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COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

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# OFFICIAL REPORT
(Hansard)

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## Evidence Session with Mr Evan Bates on Investing for Health

21 January 2010

# NORTHERN IRELAND ASSEMBLY

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# COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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**Members present for all or part of the proceedings:**
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Sam Gardiner
Mrs Claire McGill
Ms Sue Ramsey

**Witnesses:**
Mr Evan Bates

**The Chairperson (Mr Wells):**
I welcome Mr Evan Bates to the Committee. Thank you, Mr Bates, for your correspondence on the Investing for Health strategy. You have had the benefit of hearing the Department's submission, which you may have found helpful. I invite you to make a presentation lasting five minutes or a little longer, after which I will throw the session open to members to ask questions. We have not given you much warning, Mr Bates. You wrote to us and suddenly found yourself with an invitation to appear before us. In that sense at least, we are a mean, lean Committee. Your input on the investment strategy will be particularly relevant, given your background in the subject.

**Mr Evan Bates:**

I am grateful for the opportunity afforded to me by the Committee. I have provided a rough transcript of what I will say, because I thought that it might be helpful for members to have my notes while I speak.

I am the primary author of 'A report on patterns and trends in the use of hospital services in Northern Ireland 1998/9-2006/7', of which members have copies. I am grateful to the Belfast Health and Social Care Trust for publishing the report in 2008 and for funding the early stages of my work on the analysis. Incidentally, the trust had no influence on the analysis or content of the report.

'Investing for Health' declared:

"All citizens should have … fair/equitable access to health services".

Our report shows that people who live in poor areas often do not have "fair/equitable access" to hospital services. To make matters worse, that gap is getting bigger. People who live in rich areas are making more and more use of hospital services, while people in poor areas are being admitted less often. There is unmet need in deprived areas, particularly for elective care and gynaecology, plastic surgery, oncology, general surgery and orthopaedic procedures, such as hip and knee replacements.

Our report also raised concerns about services for people who live a long way from Belfast, particularly those who are less well off. People living in what used to be known as the eastern and the northern health board areas — roughly Belfast, County Down and County Antrim — are more likely to be admitted on a planned, elective basis. It is the other way round for people in the western and southern areas. They are more likely to be admitted as an emergency, and that contrast in service patterns is growing.

Another difference is that eastern area residents make relatively more use of what some people regard as leading edge clinical services, such as oncology, plastic surgery and interventional cardiology. On the other hand, some surgical procedures are becoming outdated. There are better alternative treatments for many patients, but these more traditional treatments seem to be lingering longer outside the eastern area.

Residents in the northern area undergo a high number of more traditional gynaecological procedures, such as hysterectomies, dilation and curettage, female sterilisation and surgical procedures on haemorrhoids.

The fact that residents of the western area make high use of hospital dental services is probably linked to a shortage of high street dentists. There are also above average levels of surgery for varicose veins and haemorrhoid procedures in that area.

In the southern area, there is a high utilisation of ear, nose and throat services for procedures such as the removal of tonsils.

The issue is whether those variations between the eastern area and other areas truly reflect the different needs of local people, or whether doctors in some areas are simply slower to modernise.

I have four suggestions on how a revived Investing for Health strategy could start to remove unfair access barriers to acute hospital care. Those steps are practical, even now, when expenditure is being cut. There is international evidence that, in the longer term, cutting health inequalities could save money.

First, Investing for Health promised that research inequalities would be promoted and mainstreamed and that better use could be made of existing data. Our report is only a start — a belated and unorthodox start at that. Our analysis could be improved and extended in many ways and at minimal cost. Our analysis uses data up to 2006-07, and, although more recent data is now available, no one analyses it. A statistician in the Department of Health, Social Services and Public Safety told me that such analysis requires a policy decision. Perhaps the Committee could help.

Secondly, the Executive's anti-poverty strategy proposes to tackle health inequalities. It refers to Investing for Health and the importance of the capitation formula through which the Department distributes funding to different parts of Northern Ireland. A great deal of money is involved; some £2 billion each year for acute hospital services alone. The formula is based on the flawed assumption that past use of hospitals by people who live in each area indicates their true need for funding for hospital care.

During the nine-year period that we studied, the use of hospitals by people in better-off areas rose, while the use of hospitals by people in areas that are less well-off fell. Using the capitation formula's logic, that implies that health needs must be rising in better-off areas and falling in less well-off areas, and that rich areas should, in future, be allocated a bigger slice of the funding cake and poorer areas a smaller slice.

I acknowledge that the Department of Health, Social Services and Public Safety would completely disagree with me on that. It also claims that it sees no evidence of unmet need in deprived areas, even though I have shown our report to its statisticians. The arguments and counter-arguments become highly technical, and I will not go into them now. However, I am happy to elaborate on them. I appeal to members' common sense. There is evidence of unmet need in poorer areas in Great Britain and in most developed countries. Is it likely that the problem has somehow gone away in Northern Ireland?

The capitation formula must be reviewed urgently. There needs to be a fresh and critical review of its entire methodology, a sensible assessment of unmet need and openness about the potential impact on local areas.

Thirdly, innovative pilot projects are needed in deprived areas to find out how best to identify health problems earlier and achieve earlier referrals to specialist hospital services. Scotland has been running local pilots and projects to determine how barriers can be removed most effectively.

Fourthly, and finally, we know from research here and in Great Britain that people who live in deprived areas are more likely to fail to keep outpatient clinic appointments for many understandable reasons. Current hospital policies mean that patients who do not attend usually have their referrals cancelled forthwith, which probably exacerbates access differentials. The impact of those policies on people who live in deprived areas must be investigated. If there is an adverse differential impact on people who live in poor areas, policies should be changed and hospitals instructed to take more positive steps to encourage attendance.

**The Chairperson:**

Thank you very much, Mr Bates. You have provided an interesting angle on an important issue. You may have noticed that I pre-empted some of your comments by asking a question of the Department. If access is the issue, people in the west and south of the Province are clearly

disadvantaged, and that is a crucial point. If the more up-to-date statistics were analysed, would those underline your view? Why has the Department not taken a policy decision to analyse those statistics?

**Mr Bates:**
The data that we studied at over a nine-year period tended to indicate fairly regular and steady patterns, and I have no reason to think that those patterns have changed suddenly in the past two years. Nevertheless, the data should be examined regularly every year.

The data that we analysed does not give the real answer as to why services are different in the east, south, west and north. I merely draw on my experience to suggest that it may simply be a matter of some parts of the Health Service moving ahead more quickly than others. If that is the case, perhaps encouraging various parts of the Health Service to move ahead more quickly may be a policy issue. You would need to ask the Department why it does not produce that kind of report.

My report, however, takes account of a level of detail with which the Department is probably not accustomed to working. Nevertheless, those details are vital, and the report contains information that does not come through in, for instance, the Department's inequalities monitoring report: 'Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview'. Although that report contains a couple of graphs on hospital activity, the information is highly confused and is uncertain as to whether the situation is improving or getting worse. In truth, that report misses all the relevant underlying information.

**The Chairperson:**
It would be highly embarrassing to the Department should it transpire that its policy to centralise services actually reduces communities' access to services, not based on affluence but on people's ability to access those services. I can understand, therefore, why the Department might not want to reveal that information.

**Mr Bates:**
There is a trade-off. If a service exists for only a small number of patients, it must be centralised to build up doctors' expertise, and so on. However, many of the services that we are considering do not fall into that category. Rather, they are commonly available, so, in those cases, more could

be done to examine what is going on in all sorts of hospitals throughout the region.

**Mrs O'Neill:**

Thank you for your presentation. I have to admit that I do not have my head completely around the capitation formula. You said that its methodology must be reviewed urgently. You also said that the Department would not agree with your assessment. Will you give us a bit more information on those two areas?

**Mr Bates:**

The capitation formula utilises many complicated statistical techniques, which, consequently, give it an aura of objectivity. In fact, the basic assumption that underpins the formula — that the past use of hospitals is a good proxy for people's needs — is quite flimsy. In the previous evidence session, Sir Michael Marmot and what he has been saying were mentioned frequently. I have brought a couple of pages from the first phase report of the 'Strategic Review of Health Inequalities in England post-2010'. With respect to the NHS, Michael Marmot points out that:

> "The architecture of the universal service is shaped and influenced by the more advantaged".

He continues:

> "'Unexpressed need', in terms of both prevention and treatment, tends to be insufficiently accounted for."

I pointed out a basic weakness in the formula used by the Department of Health, Social Services and Public Safety. The Department assumes that hospital usage and costs are related to people's age and gender and to what it calls "additional needs", which are, supposedly, linked to deprivation. That is wrong. In fact, there is strong evidence that hospital costs are also heavily related to whether patients are in the last year of life. Age does not matter so much. Rather, proximity to death has a bigger impact on hospital costs. Elsewhere in England, that point is well recognised. Earlier, someone mentioned Sir Derek Wanless, who, when producing his report, relied on the logic of using information about near-death costs. Furthermore, in his work here, John Appleby also relied heavily on Wanless's work, so accounting for near-death costs is not new.

However, the Department would not agree that there is unmet need in Northern Ireland. Its reports on the capitation formula said that it could not find evidence of unmet need and, again, that is in contrast to what Marmot said.

Our report shows that different clinical services have quite distinct patterns of need for elective services, and that is where the information must be broken down. Some services had a positive gradient going from poor to rich areas. For other services, the gradient went in the opposite direction. Sometimes there was a J-shaped or a U-shaped pattern, or even an inverted U-shaped pattern. I have argued that all those different patterns must be examined separately. The approach that the Department of Health, Social Services and Public Safety and its advisers have taken is to throw it all together. Not surprisingly, when everything is thrown in together and not considered separately, one ends up with a pretty murky mess. It is perhaps like taking a three-course meal but, instead of eating each course separately, throwing everything together into one pot and stirring it up. One has to try to distinguish what is going on with each part of the meal.

Regardless of all that, the Department still argues that deprived areas gained when the formula was last changed a year or so ago. Even there, I do not agree. It is a technical debate about how the Department moved from the use of electoral wards to census output areas for its analysis. The way in which that has been done has led to a biased result. One of the Department's statisticians acknowledged that I may have a point, but I have not been able to persuade the Department's statisticians to adjust the analysis to show the real impact.

**Mrs O'Neill:**
Maybe everybody else has their head around the capitation formula. Perhaps it is something that we need to discuss with the Department, at which point we could bring up the points that Mr Bates has raised.

**The Chairperson:**
Absolutely. That is essential. I was going to propose that we confront the Department with some of the points that Mr Bates has raised on the capitation formula. It is a new and novel approach. The members who represent the western constituencies may not previously have had the statistical information to back up their arguments. Therefore, I suspect that there will be support for questions to the Department.

**Mrs O'Neill:**
The report makes for easy reading, and, if more reports were written that way, it would be much easier for us to reach the end of them.

Mr Bates, you said that your analysis could be improved and extended in many ways, and you also said that the cost would be minimal, which is always welcome news. How would you do that?

**Mr Bates:**

The report was compiled on a shoestring. We examined 20 types of procedure, although there are other surgical procedures that could be analysed. Someone suggested that it would be good to consider cochlear implants. The remit could also be extended to outpatient services and referrals, new outpatient appointments and mental health services. We examined four geographical areas, but the report could be broken down into much smaller geographical areas. Private practice should be considered, and, if the report is to be updated, we should also take into account the referral of patients to private hospitals in Dublin and Britain during the past couple of years as a result of waiting list initiatives.

With slightly more statistical input, we could incorporate issues such as information about the patients' general practice: for example, which practice they come from and the distance that each had to travel to hospital for treatment. There is evidence to suggest that more affluent patients are more likely to travel further for their elective care. However, that evidence comes not from my report but from another source.

In the scheme of things, that type of analysis does not cost a great deal of money. However, this is the first and only report of its kind on a subject that has gone unreported for far too long. With regard to extending the subject matter and collecting data sets, the Department already has the data and does not need to collect it. The approach could be applied to almost any Department whose services are used by citizens and for which computerised data on the subject is available. Each time, that data information could be linked back to postcodes and areas of deprivation and analysed accordingly.

**The Chairperson:**

Have you any idea of the costs involved? Are we talking about thousands or tens of thousands of pounds?

**Mr Bates:**

Initially, we involved a statistician from Queen's University, but she moved on to a new job, and

we had to use someone from the Department's statistics branch who did the job on a grace-and-favour basis. The initial cost was something like £10,000; I cannot remember the exact figure. My costs amounted to no more than £2,000 or £3,000.

**Ms S Ramsey:**

Thank you for your presentation. You are absolutely right about the capitation formula, but we also need to go further up the line and take account of the block grant. The capitation formula is flawed at that level. I must be a bit of an anorak because I have an idea of how the formula works. It strikes me that the older the population of an area, the more money that area receives. We should consider health inequalities in areas where people die at a younger age, because that has always been a serious issue.

You talked about the available data and said that you have had conversations with various people about it. Did the Department say why no one analyses it?

**Mr Bates:**

No. During discussions about the capitation formula, I recommended that the data be analysed. The statistician involved said that no instruction had been received to do so; that would have to come from the policy side of the Department.

**Ms S Ramsey:**

In a sense, the data and the capitation formula work hand in glove. Has the capitation formula ever been reviewed?

**Mr Bates:**

Yes. It has been reviewed about five times.

**Ms Ramsey:**

When did the most recent review take place?

**Mr Bates:**

It was about a year ago. Frankly, I was unimpressed. It concluded that there was no identifiable unmet need.

**Ms S Ramsey:**

You said that the Health Service in Scotland had been running local projects. Do you have any more information about those projects, and should any of them be piloted here?

**Mr Bates:**

We should try to learn from what has worked or not worked elsewhere. Those projects are still in progress. A range of work has been carried out with different groups, such as homeless people, ethnic minorities and people who failed to turn up for hospital appointments. Work has also been done on mental health issues. It would be worth receiving fuller details from Scotland as to what is working and what is not. I understand that the Health Service in Scotland is targeting additional resources towards certain GP practices in deprived areas, so that they can undertake screening and health check-ups. I strongly recommend further pilot projects. I suggest that, in general, partnership projects work better and that good evaluation is required.

I would not suggest, however, that this is an easy matter to get right. There are a host of reasons why people in poorer areas do not receive the elective hospital care that they need, some of which are down to the individuals concerned and, therefore, not necessarily easy to fix at this stage. People may not know the significance of their symptoms, they may delay going to their GP, they may have caring responsibilities or they may simply try to put any signs of illness out of their minds. The longer that individuals ignore their symptoms, the more their condition progresses and the fewer treatment options remain open to them. They may be accustomed to seeing other family members with similar illnesses at similar ages and therefore, think that that is just the way life is. Some might also find it difficult to keep hospital appointments. However, it sometimes helps if they can afford to pay for private medicine. If individuals have another chronic illness, it may limit their treatment options once they get to the hospital, and that is the major issue.

**Ms S Ramsey:**

At the start of the meeting, the Chair mentioned the work that the Committee is doing with the RNIB. It is a matter of taking a common sense approach. It is not always the case that people do not want to attend hospital. Some patients may not be able to read a letter from the hospital because they have problems with their eyesight. Perhaps the Committee Clerk knows whether it is possible for Assembly researchers to do some work on the relevant statistics. It might be interesting to have more information on that in relation to the Investing for Health strategy.

**The Chairperson:**

As you know, Sue, we are bringing on board a researcher with statistical training. That person is not yet with us, but we will be sending him or her off to do that sort of work.

**Mr Bates:**

I was talking about the measures that help to encourage people to get treatment in hospital. Proper training of medical staff is important, because there is some evidence to suggest that doctors communicate better with people who are from the same social class. That is not any one person's fault, but there is scope for further training and communication so that doctors recognise the impact of stereotyping and the importance of trying to break down communication barriers.

**Ms S Ramsey:**

I do not know whether this is a relevant question, but did the previous presentation fill you with any hope?

**Mr Bates:**

I will answer that question on two levels. Based on the work that I have done on hospital services, the answer is no. The Department is concentrating on issues such as obesity, teenage pregnancies and smoking. However, it does not seem to be pushing the big issue of access to hospital care as part of its review. Perhaps I am totally wrong, but I did not hear the witnesses say that they want to focus on that as a major part of the review.

**Mr Gardiner:**

Thank you for your paper and presentation, Mr Bates. Following on from Sue's point, you said that your report shows that people living in poor areas do not get a fair deal when it comes to hospital admission. I have been in politics for a long time, and my constituents have never said to me that they have been denied admission to a hospital because they are poor or because of where they live. Will you elaborate on the very serious statement that you made?

**Mr Bates:**

I did not make that statement. I was elaborating on the complicated reasons why individuals from poor areas may not seek hospital care. I was simply stressing that much of that has to do with the individuals themselves. We must work with people in poor areas to try to break down the barriers

that they face. I stress that I am not saying that people are turning up for hospital appointments and being turned away. Rather, I am saying that those people need to go to hospital sooner so that they can see the appropriate doctor sooner, and, in so doing, they may have more treatment options open to them.

**Mr Gardiner:**

Surely their local GPs decide whether to refer them to hospital.

**Mr Bates:**

The GP can do that. However, the decision is also partly down to the individual and whether he or she goes to the GP at the right time.

**Mr Gardiner:**

If a child were ill, the parents would ensure that he or she goes to a GP or hospital.

**Mr Bates:**

There is much evidence in my report to suggest that people who live in poor areas make much greater use of emergency services than elective services. Generally, that is not the best way to access some of the better treatments.

**Mr Gardiner:**

I live in the Southern Trust area, and my constituents have never said to me that they been turned away from or not admitted to hospital.

**Mr Bates:**

I am not suggesting that. I have no evidence of that happening.

**Mrs O’Neill:**

In response to Samuel’s question, my understanding is that Mr Bates did not make such a suggestion. It is well known that people who live in a deprived area are less likely to seek medical attention. They are less likely to attend their GP and ask for advice. Rather, they are more likely to ignore something that worries them, not seek advice and end up in an emergency hospital admission situation. That is the point that is being made; not that people are being turned away. It is something that even the Investing for Health strategy considered. A person who lives

in a deprived area is less likely to seek medical attention or visit the GP. That is a fact.

**The Chairperson:**

That was my interpretation too.

**Mr Bates:**

Michael Marmot has been well referenced this afternoon. Perhaps another small quote from his report a few months ago may help to clarify:

> "If the NHS is going to do all it can to tackle health inequalities:
>
> a) 'Unexpressed need', in both prevention and treatment, must be recognised as clearly as 'expressed need' or 'demand' in determining funding and targeting resources."

That "unexpressed" or unmet need is what I am talking about.

**The Chairperson:**

Thank you very much, Mr Bates. We have stuck exactly to time, which is handy from the Committee's point of view. Without pre-empting what the Committee may decide, we would like some answers to the important points that you raised. This session has been extremely useful. The whole review will be a long process, so will we meet you at a later stage.

**Mr Bates:**

I would be delighted to provide any follow-up information that may be helpful to the Committee.

**The Chairperson:**

We will probably give you a wee bit more warning the next time. A slot arose, and we thought that it was too good a chance to miss. Thank you very much.