Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Budget Scrutiny Review

21 November 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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

Witnesses:

Mr Simon Wakefield	Scottish Parliament
Professor David Bell	University of Stirling

The Chairperson: I welcome Professor David Bell from the University of Stirling, and Mr Simon Wakefield from the finance scrutiny unit in the Scottish Parliament. Thank you for making this short visit. Please make your presentation, after which members will have an opportunity to ask questions or make comments.

Professor David Bell (University of Stirling): I am happy to talk about health once we get going, but because it is the subject of my paper, I thought I might concentrate on the sorts of things that Committees might focus and be effective on, and the factors that influence that. This is from my observations, having been Budget adviser to the Scottish Parliament's Finance Committee since 2007. This is my third session as a Budget adviser, and we have been thinking quite a lot about the things that matter when it comes to budget scrutiny.

There are two main areas that budget scrutiny can try to influence. The first concerns strategic direction. In this, I am thinking about, for example, whether the Committee can affect the amount of resource heading towards older people, where we know that a demographic challenge is coming. Northern Ireland has quite a big demographic challenge, even by UK standards. So, can the Committee affect that? On the other hand, and on a more prosaic level, what can the Committee do to enhance efficiency? This is about getting the best from the resources that you have at the moment. So, there are the long-term and short-term views about trying to get the best out of the resources that you are spending.

Northern Ireland spends more than any other part of the UK per head on health, but not a lot more. Scotland is about £50 out of £2,000 per head short of Northern Ireland's spend. Although Northern Ireland spends quite a lot, it is not massively out of line with Scotland.

The important thing about scrutiny is to consider who is good to consult; in other words, who you should be talking to. Typically, in the Scottish Parliament, there would be people such as the chief medical officer, and so forth, and they are always going to come with a particular point of view. It is useful to get outside experts in when you can, whether from Northern Ireland or elsewhere. Having a different perspective from someone who is not in the system is often quite good.

In Scotland, the Finance Committee would expect the Minister to give evidence, and that happens fairly frequently with us. He may or may not get a hard time, depending on how the Committee is constructed. It is often useful to get the Minister to account for, and provide clarification on, parts of the budget that you do not understand or that are not made clear.

The Finance Committee also goes out and about. I missed our latest trip, which was to Hawick. We take the budget to different parts of the country and meet schoolkids, local people, businesses, and so forth. That is a useful exercise, too. We have a variety of settings, including one such as this which is very formal. We also have round-table meetings, which are much less formal, where you would intermingle Committee members with the people to whom you are speaking. Often, those are quite useful ways of interacting.

There is a balance to be struck between incredible amounts of detail and strategic direction. Our budgets are described as being level 1, 2, 3 or 4 budgets. Level 1 outlines how much is going to health or education. Level 2 describes how much is going to the health boards. In Scotland, we do not know much more about what happens to health budgets after that, but in areas such as education, we can follow the budgets down through the different stages. It is useful to have as much detail as you can get for the sake of transparency, but you can get terribly bogged down if you have too much to handle. There is a trade-off when you are doing scrutiny.

When we are doing scrutiny, we always have a report that is discussed by Parliament. This is a slightly different situation because this is a Health Committee. All the other Committees feed into the Finance Committee their views on the Budget, and then the Finance Committee takes a report, which is discussed in Parliament. There are various influences on that report, and I am happy to answer questions about that. I will not go on about it for too long.

To conclude, it is useful to think about what you would consider to be a good outcome from a scrutiny process. What is it that would be a mark of the effectiveness of the Committee's scrutiny of the health budget? It might concern changes in budget decisions. You need someone to go through budgets forensically if you are going to have that happen. You may, irrespective of the politics involved, be able to call Ministers to account if you have conducted your scrutiny well. You may be able to influence a gradual change in strategic direction.

Although we may not really be seeing the benefits of this yet, one success of the Finance Committee's scrutiny of various budgets since 2007 is that there has been much more focus on what we call preventative spend, which is, spending before you hit the buffers. For example, it could be spending on ensuring that older people do not get unplanned admissions to hospital, which is a massive cost. Preventative spend considers what can be done by social care departments to ensure that that sort of thing does not happen.

Preventative spend goes wider than that. For the Finance Committee, it goes into areas such as early years intervention; in other words, spending money on young children between the ages of one and three is more effective as a bang for your buck than spending on 13, 14 and 15-year-olds. You can really make a big difference to people's lives if you spend early on. The focus on preventative spend has probably been our major success.

Mr Simon Wakefield (Scottish Parliament): I will run through a bit of the experience that we have had. My team is the financial scrutiny unit, and we are equivalent to the finance scrutiny team in the Research and Information Service here. I was asked to set up the unit because the Parliament identified that it needed a bit more resource on financial scrutiny and looking at public finances. We have quite a small team.

As the paper says, the Scottish Budget process is slightly different to what happens here. There is a fairly standard annual process in which a draft Budget is presented in September. Essentially, the

Committees look at it, and the Finance Committee produces a report, which is debated. In January to February, the Budget Bill to approve the Budget goes through Parliament. That is a fairly fixed annual process that we go through.

Similar to David, I was thinking about different examples of ways that Committees have looked at their budgets in the past. A fairly standard traditional approach is to start with the budget documents that are presented and, as I said, take evidence from the Minister, officials and external experts. Perhaps the focus there is often on achieving a better understanding and shining a light on the process. Perhaps a disadvantage is that that is often driven by the documents and information that are presented by the Government. Committees have also looked at specific organisations — for example, Scottish Enterprise and VisitScotland — and asked whether they are sufficiently funded and are being efficient and effective? That allows a Committee to be focused and to drill down into specifics. However, it is maybe a fairly narrow focus, and there is the potential for other big issues to be missed elsewhere in the budget if you do that.

Your Committee could take a cross-cutting approach and look at things such as preventative spend, particular treatments across the health boards, or issues such as dealing with an ageing population or drug costs. This can allow for a bit more of a focused, joined-up approach.

Outwith the budget process itself, we have looked a bit more at the work of the health boards, which accounts for a very high proportion of the spend but is not really information that is part of the normal budget process. My team has worked with the Health Committee's budget adviser in sending out a questionnaire to health boards asking for the type of information that, essentially, the Committee is interested in, about the key pressures on the health boards across the piece. It includes issues about reliance on non-recurrent funding; what the inflationary pressures are; and what the main areas are where savings are likely to be made, for example, as shown in the table, priority service developments that the boards say they are unable to progress because of lack of funding.

This, perhaps, gives you a bit of a starting point for looking into some of the cost pressures that are not presented as part of the normal budget process. It takes quite a bit of effort and resource to pull that information together and to negotiate and discuss with the boards to try to make sure that the Committee receives consistent, comparable information and that boards understand what the Committee is asking for and why. However, it is the sort of thing that the Committee has found quite useful, but there is the potential for further improvements to be made.

I will finish by talking about some of the issues that your Committee might wish to consider; one of which, as David touched on, is having a real clarity of purpose on the point of budget scrutiny.

There are a few things that the Scottish Parliament's Health Committee identified as being key questions that the public has a right to expect us to be able to answer. It could be those sorts of things, or it could be about ensuring that the actual spend taking place — where the money is going — reflects the stated priorities of the Government. Do the two things match up? Is the Committee satisfied that the process the Government have gone through in allocating their Budget is fair and transparent, and have decisions been made based on evidence? Those are the two key questions that you could think about all the way through.

A lot of this depends on the quality of information provided to the Committee. As David said, it is not just about the amount of information, it is about getting good-quality information that is relevant, compares like with like, actually answers the questions you are interested in, is focused and understandable, and is provided at the right time for your purposes.

The other point David made is about trying to pull in as much external expertise as possible. It is probably true to say that there is an increasing interest in public policy in Scotland, including in health, among the academic community and think tanks. The more of that community and the more of those people who can provide that extra and expert advice, the richer the quality of evidence will be. I think that your Committee might want to consider whether it could have a key role in stimulating that kind of work.

The Chairperson: David and Simon, thank you very much, and, again, thanks for the papers. I have a couple of points to make, and then other members will want to come in.

This could be disingenuous, but every time our Department brings information on budgets or budget scrutiny to the Committee, I am more confused when they go out. In your paper, you made the point about whether we are being provided with the relevant and right information. Sometimes, I feel that

we are being provided with a mountain load of information to confuse us even more, rather than free us up and allow us to carry out our role of scrutinising the budget to see whether money is being spent well, properly and in a focused way.

I say this because, for years, we have been told, and we have heard people saying, that the health service has been underfunded by millions. At one stage, the British Medical Association, I think, said that the health service was underfunded by £200 million. We are also told that there is a lot of wastage in the health service, and that information is available. So, on the one hand, we are being told that it is underfunded, and on the other, that there is a lot of wastage and that we need to find an effective way of spending our pound wisely, which is fair enough.

We are also told that £10 million is spent each day on health and social care in the North, but we do not know where that £10 million is spent. So, again, we try to get information to find out about that. If we know that the £10 million is being spent, we must know where every pound of that is being spent. When you try to follow that pound, things seem to get confused and clouded along the way.

Conall raised an issue a number of weeks ago about a project involving projected spend versus actual spend. If you are talking about your projected spend, you must have information and statistics about that. In fairness to the Department, the actual spend is either a lot less or above what was proposed.

On top of this, we talk about health inequalities, but other Ministers have to play their part in that, too. Departments have responsibility for early years, child poverty and supported living. It is all there. We are not trying to catch anybody out: just tell us where the money is being spent.

We also hear about targeted strategies in Departments, including our own. The question is this: is that ever additional money? It might seem as though we are targeting health inequalities or child poverty, but, technically, is it additional money when you look at how the money is then fed into the trusts or groups that are doing it?

This is quite useful. You have gone through the process and have a lot of knowledge of it. How can we get clear information on where the money is spent and where it goes on a daily, weekly or monthly basis without all the jargon? How can we get clear information on how much money is spent on health and social care and exactly where it goes? I do not know how the rest of the members feel about this, but every time we get financial documents in here, I am more confused when the officials leave than I was when they came in.

Mr McCarthy: That is how they want you to be.

Professor D Bell: I have one or two points. A budget will give you the level of spend over a year, or whatever, on some item, responsibility or other. It does not necessarily show you a change in spend. Something might have to be taken from one box and moved to another in order to get an amount of spend; so you will see a small change in some very large figure. However, in fact, a completely new programme may be being put in place on the basis of that little bit of extra spend. If that is not explained properly to you, it is very difficult for you to make any sense of it.

One thing that I do not think the Scottish Parliament has done all that well, despite having talked about it a lot, is the linkage from what you might call public accounts and what we call audit. Audit is supposed to look at what happened and how the money was spent, last year. Lessons from that could be given to subject Committees such as the Health Committee or the Finance Committee. The Auditor General for Scotland is very strong on this issue. The Public Audit Committee in Scotland gets lots of useful information, but unless that is fed back into the system, it just hangs there and is lost.

What you are trying to get to are not the inputs or the cash that is going in. You are trying to improve the health of the people of Northern Ireland. Ultimately, that is what you are after. So, when people ask you what is going on, it seems to me that you should know about the inputs and the outcomes. I do not know whether that information is being provided to you.

The Scottish Government have attempted to make progress on that issue. To be honest, it is quite difficult. They have done a number of things. There is a website called 'Scotland Performs', which is supposed to measure outcomes against targets across a whole range of things, including health. In addition, the Scottish Government have established sets of outcome agreements with public bodies, such as my university, the local authority where I live, and so on. This is not about how much money they will give to local authorities, it is about what they agree they should be aiming to produce by way of outcomes. For a local authority, it might be that a certain proportion of schoolchildren should leave

school with a certain level of qualifications. A classic health target might be to reduce the unplanned admissions of older people.

A focus on outcomes is very useful. You can get bamboozled by the numbers and the cash that is being inputted. What you have to ask is what you are getting for that, and what the measurable outcome is for that process. You can then point that out to your electorate as being the value for that extra spend in health. That is all I want to say for the moment.

Mr Wakefield: Briefly, to be fair to the Government, quite often the information they prepare is perhaps for a different purpose than for presenting to a Committee. The information has been prepared to manage the health budget. Committee members will know good-quality information when they see it, but sometimes it can be quite difficult to articulate exactly the right question to get the information you are asking for. There is no easy answer. However, if you bring in external expertise or make use of your internal research service to keep pushing and thinking about what information is required, you will gradually get closer to something that is meaningful and what you are after. It takes time and effort, and there is no substitute for getting external expertise or putting some resources into internal research if you are to get what you want.

Professor D Bell: I want to give you an example of outcomes. It just occurred to me that I was in front of the Health Committee in Edinburgh a couple of months ago. We were discussing healthy life expectancy, which is the length of time that people can expect to live a healthy life from a certain age, often from 65. Objective information on that is produced by the Office for National Statistics for all the countries of the UK. Scotland does pretty badly, to be honest. It does worse than Northern Ireland in that respect. That kind of information is useful in calling the Government to account. You say that one of your key objectives is to improve the health of the nation, but you are falling behind on healthy life expectancy, which actually has a corollary in that the difference between your life expectancy and your healthy life expectancy is the amount of time you can expect to be disabled. That is obviously unpleasant for you, but it is also going to increase the cost to the health service. That is the kind of information on outcomes that is useful in calling health boards and those concerned with the provision of healthcare to account.

The Chairperson: Before I bring in other members, I think it is useful to put on record that members of our research team here have cleared up a lot of stuff for me and other members in the papers that they have provided. They have been very good in that sense, but there are times when they do not get the information that they require to advise or support us on some of the budget stuff. However, I think it is important to mention that they do good work for us as well.

Mr McCarthy: Thank you very much for your presentation. You have just been speaking about the quality of information — relevant, comparable, focused, on time and understandable. To go back to what the Chairperson said, although lots of information comes to the Committee, it may not always be easily understood. I suggest that perhaps that is because it is presented in so sophisticated a way that it is perhaps not understandable to us as Health Committee members. It is very important that it should be basic and easily understood. Both of you mentioned the outside expertise, and I agree with you there. How has Scotland, for instance, appointed external policy experts so that they get the right people?

Professor D Bell: The Committee Clerks frequently invite people to give advice, although they do not always turn up. Iain Duncan Smith has not agreed to come up to discuss the Welfare Reform Bill, but external experts frequently do come. I am the only adviser who is on a permanent contract. We appoint short-term contracts at pretty low cost for the period of the Budget process. I know that it is slightly different in Scotland, because it is an annual event. From perhaps September until December, the Health Committee will have an adviser, probably a health economist from one of the universities. Those round-table sessions are also very useful for getting people up on an ad hoc basis. For example, one of the European experts on healthy life expectancy is a woman called Carol Jagger. She happens to be at Newcastle University, so it is no problem to get her up to widen the discussion. The round-table sessions, which are less formal, are often very valuable, as long as the outcomes of them help the Committee.

The Chairperson: Sorry; is it the Finance Committee or the Health Committee that does that?

Professor D Bell: The Finance Committee. I think the Health Committee has round-table sessions. I am not sure.

Mr Wakefield: Several of the Committees have. It is not exclusive to the Finance Committee.

The Chairperson: I know that our Finance Committee does some of that stuff. Will you just clarify whether the Health Committee does that as well?

Professor D Bell: My impression is that it does. Then you have to worry a bit about crossing borders, because the ageing of the population is a threat to Scotland's Budget. If you are going to talk about that, you have to get the health people in to discuss it, so there has been a little bit of overlap in that sense.

Mr McCarthy: Finally, you mentioned preventative spend. Is there any strong evidence that savings can be found from early intervention and prevention that would make the case for the Department shifting a greater balance of the budget in that direction? Similarly, is there strong evidence that, with appropriate funding, the community and voluntary sector are better placed to deliver some services than the state? You mentioned, for instance, the admission of older people to hospital and that that could be prevented. We entirely agree with you, but our experience is that it is very hard to convince our Department to put funding, and to continue to put funding, in that direction. In fact, it pulled funding away from meals on wheels, which means that older people are going in the direction of hospitals, and more money will be spent.

Professor D Bell: In respect of preventative spend, the evidence on interventions for young children is accepted worldwide. A guy got a Nobel prize for the work that he did on that, and there seems to be no doubt that spending on early years is good.

The evaluation of interventions in health, particularly around unplanned admissions, and so on, often is not as good as the people who are involved with it would like to claim. Scotland has set up the Change Fund, which is specifically designed to shift resource from care in the health sector per se to more care in the community. It is a £300 million fund. I am not absolutely sure that it has, as yet, been evaluated to an adequate standard, but that is something that a Committee like yours should always be asking. If an initiative like that is being proposed, how much of the budget is being set aside? You would normally expect something like 1% to make sure that it is being spent wisely. It has not been evaluated all that well, but what is absolutely clear is that Scotland has managed to more or less eliminate delayed discharges. About 10 years ago, there were lots of people stuck in hospital beds for all kinds of reasons, often because there was no suitable accommodation for them at home or because the circumstances were not suitable, but through various interventions, including the Change Fund, that problem seems to have disappeared. Of course, that means that there are more beds available for standard patients.

Mr McCarthy: In a lot of cases, the community and voluntary sector would be better placed to deliver a better service. I do not know whether you are familiar with the independent living fund.

Professor D Bell: I am.

Mr McCarthy: Up to now, that has been administered by an arm's-length body of the Department of Health, but it is proposing to shift that into the community and voluntary sector. Would you say that that is a good way forward or is it just another method of trying to save money and prevent it from getting to where it is needed?

Professor D Bell: I could go on for an hour about that. England has gone quite a long way down the line of what you might call personal budgets, where you give people in the community their own budget, and they often buy not from the local authority per se but from a voluntary or even private care provider. Scotland is starting to experiment in that area with what is called self-directed support. That gives care clients more of a say over how the resources allocated to them are used to support them. That might be quite different from what the local authority would have previously suggested and may be cheaper. I am not absolutely clear at the moment where Northern Ireland is, but in Scotland, a lot of the issues are about local authorities giving away control to the client. There is a balance in the control of what kind of service the client receives. Is it self-directed, as will increasingly be the case in Scotland, or is it simply what the local authority views as appropriate? You may be somewhere in that area, too, where somebody's first preference might be the voluntary sector rather than a local authority.

Mr McCarthy: That is where we are at. The voluntary sector has been involved in this, but there are changes. It will be thrown into a massive pot, and the fear is that those people who are entitled to it or need it will be overlooked.

Mr McDevitt: Chair, I will pick on the theme that you raised, which is that we live in a perpetual conundrum about projected budgeting and actual spend. In your opinion, Professor Bell, is there an acceptable variance in health and social care budgeting between a projected budget and actual spend? Is it a 5% or 10% margin or could there, in fact, be a 50% difference, as we often find?

Professor D Bell: If there were 50% differences, I would be inclined to —

The Chairperson: Sack the person.

Professor D Bell: — at least ask them very strongly what has happened. There are lots of examples of such issues in the health service UK-wide. Classically, with the IT projects in England, there seems to be a lack of control, or there has been in the past. In Scotland, the health boards have a fixed budget, and they cannot go beyond that. If they have overshot on one project, something else has to fall. Of course, at the end of the day, you see the same number in their budget, and the budget document may not pick up that pressure. It seems to me that that sort of information would be very valuable to the Committee. You could query that strongly, because somebody is losing out because of that.

Mr McDevitt: Is the concept of preventative spend what we call invest to save?

Professor D Bell: I think so.

Mr McDevitt: The financial policy model that we use here says that we will put £x million in upfront and it will accrue savings because of improved outcomes. Is that basically the same?

Professor D Bell: Yes, absolutely. My feeling is that the evidence for this is laudable because if you invest early on, you save a lot of grief and a lot of front line service provision, such as emergency hospital admissions, crime and all kinds of stuff. However, a lot of it might be described as quite woolly, because the spend has to be made 10 years before you see the beneficial outcomes, and linking those two things is often quite difficult.

Mr McDevitt: Professor Bell's point about the Audit Office is a seminal one, and we should pay attention to spending that happened five, six or 10 years ago.

I have one last question. We experimented here with a budgetary vehicle that we called Executive programme funds. You basically bid for funds against a particular policy outcome. There were some successes, but those funds were dropped. Normally, the Executive programme funds would be made up of a cocktail of funding from departmental lines; a series of Departments would make up the fund. The funds would be for things like a new cancer centre or a children's strategy. Have you explored them? If so, how successful is your scrutiny of them? It is quite complicated to scrutinise something that comes from seven or eight pots that may cross three or four different Departments.

Professor D Bell: That is something that Simon mentioned that we would describe as cross-cutting. We have made attempts to do that. I would not necessarily say that they have been very successful. It is difficult to know who to call to account when you have money coming from a variety of sources. It is interesting that they are no longer available. That may, perhaps, be because of tighter budgets. It would also be interesting to know whether the outcomes of those are significantly better than the average spend.

Mr Gardiner: It is good to see you. You are very welcome to Northern Ireland to give us your advice. Will you elaborate more on what you said about your experience of management of funding?

Professor D Bell: In which context?

Mr Gardiner: Health spend; we are concentrating on the money that goes through the Health Department. Are we getting sufficient funding or are we entitled to more? Is the money being spent wisely?

Professor D Bell: There is a pecking order around who gets most public spending per head. Northern Ireland is highest, followed by Scotland, Wales and then England. Arguably, Scotland is out of line — I said "arguably"; I must not be quoted on this. *[Laughter.]*

The Chairperson: This is a live evidence session. *[Laughter.]*

Mr Gardiner: Trust me.

Professor D Bell: An argument is made that there are misalignments here, but Scotland is moving to a new situation in which it will raise a much larger proportion of its own money and will make its own decisions on how much to allocate to health. I suppose that you have got to take your cue from measures of levels of ill health in the community compared with other parts of the UK, unless you take the view that health is just generally underfunded. If you take the view that health is generally underfunded now, the issue will just build up and build up because, over the next 20 to 30 years, the demographic challenge will certainly see a very substantial rise in health spend even to keep healthcare at the level it is at now. I guess that the overall indicators show that, in terms of health, Northern Ireland is probably doing slightly better than Scotland but is not quite at UK average levels.

Mr Gardiner: Yes, but what about spending? We are not better than Scotland; you have more funding than us.

Professor D Bell: Our health spend per head is about the same; there is not that much difference. It is slightly higher in Northern Ireland, but only by tens of pounds per head. Scotland possibly spends more on economic development and those kinds of issues, but its health spend per head is very close to Northern Ireland's, and both Scotland and Northern Ireland spend a bit more than England spends.

Mr Gardiner: If you have had an opportunity to study our health service, can you tell us where you think we should be spending more money?

Professor D Bell: The big challenge is older people.

Mr Gardiner: People are living much longer.

Professor D Bell: Scotland has seen a considerable move towards providing care in the community. It has a policy of what is called free personal care, which means that personal care delivered in care homes and at home is free to individuals who are deemed to need it. Other care has to be paid for, whether in a care home or in their own home. There is a view that this is unsustainable, but it should be seen as part of a broader policy that has caused more people to be cared for at home, which is actually cheaper for the public purse than caring for them in a care home. So, in fact, the number of people in care homes in Scotland has been declining. The difference is between £500 and £600 per week, compared with £150 or so for people being cared for in their own home. People prefer to be cared for in their own home, if that is possible.

Mr Gardiner: That is true, yes.

Professor D Bell: The best way to deliver a good service to older people is a key area. There is a further issue in relation to that, which is dementia. Incidence of dementia goes up very rapidly with age. So, as we live longer, the proportion of the population that will have dementia will rise. Developing strategies to deal with that seems to me to be incredibly important.

Mr Gardiner: We must seek a cure or prevention.

Professor D Bell: Absolutely. Unfortunately, although, on occasion, scientists have said that there are breakthroughs, as yet nothing has come through on the ground.

Mr Gardiner: If you have any influence, keep pushing it. Thank you.

Mr Brady: Thank you very much for your presentation. I almost lost concentration earlier when you mentioned Iain Duncan Smith and welfare reform.

My question follows on from what Sam was saying, and Kieran referred to this as well. You mentioned the demographics. It is estimated that our population of elderly people will double by 2020. One aspect that is emphasised in 'Transforming Your Care' is care in the community. There is the issue of carers, who save approximately £4 million per year here in government spending. At what stage in budgeting does that need to be addressed? It seems to me that there is quite an ad hoc approach of, "Let us wait and see." People are living longer but not necessarily more healthily. The information that we have is that the last couple of years of a person's life are probably the most expensive for healthcare. Obviously, there is a budget on a yearly basis. Compton has talked a lot about community care, care in the community and the shift from acute to social care, but at what stage do we need to start addressing that by putting in place the infrastructure? Otherwise, we will arrive at a stage where we will have all these older people who are not necessarily healthy and who need a lot of care and a lot of expense.

Professor D Bell: This point about older people who are disabled or unwell is exactly the same as the point about healthy life expectancy. It is the difference between the number of years that you can expect to live a healthy life and the number of years that you can expect to live. It is the difference between the two. Whether that is growing is a key question. If the issue is that there are more older people possibly requiring more care, because of the challenges that all parts of the UK and, indeed, all parts of Europe and many parts of the world face, the sooner that you start to put the necessary bits and pieces in place, the better. The big changes will start to kick in from the second part of this decade, I would say.

A key issue here is carers, as you say, because we rely on informal or unpaid care to a huge extent. In Scandinavian countries, it is very normal to think of the state as being the provider of care for older and frail people. In Mediterranean countries, it is very much the family. We are somewhere in between, although the numbers that I have looked at suggest that family care is more prevalent in Northern Ireland than it is in mainland Britain. Nevertheless, carers are often middle-aged women who have lots of pressures on them. They may have young children, because women are having children later. They may also be trying to hold down a job, so they are caught in three different directions at once. Thinking about how that can be done is important. I suspect that, in the future, we may need to think more about spousal care. When you look at older people living in partnerships, you see that the gender balance of caring evens out among men caring for women and women caring for men, whereas, when it comes to a child providing care for a parent, it is usually the daughter who provides the care.

This issue brings in housing. What are the appropriate housing solutions when one person is really quite disabled and requires care from their spouse? You start to move into other areas. This is kind of a cross-cutting issue.

Mr Brady: Some of us sit on the Committee for Social Development; that is why there was a sharp intake of breath when you mentioned welfare reform. There seems to be a disconnect. You mentioned housing, and there are so many overarching issues. The whole issue around carer's allowance as a wage alternative is left solely to social security when, in fact, it has such an impact on the health budget as well. There does not seem to be that connect there, and that is part of the difficulty. If there were more cross-pollination, if you like, that might go some way towards solving the problems, maybe not immediately but somewhere down the line. There should be much more of a coming together of that thought process.

Professor D Bell: Yes. I cannot disagree with that. Essentially, these are two separate worlds. The same is true in Scotland. The Department for Work and Pensions provides benefits for disabled people and, independently, the Scottish Government are, through local authorities and health boards, providing a different set of services to these people.

Mr Brady: That is the point. Obviously, what is happening through so-called welfare reform is that money is being taken away from that budget. There are displaced costs, so, inevitably, it will cost the health service more. That thought process does not seem to be in place.

Professor D Bell: That may be the case. One thing is that, under welfare reform, the attendance allowance has not been touched. That is the benefit that older people get at home if they have got —

Mr Brady: The change from disability living allowance to the personal independence payment will not affect the people who are currently on it, but it will obviously affect others as the older population increases. That is why forethought is required.

Professor D Bell: Yes.

The Chairperson: I am conscious of the time. Simon, do you want to come in on any of these issues?

Mr Wakefield: I will mention one matter. Audit Scotland recently produced a useful report that touched on one of your points about year-to-year financial management. It found that 18 of the 23 health boards came within 0·5% of their budget in 2011-12. That relates to your point about long-term planning. According to that report, a number of health boards were slightly guilty of a short-term focus in their thinking, and Audit Scotland was looking for a much longer-term focus on planning. That sort of thing is quite useful.

Mr Beggs: Thank you for your presentation. It is always useful to benefit from the experiences of others. You highlighted the importance of keeping older people out of hospital and the action that Scotland has taken for early years investment. You mentioned years 1, 2 and 3 in particular.

(The Deputy Chairperson [Mr Wells] in the Chair)

Scotland, I think, is ahead of the other devolved regions in investing in young people. That is certainly my sense, having heard Harry Burns speaking a number of years ago. You mentioned that your policy was successful in that area. I declare an interest as a member of Horizon Sure Start. What objective measurement has been used to try to assess the success of that investment? Long-term benefits flow from that, so how have you been able to measure the outcomes of that investment?

Professor D Bell: Which investment is that?

Mr Beggs: Early years.

Professor D Bell: It is still early days. I have been involved a little bit in a longitudinal study — this is relevant to Northern Ireland — that tracks people from a particular point in their life. That is the only way to really understand what the benefits of early years intervention are likely to be. We have a study called Growing Up in Scotland that follows children who were born eight years ago, which is when it started. We are looking at that study for evidence — there is some evidence, but do not ask me to quote it exactly — to help us to show the benefits of intervention. I am also involved in an attempt to get a study in Scotland off the ground that follows older people over time. It is called Healthy Ageing in Scotland. There is already such a study in Ireland called the Irish Longitudinal Study on Ageing, and there is an attempt to get one off the ground in Northern Ireland. I do not know whether you have heard of it; it is called the Northern Ireland Cohort for the Longitudinal Study of Ageing. That is all coming from pressure from the National Institute on Aging in the US, which has done a number of studies around the world.

We are trying to link people's health experience, in a questionnaire, to their educational experience and their interactions with the housing and social care Departments in order to build up a picture of people as they age. We take people aged 50 and over. I think that there has been an attempt to do that in Northern Ireland by a guy called Declan French, who is one of the main drivers behind it. That sort of evidence in the future — it will take some time — may be able to shed light on the type of policy we talked about earlier whereby you try to reduce the chance of older people being admitted to hospital in an unplanned way, and so on.

I guess what I am saying is that there is little evidence on early years intervention in Scotland. We are building it up. There are a host of studies in different parts of the world that are now starting to try to put these things together. There may be a strong case for having a longitudinal survey of ageing in Northern Ireland. However, as a Committee, it seems to me that you need to be aware of these matters and how they can help you.

Mr Beggs: Preventative work can frequently benefit the Departments of Health, Education, Justice and, perhaps, others. With programmes, there can be cocktail funding. Sometimes a programme rests with one Department, which resents having to fund it all. How is that managed in Scotland so that joint funding comes together and people are assured that money is available for the necessary early years investment?

Professor D Bell: Harry Burns, Scotland's Chief Medical Officer, talks about the importance of place. All Scottish surveys contain an index of multiple deprivation. That is the classic for health inequalities. From the top to the bottom of that index, there is a huge span in life expectancy, crime, educational attainment — the whole works. The allocation of funding is not necessarily very joined up. Scotland's two big budgets are for local authorities and health, so each of those will have some adjustment for deprivation.

Glasgow, for example, will have additional money because there are difficult areas such as Drumchapel and Easterhouse, although there are also some affluent areas. That all goes into the pot. The question is how much money is channelled to those areas — I am not saying that Glasgow does not channel — but there is not a single pot.

A similar adjustment will be made to NHS Greater Glasgow and Clyde's pot for deprived areas. Some programmes are specifically targeted, but the bulk of funding still tends to follow the local authority and health boards' specific formulas for allocating money.

Mr Beggs: Presumably, they both have to audit and be held to account over expenditure in a duplicate fashion.

Professor D Bell: Yes. They get the money, and the Scottish Government would argue that, through the outcome agreements to which I referred earlier, there will be a focus on better outcomes for deprived areas. The formula already allocates them some additional money, and the outcome agreement ties them into spending more of the money in those specific areas. It may be worth thinking about outcome agreements.

Ms Maeve McLaughlin: Thank you both for your presentation. I am interested in your comments about the strategic direction of a scrutiny Committee. You talked about the way in which a Committee can influence resourcing decisions in the longer term and, equally, how people try to get the maximum from their current resources, which could mean better outcomes in certain areas. Can the two work hand in hand? Have there been tensions? What are the lessons?

Professor D Bell: I will give you a little bit of background. When the Scottish Parliament was set up, it had a group called the financial issues advisory group (FIAG). It designed the budget process, which is what Simon talked about. A draft budget is usually constructed in September. It is discussed by subject Committees and the Finance Committee, and a report is written. In December, there is a debate in Parliament on the report, and the Bill is passed in January or early February so that something is in place for the start of the financial year. That is how it works.

FIAG was aware of those two points. As part of the UK spending review, the Government try to take a strategic view of how resources should be allocated and whether more money should go to the Health Department because of the ageing population, and so on. There was a hope that, every two to three years, in line with the UK spending review, Scotland should have the same debate about strategic issues. There was also the hope that, during the process, before the Finance Committee wrote its report, you would, effectively, try to scrutinise to make sure that the best value is being achieved from the resources that the Scottish Government are proposing to spend on different matters. There is that possible dual role. It is a question of a Committee deciding where it might be most effective. Does it want to stick with the strategic issues? Can it construct reports that are quite hard-hitting and call the Executive to account, effectively, for the way things are being done? Perhaps things are not being prepared for, or the demographic change is not being considered, and so on. The other side is the scrutiny.

Health in Scotland is a difficult area, because although there is loads of information on health, it is hard to go below health board level. Money is allocated to a board, which then decides how to allocate its funding. It has a fixed budget, and, as Simon says, they pretty much keep to those fixed budgets. The Auditor General would say that his process of looking at whether a hospital in Aberdeen can deal with more cases for the same amount of resource than, say, a hospital in Edinburgh should have some effect. We should learn from the fact that, somehow or other, the Aberdeen hospital is more efficient than the Edinburgh one. That is where audit ties in with scrutiny, and it is difficult. It might be worth thinking about getting help from your research unit.

Ms Maeve McLaughlin: Thank you for that. You posed a question on what would be a good outcome for a scrutiny Committee. It might be about budget decisions, but, critically, it is about measuring outcomes. There are obstacles in measuring health outcomes. My sense is that there is, increasingly

through policy, a shift towards the notion of early intervention and community primary care, but that measuring the outcomes of that can be vague. Some work is required on that issue. Roy mentioned the notion of outcome agreements. What power of enforcement or teeth does it have? What sanction will be in place to ensure delivery?

Mr Wakefield: Each year, the health boards need to prepare local delivery plans, which need to be signed off by the Scottish Government. That happens ahead of the year to which the plans apply, so there is a monitoring role for the Scottish Government.

Ms Maeve McLaughlin: To be quite blunt, if a Department, a health board or a health trust fails to meet targets, what sanction is there?

Professor D Bell: The Scottish Government closed down a health board — I think it was NHS Argyll and Bute — because it did not seem to be sound, and it was subsumed by a nearby health board. Clearly, there are limits to which health boards can vary from their financial responsibilities or outcomes. Those outcome agreements are closely negotiated, so there is a moral suasion, with a lot of pressure being applied to the body in question. Universities are under that pressure, and widening access is one of the pressures that the Scottish Government have put on the university sector. If the Government are prepared to do it, they can make those kinds of outcome agreements quite tough.

The Deputy Chairperson: Professor Bell and Mr Wakefield, thank you very much for giving evidence, which has been very helpful. We may have been a bit longer in our questioning than you expected, but that indicates the value of your contribution. Thank you very much.

Professor D Bell: Thank you.