulting from road accidents. It is a prime cause of air pollution negatively impacting on the environment. Busy roads cause noise and disrupt communities. Transport is the fastest growing source of carbon dioxide, a greenhouse gas known to contribute to global warming.

9.22 Transport-related injuries also affect poorer people disproportionately. Children from Social Class V are five times more likely to be knocked down than children in Social Class I (Roberts & Power, 1996). Research by the DETR also shows that Asian
children are more likely than white children to be injured in road accidents (DETR, 2001).

9.23 Procurement is often used for supplying food. Food has a direct impact on health as a result of diet, nutrition and food safety issues.

9.24 The procurement of new building presents opportunities for the promotion of a healthy built environment as described in section 8.

Effectiveness
9.25 An extensive literature review of SP commissioned by Defra found very little information about the social outcomes of public procurement (Green Alliance 2005). A more recent review carried out by Walker and Brammer found that, although there is a relatively well-developed body of research investigating aspects of SP in private sector organisations, studies have mainly focused on environmental issues in procurement, with the social aspects of SP being under-researched to date (Walker & Brammer 2007).

9.26 It is interesting to note that the public sector appears to be taking a similar focus in SP to the Commission. Walker and Brammer noted that “contrary to the current emphasis in policy, the public sector seems currently to be focused on the social and economic, rather than environmental, aspects of SP... public sector organisations appear to be oriented towards supporting local economies and communities by buying from small and local suppliers, providing EU procurement regulations are followed” (Walker & Brammer 2007).

9.27 Barriers and enablers for SP have now been identified in a number of reports. EU procurement laws appear to be a perceived rather than actual barrier to SP. Lack of understanding of relevant EU legislation is identified in a number of studies as a barrier to successful SP. Other barriers often identified included; public sector organisations having to achieve targets that are do not correspond with SP, lack of leadership and/or organisation culture conducive to SP, cost or perceived costs, conflicts between different agendas i.e. efficiency agenda v. full cost recovery and sustainable procurement, local businesses/SME etc having difficulty accessing procurement process.

9.28 Many of the enablers are the ‘opposite’ of the barriers. Other enablers identified include: commissioning outcomes rather than outputs, developing a common language in commissioning and procurement for terms such as “public value”, “social requirements” and “community benefits”, avoiding excessive use of the full EU tender process when this is not always required, commissioners adopting policies which enable a wider range of social, economic and environmental benefits to be accepted, promoted and delivered as being of public value, training and capacity building (Anthony Collins Solicitors 2007; Sacks, 2005; Green Alliance, 2005).

Analysis, conclusions and recommendations
9.29 Procurement impacts on a range of health determinants. There is strong evidence available identifying the relationship between these health determinants and a range of health outcomes. However there is limited evidence presently available about impact of SP on these determinants. This reflects the emerging nature of this field of research.

9.30 The Commission’s proposal to develop a procurement concordat builds on an extensive body of policy at different levels. The Commission has recognised the relationship between procurement and some determinants of health such as employment and economic benefits. If the PC is successfully implemented, it is possible that this will impact positively on local employment and economy and result in positive impacts on health. By becoming an example of good practice and leading the way in lobbying in this area, the Commission could provide a valuable contribution to the development of SP at LCR and national level.
9.31 In order to maximise the potential impacts on health and, in particular, to target health inequalities, it is recommended that the commission broaden the scope of the Procurement Concordat and consider the following recommendations:

- Ensure that the PC has a clear remit to address all three elements of SP – environment, social and economic.
- Use SP as a tool to explicitly address inequalities. This should extend beyond the labour market and economy (gender, ethnicity, environment etc.)
- Use the PC to address issues of social justice including environmental justice and human rights.
- Commission research into identifying how SP can be used to promote health and target health inequalities in the LCR.
- Commission a scoping exercise to identify examples of good practice to build on.
- Consider impacts on health beyond LCR (e.g. climate change, health staff migration).
- Utilise the involvement of the public sector in the PC to engage with the private sector.
- Ensure that the promotion/use of SP clauses is balanced with actions to address ‘supply side’ issues such as providing support to local businesses to be able to effectively compete.

10. Conclusion

10.1 The Commission’s proposals outlined in the April document are timely and address highly relevant issues in the LCR and beyond. They are generally appropriate with some ‘Big Ideas’, e.g., the proposal to promote flexible working arrangements, needing minor refinement to avoid any unintended negative impacts on health.

10.2 In most cases, although there was evidence of the relationship between the key theme and health, there was no direct evidence of the impact of the proposals on health. For example, although proposals to reduce alcohol harm by reducing access to alcohol through the licensing process seems intuitively right, there is no evidence to confirm that this will succeed. In addition, for some proposals where there was evidence related to the ‘Big Ideas’, e.g., Incapacity Benefit and Health at Work, the effectiveness of these interventions varied; the detail of the final proposals will, therefore, determine if they are successful.

10.3 As such, in general the proposals described in April may contribute to improving health in the LCR. The proposals also have the potential to contribute to reducing inequalities between the LCR and the England average by providing a focus or ‘adding value’ to existing action in these key areas. Their impact on reducing health inequalities within the LCR, however, needs further consideration. A concern for some key informants was that an explicit mandate from policy-makers was needed to take the proposals forward. The final report will need to be clear how this is to be achieved.

10.4 The HIA recommendations seek to ensure that HiW proposals reduce health inequalities; they also seek to enhance the overall impact of the proposals by ensuring interventions at appropriate levels as described in the various models. Where evidence is lacking, quality research is proposed.

10.5 With the Commission’s adoption of these recommendations, commitment to delivery as well as clear delivery mechanisms the HiW Commission’s final proposals will make a significant contribution to the improvement of health and wellbeing in the LCR, and to ensuring those with the poorest health have their health improved even faster than the average. The Commission should be commended for their approach and the work they have done in this area; their focus on these important areas has added, and will continue to add, value to mainstream activity.

A full copy of IMPACT’s report, plus bibliography, is available upon request.
Appendix 3
Health in the Liverpool City Region
Lynn Deacon, Jennifer Mason and Rebecca Harrison, North West Public Health Observatory

Introduction

This appendix summarises general health data gathered and presented by the North West Public Health Observatory (NWPHO) as part of its function to provide research support to the Health is Wealth Commission.

The NWPHO research team presented relevant, current, available data and intelligence during five evidence sessions which took place from November 2007 to April 2008, focussed around the themes of alcohol, incapacity benefit, adult health and lifestyles, children and young people’s health and children and adults’ education and skills. The information helped to explore and highlight the scale and/or severity of health and wealth issues across the Liverpool City Region.

Included within this appendix are some of the key health measures relating to the adult population, encompassing mortality, disease, health and lifestyle indicators. Separate, more detailed profiles of two core themes (alcohol and incapacity benefit) within the Liverpool City Region have also been published as standalone documents, outside this report. A summary of wealth in the Liverpool City Region is also included to provide the contextual background for the health indicators presented.

The inclusion of data for eight English core cities27 is a key feature throughout this appendix in order to highlight the relative position of the Liverpool City Region local authorities in relation to comparable areas within England. Each health indicator includes reference to national (England) comparators: the best performing local authority in England and the national average. The relationship between health and deprivation is also explored to establish whether there is greater prevalence of poor health outcomes in more disadvantaged areas. All local authorities in England are included in this deprivation analyses to help increase confidence in the results (for more details see the following technical note).

This appendix therefore provides an accurate and up to date picture of health in the Liverpool City Region set in context against other areas and helps to provide a baseline from which progress in tackling poor health outcomes and health inequalities more generally across the region can be measured in the future.

Acknowledgements

The health data in this appendix has been taken from the national Health Profiles 2008, produced by the Association of Public Health Observatories (APHO) on behalf of the Department of Health28. The profiles provide a snapshot of health across each local authority in England using key health indicators to enable comparison locally, regionally and nationally, as well as over time to help local organisations and partnerships plan services. Some text has been taken from the metadata which accompanies each indicator and describes its relevance.

27 The eight English core cities presented are Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle-upon-Tyne, Nottingham and Sheffield. Throughout the document Newcastle-upon-Tyne is referred to as Newcastle. As London contains numerous local authority districts it has been omitted for brevity.

28 www.healthprofiles.info
Technical notes

Bar charts
Each health indicator in this appendix includes a chart showing values for that measure across the Liverpool City Region local authorities. Bars are shaded red for any value which is significantly worse than the national average (based on 95% confidence intervals) or green for any value which is significantly better than the average. The England average is represented by a straight line across the bars. The best English local authority value (‘England best’) is also shown on each chart to highlight the difference between the Liverpool City Region values and the best nationally – the position where it is possible to be (although these ‘best’ areas do not generally have similar social and economic characteristics to the Liverpool City Region).

Tables
Data for the Liverpool City Region districts and the English core cities is also included in tables alongside each bar chart. The cells within the tables are also shaded red or green depending on whether values for each area are significantly worse or better than the England average. These are presented in rank order – the worst area is listed at the top of the table and the best area at the bottom.

Scatter plots
Also included in this report are a number of scatter plots. These are a visual assessment of whether there is a relationship between a particular health variable and the Index of Multiple Deprivation (IMD) 2007 average score for local authority areas. A correlation coefficient (r) can also be calculated. ‘r’ takes a value between -1 to +1 (+1 means that there is positive correlation and whenever one variable has a high [low] value, so does the other, while a value of -1 means that there is a negative correlation and whenever one variable has a high [low] value, the other has a low [high] value). A correlation coefficient of 0 means that there is no linear relationship between the variables.

To help provide a more precise measurement of the degree of correlation, an r² value is then calculated and included alongside each scatter plot. r squared is a mathematical measure showing the amount of variation in a particular health indicator that can be ‘explained’ by variation in the IMD average score. For example, an r² value of 0.58 shows that 58% of the health measure/outcome could be attributed to the level of multiple deprivation. The following values for r squared are used by NWPHO to describe the relationship between the two variables under study: 0.091 to <0.16 (weak), 0.16 to <0.36 (moderate), 0.36 to <0.64 (strong) and 0.64 to 1 (very strong).

All local authorities in England are included in the calculation, with the exception of Isles of Scilly and City of London, due to small numbers of individuals in these areas.
1. Life expectancy and causes of death

The national health inequalities target for life expectancy aims to increase average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women, and to reduce health inequalities by 10% by 2010 as measured by (infant mortality and) life expectancy at birth (Department of Health Public Service Agreement priority 1), including to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

This section includes data on five key indicators: life expectancy at birth, deaths from smoking, early deaths from heart disease and stroke, early deaths from cancer and road injuries and deaths. Mortality data quality and coverage is extremely good. The figures are three year averages taken from the most recent information available (for the period 2004-06) to provide large enough numbers to ensure that the presented figures are sufficiently robust.

1.1 Life expectancy at birth

Life expectancy at birth is a summary measure of all cause mortality rates in an area in a given period. It is the average number of years a newborn baby would survive, were he or she to experience the particular area’s age-specific mortality rates for that time period throughout his or her life. All cause mortality is a fundamental and probably the oldest measure of the health status of a population. It represents the cumulative effect of the prevalence of risk factors, prevalence and severity of disease, and the effectiveness of interventions and treatment. Differences in levels of all-cause mortality reflect health inequalities between different population groups, such as between genders, social classes and ethnic groups. Life expectancy at birth is chosen as the preferred summary measure of all cause mortality as it quantifies the differences between areas in units (years of life) that are more readily understood and meaningful to the audience than those of other measures. The data is presented here for both males and females separately.

1.1.1 Males

- On average, men in the Liverpool City Region live shorter lives than men across England. Within the region, Liverpool (73.8 years) has the lowest male life expectancy at birth and Sefton (76.2 years) the highest. All six local authorities in the area have a significantly worse male life expectancy at birth than the England average of 77.3 years (Figure 1).

- Male life expectancy at birth in Liverpool is the third lowest in England. Here, male life expectancy is 9.3 years lower than in Kensington and Chelsea, the local authority with the highest male life expectancy at birth in England (83.1 years).

- As well as Liverpool, Halton and Knowsley are among the worst 10 English local authorities for male life expectancy.

- Most other comparator cities have better male life expectancy at birth than the Liverpool City Region authorities. Bristol, Leeds and Sheffield have better male life expectancy at birth than all Liverpool City Region local authorities. Birmingham and Newcastle-upon-Tyne have better male life expectancy than Halton, Knowsley and Liverpool and only Manchester (the worst in England) has worse life expectancy than all local authorities.

- Male life expectancy at birth has increased in all six local authority areas in the Liverpool City Region as well as across England between 1991-93 and 2004-06. However, over this period the proportionate increase in life expectancy has not been as great in the Liverpool City Region as in England and therefore the gap between the area and England has widened, particularly in Halton, Knowsley and St Helens.

- Within each local authority in the Liverpool City Region, there is further evidence of health inequalities in male life expectancy at birth. In Wirral, Sefton, Halton and St Helens male life expectancy is 7 to 8% longer in the least income deprived fifth of small areas within each authority than the most income deprived. Within Liverpool the gap is slightly larger (8.6%).
Across England, there is a very strong relationship between male life expectancy at birth and deprivation. Life expectancy decreases as deprivation increases ($r^2 = 0.7192$) (Figure 2).

1.1.2 Females

- On average, women in the Liverpool City Region live shorter lives than women across England. Within the region, Liverpool (78.3 years) has the lowest female life expectancy at birth and Sefton (81.0 years) the highest. However, all six local authorities in the area have a significantly worse female life expectancy at birth than the England average of 81.6 years (Figure 3).

- Female life expectancy at birth in Liverpool (along with Hartlepool) is the worst in England (78.3 years). Here, female life expectancy is 8.9 years lower than in Kensington and Chelsea (87.2 years), the local authority with the highest female life expectancy at birth in England.

- Many of the other comparator cities have better female life expectancy at birth than the Liverpool City Region authorities. Liverpool's poor female life expectancy is closely followed by Halton's, the third worst local authority in England. Leeds, Bristol and Sheffield have better female life expectancy at birth than all Liverpool City Region local authorities. Only Manchester has female life expectancy similar to that in Halton and Liverpool.

- Female life expectancy at birth has increased in all six local authority areas in the Liverpool City Region as well as across England between 1991-93 and 2004-06. However, over this period the proportionate increase in life expectancy has not been as great in Halton, Knowsley, Liverpool and St Helens as in England and

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**Figure 1:** Male life expectancy at birth, 2004-06.  
(a) Liverpool City Region districts, England best and England average

**Figure 2:** Male life expectancy at birth and Index of Multiple Deprivation 2007 average score. English local authorities, 2004-06.

**Table:**

<table>
<thead>
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<tbody>
<tr>
<td>Worst</td>
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</tr>
<tr>
<td>Sheffield</td>
<td>77.0</td>
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</tbody>
</table>

**Source:** APHO and Department of Health

- Across England, there is a very strong relationship between male life expectancy at birth and deprivation. Life expectancy decreases as deprivation increases ($r^2 = 0.7192$) (Figure 2).
Therefore the gap between these areas and England has widened, particularly in Halton and Liverpool.

- Within each local authority in the Liverpool City Region, there is further evidence of health inequalities in female life expectancy at birth. In Liverpool, Halton, St Helens and Sefton female life expectancy is around 10-12% longer in the least income deprived fifth of small areas within each authority than the most income deprived. Within Wirral the gap is larger (14.2%).

**Figure 3: Female life expectancy at birth, 2004-06.**

a) Liverpool City Region districts, England best and England average

b) Liverpool City Region districts and English core cities

<table>
<thead>
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</tr>
<tr>
<td>Leeds</td>
<td>81.6</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

- Across England, there is a strong relationship between female life expectancy at birth and deprivation, with life expectancy decreasing as deprivation increases ($r^2 = 0.5243$) (Figure 4).

**Figure 4: Female life expectancy at birth and Index of Multiple Deprivation 2007 average score. English local authorities, 2004-06.**

Source: NWPHO from Source: APHO and Department of Health and Communities and Local Government (IMD 2007)

### 1.2 Deaths from smoking

Smoking still causes between 1 in 6 and 1 in 10 of all deaths in England, and accounts for about half of the inequality in death rates between Spearhead and non-Spearhead areas. It remains the biggest single cause of preventable mortality and morbidity in the world. High smoking attributable death rates are indicative of poor population health and high smoking rates. Although a zero rate is unlikely to be achievable, lower rates than the best in England are seen in California and Scandinavian countries.

- On average, 3,218 people die from smoking in the Liverpool City Region each year.

- Knowsley has the highest rate of deaths attributable to smoking in the Liverpool City Region (355.0 per 100,000 population) and Sefton has the lowest rate (248.3) (Figure 5).

- Each Liverpool City Region local authority has a death rate from smoking which is significantly worse than the England average (225.4) and Knowsley’s rate is the worst in the country.

- East Dorset has the lowest rate of deaths from smoking in the country as a whole (139.4). Knowsley’s rate is over 2.5 times higher than this.

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29 The Spearhead group announced in November 2004, consisting of 70 local authorities, includes the fifth of areas with the worst health and deprivation in England. These areas form the focus for improvements in life expectancy and to help narrow the gaps compared to the rest of England.
• Liverpool City Region local authorities rank poorly compared to the English core cities. Knowsley has the highest rate overall and only Manchester (353.8 per 100,000 population) has a higher rate of smoking attributable mortality than the other five Liverpool City Region local authorities. Two core cities (Sheffield and Bristol) have lower rates of smoking attributable deaths than any local authority in the Liverpool City Region.

Figure 5: Smoking attributable mortality rate (over 35 years) per 100,000 population, 2004-06.

a) Liverpool City Region districts, England best and England average

b) Liverpool City Region districts and English core cities

<table>
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<tr>
<td>Wirral</td>
<td>257.4</td>
</tr>
<tr>
<td>Leeds</td>
<td>257.2</td>
</tr>
<tr>
<td>Sefton</td>
<td>248.3</td>
</tr>
<tr>
<td>Sheffield</td>
<td>243.2</td>
</tr>
<tr>
<td>Bristol</td>
<td>240.8</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

• There is a very strong relationship between smoking attributable deaths and deprivation across the English local authorities ($r^2 = 0.6985$). As the level of deprivation increases the rate of deaths increases (Figure 6).

Figure 6: Smoking attributable mortality rate and Index of Multiple Deprivation 2007 average score. English local authorities, 2004-06.

Source: NWPHO from APHO and Department of Health (smoking attributable mortality rate) and Communities and Local Government (IMD 2007)

1.3 Early deaths from heart disease and stroke
Circulatory disease accounts for 40% of all deaths (and 30% among under 75 year olds). Mortality is a direct measure of health care need reflecting the overall circulatory disease burden on the population, both the incidence of disease and the ability to treat it. The mortality rate may be improved by reducing the population’s risk (e.g. encouraging healthier lifestyles and reducing exposure to smoking), by earlier detection of disease and by more effective treatment.

The under 75 circulatory disease mortality rate is a key target indicator in the 1999 Public Health White Paper Saving Lives: Our Healthier Nation. The target is to reduce the number of deaths from circulatory disease in people aged under 75 years by at least two-fifths by 2010. The baseline for monitoring this target was the three year period 1995-97. This measure supports delivery of the Department of Health PSA targets and Local Delivery Plans (LDPs) and is relevant to Choosing Health, Coronary Heart Disease National Service Framework and Programme for Action.

• Around 1,726 people die early from heart disease and stroke annually in the Liverpool City Region.
Knowsley has the highest rate of mortality from heart disease and stroke across the Liverpool City Region (124.0 per 100,000 population under 75 years) and Sefton the lowest (88.6).

Every Liverpool City Region local authority (with the exception of Sefton) has a rate which is significantly worse than the England average (84.2).

East Dorset has the lowest rate of early deaths from heart disease and stroke in the country (39.7). Knowsley’s rate is 3.1 times higher than this.

Manchester has the highest rate of early deaths from heart disease and stroke across the core cities group (142.4), followed by Knowsley. Nottingham and Liverpool also have high rates, but Sefton compares more favourably with the English core cities.

Figure 7: Mortality rate from heart disease and stroke (under 75 years) per 100,000 population, 2004-06.

Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worst</td>
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</tr>
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</tr>
<tr>
<td>Knowsley</td>
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<td>Nottingham</td>
<td>121.2</td>
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<td>Liverpool</td>
<td>120.2</td>
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<td>Birmingham</td>
<td>110.8</td>
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<tr>
<td>Halton</td>
<td>110.0</td>
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<td>St Helens</td>
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<tr>
<td>Newcastle</td>
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<tr>
<td>Leeds</td>
<td>91.2</td>
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<tr>
<td>Wirral</td>
<td>91.0</td>
</tr>
<tr>
<td>Bristol</td>
<td>90.1</td>
</tr>
<tr>
<td>Sefton</td>
<td>88.6</td>
</tr>
<tr>
<td>Sheffield</td>
<td>88.2</td>
</tr>
</tbody>
</table>

Best

Source: APHO and the Department of Health

There is a very strong relationship between deprivation and mortality rates from heart disease and stroke ($r^2 = 0.7504$). As deprivation increases the rate of deaths increases (Figure 8).

Figure 8: Mortality rate from heart disease and stroke (under 75 years) and Index of Multiple Deprivation 2007 average score. English local authorities, 2004-06.

Source: NWPHO from APHO and Department of Health (mortality rate from heart disease and stroke) and Communities and Local Government (IMD 2007)
### 1.4 Early deaths from cancer

Cancer is among the three leading causes of death at all ages except for pre-school age children in the UK, accounting for 26% all deaths. If current incidence rates remain the same, by 2025 there will be an additional 100,000 cases of cancer diagnosed each year as a result of the ageing population. Inequalities exist in cancer rates between the most deprived areas and the most affluent.

Early mortality from cancer is a direct measure of health care need as public health interventions for prevention, early diagnosis, effective treatment can all reduce the burden of cancer morbidity and mortality.

The directly age-standardised mortality rate from all cancers for persons aged under 75 is a target indicator in the Saving Lives: Our Healthier Nation strategy. The target is a 20% reduction by the year 2010 from the baseline rate in 1995-97. This measure supports delivery of the Department of Health PSA targets and LDP and is relevant to Choosing Health, Cancer National Service Framework and Programme for Action.

- Around 2,336 people die early from cancer annually across the Liverpool City Region.

- Halton has the highest rate of early deaths from cancer in England (167.8 per 100,000 population aged under 75 years). St Helens has the lowest rate overall in the Liverpool City Region (126.7).

- Every Liverpool City Region local authority has a mortality rate which is significantly worse than the England average (117.1 per 100,000 population).

- Halton’s rate of early deaths from cancer is 2.2 times higher than the rate in Kensington and Chelsea, the local authority with the lowest rate of early deaths from cancer in England (76.7).

- Compared to the core cities group, Halton has the highest rate of early deaths from cancer overall (167.8) followed by Liverpool (166.0) and Manchester has the third highest (165.8). Knowsley has a worse rate than all remaining core cities. But only Sheffield and Leeds have worse rates than Sefton and St Helens.

#### Figure 9: Mortality rate from cancer (under 75 years) per 100,000 population, 2004-06.

- **a) Liverpool City Region districts, England best and England average**

- **b) Liverpool City Region districts and English core cities**

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Rate</th>
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<tbody>
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<td>Manchester</td>
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<td>Knowsley</td>
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<td>Newcastle</td>
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<tr>
<td>Nottingham</td>
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<td>Wirral</td>
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<tr>
<td>Birmingham</td>
<td>127.7</td>
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<td>Bristol</td>
<td>127.5</td>
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<td>Sefton</td>
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<td>St Helens</td>
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<td>Sheffield</td>
<td>122.8</td>
</tr>
<tr>
<td>Leeds</td>
<td>122.5</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

- The relationship between deprivation and the early mortality rate from cancer is strong ($r^2 = 0.5699$). As deprivation increases, mortality rates from cancer increase.
1.5 Road injuries and deaths

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. For children and for men aged 20-64 years, mortality rates for motor vehicle traffic accidents are higher in lower socio-economic groups. For instance, there would be 600 fewer deaths in men aged 20-64 years from motor vehicle traffic accidents each year if all men had the same death rates as those in social classes I and II combined\(^{30}\). The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, road infrastructure and vehicle safety\(^{31}\).

One of the Department of Transport’s PSA targets is to reduce the number of people killed or seriously injured by 40%, and the number of children killed or seriously injured by 50% by 2010 compared with the baseline of 1994-98. In Saving Lives: Our Healthier Nation, ‘accidents’, including road traffic collisions, were identified as one of the four main priority areas. Tackling Health inequalities: a programme for action also included a headline target to reduce road casualty numbers in disadvantaged areas.

- Around 770 people are injured or died on the roads in the Liverpool City Region annually.
- Liverpool has the highest rate of road injuries and deaths across the Liverpool City Region (62.2 per 100,000 population) and this is significantly worse than the England average. Sefton has the lowest Liverpool City Region rate overall (37.6). Three Liverpool City Region local authorities (Knowsley, Sefton and St Helens) have rates that are significantly better than the national average (56.3).
- Oadby and Wigston in Leicestershire has the lowest rate of road injuries and deaths in England (20.8), one-third of the rate in Liverpool.
- St Helens, Knowsley and Sefton have better rates of road injuries and deaths than any of the eight core cities. The core city with the highest rate of road injuries and deaths is Nottingham (66.0) while Liverpool and Wirral have higher rates than the remaining seven core cities.

Figure 11: Rate of road injuries and deaths (all ages) per 100,000 population, 2004-06.
a) Liverpool City Region districts, England best and England average

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b) Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
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<th>Rate</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Liverpool</td>
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<td>Wirral</td>
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<td>Manchester</td>
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<td>Newcastle</td>
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</tr>
<tr>
<td>Sefton</td>
<td>37.6</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

- There is no obvious relationship between the rate of road injuries and deaths and deprivation across the English local authorities ($r^2 = 0.0747$).

Figure 12: Rate of road injuries and deaths (all ages) and Index of Multiple Deprivation 2007 average score. English local authorities, 2004-06.

2. Diseases and poor health

2.1 Drug misuse

This indicator estimates the number of problem drug users (crack and opiates) aged 15-64 years resident in an area in 2004/05. The measure is intended to help monitor the likely health care burden from drug misuse.

- It is estimated that there are 14,887 problem drug users in the Liverpool City Region.

- The rate of problem drug users in the Liverpool City region is 15.4 per 1,000 population, ranging from 22.4 in Liverpool to 10.3 in Halton (Figure 13).

- Liverpool and Wirral have rates of problem drug users that are significantly worse than the England average (9.9).

- The rate of problem drug users in Liverpool is almost 20 times greater than in Rutland, the local authority in England with the lowest rate (1.3 per 1,000 population).

- Across the core cities, Bristol has the highest rates of problem drug users (28.1). Bristol is the third worst in England on this measure while Liverpool is twelfth. The majority of the other Liverpool City Region local authorities (Knowsley, Sefton, St Helens and Halton) have low rates of drug misuse compared to the core cities group.

Figure 13: Rate of problem drug users (aged 15-64 years) per 100,000 population, 2004/05.

a) Liverpool City Region districts, England best and England average
b) Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol</td>
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<tr>
<td>Birmingham</td>
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<td>Wirral</td>
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<tr>
<td>Newcastle</td>
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<tr>
<td>Leeds</td>
<td>13.4</td>
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<tr>
<td>Sheffield</td>
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<tr>
<td>Knowsley</td>
<td>10.9</td>
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<tr>
<td>Sefton</td>
<td>10.8</td>
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<tr>
<td>St Helens</td>
<td>10.5</td>
</tr>
<tr>
<td>Halton</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

- Across England, there is a strong relationship between the rate of problem drug users and deprivation, with the rate of problem drug users increasing as deprivation increases ($r^2 = 0.4977$) (Figure 14).

Figure 14: Rate of problem drug users (aged 15-64 years) and Index of Multiple Deprivation 2007 average score. English local authorities, 2004/05.

Across the districts, this ranges from 4.39% in Halton to 3.70% in Liverpool.

Four of the local authorities in the Liverpool City Region (Halton, Knowsley, St Helens and Wirral) have a significantly higher percentage of people recorded with diabetes than the England average (3.72%).

• The percentage of people recorded with diabetes in Halton is twice as high as in Kensington and Chelsea (2.05%), the local authority with the lowest percentage in England.

Across the English core cities, Birmingham has the highest percentage of people recorded with diabetes (4.62%) followed by Halton, Wirral and St Helens. Newcastle, Bristol and Leeds have significantly better percentages of people recorded with diabetes than the England average.

2.2 Diabetes

As a treatable and preventable condition, diabetes disproportionately affects the elderly and individuals from minority ethnic populations. It is estimated that 2.3 million people in the UK have diabetes but around 750,000 people have the disease and don’t yet know they have it.

- Around 58,870 people in the Liverpool City Region are recorded as having diabetes.

- The total percentage of people recorded with diabetes in the Liverpool City Region is 3.96%. Across the districts, this ranges from 4.39% in Halton to 3.70% in Liverpool.

- Four of the local authorities in the Liverpool City Region (Halton, Knowsley, St Helens and Wirral) have a significantly higher percentage of people recorded with diabetes than the England average (3.72%).

• The percentage of people recorded with diabetes in Halton is twice as high as in Kensington and Chelsea (2.05%), the local authority with the lowest percentage in England.

- Across the English core cities, Birmingham has the highest percentage of people recorded with diabetes (4.62%) followed by Halton, Wirral and St Helens. Newcastle, Bristol and Leeds have significantly better percentages of people recorded with diabetes than the England average.

Figure 15: Percentage of people recorded with diabetes (all ages) per 1,000 population, 2005/06.

a) Liverpool City Region districts, England best and England average

<table>
<thead>
<tr>
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</thead>
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<td>Liverpool</td>
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<td>St Helens</td>
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</tr>
<tr>
<td>Wirral</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Source: NWPHO from APHO and Department of Health (problem drug users) and Communities and Local Government (IMD 2007)

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32 On GP registers.
b) Liverpool City Region districts and English core cities.

<table>
<thead>
<tr>
<th>Local authority</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
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<tr>
<td>Halton</td>
<td>4.39</td>
</tr>
<tr>
<td>Wirral</td>
<td>4.22</td>
</tr>
<tr>
<td>St Helens</td>
<td>4.15</td>
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<td>Manchester</td>
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<td>Knowsley</td>
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<td>Sheffield</td>
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<td>Nottingham</td>
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<tr>
<td>Leeds</td>
<td>3.48</td>
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</table>

Source: APHO and Department of Health

- Across England, there is a moderate relationship between the percentage of people with diabetes and deprivation, with the percentage increasing as deprivation increases ($r^2 = 0.3176$).

Figure 16: Percentage of people recorded with diabetes and Index of Multiple Deprivation 2007 average score. English local authorities, 2005/06.

3. Adults’ health and lifestyle

3.1 Adults who smoke

Smoking is the most important cause of preventable ill health and premature mortality in the UK. It is linked to respiratory illness, cancer and coronary heart disease. Smoking not only affects the smoker; over 17,000 children under the age of five are admitted to hospital every year with illnesses resulting from passive smoking. The following percentages are estimates created using data from the Health Survey for England (HSE).

A list of disease specific conditions attributable to smoking is published in The Smoking Epidemic in England, Health Development Agency (HAD), 2004 (www.nice.org.uk/page.aspx?o=502811)

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

- Across the Liverpool City Region, Liverpool and Knowsley have the highest estimated percentages of adults who smoke (34.3% and 34.2% of all people aged over 16 respectively), while Wirral has the lowest (22.8%).

- The proportions of smokers in Liverpool, Knowsley and Halton are all significantly worse than the England average (24.1%).

- The estimated percentage of adults who smoke in Liverpool is 2.5 times higher than the percentage in East Dorset (13.7%), England’s lowest rate.

- Of the English core cities, Nottingham has the highest percentage of adults who smoke (36.2%). Liverpool and Knowsley also have relatively high percentages compared to the English core cities, but Sefton and Wirral have the lowest rates.
Figure 17: Percentage of adults (aged 16 and over) who smoke, 2003-05.

a) Liverpool City Region districts, England best and England average

b) Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
<th>Local authority</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<td>Nottingham</td>
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<tr>
<td>Knowsley</td>
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<td>Manchester</td>
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<td>Leeds</td>
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<td>St Helens</td>
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<td>Birmingham</td>
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<td>Bristol</td>
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<td>Sefton</td>
<td>23.7</td>
</tr>
<tr>
<td>Wirral</td>
<td>22.8</td>
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</tbody>
</table>

Source: APHO and Department of Health

- There is a strong relationship between the percentage of adults who smoke and deprivation ($r^2 = 0.5037$). The level of deprivation increases as the percentage of adults who smoke increases.

Figure 18: Percentage of adults who smoke and Index of Multiple Deprivation 2007 average score. English local authorities, 2003-05.

Source: NWPHO from APHO and Department of Health (percentage of adults who smoke) and Communities and Local Government (IMD 2007)

3.2 Binge drinking adults

Levels of alcohol consumption have increased over the last decade and nowadays over 90% of adults in Britain drink alcohol. Both the frequency and the level of alcohol consumed among the general population provide a measure of the potential level of harm being applied on different sections of the population.

The Government advises that adult men should not regularly drink more than 3-4 units of alcohol a day and adult women should not regularly drink more than 2-3 units of alcohol a day. For this measure, ‘binge drinking’ is defined as drinking twice the daily recognised sensible levels in any one day (8 or more units a day for men and 6 or more units a day for women) on the heaviest drinking day in the last seven days.

- An estimated 95,143 adults in the Liverpool City Region engage in binge drinking.
- Liverpool has the highest percentage of adult binge drinkers in the Liverpool City Region (26.9%), while Sefton has the lowest (22.1%).
- Every Liverpool City Region local authority has a significantly worse percentage of binge drinkers than the national average (18.0%).
- The percentage of Liverpool adults who binge drink is 2.8 times greater than Harrow, the English local authority with the lowest percentage.
- Liverpool, Knowsley and Halton rank among the worst 10% of all English local authorities for adults who binge drink.

- Newcastle has the worst level of binge drinking in England, followed by Manchester. Compared to the English core cities, Liverpool City Region districts have relatively mixed rankings, with Liverpool and Knowsley having higher levels of binge drinking than five core cities, but Sefton and Wirral having lower rates than five core cities.

Figure 19: Percentage of adults (aged 16 and over) binge drinking, 2003-05.

a) Liverpool City Region districts, England best and England average

\[ R^2 = 0.146 \]

b) Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
<th>Local authority</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>Knowsley</td>
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<td>Halton</td>
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</tr>
<tr>
<td>Birmingham</td>
<td>17.8</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

- There is a weak relationship between binge drinking and deprivation ($r^2 = 0.146$): there is some evidence of binge drinking increasing as deprivation increases.

Figure 20: Percentage of adults binge drinking and Index of Multiple Deprivation 2007 average score. English local authorities, 2003-05.

3.3 Healthy eating adults

The indicator is a measure of a protective lifestyle factor. A diet rich in fruit and vegetables confers protective effects against the development of heart disease and certain cancers. It has been estimated that eating at least five portions of a variety of fruit and vegetables a day could reduce the risk of deaths from chronic diseases such as heart disease, stroke and cancer by up to 20%.

It is also suggested that diet might contribute to the development of one-third of all cancers, and that increasing fruit and vegetable consumption is the second most important cancer prevention strategy, after reducing smoking. In 1998, the Department of Health’s Committee on Medical Aspects of Food Policy and Nutrition reviewed the evidence and concluded that higher vegetable consumption would reduce the risk of colorectal cancer and gastric cancer. There was also weakly consistent evidence that higher fruit and vegetable consumption would reduce the risk of breast cancer. These cancers combined represent about 18% of the cancer burden in men and about 30% in women.
Higher consumption of fruit and vegetables also reduces the risk of coronary heart disease and stroke. A recent study found that each increase of one portion of fruit and vegetables a day lowered the risk of coronary heart disease by 4% and the risk of stroke by 6%. Evidence also suggests an increase in fruit and vegetable intake can help lower blood pressure.

‘Healthy eating adults’ in the context of this indicator are defined as adults who eat five or more portions of fruit and vegetables per day. A portion of fruit or vegetables is an 80g serving. These are model-based estimates using Health Survey for England data.

- Knowsley has the lowest estimated proportion of healthy eating adults in the Liverpool City Region (17.8%) and Wirral the highest (27.4%).

- Four out of the six Liverpool City Region local authorities (Halton, Knowsley, Liverpool, St Helens) have significantly worse proportions of adults who eat healthily compared to the England average (26.3%).

- Kensington and Chelsea has the highest proportion of adults who eat healthily in England (45.8%), around 2.6 times the proportion in Knowsley.

- Wirral has a higher proportion of healthy eating adults than any core city, but Knowsley has a lower proportion. Halton, St Helens and Liverpool all have slightly higher proportions of healthy eaters than Newcastle (20.3%), but less than the remaining core cities.

**Figure 21:** Percentage of adults (aged 16 and over) who eat healthily, 2003-05.

a) Liverpool City Region districts, England best and England average

b) Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
<th>Local authority</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>17.8</td>
</tr>
<tr>
<td>Newcastle</td>
<td>20.3</td>
</tr>
<tr>
<td>Liverpool</td>
<td>20.6</td>
</tr>
<tr>
<td>Halton</td>
<td>21.0</td>
</tr>
<tr>
<td>St Helens</td>
<td>21.0</td>
</tr>
<tr>
<td>Manchester</td>
<td>21.5</td>
</tr>
<tr>
<td>Bristol</td>
<td>23.9</td>
</tr>
<tr>
<td>Birmingham</td>
<td>25.1</td>
</tr>
<tr>
<td>Nottingham</td>
<td>25.4</td>
</tr>
<tr>
<td>Sefton</td>
<td>26.0</td>
</tr>
<tr>
<td>Leeds</td>
<td>26.8</td>
</tr>
<tr>
<td>Sheffield</td>
<td>27.1</td>
</tr>
<tr>
<td>Wirral</td>
<td>27.4</td>
</tr>
</tbody>
</table>

Source: APHO and Department of Health

- There is a moderate negative relationship between the percentage of adults who eat healthily and deprivation ($r^2 = 0.3146$). As deprivation decreases, the proportion of adults who eat healthily also decreases.

**Figure 22:** Percentage of adults who eat healthily, 2003-05.

$R^2 = 0.3146$

Source: NWPHO from APHO and Department of Health (adults who eat healthily) and Communities and Local Government (IMD 2007)
### 3.4 Physically active adults

People who have a physically active lifestyle are at approximately half the risk of developing coronary heart disease compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities.

In terms of mortality, morbidity and quality of life, the Chief Medical Officer has estimated the cost of inactivity in England to be £8.2 billion annually. Evidence for the effectiveness of interventions to increase the population levels of physical activity is summarised in ‘The Effectiveness of Interventions to Increase Physical Activity: A Systematic Review’.

Sport England has as an objective agreed with Government to increase participation in sport by an average of one per cent a year over three years to 2008. The Framework for Sport in England has identified a longer-term target to continue this growth to at least 2020 to establish England as the most active nation in the world.

This indicator measures participation in moderate intensity sport and active recreation on 20 or more days in the previous 4 weeks (averaging 5 or more times per week) aged 16 and over as percentage of respondents to the Sport England Active People Survey, 2006.

- The total percentage of adults who are physically active in the Liverpool City Region is 10.0%, with local authority percentages ranging from 9.3% in Liverpool to 11.9% in Sefton.

- Liverpool, St Helens and Wirral have significantly worse percentages of adults who are physically active than the England average (11.6%).

- The percentage of adults who are physically active in Teesdale in Durham (17.2%), the local authority with the best percentage in England, is 1.8 times higher than in Liverpool.
- Although Liverpool, Wirral and St Helens have the lowest proportions of physically active adults in the Liverpool City Region, Birmingham (9.2%) and Sheffield (8.6%) have lower proportions still. However, all Liverpool City Region local authorities (with the exception of Sefton) have lower percentages of physically active adults than the other five core cities.

![Figure 23: Percentage of adults (aged 16 and over) who are physically active, 2005-06.](chart)

**Local authority** | %
--- | ---
Sheffield | 8.6
Birmingham | 9.2
Liverpool | 9.3
Wirral | 9.5
St Helens | 9.7
Halton | 9.9
Knowsley | 10.0
Leeds | 10.2
Bristol | 10.3
Manchester | 10.9
Nottingham | 11.0
Sefton | 11.9
Newcastle | 12.3

Source: APHO and Department of Health
• Across England, there is some evidence of a moderate relationship between the percentage of adults who are physically active and deprivation, with physical activity decreasing as deprivation increases ($r^2 = 0.2561$) (Figure 24).

Figure 24: Percentage of adults who are physically active and Index of Multiple Deprivation 2007 average score. English local authorities, 2005-06.

Source: NWPHO from APHO and Department of Health (percentage of adults who are physically active) and Communities and Local Government (IMD 2007)

3.5 Obese adults

Obesity in adults is defined for epidemiological purposes as a body mass index (BMI) over 30 kg/m². There are many routes by which obesity is a detriment to wellbeing. For example, it is associated with all cause mortality (decreasing life expectancy by up to nine years), causes insulin insensitivity (which is an important contributory factor in diabetes, heart disease, hypertension and stroke) and it is linked to the development of hormone-sensitive cancers. The increased mechanical load also increases liability to osteoarthritis and sleep apnoea. There are also known psychosocial penalties to being overweight.

• Within the Liverpool City Region, Halton has the highest estimated proportion of obese adults (26.8% of all adults aged over 16) and Wirral has the lowest proportions of obese adults (21.7%).

• Halton’s percentage of obese adults is significantly worse than the England average (23.6%), but the other local authorities have percentages not significantly different from England’s.

• Tower Hamlets has the lowest estimated proportion of obese adults in the country (11.9%). Halton’s estimated percentage is 2.3 times higher than this.

• Nottingham has greater prevalence of adult obesity (27.6%) than any other core city or Liverpool City Region local authority, followed closely by Halton (26.8%). However, Wirral, Liverpool and Sefton are worse than just Leeds (20.6%).

Figure 25: Percentage of adults (aged 16 and over) who are obese, 2003-05.

a) Liverpool City Region districts, England best and England average

b) Liverpool City Region districts and English core cities

<table>
<thead>
<tr>
<th>Local authority</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nottingham</td>
<td>27.6</td>
</tr>
<tr>
<td>Halton</td>
<td>26.8</td>
</tr>
<tr>
<td>Manchester</td>
<td>25.8</td>
</tr>
<tr>
<td>St Helens</td>
<td>25.3</td>
</tr>
<tr>
<td>Sheffield</td>
<td>24.3</td>
</tr>
<tr>
<td>Knowsley</td>
<td>23.4</td>
</tr>
<tr>
<td>Birmingham</td>
<td>23.4</td>
</tr>
<tr>
<td>Newcastle</td>
<td>22.6</td>
</tr>
<tr>
<td>Bristol</td>
<td>22.5</td>
</tr>
<tr>
<td>Sefton</td>
<td>22.0</td>
</tr>
<tr>
<td>Liverpool</td>
<td>21.9</td>
</tr>
<tr>
<td>Wirral</td>
<td>21.7</td>
</tr>
<tr>
<td>Leeds</td>
<td>20.6</td>
</tr>
</tbody>
</table>

Source: APHO and the Department of Health

• There is no evident relationship between the percentage of obese adults across the English local authorities and deprivation ($r^2 = 0.0409$).
4. Wealth in the Liverpool City Region

4.1 Labour market status of the working age population

Economic activity
- Recent data shows that a lower proportion of the Liverpool City Region working age (16 to retirement age) population are economically active\(^{35}\) (73.6\%) than in England as a whole (78.6\%).

- The percentage of the working age population in employment (68.1\%) is below the England average (74.4\%).

- The ILO unemployment rate\(^{36}\) across the Liverpool City Region is 7.5\%, higher than across England (5.4\%) (Figure 27).

Economic inactivity
- More people are economically inactive in the Liverpool City Region\(^{37}\) (26.4\%) than in England overall (21.4\%). Of those who are economically inactive, 20.4\% ‘want a job’, lower than the average proportion in England (24.8\%) (Figure 27).

- 79.6\% of the economically inactive in the Liverpool City Region ‘do not want a job’, which is higher than in England (75.2\%). Those who ‘do want a job’ can include individuals looking after the home/family (i.e. children/family), students, the retired and those in ill health.

---

\(^{35}\) A person is ‘economically active’ if they are either employed or ILO unemployed.

\(^{36}\) The ‘unemployed’, according to the International Labour Organisation (ILO) definition is expressed as a percentage of the relevant economically active population includes a wider definition of unemployment than the ‘claimant count’. The unemployed are those who are not in employment, want a job and have actively sought work in the previous four weeks and are available to start work within the next fortnight or who are out of work and have accepted a job which they are awaiting to start in the next fortnight.

\(^{37}\) The economically inactive population includes everyone of working age who is left over after counting the employed and the unemployed (including those who are not seeking or available to start a job): Centre for Economic and Social Exclusion (CESI) (2008) ‘Who are the economically inactive?’ Labour Market Analysis, Working Brief 160. www.cesi.org.uk/statdocs/0412/WB160%20Anyis.pdf.
Figure 27: Liverpool City Region working age population, January – December 2007.

Working age population:
900,100

Economically active:
662,400 (73.6%)
England: 78.6%

Economically inactive:
237,700 (26.4%)
England: 21.4%

In employment:
612,800 (employment rate: 68.1%)
England: 74.4%

ILO* unemployed:
49,600 (unemployment rate: 7.5%)
England: 5.4%

Who want a job:
48,600 (20.4% of ec. inactive)
England: 24.8%

Who do not want a job:
189,100 (79.6% of ec. inactive)
England: 75.2%

Incapacity Benefit (IB/SDA) claimants*:
11.70% of working age population
England: 6.74%

Source: Annual Population Survey, Office for National Statistics

Notes:
# Source: NWPHO from Department for Work and Pensions (benefit data) and Office for National Statistics (mid-year population estimates).
* International Labour Organisation (ILO)

4.2 The Indices of Multiple Deprivation 2007
The English Index of Multiple Deprivation 2007 (IMD 2007) is the Government’s official measure of multiple deprivation at a small area level. The IMD 2007 is based on the small area geography known as Lower Super Output Areas (LSOAs). LSOAs have between 1,000 and 3,000 residents, with an average population of 1,500 people. In most cases, these are smaller than wards, therefore allowing the identification of small pockets of deprivation. There are 32,482 LSOAs in England. The LSOA ranked 1 by the IMD 2007 is the most deprived and the LSOA ranked 32,482 is the least deprived.

The Index is a composite ‘multiple deprivation’ score aggregated from seven distinct domains or dimensions of deprivation:

• Income;
• Employment;
• Health and disability;
• Education;
• Skills and training;
• Barriers to housing and services;
• Living environment and crime.

These are weighted and combined to create the overall IMD 2007. The majority of the data underpinning the IMD 2007 represents 2005 although some data covers a number of years, such as an average of 2003 to 2005.

Overall, 34.0% of the Liverpool City Region population live in the 10% most deprived LSOAs in England, while almost half of the Liverpool City Region (45.9%) live in the 20% most deprived LSOAs nationally, and 64.3% are living in the most deprived 40% (Table 1).
Figure 28: Index of Multiple Deprivation quintiles.  
Liverpool City Region, 2007.
Table 1: Percentage of the Liverpool City Region population living in the most deprived LSOAs, 2007.

<table>
<thead>
<tr>
<th>Lower Super Output Areas</th>
<th>Percentage of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% most deprived LSOAs</td>
<td>34.0%</td>
</tr>
<tr>
<td>20% most deprived LSOAs</td>
<td>45.9%</td>
</tr>
<tr>
<td>40% most deprived LSOAs</td>
<td>64.3%</td>
</tr>
<tr>
<td>60% most deprived LSOAs</td>
<td>82.1%</td>
</tr>
<tr>
<td>80% most deprived LSOAs</td>
<td>94.3%</td>
</tr>
<tr>
<td>100% of LSOAs</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: NWPHO from Office for National Statistics (mid-year population estimates) and Communities and Local Government (Index of Multiple Deprivation 2007)

**Rank of average score**

In terms of rank of average score (one way of depicting average deprivation in an area), Liverpool is ranked the most deprived local authority (1st out of 354 local authorities in total) across England in 2007. The ranks for the other five local authorities in the Liverpool City Region range from 5 in Knowsley to 83 in Sefton.

Liverpool also had top ranked position in the previous Index of Multiple Deprivation 2004. However, every other local authority in the Liverpool City Region has improved its rank of average score between 2004 and 2007. Wirral has experienced the greatest shift in rank between the production of the 2004 and 2007 indices with a 12 point shift from a rank of 48 in 2004 to 60 in 2007.

**Local authority measures**

In addition to the deprivation measures produced at LSOA level, six summary measures of the IMD 2007 have been produced at a local authority district level for each of the 354 local authorities in England. As there is no ‘best way’ of comparing local authorities, no measure is favoured over another. However, it is useful to examine the Liverpool City Region local authority rankings for some of these measures, and furthermore, the make a comparison between deprivation and health indicators to investigate the existence of relationships between deprivation and poor health. This has been done in previous sections, using the actual local authority average score value (not ranking). The local authority measures for 2007 can also be compared to their equivalent rankings in 2004, to highlight where a local authority ranking has improved or declined. It is important to note that a change in position/rank does not guarantee that deprivation levels in a particular local authority have become better or worse, only that the level of deprivation has changed relative to deprivation levels in all other 354 local authorities in England as a whole.
Table 2: Rank of average score. Liverpool City Region, Indices of Multiple Deprivation (IMD), 2004 and 2007.

<table>
<thead>
<tr>
<th>Local authorities</th>
<th>2007</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>30</td>
<td>21</td>
</tr>
<tr>
<td>Knowsley</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Liverpool</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sefton</td>
<td>83</td>
<td>78</td>
</tr>
<tr>
<td>St Helens</td>
<td>47</td>
<td>36</td>
</tr>
<tr>
<td>Wirral</td>
<td>60</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: Communities and Local Government

Rank of employment scale

The employment scale measure assesses the employment deprivation people in each area face. In terms of rank of employment scale, Liverpool is ranked the second most deprived local authority out of 354 local authorities in total across England in 2007. The ranks for the other five local authorities in the Liverpool City Region range from 8 in Wirral to 77 in Halton (Table 3).

Liverpool also had second highest rank position in the previous Index of Multiple Deprivation, although every other local authority in the Liverpool City Region however has improved its rank of employment scale between 2004 and 2007. Knowsley has experienced the greatest shift in rank/position between the production of the 2004 and 2007 indices with a 15 point shift from a rank of 30 in 2004 to 45 in 2007 (Table 3).

Table 3: Rank of employment scale. Liverpool City Region, Indices of Multiple Deprivation (IMD) 2004 and 2007.

<table>
<thead>
<tr>
<th>Local authorities</th>
<th>2007</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>77</td>
<td>65</td>
</tr>
<tr>
<td>Knowsley</td>
<td>45</td>
<td>30</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sefton</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>St Helens</td>
<td>51</td>
<td>40</td>
</tr>
<tr>
<td>Wirral</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Communities and Local Government
Rank of income scale

The income scale assesses the level of income deprivation faced by people in each area. In terms of rank of income scale, Liverpool is ranked the third most deprived local authority out of 354 local authorities in total across England in 2007. The ranks for the other five local authorities in the Liverpool City Region range from 21 in Wirral to 92 in Halton (Table 4).

Every local authority in the Liverpool City Region improved its rank of income scale between 2004 and 2007, although Liverpool’s ranking only improved by one place. Halton experienced the greatest shift in rank according to the 2004 and 2007 indices with a 15 point shift from a rank of 77 in 2004 to 92 in 2007 (Table 4).

Table 4: Rank of income scales. Liverpool City Region, Indices of Multiple Deprivation (IMD), 2004 and 2007.

<table>
<thead>
<tr>
<th>Local authorities</th>
<th>2007</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>92</td>
<td>77</td>
</tr>
<tr>
<td>Knowsley</td>
<td>50</td>
<td>38</td>
</tr>
<tr>
<td>Liverpool</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sefton</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>St Helens</td>
<td>71</td>
<td>64</td>
</tr>
<tr>
<td>Wirral</td>
<td>21</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Communities and Local Government

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40 It is important to note that a change in position/rank does not guarantee that deprivation levels in a particular local authority have become better/worse, only that the level of deprivation has changed relative to deprivation levels in all other 354 local authorities in England as a whole.
### ‘Traffic light’ health indicators - Liverpool City Region local authorities

**KEY:** District value against the England average based on 95% confidence intervals (CIs) unless otherwise stated.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>England</th>
<th>Halton</th>
<th>Knowsley</th>
<th>Liverpool</th>
<th>Sefton</th>
<th>St Helens</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIFE EXPECTANCY AND CAUSES OF DEATH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male life expectancy at birth (2004-06)</td>
<td>77.3</td>
<td>74.3</td>
<td>74.4</td>
<td>73.8</td>
<td>76.2</td>
<td>75.3</td>
<td>75.7</td>
</tr>
<tr>
<td>Female life expectancy at birth (2004-06)</td>
<td>81.6</td>
<td>78.4</td>
<td>79.0</td>
<td>78.3</td>
<td>81.0</td>
<td>80.2</td>
<td>80.8</td>
</tr>
<tr>
<td>Smoking attributable mortality rate (over 35 years) (2004-06)</td>
<td>225.4</td>
<td>313.1</td>
<td>355.0</td>
<td>349.8</td>
<td>248.3</td>
<td>277.3</td>
<td>257.4</td>
</tr>
<tr>
<td>Mortality rate from heart disease and stroke (under 75 years) (2004-06)</td>
<td>84.2</td>
<td>110.0</td>
<td>124.0</td>
<td>120.2</td>
<td>88.6</td>
<td>103.9</td>
<td>91.0</td>
</tr>
<tr>
<td>Mortality rate from cancer (under 75 years) (2004-06)</td>
<td>117.1</td>
<td>167.8</td>
<td>155.7</td>
<td>166.0</td>
<td>127.4</td>
<td>126.7</td>
<td>130.4</td>
</tr>
<tr>
<td>Rate of road injuries and deaths (2004-06)</td>
<td>56.3</td>
<td>56.2</td>
<td>40.8</td>
<td>62.2</td>
<td>37.6</td>
<td>41.5</td>
<td>60.8</td>
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<td><strong>DISEASE AND POOR HEALTH</strong></td>
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</tr>
<tr>
<td>Rate of problem drug users per 1,000 population (2004/05)</td>
<td>9.9</td>
<td>10.3</td>
<td>10.9</td>
<td>22.4</td>
<td>10.8</td>
<td>10.5</td>
<td>15.7</td>
</tr>
<tr>
<td>Percentage of population (all ages) recorded with diabetes (2005/06)</td>
<td>3.72</td>
<td>4.39</td>
<td>4.07</td>
<td>3.70</td>
<td>3.72</td>
<td>4.15</td>
<td>4.22</td>
</tr>
<tr>
<td><strong>ADULTS’ HEALTH AND LIFESTYLE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adults who smoke (2003-05)</td>
<td>24.1</td>
<td>30.5</td>
<td>34.2</td>
<td>34.3</td>
<td>23.7</td>
<td>25.1</td>
<td>22.8</td>
</tr>
<tr>
<td>Percentage of adults binge drinking (2003-05)</td>
<td>18.0</td>
<td>23.2</td>
<td>23.8</td>
<td>26.9</td>
<td>22.1</td>
<td>22.9</td>
<td>22.2</td>
</tr>
<tr>
<td>Percentage of adults who eat healthily (2003-05)</td>
<td>26.3</td>
<td>21.0</td>
<td>17.8</td>
<td>20.6</td>
<td>26.0</td>
<td>21.0</td>
<td>27.4</td>
</tr>
<tr>
<td>Percentage of adults who are physically active (2005-06)</td>
<td>11.6</td>
<td>9.9</td>
<td>10.0</td>
<td>9.3</td>
<td>11.9</td>
<td>9.7</td>
<td>95</td>
</tr>
<tr>
<td>Percentage of adults who are obese (2003-05)</td>
<td>23.6</td>
<td>26.8</td>
<td>23.4</td>
<td>21.9</td>
<td>22.0</td>
<td>25.3</td>
<td>21.7</td>
</tr>
</tbody>
</table>
Sponsors

- Merseyside Fire & Rescue Service
- Halton Borough Council
- Liverpool University
- Knowsley Council
- The City of Liverpool
- Northwest Regional Development Agency

- Halton and St Helens NHS Primary Care Trust
- Knowsley NHS Primary Care Trust
- Liverpool NHS Primary Care Trust
- Sefton NHS Primary Care Trust
- Sefton Council
- St. Helens Council
- The Mersey Partnership
- Wirral Council