A DESK-BASED HEALTH IMPACT ASSESSMENT OF THE NORTH WEST REGIONAL ECONOMIC STRATEGY

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The North West Regional Economic Strategy: A desk-based Health Impact Assessment

Contents

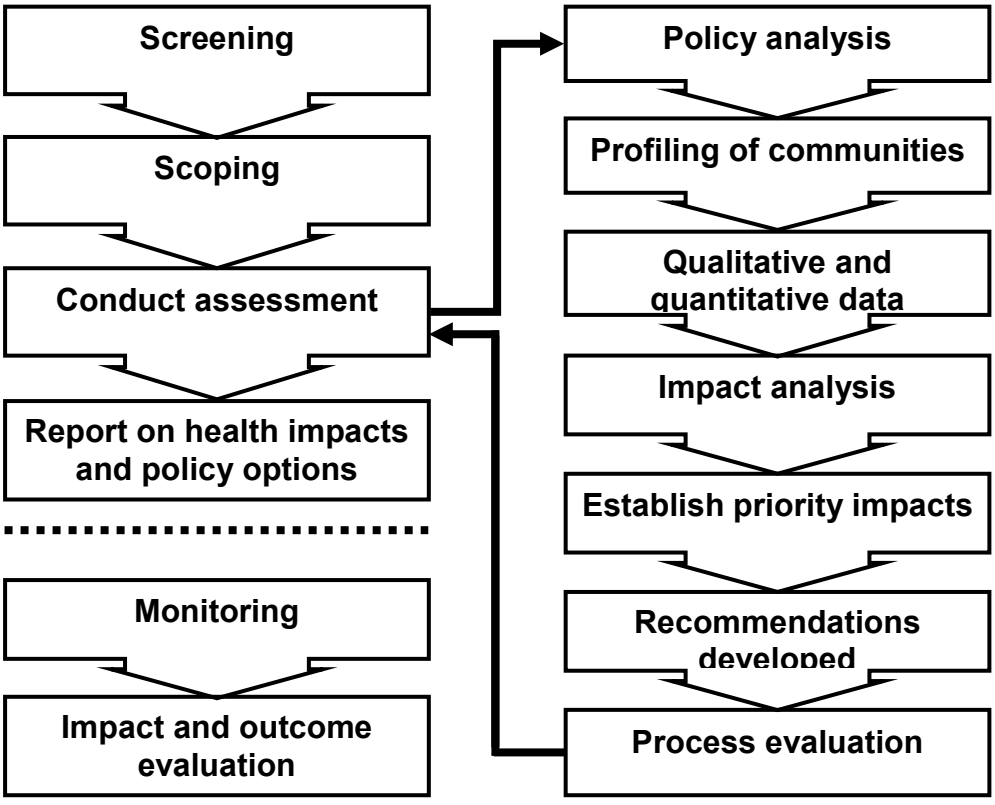
List of tables and figures

Introduction

This report describes the potential health effects of the North West Regional Economic Strategy (RES) on the population of the North West, identified from the desk-based health impact assessment. Health Impact Assessment (HIA) is concerned with improving health and reducing health inequalities. HIA can be of different depths and durations; for pragmatic reasons this HIA was undertaken as a desk-based exercise over a two-day period in October; this was subsequently amended in acknowledgement of the revisions made to the RES (version 5) and the incorporation of many of the recommendations from the draft HIA. Although a strategy of this magnitude would ideally be subject to a more comprehensive assessment (Figure 1), it has been possible to make a number of general points about the RES which will hopefully 'add health value' to decisions regarding the final RES, the ultimate purpose of a HIA.

This work was commissioned by the North West Development Agency (NWDA).

Figure 1 A generic HIA methodology (Abrahams et al, 2004)



Aim and objectives of the desk-based HIA

To identify and assess the health effects of the draft RES produced in July 2005.

In particular,

- To identify the main impacts of the proposals on key health determinants, e.g. economic activity/inactivity rates, socio-economic working conditions, educational attainment and qualification levels, transport/traffic infrastructure, in qualitative terms
- To describe the potential impacts of the proposals on the health outcomes of the population in broad qualitative terms
- To describe the potential impacts of the proposals on health services in broad qualitative terms
- To describe the differential distribution of impacts across the population, e.g. population sub-groups (women, BME groups, older people, people with disabilities)
- To identify priority impacts resulting from the RES proposals
- To make recommendations to North West Development Agency

Methods

The timescales associated with the formal consultation of the RES were such that a desk-based HIA was undertaken including the following methods:

Policy analysis
Review the RES consultation document and analyse against the following criteria:

- Policy development
- Policy content
- Policy implementation
- Health impact analysis in policy planning ('health proofing')

Profiling
To collate and review key statistics for the Northwest.

Data analysis
To collect and review data from the literature and other sources, e.g. the SEA of the RES.

Impact analysis
To identify evidence of impacts from the data collated and to characterise the potential health impacts from these in terms of health determinants affected and the potential effects on health outcomes and health services.

Limitations of the study
There is a necessary compromise between brevity and rigour in any study and this one is no exception. In particular, the lack of participatory approaches, opportunity to access a broader evidence base, to undertake a more up to date and comprehensive health profile, and to model the health effects of key scenarios would have added to the rigour of this work.

Policy Analysis

The RES is the region's rolling 20-year strategy to shape the future economic direction of the Northwest; the draft RES first produced in July 2005 and updated in October, focuses on the next three years. The NWDA leads the development of the strategy on behalf of the region, but it is a strategy for all those seeking to develop the economy of the Northwest.

The overall vision of the RES is to:

'Transform England's Northwest through sustainable economic development into a competitive, high added value, knowledge-based inclusive economy.'

The RES seeks to achieve this vision by focussing on 5 themes:

Table 1 Contents of version 5 of the RES

BUSINESS
Aim: Assist the creation of the creation development and attraction of competitive, high value activities and profitable businesses within a culture of enterprise and innovation
Major objectives: ◆ Developing higher value added activity through innovation and the application of science ◆ Encouraging higher added value activity through internationalisation ◆ Developing an enterprise culture and job growth in underperforming locations and communities ◆ Developing sectors
SKILLS AND DEVELOPMENT
Aim: Ensure the current and future workforce has the skills required by business through lifelong learning
Major objectives: ◆ Increasing the proportion of the workforce with basic skills required to work ◆ Ensuring appropriate level 2/level 3 provision for sectoral needs ◆ Increasing the proportion of the workforce with level 4 skills ◆ Encouraging workforce development ◆ Improving leadership and management ◆ Developing enterprise skills in the population ◆ Maintaining the size of the workforce due to an ageing population
REGENERATION
Aim: Ensure economic growth by creating the conditions for investment and sustainable communities
Major objectives: ◆ Releasing the full urban renaissance of the City Regions of Manchester, Liverpool and Central Lancashire ◆ Tackling worklessness and unemployment in deprived areas within and close to areas of economic growth, i.e. City Regions by linking people, jobs and training ◆ Creating the conditions for sustainable growth in urban areas with few economic drivers ◆ Creating the conditions for sustainable growth in rural areas ◆ Joining up the responses and increased capacity to deliver sustainable economic growth
INFRASTRUCTURE
Aim: Ensure that the Northwest has a high quality and effectively utilised transport, communication, housing and sites infrastructure
Major objectives: ◆ Enhance the road and rail infrastructure within the region ◆ Enhancing the road rail and interconnectivity of the region with other areas ◆ Providing appropriate sites and premises for development across the region ◆ Creating a high quality physical environment ◆ Creating the housing quality & quantity to support economic growth ◆ Making the best use of the ICT infrastructure

◆ Ensuring a supportive planning framework
QUALITY OF LIFE
Aim: Nurture and promote the Northwest as an attractive place to live, work and invest
Major objectives: ◆ Improving the image of the Region ◆ Building on the impact of major events ◆ Developing the uniqueness of the Region's Cultural Offer ◆ Capitalising on and strengthening the Natural and Built Heritage Environment ◆ Increasing the quality, range and value of the business and leisure visitor economy

The draft RES is a coherent and well-presented document. The aims and objectives were clearly described, and related to the current context that was also well defined. It defines the activities to support this vision, however, some themes whilst clear about what they wanted to achieve were less specific about how e.g., 'increasing the proportion of the workforce with level 4 skills' included the action 'work to ensure graduate retention'. In addition, it was not possible to verify the evidence-base under-pinning those interventions that were described although it is acknowledged that an evidence-base has been referred to. The RES review process was described as being steered by an Advisory Group of regional partners, including, with subsequent distribution to an email network of over 4,000 people. However it was also indicated that the region's businesses have only 73% computer coverage. Collectively these minor issues indicate possible risks in achieving the targets that have been set.

There was some reference to health and health services in the draft RES. Under the 'Business' theme, healthcare sector specialisms were identified as one of the sectors to develop; influence on public sector procurement was also referred to. In addition, under 'Regeneration', tackling worklessness in deprived areas has been linked to Pathways to Work pilots and targeting Incapacity Benefit claimants; whilst not explicitly mentioned this is associated with chronic long-term health conditions or disability. There was no indication that the potential health effects of the RES had been systematically considered during its review, or that a health representative from the Public Health team at Government Office Northwest had been involved, however a Non-Executive Director from Cumbria and Lancashire Strategic Health Authority, was a member of the Advisory Group.

Health Profile

Demographics, employment and population health

Key statistics for the Northwest (Table 2) reveal poorer health in the region compared with England and the UK as a whole. Within the region there are also pockets of particularly poor health, which mirrors the areas of high deprivation, including worklessness and low educational attainment, e.g., in Liverpool, Manchester and East Lancashire.

Table 2 Key health statistics for the Northwest

	North West	UK*/ England**
Population, 2002 (000s) % aged under 16 % SPA and over	6,771 20.3 18.6	59,229* 19.9* 18.4*
Standardised mortality ratio, 2002	109	100*
Infant mortality rate, 2002	5.4	5.3*
% of population who are obese, 1995	20***	19*
% self-reported work-related illness, 2001	5.2	5.4**
% with Limiting Long Term Illness (LLTI), 2001	20.7	17.9**
% of working age with LLTI, 2001	10	8.2**
% self-reported good health, 2001	66.9	68.8**
% individuals providing 50 hours or more care pw	2.4	2.0**

*** North & Yorks

Life expectancy in Manchester for men is 70 years, compared with 76.5 years for women; in South Lakeland this is 77 years for men and 80 years for women (GONW, 2003). In the UK women however tend to self-report poorer health for most ethnic groups (ONS, 2001). They also are more likely to work part-time, to be paid 22% less than the gross hourly rate for men (Eurostat, 2003) and not to hold senior positions in the public or private sector. In 1998, 5% of police officers at superintendent level and above were women, 18% of senior civil servants and 24% of secondary head teachers. Putting these figures into context 16% of police officers are women 51% of all civil servants and 52% of secondary school teachers. Whilst there have been improvements in recent years there is still much to do to reduce gender pay differences from both direct pay-related discrimination and indirect discrimination related to labour market participation, occupational choice and career progression.

There are also significant differences in self-reported health by ethnic minority group. In England, Pakistani and Bangladeshi men and women had the highest rates of self-reported poor health, approximately 1.5 times higher than their white British counterparts. A similar pattern is expected at regional level. In addition to this, as highlighted in the RES, employment and activity rates for BME groups have been consistently and significantly lower compared with the white population. The 2002 Labour Force Survey (ONS, 2004) shows a 25% employment rate difference between white and some BME groups in England. Unemployment of BME groups at 13% was also significantly higher than the overall unemployment rate of 7.7% in 2002. Data shows that there is a higher level of inactivity in BME groups with 33.9% inactive compared with 26.9% for

the working population as a whole. There are complex reasons for the gap between rates such as differences in educational attainment; however an analysis of employment/unemployment rates of highly qualified people still shows a disparity between white and BME groups.

People with disabilities in the UK are also significantly under-represented in the workforce (28%) with less than half in employment. In the Northwest, there is a 5.3% lag in employment, increasing to 7.3% for disabled people from BME groups. A key challenge for the RES is to enable more disabled people's engagement with the labour market and addressing barriers that might prevent this. Similarly the proportion of people who are in receipt of Incapacity Benefit (IB) due to ill health now exceeds the proportion that are unemployed; the Northwest has the highest proportion of IB claimants at 9% of the working age population. Proposed action in the RES within the Regeneration theme will be discussed later.

In the UK, in 2002, 70.5% of older people (50-SPA) were economically active compared with 74.7% of the working age population. Again this is likely reflected in the Northwest. In addition to affecting labour supply there are implications for the ratio of working to inactive/dependent populations.

The Equality Impact Assessment of the RES (2005) reported that 'if the economy delivered equal opportunities (pay and participation) …the Northwest could perform more than 25% more efficiently'.

In addition to a population with poorer health and labour market inequalities, the Northwest has a decreasing and ageing population, due to declining birth rates, net outward migration and increased longevity. Population projections to 2010 suggest that the:

- population decline will be largest in the under 50s, particularly the under 15 year old age group
- increase in all age groups over 50 will be largest in 65-75 year olds
- large increase in black and minority ethnic communities will be mainly from the Asian sub-continent
- increase in Disability Living Allowance will exceed 10%

The above factors have significant implications for medium and longer-term economic activity in the region. In particular the economic strategy will need to embrace an older and more culturally diverse population; in addition the needs of women and people with disabilities will also need to be more adequately accommodated in economic development strategies. Whilst it is acknowledged that the RES refers to the Regional Equality and Diversity Strategy and that an Equality Impact Assessment of the RES was being undertaken, action to address this was only evident under the Regeneration theme. It would be appropriate to include this as a cross cutting theme throughout the RES.

Work-related health

The Northwest has a lower rate of self-reported work-related ill health compared with England. Trends in work-related accidents and ill health have

shown a general fall in recent years. However, the following represent occupational groups and contract types with an increased risk in serious injuries:

- agriculture, construction, manufacturing and mining sectors
- temporary, shift and night time workers

Younger men are also more likely to have an accident at work, whilst fatal accidents were more likely to involve older men.

However there are particular concerns regarding the increase in ill-health in certain occupations and conditions (HSE, 2003):

- protective services (e.g. police), health and social welfare (e.g. nurses), teaching, skilled construction and building trades, research professionals
- mental health, (e.g. stress, anxiety, depression) and musculoskeletal disorders

In the UK over 33 million days were lost in 2001 due to ill health.

It is recognised that in addition to exposure to various physical risk factors or conditions, the psychosocial work environment can also contribute to both the psychological and physical health of workers, positively and negatively. Negative factors include working at very high speed, occurrence of unforeseen interruptions at work, lack of ability to choose the working methods and matching skills and work demands (Paoli & Merllie, 2001).

Productivity is a key issue to be addressed within the RES; it may be appropriate to explore the relationship between productivity, health at work and the psychosocial work environment.

Healthcare

The NHS is a major employer in the Northwest. In addition to employment, it contributes to the economy through its purchasing activity, skills and through capital projects. More recently as a result of the Government's drive to develop plural healthcare provision, i.e. health services provided by NHS, private and voluntary sector providers, there has been inward investment in the region from overseas healthcare providers, such as the South African based Netcare Holdings at the Greater Manchester Surgical Centre. However it is unclear what the value of the total inward investment through this means has been in addition to existing NHS funding.

Within Greater Manchester, NHS organisations have developed a Greater Manchester NHS Procurement 'Hub' (December 2004). This seeks to increase overall NHS procurement efficiency by streamlining purchasing functions whilst increasing the 'purchasing power' with a larger group of organisations. It is anticipated that this model will be replicated across the region with the establishment of the new Northwest Strategic Health Authority. The RES identifies the need to ‘promote [appropriate] procurement policies’ with the public sector; it will be important for Northwest businesses, especially SMEs, to be familiar with these new procurement arrangements in order that they can maximise business opportunities.

NHS capital programmes in the Northwest were estimated at £4.5bn. between 2003 and 2008 (NWDA, 2004). It is unclear what opportunities for piloting environmental technology have been agreed. Similarly opportunities to maximise the potential for local regeneration through the Local Improvement Finance Trust (LIFT) process, whereby private sector partners develop joint ventures (LIFTCos) with Primary Care Trusts, local authorities, GPs, Partnerships for Health and other partners, was not evident.

A productive economy needs a healthy and fit workforce, as well as one that is efficiently and effectively treated and cared for during accidents or illness. Access to primary, secondary and emergency health services is improving across the Northwest. However there are still 'bottlenecks' in the system including timely access to diagnostics, increasing the basket of day-case procedures and the effective management of long-term conditions. Different occupations, contract types, working conditions and practice will inevitably impact on health and ultimately health services, initially through general practice. Other effects of changing labour markets on health services include the management of ill health, e.g. Doctor's certification.

Increasing GVA and employment

Recent economic performance indicators provide evidence that the Northwest economy is growing at a faster rate than the rest of the country. For example, in 2002/2003 the Gross Value Added (GVA) was 18% in the Northwest and the employment rate increased by 3% compared with a GVA of 16% and no increase in the employment rate in England. Although it is difficult to isolate the contribution of the RES from the performance of the strong economy as a whole, the activities defined in the RES are likely to continue to contribute to the regions economic development.

An increase in employment will have positive effects on the health of the population as a whole. Using a GDP-employment model, Brenner (2002) forecast a reduction in all cause mortality in the UK with a 2-14 year lag with an increase in GDP and employment. It is believed that this is primarily due to the increase in per capita income resulting from GDP growth. There is also some evidence that where employment increases household income, there may be short and long-term benefits to the children of these families by enhancing the family environment. But whilst there is evidence that increases in employment in general improve public health, there are exceptions to this rule; this will be described later.

The RES identifies and focuses action on sub-regional areas within each theme. However the emphasis on labour market inequalities (LMI) is confined to the Regeneration theme. As has been previously described, increases in employment are not uniformly shared between different population sub-groups. There are complex factors associated with each of these LMI. Whilst there is much positive action identified to reduce these inequalities, e.g. aligning strategies, investment plans and services of the Learning and Skills Council and Jobcentre Plus to focus on residents and areas with the greatest employment gaps, the RES could maximise this impact by having action to reduce LMI as a cross cutting theme. For example, under the Business theme actions could be to develop a business culture that embraces diversity in the workforce, to identify and promote businesses as 'champions' for workforce diversity. It is acknowledged that version 5 of the RES seeks to address the underlying causes of LMI beyond the earlier focus on enhancing employability (the supply side) by identifying action to work with employers to ensure employment opportunities for disadvantaged groups (the demand side), and to remove practical barriers to work such as transport. This reflects national guidelines (Cabinet Office, 2003; ODPM, 2000).

It is anticipated that the RES will contribute to increasing employment for the disadvantaged groups; with a comprehensive approach tackling all factors contributing to LMI with equal vigour, it is possible that this will reduce the labour market disparities that exist; progress will need to be carefully monitored in view of the evident difficulties over thirty years after the Equal Pay, Race Relations and Sex Discrimination Acts. With an increase in employment, there will be an associated improvement in health. As many of these groups, e.g. Pakistanis and Bangladeshis, already have poorer health

than the population as a whole a reduction in these health inequalities could only be achieved if the rate of employment for these groups increases at a faster rate than the working population as a whole.

Employment type

There are trends in the region and across the country that show an increase in part time and other forms of flexible employment. It is likely that the RES will contribute to increasing this trend. Part-time work has both potential positive and negative impacts on health. When part-time work is the preferred option for the employee and contributes to a satisfactory work/life balance it is likely to have a positive health impact. In those circumstances part time workers report less health related absenteeism than full-time and temporary workers; part-time workers also report less stress than full timers (Benach et al, 2002). However, part-time work is not always voluntary (EFILWC, 2000). This may have negative health impacts associated with low income and they may share some of the characteristics of psychological stress associated with unemployment (Paoli & Merllie, 2001). Other potential negative impacts associated with part-time work are less involvement in the organisation, and less career development or training opportunities. Part-time work is also often unskilled and subject to poor working conditions, although the exposure to hazards is less than for full time workers.

The creation of more and 'better' jobs, including ‘high value added’ jobs links closely to the European Commission agenda for 'quality work'. Ten quality work indicators have been defined (EC, 2000), e.g., intrinsic job quality, skills, life long learning and career development. It has unclear if a similar Northwest definition for better jobs and high added value jobs; it has been assumed that these are jobs requiring level 4 skill levels in productive growth industries. Associated with this is that they are well remunerated. An increase in household income will have positive health impacts as previously described.

It needs to be emphasised however that not all employment is beneficial to health. Some work characteristics are as damaging as unemployment. Workers that are in jobs of poor quality, including low paid and precarious (insecure) work, have similar health scores to the unemployed. Some evidence from the US also indicates negative health impacts on the cognitive, emotional and behavioural development of children from families where families move from unemployment to employment but where there is no increase in family income or the job is of poor quality.

Whilst there was no mention of the development of flexible labour markets in the RES, there is an increasing trend nationally and internationally in this direction, and it would be remiss if the potential negative health impacts of this new labour market trend were not mentioned. Additional information can be provided if required.

Skills and regeneration

Labour market interventions have had different degrees of success in facilitating the transition from unemployment to employment and sustaining this employment. The impact on the health and well being of the individuals involved in these programmes has also varied. In general 'work first' approaches were not found to be successful with people who had been long

term unemployed or who were not 'job ready' and increased mental health problems, such as anxiety. In regenerating communities it will be important to use interventions that are sensitive to the issues they face and to their ideas for overcoming these. For example, Croxteth Communiversity in Liverpool is owned and run by the community; it delivers education and training ranging from basic skills to Level 4 programmes e.g. BTEC Health and Social Care delivered by qualified trainers who live in the area. However it is generally recognised that increasing educational attainment and qualifications contributes to improving health through a combination of increased earning potential and reduced exposure to risk factors or risk conditions at home or work.

There is the potential to increase both productivity and the psychosocial work environment by improving management skills. There is strong evidence from the literature showing the relationship between psychosocial work characteristics and work-related ill health - the Job Strain model. The health effects range from sickness absence, mental health problems, musculoskeletal disorders and even cardiovascular disease. Lack of job control is the key psychosocial factor associated with increased cardiovascular risk (e.g. Marmot et al, 1997). More recently however there are indications of a different interplay of psychosocial work factors negatively influencing worker health when the organisation is going through a period of considerable change and where employees feel insecure; these include increased job control, increased demand, decreased skill discretion and support. By incorporating a health dimension into the management skills training this could promote organisational productivity as well as a healthier working environment.

Recommendations

1. Reduce labour market inequalities (LMI) by
- Making the reduction of LMI a cross cutting theme for the RES
- Identify business diversity champions
- Setting targets to reduce LMI

2. Increase the positive/reduce the negative health effects of employment
- Increase 'job quality' and 'quality work' as defined by the EC's quality indicators through benchmarking and monitoring progress
- As part of action to develop healthy workplaces, include a workplace health module into management skills training (e.g. HSE's Management Standards for reducing Stress in the Workplace)
- As part of action to develop healthy workplaces, introduce working practices that promote healthy psychosocial work environments, whilst increasing productivity

3. Ensure a positive transition from inactivity to employment
- As part of action to address and reduce causes of IB, work with communities to develop programmes to build skills and confidence for work
- As part of action to address and reduce causes of IB, link IB claimants with the 'Expert Patient' programmes to help build skills and manage long term conditions
- Pilot programmes such as the ‘Aim High: Routeback’
- Link regeneration with community health development

4. Integrate health into future RES reviews by
- Ensuring executive health representation on RES advisory group, e.g., GO-NW public health team
- Monitoring health service developments to ensure economic development opportunities for the region are maximised, e.g. Greater Manchester Procurement hub, LIFT

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