Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health Inequalities Review: Institute of Public Health in Ireland

3 October 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Ms Maeve McLaughlin

Witnesses:

Dr Helen McAvoy	Institute of Public Health in Ireland
Mr Owen Metcalfe	Institute of Public Health in Ireland
Dr Joanna Purdy	Institute of Public Health in Ireland

The Chairperson: You are more than welcome. Thank you for the briefing paper that you sent to the Committee and for taking the time to come up to brief us as we look at health inequalities. I will hand over to you to make the introductions and give your presentation, and we will then open up the session for questions or comments.

Mr Owen Metcalfe (Institute of Public Health in Ireland): Thank you very much, Chair. I welcome this opportunity. I am the director of the Institute of Public Health in Ireland. With me today are Dr Helen McAvoy and Dr Joanna Purdy, who are members of the team in the institute. I will give a short introduction on the background to the institute, its orientation and some of its work. My colleagues will then provide more detail on the specific issue under discussion today, the early years.

Some of you will be familiar with our history. We were established in 1998 to bring about increased support for co-operation on public health on the island of Ireland. The issue under discussion today is of particular importance and relevance to us. Since the beginning, we have sought to place an emphasis on health inequalities. Simply put, we believe that, for example, the fact that males living in the 10% least deprived areas can expected to live, on average, almost 12 years longer than their counterparts in the 10% most deprived areas is unfair and unjust. Since we were established 14 years ago, we have tried to address the issue of health inequalities through our all work. It is of great comfort and solace to us to know that the issue is now being prioritised.

Our work in looking at and focusing on health inequalities is built on three strands, the first of which is health information and health intelligence. We want to improve the analysis of existing data sets and be able to advise on their content to support better decision-making for better health. An example of

the work that we do in that area is Health Well and its community profiles. So if, for example, you want to find out the levels of smoking in a particular local government district or breastfeeding rates in a particular area, you can go to the Health Well and explore the information and data available there. If you want to look at what policies to address some aspect of health are available for young people, you can also turn to the Health Well.

The second strand is our evidence-based policy development to support Departments and agencies, their strategies and plans. We prepare consultation responses, and particularly relevant to the issue of early years were our recent submissions to the Northern Ireland breastfeeding and maternity strategies. We try to give people the information that we feel will help them in their decision-making process during policy development phases. We have also been critically and centrally involved in the development of the Fit and Well strategy and, in parallel to that, the Your Health is Your Wealth strategy. Those are public health strategies that have been developed, North and South, and it is a happy coincidence of timing that, in the next few months, we will have two brand new public health strategies on the island that will provide the guidance for the future of public health. We also work with the Public Health Agency (PHA), and we are delighted that the early years issue also receives priority in its strategic framework.

The final strand of our work is capacity-building, in which we try to equip people with the skills and vision necessary to see their policies through a health lens. We have done this through concrete training in health impact assessment, but we also produce evidence reviews to highlight and emphasis the relationship between areas such as transport, the environment and, critically in relation to this topic, education and health. So decision-makers can pick up our review and find central evidence that supports the relationship between those areas.

We are very pleased to be here. I will now ask Dr McAvoy to carry on and detail more specifics in the types of areas that we have looked at and explored.

Dr Helen McAvoy (Institute of Public Health in Ireland): Thank you, Owen. To give you a bit of an overview of what I hope to cover in the next few minutes, I will set out some of the concepts and evidence that underpin the role of early years in tackling health inequalities; discuss some findings from the data in the Northern Ireland context; look at the current policy landscape around early years in Northern Ireland; and set out some considerations for policy development.

I will start with the conceptual piece. Giving every child the best start in life has become a priority theme for a number of Governments seeking to reduce health inequalities. This has come from the work of the World Health Organization's Commission on Social Determinants of Health. When it looked at the evidence, it became very clear that early years must now form a central foundation of all health inequality policies. The foundations of all aspects of human development — physical, psychological, social and emotional — are laid down in early childhood. We know that babies and infants thrive where there is good early nutrition; a warm, loving family; and frequent exposure to environments conducive to safe physical play, learning and social interaction. As parents and grandparents of young children, you will probably know that already.

International evidence for early years intervention goes well beyond that. It hinges on two critical factors, the first of which is that there is good evidence that it works. The experimental evidence from a large number of studies, largely conducted in the US and starting in the 1950s and 1960s, shows that early years interventions are very effective and show positive outcomes not just in the short term but in the long term. The second critical factor is that investing in early years is good value for money. Later interventions in, for example, adolescence, although still important, are considerably less effective. Many early years interventions are estimated to have very high benefit-cost ratios and rates of return, which is certainly piquing the interest of economists as well as public health professionals.

In the US, it has been estimated that for every dollar spent on early years childhood intervention, the return is $16. Some financial modelling analysis has been done for the Scottish Government, and it estimated that the total potential annual saving accruing from investment in improving early years outcomes in Scotland could be as much as £5·4 million. So the evidence tells us that, if society intervenes early enough, it can raise a range of abilities for disadvantaged children, equipping them better to thrive, not only at school and later in the workplace, but in many other aspects of their adult lives, including relationships and their ability to parent well in due course. Some of the outcomes now known to be positively associated with early years interventions include better educational attainment; reduced risk of teenage pregnancy, antisocial behaviour and criminality; and better mental health. In addition, it is now becoming apparent that a number of soft skills are associated with early years, such as self-confidence, self-esteem and the ability to relate and have good relationships.

I presented a snapshot of data on early years interventions in Northern Ireland in the briefing paper, and I will comment on just one or two of those. We know that child poverty can threaten optimal early years development in direct and indirect ways. At present, using the relative income poverty measure, about 21% of children in Northern Ireland are considered to live in poverty. Children living in lone-parent families, those in families with large numbers of children and those with unemployed parents are at greatest risk, but we also know that there is a significant issue with children growing up in families that would be considered working poor.

An analysis of the Northern Ireland sample of the millennium cohort study (MCS), a longitudinal study of infants that looks at outcomes at the age of five across the UK, gives us some good news. At age five, children in Northern Ireland fared, on average, better than those in England, Scotland and Wales in cognitive scores, educational assessments, behavioural assessments and general health. However, there were issues in Northern Ireland households with the home learning environment. Common themes across the countries in the UK were that low birth weight, child poverty and disadvantage were associated with poor child development in all jurisdictions.

The health and social care inequalities monitoring system in the Department of Health, Social Services and Public Safety (DHSSPS) produces a lot of data on pregnancy and early years. The common theme is that young children in poor communities have not benefited to the same extent from gains in population health. An example of that is infant mortality; that is, deaths occurring the first year of life. In Northern Ireland, such deaths have reduced dramatically in the past 20 years, as they have in many other European countries. However, the reduction has not been shared equally. There is, in fact, evidence of some small increases in infant mortality in the most deprived areas of Northern Ireland over the past decade. We know that a healthy environment in the womb is critical to infants having a good starting point in their early developmental years. In Northern Ireland, as is the case with many other countries across the UK and Europe, women from disadvantaged circumstances are more likely to have a low-birth-weight baby. Low-birth-weight babies in Northern Ireland are predicted to have worse educational, cognitive, behavioural and general health outcomes at age five. That is, in part, related to issues such as higher smoking rates in pregnancy among disadvantaged mothers, but there are other factors as well.

We know that breastfeeding provides the very best nutrition and is associated with the optimal physical and brain development of young children, yet significant inequalities in breastfeeding remain. In a comparison of babies born in the least and most deprived areas of Northern Ireland, babies in the least deprived areas were twice as likely to receive the benefits of breast milk. Owen referred to the longer term outcomes in health inequalities and life expectancy, but another important point is that adverse early years experiences, particularly in the more extreme cases of abuse or neglect, place young people and adults at significant risk of mental ill health and suicide. Some of the most sizeable inequality gaps between deprived areas in Northern Ireland overall were found in the number of admissions of young people and adults for self-harm. We need to think about the role of early years in promoting resilience and good mental health right from the beginning.

In the policy landscape, in general, an early years focus in government policy requires a commitment to enhancing the quality of disadvantaged families' early education and community environments. We need better outcomes from improved early years services environments, but those need to be backed up by government policies that are strong on protecting young families' incomes, good housing and access to education, employment and social protection, particularly in the domain of child poverty.

A draft early years strategy is under consideration by the Department of Education. We understand that Minister O'Dowd is committed to developing a strategy that sets out a road map for securing better outcomes for young children through a focus on education and linking of early years services with a new foundation stage in the first years of primary school. He has also said that there is a commitment in the strategy to focus on disadvantaged areas, and we certainly welcome that.

It is also envisaged that the early years strategy will mark out synergies and integrate well with existing strategies that have a focus on early years, including the children and young people strategy, the literacy strategy and the child poverty strategy. It has been proposed that, to some extent, the Delivering Social Change framework set out in the Programme for Government could be a key mechanism for delivering on the aspirations in early years outcomes across a number of strategies.

In health, the implementation of Fit and Well, the 10-year public health strategic framework for Northern Ireland, currently out for consultation, will be critical. That proposes a life-course approach but set outs the early years as a strategic priority for reducing health inequalities, including a focus on

pregnancy and pre-birth determinants of child health. It is critical that, as well as supporting the growth of new and innovative, locally based early years services — we have seen that happening in recent years — we need to enhance the established public health programmes that already support good health in the early years, including our programmes of childhood vaccination, child health screening and developmental assessment.

Improving outcomes in the early years will also be enhanced by adequate resourcing to support the implementation of key public health strategies, particularly in the domains of maternity care, breastfeeding, overweight and obese children, physical activity and play. Success in tackling inequalities in child health must be an important goal of early years work across all Departments.

It is of interest that an early years strategy is also being developed by the Department of Children and Youth Affairs in the Republic of Ireland. In Scotland, an early years framework was published a number of years ago, and there is much to learn from its experience to date. Australia has published its national early years childhood development strategy, but it is fair to say that, globally, this area is still in an early stage of development.

As for the implications for policy, the commitment to achieve more equitable child development in the early years must be a priority at a whole-of-government level. There should be endorsement by and support from the Northern Ireland Executive, the Office of the First Minister and deputy First Minister (OFMDFM) and other Departments, because all Departments have a role, and accountability will be critical. Despite the challenges posed by the recession, a clear focus must be maintained on tackling child poverty. We need to consider carefully the economic and social circumstances of families with young children within the tough budgetary decisions on social protection and the allocation of resources.

Consideration should be given to increasing the proportion of overall expenditure allocated to the early years. Where that is not possible because of budgetary constraints, at the very least, expenditure should be focused progressively across the social gradient, giving preferential resourcing to disadvantaged areas.

Early years education is also very important, as is the level and quality of its provision. That should be subject to continuous quality cycles and development, again with a focus on socially disadvantaged families, and performance management systems to support the outcomes that we expect in socially disadvantaged areas. For a long time, we had very little information about what happened in the early years. There were surveys of schoolchildren but very little information on what happened in the years before children attended the state school system or before they were able to answer a questionnaire. That is improving with time. In particular, longitudinal studies of childhood, such as the MCS, tell us a lot about the current situation and about what we can expect from policy changes in the future. It is critical that we continue to resource and develop our longitudinal studies and look at research and evaluation to find out which services work best in which settings. That will be the key to developing evidence-based policy in the long term.

Mr Metcalfe: I would just like to add that Dr McAvoy is from a health background, and Dr Purdy is from an education background. We regard the combination of abilities in both areas as essential and an indicator of the requirement to provide joined-up thinking across Departments. So we brought Dr Purdy along to answer any specific education questions that might arise.

The Chairperson: The paper is very interesting. We are looking at the whole issue of health inequalities. I am conscious that you are not here to speak on behalf of a Department, either North or South, and I remind members of that. Some of our constituencies probably have bigger pockets of health inequality than others, but, in my view, health inequalities have not changed over the past number of years. It struck me that other Departments have a responsibility. When we go back a number of years to the public health agenda and the Investing for Health strategy, all Ministers gave a commitment and signed up to do what they thought would help to improve public health and tackle health inequalities. So I agree with you that accountability is critical and that other Departments have a role. Unfortunately, the Health Department deals with the outcomes.

In my constituency — I know that it happens in other constituencies — it seems that, when there is a pilot project to target health inequalities, whether through early intervention, the juvenile justice system or mental health breakfast clubs, the community sees the benefits and then has to battle to get the money. I am of the view that we tend to put money together in a piecemeal way for those types of projects and do not recognise the serious benefits of early intervention. Importantly, we now have, as you said, two public health policies on the island. Is the necessary commitment being shown through

the involvement of our Public Health Agency here in the North and through what is happening in the Executive? Health inequalities have not changed this year, so do you think that we will now start to see changes?

Mr Metcalfe: It is gradually dawning on people that health inequalities are part of everybody's remit. It is not just DHSSPS's responsibility to address health inequalities, but it has taken a long time to get that message across to all Departments. That is why we stress that one of the best things that you can do in this area is have the appropriate policy in place. That policy must be mandated from the very top, at Executive level, with accountability through the various Departments. There are indications in the consultation document for Fit and Well that all Departments will step up to the plate and play their role to identify specific actions that they have to undertake to participate in making a difference. That is welcome.

Tackling inequalities is difficult; there is no doubt about that. There are challenges for every Department, but that must, and hopefully will, remain a central plank of Fit and Well and the PHA's strategic framework. Accountability is critical, but we must also look for an ongoing commitment to the type of programmes that have been shown to make a difference. Although we talked about them being pilots, I noticed that Sure Start and Roots of Empathy are getting traction, and there is commitment to extend support for these vital programmes. You cannot just hit something piecemeal; you have to have a strategic plan, and inequalities have to be central to a lot of areas. However, you have to prioritise what you can address in each area, especially when there are tight resource constraints. It is disheartening to notice that the gap is not narrowing, but we are forever hopeful of that continued commitment and engagement and cross-party and cross-departmental support for prioritising the issue.

The Chairperson: We have a priority because we are a Committee that looks after health, social services and public safety. However, other Committees have priorities, and although we all know that public health is a cross-departmental issue — in fact, it should be an Executive priority — other Committees are faced with their own priorities. There is a battle to change the mindset about what public health actually is. It is about being proactive.

Given the current spend on the public health agenda in general, do you believe that, as things sit, there is a focused approach to targeting health inequalities?

Mr Metcalfe: That has happened in Investing for Health and Fit and Well. Commitment and accountability mechanisms could be stronger.

The Chairperson: From other Departments?

Mr Metcalfe: From every Department, yes. There is a requirement to engage continuously with those Departments. We have met and worked with many Departments in the context of our health impact assessment training, and we need ongoing commitment from those Departments. A mechanism such as the ministerial group on public health is, potentially, extremely valuable for getting that sign-up, engagement and continuous commitment. I see that as virtually an exemplary mechanism across Europe and something that needs to be examined, explored, built on, developed and continued.

The Chairperson: I have asked the Committee Clerk to find out when that ministerial group last met, because we had a ministerial subgroup on suicide and self-harm and it was 18 months before it met. If there is no commitment at that level, we need to look at that.

You mentioned the focus on maternity care a few times, and you mentioned the breastfeeding strategy. Is there enough focus on maternity care, even after birth, to encourage new mothers to get involved in breastfeeding? You cannot drive a car unless you have a licence. Is there the same type of commitment when there is a new birth?

Dr McAvoy: We have made a submission to the consultation on developing a new 10-year framework for breastfeeding, and I was very heartened to see the quality of the consultation document and the commitment to make this a 10-year policy goal, because we have not had that same level of commitment to breastfeeding previously.

In Northern Ireland, the rates of initiating breastfeeding are lower than those in GB, and the duration of breastfeeding is shorter and falls off more quickly. We are doubly disadvantaged, and we need to look at both issues. One issue is changing the culture between feeding babies naturally and bottle-feeding,

and there are issues around some of the legislation on breastfeeding. Scotland brought in legislation that protects the rights of women who breastfeed in public places, for example, and although those things are not the be all and end all, they are small steps towards changing the culture to make breastfeeding the norm. It is interesting that we have a strategy that talks about normalising something that is actually normal.

The Chairperson: I raised that issue, and the pre-birth issue, last week. We have been advised, and we are waiting for confirmation, that the National Institute of Health and Clinical Excellence guidelines state that any woman who is due to have a caesarean section should get an antibiotic. My information is that that never happens. There are small measures that do not cost a lot of money but could save an awful lot in the long run.

Dr McAvoy: There has been some analysis of breastfeeding figures, North and South. Some hospitals have invested in the promotion of breastfeeding, but we also need investment during pregnancy by way of getting women to think about this before they have their baby as well as getting support in communities. We need extra development at that level, along with what happens in the hospitals, because hospitals can get very rushed and busy with other things. Something has to happen during the time the woman is pregnant. She has to be encouraged, not just through interfacing with the health services, but by the community in which she lives. The support that she gets from other women, in her family and in her community, can help her when making that decision.

The Chairperson: Are members content that we get that information from the ministerial group on public health?

Members indicated assent.

Mr McCarthy: Thank you very much for your presentation and briefing paper. I have a couple of questions: page 5 of your presentation references the MCS. Will you give us an update on how that is going and what has been learned so far? I think you mentioned that we came out on top for age five, which is interesting.

Secondly, page 3 of your paper draws attention to the fact that parents with long-standing illnesses and mental distress are linked to worse health outcomes for children. The Fit and Well strategy that you both mentioned emphasises that we have a disproportionately high prevalence of mental ill-health, so general support for parents, including those who are already suffering with mental health problems, including alcohol-related illnesses, is key to ensuring that our children grow up as healthy as possible.

A lot of good work is going on already, as you mentioned, in Sure Start. We also have Home-Start and we had Life Start, which unfortunately fell by the wayside because of a lack of funding. Home-Start is struggling, too, but it does excellent work. It would be useful to know whether you think we could learn anything from the other jurisdictions you mentioned in your document; for instance, the South of Ireland, Scotland, Australia or any other countries.

Dr McAvoy: The millennium cohort study is a longitudinal study carried out across the UK that follows children on a regular basis from birth upwards. What is useful about it is that it allows each of the UK jurisdictions to compare with each other using the same survey methodology. This report from 2010 is a report on the consequences of childhood disadvantage in Northern Ireland for children aged five, and it was commissioned by the Office of the First Minister and deputy First Minister. It provides a very good overview of the factors that are related to childhood disadvantage at that age. The beauty of longitudinal studies is that you can follow the children over time as they get older and you can see, not just the short-term outcomes as they enter school, but how they get on in school as they progress.

There is a longitudinal study in the Republic of Ireland called 'Growing Up in Ireland'. It came in a little later than the millennium cohort study, but there are several North/South comparisons that examine how children are progressing across the two surveys over time. It is a very useful comparative tool, particularly in highlighting some of the differences in the way early childcare and education are structured. I think that it will be very informative.

To the best of my knowledge, those studies are still enjoying the support of some government funding. I hope that they continue to do so.

There are particular issues around the mental health of parents because of the economic situation at this particular time. There may be redundancies in the family, or people may be in very low-paid employment. Incomes are going down, which puts stress on families to meet their needs, including those of their children. We have done some work around men's health, in particular, and the impact of unemployment on their physical and mental health. Owen would be best placed to explain that.

You are correct in identifying the role of alcohol and the harm it causes through mental illness and the effect it can have on the family unit. I think we need to get tough on alcohol, and this is a priority both North and South. The institute will be involved in some North/South co-operation work on alcohol in the coming months, and we are watching with great interest some of the developments from the minimum alcohol pricing Bill in Scotland.

As to your last point about looking at what is happening in other jurisdictions, it will be very interesting to see what comes out of the Republic of Ireland's strategy, which is being operated by the Department of Children and Youth Affairs. I know there was a children and young people's unit in OFMDFM, though I am not sure about the status of that unit now. The early years strategy is now being led by the Department of Education, and I hope that it will still have an eye to all these other important outcomes in early years that are directly and indirectly related to education. One of the strong elements of the Scottish approach was that they commissioned a piece of work that looked at the economics, savings and benefits derived from early years investments. I think that helped them to get their strategy across the line and to get investment at a time when finance Departments had to decide what to invest in.

Mr McCarthy: It is about trying to convince people that, by investing early, they can save in the long run.

Dr McAvoy: Yes. When it comes to decisions, money talks, and I think looking at the economics involved is important. I am not an economist but I can read enough of it to understand when something makes good economic sense.

Mr Metcalfe: I have one further point to make about examples of good practice. It is worth having a look at what has been happening in New Zealand, which has a 10-year plan that concentrates on early years and on the educational components of what happens to young people in centres. One critical thing about this is that it is not just about education in isolation. In the centre, you also have the allied services from health — so you have your physiotherapist and your practice nurse and such people. It is a 10-year plan, and it involves several departments. It is already showing a lot of returns on investment.

Mr McCarthy: Would it be worth the Committee having a trip to New Zealand? *[Laughter.]*

The Chairperson: Let us hope that the media have picked up on the fact that Kieran McCarthy proposed that. *[Laughter.]*

Mr McCarthy: One member.

The Chairperson: And a one-way ticket. *[Laughter.]*

Mr Metcalfe: You could start with Scotland.

Mr Brady: Thank you for your presentation. It was very comprehensive. You spoke about inequalities. Males in less deprived areas live, on average, 12 years longer. It strikes me that you have a very comprehensive public health strategy, North and South, and there is a certain irony in that we are now facing benefit cuts through welfare reform.

There are social welfare policies in the South, such as single working-age payments, which are probably just as draconian if not more so than what we are facing. I am not sure how you equate the fundamentals of people living on benefit and who are in the most deprived areas. The reason they are on benefits is because they live in the most deprived areas, and it is the same in the South. There seems to be a certain irony in that you are doing a very good job but are fighting against the tide because all this stuff is coming at us. It will undoubtedly create even more inequalities, particularly in health, because people cannot afford to eat and heat their houses. It is affecting the most vulnerable — the young, teenagers and older people.

Obviously, it is not your fault, because you are in a different sphere. The point has been made about a cross-departmental approach. Pam and I sit on the Committee for Social Development, which is dealing with the cuts, and on this Committee. There is so much overarching stuff involved with those two Committees. If there were proper cross-departmental feed-in, maybe some of the problems could be alleviated by mitigating the effects of the changes. On the one hand, you can have Sure Start and all of that doing a very good job, but when those kids get home, if there is not enough money to feed them, clothe them properly or heat the house, there will be huge problems.

Dr McAvoy: It is a big challenge. Ireland and Northern Ireland have had some difficulties in comparing well on child poverty rates. The OECD looked at this across Europe and examined different policies on childhood, the distribution of income and the prioritisation of the types and location of children's services. With that evidence, and the review of child poverty undertaken in the Republic of Ireland, it seemed clear that income is definitely part of the solution to child poverty, but so is investment in the local neighbourhood, as regards access to play, and in local health services, the local social services and family support services. A dual approach is needed to tackle child poverty. It is not just about income, but income is certainly important. Where income is taken away from families, we need to think about cushioning them from the effects of that as regards the design and delivery of local support services.

Obviously, this is a very difficult economic climate, North and South, and tough decisions will have to be taken. At the moment, we spend the majority of our money on children in their secondary school years and a minority of the money in their early years. From what the economists and the research are telling us, it now looks as though it might be smarter to spend more money in the early years and spend perhaps a little less, or in different ways, in the later years of childhood. That is one way of configuring things. What we need to consider in the early years is that many children will be at home for most of the day — they may go to an early childcare service for a few hours in the day — so we need to think about the resources needed in the home and not just leave it to families to meet those needs.

Mr Brady: The ages, particularly of lone parents, are going down. It is difficult for lone parents to be available for work if they have a one-year old, yet we do not have any childcare provision worth talking about. There are plenty of crèches, which are extremely expensive, but childcare provision in England and Wales is a statutory right under legislation, and local authorities have to provide it. We do not have that here, yet the same "standards" are going to be imposed here as in Britain. There is no doubt that this is going to create more problems than it solves.

Dr Joanna Purdy (Institute of Public Health in Ireland): I will pick up on your point about affordable childcare. If childcare is not affordable, it makes working impossible and it does not make it an easy decision. Our Prime Minister has spoken about making benefits less attractive and going out to work the more attractive option. In order to do that, we want to make the economic climate such that jobs are available but that those jobs do pay, and that there is incentive to work, balanced with affordable childcare. You are right; it is very expensive.

Mr Brady: Statistics that came out yesterday suggest that there are 5·8 applicants for every job in the North. We are not going to solve that problem easily. If someone accesses the childcare element of working tax credit, their child has to be looked after by a registered childminder. If your granny, your auntie or your sister registers, they also have to look after at least one other child who is not related to them, which seems to defeat the whole purpose. Initially, working tax credit was introduced to encourage lone parents to get back to work. It has done the complete opposite. That is just an observation.

Dr Purdy: I take your point, and I agree.

The Chairperson: *[Inaudible.]* the work we are trying to do.

Ms Maeve McLaughlin: Thank you for your presentation. I have just a couple of points to make. Initially, it struck me that improving the analysis of the data sets is critical. I recognise that from my constituency as regards Derry and the wider north-west. When we were working our way through a regeneration process, some obstacles related to some Departments releasing information, and perhaps storing information but not collating it. That provides real challenges. I am listening carefully to what you are saying about that having improved. That is good.

In our process, which I am most familiar with, through the regeneration, the learning was that regeneration is economic, physical and social, and that you cannot separate those if you are going to have a meaningful process and outcomes. One of the catalyst projects for us was early intervention in health and education. You can have the best schools in the world — and we have a really good schools estate here — but if you do not have early intervention directed to the child or the wider family before the child is seven, forget about it. That links with infancy and mental health, and some of the issues that spring from that are quite stark.

I listened to the economics involved, and you mentioned the Scottish model and the — I think — £5·4 million savings made through intervention processes. I know that Kieran asked a similar question, but I am interested to know whether the island of Ireland has looked at these costings. Ultimately, the economic argument is critical.

You noted that young children in poor communities have not benefited, and that is right. They have not benefited from any of the wider changes in public health. Key to this — and you referred to it yourself — is preferential resourcing to disadvantaged communities. That has to be key to what we do. It has to be about targeting resources. Then, importantly, and I know this can be quite technical, it is about measuring outcomes. One thing that we have learned, and 51% of our population is in high social need, is that in order to change patterns and outcomes, you need to monitor and manage. You need to have a framework in place that can do that. The programme, projects and initiatives across health or education cannot just be somebody's idea. They have to be evidence-based and we have to be moving towards actually changing the outcomes for tens of thousands of residents.

What I picked up was that commitment and accountability could be stronger. Performance monitoring and outcomes-based monitoring have to kick in. I have looked at the health inequality information that the Department has supplied. If you take it by constituency, how will programmes such as Transforming Your Care or Fit and Well target the three most deprived constituencies? I have not received that answer yet. I welcome the fact that there is a change in the data sets and a shift in the thinking, because a lot of this was about thinking, the mindset of early intervention and the potential that it has longer term, but I think that the frameworks around measuring and monitoring all of this are critical.

Mr Metcalfe: I will respond to a couple of those points quickly. If you go to 'The Health Well' section of www.publichealth.ie and look at the analysis of the data sets there, I think you will find them very valuable with respect to local government district profiles. Secondly, the Economic and Social Research Institute in Ireland did a piece of work and estimated the return on the investment at 7:1. Helen quoted the American piece of work showing 15:1 or 16:1 — that for every dollar, you got a $15 return. The Economic and Social Research Institute did a piece of work that estimated that for every euro invested in early years, you got a €7 return. You might want to look at that piece of work in that context.

Ms Maeve McLaughlin: Was that 7:1?

Mr Metcalfe: That was the return on investment in early years.

Ms Maeve McLaughlin: Was that across the island?

Mr Metcalfe: No; it was in the Republic of Ireland. It was done by the Economic and Social Research Institute. I am not aware of a similar analysis or piece of work having been done in the North.

The Chairperson: I think that Barnardo's did a similar piece of work one or two years go.

Mr Metcalfe: The targeting and measuring you referred to is an essential part of the work, and it has to go hand in hand with accountability measures. The difficulty is in how you protect the vulnerable during that period of development. Unless you can protect them, you will head into greater inequalities with greater costs to society across a range of measures, whether it is in crime, teenage pregnancy, drug misuse, etc. In societal terms, it is well worthwhile not making societies more unequal. Rather we should try to make them more equal. That is even more critical at this time.

Dr McAvoy: I want to respond to what you said about school performance. The Programme for International Student Assessment study is a fairly big study that looks at school performance across a number of different countries. One of the key factors in early school performance appears to be

whether a child has attended early years education before school. It is a great leveller for school readiness.

One of the important aspects of early years that we may need to look at is having some sort of school readiness standard when children start school. Often, those things are more of the social, emotional and behavioural aspects of children in junior infants or P1, such as whether they can sit in their seats, concentrate, take instruction and toilet themselves. All those basic life skills need to be as valued as much as, maybe, the ability to count, and so on. We need to look at school readiness in a more holistic way. Although everyone is not destined to succeed and do fantastically well in their exams, it is important that school provides them with the opportunities for self-esteem, self-confidence and being able to make their feelings known. Those kinds of soft skills are critical in the workplace, particularly for children who, maybe, are not destined to do full state examinations or whatever. I think that we need to value the soft skills as well as the hard things we already measure.

Mr Dunne: Thank you very much for your presentation. On page 4 of your paper, you referred to teenage mothers facing particular challenges, and we certainly find that to be a big issue. You state:

> *"The teenage birth rate in the most deprived areas was around twice that of Northern Ireland as a whole."*

That is an quite an alarming statistic. We are all concerned about the number of teenage parents. It is not just about the mums; the parenting issues need to be addressed. Young people have no parenting skills, and we need to concentrate on providing them with such skills. Is the system fit for purpose to support those young people? Years ago, people were supported in their homes by health visitors and social services. Are the services fit for purpose?

Secondly, the issue of absenteeism was in the media quite a bit this week, especially among young people in loyalist working-class areas. Is there an interrelationship between education and health inequalities? If so, how can that be addressed?

Mr Metcalfe: I will take the second question, and perhaps the others might have something to say about teenage mothers, the birth rate and whether the services are fit for purpose. There is a very distinct relationship between education and inequalities. The more education you have, the better chances you have of getting on in life, of earning more, etc. Education and health —

Mr Dunne: They are very interrelated.

Mr Metcalfe: Inextricably linked, yes; they are very interrelated. It goes back to the point the Chair made at the very start that this is not just the remit or responsibility of one Department. That is why we produced 'Health Impacts of Education: A Review' a couple of years ago, just showing what the links are and how people in education can deal with those issues.

I do not know whether Joanna or Helen would like to talk about — Joanna, do you have anything to say about the services?

Dr Purdy: I cannot comment specifically on absenteeism, but I can comment on the general point of educational and health inequalities, which links back to Maeve's point. I am thinking about looking at outcomes. If we take, for example, literacy standards, the Communication and Education Together project in the Belfast Education and Library Board area has been running for a number of years now. Speech and language therapists support teachers and classroom assistants to provide children with the necessary strategies to help them overcome any literacy difficulties. There are opportunities there for health and education to work together. That has been a very successful programme, so much so that although it started out targeting the most deprived children and those with the lowest literacy levels in the Belfast Board area, it has now grown.

In the briefing document, Helen mentioned the family nurse partnership, which supports young mothers, and I know that there are proposals to extend the support for young mothers in the most deprived areas of Belfast. The professionals and practitioners who work in those areas recognise that those young women need greater support to develop their parenting skills. That support and how it can be best delivered is being considered.

Dr McAvoy: They say that parenthood is tough, but teenage parenthood is very tough. I do not know enough about the set-up of different services in different areas to say whether they are fit for purpose.

However, I do know a little about the evidence of what works to reduce the risk of teenage parenthood at a population level and what works to preserve good outcomes for the babies of teenage mothers.

A review that was undertaken of programmes in Canada showed that teenage mothers are at a higher risk of having low-birth-weight babies. That may be because they present very late to health services, or there may be issues with smoking or other health behaviours as they come to terms with the fact that they are pregnant. Where they looked at different programmes, the programmes that were integrated, which were linked to opportunities for teenage mothers to link into education, employment, apprenticeships and childcare, seemed to work better, not just in the long-term outcomes for the mothers and the children but directly in pregnancy. Mothers who enrolled in those programmes at an early stage were at a lower risk of having low-birth-weight babies. Therefore, there seems to be something about locally appropriate, integrated services that do not just look at a teenage mother from a health perspective, like they would in an antenatal clinic, but at the other aspects of her life, such as her aspirations for her future employment, earning capacity and education. Those integrated services seem to work quite well, both short term and long term.

Mr Gardiner: I will be very brief, because my question about early years strategies was stolen by my colleague at the end of the Table, so I am not going to labour you any longer in relation to that. However, I would like to express my gratitude to you for coming and for the professional way you have handled the meeting and your answers.

Mr Wells: Thank you for your presentation. I do not know whether any of you were at the PHA seminar in the Long Gallery during the previous term of the Assembly. At that, we heard graphic information from Glasgow and from a professor from Dundee University with a name that I cannot pronounce. Perhaps someone else could pronounce it. It is a Polish name.

The Chairperson: It was Professor Suzanne Zeedyk.

Mr Wells: Yes. It was very gripping stuff. It was also very depressing, to be honest, but it was, perhaps, one of the most effective seminars we have ever had in this Building. The message was that if we do not intervene early, the chances of recovering the situation later on in life are not only extremely difficult but incredibly expensive. The graph showed just how much you needed to spend to get the tiniest response. Your message is very similar to that. The question is this: are there any quick hits here? This obviously requires a fundamental change of emphasis as to how we do things. It is a very long-term programme that will be slow and difficult to measure. However, are there any single quick hits? For instance, if every person in a deprived area gave up smoking, could we quantify the impact of that on health outcomes? Equally, could we quantify the impact if everyone gave up heavy drinking and became a social drinker or if we eliminated soft drugs from our deprived areas? What is the big hit here? What is the thing that, if we could concentrate on it immediately while we are developing a much longer-term strategy, would produce the best outcomes?

Mr Metcalfe: Very particularly, making inroads into poverty is probably the single biggest thing that you can do. Smoking, drinking and drug misuse are almost products of the environment. You can address lifestyle, but you also need to address the social determinants of health. To get people out of the poverty trap, you need to address housing, education, transport and all those types of things. If there were a magic bullet, I think that we would have seen it. What struck me about, say, going back to the New Zealand thing again, is that that was a 10-year strategy; it is long term. In Sweden, they adopted public health goals that had a 10-year cross-departmental, cross-party sign up, so it was not something that could just give a very immediate win.

Helen, I do not know whether you have examples of specific interventions that can give a quick return. Having worked in the area for 25 years, I think all the evidence seems to be saying that there are no magic bullets. It is very much for the long haul, and it is very much about the whole of government — cross-department alliances — that will make a difference in societal terms.

Mr Wells: That brings us to what Mr Brady was saying earlier: the trend is going in the other direction. The Welfare Reform Bill will certainly not leave deprived communities with more income. That is the one thing guaranteed. Therefore, the trend for unemployment and benefits is going the wrong way. Because of the principle of social security parity, we do not have an awful lot of say on the issue; we are very much tied by that. On the basis that it will take a very long time to turn the tanker, it is not mutually exclusive to look at one or two issues to see if, for instance, the police are having a real crackdown on drug abuse and drug trafficking. If we manage to crack that, which is unlikely, do we know statistically what outcomes that would produce?

Mr Metcalfe: In respect of long-term population health, if you could stop smoking, that would be a major win. Again, that is a long-term agenda.

Mr Wells: You talked about housing. We have created some brand new state-of-the-art housing estates in, for instance, Poleglass. Those estates have not been long built. Yet, the same social problems and outcomes are arising in the comparatively new, well-insulated and well-provided-for working-class estates as they are in the very poor, older deprived areas. It does not seem that you can buy your way out of the problem by providing good housing. Certainly, my experience in South Down is that you still get terribly difficult problems in very modern estates, and Downpatrick has many of these.

The Chairperson: I think the issue, Jim, in fairness, is that that is what we have been doing. We have been building estates, not communities, and we have not been building facilities. You mentioned Poleglass; it was years before it got any community facilities, shops or health centres. That is the mindset that we needed to break.

Mr Wells: I accept that, Madam Chair, but what I am saying is that building new houses alone does not solve the problem.

The Chairperson: No.

Mr Wells: So I am trying to think is there anything that can be done quickly to try to help address this huge inequality, which is so stark in Northern Ireland. Literally, you can have people on one side of a road living long, healthy lives, and the others dying far too young.

Dr McAvoy: I think that we need to look at the relative contribution of health behaviours, such as higher rates of smoking, alcohol use, and so on. When that is broken down in complex analyses, it is shown that that is only part of the issue. Health behaviours are very important in determining how long you live, how long you live in good health, your risk of dying before the age of 65, and so on. However, there are other factors related to poverty and disadvantage that are not captured. So, a focus on health behaviours alone may not bring you the return that you expect for health inequalities.

As for quick wins, I would have to really think about that one. I do not have anything off the top of my head. I think there is a particular issue around the thinking now about the importance of early years in health inequalities. I think that we need to look at the balance of investment that we spend across our children and what years we really want to — whether we want to rebalance that investment more towards early years and less towards the years in middle childhood and adolescence.

Mr Metcalfe: The types of societies that do best — generally speaking, the ones that have the greatest life expectancy and the greatest health life expectancy — are probably the Scandinavian countries and northern Europe. There, there is a premium on redistribution and, if you like, addressing and targeting the more disadvantaged sections of society. There are very definite minimum standards that seem to be higher there than in other countries. Where you can reduce that gap, you seem to get better societies on the whole, but that is not an overnight solution.

Mr Wells: On page 4 of the paper, you mention family nurse partnerships. I hope that I did not miss this, as I came in slightly late to your presentation. I understand that the Western Trust is looking at that option, which is quite exciting, but also very labour-intensive and expensive. Is there any evidence of that working elsewhere in the British Isles or Europe? Have we any examples of how that particular high-intensity-type relationship succeeds or otherwise?

Mr Metcalfe: I do not have an example. Do you know, Joanna?

Dr Purdy: I am not aware of any evaluations of those types of partnerships, just off the top of my head.

Mr Wells: If it does work — and, on paper, it looks like a good idea — I shudder to think what it would cost to carry it out on a Northern Ireland-wide basis. You would be devoting an awful lot of family nurse time to vulnerable families, and although I am absolutely certain that they would benefit from that level of care and attention, to roll that out for all the thousands and thousands of vulnerable families in Northern Ireland — I just would worry. That is why I am looking to see whether there is any

quick option that we can at least try in order to start to bridge the gap without solving the whole problem. I would say that, in five years' time, the economic disparities will be greater in those families, rather than lesser, because of the two forces of the economic downturn and welfare reform, which is dedicated to taking benefit out of those communities in very large numbers. You have to realise that that is going to leave them in a worse position as far as early years is concerned. There is not a lot you can do about that.

Mr Metcalfe: It is indicative of the direction in which we have to travel. We have to be actually working across Departments, but with a long-term commitment. The places that we know about where there has been progress have taken that joined-up approach and have really addressed what we call the determinants, not just one determinant like housing, but things like fuel poverty, food poverty, income redistribution — across the board. It is of particular concern that those kinds of benefits might be addressed in a manner that would target the most disadvantaged and make them even more susceptible to vulnerability.

Mr Wells: Also, is there any evidence that the breakdown of the standard family is causing greater problems in early years? Following the recent riots that occurred in England — in London — they found that something like 60% of those arrested had no identifiable father figure, because the father either was never present or had long since left, leaving a young mother to raise children in very difficult circumstances. To put it another way; even if we spend all this money, but the family structure continues to break down, will that be an inexorable trend that will continue to cause problems?

Dr McAvoy: On that point, in the millennium cohort study, one of the factors that was different in Northern Ireland as opposed to England, Scotland and Wales, was that there was slightly more involvement by the mother's partner in child-rearing. There seems to be something slightly better about that situation in Northern Ireland. I am not saying that it is universally the case, but the figures here seem to indicate that mothers' partners, be they husbands or otherwise, were more involved in child-rearing, and I thought that was interesting.

Mr Wells: That may simply show that the breakdown in the nuclear family in Northern Ireland is simply lagging behind the rest of the United Kingdom, and that we are rapidly heading towards the same predicament. Clearly, for a young man in particular, if there has been no father figure, it must be incredibly difficult to set boundaries and discipline and to provide the wherewithal to raise the child properly. There is obviously a lot more poverty in single-parent families. All the indications would state that family relationships are breaking down in Northern Ireland, albeit maybe a decade behind the level of the rest of the UK. Certainly in parts of the Republic, in places like Limerick and Dublin, there has been a dramatic fall in the number of standard family units. Regardless of whether you see this as a moral issue, there is no doubt that it is easier to rear children and have good health outcomes if there are two people bringing in an income or helping to protect and rear the children. That is just a fact of life. It is much more difficult as a single person. Is that another issue coming along the line in Northern Ireland?

Mr Metcalfe: Probably, but we do not know. We do not have the data to support what the differences are at the moment. We have information about lone-parent families, but in societal terms, we do not have enough data to address the question that you are raising.

Dr McAvoy: We know that children do better in traditional family units, but there are often things driving those units in the first place. However, from my perspective, the lone parent group is a very diverse one. Certainly, there are the young never-marrieds, but there are also separated and divorced groups, and there are widows and widowers in that mix of lone parents, and I think we need to look at the different challenges that those families face. They are different, and they face different challenges at different stages of their lives. They are not universally young, unmarried mothers; they are a diverse group, and they are becoming increasingly diverse. For example, the age of lone parents is higher than it used to be. They are quite often never-marrieds who may have their first baby in their thirties, for example. I think we need to better understand lone parents in order to configure an approach as to supporting them.

The Chairperson: We also need to make sure that we do not send out the message that lone parents are the cause of all ills in society. The point was made that 60% of the ones involved in the riots in England have no father figure, but 40% of them did.

Mr Wells: Some of those effects are quite ephemeral. There was a father that they could identify, but not much more.

The Chairperson: I know, but 40% of them did. There were also people from very affluent families involved in those riots. It is not always people from socially disadvantaged backgrounds. I am proud to say that I am from a socially disadvantaged area. Granted, I am not a lone parent, nor did I come from that, but we need to be careful and remember that it is easy to brand people.

Jim, as regards the point you made around family nurse partnerships, we will get more information on that from the Department.

Ms Brown: Thank you all for your presentation today. It has been very interesting. A lot of questions have been asked, and I do not have much really to ask. I just want to make a comment about the necessity of early intervention. I was at the same event that Jim was at where we saw examples from Scotland that were absolutely horrific. Obviously, a cross-departmental look at the whole issue will be the best thing that we can do. Obviously, that has to be looked at. Education is vital, and we know what a big thing this fuel poverty issue is as well.

In your presentation you talked about child poverty, and you noted there that around four in 10 poor children are working poor, where the family has at least one adult in paid employment. We are becoming increasingly aware of that struggle that people who are maybe not on benefits are having. I also want to ask about obesity. How serious a problem is it recognised as? We are all aware of smoking and drinking, but a lot of people who are very against smoking and drinking are quite happy to eat themselves to death. How seriously do you think that is being treated on the whole?

Mr Metcalfe: The figures for overweight and obesity among young people, both North and South, are scary. Maybe 25% of three- or four-year-olds are overweight or obese. That needs to be a priority. The consequences of that for all types of health problems later on are immense. Again, it is not something that can be addressed by one Department. Everything that we say here points to the imperative for that cross-departmental approach to addressing obesity through parenting, food availability, distribution and maybe legislation. All those things have a role to play. There is not a simple, single solution or fix for the issue of obesity. It is really challenging.

Ms Brown: You see the whole health inequality issue, I am sure, as a long-term project. There is very little that you can do quickly and immediately that will have any lasting impact. It is about a whole change of lifestyle and education, and breaking that cycle.

Dr McAvoy: One of the areas that is certainly worth looking at, and which spans a number of things here, is around parenting programmes and supported parenthood. There have been a number of programmes, some funded by Atlantic Philanthropies, both in the Republic of Ireland and Northern Ireland, that are in various phases of their evaluations. Some of the early findings are coming out from those. They are, methodologically, very robust studies of children whom we know are living in Ireland and Northern Ireland, so we have a good degree of confidence in what is coming out from them. Some of them are in deprived areas of Northern Ireland and the South. One of the early messages that seem to be coming out is that parenting programmes seem to be working quite well. The programme for life evaluation is one that I particularly have in mind, in the ability of the parent to support good nutrition in the home, physical activity and home safety. We know that parenting programmes in disadvantaged communities have good outcomes internationally, but we always like to have data from our own communities to be able to stand over it with some confidence. Investing in parenting programmes seems to be working quite well in the evaluations to date. The challenge will be to look at the findings from those studies that were funded by Atlantic Philanthropies and draw together the knowledge from those for future development and endorsement of programmes by government in due course. That is the stage that we are at with that.

The Chairperson: Pam, as you know, during the last mandate, the Committee held an inquiry into obesity and other associated eating disorders, so we did get an update. We can get a further update from the Department on where the recommendations are sitting.

I want to make a few points. This has been a very interesting presentation and discussion. You have probably highlighted a lot of the reasons why we have decided to look at health inequalities. It is not just a health issue. Other Departments have a role to play. I said at the start — and you mentioned it during the course of your presentation — that other Departments have good projects. I have a concern — I am sure a lot, if not all, members share it — that some projects are piecemeal, some are

still in pilot mode years after they were set up, and some do not even come out of the community that they were piloted in, whether that is around literacy or numeracy or a lot of that stuff. That leads to further problems. We also need to highlight the fact that there have been great projects in the community and voluntary sector. However, they were seen as pilot projects. Jim and others mentioned a quick fix or a quick win, and some of those projects were winning. You talked about the Atlantic Philanthropies: the virtual reality babies were having an impact on teenage parenthood in some communities, and the likes of Sure Start and breakfast clubs and all of that stuff. However, the concern is that they were seen as pilot projects, and it then became a battle for community groups and Departments to sustain them or spread them to other constituencies.

Maeve made points about changing the mindset, and others said that it is about the individual mindset and about individuals changing their lifestyle. It is also about changing the mindset in the statutory sector and, indeed, in Departments. Monitoring the outcomes is crucial, but there has to be a commitment from all the Departments, and it is important that organisations such as yours work closely with us in this phase of us looking at health inequalities and, if there are models of best practice, steer us in that direction. If there is information that you think we need, let us know.

The joint meeting between us and the Health Committee in Leinster House was interesting. Again, there was information you provided there, and we can possibly look at some of the projects that can happen around the border corridor areas or the projects that are happening in constituencies in the Twenty-six Counties. We can learn the lessons from there, if need be. On behalf of the Committee, I thank you again for the paper and the presentation. Stay in touch and help us through this.

Ms Maeve McLaughlin: It would be useful, for the economics of this, if we could get an accurate figure for island-wide savings from early intervention. I know that an analysis has been done here, and a number seem to have been done throughout the Twenty-six Counties. It is very important to get that island-wide figure as a benchmark of the savings that can be made if we invest early.

Mr Metcalfe: We will have a look. Thank you very much, Chair. We welcome the Committee's attention to the issue. That probably goes without saying, but thank you anyway.