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National Assembly for Wales / Cynulliad Cenedlaethol Cymru Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from BMA Cymru Wales – PHB 76 / Tystiolaeth gan BMA Cymru Wales – PHB 76

PUBLIC HEALTH (WALES) BILL – GENERAL PRINCIPLES

Consultation by the National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

4 September 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the National Assembly for Wales' Health and Social Care Committee on the general principles of the Public Health (Wales) Bill.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

When the Welsh Government published the Public Health White Paper in 2014, BMA Cymru Wales expressed extreme concern that the proposals contained within it represented a significant step backwards from the more innovative high-level proposals that had been contained within the preceding Public Health Green Paper published in 2012.

We have therefore been further disappointed that the now-published Public Health (Wales) Bill currently contains a narrower set of proposals than even the White Paper.

Whilst we are nonetheless broadly supportive of many of the proposals that have been brought forward within the Bill as published, we do feel that it represents a missed opportunity to provide more ground-breaking legislation that could have made Wales an international exemplar in the field of public health.

Health Impact Assessment (HIA)

We are particularly disappointed by the absence of proposals within the Bill to place Health Impact Assessment (HIA) on a statutory footing.

As far back as 1999 the then Welsh Assembly Government committed to taking forward HIA, and set out its approach in a document entitled *'Developing Health Impact Assessments in Wales'*.

In the present Assembly term, the idea of introducing HIA in Wales on a statutory basis was also consulted upon by the Welsh Government in the Public Health Green Paper published in 2012. The subsequently published summary of responses to that Green Paper stated that *"there was a high level of support for the concept of using Health Impact Assessment as a method for ensuring health issues are considered as part of policy making."* It also stated that a clear majority of those who responded indicated that Welsh Ministers, Welsh Government departments and local authorities should be required to use HIA.

We also note that the Minister for Health and Social Services, Mark Drakeford, expressed support last year for undertaking HIA in relation to local authority planning and licensing applications. During a plenary debate on an update statement on the Public Health White Paper on 7 October 2014, he said: *"I would be very keen—I always have been—to be able to make the public health impact one of the considerations that local authorities are able to take into account in making planning and licensing determinations."*

The Chief Medical Officer for Wales, Dr Ruth Hussey, has also expressed her support for HIA, telling the Health and Social Care Committee on 8 October 2014: *"…we should be using health impact assessments at the beginning of a process to ask how we can get the most health benefit from whatever proposals, policies or services we are developing, and to ask whether we can get added value."*

Given this recent consideration and expression of support, we were extremely surprised and disappointed to see that the idea of legislating to require HIA in specific circumstances was dropped in the Public Health White Paper and has not been reinstated in the Bill as published.

Appendix 1 to this submission outlines in more detail our case for placing HIA on a statutory footing in Wales through incorporation of such a proposal within the Bill. We suggest a requirement for the use of HIA be placed on the face of the Bill, with regulations subsequently being brought forward to specify in exactly which circumstances a mandatory HIA would be required. In the first instance we would suggest that these regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning applications, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

Minimum unit pricing for alcohol

In our responses to both the Public Health Green Paper and the Public Health White Paper, we expressed strong support for the proposal to introduce minimum unit pricing for alcohol in Wales. We are disappointed that, owing to the on-going legal challenge to a similar proposal in Scotland, it has not been possible to include this proposal in the current Bill. However, we recognise that the Welsh Government has recently published a draft Bill for consultation aimed at taking the initiative forward in future should the legal challenge in Scotland be appropriately resolved.

We are pleased that the Welsh Government therefore still intends, if possible, to introduce minimum unit pricing for alcohol at a later date, and we look forward to responding positively to the consultation on the Draft Public Health (Minimum Price for Alcohol) Bill in due course.

Obesity and nutritional standards

The Public Health White Paper sought views on introducing nutritional standards in certain public sector settings, as well as asking what other steps could be taken on these issues.

We are especially disappointed that those proposals have now been dropped and that there are no specific proposals within the Bill directed at tackling obesity. We believe this further weakens the impact that this Bill will have.

In our view, the proposals for introducing nutritional standards in both pre-school settings and care homes should be reinstated, as well as being extended to cover hospitals in Wales by way of an update to the implementation of the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2012).

Our members witness first-hand the effects of obesity on the health of their patients. We would therefore also like to see further measures brought forward aimed at assisting people in Wales to make healthier nutritional choices. While doctors have a key role in providing advice on dietary choices and physical activity patterns, we feel this needs to be supported by a comprehensive range of public health interventions to tackle the obesity epidemic. In our view, individual programmes alone are likely to have little effect and legislative measures are also required to help people make healthy choices as part of a comprehensive strategic approach.

We do, however, recognise that some of the legislative changes we would wish to see may be outside the competence of the Welsh Assembly. We have, for instance, repeatedly called for the introduction of a standardised, consistent approach to food labelling, calling for all pre-packaged products to have front of pack labelling based on a ‘traffic light’ colour coding system combined with information on guideline daily amounts (now known as reference intake). We have been disappointed that neither the EU nor the UK Government has backed mandatory ‘traffic light’ labels for food packaging.

We remain concerned that unhealthy food is positively marketed to a young audience and feel there should be a complete ban on the advertising and marketing of unhealthy foodstuffs. This should include product placement and inappropriate sponsorship programmes targeted at school children.

It should also be noted that a significant proportion of the UK population is consuming saturated fat, salt and added sugar at levels above recommended guidelines; and too little fruit, vegetables, oily fish, and fibre. More therefore needs to be done to promote healthy eating. One option that could be considered would be to subsidise the cost of fruit and vegetables.

Maternal obesity is associated with increased maternal and fetal risks in pregnancy, as well as increased intervention rates and an increased risk of major chronic disease for their offspring in adulthood. With rates of obesity in pregnancy rising across the UK, steps need to be taken to ensure that young people understand the importance of health and wellbeing before pregnancy – giving attention to their diet and optimal body weight before planning a pregnancy. This could include offering nutrition education and counselling, which have been shown to improve knowledge and behaviour. We also support the need to provide education and support aimed at promoting and prolonging the duration of breastfeeding.

We recognise that physical activity levels in Wales and the rest of the UK are very low and have been declining for the past 30 years, whilst sedentary activity is increasing. Promoting physical activity is therefore an important aspect to reducing levels of obesity in the UK. Initiatives such as the application of the Active Travel (Wales) Act 2013 can play a contributory role, alongside the promotion of other activities that involve physical exercise.

Other initiatives which could be taken forward would be to require all NHS premises to clearly display the healthcare risks involved with junk food and drinks, especially in catering areas and on vending machines; and for NHS premises to ban the sale of junk food and unhealthy drinks or offer subsidised healthier options.

Tobacco and nicotine products

BMA Cymru Wales is largely supportive of the proposals laid out in Part 2 of the Bill and would consider that on balance the available evidence favours their enactment. In particular, we support:

- creating a national register of retailers of tobacco and nicotine products;
- adding to the offences which contribute to a Restricted Premises Order (RPO);
- prohibiting the handing over of tobacco or nicotine products to people under the age of 18; and
- restricting the use of nicotine inhaling devices such as electronic cigarettes in enclosed and substantially enclosed public and work places, bringing the use of these devices in line with existing provisions on smoking.

E-cigarettes

While e-cigarettes have the potential to reduce tobacco-related harm, by helping smokers of convetional cigarettes to cut down and quit, we believe that a strong regulatory framework is required for their sale and use in order to:

- prohibit their use in workplaces and public places to limit second hand exposure to the vapour exhaled by the user, and to ensure their use does not undermine smoking prevention and cessation by reinforcing the normalcy of cigarette use;
- restrict their marketing, sale and promotion so that it is only targeted at smokers as a way of cutting down and quitting, and does not appeal to non-smokers, in particular children and young people; and
- ensure they are safe, quality assured and effective at helping smokers cut down or quit.

Emerging evidence suggests that e-cigarettes are predominantly used together with conventional cigarettes by current smokers, for the purposes of cutting down or quitting smoking or to circumvent smoke free legislation.[1] It is evident that the risks of using e-cigarettes with tobacco cigarettes (dual use) are likely to be much less beneficial than quitting smoking completely, or switching exclusively to e-cigarette use.

Current evidence suggests that e-cigarettes are primarily effective in helping smokers reduce the intensity of smoking (by cutting down), rather than the duration of smoking (by quitting). We support a regulatory framework that helps to ensure they are effective cessation aids.

Data from the 2011 International Tobacco Control Four Country Survey (Australia, Canada, UK, US) confirms that individuals report using e-cigarettes because they believe they are less harmful than cigarettes (79.8%), to reduce smoking (75.8%), and to help quit smoking (85.1%).[2,3]

E-cigarettes are no doubt less harmful than smoking tobacco and, while we welcome the recent research published by Public Health England,[4] we believe that there needs to be much more research into the safety of their long-term use.

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1 Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87

2 Adkinson SE, O'Connor RJ, Bansal-Travers M et al (2013) Electronic nicotine delivery systems: international tobacco control four country survey. American Journal of Preventative Medicine **3**:201

3 http://www.ash.org.uk/files/documents/ASH_891.pdf

4 Public Health England. E-cigarettes: an evidence update (2015) Available at: https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

While BMA Cymru Wales supports the use of licensed nicotine replacement therapies (NRT) as a smoking cessation aid, it should be recognised that the consumption of nicotine is not risk-free. Nicotine is a highly addictive substance and users can become physically dependent.[5] We are also concerned by the lack of regulation to ensure the efficacy, quality and safety of e-cigarettes including the variable concentration of nicotine in these devices.

Nicotine withdrawal is associated with craving, anxiety and stress.[6] Research suggests that nicotine may be an important mechanism by which tobacco promotes tumour development, progression and resistance to cancer treatment; this is a particular issue for dual-use of e-cigarettes and conventional cigarettes.[7] The physiological effects of nicotine include increased blood pressure, increased heart rate, transient tachycardia and vasoconstriction.[8,9,10]

Symptoms of nicotine toxic overdose include tremors, nausea, vomiting, convulsions, neuromuscular blockade, diarrhoea and gastrointestinal irritation.

Chronic exposure to nicotine is associated with an increased risk of stroke, hypertension, reproductive disorders, peptic ulcer disease and high total cholesterol.[11]

[5] Markou A (2008) Neurobiology of nicotine dependence. Philosophical Transactions of the Royal Society **363** (1507): 3159-68

[6] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303

[7] Warren GW & Singh AK (2013) Nicotine and lung cancer. Journal of Carcinogenisis **12**:1

[8] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303

[9] Institute of Medicine (2001) Clearing the smoke: assessing the science base for tobacco harm reduction. Washington: National Academy Press.

[10] Bhatnagar A, Whitsel LP, Ribisil KM et al (2014) Electronic cigarettes: a policy statement from the American Heart Association. Circulation (Epub ahead of print 24.08.14).

[11] Institute of Medicine (2001) Clearing the smoke: assessing the science base for tobacco harm reduction. Washington: National Academy Press.

In addition to nicotine, e-cigarettes have been found to contain a range of other substances with negative health implications.[12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29] Studies have also indicated that bystanders can be exposed to vapour emitted from e-cigarette use,[30,31,32,33] and the World Health Organisation (WHO) has warned of the potential adverse health effects of exposure to toxicants and particles contained within e-cigarette vapour.[34]

Despite the evidence of risk associated with using e-cigarettes, it is nonetheless worth emphasising that substituting tobacco with e-cigarettes is likely to substantially reduce exposure to tobacco-specific toxins and the potential health risks associated with exclusive e-cigarette use are therefore likely to be very much lower than the risks of smoking tobacco cigarettes.

On balance, however, whilst we believe that more research is required around the extent to which hand to mouth use of e-cigarettes either breaks or reinforces smoking behaviours – and the actual effectiveness of e-cigarettes in helping smokers to quit – from our overall view of the evidence that is currently available, we would agree that their use should be banned in enclosed public and work places as is currently the case for smoking tobacco.

In our view, it is vital that the use of e-cigarettes does not undermine the success of conventional tobacco control measures by reinforcing the normalcy of smoking behaviour in a way that other products containing nicotine do not. This specifically relates to the way these devices commonly resemble tobacco

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[12] Etter JF (2010) Electronic Cigarettes: A survey of users. BMC Public Health **10:** 231.
[13] Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87
[14] Vardavas CI, Filippidis FT & Agaku IT (2014) Determinants and prevalence of e-cigarette use throughout the European Union: a secondary analysis of 26,566 youth and adults from 27 countries. Tobacco Control **10**: 1136.
[15] Cahn Z & Siegelb M (2011) Electronic cigarettes harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? Journal of Public Health Policy **32**: 16 – 31.
[16] Cheng (2014) Chemical evaluation of cigarettes. Tobacco Control **23**: ii1 1-7
[17] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[18] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[19] Vickerman KA, Carpenter KM, Altman T et al (2013) Use of electronic cigarettes among state tobacco cessation quitline callers. Nicotine and Tobacco Research **10:** 1787 - 91
[20] Cahn Z & Siegelb M (2011) Electronic cigarettes harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? Journal of Public Health Policy **32**: 16 – 31.
[21] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[22] Etter JF (2010) Electronic cigarettes: a survey of users. BMC Public Health **10**: 231.
[23] Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87
[24] Cahn Z & Siegelb M (2011) Electronic cigarettes harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? Journal of Public Health Policy **32**: 16 – 31.
[25] Goniewicz ML, Knysak J, Gawron M et al (2013) Levels of selected carcinogens and toxicants in vapour from electronic cigarettes. Tobacco Control **23**(2): 113-9
[26] Williams M, Villarreal A, Boshilow K et al (2013) Metal and Silicate particles including nanoparticles are present in electronic cigarette cartomizer fluid an aerosol. PLOS one **8**(3): e57987.
[27] Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87
[28] Farsalinos K, Romagna G, Allifranchini et al (2013) Comparison of the cytotoxic potential of cigarette smoke and electronic cigarette vapour extract on cultured myocardial cells. International Journal of Environmental Research and Public Health **10**(10): 5146-62.
[29] Vardavas CL, Anagnostopoulos N, Kougias M et al (2012) Short term pulmonary effects of using an electronic cigarette: Impact on respiratory flow resistance, impedance, and exhaled nitric oxide. Chest **(141**)6.
[30] Grana R, Benowitz N & Glants SA (2013) Background paper on e-cigarettes (electronic nicotine delivery systems) San Francisco: University of California.
[31] Schripp T, Makewitz D, Uhde E et al (2012) Does e-cigarette consumption cause passive vaping? Indoor Air **2**3(1) 25-31
[32] Pellegrino RM, Tinghino B, Mangiaracina G et al (2012) Electronic cigarettes: and evaluation of exposure to chemicals and fine oarticulate matter (PM) Annali di Igiene: Medicina Preventiva e di Comunita **24**:279 - 88
[33] McAuley TR, Hopke PK, Zhao J et al (2012) Comparison of the effects of e-cigarette vapour and cigarette smoke on indoor air quality. Inhalation Toxixology 24: 850-7
[34] World Health Organisation (2014) Electronic nicotine delivery systems. Geneva: World Health Organisation.

cigarettes, in terms of appearance, nomenclature and the way they are used, as well as features such as flavouring and styling that are potentially highly attractive to children, and may include cigarette brand reinforcement. And because e-cigarettes commonly resemble tobacco cigarettes, and may not be immediately distinguishable from them, we also believe that restricting their use in current smoke-free areas will aid the managers of such premises in their ability to enforce the current smoking ban.

It is our concern that the e-cigarette marketing methods used across a range of advertising media and locations are likely to appeal to children, young people and non-smokers. These include point-of-sale displays; advertising via television, radio, in-print media and online; on billboards near schools; at university freshers' fairs; and the marketing of flavoured e-cigarettes.[35]

BMA Cymru Wales is also concerned that e-cigarette marketing may have an adverse impact, reinforcing conventional cigarette smoking habits, as well as indirectly promoting tobacco smoking, increasing the likelihood of young people starting to smoke.[36,37,38]

The e-cigarette market increased by 340% in 2013, and is estimated to be worth £193 million.[39] There are now more than 450 brands of e-cigarette, and 7,700 unique flavours.[40]

E-cigarette promotion ranges from being advertised as 'a healthier alternative to smoking traditional tobacco products', to evocative advertising with phrases such as 'love your lungs', 'vape with style', 'smoking is so last season' and 'add flavour to your lifestyle'. The advertising and promotion also frequently makes positive associations with recreational activities, sports and youth culture, and can incorporate celebrity endorsements.[41] [42] [43] [44] The UK Advertising Standards Authority (ASA) has previously ruled that certain e-cigarette advertisements were considered misleading and made unsubstantiated claims relating to health.[45]

In terms of accessibility, e-cigarettes can be bought from a variety of high street outlets, ranging from newsagents, superstores, and pharmacies to pubs and specialist shops. E-cigarettes and liquid nicotine can also be purchased online, even in wholesale quantities.[46]

The legal status of e-cigarettes varies around the world. In some countries (eg Denmark, Canada, Israel, Singapore, Australia and Uruguay) the sale, import, or marketing of e-cigarettes is either banned, regulated in various ways, or the subject of health advisories by government health organisations. In others (eg New Zealand), e-cigarettes are regulated as medicines and can only be purchased in pharmacies.

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[35] English PM (2013) Re: EU policy on e-cigarettes is a "dog's dinner" says UK regulator (rapid response) BMJ **347**: f6871.

[36] Andrade M, Hastings G & Angus K (2013) Promotion of electronic cigarettes: tobacco marketing reinvented? BMJ **347**: f7473

[37] National Institute for Health and Care Excellence (2013) Tobacco: harm reduction approaches to smoking. Manchester National Institute for Health and Care Excellence.

[38] Cancer Research UK (2013) The marketing of electronic cigarettes in the UK. London: Cancer Research UK.

[39] Public Health England (2014) E-cigarette uptake and marketing. London: Public Health England.

[40] Zhu S-H, Sun JY, Bonnevie N et al (2014) Four hundred and sixty brands of e-cigarettes and counting: implications for product regulation. Tobacco Control **23**: iii3-9

[41] Andrade M, Hastings G & Angus K (2013) Promotion of electronic cigarettes: tobacco marketing reinvented? BMJ **347**: f7473

[42] Grana R, Benowitz N & Glants SA (2013) Background paper on e-cigarettes (electronic nicotine delivery systems) San Francisco: University of California.

[43] Cancer Research UK (2013) The marketing of electronic cigarettes in the UK. London: Cancer Research UK.

[44] US Senate report (14.4.14) Gateway to addiction? A survey of popular electronic cigarette manufacturers and targeted marketing to youth.

[45] www.asa.org.uk/Rulings/Adjudications/2013/5/Nicocigs-Ltd/SHP_ADJ_219974.aspx (Last accessed October 2014)

[46] Kamerow D (2014) The poisonous "juice" in e-cigarettes. BMJ **348**: g2504

In the UK, e-cigarettes are subject to regulation under the General Product Safety Regulations 2005, the Chemicals (Hazard Information and Packaging for Supply) Regulations 2009, and by trading standards.[47] Worryingly, there is no requirement for manufacturers of e-cigarettes to list the nicotine content of their products, to include childproof safety features, or to take measures to protect against accidental overdose.[48]

Laboratory analysis of e-cigarettes indicates that labelling of nicotine levels in e-cigarette liquid may be inconsistent and misleading.[49] The Trading Standards Institute and others have stated that safety concerns have come to light around some brands of e-cigarettes, including electrical safety, the need for proper labelling, and the provision of child resistant packaging.[50] [51]

BMA Cymru Wales would advocate the introduction of stringent guidelines in terms of appropriate labelling and childproof safety features.

Extending restrictions to non-enclosed spaces

We recognise that a clear case can be made that banning smoking in certain circumstances in open spaces will have a positive health benefit in the same way as it does within enclosed spaces. We note that whilst voluntary smoking bans have been effective in some areas when applied to open spaces, in others they remain largely ignored and extremely hard to enforce locally.

We therefore support the proposals in the Bill that create the provision to extend statutory restrictions on smoking and e-cigarettes to certain non-enclosed spaces which could include such locations as hospital grounds and children's playgrounds.

Careful consideration may, however, need to be given to how this is applied in order to take account of the impact on individuals using e-cigarettes if they are forced to share a defined combined 'smoking area' with users of tobacco cigarettes.

We note the approach that has been advocated in the Bill of enabling additional locations that could come under the scope of these restrictions to be subsequently specified in regulations, and welcome the stipulation that the addition of new locations can only be supported when Welsh Ministers are satisfied that doing so is likely to contribute towards the promotion of the health of the people of Wales.

National register and Restricted Premises Orders (RPOs)

BMA Cymru Wales welcomes the provisions within the Bill to establish a tobacco retailers' register. We believe it is a proportionate and reasoned measure which need not be overly bureaucratic or burdensome on retailers.

We believe that its establishment would be a pragmatic step that will help to prevent underage sales and sales of illegal tobacco. It will also assist in ensuring compliance with the point of sale display and advertising regulation.

The additional information that will be gathered as a consequence of the introduction of the register and the strengthened RPO regime, will assist local authority trading standards officers in identifying where tobacco is, or is not, permitted to be sold and thereby help in enforcing tobacco and nicotine offences.

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[47] Trading Standards Institute (2010) Response of the Trading Standards Institute to MHRA consultation on the regulation of nicotine containing products. Basildon, Essex: Trading Standards Institute.

[48] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303

[49] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.

[50] Trading Standards Institute (2010) Response of the Trading Standards Institute to MHRA consultation on the regulation of nicotine containing products. Basildon, Essex: Trading Standards Institute.

[51] North East Lincolnshire Council press release (05.01.12) Use e-cigarettes with care, warn trading standards officers.

Creating a new offence for knowingly handing over tobacco and nicotine produces to a person under the age of 18 is also something that we support.

Additional suggestions

To ensure successful and expedient implementation of the Public Health (Wales) Bill we would urge the Welsh Government to ensure an appropriate commensurate budget to ensure that the general public is made fully aware of the implications of the Bill coming in to force.

In addition to the Bill, BMA Cymru Wales would advocate regulating e-cigarettes as a licensed medicinal product to best reflect their use for harm reduction, bringing them in line with other existing NRT products, and ensure effectiveness, quality and safety. This form of regulation would also provide the necessary controls on their marketing and promotion.

Special procedures

The proposals in the bill to create a compulsory, national licensing system for practitioners of specified procedures in Wales – such as acupuncture, body piercing, electrolysis and tattooing – seem reasonable in our view.

We also support the proposal to give Ministers the power to amend the list of special procedures to which this licensing system will apply through regulations.

As we previously indicated in our response to the Public Health White Paper, we would suggest that consideration could also be given to including the following additional procedures under the proposed licensing system:

- laser hair removal;
- chemical peels;
- dermal fillers;
- scarification/branding; and
- sub-dermal implantation (or 3D implant).

Intimate piercing

We are supportive of the plan to prohibit the intimate piercing of anyone under the age of 16 in Wales. The proposals in this section of the Bill would therefore seem reasonable.

Pharmaceutical Services

The Bill includes provision to require each local health board to publish an assessment of the need for pharmaceutical services in its area with the aim of ensuring that decisions about the location and extent of pharmaceutical services are based on the pharmaceutical needs of local communities.

Whilst such a proposal seems superficially reasonable, we are concerned about the experience in England where the interpretation of a similar requirement for pharmaceutical need assessments has led to the withdrawal of dispensing rights for some GP practices, with potentially catastrophic impact on some rural communities if this were to be repeated in Wales. The experience in England is that there seems to be no mechanism whereby the pharmaceutical needs assessment considers the wider primary healthcare needs of a locality – particularly a rural one. As such, we would be concerned that the resultant provision of additional pharmaceutical services under section 81 of the National Health Service (Wales) Act 2006 would be unlikely to compensate for the closure of a local GP practice.

The *Cost of Service Inquiry*[52] conducted in 2010 by the Department of Health in England demonstrated the cross-subsidy of services provided under the General Medical Services (GMS) contract by dispensing

[52] http://www.pwc.co.uk/government-public-sector/publications/cost-of-service-inquiry-for-community-pharmacy.jhtml

in rural dispensing practices. Many of these dispensing practices rely on the additional profit from dispensing to remain viable when catering for often small and dispersed registered patient lists.

The additional pharmaceutical services mentioned in the Explanatory Notes which accompany the Bill – flu immunisation, smoking cessation and emergency contraception (and indeed many others) – are ones that are provided under GMS services already. However, there have been instances in England where, because such services have not been provided under a pharmaceutical contract, there has been a determination that there were unmet pharmaceutical needs and thus applications to provide additional pharmaceutical services were agreed. This led to the closure of dispensing services even in areas that have been defined as controlled localities (i.e. areas that have been designated as being 'rural in character' such that, in certain circumstances, doctors can provide pharmaceutical services to certain of their eligible patients.) This, in turn, can have a huge negative impact on the provision of GMS services in such localities. With current GP recruitment problems this could be devastating for rural areas and lead to directly to GP practice closures.

Ideally, we would therefore suggest that controlled localities be excluded from the proposed provisions of the Bill. Failing that, as an absolute minimum, GMS services similar to extended pharmaceutical services should be required to be considered in any pharmaceutical needs assessment, and all pharmaceutical needs assessments should include a risk assessment to existing GMS provision of any new approvals to provide pharmaceutical services.

In the light of these quite serious concerns, the view of BMA Cymru Wales is that we believe the provisions in this section of the Bill might improve the planning and delivery of pharmaceutical services, but only as narrowly defined and in isolation.

We further believe that the proposals will encourage existing pharmacies to adapt and expand services according to local need – an aim we can most certainly support.

However, it must be recognised that the proposals relating to pharmaceutical services in the Bill have the potential to seriously undermine public health in Wales if (as they have in England) they negatively impact on the provision of GMS GP services in rural areas and lead to the closure of existing GP practices.

Provision of toilets

We welcome the proposed provisions in this section of the Bill. These proposals seem both sensible and reasonable, and we are therefore happy to provide our support.

APPENDIX 1 – The case for Health Impact Assessment (HIA)

Introduction

Pre-assessing new policies, plans or programmes in order to avoid any unforeseen negative impacts on the environment or equalities is already well-established within decision-making by public bodies in Wales. However, there is clearly also a strong case to be made that we should be equally seeking to avoid or minimise any negative impacts on the health and well-being of the Welsh population, as well as promoting positive impacts. Indeed, this would appear to be both a logical and desirable development of an already well-established approach.

It also makes sense in light of the accepted recognition that health is, to a large extent, determined by factors outside of healthcare provision. Known as the wider determinants of health, these include social and community factors; access to services; and economic and environmental factors.

It can hopefully be taken as a given that public bodies in Wales would wish to avoid negative impacts on health that could arise from decisions they might be taking, or from the application of new policies they might be adopting. But if we are considering potential deleterious consequences that are neither

intended nor envisaged, it cannot simply be assumed that these will be obvious in the first instance and hence mitigated against automatically.

If such outcomes are therefore to be systematically avoided, it would seem logical that some form of pre-decision assessment needs to be undertaken before decisions are made, plans approved or new policies adopted. This would maximise the likelihood that something that might not otherwise be obvious can brought to the fore and properly considered in a timely manner.

HIA is a well-established tool that can fulfil this role. The World Health Organisation (WHO) defines HIA as '*a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIA helps decision-makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health*.'[53] A definition known as the Gothenburg Consensus describes HIA as a combination of procedures methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.[54]

As practiced in Wales, HIA assesses the implications for health and wellbeing through the broad lens of the wider determinants of health. It is a process which considers to what extent the health and well-being of a population may be affected, whether positively or negatively, by a proposed action – be it a policy, programme, plan or project. As such it can provide an opportunity to identify ways in which health benefits can be maximised as well as how health risks can be minimised. It can not only identify health impacts and health inequalities affecting the general population, but also those affecting vulnerable groups (e.g. children, young people, the elderly etc.). It can be used to identify opportunities for health improvement, as well as to fill identified gaps in service provision or delivery.

For as long as its application in decision-making by Welsh public bodies remains optional, however, its effectiveness in avoiding un-envisaged negative impacts on health – or in identifying ways in which health benefits might be maximised – will in our view be substantially reduced. It might only be through the undertaking of an HIA that an unforeseen negative impact on health might is in fact identified.

Relationship with existing policy and legislation

The use of HIA can also be seen as a logical progression of the current policy direction in Wales, complementing the aims of many recent developments in legislation.

For instance, the Active Travel (Wales) Act 2013 requires Welsh Government and Welsh local authorities to undertake continuous improvement through the development of transport infrastructure that can facilitate travel by active means – thereby helping people to undertake healthier travel options. However, whilst this will lead to a certain amount of new transport infrastructure being developed to further the aims of this Act, it is possible that other new transport infrastructure may also be developed alongside which is not assessed for its impact on health and which might therefore have an un-considered negative impact, or might not be developed in a manner which maximises the opportunities for promoting health benefits. In our view it therefore makes sense for all new transport infrastructure to be assessed for its impact on health so that health concerns can be brought to the fore whether or not the infrastructure in question is being specifically developed to further the aims of the Active Travel (Wales) Act 2013. That way Wales can adopt a more holistic approach to furthering this policy aim.

Another example of where HIA could provide added benefit can be highlighted in relation to planning considerations, where we would also argue that it might not be seen as sufficient to only require HIAs to be undertaken at the level of the over-arching Local Development Plan (LDP). Generalised land use allocations within an LDP will not necessarily reveal the impact on health that individual development

[53] http://www.who.int/hia/en/

[54] European Centre for Health Policy. Health impact assessment: main concepts and suggested approach. Gothenburg consensus paper. Brussels: WHO European Centre for Health Policy. 1999. Available at: http://www.euro.who.int/document/PAE/Gothenburgpaper.pdf

proposals, which are subsequently brought forward during the lifetime of the plan, might have. It may only become apparent once the specific details of individual planning applications are known what impacts they could have on a broad-range of public policy considerations, including health. It might therefore be considered that certain categories of planning applications – e.g. housing developments above a certain size – could be subject to HIA.

Application

HIAs need not be overly burdensome. This is often used as an argument against their use being made a requirement, but the first stage in the process should be a screening exercise which can determine whether an HIA would both be valuable and feasible within a particular decision-making context.

In our view, it would be too simplistic to just dismiss this as a tick box exercise. A methodology could be developed which would ensure those policies, plans and programmes which should be subject to an HIA could then go on to be subject to a suitably more rigorous assessment – but for those for which this would not be necessary, this can also be straightforwardly identified.

Additionally, HIA need not be undertaken as a stand-alone process but could also be undertaken as part of a wider, but integrated, impact assessment. An example of this is the approach which was employed in Tasmania[55] as a result of legislation introduced there in 1996. That legislation required all proposed developments requiring an environmental impact assessment (EIA) to also be subject to an HIA, with these being carried out as part of one integrated assessment.

Indeed it should be recognised that broad HIA can provide added benefits even in circumstances where EIA is already required. Even though there may be a requirement within EIA to consider human health, this may done in a manner which could be much narrower in scope than would be required in an HIA. At present, for instance, EIA undertaken in accordance with current EU regulation only looks at negative risks and implications for health, and only those which may be caused by environmental determinants.

Undertaking HIA alongside other assessments, as part of a wider integrated assessment, could be seen as a worthwhile adjunct to the recently passed Well-being of Future Generations (Wales) Act 2015 which seeks to promote a healthier Wales as one of its seven identified well-being goals. Whilst this Act requires public bodies in Wales to set objectives that will further each of these well-being goals, it does not however establish a specific requirement for Welsh public bodies to consider the impact on health of other decisions they may make, or of new policies they may adopt, when these are outside of those which are specifically being brought forward to further the aims of the Act. A mandatory application of HIA by Welsh public bodies could therefore ensure that the impact on health and wellbeing is considered more widely across the board, thereby more effectively delivering the intention of a health-in-all-policies approach.

HIA is an open and transparent process which promotes the active inclusion and participation of key stakeholders and communities affected. It can therefore ensure greater involvement of these groups in decisions that affect them. As such, it can bring reassurance in relation to certain decisions that potential impacts on health and well-being are properly understood.

Existing requirements for HIA use in Wales

It should be recognised that there are already circumstances in which HIA is referenced in existing guidance in Wales. Examples include the *Vibrant and Viable Places: New Regeneration Framework (2013)*[56] which includes the need for a HIA to be included in all Stage 2 bids for Welsh Government funding; the *Welsh Transport Appraisal Guidance (WelTAG), 2008*[57]; the *Collections, Infrastructure and*

[55] Ewan C, Young A, Bryant E, Calvert E, Calvert D. *National framework for environmental and health impact assessment.* Canberra: National Health and Medical Research Council, Australian Government Publishing Service, 1994. Available at: https://www.nhmrc.gov.au/guidelines-publications/eh10

[56] http://gov.wales/topics/housing-and-regeneration/regeneration/vibrant-and-viable-places/?lang=en

[57] http://gov.wales/topics/transport/planning-strategies/weltag/?lang=en

Markets Sector Plan[58] which covers the management of waste*;* and the *Minerals Technical Advice Note (MTAN) 2: Coal*[59], which provides planning advice in relation to facilities for coal extraction including open-cast mining. These include circumstances in which HIA has already been made a mandatory requirement in Wales.

Making HIA a statutory requirement

Given that there are already circumstances in which Welsh Government has specified that HIA should be undertaken, it could therefore be a logical progression to include a statutory requirement for HIA in certain defined circumstances. Indeed, such a provision could substantially strengthen the scope and impact of the Public Health (Wales) Bill, as well as being seen as an evolution of the existing approach.

The principle for HIA to be a requirement in specific situations could be incorporated on the face of the Public Health (Wales) Bill, with the intention that regulations would subsequently be produced which could then specify in exactly which particular situations a mandatory HIA would be required. That way the requirement for mandatory HIA could initially be applied in a number of discrete areas where it is most apparent that this would be of benefit, with scope for this to be easily broadened to further areas in the future. This would be a similar approach, for instance, to the manner in which the provisions of the Welsh Language (Wales) Measure 2011 are being applied.

In the first instance, we would suggest that regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning application, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

Summary

We feel that a mandatory requirement for HIA in certain defined circumstances would be entirely in line with the wider Welsh Government policy direction and recent legislative developments.

It would ensure greater consideration within decision-making of ways in which negative impacts on health can be mitigated against and positive health benefits maximised, thereby ensuring unforeseen impacts are avoided at the same time as providing greater reassurance for communities in the way such decisions are reached.

Legislating for mandatory HIA could provide a significant contribution to improving the future health and well-being of the Welsh population, at the same time as helping Wales to become a World leader in the application of public health policy.

[58] http://gov.wales/topics/environmentcountryside/epq/waste_recycling/publication/cimsectorplan/?lang=en
[59] http://gov.wales/topics/planning/policy/mineralstans/2877461/?lang=en