
IMPACT

**THE INTERNATIONAL HEALTH IMPACT ASSESSMENT
CONSORTIUM**

DRAFT

**A Health Impact Assessment of the Health is
Wealth Commission's 'Big Ideas'**

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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 well being 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 were 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
- 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 a 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, long standing 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 a 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 socioeconomic 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 (Mackenbach, 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 socioeconomic 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 bye-laws, 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’.

Incapacity 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 addresses the Labour Market Inequalities that exists – 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 were 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 socioeconomic 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 well being, 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 – a LCR 'Health at Work' Charter particularly focusing on the psychosocial work environment may contribute to existing measures to improve worker health and well being 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 to 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 in 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.
- 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 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 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/5qxi62> 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.

5.3 For example, the 'Local Alcohol Strategy Toolkit' (2004) <http://tinyurl.com/6j9bhs> prepared by the London Drug and Alcohol Network and Alcohol Concern for the Government, comprehensively mapped a wide range of policy drivers, reflecting a socio environmental model of health. Following enactment of the Licensing Act (2003) in 2005 <http://tinyurl.com/6q26ku> and the publication of the updated 'Alcohol Harm Reduction Strategy' in 2007 <http://tinyurl.com/6oxsma>, with an apparently narrower more "judicial" view, the 'Local Alcohol Strategy Implementation Toolkit' (2008) <http://tinyurl.com/6fhqbf> was published by the Home Office.

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 Commissions' 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/6aqxce>. 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/6qulmt>, 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/657tvm>. 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.

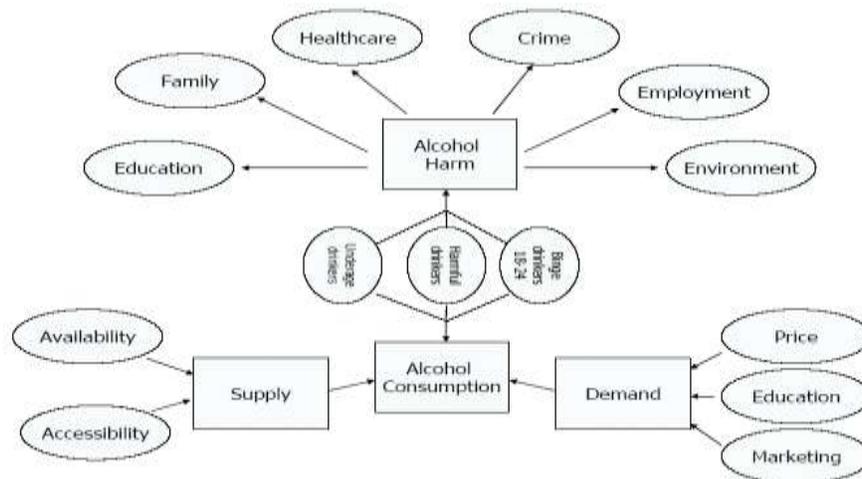
5.18 The lack of robust cost-effectiveness studies relating to harm reduction was identified by the WHO Expert Committee on problems related to alcohol consumption (2007) <http://tinyurl.com/5snwzs>

5.19 Both the HIA of the review of the Alcohol Harm Reduction Strategy for England (2007) <http://tinyurl.com/5qlwyf> 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/5vqjw> 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.

Figure 1 Alcohol and health model



Source: Cave, B., Ison, E., Stuckler, D., Coutts, A. (2007) Review of the National Alcohol Harm Reduction Strategy for England Health Impact Assessment. Department of Health <http://tinyurl.com/5vbcjc>

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 Commissions' 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 harmonisation 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 aides 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/5mac36> and <http://tinyurl.com/5d9b4s> and for example, the BMA <http://tinyurl.com/636uaf>.
- Advocate that relevant agencies lobby for adoption of common bye-laws, 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+ years) 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, Sedgfield 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 (NWPFO, 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 & Bamba, 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 well being 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 socioeconomic 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 (NWPFO, 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 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 reciprocity 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.

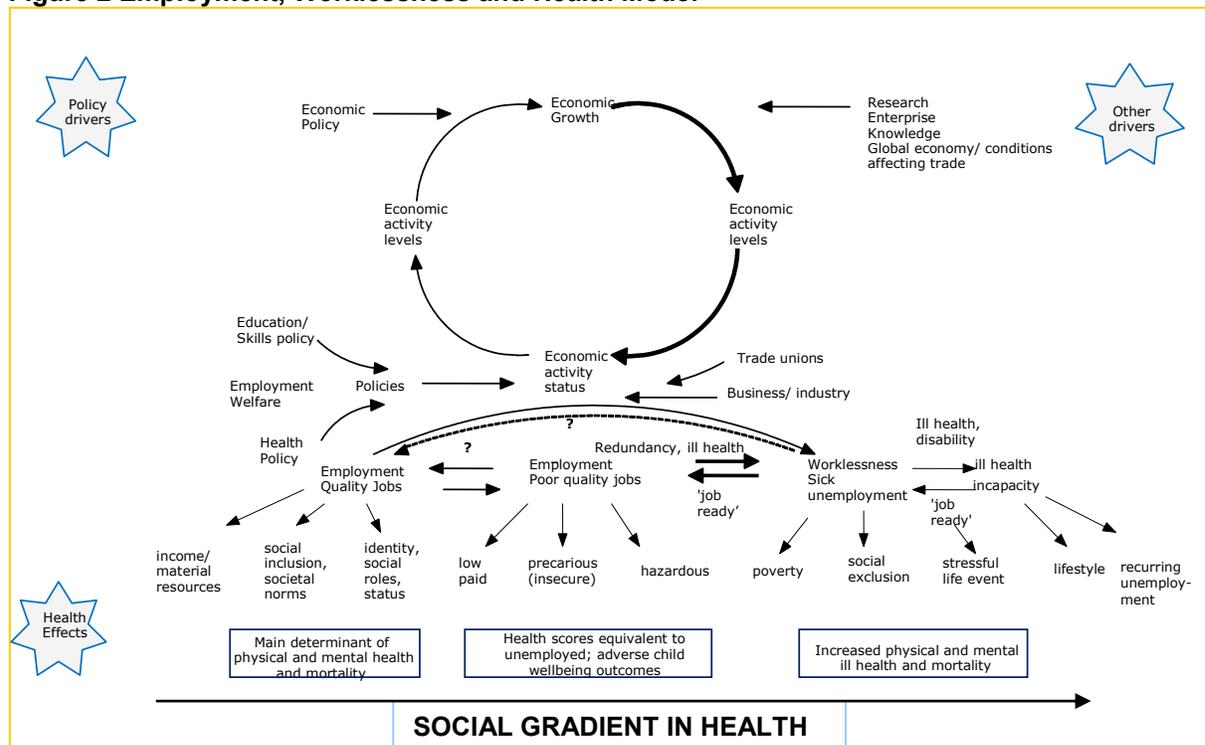
6.37 These results were undermined by most jobs typically being low paid and poor quality, with limited earnings growth over time, or employment retention prospects (Gregg et al, 2007; Huston, 2002). In addition although absolute child poverty was reduced, if a parent's move from benefit to employment meant no increase in household income, child well being 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.

Figure 2 Employment, Worklessness and Health Model



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 exists – 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 indicate 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 well being 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 socioeconomic 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 socioeconomic 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 'fexicity', 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 promotion 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 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 well being 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 well being. 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 well being 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).

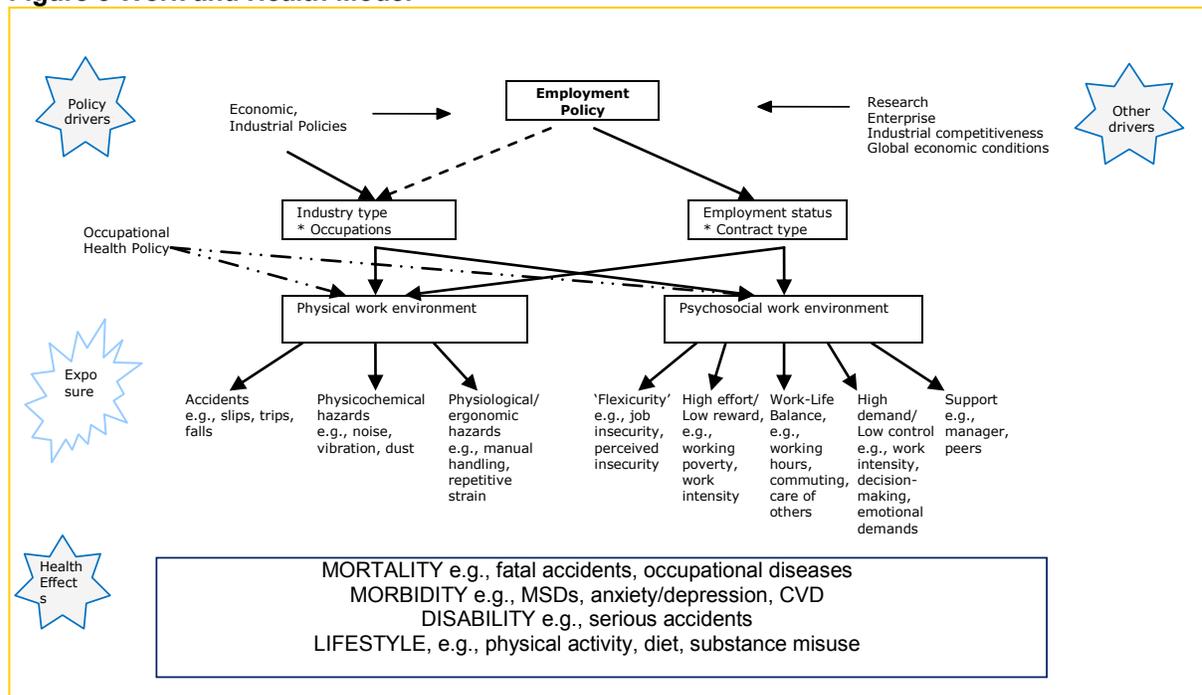
7.34 In spite of the support for the development of Occupational Health and Safety Systems and Services from, e.g., WHO, the EC and Dame Black, and an intuitive belief that this will improve health and safety of workers, there is limited evidence to support this; the findings from a systematic review 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.

Figure 3 Work and Health Model



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 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 arrangement 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 well being. 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 well being. 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 sub-contractors' obligations towards their workers;
- Commissioning 'evidence of effectiveness' studies – commission high quality prospective studies to assess the effects '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.

8.10 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 in (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 site 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., CABA 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, CABA'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 CABA'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 in 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 (McCrudden 2004). McCrudden 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" (McCrudden 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 Commissions 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 impact 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 well being 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.

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