Healthy cities, healthy economies:

Health, wellbeing and competitiveness

Introduction

This position paper sets out the linkages between urban economies and health in order to inform senior officers and members of Core Cities[1] and relevant stakeholders. Drafted by the Health Working Group, it will become the starting point for a programme of work.

The unique role of Core Cities

Core Cities are a unique and united local authority voice to promote the role of England's eight largest city economies outside London. These cities drive local and underpin national economies. Working in partnership, they aim to enable each City to enhance their economic performance and make them better places to live, work, visit and do business. Following the announcement of the transfer of public health functions to local authorities, Core Cities has formed a Health and Wellbeing Working Group to develop policy and thinking to drive service improvement and link considerations of health improvement to those for economic success.

Core Cities have a distinctive and critical role in England in linking and delivering improved health and economic outcomes. These cities' wider urban areas generate 27% of the country's economic output, and have the capacity to achieve much more. Yet within their populations of some 16 million people, significant and persistent deprivation exists alongside a profile of health inequalities, the strongest indicators of which are relative poverty and unemployment. The Core Cities therefore have a unique potential as major urban areas that can link health outcomes and economic opportunity.

Core Cities have consistently made evidence-based policy arguments for greater devolution of control over specific policy levers of growth and productivity to improve efficiency and outcomes. Health outcomes can also be improved through this approach, and the Community Budget Complex Families and Whole Area pilots offer a critical insight into the improvements and efficiencies that can be gained by adopting a different, 'place-based' focus on specific challenges, tasking national agencies to work differently at the local level.

Improving health, driving growth

Health is influenced by the economy and the economy is affected by the health of the population and the workforce. The Global Report on the Social Determinants of Health from the World Health Organisation set the scene for the importance of economies and the distribution of wealth within societies for health outcomes, and the UK Marmot Review held after this made the case for addressing health inequalities in the UK, with fairer income distribution and reduction in the inequalities in income within our society as a vital ingredient.

Relative poverty has been shown, through extensive research by Richard Wilkinson and others, to be a major health determinant, so that poor people in relatively rich societies surrounded by visible affluence fare very badly physically and mentally[2]. So low pay, unemployment, poor benefits all

[1] The 8 Core Cities are: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield.

[2] Wilkinson, R.G & Pickett, K. (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London, Allen Lane.

serve to undermine health, and as Marmot has shown, this inequality affects everyone and undermines health whatever their status. In other words, everyone suffers from inequality; more egalitarian societies do better. This work has also shown that more equality benefits economies. Work affects health in other ways too, the management culture, control over decisions in the workplace and the individual's work, work hazards, working conditions are all very important for health and the economy. The NHS is a major procurer, and owner, and employer but we do not always give it sufficient regard as big business in our cities, providing important 'anchor institutions', attracting skilled workers.

Our cities are facing major demographic change. We need changed employment patterns and practices for the growing numbers of older people who will wish to and need to work. There is also a growing need for supported employment opportunities, for example, as people with learning disabilities live longer.

The Work Programme is designed to get people into work and to stay in work and whilst it is early days, it is clear this programme will only help a small number of those that are unemployed, e.g., in Sheffield 4,000 from 50,000 unemployed.

Many of those who are unemployed are incapacitated due to illness. Some of this is physical but a worrying trend is that mental ill health affects many of those without work and stops people from entering the labour market, and a growing number of this group are young people. Depression, unhappiness, poor-self esteem and addictions are all concerns.

Core Cities are rightly focused on growing economies, addressing the recession, attracting inward investment and creating jobs. It is important that it is clear what growing the economy is for: to address wellbeing; to make life better for all; to redistribute wealth; to offer improved services for the vulnerable; creating a sustainable economy for the long term. We know that 'trickledown economics' do not provide solutions to the challenges cities face and it is therefore vital that Core Cities articulate their economic model and its underlying values. It is also very important with the depletion of natural resources that economic growth is sustainable; some academics suggest our rates of growth are not sustainable. If so where does that put our cities' economic and environmental strategies and how can we start to address issues of sustainable growth and socially useful work? It may be that many people will be unemployed in the traditional sense for long periods, how can they make a contribution without paid work, feel and be valued and also thrive?

Health inequalities: holding back growth and creating dependency

Health Inequalities and the Economic Crisis

In all European countries, the most disadvantaged groups still have the worst health and highest levels of mortality. Despite the growing number of policy commitments to tackle inequities, overall improvements in health have been dogged by persistent and increasing inequalities. Policies and interventions that were put in place to alleviate these deprivations have had little positive effect.

The crisis has reinforced and accentuated long-term trends of inequality, low pay and related poverty in Europe. Currently, 17.5 million people are experiencing 'in-work' poverty in the EU. Many households are under financial stress. Across demographic groups, the picture is also variable. Young people experienced double the unemployment rates of other age categories. In the three Baltic States as well as Ireland and Spain youth unemployment has risen dramatically.

The initial impact of the crisis was characterised by high rates of male redundancies. In all countries, the unemployment rate for men has increased by 30-50 per cent more than for women. However, women have increasingly experienced higher wage cuts than men. The crisis has had

disproportionate impacts upon a variety of groups such as ethnic minorities, the disabled and women. This is a trend will continue to get worse given the forthcoming public sector 'shock' where ethnic minority groups and women are strongly represented. Low skilled workers across almost all European countries have been badly affected. Initially, the impacts fell mainly upon high-skilled jobs, especially those in the financial services sector. Subsequently, the crisis affected manufacturing and construction companies that traditionally employ a high percentage of unskilled or semi-skilled labour and has gone on to have a severe impact upon public sector employment. Paid employment and education no longer provide guaranteed routes out of poverty. Instead people can remain trapped in cycles of in-work poverty, unemployment and welfare benefits which can affect many different groups of people.

Poverty, relative poverty and health

Poverty arising from unemployment or poorly paid work will inevitably affect health, indeed much of the historical debate concerning the causes of ill health and health inequalities has focussed upon the damage done by material poverty. This may be so in areas of low levels of economic development, where income generally predicts a person's health. However, at high levels of economic development, (e.g. in the EU) the effect is modest. As above, research shows that *relative* income and hierarchical comparisons (the social gradient rather than absolute levels) predict health and wellbeing[3], and in addition, everyone's wellbeing and health is poorer in societies with wider income inequalities.

However work is important in health, not just for material reasons. According to the evidence base the 'psychosocial' pathways of relative deprivation such as control, mastery, insecurity, anxiety, social isolation, remain largely unacknowledged and untouched by economic and social policy interventions. However, evidence shows that these factors influence and predict health outcomes and that their prevalence is affected by socioeconomic structures, and people's place within them. Policy interventions aimed at addressing economic issues can therefore have a positive (or negative) impact on health, for reasons beyond actual pay.

Adopting an asset based approach to Public Health in an economic context

Among the scientific community and in certain political and policy spheres there is acceptance that social conditions do much to determine people's health. Extensive evidence underlines the important relationship between social circumstances and health and wellbeing. Historically, approaches to public health have been based on a deficit model. That is, they have tended to adopt a segmented approach to identifying problems and needs in terms of individual health behaviours, a lack of medical, hospital and welfare services (downstream / mid stream factors) or emphasise the upstream factors and interventions such as macro-economic and fiscal policies.

In contrast, an 'assets' model aims to bolster the positive capabilities of people and communities. They focus on promoting 'salutogenic' (health giving) resources that promote self-efficacy and coping strategies, and take a positive and inclusive approach to action on health. This focuses on people's resources and capacities to create health using longstanding psychosocial concepts of resilience, wellbeing and social capital. The model suggests that population health can be improved by developing opportunities that create and sustain health via psychological, social and community resources and processes. This fundamental shift in orientation is particularly important in the relationship between work and health, and is the key factor in why health is relevant in to the Core Cities Group whose primary collective concern is to improve economic competitiveness.

[3] Wilkinson, R.G & Pickett, K. (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London, Allen Lane.

Failure to recognise these relationships may result in policies in the economic area failing to maximise the potential increases in health and wellbeing, and therefore the minimising of 'care costs' (The size of the Health 'Treatment' economy in a City is about the same size as the Local Authorities Total Budget (both are worth around £1billion in Sheffield).

Growth and employment

Economic growth

Cities are the UK's centres for future growth but they also have significant levels of unemployment and worklessness, with too many people and communities disconnected from economic opportunities.

At this time of high unemployment, the challenge for people in finding work is far greater and the risk of ingrained poverty and poor health is heightened. These issues need to be addressed in the long-term if cities are to reach their economic potential, as economic inactivity brings with it a huge cost in human terms (benefits, health costs etc) and represents an untapped economic asset – one which if invested in could contribute to business needs and productivity at the same time as boosting health, well-being and prosperity.

Providing opportunities for unemployed and workless people to work primarily demands more jobs, however jobs alone will not be enough. Individuals who have been out of the labour market for a significant amount of time may have complex barriers to work, poor health low confidence and skills levels, and as such we also need to equip them with the support and skills they need to access job opportunities.

Furthermore if cities are not empowered to act, unemployment and worklessness could act as a brake on cities productivity and growth. There is a real risk that if unemployed and workless people do not receive the right support then when growth returns we may not have the skilled, healthy and work-ready labour force the economy needs to grow.

Nationally and internationally, emphasis has been placed on the role of SMEs and business start-ups in driving economic recovery and job creation. However, it is unclear whether sustainable employment can be generated solely by using these mechanisms. Less than 50% of start-ups survive for five years and few develop into major businesses (OECD), therefore working to provide opportunities and routes into work with major employers is also critical.

Health and work

The Marmot review of health inequalities states that employment is important for improving health, and that job security and attaining 'better' jobs has a positive effect on the way people live and feel, and the choices they make with respect to their health. It also highlights that being out of work has multiple negative effects on an individual's health, and further that these health risks are often progressive with the length of time an individual is unemployed.

We can identify three main areas where work and health interconnect:

1. **Workplace health** – This is about ensuring that businesses see value in and invest in the health of their workforce. Often businesses do not recognise the benefits this can bring (productivity, staff loyalty, increased attendance). Moreover, healthy workplace practices can help to prevent health problems developing and as such can avoid business costs such as sickness absence, severance and recruitment costs. Workplace health is not just a concern of lifestyle issues. Wider employment practices such as job design, the degree of control over one's working day and organisational culture also affect employees' wellbeing and health.

2. **Supporting people who are employed but not at work through ill health** - Working with employers and supporting workers to manage health conditions in work is a key element of this work. There are key services available which do this, not least through GPs. However, GPs need a brokered relationship with employers, to understand workplaces, in utilising new tools likes Fit Notes. There is an important job retention element to this work, where supporting individuals and businesses to help staff get back to work after periods of sickness can help to prevent unemployment occurring.
3. **Ill health is major barrier to work for unemployed and workless people** – it is clear from the evidence that individuals claiming Incapacity Benefit see their poor physical and or mental health or disability as a near-universal limitation to work. Early indications through the Work Programme locally have also highlighted that health barriers to work, even for those claiming JSA, are significant. Employment and health interventions need to come together to build a package of support for individuals so that they can have the choice and support to engage with work.

Across these three areas, mental health conditions are a consistent issue, for example[4]:

- 40% of employers view workers with mental health conditions as a significant risk.
- 42% of employers underestimate the prevalence of mental health in their workplace.
- Mental health is the primary illness causing worklessness (approximately 11,000 in Sheffield).
- 87% of people out of work due to mental health conditions have been out of work for more than 2 years, most for 5 years.
- Poor mental health can be self-perpetuating, with the deterioration of skills and confidence often leading to further mental health problems.

There is also a strong association between other health conditions (particularly musculoskeletal conditions) and developing a mental health condition.

- Where prolonged pain and periods of out of work in many cases leads to depression.
- There is increasing evidence that work enables people with mental health conditions to achieve recovery and increased independence thereby decreasing the cost of support services.

The issues around mental health conditions need to have a clear focus as without early identification and intervention, mental health conditions can lead to a pervasive cycle of unemployment and further ill health.

It is also important to recognise that in health terms, not all work is 'good'. There is strong evidence that unemployment, 'bad' employment and in work poverty are all harmful to health, and related to:

- Higher mortality;
- Poorer general health;
- Lengthy illness;
- Poorer mental health, psychological distress, minor psychological/psychiatric morbidity;
- Higher rates of medical consultation, medication, and hospital admission.

[4] Cited in Sheffield Employment Strategy (2012) from a survey of incapacity benefit claimants, Professor Steve Fothergill presentation, Tackling worklessness in Sheffield, 2011.r

On the other hand, 'good' work and employment is a substantial asset for health and wellbeing. Findings conclude that:

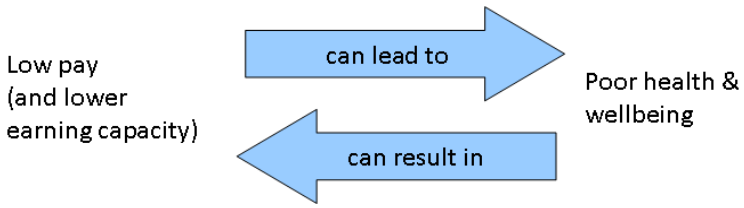
- Employment is generally the most important means of obtaining adequate economic resources, which are essential for material wellbeing and full participation in society. This benefit is felt by whole family units; not just the individual. There are therefore links with issues such as child poverty;
- Work meets important psychosocial needs in societies where employment is the norm;
- Work is central to individual identity, social roles and social status;
- Employment and socio-economic status are the main drivers of social gradients in physical and mental health and mortality.

'Good' / 'bad' work and employment is thought of in terms of the psychosocial attributes –demands, control, support, insecurity as well as the material aspects associated with employment such as income. Work and employment which is beneficial and protective for health is taken to possess a number of key characteristics such as high levels of job control, supervisor and peer support, low levels of insecurity and the absence of in-work poverty. Good health and wellbeing are among the most valuable assets workers possess.

Dame Carol Black's review of the health of the working age population, 'Working for a Healthier Tomorrow' (2008), estimated the economic cost of sickness absence and worklessness to be £100 billion a year. However, this estimate predates the economic downturn, e.g. Bristol City Council's current estimate of the cost of its own sickness absence is £8 million a year. In a recent Health at Work survey (2011), one in three staff were found to have underlying health conditions, six out of ten were overweight or obese, and one in three described their stress levels as poor or very poor.

Low Pay

Low pay can be considered both a **symptom and a cause** of poor health. Low pay and health are **mutually reinforcing** issues which impact on the wellbeing of people and city economies. In simple terms, having less money reduces the capability of people to achieve a good standard of wellbeing and access the services they need which impacts on their health and quality of life. Equally and as demonstrated above, poor physical and mental health often undermines a person's capacity to work and access higher paid jobs.



Marmot argues that low pay and poor working conditions "make people ill" and that the relationship between low pay and health operates in several ways:[5]

1. **People with lower incomes don't buy the goods and services that maintain and improve their health *or* they have to buy cheaper goods and services which actually increase their health risks.**

[5] Marmot, M (2010) *Fair Society Healthy Lives (The Marmot Review)*, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report p68

This emphasises the 'mutually reinforcing' point as people on low incomes are often in a vicious circle where their earning capacity limits their ability to access products and services which improve their wellbeing, which then impacts on their physical and mental wellbeing, undermining their employment activities, restricting capacity to increase income levels.

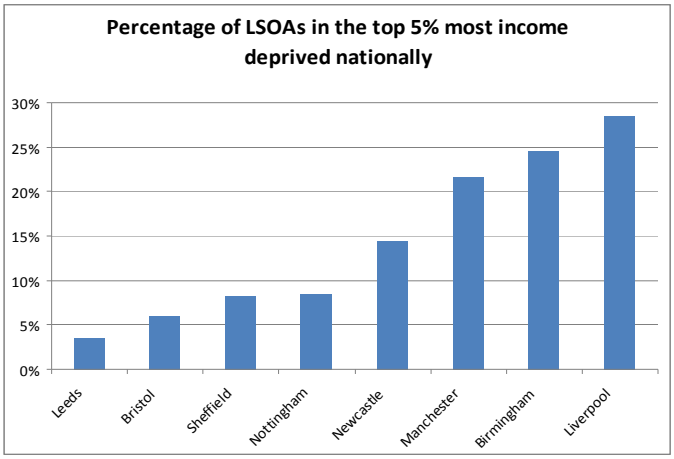
Examples include: lower paid people are less likely to have insurance but are more likely to be victims of crime; and lower paid people are likely to pay more for essential utilities.

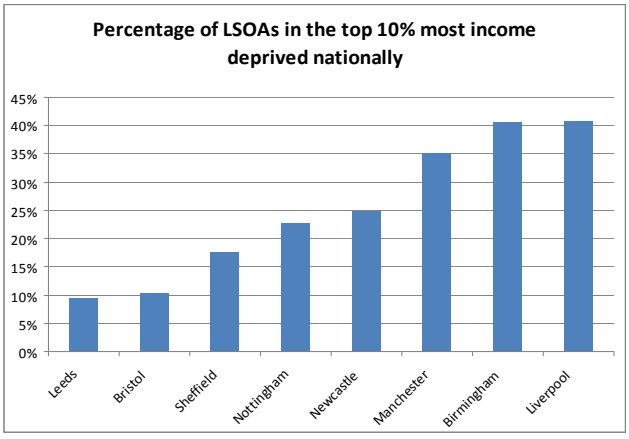
2. **Lower pay prevents and restricts the ability of people to be involved in 'social life', generating feelings of exclusion and lower status.**

   The mental wellbeing implications associated with lower pay limit a person's involvement in social activity, reduce aspiration and increase perceptions of social worth or status.[6] It may also ensure that people have fewer 'bridging social capital' experiences and relationships which may create positive aspirations and opportunities.

Low pay is not the direct result of poor levels of health; it is **intrinsically linked to the life experience of individuals** which ensures that certain social groups are more likely to experience low pay (e.g. people with disabilities, lone parents, carers, young people) than others. A study in 2000 [7] suggests that "in adult life, an individual's living standards and health are determined partly by their life-course experience up to that point and partly by the social roles — in terms of marital status, employment and parenthood — that they assume". Therefore, a person's ability to earn and be healthier is intrinsically driven by their life experience: their upbringing, quality of life and childhood development; their education and skills; and employability.

Communities in England's Core Cities have significant deprivation issues which undermine people's health and wellbeing and their ability to earn. The charts below (focused on Lower Super Output Areas (LSOAs) a consistent statistical geography) demonstrate that communities in the eight Core Cities are amongst the most income deprived in the country and this is mirrored by similar levels of health, education and employment deprivation.



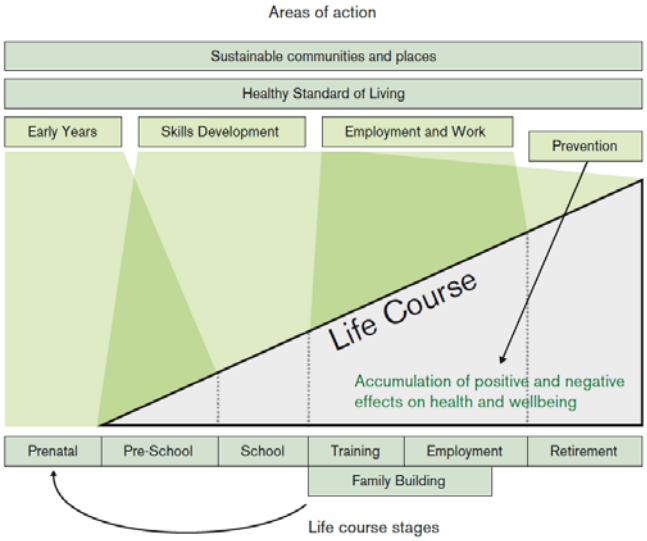


If city economies are to deliver the growth that the UK economy needs, businesses need an educated, skilled and healthy workforce to drive productivity, efficiency and innovation. The development of 'living wages' for employees can help to improve the financial position of employees but to fundamentally address the low pay/poor health issue, a step change is needed. Core Cities

[6] Ibid, p74

[7] Benzeval, M, Tayor, J. and Judge, K. (2000) Evidence *on the Relationship between Low Income and Poor Health: Is the Government Doing Enough?* http://www.ifs.org.uk/fs/articles/0029a.pdf, p5

need to be empowered to work alongside businesses to get people into work and into *better paid* and more fulfilling work by having greater control over education and skills provision to ensure employees have the skills which the local economy needs.



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Another by-product of the economic situation is under-unemployment. There has been a rapid increase in the numbers of part-time workers, many of whom would prefer full-time work. While the numbers of women working continues to rise, men's part-time employment has doubled since 2007 (TUC, 2012). An involuntary shift to part-time working puts further pressure on household incomes.

The impact of unemployment and dependency

Unemployment

Unemployment and worklessness are a major economic issue for cities, with thousands of people who are economically inactive, claiming incapacity benefit and other long term benefits.

Pre-recession Job Seekers Allowance (JSA) levels across Core Cities were improving due to a sustained period of growth, however unemployment has now increased the number of people claiming JSA by approximately 70,000 across the Core Cities (excluding their wider urban areas). Young people have been particularly affected during this recession and over a third of claimants are aged under 24.

At August 2011 there were over **460,000 people claiming out of work benefits in the Core Cities**. Of these:

- Over were 166,000 claiming Job Seekers Allowance
- 233,000 were claiming Incapacity Benefit or Employment Support Allowance
- 61,000 lone parents were claiming work related income support

[8] Marmot, M (2010) *Fair Society Healthy Lives (The Marmot Review)*, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

Key Benefits				
Aug-11	**Total**	**job seeker**	**ESA and incapacity benefits**	**lone parent**
Leeds	62,410	23,640	30,710	8,060
Sheffield	47,560	17,340	24,730	5,490
Nottingham	35,860	13,390	17,220	5,250
Birmingham	121,450	50,840	53,270	17,340
Bristol	38,630	11,910	21,340	5,380
Liverpool	65,190	20,740	36,950	7,500
Manchester	61,780	19,130	33,850	8,800
Newcastle upon Tyne	27,770	9,170	15,110	3,490
Total	**460,680**	**166,170**	**233,190**	**61,320**

Key Benefits (Under 25)				
Aug-11	**total**	**job seeker**	**ESA and incapacity benefits**	**lone parent**
Leeds	13,940	7,110	1,890	2,750
Sheffield	11,060	5,790	1,700	1,750
Nottingham	8,090	4,230	1,010	1,830
Birmingham	28,000	15,680	3,380	4,690
Bristol	7,520	3,300	1,250	1,610
Liverpool	12,240	6,460	2,000	1,980
Manchester	12,220	5,710	1,960	2,500
Newcastle upon Tyne	5,830	2,860	960	1,050
Total	**98,910**	**51,120**	**14,150**	**18,160**
% of total claimants	21.4%	30.7%	6.06%	29.6%

It is important that we support newly unemployed people move back into work as soon as possible to prevent deskilling. Public sector funding reductions are continuing and as growth has been illusive since the end of the recession there is a growing risk that the cyclical unemployment caused by the recession will become a longer term problem, as people's health, incomes, skills and confidence are deteriorated the longer they remain out of work.

As well as working with individuals affected by the recession, we must not ignore the fact that this growing tide of recently unemployed people will push thousands of workless people further back in the queue for the limited number of jobs that are available. As such, those who have already experienced long periods of worklessness, or who face specific barriers to work, will be comparatively disadvantaged in the labour market and can find themselves 'trapped' with few employment opportunities.

Without appropriate intervention, the recession will compound the long term problem of worklessness which has plagued cities since the 1990s.

Welfare reforms

The Coalition Government has identified two key problems with the current welfare system; firstly, work incentives are poor, secondly the system is too complex. Government's stated aim is to reform the system "to help people to move into and progress in work, while supporting the most vulnerable." Reducing public expenditure on welfare is a further driver for the welfare reforms.

The Welfare Reform Act was passed earlier this year and there are over 40 changes to the welfare system between January 2011 and October 2013. Government are looking to save £18bn per year by 2014/15 and in his recent budget statement the Chancellor raised the prospect of saving a further £10bn in the next spending round.

The reduction in benefit payments and tax credits may have an impact on the health of people who currently do not have poor health if it reduces their income.

There are also some specific aspects of the welfare reforms that will have an impact on people with poor health. Between 2011 and 2014 all **existing Incapacity Benefit customers will reassessed** in order to determine whether or not they will receive Employment Support Allowance (ESA) or Job Seekers Allowance (JSA.) If they are deemed fit to work they will receive JSA (or Universal Credit depending when they are reassessed) and be subject to the conditionality framework for these benefits. They will also see their income reduce by an average of £35 per week. Nationally around 1 in 3 people are being assessed as being capable of work. These assessments are proving controversial with 40% of the decisions being overturned on appeal. This figure increases to 67% where the appellant is represented by a trained adviser. Those remaining on ESA will not see an initial drop in income but depending on individual circumstances may see their future income increase at a lower rate than it previously would have. This would have a knock on negative impact on other benefit awards such as Housing Benefit or Council Tax Benefit (Council Tax Support.)

The **Personal Independence Payment will replace the Disability Living Allowance** (DLA) from 2013-14. A new "objective medical assessment" will be introduced for both new and existing working age DLA claims from 2013-14. Government have said this will save over £1 billion a year by 2014-15 and reduce the DLA caseload by 20%. Those not found to be entitled to Personal Independence Payment will be informed and their DLA will stop. They may be able to claim other benefits.

DLA is not an out of work benefit and supports many disabled people in work. The figures for disabled people in work and receiving DLA vary. DWP estimates about 9% of the people receiving DLA are in work.[9] In one study, 20% of the disabled people receiving DLA and no other benefits were in work and 40% of the single, disabled people living with their parents were also in work.[10] In the largest recent survey of people receiving DLA, 56% said they may have to leave work if they lost support.[11]

[9] DWP 'Disability Living Allowance and work: Exploratory research and evidence review' 2010; see: http://research.dwp.gov.uk/asd/asd5/rports2009-2010/rrep648.pdf

[10] DSS (forerunner to DWP) 'Disability Benefits and Employment' Richard Berthoud and Karen Rowlingson, 1996; see: http://research.dwp.gov.uk/asd/asd5/rrep054.pdf

[11] See: http://www.disabilityalliance.org/r68.doc#_Toc285815634

Healthy workplaces

Workplace hazards

Health and safety and successful business or organisation performance are complimentary. Many of the Core Cities have residents living with the legacy of previous heavy industry or asbestos exposure. Slips trips and falls still account for many preventable deaths and serious injuries. Musculoskeletal problems are a huge issue for employers and the NHS, and stress is an increasing threat as organisations in the public and private sector further reduce costs, sometimes in order to compete locally and with global competitors many of whom will have much poorer standards of workplace health than our own. The costs of stress can be equal in personal and financial terms to other workplace injuries yet it may be less of a focus than more traditional health issues in the workplace.

Although the UK has performance on accidents and work related ill health better or equal to European comparators, the costs remain huge. The labour force survey reports:

- The total number of working days lost has fallen over the past decade from an estimated 39.8 million in 2000-02 to 26.4 million
- In 2010/11, 22.1 million days were lost due to work-related illness and 4.4 million due to workplace injuries.
- On average, each person suffering took around 15 days off work, 19 days for ill health and 7.2 days for injuries on average.
- Stress, depression or anxiety and musculoskeletal disorders accounted for the majority of days lost due to work-related ill health, 10.8 and 7.6 million days respectively.
- The average days lost per case for stress, depression or anxiety (27 days) was higher than for musculoskeletal disorders (15 days).

In addition, 171 workers were killed at work, a rate of 0.6 fatalities per 100 000 workers and 115 379 other injuries to employees were reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, a rate of 462.1 per 100 000 employees.

Councils can both lead by example and ensure through their contacts with organisations that they raise awareness of this. Workforce health may contribute significantly to bottom line costs in the workforce.

There may be opportunities for councils to promote this and pathways to assistance and better practice through the LEPS or through working with NHS services. There is a huge negative campaign against regulation yet many businesses appreciate the sensible advice that independent local authority officers can provide. The HSE has scaled back its inspection regime and the better regulation agenda is reducing burdens on business e.g. RIDORR drops to a 7 day incapacitation trigger. Overall deregulation is likely to result in an increase in injury, incident and illness rates.

A different approach to workplace hazards is required as councils will no longer have the resource to inspect their way to better compliance in the local business sector. A risk based approach is well established but increased use of social norm type marketing backed by focussed, collaborative preventative interventions that result in sustained behaviour change are required. The Lord Young and Lofstedt report encourages a more simple, targeted approach to managing/enforcing risk, including a new national code for workplace enforcement that will direct LA interventions and programmes.

Sustainable economic growth

Living within our environmental limits and towards a policy of **One Planet Living** underpins the principles of sustainable economic growth. As a consequence of unsustainable growth, climate change presents unprecedented and potentially catastrophic risks to global and local health and well-being.

Although considerable uncertainty surrounds future climate change risks, there is sufficient evidence to begin recognising the likely impacts and preparing for mitigating them. In response, the Government's Department of Environment, Food and Rural Affairs (DEFRA) has prepared a comprehensive climate change risk assessment (CCRA) as an evidence base for the forthcoming National Adaptation Plan. The CCRA has produced preliminary findings indicating that the greatest need for action within the next five years may be in the following areas:

- Overheating of buildings and other infrastructure in the urban environment.
- Risks to health (e.g. from heatwaves and flooding) and impacts on NHS, public health and social care services.
- Flood and coastal erosion risk management.
- Specific aspects of natural ecosystems (e.g. managing soils, water and biodiversity).
- Management of water resources, particularly in areas with increasing water scarcity.
- Economic opportunities, especially to develop adaptation products and services.

Core Cities Group works actively on these issues through its Climate Change Working Group. Because of their economic role, large populations and urban density, Core Cities have the potential to contribute to tackling climate change mitigation and adaption in a nationally and internationally significant way.

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Core Cities are already vulnerable to extreme weather events, in floods, droughts, chemical and sewage pollution, heatwaves and very cold weather. Locally and nationally air quality has generally been improving. However, in the most polluted areas, near motorways and within busy urban centres, it has not improved (or has even worsened). All of the Core Cities are challenged with meeting the National and European thresholds for air quality and as climate change intensifies it is anticipated that increases in ozone concentrations will result in an additional 1,500 deaths per year across the UK. It is estimated there will be an increase in respiratory problems from the damaging effects of surface ozone during the summer as well as an increase in skin cancers and cataracts.

Measures to improve health have a direct relevance for sustainability. Many improvements that cities want and are making will impact jointly on health and climate change, e.g. maintaining and restoring greenspaces and building community capacity. Less sustainable communities also tend to be less healthy. There is substantial evidence of a social gradient in the quality of neighbourhoods. Poorer people are more likely to live in more deprived neighbourhoods. The more deprived the neighbourhood, the more likely it is to have social and environmental characteristics presenting risks to health. These include poor housing, higher rates of crime, poorer air quality, a lack of green spaces and places for children to play and more risks to safety from traffic. Poorer communities tend to experience higher concentrations of pollution and have a higher prevalence of cardio-respiratory and other diseases. Sixty-six per cent of carcinogenic chemicals emitted into the air are released in the 10 per cent most deprived wards. Creating a physical environment in which people can live healthier lives with a greater sense of well-being is a hugely significant factor in reducing health inequalities.

Living close to areas of green space – parks, woodland and other open spaces – can improve health, regardless of social class.

All this means our economic policies need to take account of the kind of businesses and industries we seek to grow and attract, we need businesses which are green in nature – i.e. do not deplete natural resources and processes and products ,protect and promote the health of the workforce and surrounding areas .

Future work of the Health and Wellbeing Group

The Group is working with Treasurers to understand the financial impacts of the transfer of Public Health functions to Core Cities authorities, in preparation for further defining a forward work programme between all 8 cities, involving Health and Well Being Boards.

Direct and positive engagement exists between the group and the Department of Health and Public Health England.

Further work to develop the evidence base for health and wellbeing in relation to economic growth and productivity is planned.

This will build partly on an existing evidence base developed between the Primary Care Trusts of the Core Cities through their two-year Health Improvement Collaborative programme.

In addition, new evidence which can contribute significantly to future practice is already emerging, e.g. through the Community Budget Pilots.

Work to develop closer links with research resources and opportunities presented within the Health Sector, to make economic prosperity a 'factor' in this research going forward. For example the National Institute of Health Research (NIHR) already operates CLaRHC (Collaborative Leadership and Research in Health and Care) but it is primarily a partnership between the Primary Care Trusts and Universities. With Public Health in the Local Authorities the Core Cities could play a key role in influencing this agenda to develop the evidence base

Following the above and with agreement of cities, representation will be made to Government regarding shared priorities between the cities on this agenda.