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Health impacts – A strategy across Government



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Executive Summary

There have been big improvements in health and life expectancy over the last 100 years. A child born today is expected to live nine and a half years longer than one born in 1948, the year the NHS was established.

But Government cannot afford to be complacent. Health and life expectancy are not shared equally across the UK population. A different approach is therefore needed: one that makes a stronger connection between the policies of Government as a whole, and health issues.

Government has made large investments in modernising the NHS, but there is a risk that the positive effects stemming from this investment could be blunted, and the demands on the health service further intensified, if other Government departments do not sufficiently take into account the health impacts – either negative or positive – of their policies. The importance of securing and improving the health of the population, in its broadest sense, means that the health agenda must be the business of all Government departments, not left simply to the Department of Health. Terminology may appear at first sight a rather trivial issue, but we think it important – the phrase health of the population is much more inspiring and motivating than the traditional descriptor public health.

Therefore we believe that improving the health of the whole population whilst reducing health inequalities especially for those with the poorest health should be an overall objective for the whole of Government.

In considering policy options, Ministers need two things: first, robust analysis and evidence about health issues, and second: the ability to make the right connections which itself requires a knowledge of what information is available. Without either of these strands, the health impacts of particular policies cannot properly be taken into account. The lack of familiarity with health issues, and with the relevant evidence base, is a significant constraint across Government when policies are being pursued which might have an impact on the health of the population. The evidence base therefore needs to be more comprehensive and robust and a joint approach across Government is needed, including mechanisms for joining up Government databases.

One particular mechanism – Health Impact Assessments – provide an important means for achieving this outcome, but they need to focus on the most important policy issues. Therefore identification of the key areas that should be subject to an assessment is key to making the process effective. CST has contributed to the consultation that was run by the Better Regulation Executive that sought responses on the proposed revision of the Regulatory Impact Assessment. CST's full response can be seen at annex A. CST makes the point that any de-coupling of Health issues from Impact Assessment needs a replacement mechanism to be in place that covers health issues and is mandatory.

Skills gaps need to be addressed, both in terms of the ability of officials outside the Department of Health (DH) being able to identify the expert advice and evidence they require, and within DH to influence policy-makers in other departments on the health impacts of their policies. Government therefore needs to put in place mechanisms for training Government policy-makers in the wider determinants of health, and the use of evidence.

Engagement of the widest possible range of stakeholders across Government is crucial to ensure all Government departments, and not just DH, think through the health impact that their policies will have. This needs to take place at the earliest stage of the policy-making process and not simply as an add-on once the particular policy is nearing finalisation. We recognise concerns that this approach may lead to certain policy options becoming more complex and contentious, and that there may be tensions between meeting local needs and avoiding duplications and fragmentation across the UK as a whole. We believe that these tensions and complexities can be addressed case-by-case, and that best practice on addressing these difficult areas can be built up and disseminated.

Where contentious policy issues emerge, particularly where there is a conflict between health of the population objectives and other policy objectives, consultation that is honest about this is crucial – both within and outside Government – from an early stage, and it is essential that this consultation be informed by the available evidence.

Consultation with health professionals is an important part of the process, but by itself it will not be enough. Wider public dialogue, to inform policy not determine it, will be an important component to ensure public acceptability, which itself is an absolute necessity for a successful UK health policy.

Recommendations

OVERARCHING OBJECTIVE

Improving the health of the whole population whilst reducing health inequalities especially for those with the poorest health should be an overall objective for the whole of Government. This requires well-informed, evidence-based policy development in all Government departments and better connectivity between Government departments with DH at the centre. CST believes that the following recommendations would go a significant way to achieving these objectives.

Recommendation 1: More resource should be devoted to ensuring that national data on the health of the population is more comprehensive and robust so that it provides the strong evidence base necessary for good policy-making.

Recommendation 2: A joint approach across Government involving Department of Health is needed. The first step should be for priority Government departments to assess, with the Department of Health, the evidence base required to ensure that policy-making in that area of Government can always be informed by the best available evidence about health impacts. How departments and DH carry out this work should be agreed by both sides in each case.

Recommendation 3: Mechanisms are needed to join up Government databases to help collate the necessary evidence base, identify the evidence gaps, and ensure the necessary access to information by policy-makers and researchers and ensure that the necessary safeguards are in place as set out in our earlier report on Personal Information.¹

Recommendation 4: Health issues need to be made more focused and visible within the Regulatory Impact Assessment process. Government should refine its policy on Health Impact Assessments to improve their effectiveness by focusing effort on those policy areas where there is potentially a real health gain, and remove from other policy areas the need for a full Health Impact Assessment unless there is a specific case for it.

Recommendation 5: Mechanisms are needed for training Government policy-makers, across all departments, in the wider determinants of health and the use of evidence to assess them, so that they can be applied with confidence. Consideration should be given to training on health of the population being part of the National School for Government training programme.

¹ CST Personal Datasets Report can be found at <http://www.cst.gov.uk/cst/reports/#10>

Recommendation 6: When policy issues affecting the health of the population are being determined, Government needs to involve as wide a range of stakeholders as possible and at the earliest stages in the process. Procedures and incentives to ensure joined up working on public health issues across Government need to be developed, harmonised with other processes, and embedded across Whitehall – and first of all within the seven departments highlighted in paragraph 48. This should entail a range of methods, ranging from the use of Regional Directors of Public Health and expert committees to stakeholder mapping exercises.

Recommendation 7: Government should develop stakeholder dialogue processes (not just involving public health experts and policy makers/officials) at an early stage in the policy-making process, and identify a set of key topics for the dialogue process. More creative forms of consultation should be developed, including short consultation sessions across the country, focus groups and on-line techniques.

The detailed arguments supporting each of these recommendations are set out in the report.

Introduction

1. There have been big improvements in health and life expectancy over the last 100 years. Life expectancies in 1900 of 45 years for men and 50 years for women have risen to 76 and 80 years respectively for a baby born in 2004. A child born today is expected to live nine and a half years longer than one born in 1948, the year the NHS was established.
2. Many factors have contributed to this increasing longevity: economic growth, better nutrition and housing, as well as advances in medicine and technology. But future progress on this scale cannot simply be taken for granted. As life expectancies continue to increase, ensuring a good quality of life for the increasing numbers of older people in the population will represent major challenges.
3. Health and life expectancy are not shared equally across the UK population – one survey² reported that 81% of people in higher socio-economic groups consider themselves to be in good health, compared to 61% of people in the lowest groups, and 73% of people in higher socio-economic groups expect to be in good health in 10 years time, compared to 53% of people in the lowest groups. The Department of Health, “Tackling Health Inequalities: Status Report on the Programme for Action”, was published in August 2005. It provides a first review of data against the 2010 health inequalities Public Service Agreement (PSA) and highlights the fact that there has been no improvement in the indicators used for the key PSA targets – life expectancy in the worst areas and infant mortality in routine and manual social groups. The importance of securing and improving the health of the population, in its broadest sense, means that the health agenda must be the business of all Government departments, not left simply to the Department of Health.
4. One of the founding principles of the NHS is that it should improve health and prevent disease as well as providing treatment for those who are ill. Government has made large investments in modernising the NHS, but there is a risk that the positive effects stemming from this investment could be blunted, and the demands on the health service further intensified, if other Government departments do not sufficiently take into account the health impacts – either negative or positive – of their policies.
5. In considering policy options, Ministers need robust analysis and evidence about health issues, if they are to take them fully into account. The Department of Health White Paper ‘Choosing Health’ (2004) committed the Government to assessing health impacts in policy-making:³

Chapter 8, Paragraph 3 of Choosing Health 2004.

To avoid the risk that in some cases, interventions may contribute to widening health inequalities, Government departments, and particularly the Office of the Deputy Prime Minister and Department of Health, will ensure that initiatives and programmes are health inequality ‘proofed’. This will involve consideration of whether any policy changes or remedial actions are necessary to prevent any negative effects on health inequalities. The impact of ‘non-health’ interventions on population health should also be more routinely considered both before implementing policies (through Health Impact Assessments (HIA), for example) and afterwards through evaluation.

² Opinion Poll conducted by OLR Ltd in 2004

³ Available at <http://tinyurl.com/4uovd>

6. We are pleased that Government understands clearly the consequences of not investing in improving public health. The 2002 Wanless review 'Securing Our Future Health: Taking A Long-Term View' looked at three different scenarios, including a 'fully engaged' scenario in which:
 - the level of public engagement in relation to health was high
 - life expectancy went beyond current forecasts
 - health status improved dramatically
 - use of resources was more efficient; and
 - the health service was responsive with high rates of technology uptake
7. The fully engaged scenario was the least expensive scenario modelled and delivered better health outcomes. In absolute expenditure terms the gap between the best and worst scenarios was shown to be large – around £30 billion by 2022/23, or half the current NHS expenditure.
8. There are particular perceptions that are hard to break down. For example, it is widely felt that within and outside Whitehall 'health' means 'sickness' and the Department of Health (DH) is seen as the 'department for sickness'. The use of the term *public health* is intended to communicate not just prevention of illness but also promotion of health. However, *public health* itself can be a problematic term. For the individual it may translate into "other people's health"; for those working in Government departments it pigeon-holes particular issues and so makes it easy for them to be passed on to 'public health officials' to be dealt with. Rather than *public health* we should be thinking in terms of the *health of the population*, which should be everyone's concern.
9. There is a need to develop a motivating language for discussing public health-related issues. A better way of referring to the issues would be to refer to the twin aims of *improving the health* of the whole population whilst *reducing health inequalities* that still characterize the UK population. Our concept is that of a health escalator, where everyone moves upwards towards better health, with those on the lowest steps moving fastest. This revised focus will, we believe, help to prioritise the agenda. We believe that *improving the health of the whole population whilst reducing health inequalities* is a more engaging and motivating rationale for considering health determinants in policy-making, and one that the population as a whole – health professionals, civil servants and the general public – can rally behind.
10. CST looks to add value and not simply replicate work being done elsewhere. Our approach has therefore concentrated on Government departments other than DH, to understand how far they take the health impacts of their policies into account and, in particular, how scientific evidence is used in, and applied to, policy-making.
11. We are convinced that the Department of Health cannot drive forward the agenda alone. Nor should they have sole responsibility for maintaining the evidence base for the health of the population, as that would further compartmentalise the health of the population as the responsibility of a single department. The central theme of our report is that all Government departments have an important role to play in raising the health of the nation. This means a better cross-Government approach with DH acting as the hub, connecting together the evidence bases of other departments. Our recommendations set out ways in which Government can achieve these objectives, and thereby help to ensure that departments collectively support improved health for the population by taking into account health impacts, and the potential for health improvement, when developing their policies.

CST welcomes the cross-Government work that the Department of Health already undertakes. Indeed Department of Health should continue with their own initiatives with other Government departments. Examples of this include:

- The Domestic Affairs Sub Committee on Public Health⁴
- The Ministerial Inter-Departmental Group on Physical activity⁵
- The Health, Work and Well-Being strategy with Department of Work and Pensions and the Health and Safety Commission⁶
- Various scientific advisory committees⁷

CST proposals would seek to complement and improve on what is already being done. We would welcome the opportunity to feed our findings into, for example, the committees mentioned above.

12. Despite an overarching Government commitment to improving the health of the population, there is no guarantee that Departments and Agencies, outside those with a specific health remit, will consider the public health consequences of their own policies. Two of our case studies illustrate this point. The first is the way in which Department for Culture Media and Sport (DCMS) dealt with the Licensing Act. Health of the population considerations were ruled out, and the focus of the Act shifted away from health when responsibility was transferred from Home Office to DCMS. There was also a lack of clarity around the evidence base. One lesson from the considerable political and media controversy is that any policy concerned with alcohol or any subject relevant to the health of the population must consider health implications as the policy is being formulated.

Case Study Box 1

The Licensing Act sets out to modernise outdated Licensing legislation, in some respects unchanged since 1915. The objectives of the Licensing Act are: public safety; the prevention of crime and disorder; the prevention of public nuisance; the protection of children from harm. Department for Culture Media and Sport (DCMS) states 'It is important to note that there are no other Licensing objectives, so that these four objectives are paramount considerations at all times.'

Therefore public health is not an objective of the Licensing Act. It was considered as an objective, but was discounted in 1998 when the Government announced the intention to produce an Alcohol Harm Reduction Strategy (AHRS) to be taken forward in parallel with the Act.

The Act, then situated in the Home Office, would focus on crime and disorder, and the Strategy, then situated in the Department of Health would focus on health. As a result, health impacts were not considered in the formation of the Act. The development and publication of the AHRS was delayed – it was transferred from the Department of Health to the Prime Minister's Strategy Unit, and then finally to the Home Office; as it moved, its focus shifted away from health, broadening to include crime and disorder, education and management of the night time economy. It was finally published in March 2004.

4 This is chaired by the Deputy Prime Minister and was set up to co-ordinate and monitor the implementation of the Government's policies to improve public health and reduce health inequalities.

5 This has recently been set up to look at the role of government, local agencies, businesses and the third sector in increasing physical activity levels. It will identify where policies, legislation and Acts serve as barriers to local action to promote physical activity and what are the opportunities to address these.

6 This aims to break the link between health and inactivity to advance the prevention of ill health and injury and encourage good management of occupational health.

7 For example the Committee on Medical Aspects of Radiation in the Environment; the Committee on Medical Effects of Air Pollution; the Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment.

Meanwhile, responsibility for the Act was transferred from the HO to the DCMS in 2001, prompting accusations that its focus shifted away from the reduction of crime and disorder and towards the interests of the tourism and leisure industries. The public health lobby, which had not engaged substantially with the Licensing Act on the understanding that their concerns would be addressed in the AHRS, began to raise concerns. The DCMS believes that this chronology helps to explain why the RIA, stakeholder engagement and three month public consultation (to July 2003), all conducted to inform policy formation, focused exclusively on the four objectives.

The key question retrospectively is, should health have been a consideration of the Licensing Act, or indeed should it be of any Licensing regime? [CST postscript: it is interesting to note that the effects of secondary smoking have received widespread coverage, contrasting sharply with the relatively small interest generated on the effects of secondary alcohol.]

The Better Regulation Task Force (BRTF) in their 1998 report, Licensing Legislation, concluded that the fundamental objectives for liquor Licensing law are: Promoting a safe and peaceful society; Restraining citizens from damaging themselves⁸. On one hand, some maintain that public health should not be a concern of Licensing, arguing that consumption levels are governed by affordability rather than Licensed opening hours or any other factor, and that therefore the only way to reduce harm is to decrease affordability. However, many now feel that there is a gap in the policy where health should have been, and the second objective of the BRTF report would support this.

13. The second example concerns the Fuel Poverty Strategy. In general, this is considered a good example of taking health considerations into account as it involved a great deal of coordinated and effective work. However, our case study reported a concern that there were still other areas of policy that have an impact on the relationship between health and fuel poverty (such as fuel prices and levels of household income for the most vulnerable) which were not yet addressing health impacts.

Case Study Box 2

The Fuel Poverty Strategy was put in place with the dual aims of improving energy efficiency and reducing the costs of fuel for the 'fuel poor' households (identified by a combination of indicators such as household income, the number of people in the household and the level of insulation of the house).

The suggestion from the UK Public Health Association – an independent voluntary organization – is that a more coordinated, integrated approach to tackling fuel poverty is to a significant degree still lacking. As one stakeholder reflected, "Don't get me wrong, Defra has done a great job, but there is still no systematic approach to join up issues relating to health; there are fuel poor households threatened by the associated health problems which are not receiving the funds available."

It is also important to note that the ability to eradicate fuel poverty is limited by a number of factors that are outside the control of the Fuel Poverty Team and the health care professionals, such as fuel prices and levels of household income. Further collaboration with the Treasury may be required to tackle some of these issues.

⁸ Better Regulation Task Force, Licensing Legislation, July 1998

14. Our recommendations cover three main areas. The first covers the availability and use of evidence – how far health evidence has been sought, the quality of that evidence and any shortcomings that need to be remedied. There is some synergy here with our earlier report on personal information which recommended linking datasets to generate robust evidence about the health of the population⁹. Our second area is stakeholder engagement – in this case involving Government and other public sector bodies in the policy-making process. This will enable health considerations to be embedded within departments at the very earliest stages of policy development and in a common and consistent way, which will result in more robust and predictable Government policy. Our final set of recommendations cover ways in which broader dialogue and engagement with the public can be achieved – the subject of an earlier CST report¹⁰ and an underpinning theme of our work.

OUR EVIDENCE BASE

15. CST has developed its evidence-base by commissioning the Henley Centre to produce a set of case studies to help our assessment of whether current practice meets the government's aspirations. These case studies have helped us to identify both barriers to effective assessment of actual and potential health impacts, and factors which facilitate good practice. These case studies help to demonstrate best practice for Government which links directly to the Better Regulation agenda, and we draw on them to provide advice and examples of best practice to government.
16. Two particular case studies produced by the Henley Centre – the Greater London Authority's Cultural Strategy and the Fuel Poverty Strategy – highlighted good, if not best practice. Other case studies had both good and weak points – for example the North West Regional Spatial Strategy was much stronger than that from the East of England. The Licensing Act 2003 is an example where assessment of health impacts had significant weakness, and while we do not want to dwell unduly on this case study, there are important lessons for Government.
17. CST held a workshop in March 2006 to discuss the question of the health of the population considerations in policy making. The workshop provided an opportunity for us to involve stakeholders and experts in our work. CST would like to thank all those who participated in the workshop.

⁹ CST Personal Datasets Report can be found at <http://www.cst.gov.uk/cst/reports/#10>

¹⁰ Policy through Dialogue which can be found at <http://www.cst.gov.uk/cst/reports>

Reviewing the evidence base

18. The lack of familiarity with health issues, and with the relevant evidence base, is a significant constraint across Government when policies are being pursued which might have an impact on the health of the population.
19. There are three specific issues surrounding the health of the population evidence base. First, how available is the appropriate evidence; second, how robust is it; and third, how is that evidence used.

AVAILABILITY OF EVIDENCE

20. It is essential to have a strong evidence base to drive decisions on health impacts. One unique advantage that the NHS possesses is the ability to generate national data on the health status of the population. But, as the Wanless Report has pointed out, that evidence base is weak¹¹. However, in particular circumstances, for example as shown by the Fuel Poverty case study, it can be both robust and clear.
21. The weakness is partly due to a lack of funding of public health intervention research, reflecting a low research capacity in the community – too few people with too little expertise. We believe there is a genuine problem about the availability of appropriate health of the population data suitable for policy-making across Government, and that the situation needs to be remedied urgently.
22. The available evidence base is often either incomplete or subject to dispute and will need to be developed if Government is serious about using policy making across government to improve public health. This is not intended to be a criticism either of the quality of the science or the use of that science; rather it reflects the complexities inherent in this sort of work.
23. An example is the National Air Quality Strategy case study, where the evidence base, even in an area which is clearly recognised as having an obvious relevance to health, was not straightforward. Whilst this is a complex area suffering from significant uncertainties, the case study recognised clearly the need to develop the evidence base alongside the development of policy.

Case Study Box 3

The Air Quality Strategy sets out the future of air quality in the UK in the medium term. It describes the current and likely future levels of air pollution and provides a framework to help identify what measures can be introduced to help improve air quality. The objectives laid out focus on the reduction of the main pollutants.

However, the process is made more difficult by the complex nature of the evidence base for the impact of air quality on public health:

Therefore, whilst all available evidence is taken into account, aspects of it are subject to change and refinement.

¹¹ Securing Good Health for the Population; Derek Wanless February 2004; Chapter 5

ROBUSTNESS OF THE EVIDENCE

24. At the CST workshop three issues relating to evidence were raised:
- Evidence is rarely definitive
 - Evidence is emergent. (For example, it took many years for the full picture on the damaging effects of smoking on health to emerge; we have built up a stronger and stronger picture over time)
 - Evidence is not the only factor that influences policy decisions. A range of factors will influence policy makers as they make decisions, for example political considerations and the views of the public. It is important to raise the relative importance of evidence against other factors, rather than simply put the evidence out there and hope for the best.

There have been strong health of the population successes – immunisation, smoking, and environmental pollution, but also some failures – particularly on alcohol/drugs and obesity. Obesity rates are increasing, particularly amongst children¹². In an attempt to halt the year-on-year increase in obesity among children under 11 years by 2010, there is a joint Public Service Agreement target between DCMS, DfES and DH.

25. We support the view that there is not enough evidence in the area of the health of the population, and that existing evidence is not easily accessible or well interpreted. More research is required, in many areas, as Wanless has observed: *'the relationship between wider determinants and health is well established but complex. Further research in this area would be beneficial in order to fully understand the determinants of health and health inequalities¹³.'* There is therefore a need to invest more money in capacity development for health of the population research, the research itself, and to prioritise the important needs. We welcome the fact that the UK Clinical Research Collaboration has a working group on public health research chaired by Professor Ian Diamond. We look forward to receiving the outcome of the work of this group.
26. Our case studies provide two examples. The first is an example of best practice from the GLA Cultural Strategy, where potential health impacts were brought into an area of policy in which the connection was not obviously relevant at first sight – salience was demonstrated by a rapid evidence review, based on clear and consistent methodology, at an early stage (see case study 5 for more details)
27. The second example is the National Air Quality Strategy. Policy development began with a thorough review of evidence about health impacts of air quality. Having access to very up to date evidence was shown to be particularly important.

Case Study Box 4

The Air Quality Forum was set up in March 1998 as a consequence of the 1997 strategy. It was set up to allow stakeholders (from Government, industry, the voluntary sector and the health sector) to put views to Government on the review of the National Air Quality Strategy and evaluate progress on local air quality management. The Forum meets every quarter, with the following health groups represented: British Medical Association; British Lung Foundation; National Asthma Campaign; British Heart Foundation. The forum was consulted at an early stage in the creation of the 2000 strategy.

¹² <http://www.parliament.uk/post/pn205.pdf>

¹³ 'Securing Good Health for the Whole Population,' Derek Wanless, December 2004

Air quality is an area of policy which requires a detailed and extensive evidence base from which to set objectives and justify policy. The 2000 strategy represents a good example of where this has been done. In particular, drawing from the Air Quality Forum allowed for the most relevant and up to date research to be incorporated. However, it must be remembered that much of the evidence in this area retains a degree of uncertainty.

Recommendation 1: More resource should be devoted to ensuring that national data on the health of the population is more comprehensive and robust so that it provides the strong evidence base necessary for good policy-making

IMPROVING THE EVIDENCE BASE – CROSS-DEPARTMENTAL ASSESSMENTS

28. The evidence base is highly fragmented within and across Government, not least within DH itself. It may be at best patchy, at worst non-existent, in other departments.
29. Mechanisms are therefore needed to ensure departments collaborate with the DH to establish, develop, and maintain an agreed high level evidence base on the health impacts of policy areas for which they are responsible. The first stage should be for departments to agree with DH an assessment process for identifying the major strategic gaps in their evidence bases.
30. Rapid assessments of evidence have proved to be invaluable at a regional level (see case study 5, the GLA's Culture Strategy) not only as a means of highlighting areas for consideration at the start of the policy-making process, but also for fostering partnership working in moving forward.
31. We believe there is widespread support from departmental stakeholders for such an approach. It will allow them to assess with DH the public health evidence relevant to their own specific remits and quickly demonstrate the extent of the interfaces between each department and health of the population impacts. It will also help departments to assess where the expertise in evidence and evaluation lies, and will act as the starting point for a collaborative approach between DH and other departments to ensure better policy-making and joint ownership of the health of the population remit. Evidence assessments should also be conducive to a more innovative approach and provide mechanisms for identifying new gaps for further research.
32. There is a parallel here in terms of the work conducted by the Office of Science and Innovation.

Government Science Reviews

In 2003, the Chief Scientific Adviser set up a rolling programme of reviews of Government science to assess its quality and use. The Office of Science and Technology (OST) is reviewing the way Government departments identify their research requirements, and commission and use science and scientific research.

The overall aims of the review programme are to:

- maintain and improve the quality and use of science in Government;
- review existing departmental systems for assuring the quality, management and use of their science;
- disseminate examples of best practice from within the UK and abroad;
- inform and support the Government's CSA in his role of "advising the PM and the Cabinet on the overall health of science and scientific research funded by Government departments".

The Review Process

Reviews are carried out by dedicated staff in OSI using consultants, overseen by a steering panel of senior officials, academics and other experts. Reviews entail analysis of documentary evidence and consultation with stakeholders, e.g. programme managers, policy officials, scientists and advisory committees, as well as the wider stakeholder community. Approved review reports are published and departments are expected to report on progress in implementing the recommendations or justifying their reasons for not doing so. In most departments, the management and use of science extends beyond the research that is actually commissioned. The review process takes into account other activities, such as the use of existing knowledge.

33. We have considered carefully whether the development of the health evidence base should be undertaken immediately by all departments, or initially with a selection of those with larger health impacts. While we think there is a case for all departments undertaking these assessments we recognise there are associated costs and resource implications. Therefore we believe that prioritisation is necessary. There are some priority departments for early joint assessments – Transport, Education and Skills, Communities and Local Government, Home Office, Work and Pensions and Environment, Food and Rural Affairs. Recognising that departments are or will be undergoing Capability Reviews, we do not want these assessments to add more to their administrative burdens than is absolutely necessary. Therefore we do not wish to be prescriptive on how these assessments should be carried out. Rather, we would leave it up to departments and DH to agree the format and scope. But these assessments need to have a clear focus, otherwise they risk becoming unmanageable.

Recommendation 2: A joint approach across Government involving Department of Health is needed. The first step should be for priority government department to assess, with the Department of Health, the evidence base required to ensure that policy-making in that area of government can always be informed by the best available evidence about health impacts. How departments and DH carry out this work should be agreed by both sides in each case

USE OF EVIDENCE

34. While acknowledging that there are significant gaps in the evidence base, there is also a great deal of good evidence that has been compiled, but which is not used. This is a dual problem of accessibility and knowledge: the evidence is not always accessible, and there is also a lack of expertise in utilising evidence compiled for one purpose to a different research area. Safeguards will also be needed¹⁴.
35. On the question of how evidence is used, there have been case studies in which randomised control trials have been used, demonstrating the value of piloting interventions and analysing their effects¹⁵.

Work done at the London School of Hygiene and Tropical Medicine shows that science ('what we know') is not the same as decision-making ('what we should do') and recommends better use of decision techniques (for example decision analytic modelling) in policy making. This facilitates two important outcomes: (1) a plan of immediate action, and (2) an understanding of what future research needs to be done to enable better decision making.

Fostering an evaluative culture is the critical issue here. In many instances, health is considered with a 'common sense' rather than a scientific approach. Case studies could be employed to demonstrate the value of testing assumptions in pilot trials, leaving enough time to make changes to review policy, rather than rolling policy out before results have been collected and understood. There was a fear in Government of 'going back' or being forced to admit to a 'U-turn' when in fact a review of the evidence should be strongly defended and indeed advocated as an important element of any evidence-based decision-making process.

LONGITUDINAL STUDIES

36. Much valuable health of the population evidence depends on the maintenance of longitudinal studies. These are a significant financial investment, and a decision to go on funding them cannot be undertaken lightly. However they are also an extremely important resource for evidence about the health of the population. As many health of the population studies – by their very nature – require long-term analysis, there is a need to plan for the future, identifying likely potential gaps in advance whenever possible. It is important to ensure that, where possible, longitudinal data sets collected for one purpose should also be available to, and compatible with, other health of the population projects. We flagged up the need for creating gateways for Government databases to share information, together with the necessary safeguards, in our earlier report on Personal Information¹⁶.

Recommendation 3: Mechanisms are needed to join up Government databases to help collate the necessary evidence base, identify the evidence gaps, and ensure the necessary access to information by policy-makers and researchers and ensure that the necessary safeguards are in place, as set out in our earlier report on Personal Information.

¹⁴ See CST Personal Datasets Report, which can be found at <http://www.cst.gov.uk/cst/reports/#10>

¹⁵ A randomised study into the introduction of smoke alarms in Camden and Islington produced the counterintuitive result that the installation of a smoke detector had no effect on the number of related fire injuries and emergency call-outs. Although smoke alarms had been given to residents, in many cases they were not being used, or had been switched off.

¹⁶ CST Personal Datasets Report can be found at <http://www.cst.gov.uk/cst/reports/#10>

SPECIFIC MECHANISMS: HEALTH IMPACT ASSESSMENTS

37. Currently there are a number of tools in place for capturing and evaluating different kinds of evidence, for example the Environmental Impact Assessment (EIA) for environmental evidence, the Health Impact Assessment (HIA) for health evidence and the Cost Benefit Analysis (CBA) for economic evidence. These all operate within the overall Regulatory Impact Assessments (RIA) which Government departments and agencies are required to undertake when they are proposing to introduce new legislation or make policy changes to existing legislation. The National Assembly of Wales has adopted a similar approach¹⁷.
38. However, health is not currently highlighted in the RIA, and both RIAs and HIAs are considered to be intimidating to the uninitiated. Neither is as accessible or as user-friendly as they need to be. Since April the National Institute for Health and Clinical Excellence (NICE) no longer covers Health Impact Assessment. The HIA Gateway website, although remaining attached to the NICE website has not been maintained since then. It contains a significant amount of evidence and if regularly updated it could provide a valuable resource for policy makers. The Department of Health has recently issued a feedback form for users to ascertain its usage and possible areas for development. The results are currently being analysed and these will inform its future development.
39. The perception exists that HIAs are currently conducted in an ad-hoc way which also risks their being seen as a bureaucratic tick-box exercise. However, there is a need to capture the health impact evidence in one place if it is to be successfully used to influence policies elsewhere, and through a consistent, robust, systematic and predictable process.
40. In general HIAs achieve their purpose but they need to focus on the most important policy issues: identification of those key areas that should be subject to an assessment is key to making the process effective. Sometimes it is not immediately obvious that a particular policy has health implications, either positive or negative. Equally, there is a need for greater specificity: policy areas where it would make little sense to require HIAs should be identified at an early stage ie there should be proportionality in this process.
41. The GLA Cultural Strategy case study shows that rapid reviews of evidence and a systematic and robust approach in conducting an HIA have proved to be invaluable at a regional level, not only as a means of highlighting areas for consideration at the start of the policy-making process but also for fostering partnership working moving forward.

Case Study Box 5

GLA Culture Strategy 2004 – Rapid Evidence Review and HIA Process.

A rapid evidence review, which underpinned the HIA, was commissioned at the beginning of the policy making process. Although there was insufficient time to commission primary research, the rapid review assimilated all the relevant existing evidence (both UK-wide and internationally) on potential links between culture and public health. The evidence base was summarised and published by the London Health Commission in Culture and Health, Making the Link.

Sue Atkinson, London Regional Director of Public Health, sees the rapid evidence review as a key part of the GLA's success in taking public health into account:

¹⁷ See 'Improving health and reducing inequalities, a practical guide to health impact assessment' 2004

'Pulling out evidence of the interfaces between public health and the policy area in question is an extremely effective way of highlighting health impacts. Often if you say 'health,' people think of the NHS. Policy makers cannot be public health experts, but a comprehensive overview of the evidence is a good way of demonstrating what we are talking about.'

There is no single agreed national HIA approach or methodology. However, the GLA has led the way in adopting HIA systematically and collaboratively across all policy making since its Transport Strategy in 2001. The completed HIAs have themselves been subject to review and suggestions for improvement. A high level of staff awareness regarding public health and the knowledge that their policy will be subject to an HIA ensures that policy writers routinely consider health impacts early in the drafting process, as well as integrating public health with a broad range of overlapping issues where necessary. The overall result is that consideration of public health at the GLA is a collaborative and integrated process, and is not 'just good on paper.'¹⁸ Problems of revising strategy in order to retrospectively take public health into account are also avoided. HIA is used by the GLA as a tool to improve the existing consideration of health, rather than merely to alert policy makers to its relevance.

Recommendation 4: Health issues need to be made more focused and visible within the Regulatory Impact Assessment process. Government should refine its policy on HIAs to improve their effectiveness by focusing effort on those policy areas where there is potentially a real health gain, and remove from other policy areas the need for a full HIA assessment unless there is a specific case for it.

42. But the limitations on the availability, robustness and use of the evidence base are only a subset of the issues that need to be addressed. Even if the evidence base were perfect, real questions would remain about the extent to which officials in departments other than Health were able to get advice about how to access that evidence. We consider this below, and under Stakeholder Engagement.

SKILLS GAPS

43. We have found a number of skills gaps, which fall into two distinct groups. The first concerns the needs of officials in Government departments other than Health. Officials outside DH need to be able to identify exactly what expert advice or evidence on health issues they require, where to look for that information, and, assuming that the information is not readily available or is incomplete, ways of identifying and commissioning the research needed to obtain it. These officials, once they have the expert advice, then need to ensure they have the necessary skills and training in order to use and interpret the health evidence in ways that lead to better policy.
44. The second set of skills gaps concerns the training needs for health of the population professionals and DH officials, so they can communicate clearly the purpose and benefits of the health impacts of particular policy options, and thereby influence policy-makers and other stakeholders in other parts of Government.

¹⁸ NHS Executive London, A short Guide to Health Impact Assessment, Informing Healthy Decisions, p3.

45. Government therefore needs to put in place mechanisms for training Government policy-makers in the wider determinants of health, and the use of evidence. Part of this training should involve commissioning and interpretation of evidence so that officials have the necessary understanding and confidence, for example in commissioning the use of randomised control trials to minimise bias, and to understand how the research they commission relates to other workstreams, as well as greater proficiency in using tools such as HIAs.

Recommendation 5: Mechanisms are needed for training Government policy-makers, across all departments, in the wider determinants of health and the use of evidence to assess them, so that they can be applied with confidence. Consideration should be given to training on health of the population being part of the National School for Government training programme.

The policy making process

STAKEHOLDER ENGAGEMENT

46. We firmly believe that the whole philosophy and culture on how policy-making across Government impacts on the health of the population needs to be improved. We have a clear starting point, namely that when policy issues affecting the health of the population are being determined, Government needs to involve as wide a range of stakeholders as possible and at the earliest stages.
47. Our case studies provide two examples. The first relates to the Regional Spatial Strategies and shows that the East of England one had a pretty low level of linkage with health issues, for example in transport, housing and employment, whereas the North West one had a much greater level of linkage. A key difference seems to have been early engagement between health of the population officials and planners at an early stage in the North West – the East of England example show that without such engagement, health does not figure. The case studies demonstrate that planners (in this instance) found it very difficult to understand the potential health consequences without the input of public health professionals.

Case Study Box 6

The benefits identified in the North West RSS centre around the close interaction between planners and health officials. The early involvement of a member of the Regional Health Group, a dedicated health workshop and a Technical Advisory Paper on health all served to establish the significant link between regional planning and health.

The Technical Advisory Paper (December 2004) was particularly useful in this regard, as it listed the socioeconomic and environmental conditions, which have a health impact. It takes each of the core areas addressed by the RSS (economic development, regeneration, retail, etc.) and summarises the specific links they have to health. For example, the 'Building Communities' section contains the following recommendation:

"Associated initiatives should be developed in a holistic manner and include consideration of regional health priorities related to Lifestyle Risk Factors such as tobacco, accidents, sexual health and teenage pregnancy"

The most crucial issue for the East of England RSS was timing. The region embarked upon the RSS development process at an earlier stage than most other regions (perhaps due to ODPM's specific interest in the Spatial Strategy which would apply to the Thames Gateway development).

An extended timeframe should have been of benefit to the policy process, in that it allows for greater consultation time and stakeholder engagement. However, in this case, the early commencement of the process meant that the RSS development process was unable to utilise the Regional Health Strategy, which was still in formation at the time. As the diagram below shows, the Health Strategy is intended to be an integral part of the Region's planning but it has only been possible to feed into the RSS during the Examination in Public process.

48. It is important that all Government departments – and not just the Department of Health – are actively made to think through the impacts that their policies will have. However, for practical purposes and to ensure maximum impact, we suggest that a smaller set of key departments should be targeted in the first instance – Transport, Home Office, Communities and Local Government, Environment, Food and Rural Affairs, Education and Skills, Work and Pensions and Ministry of Defence.
49. Stakeholder engagement should include more than just information provision (although this is valuable) and should concentrate on providing a clear sense of direction and raising awareness through a clear understanding of the issues and benefits. The starting point for this engagement process should be the joint review of the evidence base between DH and the relevant department (see Recommendation 2). There is also a need to develop a common language – it may be conceptually difficult for local authority planners to understand the relevance of health of the population issues beyond the obvious – for example the need to allocate land for health premises.
50. The second example of good practice is the Fuel Poverty case study (see case study 7)

MECHANISMS FOR STAKEHOLDER ENGAGEMENT

51. There have been some welcome developments. The recent attachment of each Regional Director of Public Health (RDPH) to one or more Government departments, in addition to their existing regional responsibilities, is playing a significant part in highlighting where departments can contribute to the public health agenda, and where the consideration of health in policy making could be improved. Feedback from the case studies suggests that this appears to be working relatively well, but that the important role of the RDPH needs to be championed further.
52. We agree with this diagnosis. We believe that strengthening and promoting of the role of the RDPHs in their workings with Government departments is needed, particularly where issues are complex. The existing departmental expert committees provide formal structures for communication that have proved useful, although these mechanisms are used more fully in some departments than others. Finding synergies between health of the population and other agendas and mapping these connections to benefit everyone involved is essential. Government departments should work with DH and health professionals to conduct stakeholder-mapping exercises. This should also be a component of the joint review (see recommendation 2).
53. Stakeholder engagement needs to be a continuous process and mechanisms put in place to ensure it happens in this way. Again, we see a pivotal role here for RDPHs. Following the review of the evidence base and stakeholder mapping exercise for a particular department, there needs to be a core group of officials from that department, and health professionals from DH, who are charged to ensure that health impacts are properly considered during the policy development process. This would ensure that the process was a *living* process.
54. Assessment tools such as RIAs and HIAs provide a set of frameworks around which increased stakeholder engagement could be built. Where these are used well they are effective (see paragraph 42).

TIMELINESS OF STAKEHOLDER ENGAGEMENT

55. Our evidence suggests that health considerations need to be embedded into policy-makers' consciousness at a much earlier stage than currently. Too frequently health of the population professionals are brought into the process when a policy is well developed. This can leave little scope for change, and often results in public health being considered an add-on or an afterthought to a policy rather than a critical element from the start.
56. The GLA Cultural Strategy case study shows how specific and knowledgeable input, inserted at an early stage, can bring health issues into policy areas where they are by no means obvious (for details see case study 5).
57. Therefore health experts need to be fully involved from the start of the policy process, allowing them to shape the policy in such a way to reflect cross-cutting health of the population issues. Public Service Agreements (PSAs), agreed between individual departments and the Treasury which set out the key improvements that the public can expect from Government expenditure, are useful mechanisms. More importantly, shared PSAs between departments and DH provide a means of promoting cross-Departmental collaboration as departments will have to report on joint achievements at regular intervals¹⁹. However, PSAs are high-level mechanisms, and we consider that more incentives for collaborative working are needed at both working and individual levels, and that clear objectives and targets need to be set that go beyond simply asking for 'partnership working'. It will be necessary to specify what this means in practice: for example joint appointments, where employed, are an effective way of working.
58. An example of stakeholder engagement both at an early stage and being wide-ranging is illustrated by one of our case studies.
59. The Warm Homes and Energy Conservation Act, 2000 identified the need for a Fuel Poverty Strategy to be drawn up:

"It shall be the duty of the authority to prepare and publish, before the end of the period...a strategy setting out the authority's policies and ensuring, by means including the taking of measures to ensure the efficient use of energy, that as far as reasonably practicable persons do not live in fuel poverty."

Case Study Box 7

Both the purpose and scope of the Fuel Poverty Strategy were well defined, making the timetable for the policy's formation a fairly straightforward process: Whilst there was only one consultation period, it involved a wide range of stakeholders. 3000 copies of the draft were sent out to individuals, Members of Parliament, local authorities, the energy sector (including producers, suppliers and manufacturers), the health sector, a wide range of organisations with interests or responsibilities in fuel poverty, the poor, elderly, sick and disabled and the environment. Some specific health related bodies that were involved in this process included a number of Health Authorities and Primary Care Trusts, the Community Practitioners and Health Visitors Association and the Health Social Services and Public Safety Committee.

The high numbers and broad range of those involved in the consultation period allowed for a number of crucial aspects of the strategy to be honed for implementation. These included the definition of fuel poverty and 'vulnerability' and creating a Fuel Poverty Advisory Group, amongst many others.

¹⁹ For example: Public Service Agreement target on health inequalities: to reduce by 2010 inequalities in health outcomes by at least 10 per cent as measured by infant mortality and life expectancy at birth.

Recommendation 6: When policy issues affecting public health are being determined, Government needs to involve as wide a range of stakeholders as possible and at the earliest stages in the process. Procedures and incentives to ensure joined up working on health of the population issues across Government need to be developed, harmonised with other processes, and embedded across Whitehall – and first of all within the seven departments highlighted in paragraph 48. This should entail a range of methods, ranging from the use of RDPHs and expert committees to stakeholder mapping exercises.

TENSIONS 1: LOCAL VERSUS CENTRAL

There are three important factors here:

- the importance of ensuring policies meet local needs
- to ensure that achieving the first does not lead to duplication or fragmentation across the UK as a whole
- the limitation that a shortage of individuals with the right expertise places on the whole system.

60. There are a number of reasons why some regions have managed to establish good practice in this area: stakeholder engagement is often most effective at a local level (where the most appropriate experts can more readily be identified and engaged with), more creative forms of consultation and engagement can be trialed, and the evidence base of health of the population impacts in a particular area is well known to those involved in the policy development process.
61. Good practice has been observed at the local and regional level The Greater London Authority (GLA) Culture Strategy 2004 was the first culture strategy for London, written in the first term of the GLA (2000-2004). It aims to set a 'broad and challenging agenda' maintaining and improving London's cultural strengths by focusing on four key objectives:

Case Study Box 8

GLA Culture Strategy 2004 – Objective and Approach

- Excellence: to enhance London's status as a world class city of culture
- Creativity: to promote creativity as central to the success of London
- Access: to ensure that all Londoners have access to culture in the city
- Value: to ensure that London gets the best value out of its cultural resources.

Local authorities are expected to prepare a culture strategy in line with DCMS guidance, which places culture within the context of central Government's key objectives, including 'the cross-cutting agendas of: public health, community safety, social inclusion, environmental sustainability, regeneration, the 'Active Community' initiative and lifelong learning.' Therefore the consideration of health of the population, and joining up health of the population thinking with thinking on other issues is imperative.

The evidence base (as carried out by the rapid evidence review) underpinned the Health Impact Assessment which was carried out on the Cultural Strategy. Stakeholders reviewed the evidence base, prioritised the most critical issues, and took these forward to a broader HIA workshop which involved 80 stakeholders from a range of organizations including primary care trusts, DCMS, the Arts Council of England, Sport England, London borough councils.

The session was chaired by Dr Sue Atkinson, Health Advisor to the Mayor. The evidence review and HIA process both helped to identify gaps in the provision of culture in London in relation to health of the population, including lack of access to facilities for disabled people. It also identified further opportunities, such as the potential power of the cultural strategy to link members of different social strata, for example rich and poor. The collaborative approach and systematic use of evidence and consultation ensured that health of the population was considered early – and comprehensively – in the drafting of the cultural strategy.

62. Whilst this does not negate the clear need for a focus on the health of the population considerations in policy making at the national level, it points towards best practice in one region being shared more effectively with other regions.
63. As expertise is scarce, there is a need to balance work in the regions with that in central Government and not duplicate expertise. The current ‘gatekeepers’ of knowledge, such as the RDPH, have a wide remit. Although this creates the potential for greater connections to be made across policy areas, it also means that they are a tightly-stretched resource. They may need more support. The Fuel Poverty case study highlighted the importance of focus groups involving health professionals rather than formal consultations as these consultations may not get the attention they need given the enormous pressures on health professionals’ time.

TENSIONS 2 – POLICY COMPLEXITIES

64. There are understandable concerns, not least amongst policy-makers, that introducing health of the population issues into policy making across Government will inevitably lead to certain policy options becoming more complex and contentious.
65. Inevitably there are instances where this will be the case – for example the Green Paper on Parental Separation did address health impacts: in this case, mental health, and acknowledged that this introduced considerable complexities – which nonetheless need to be incorporated into effective policy making.

Case Study Box 9

The Parental Separation Green Paper (or Command paper) puts forward proposals for providing services and improving the judicial system, with the aim of ensuring children continue to have a meaningful relationship with both their parents following parental separation, as long as it is safe. It was produced by the Department for Constitutional Affairs (DCA), along with the DfES and the DTI.

The ‘Supporting Evidence for documentation’ Paper for the Green Paper makes clear that the nature of the evidence in this area is a complex one, stating early on that ‘the impact on children of parental separation is an inexact science characterised as it is by strong and changing emotions’²⁰. This is an important recognition of the fact that mental health is often neglected as a critical aspect of public health. The necessarily complex and nuanced nature of the evidence base for mental health issues should not prevent it from being a critical area of exploration when public health is being incorporated into policy making.

²⁰ Children’s needs and parents’ responsibilities, Supporting evidence for consultation paper, 2004

CREATIVE WAYS OF CONSULTATION

66. In areas where contentious policy issues emerge, particularly where there is a conflict between health of the population objectives and other policy objectives, consultation that is honest about this is important both within and outside Government from an early stage, and it is essential that this consultation be informed by the available evidence.
67. Our case studies have examples, which show what works and what does not. The Fuel Poverty Strategy involved wide consultation at an early stage, where health issues, when made explicit, underscored a policy, which has been effective from a health perspective. By contrast, the Licensing Act shows that consultation in itself will not necessarily lead to an understanding of health impacts – DCMS did consult on the Licensing Act but, because health impact was not on their agenda, the consultation made no difference in this respect.
68. The importance of formal consultation with health of the population professionals is now reasonably well established across many Government departments. However, most consultation remains of a very traditional nature: a draft document is put out to consultation; opinions are requested by a particular date, and feedback will be duly considered.
69. Our research indicates that this is not always the most effective way to involve a broad range of health of the population professionals. Pressure on time and the lack of confidence many feel about responding to a an official Government consultation exercise means that the true expertise of public health professionals is not always captured via traditional consultation exercises.
70. An effective methodology could involve the policy team holding (for example) several two-hour consultation sessions in different localities across the UK. A short presentation by the policy team outlining the main elements of the draft policy, followed by an opportunity for health professionals to raise questions and comment on the draft, could prove more effective. Similarly, focus groups and online questionnaires could be considered more often.
71. Such techniques expose policy makers more directly to the opinions of the health professionals, and ensure that such professionals feel empowered to contribute to the policy development process.

PUBLIC ENGAGEMENT/DIALOGUE

72. Consultation with health professionals is an important part of the process, but by itself it will not be enough. Wider public dialogue, to inform policy not determine it, will be an important component to ensure public acceptability, which itself is an absolute necessity for a successful UK health policy. Therefore, public engagement before decisions are made is vital.
73. In approaching public engagement it is important that the issues are clearly articulated and that people have the freedom to re-define the issues in ways consistent with their values. Structured processes are needed that create a space in which the public, policy makers, other stakeholders and experts can engage in deliberative dialogue to re-evaluate their perspectives, evolve their thinking and explore ideas of mutual understanding which enable the outcomes to command acceptance and respect.

74. It is important to engage with a diverse range of people, and in particular to harness the energy and enthusiasm at more junior levels in order to bring about cultural change.
75. Previous experience suggests that finding people who are genuinely non-aligned is key. This allows the debate to be opened up, and avoids capture by special interest groups. A great deal has been learned from diverse but representative groups once they have engaged with a variety of parties, and not just with officials or the obvious stakeholders.
76. It is equally important to recognise that consideration of potential health impacts of policies will almost certainly involve considering complex factors which will need to be balanced out – gain in one policy area may have negative health consequences, or vice versa.
77. CST has already made recommendations on public engagement/dialogue²¹. Many of these are relevant here, in particular the need for transparency about the issues and the processes to be used.
78. There are two important principles. The first is to adopt a co-ordinated approach to integrating health of the population. If different policies, strategies or initiatives are jointly intended to address public health, it is vital that they run truly in parallel with frequent communications between the policy teams. This reduces the risk of health of the population either being silos, or falling between policies. It also limits the likelihood of a policy shifting in its focus in line with the specific interests of a particular team or Minister.
79. A second important principle is that engagement needs to be multi-stage. A single big bang is unlikely to work. We think there need to be at least two rounds; the first to allow people to frame the issues in their own way and help to shape the process, and the second round(s) to engage on substance. Dialogue should not be artificially constrained – it needs to be very wide-ranging, for example exploring the interconnections between scientific, economic, social, ethical and environmental issues.
80. There is expertise within the OSI's Sciencewise programme on how public dialogue exercises can be taken forward. It is part of the Sciencewise remit to help to increase and improve public dialogue on S&T across Government.
81. One issue to explore through public dialogue would be the extent to which individual citizens are prepared to make trade-offs between the benefits of greater sharing of health information between Government departments and agencies, and the potential loss of privacy this would entail.
82. A second issue would be the willingness of people to have more constraints placed on their personal and recreational activities where this could promote better health for themselves and their families.

Recommendation 7: Government should develop stakeholder dialogue processes (not just involving public health experts and policy makers/officials) at an early stage in the policy-making process, and identify a set of key topics for the dialogue process. More creative forms of consultation should be developed, including short consultation sessions across the country, focus groups and on-line techniques.

²¹ Policy through dialogue: informing policies based on science and technology

Annex 1



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12 October 2006

Dear Sir/Madam

**CST response to 'The Tools to Deliver Better Regulation – Revising the
Regulatory Impact Assessment: A Consultation'.**

Please find attached the response of the Council for Science and Technology to the consultation on the revision of the Regulatory Impact Assessment.

Yours sincerely

David King

Keith Peters

COUNCIL FOR SCIENCE AND TECHNOLOGY RESPONSE TO – ‘THE TOOLS TO DELIVER BETTER REGULATION – REVISING THE REGULATORY IMPACT ASSESSMENT: A CONSULTATION’.

The Council for Science and Technology welcomes the opportunity to comment on this consultation. We would like to focus both on the broader ramifications of the proposals and specifically on the proposal to de-couple health from the overall remit of the Regulatory Impact Assessment (RIA) in light of CST’s report on Health Impacts²².

BROADER OBSERVATIONS

The consultation document recognises the problem of fragmentation and broadening:

In recent years Regulatory Impact Assessment guidance has been widened and requires a broad range of information to be included in assessments, for example health, sustainable development, older people and devolved countries. While this has been done for well-intentioned reasons, the cumulative effect has been to detract from the core purpose of the Regulatory Impact Assessment: i.e. ensuring that the costs and benefits of the policy options are identified, quantified wherever possible and set out transparently.

We understand the concerns. But there is a real risk that too narrow and tight a remit may, if not handled very carefully, have serious repercussions for better policy making across Whitehall.

CST believes that this consultation is looking to isolate economic impact assessment from all of the other factors that are essential to consider when making good policy. Amongst these factors, health is clearly extremely important, as are many other social and environmental impacts (e.g. sustainable development).

The danger is that, if RIAs consist of purely economic assessment, all the other key factors in policy making will be downgraded or ignored. Costs and benefits must be broader than those purely measured economically, and impacts in areas such as health and the environment must be considered. We explore below exactly how that might be done.

Although the proposed summary sheet does highlight non-monetised costs there is a real danger that this will not be strong enough to alert policy makers of the need to consider health, social and environmental factors, particularly in areas where quantification is particularly difficult.

This is particularly important where policy makers have a range of policy options and where, for example, the health impacts of each may be quite different – in those cases health impact assessments could be the determining factor in deciding which option to choose; the absence of any such requirement could mean that sub-optimal policies were put in place which were then shown to have significant health or other impacts. At the very least, we urge that there is clear guidance and signposting on all health, social and environmental factors in the re-vamped Impact Assessment.

We feel, as a matter of urgency, that the Better Regulation Executive (BRE) should develop a clear proposal on how and where health, social, environmental impacts will be taken into account under any new regime that they propose to introduce.

²² Due to be published December 2006

MANDATORY REQUIREMENTS FOR HEALTH IMPACT ASSESSMENTS

CST's report – Health Impacts, a strategy across Government – has the overall message that improving the health of the population as a whole, as well as reducing health inequalities, should be the business of all government departments and not just the Department of Health.

A pre-requisite to achieve these objectives is to have a more comprehensive and robust evidence base together with a joint approach across Government including mechanisms for joining up Government databases. One particular mechanism – Health impact assessments – has provided an important means for achieving this outcome.

Any de-coupling of Health issues from Impact Assessment needs a replacement mechanism to be in place that covers health issues and is **mandatory**. Our concern is that without such a mandatory requirement there will be no incentive for departments to consider health impacts when deriving their policies. A robust, highly visible, **mandatory** mechanism therefore needs to be in place to ensure health impacts are taken into account. If not, we risk jeopardising the Government's objective of improving the health of the population as a whole.

Our report will be published shortly. We would be very pleased to discuss further with the BRE ways forward – in particular ways in which health issues can continue to be considered in a robust and consistent manner within the framework of better policy making.

Council for Science and Technology

12 October 2006

Annex 2

LIST OF ACRONYMS

AHRS	Alcohol Harm Reduction Strategy
BRE	Better Regulation Executive
BRTF	Better Regulation Task Force
CBA	Cost Benefit Analysis
CSA	Chief Scientific Adviser
CST	Council for Science and Technology
DCA	Department for Constitutional Affairs
DCMS	Department for Culture, Media and Sport
DfES	Department for Education and Skills
DH	Department of Health
DTI	Department of Trade and Industry
EIA	Environmental Impact Assessment
GLA	Greater London Authority
HIA	Health Impact Assessment
HO	Home Office
MoD	Ministry of Defence
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
ODPM	Office of the Deputy Prime Minister
OST	Office of Science and Technology
PSA	Public Service Agreements
RDPH	Regional Director of Public Health
RIA	Regulatory Impact Assessment
RSS	Regional Spatial Strategy
S&T	Science and Technology
UKCRC	UK Clinical Research Collaboration

