Putting Health in the Policy Picture

Review of how Health Impact Assessment is carried out by government departments

Executive Summary

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29 January 2010

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Foreword

As part of the Department of Health White Paper *Choosing Health: Making healthy choices easier*, we built health into government policy making by launching health assessment as part of regulatory Impact Assessment. Now, the new government Impact Assessment process has become a very important tool for checking that we develop policies taking into account all possibilities, including health and wellbeing.

This research is our first attempt to systematically consider how Health Impact Assessment is being used within Impact Assessment, and whether it can affect policy making at national level.

It shows that other government departments are taking health into account, and in some instances providing excellent examples of analysis, but that there is still more we need to do. We fully appreciate and value the work that other government departments can do to shape our society so that it promotes healthy living and prevents health inequalities. We will therefore take this opportunity for engaging with colleagues across government to see how best we can implement the recommendations.

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Putting Health in the Policy Picture is a summary of an in-depth study of how Health Impact Assessments are carried out across government departments.

The study was carried out by the Centre for Health Impact Assessment at the Institute of Occupational Medicine, an independent centre of scientific excellence in the field of health impact assessment and public health. It was commissioned as part of the Informing Healthier Choices programme.

Informing Healthier Choices is a Department of Health programme to make public health intelligence more accessible, useful and timely, and to give people the tools, skills and knowledge to use it, thereby ensuring that everyone with a responsibility for planning and commissioning services for healthy individuals and populations can do so on the basis of the best available knowledge.

The programme works to achieve these aims through a high-level partnership from across public health and beyond.

1. Introduction

1.1 Reason for the research

1.1.1 The consideration of health and wellbeing in the Government's impact assessment process is mandatory. As part of the White Paper *Choosing Health* (2004), the Government gave a commitment to building health into all future legislation by including health as a component in regulatory impact assessment (RIA).[1] In 2007, the Cabinet Office and the Business, Enterprise and Regulatory Reform Department (BERR) revised RIA to the current Impact Assessment (IA) process where Health Impact Assessment (HIA) is now a Specific Impact Test (SIT) which is owned by the Department of Health (DH). This means that improving population health and wellbeing is built into all national policy.

1.1.2 There is no current mechanism for establishing how health is being taken into account in policy making, whether HIA is being used, or how HIA is applied in other government departments (GDs). DH is aware of some good examples but needs to have a better level of understanding of how GDs are carrying out HIA to know whether the commitment in *Choosing Health* is being delivered.

1.1.3 The National Audit Office report *Delivering High Quality Impact Assessments* has also highlighted the value of internal and external scrutiny in helping to improve and maintain the quality of government IAs.[2]

1.1.4 Business Innovation and Skills (BIS) is the lead department on the cross-government IA process and provides general IA guidance and templates.[3] [4] General IA guidance is also provided in HM Treasury's *Green Book: Appraisal and Evaluation in Central Government.*[5]

1.1.5 This research is intended to inform future development work on HIA for both DH and other GDs, and identify the tools, support and help required by very diverse policy makers and analysts, with varying levels of expertise and understanding of health and wellbeing issues, so that they can carry out HIA effectively.

1 HM Government and Department of Health (2004). *Choosing Health: Making healthy choices easier.* Chapter 8 Making it happen – national and local delivery. Regulation 4: 'The Government will build health into all future legislation by including health as a component in regulatory impact assessment.' Page 175. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

2 National Audit Office (2009). *Delivering High Quality Impact Assessments.* Part 3 Scrutiny of Impact Assessments. www.nao.org.uk/publications/0809/high_quality_impact_assessment.aspx

3 BERR has merged with the Department for Innovation, Universities and Skills (DIUS) and is now part of the Department for Business, Innovation and Skills (BIS).

4 BERR/BIS website. Preparing Impact Assessments. Accessed 29 January 2010. www.berr.gov.uk/whatwedo/bre/policy/scrutinising-new-regulations/preparing-impact-assessments/page44077.html

5 HM Treasury. *The Green Book: Appraisal and evaluation in Central Government.* Accessed 29 January 2010. www.hm-treasury.gov.uk/data_greenbook_index.htm

1.1.6 Analysis of recent IAs shows how HIA can result in actual improvements in health and wellbeing and how it can help to tackle health inequalities.

1.1.7 The recommendations include improving processes of engagement between DH and other GDs; support for policy leads and analysts through information and advice; better baseline data and tools; and increased opportunities for training in the use of HIA.

1.1.8 Note: throughout this report the term 'health' is synonymous with 'health and wellbeing'.

2. Context and Purpose of the Research

2.1 The wider policy context

2.1.1 Two key government reviews add to the importance of HIA for GDs.

2.1.2 The first is the Strategic Review of Health Inequalities in England post-2010, chaired by Sir Michael Marmot, to identify the health inequalities challenge facing England, the evidence base most relevant to underpinning future policy and advise on possible objectives and measures. The report of the Marmot Review, *Fair Society, Healthy Lives*, was published in February 2010.[6]

2.1.3 The second is *Health is Global: a UK Government Strategy 2008–13*.[7] This Strategy states that if the UK is to protect the health of its population, harness the benefits of globalisation and make the most of its contribution to health and development across the world, it needs to have a clear, coherent and co-ordinated approach to the many issues that influence global health and contains the commitment:

> *"We will use impact assessments to take greater account of the global health impact and equity of our foreign and domestic policies across government, as part of the new government impact assessment process."*

2.2 What is Health Impact Assessment?

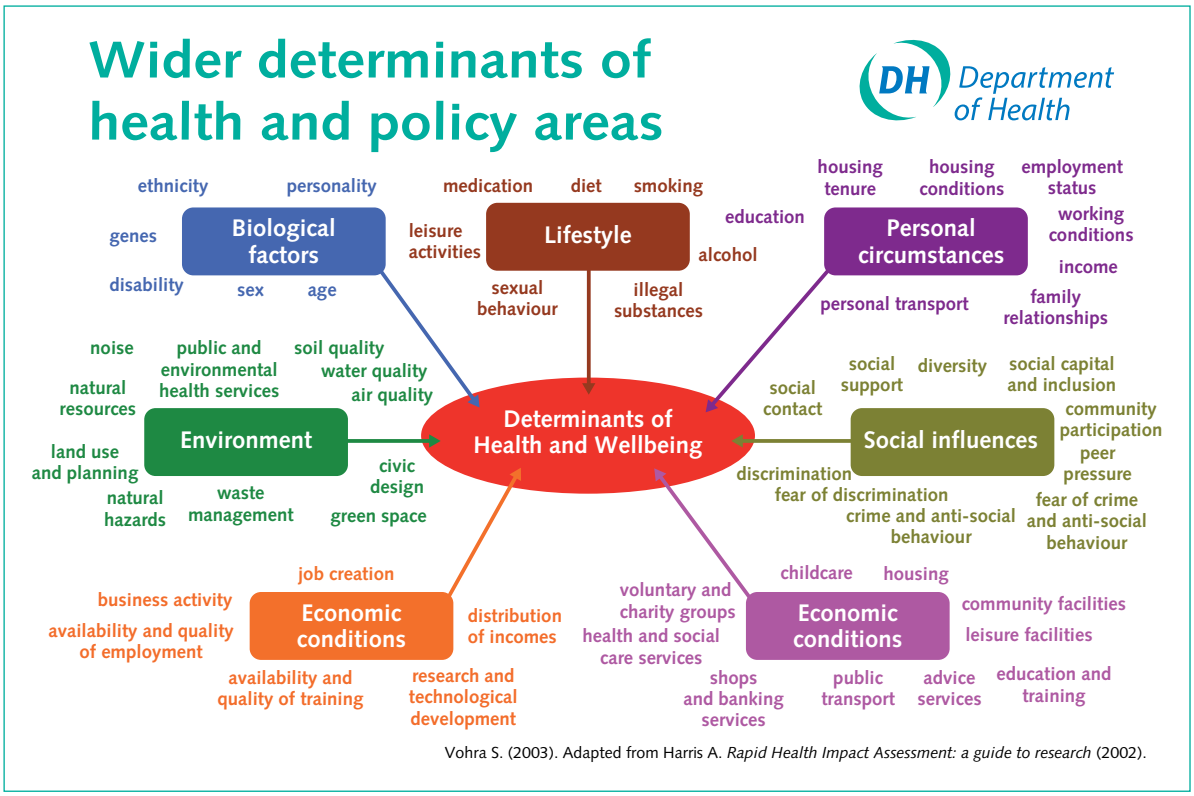
2.2.1 HIA is the systematic prediction of the potential positive and negative health and wellbeing impacts of new policies, plans, programmes and projects (proposals), including how these impacts are distributed across a population.[8] Research shows that proposals not directly related to health can have direct effects on the physical and mental health and wellbeing of populations, as well as indirect effects through the wider social determinants of health (See Figure 1).

6 http://www.ucl.ac.uk/gheg/marmotreview

7 HM Government (2008). *Health is Global: a UK Government Strategy 2008–13*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702

8 Health Development Agency (2002). *Introducing Health Impact Assessment (HIA): Informing the decision-making process*. Department of Health. www.nice.org.uk/niceMedia/documents/hia.pdf

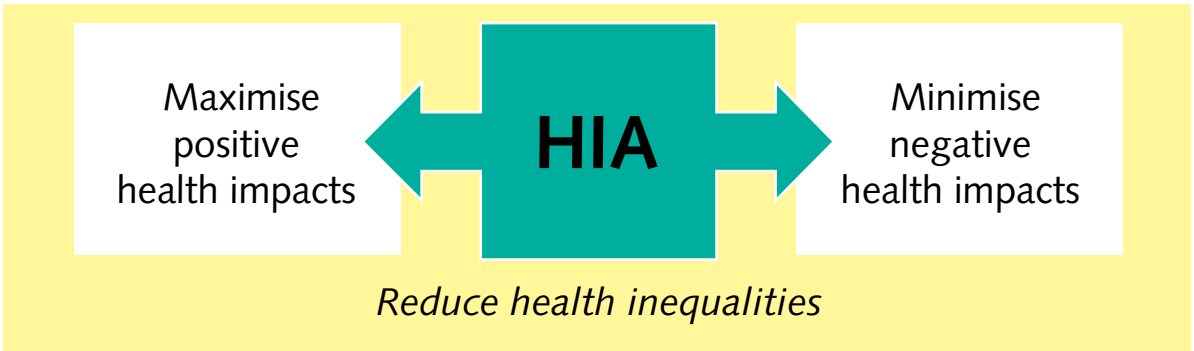
Figure 1: The wider social determinants of health and wellbeing



Vohra S. (2003). Adapted from Harris A. *Rapid Health Impact Assessment: a guide to research* (2002).

2.2.2 HIA should therefore offer recommendations for measures to maximise positive health impacts, minimise negative health impacts and reduce health inequalities. All three of these are a priority for DH in conjunction with other GDs (See Figure 2).

Figure 2: What Health Impact Assessment aims to do



2.3 Study aims

2.3.1 The aims of this study were to:

- assess whether GDs, including DH, are using the HIA screening questions appropriately and carrying out a full HIA if the screening identified the need for it;
- assess whether the HIAs currently undertaken within IAs cover the full range of impacts and address health inequalities; and
- Assess whether the use of HIA influences policy.

2.3.2 The methodology for the research is set out in Appendix 1.

2.4 Existing HIA

2.4.1 The specific HIA guidance, provided by DH, sets out three screening questions for GDs to answer when considering whether a full HIA is needed. These questions are:

1. Will your policy have a significant impact on human health by virtue of its effects on the following wider determinants of health?
   Income, Crime, Environment, Transport, Housing, Education, Employment, Agriculture, Social Cohesion.
   Consider the potential to have a health impact.

2. Will there be a significant impact on any of the following lifestyle related variables?
   Physical activity, Diet, Smoking, drugs, or alcohol use, Sexual behaviour, Accidents and stress at home or work.
   Consider risk factors that influence the probability of an individual becoming more or less healthy.

3. Is there likely to be a significant demand on any of the following health and social care services?
   Primary care, Community services, Hospital care, Need for medicines, Accident or emergency attendances, Social services, Health protection and preparedness response.
   Consider the likely contacts with health and social service provision.

2.4.2 If the answer is 'Yes' to two or more of these questions then there is a requirement to do a HIA, which includes answering three additional questions covering the disproportionate impacts on specific groups (health inequalities), impacts on health and social care and community concerns about health impacts of policy change.

3. Key Findings

3.1 Number of Impact Assessments reviewed

3.1.1 310 IAs met the criteria for inclusion in this study. Appendix 1, Table 1 shows the number of IAs included in this research project by GD. Where a Bill or policy contained a number of proposals with an associated IA, each of these IAs has been reviewed individually.

3.2 Use of screening questions

3.2.1 Only 17 IAs (5% of the 310 reviewed) explicitly answered the three DH HIA screening questions; these all concluded that an HIA was not required and in almost every case the HIA review team agreed with this judgement. However, there appeared to be an assumption within IAs that only potential negative effects or important positive benefits would trigger an HIA.

3.3 Coverage of health and wellbeing

3.3.1 Over half of the IAs (159) made some mention of health and there were some good examples of coverage of specific aspects of HIA. However, overall the quality of coverage of health impacts was very variable, ranging from six IAs, outside of DH, where in-depth/full HIAs had been carried out that demonstrated a good consideration of the wider social determinants, and included the quantification and monetisation of health impacts, to 60 IAs that made a simple statement that there were no, or no detrimental, health impacts.

3.4 No statement of health impacts

3.4.1 IAs with no explicit statement on health impacts of any kind were twice as likely to assume that health impacts did not need to be considered when, from the review team's judgement, they should have been.

3.5 Basic coverage of health

3.5.1 Where health impacts were considered in a basic or fairly systematic way, the majority of IAs provided a reasoned and logical analysis of the potential negative and/or positive health impacts that they identified. The box overleaf shows a good example of this.

Effective consideration of health and wellbeing impacts

The Home Office carried out an IA as part of its consideration of moving to a mandatory code of practice for the alcohol industry.

The aim of the policy was to decide whether moving from a voluntary to a mandatory code would encourage the more responsible sale of alcohol. Specific research had been commissioned which showed that the voluntary code was not being adhered to and the policy makers anticipated that mandatory standards would increase compliance and bring a range of benefits, including health benefits.

Throughout the IA, there is a careful and detailed assessment not only of health impacts, but also of the wider determinants of health and wellbeing.

The IA states: *"Whilst health is not an objective of licensing, this option will lead to significant collateral health benefits, both in the short and long run if a reduction in overall consumption is observed... it is estimated that alcohol costs the NHS £2.7bn per year. Therefore, we anticipate significant cost savings to the NHS with particular benefits to young people and binge drinkers, who are both at a high risk of developing alcohol related health problems."*

3.6 Awareness of health impacts

3.6.1 There was a strong overlap, though not complete agreement, between the IAs that, according to the review team, needed a more detailed systematic consideration of health impacts (rapid or in-depth HIA) and those where a basic or fairly systematic consideration of health impacts had been undertaken. This shows that policy teams were reasonably good at recognising which policies were likely to affect health, although they were not always able to fully assess the implications of this.

3.7 Quality of health assessments

3.7.1 The review team developed a methodology for assessing the coverage of health which had 10 dimensions. They judged that 25 IAs (8% of the total and 16% of the 159 IAs that made a mention of health and wellbeing impacts) provided a good analysis of health impacts, even though they did not meet all the 10 dimensions of good practice developed by the review team. Only a very few IAs, outside of DH, fully met all the 10 dimensions of good HIA practice.

3.8 Health inequalities

3.8.1 Health inequality or equity impacts were discussed; however, the level and depth of coverage were not systematic or in-depth across most GDs. In a few cases, some of the distributional impacts were considered in the equality Impact Assessment (although socioeconomic inequalities were rarely addressed in them).

3.9 Health Impact Assessment influence on policy

3.9.1 Six dimensions for categorising the impact of HIA on policy were developed by the review team. This enabled them to judge that 118 (38%) of the 310 IAs reviewed would have benefited from a more systematic consideration of the health impacts (rapid or in-depth/full HIA), and in most of these (31%) the HIA would have supported the option and provided a more complete and better informed cost-benefit analysis.

3.10 Meetings with other government departments

3.10.1 Five departments attended meetings with the review team. These confirmed that analysis of health-related issues, where it occurred, was generally integrated into the IA within the overall policy development process. Such consideration was rarely thought of as 'health impact assessment', and health issues were more often seen as 'social', 'welfare' or 'amenity' issues. So while a range of health issues were on the policy agenda, policy leads and analysts were often not using the available DH guidance to identify and analyse them.

3.10.2 Where policy leads or analysts have a low awareness of the health implications of a proposal, the Health SIT within the IA is unlikely be undertaken.

3.10.3 Having strong internal structures and an embedded departmental objective on health was seen to have a significant influence on how well and in what way health was considered.

3.10.4 Overall, it was recognised that the consideration of health impacts does add value to policy making, particularly where it acts as a policy driver, e.g. air quality concerns or drug harm, and where health costs and benefits strengthen the argument for a non-health policy intervention. Such as education (see Appendix 2).

3.11 Quantification of costs and benefits

3.11.1 As part of the study the review team analysed three policies and quantified the health costs and benefits. These have been written up as case studies for use in training. An example is provided in Appendix 2. In carrying these out, the review team identified two gaps in public health evidence and data:

- There is a weak and variable evidence base for policy areas covering the wider determinants of health, and where there was evidence, it is not geared towards quantification of health impacts and monetisation of costs and benefits.
- There is a lack of baseline data on the underlying health status and burden of disease of the population and its implications for other GDs' policies. This makes it difficult to quantify and monetise health inequalities.

4. Conclusions

4.1 Summary

4.1.1 Overall, the level of consideration of health impacts in government IAs is encouraging, given that it has been just 18 months since the new IA process came fully into operation.

4.2 Strengths in existing practice

4.2.1 While systematic HIA is seldom done as part of the IA process, some basic level of considering the possible health impacts is relatively widespread.

4.3 Weaknesses in existing practice

4.3.1 The use of the DH's three HIA screening questions is not widespread. Where the screening questions are answered, and explained with evidence, it generally helped the IA teams to consider the potential health impacts, and the need for doing an HIA, more appropriately.

4.3.2 When health impacts are considered there is a tendency to:

- focus on negative health impacts at the expense of positive health impacts;
- focus on a small number of the determinants of health;
- not consider health inequalities; and
- not use public health evidence to back up statements.

4.3.3 HIA is not widely seen as equally important for considering positive health impacts, i.e. that it can highlight those policy options which maximise positive health impacts for the whole of a target population, such as community safety.

4.3.4 Quantification of health impacts, and their subsequent monetisation as costs and benefits, is not explicitly considered in the majority of IAs. Where quantification is done, it is generally:

- of negative health and wellbeing impacts; and
- on impacts where there are established and agreed methods for quantifying and monetising the impacts, e.g. quality-adjusted life years, cost of victim harm, cost of substance misuse, air pollution mortality and morbidity costs, and value of a life saved/fatality prevented.

4.4 Support for carrying out Health Impact Assessments

4.4.1 From the meetings conducted with GDs, the following points were ascertained:

- There is a widespread lack of awareness and use of the online guidance already offered by DH.
- There is a need for DH to be more proactive in supporting GDs to undertake HIAs. This ranged from the suggestion that DH actually carry out the HIA on the GD's behalf, to a desire for DH to provide more HIA tools, support and evidence as well as access to DH health impact experts. It was also suggested that short and focused training and induction sessions might be offered by DH to GDs to help improve the consideration of health impacts across government.

4.5 Challenges to quantifying and monetising health impacts

4.5.1 The development of the three quantification case studies identified a number of challenges to quantifying health impacts and assigning monetised costs and benefits to them. These are:

- How to decide what health impacts should be considered when there is wide-ranging, contradictory, conflicting, uncertain or weak public health evidence on the positive and negative health impacts of a policy?
- How to decide which method for quantifying health impacts should be used when the public health literature identifies more than one method and each method generates significantly differing estimates?
- How to find baseline population and sub-group information to estimate the size of the population or sub-group that is affected by a particular health impact?
- How to decide on which monetisation approach to use when the economics literature has identified more than one approach to monetising the quantified health impacts?

4.6 Value of doing Health Impact Assessments

4.6.1 The added value of HIA, and quantifying and monetising the possible health impacts, is as follows:

- It provides a more complete analysis of costs and benefits – public health gains and costs. This leads to a better choice of policy options, the implementation of a better policy intervention overall and the full benefits of a policy being realised.
- It identifies the best target population for a policy intervention by identifying who is, or is not, likely to benefit from a health perspective.

- It identifies policy and implementation measures that can help minimise any negative health impacts, maximise positive health impacts and reduce health inequalities.
- It identifies important health indicators of policy success that should be incorporated into evaluations of policy.

5. Recommendations

The following recommendations are for consideration by DH.

PROCESSES

5.1 Recommendation 1:

All GDs should explicitly answer the DH HIA screening questions in all IAs that they undertake.

5.1.1 This should include:

- reviewing the questions early on in the policy-making process and at key points throughout the policy development cycle, particularly when an HIA is judged not to be needed; and
- when an HIA is judged not to be needed, providing a written explanation within the IA for how this judgement was reached.

5.2 Recommendation 2:

Advocate more widely in GDs to move HIA up the policy-making agenda.

5.2.1 DH should plan to:

- provide greater input into the departmental Better Regulation Units (or equivalent) which have a key role in most departments on how IAs advise on specific Impact Assessments;
- inform chief economists who sign off the evidence base for IAs about the coverage of health impacts in their IAs;
- brief directors-general who 'sponsor' key departments and are crucial leaders and opinion-formers on the benefits of covering health in their policy formulations; and
- feed into the chief analysts network and support them to improve HIA practice within GDs.

5.3 Recommendation 3:

Develop stronger links between DH and other GDs in specific cross-cutting public and environmental health policy areas.

5.3.1 There are established strong links between DH and other GDs in particular policy areas, e.g. interdepartmental working groups on air quality, noise and alcohol. Further linkages in other policy areas of public health relevance, e.g. energy, culture, education and work, are likely to strengthen the routine consideration and analysis of health impacts in those areas. It is recommended that DH take the lead in identifying areas of common interest through, for example, the strategic partnership agreements, and actively engage with key policy makers and analysts within other GDs working in those areas.

5.4 Recommendation 4:

Undertake regular reviews of performance across GDs.

5.4.1 To help DH continuously improve its support for the HIA process across government, there needs to be a regular review process that revisits the findings of this study and evaluates progress. The findings of this study should be communicated to, and discussed with, each GD in order to provide a baseline for improving HIA practice across government.

5.5 Recommendation 5

Develop a DH communication strategy for HIA.

5.5.1 There is a low level of awareness of existing guidance, tools and support provided by DH on HIA, and this needs to be addressed with a programme of targeted communication to key audiences across GDs. The examples of good practice identified by this study should be developed into a 'hints and tips' web page and booklet, and communicated across GDs.

SUPPORT SYSTEMS

5.6 Recommendation 6:

Enable access to health experts by IA staff in other GDs.

5.6.1 Policy makers and analysts indicated that they wanted to know who to call for advice and information. This could be achieved by maintaining and distributing an up-to-date list of DH experts, and other sources of public health intelligence, such as Regional Directors of Public Health and key contacts in the Public Health Observatories.

5.7 Recommendation 7:

Provide up-to-date policy-relevant evidence.

5.7.1 The provision of an online public health impact evidence base for national policies and plans could improve the use of evidence in HIAs. Causal pathway diagrams may be useful in helping GDs with a low awareness or low prioritisation of health to visualise and make the connection between health and their policy areas. The further development of the HIA Gateway website, managed by West Midlands Public Health Observatory, could include the provision of policy-relevant updates and newsletters.[9]

5.8 Recommendation 8:

Clarify BIS IA guidance on first round effects.[10]

5.8.1 There seems to be some ambiguity and uncertainty with incorporating significant wider impacts while focusing the IA on first-round effects only. It is recommended that BIS and DH have a discussion on how the current guidance can be amended so that the focus on direct effects does not limit the consideration of health impacts at national and global levels.

5.9 Recommendation 9:

Review DH HIA guidance and support.

5.9.1 The current DH online guidance should be reviewed and updated so that it is more relevant to GDs. It should also provide guidance on how to:

- identify the important health impacts and the differential impacts on different sub-groups within a population when the public health evidence is conflicting, uncertain or weak;
- choose a method of quantifying health impacts when there is more than one method identified in the public health or economics literature;
- decide which approach to use in monetising the quantified health impacts when more than one approach is identified in the literature; and
- avoid double-counting health, social, welfare and amenity costs and benefits.

9 www.hiagateway.org.uk

10 This term is used in BERR's Impact Assessment Guidance (Page 6, Point 29). Description and scale of key monetised costs and benefits accrued by the main groups affected by the proposal or other impacts (such as particular environmental impacts) should be clearly stated. Generally, these should usually only cover the first round effects of the policy. However, further impacts may need to be considered in some circumstances – see examples in HM Treasury's Green Book guidance on appraisal and evaluation. Accessed 29 January 2010. www.berr.gov.uk/whatwedo/bre/policy/scrutinising-new-regulations/preparing-impact-assessments/page44077.html

BASELINE DATA and TOOLS

5.10 Recommendation 10:

DH to work with GDs to identify gaps in existing population and sub-group level datasets that are needed to accurately estimate the size of the population affected by the health impact of a policy, and to provide baseline data on the burden of disease and health status of the population and policy-relevant sub-groups.

5.10.1 This includes census data as well as baseline data on the number of vulnerable people as identified by the policy under consideration; existing health/disease prevalence data; healthcare treatment numbers and costs; and determinants of health data that is linked to population and sub-group demography data.

5.11 Recommendation 11:

DH to develop GD-specific health impact quantification and cost-benefit tools.

5.11.1 In collaboration with relevant GDs, DH aims to develop specific recommended approaches and tools for the economic valuation of public health impacts in key policy areas. In this way DH can provide added value to GDs and improve the systematic consideration and quantification of health impacts. This will need ongoing review as new approaches and evidence emerge on better ways of quantifying and monetising health impacts.

SKILLS

5.12 Recommendation 12:

Develop an HIA training and induction strategy.

5.12.1 GDs expressed an interest in training, and the suggestion was made for short training courses, perhaps over a lunchtime, that are part of a continuing professional development programme, and which will raise awareness and improve the HIA skills of policy makers and analysts. DH might also consider the regular provision of induction training for new policy makers and analysts.

Appendix 1: Study Methodology

A1.1 Methods used

A1.1.1 A total of 310 Impact Assessment (IA) reports across 15 government departments (GDs), produced between November 2007 and March 2009, were reviewed in terms of their consideration of health impacts (See Table 1). The IAs were gathered from GD and Business Innovation and Skills (BIS) websites. They were reviewed using a set of 10 quality/developmental criteria for Health Impact Assessment (HIA) best practice. These were developed from existing international good practice guidance and the requirements of the IA approach in government.

Table 1: The number of Impact Assessments identified and included in this research project by government department

Government department	IAs included in current review
Business, Enterprise and Regulatory Reform	31
Cabinet Office	0
Children, Schools and Families	0
Communities and Local Government	70
Culture, Media and Sports	13
Defence	2
Energy and Climate Change	8
Environment, Food and Rural Affairs	21
Foreign and Commonwealth Office	2
Government Equity Office	2
Health	39
Home Office	23
Innovation, Universities and Skills	3
International Development	0
Justice	50
Transport	6
Treasury	33
Work and Pensions	7
Total	**310**

A1.1.2 Meetings were held with five GDs that could meet with us within the timescale of the research project. The meetings were conducted using a structured topic and question sheet to ensure that key topics were discussed.

A1.1.3 Three illustrative case studies on the quantification and monetisation of health impacts were developed in three policy areas to identify the value and challenges of conducting policy HIAs.

A1.2 Limitations

A1.2.1 This study provides a good and representative assessment of how HIAs were carried out between November 2007 and March 2009 in the majority of GDs. However, it did not review the IAs undertaken by government agencies.

A1.2.2 For some GDs few or no IAs were retrieved. This may have been either because they were not published online at the time of the study, or because a Regulatory Impact Assessment (RIA) was undertaken before November 2007 when the new IA process was fully operational, and changes to the policy are therefore being assessed through the original RIA.

A1.2.3 The HIA review team relied solely on the information in the IA report to assess whether and what health determinants were likely to be impacted by the policy under consideration.

A1.2.4 For approximately 20 of the 310 IAs reviewed, the two experienced HIA practitioners disagreed on the need for an HIA. A consensus was reached following a discussion. This suggests that for a small number of IAs there is likely to be some difficulty in judging whether an HIA is needed or not. Where this occurs the issue is best resolved through discussions with the wider policy team and internal/external colleagues with experience of HIA.

Appendix 2: Quantified Case Study

Quantifying the Health Impacts of education policies

Illustrative cost-benefit analysis of the Health Impacts of an apprenticeship scheme policy

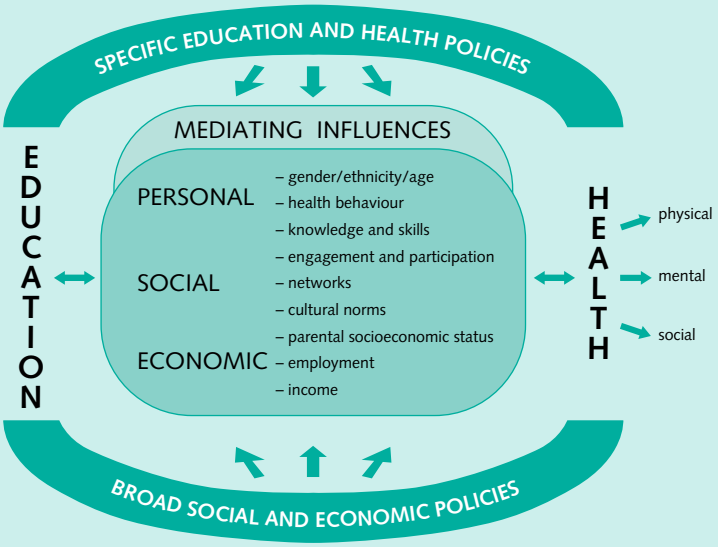
Health Impacts of education

Education can have an impact on health in a two important ways.[11] [12]

Firstly, it improves the life chances and opportunities of people in terms of access to employment, uptake of health promotion and disease prevention information, and being able to articulate need and hence access services more effectively. Figure 1 shows the causal pathways by which health and wellbeing are affected by education.

Secondly, education can also enhance wellbeing by improving people's feeling of self-worth and by reducing poverty as a result of increased skills levels and employability. Parental education can improve the health, wellbeing and life chances of children. Education affects all age groups but its greatest effects are on children and young people. It is currently unclear what the differential effects of different types of schooling/education activities are.

Figure 1: Causal pathway by which education influences health and wellbeing[13]



11 Feinstein L, Budge D, Vorhaus J and Duckworth K (compiled and edited) (2008). *The social and personal benefits of learning: A summary of key findings*. Centre for Research on the Wider Benefits of Learning, Institute of Education. www.learningbenefits.net/Publications/FlagshipPublications.htm

12 Organisation for Economic Co-operation and Development/Centre for Educational Research and Innovation. (2006). *Measuring the effects of education on health and civic engagement: Proceedings of the Copenhagen Symposium*. www.oecd.org/dataoecd/23/61/37437718.pdf

13 Higgins C, Lavin T and Metcalfe O (2008). *Health Impacts of Education: A review*. Institute of Public Health in Ireland. www.publichealth.ie/publications/healthimpactsofeducationareview

However, education can also potentially have two negative health and wellbeing impacts through:

- raising aspirations and expectations which a person is unable to fulfil or achieve; and
- disappointment, the loss of self-esteem, and shattering of hopes and dreams when a person fails to complete a course or achieve a desired goal, e.g. to go to university or to a specific university, or get a job.

Health and wellbeing costs and benefits identified and monetised

Given the range of outcomes, some of which overlap and some, which are determinants of health, e.g. dietary habits, the best health measure identified in the literature is the quality-adjusted life year (QALY) gained for each year in education. Other health outcomes that have been quantified which are likely to feed into a QALY estimate include likelihood of depression and reduction in general morbidity (e.g. through increased uptake of health promotion messages, better income, more fulfilling employment).

Any assessment needs to consider the positive health and wellbeing impacts from the successful completion of a course of education, as well as the potential negative health and wellbeing impacts if a person fails a course or drops out without completing it. Then not only does the person receive zero positive health and wellbeing impacts, but their level of wellbeing may fall if they regard themselves as a failure.

Assuming the target for the policy is to increase the number of young people in apprenticeship schemes by 250,000:

- *for a 20% drop-out rate*, the estimate of benefits ranges from £756 million to £1.28 billion.
- *for a 40% drop-out rate*, the estimate of benefits ranges from £432 million to £732 million.
- *for a 60% drop-out rate*, the estimate of benefits ranges from £108 million to £183 million.

Value of quantifying and monetising health and wellbeing impacts for energy efficiency policies

The health (and wellbeing) impacts of an Apprenticeship scheme are positive even for high drop-out/failure rates (up to 66%). This is particularly so given the targeting of Apprenticeship schemes towards those with existing low educational attainment at school.

Conclusion

Apprenticeship schemes provide significant health and wellbeing benefits overall. Given the existing inequalities between certain groups in gaining access to quality training, the scheme should have a particular focus on women, those from black and minority ethnic backgrounds and those with disabilities. From a health and wellbeing perspective these groups also tend to have lower levels of existing good health and wellbeing.[14] Given the significant loss of health and wellbeing benefits, the scheme should focus on reducing the drop out/failure rate.

14 Department of Health (2003). *Tackling Health Inequalities: A programme for action.* Department of Health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_400826

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