Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

World Health Organization European Health Strategy

25 October 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

World Health Organization European Health Strategy

25 October 2012

Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Ms Pam Brown
Mr Gordon Dunne
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Joan Devlin	Belfast Healthy Cities
Dr Erio Ziglio	World Health Organization

The Chairperson: This is a single-issue meeting. We agreed to do this when we found out that a conference was taking place. We are piggybacking on that conference, and I thank you for coming here and meeting the Committee. I will hand over to you to do the introductions and make your presentation. I will then open it up for questions and comments. I really appreciate the fact that you have taken the time out to speak to us. We are looking at health inequalities, and any expertise that we get from you is more than welcome. Thank you.

Ms Joan Devlin (Belfast Healthy Cities): Thank you very much for the invitation. We are very pleased to be here. Most of you will be aware that Belfast is one of almost 100 cities that are designated to the World Health Organization (WHO) European Healthy Cities Network. Belfast Healthy Cities is the organisation that is responsible for delivering, in partnership with a range of partners at a local level and at Department level, a range of requirements that are laid down by the World Health Organization. We are now coming to the end of 25 years of Belfast being a healthy city and, as part of that, we are having a lecture series to celebrate it.

We also look at developing training and capacity and exchanging the knowledge from some of the best practice that is in WHO Europe. We were delighted that Erio was able to come today and be the keynote speaker for the first lecture in the series. We have six lectures, and we have a number of international speakers who are renowned for their work across the world on social determinants of health and health inequalities. Erio is the WHO expert on this.

Dr Erio Ziglio (World Health Organization): Thank you. Can you understand my accent?

Mr McCarthy: You are all right. We are used to those sorts of accents.

Dr Ziglio: Thank you for the invitation. I am delighted to be here. I was in Northern Ireland for the first time many years ago, in 1978. Every eight or 10 years, I have come back, and I can see a lot of progress in this part of Europe.

As you know, my responsibility in the European office of the World Health Organization is mainly on areas that are related to social and economic development. I do not deal with viruses or bacteria, but my responsibility is in an area that can create a lot of problems for health. It includes poverty, which is not a bacteria or a virus but has a tremendous impact on health. It includes stigmas and social exclusion. My responsibilities are mainly in those areas.

I will cover three areas in 10 minutes, if that is OK with you. First, I will spend a minute on the context of thinking about health. Can we produce health and reduce health inequities in Europe, which has 900 million people and 53 countries? Can we do that in a way that is equitable and that, hopefully, results in good news for the economy, given the situation in which we find ourselves in Europe?

I will say a few words about Health 2020, and I have a copy of the small version of that policy document. You might know that, two years ago, we proposed to our 53 countries that they accept us working with them to have a policy framework that can be used to think about health, promote health and reduce health inequities. I know that those are big goals in your Fit and Well strategy. If that can be done with a clear vision while agreeing on some principles and values, a framework can be set that can be adapted to different situations in Europe. It is one thing to do it in Russia and another to do it in this country; it is one thing to do it in Portugal and another in Tajikistan. We were surprised when the countries said yes and welcomed this. I am delighted to report to you that, after two years of hard work, negotiation, discussion and participation with countries, this policy framework has been adopted. I have two copies for you. There is a short version of about 13 pages and a bigger version for technical people, such as public health experts. I hope that this can be a good tool to inspire countries and to inspire development.

I will finish by sharing with you some lessons and promising practices that a country such as yours could be interested to know about. If you are interested, we can follow that up after the meeting. Will that be OK?

The Chairperson: Yes.

Dr Ziglio: On the context, it is quite clear that, if you want to produce health and reduce health inequity, you cannot think that you can do it just in the health sector. We have to be able to manage different kinds of situations, conditions, opportunities and challenges.

I have been working with the WHO for more than 20 years. I am delighted that Europe is the only region of the WHO where there has been an agreement on health. We have something on which we can agree a vision on values, principles and priorities. Other regions, such as the Pan American Health Organization regional office of the World Health Organization and the regional offices for the western Pacific and Asia and Africa do not have that. I am quite proud that we have tried somehow to be united on that. We are the only sector that is doing this. I have not seen this done in education, housing or social security, so it is good news. Now, the issue is to implement it.

There are several reasons why we have done this. Let me share two of those with you. First, Europe has 53 countries and 900 million people. Undoubtedly, in the past couple of decades, with some exceptions, there has been some improvement in health and well-being. The problem is that that improvement has not been equal among those 53 countries and within them. I can see that you have the same issue in Northern Ireland. I saw some data from Northern Ireland, on Belfast in particular, that shows that there is a difference in average life expectancy of 6·6 years between one part of Belfast and another. You find that kind of average in most high-income western countries. My slide shows trends in life expectancy in Europe, including the trend in the United Kingdom. You can see the trend among the 53 countries, for the 15 countries that comprised the European Union before May 2004 and for the countries the countries that joined the EU in 2004 or 2007. From that graph, you can see that there are big differences between parts of the EU. If you look inside those countries, you will also find big differences. Undoubtedly, you will not be surprised that the policy of promoting health and reducing health inequity is central. It is also central to your Fit and Well strategy.

You work on the Health Committee, so I do not need to convince you of the second reason. We find that there are new demands from citizens and new challenges and opportunities. Now, there is the issue of lower economic growth and the austerity policy that countries are facing, and we want to

ensure that we do not lose the gains that we made in the past decade. There are other reasons, but those are the main reasons why we have tried to have a policy framework on which we all agree.

I have finished that part, and, if you do not mind, I will share with you some good practices and lessons. My job involves providing a lot of technical assistance to countries. My work is at the national level and the subnational level. At a subnational level, my main work is to look to work at the first level of policymaking below national level. In Germany, it is the Länder; in Spain, it is the autónomas; and, in Switzerland, it is the cantons. I work at both levels, and I also work closely with the Healthy Cities Network at a local level. If you want to implement something such as this, it is not something that is just for the capital or to be done at a national level. It has to be done as part of the country's strategic policy.

I will now look at some innovations and lessons from both levels. First, I do not know whether you will agree on this, but I can see some potential for sustainable development in the area of promoting health and reducing health inequity. That has to be done within an overall strategic plan for the country. For example, a strategic plan should address at least three questions. The first two are: where do we produce health in Northern Ireland?; and what strategy will deliver the highest equitable health gains for our population? The third question is really key. You will have many strategies to select from, and you have to ask which strategy will deliver good results for health and provide added value to local and national development. There are not many, but with those countries that try to put the issue of promoting health within this overall strategic approach, I can see that the development is more sustainable. When that is not there, you usually find that there is good commitment in countries in Europe. People really want to do something, but, at the end of the day — sorry if I am not being very diplomatic — you find a little project here and a little project there. Health inequity is a big issue, as you will know, and we cannot address it with isolated, fragile, time-based little projects.

I can give an example. I always think about which country you would be interested in that would be comparable to you, so I would definitely recommend looking at what is happening in Slovenia right now. It is a country with a population of a little bit more than Northern Ireland. It has 1·9 million people, and I think you have a population of 1·7 million. The dark part of the picture on the right hand side is an area called Mura. It had the worst indicators around health, unemployment and young people moving to big cities, etc. It had a huge problem. After 10 years of work, you can see that this is now a part of the country where health inequities are getting the best record. Unemployment has been reduced, and it is now below average. Therefore, it is doing well. What happened there? I was personally involved. First, I asked about the future of that part of the country? For a number of reasons, they identified three sectors: health, agriculture and tourism. I can give you more details later if you want. They tried to have a plan where health, agriculture and tourism worked together. But, and this is perhaps the main message, they were not just about looking at what is good for tourism, what is good for health and what is good for agriculture. They tried to have an agreement among the three sectors, through which, one day you had to go to the Government, both national and local, to discuss the allocation of resources, money and technology. They try somehow to support each other. For example, there are many relationships between agriculture and tourism, but we in health do not care too much about what they do. But we in health are going to support them when they talk about allocations, as long as tourism is going to support relationships between health and agriculture. The prevention of accidents in agriculture is a big issue.

Agriculture is going to support issues relating to health and tourism, so they have a bargaining framework, and they have worked miracles. They got the idea of looking at all sorts of issues and having targets so that everything is good for social capital, agriculture, health and tourism. Everything that can improve the physical environment is good for the three areas. They have an overall plan that is a little bit different from the traditional one where people plan on health, agriculture people plan on health, tourism plans on health, and they fight when they have to go for the allocation of resources, and, during an economic recession, they fight even more. So, I thought that that was a good example. If you are interested, I can leave one of their reports with you. It contains much more data on that.

Another issue relates to how we can strengthen our health system, given the fact that we are going to see increased vulnerability. We are documenting all sorts of practices there. If I have read correctly your Fit and Well strategy, I can see that you have two main priorities. One is young people, and the other one is vulnerable groups. What I see in Europe is a lot of emphasis on access. People should have access to services. That is wonderful, but it is not enough. I am sure you have probably solved this issue here in Northern Ireland if you have police being contacted because they would like to give you visibility of your work. We need to monitor treatment because, very often, people get the same access, but they do not necessarily get the same treatment for the same condition. Very often, you can have the same access and the same treatment but, for a number of social issues, you can have

different outcomes or costs, be it financial cost or other types of costs. So, what I am saying is that, when we talk about strengthening the health system to deal with vulnerable people, we need some way to monitor performance, at least, in those four areas. Most of the evidence that I have seen in Europe relates only to access. Access is crucial. However, the other three areas are also crucial. If you want more experience of that, I could give you examples of vulnerable groups in Spain. Perhaps, I will come back to that if you are interested.

Allow me to conclude with two more examples. The first is that, perhaps because of the economic crisis, I see that, in Europe, typical sectoral behaviour is going to change. Sectors will be forced to change. We in health will continue to work as we have done. The same is happening in other sectors. The idea that everyone is in their own boat is over. It is much more likely that we will see examples of when sectors can work a little bit better together. I know that you are familiar with what is happening in south Australia and in Scotland, where there have been interesting developments in the Government's approach. There are two important things. I do not know whether you also have examples in your country. There will be more opportunities for integrated budgets and joint funding. Let me be clear about what I mean. I do not know what vulnerable groups there are in Northern Ireland. In several EU countries, one vulnerable group could be the Roma population or migrants with low incomes. When you have to deal with health issues for such groups, very often, at least four policy sectors are crucial. Our own sector is one. Then, there is the issue of housing, which is very important for people in the vulnerable group. Another important area is employment. Another area is education, particularly if they have children. I see innovation in some countries where those four sectors have put their budgets together. It is not that the health sector will give A and the other sector will give B; they pool their budgets together. That can also an impact on funding for human resources. Perhaps a person in public health can be 50% financed by the National Health Service and another 50%, perhaps, by the local development agency or employment area. In Europe, I see those things coming up more and more. Some are related to the economic crisis. Some could be related, perhaps, because it is the right way to go.

Finally, with regard to something that we will see in the afternoon, I think that we will also have to look a little at the way in which we structure our public health programmes. Do you know who the person in the picture is?

The Chairperson: Ray Charles.

Dr Ziglio: It is Ray Charles. I was in a meeting like this, and I asked, "Who is this person? Do you know him?" They replied, "Yes. It is Nelson Mandela." *[Laughter.]* I usually tell this story because it is a fantastic story about public health and it is an important lesson. You probably know that, a few years before he died, Ray Charles put his money into a foundation. It is called the Ray Charles Foundation, which you can google. What is surprising is that people like me and, perhaps, you, who come from the health sector, would expect him to put his money where his problem was — prevention of blindness, new research on the recreation of the macular tissue in the eye or that kind of thing. If you are a social worker, you might do something on poverty and health. He put his money where his main asset is, and his main asset is his ears. He is blind. He said, "You health people, leave me alone. You cannot do anything for me. Can you do something about my ears? If you can do something about my ears, I will be interested." All his money is used for the prevention of hearing impediments. If he could hear, he could compose his music, he could be connected, and he could get on with his life.

Assets are a very important thing for health promotion and reduction of health inequities. We tend to look mainly at where the problems are. All our documentation is about problems, problems, problems, and we have to keep that. However, where there are problems, there are also opportunities. People see the light and see something that can be done. My office is working to look at what salutogenic assets can be found in people, communities and social networks that are good for people's health. We try to somehow to bring that together with our more technical public health expertise. There is a big area of innovation there, because these assets can go from individuals to society. I will talk more about that later.

That could be an interesting issue for a country like yours. No matter where you are in Northern Ireland, you have data on the deficit, mortality, morbidity, etc. Deficit levels can be high or low. However, you also have assets. As I said, I come here every seven or eight years. I see a lot of development in this country. It is not paradise, but I can see that the country is developing. You still have problems, but it is good to see that development. You were probably able to do all that because you have a good infrastructure and good human resources. You have quite a lot of local talent. You

have the institutions that are working and, therefore, able to attract this kind of development. I hope that you have good social networks and good levels of social cohesion, solidarity, and so on.

All those things can help to build your public health programmes, particularly in the area of health inequities, by bringing these things in rather than leaving them out. They are free; they do not cost anything. They are there, and they need to be mobilised. Ideally, you want to have a very high level of assets that produce health and a very low deficit. This is a tool that we use a lot in countries now. When I go to a country, I do not ask where the problems are, because I have the data. Instead, I ask this: where are the possibilities to develop?

I will stop there, because I do not want to go over my time. I hope that I have been able to give you a few ideas of the innovation that I have seen in Europe. As far as the World Health Organization and the new policy is concerned, the policy and vision is good but we need know-how and practical examples. We need pioneering on the implementation side. We need new research in this area. I would be delighted if we could have good co-operation with you, perhaps as a follow-up to your Fit and Well strategy. I hope that it was not confusing. I will be delighted to take up any issues that you want.

The Chairperson: OK, Erio and Joan, thanks very much. That was thought-provoking and raised some issues for me. I will go through some of them. You might not be aware of the specific detail — Joan can probably help you out with some of that — but we, as a Committee, are keen to look at the issue of health inequalities. You mentioned the Department's Fit and Well strategy. Prior to that — 10 years ago — we had an Investing for Health strategy. It seems that, while there has been a targeted approach and a bit of success on specifics, the areas in which we suffer health inequalities have not changed.One or two of the issues may be targeted. We all have a vision of what we think needs to be done to get to that point, but we are slightly different, in the sense that we have our own local government in the form of the Assembly, Ministers, the Executive and all the connected agencies. Sometimes the strategy that local government could follow is not necessarily a health strategy. In my working life, I have found that, even if new houses are being built, there is not a health focus on those houses. There is not a focus on play facilities, community facilities or even traffic-calming measures, so, for a long time, we have been working outside of that partnership approach. I can see some positive difference, and that is important.

I have a concern that, a number of years ago, the British Medical Association (BMA) said that health was underfunded to the tune of £200 million a year.

Dr Ziglio: Can you repeat that?

The Chairperson: It said that the health budget here was underfunded to the tune of £200 million a year. We are dealing with the legacies of underfunding in health, of coming out of the conflict and of social deprivation and health inequalities. All are connected. It has taken us a while to get to the stage at which we need to have a partnership approach.

That is where I am coming from on this. It strikes me that, in your presentation, you talked about an integrated approach. I know that officials are here. We have had battles both at constituency level and at Assembly level. Departments have been battling one other to see who funds stuff. Breakfast clubs and after-school clubs are examples, and the integrated services for children and young people was a classic example. It seems that, although we have the vision and the good work happening, when it gets to a senior level it is all about, "You are not getting my money." We need to look at that issue.

How can we convince people at those levels that it is not about health spending all of education's money or all the Department for Social Development's money? It is about a collective working arrangement to implement the Investing for Health strategy that we had in place 10 years ago. We are now into the Fit and Well strategy. How can we make changes? It would be interesting to get the information on Slovenia, with which you made a comparison. How can we convince the people who have the vision and the tools to deal with it without involving politics or without them protecting their own wee corner? How can Europe, through the World Health Organization, advise or guide us or give us the tools to convince people?

Dr Ziglio: The countries that I work with have to deal with those kinds of issues. I do not want to be misunderstood. I have put a lot of emphasis on the issue of integration and working between sectors. If you want to have governance for health, we have to do a lot of work in the health sector. We also

need to ensure somehow that we work with other sectors, even from a selfish point of view, Sue. If you think about it, many of the problems that we find in primary healthcare are not really caused by our sector but by failures in other sectors. They are very fragile sectors, and the mistakes that are made have to be dealt with by the health sector.

Having said that, I think that the health sector has to put its own house in order to a certain extent. There are a number of things that we could do before talking to other sectors.Let me give you a couple of examples. We find many countries in Europe where the health sectors are still creating a lot of problems for green policy and the environment. That is because their health sectors use a lot of energy. When you build a hospital, you create a lot of traffic if you do not plan everything together. There may be an ineffective way of managing hospital waste, and so on. It is a huge area and, we as a sector have to clean up our own house.

In addition, we are all probably underfunded, although health sectors still have a big budget, from an economic point of view. From the point of view of utilisation of human resources and land, we are heavy users. In that respect, we should talk to sectors that do things differently.

You are interested in the Slovenian example, and I am not surprised. I am happy that I brought it as an example. The health sector there was very underfunded. There was very little money there. Things changed when development issues were agreed on. It was asked, "What is the future here? How shall we contribute?" What is unbelievable is that the people who are engaged in health were those who were able to steer that development. They were unable to work together to create an infrastructure to utilise resources from the regional and structural funds of the EU. We helped them a little bit with that, but now they are the experts, and we use them to educate other countries. It was possible, somehow, to move forward and have objectives through which everyone can recognise themselves. If you just go to some of the sectors and say, "You should do more for health", people will respond, "Look, I already have a lot of problems in my own sector."

Those are the efforts that we have to make. Those countries in Europe that try so hard to promote the health and development agenda right, I can see some interesting innovation.

Ms Devlin: At the minute, we also have the health equity sub-network meeting here. One of the issues that was discussed yesterday by the guys from Norway and Denmark was the use of an economic tool that looks at the costs of inequalities in each of the sectors. The tool operates on four levels. I do not know the full detail of it, because we heard about it only yesterday. However it is something that we could share with you.

Dr Ziglio: The economic argument is important, and we have a lot of evidence for that. On the one hand, you can also say that there was a lot of evidence in the area of prevention. If you invest in prevention, it is good for the economy, for our own sectors, and so on. On the other hand, we still have an average of 3% of the health budget invested in prevention. The economic argument is important, but we need something in addition to it.

The Chairperson: Do you find that there is a collective targeted approach from governments? When you are targeting health and inequalities, for example, is a targeted economic approach taken to specific areas where there are health inequalities, and would that turn around those areas? If there is a focused approach to bring in inward investment or create jobs, does it mitigate health inequalities?

Dr Ziglio: Let me be sure that I understood your question fully. Are you asking whether economic targets are linked to health targets?

The Chairperson: When you talk about health inequalities, you find that they are mostly located in areas of high social need. If an economic approach were taken to the areas of high social need, would health inequalities start to change, simply because there had been investment? Even though that is not a health issue, investment has been made.

Dr Ziglio: We have to put the issue of economic development under the microscope. There is a lot to it. We need to look at which countries' economic development can have an impact locally. If you remember, there are three questions on my strategic plan. Economic development comes and goes, and then the community can become very frustrated, because there has been big economic change, with tax incentives and so on. The global market will bring a lot of changes, but then that community goes backwards. Therefore, we need somehow to talk about economic improvement that is stable and local.

I go back to the example of Slovenia, but there are other examples. The three sectors mentioned there were very aware of the future. If you look at that country's geographical position, you see that tourism could be a big resource. Agriculture there was very backward. It was not very efficient. However, that meant that the countryside was very unpolluted and uncontaminated. Slovenia set out to reorganise completely the countryside locally, and in such a way that it would become an attraction for tourism and such things. The sectors did not fight over resources. Tourism and agriculture interests usually fight a lot over human use of resources, such as water. However, that was locally based. Then, developments on economic and health targets for promoting health and the eradication of inequities become more stable and locally owned.

Mr McDevitt: Thank you very much for your time. I am very interested in the idea of health diplomacy. I have skimmed through your Health 2020 report. I notice that paragraph 17 talks about Health Ministers and public health agencies becoming advocates and leaders for change across portfolio areas beyond health. You sit at WHO level. I wonder what really good examples you can point to of institutional governance arrangements that have allowed Health Ministers to go beyond simply being able to say the right things to having policy, financial or constitutional levers that mean that they can actually do the right things.

Dr Ziglio: What you just mentioned — governance — is actually the central issue of the policy, and perhaps the key issue for the future.

Let me say something about health diplomacy. It came mainly from work in dealing with those regions. As I explained earlier, the first level of policymaking is regional. To some extent, it is a little bit like your situation, although you would not call yourself a region. Many issues that you have to deal with here are perhaps particular to Northern Ireland. Other issues relate mainly to the UK. Others relate mainly to the European Union. There are many issues and regulations that, to a certain extent, you cannot really control. Some issues can be global, such as those that relate to epidemics, and so on.

People who work at that level ask us about diplomacy, because, to a certain extent, they need to be supported in that area. Even if you get support and have experience of dealing with issues at EU level, you have to deal with global issues. Having said that, if the Health 2020 policy is implemented, your level is absolutely crucial. Therefore, the area of health diplomacy is one in which we would like to provide support to countries and to people such as you through that network.

On the issue of governance, we have commissioned a number of studies to inform the policy. One relates to health inequities. One relates to governance, because there are big changes in that area. Things are changing very quickly. I would be delighted to leave it here with you. It is called, 'Governance for health in the 21st century'. We made a distinction between "health governance" and "governance for health". Governance is in the sectors. Governance for health is the issue that you mentioned — how we deal with other sectors.

Ms Devlin: On the Healthy Cities Network, I want to add that the health committee in the municipality of Horsens in Denmark, which has authority over all the sectors, consists of the chair of every other committee. It is a bit like the concept of the ministerial group on health here, but it is its committee, and I think that it is a really interesting idea. It reflects the inter-sectoral nature.

Mr McDevitt: I do not want to hog the questioning, but we are having a debate about health and, separately, a debate about institutional reform. Of course, they are not joined up, because why would you want to join things up, eh?

I am interested in whether you notice across Europe in jurisdictions and regions — we consider ourselves to be region, and it is quite OK to talk about this place as a region — a thematic approach at government level rather than a departmental or silo approach. For example, in Scotland, Ministers have moved away from simply running Departments to running themes. Have you noticed that, and, if so, have you any observations on it?

Dr Ziglio: First, entities of the size of Northern Ireland are potentially in a much better situation than any other because of their size. We discussed that earlier. Europe is interesting, in that it has 53 countries. It is amazing that 25% of those countries have a population of five million — the size of Scotland — or less. Twenty per cent of the European countries have a population of three million or

less. That is an interesting situation. Population size matters in public health, and it matters on the issue that you are mentioning.

On the issue of having the kind of innovative infrastructural development of how the Government work, Scotland is an interesting country. We have an agreement with the Scottish Government and the Chief Medical Officer, Sir Harry Burns, to analyse this, because those kinds of innovative things are not much known. Everyone is struggling to find their own way.

They have agreed to look at that. They have a very interesting approach, but, to be sustainable, you have to look at the details and ask whether it works downwards. Perhaps it works at a national Scottish level, but what is the relationship between the national level and the local authorities? The local authorities, perhaps more so than in Northern Ireland, have probably more jurisdiction over health matters, social issues, and so on. There has to be a two-way road. In some countries, there is a good framework at national level, and they know a lot about national level but not how that is implemented below that.

Mr McCarthy: Thank you very much for your presentation. Earlier, you mentioned prevention, and I would have thought that that was the number one priority. Out of the 53 countries, are there any where you can pinpoint where investment has been made in early prevention jointly from the health and education budgets, resulting in a reduction of incidences of inequalities?

Joan, you mentioned the Healthy Cities Network. We must not forget about having healthy rural communities. I represent a rural area. It is fine to concentrate on cities, but there are health inequalities in rural areas. Elderly, vulnerable people are sitting totally isolated and not knowing where to go, and that is a very important point. The main thing is prevention. For instance, getting kids to stop doing preventable things such as smoking and drinking can prevent illness in later years. Have you come across any area or region that has invested in early prevention that has paid off?

Dr Ziglio: There are many examples. I will mention quickly three issues. The evidence is there to a certain extent, but it is not 100%. There are a lot of opportunities for preventative work that works, and the financial resources can be utilised better in our sector.

We did another study on prevention to inform this policy. We decided not to get WHO to do the study, because everybody says, "Of course WHO says that." Therefore, we asked the Organisation for Economic Co-operation and Development (OECD) to do it. The evidence is very clear, and the lesson was this: what are the barriers preventing us from working on that evidence? It makes sense and is good, so why do we still have only 3% of the total amount invested in that area? There is a huge issue with inequities, because that 3% does not benefit everyone in the same way. People such as us perhaps get the best service, but others do not. The issue of rural areas is a huge problem in some countries.

I am going to Brazil, and when I come back, I will go to Poland. When Poland joined the EU, around 40% of its human resources was linked to agriculture. Now, because of the EU, that has had to go down to 4% or 5%. I do not know what the percentage is in Northern Ireland; it may be 3% or 4%. Where do you find those people? Agriculture is rural, so you have to invent rural economies. Furthermore, how will the health system work in those areas? Those are huge issues. You are absolutely right that most of our data are on urban issues, and for good reason. However, we also need to look above those. In some countries, rural issues are more important than others.

Finally, the key is this: can we double the percentage of resources for prevention from 3% to 6%? If we take whole budgets into consideration, that should be feasible. I think that it would be possible to do that. We are not talking about changing everything. We are talking about going from 3% to 6% in, let us say, a decade.

What we can see in Europe is a trend towards at least trying to get the health budgets more balanced between hospital-based services and territorial services. Do you know what I mean by primary healthcare and territorial services? I think that rural areas will benefit a lot from that. Take, for example, Italy: the management of its system is basically sub-national. Therefore, in some regions, 48% of the total budget is hospital-based and over 50% is territorial. There are big issues in respect of the rural situation. However, in Italy, the issue is more about mountains — the Alps — than rural areas.

Ms Devlin: To add to that, we do a piece of work through the UK Healthy Cities Network. There is a guy called Dr Derek Cox — Erio, you probably know him — who has done some very good work in Scotland on rural inequalities, and that will be useful as a reference.

Mr Dunne: Thank you very much for your presentation. I see Slovenia here and a triangle. What does the "D" represent in the triangle? Is that the output?

Dr Ziglio: No, it works in this way. Usually when we work with other sectors, we say, "Let us go for a win-win-win situation." Those wins will be good for health, for agriculture and for tourism. We usually stop there. However, what they tried to do is look at other decisions where one sector cannot be affected. Decisions B and C, for example, would benefit only two out of the three sectors. Therefore, Slovenia put in place a package on which the sectors agreed, shook hands and said, "You have to support the decisions on agriculture and tourism, but, of course, you want to make sure that those decisions do not damage health." When we look at the location, resource, and so on, we are there together. If someone does not play ball, the whole partnership collapses. I found it interesting, because we usually just look at D. In the real world, not everyone wins; sometimes they can lose. If one sector is losing, do we have some kind of compensation or some way of making sure that they do not pull out of the partnership?

Sorry, perhaps I was not able to give you an answer.

Mr Dunne: That is OK. Is health a priority at the top of the pyramid?

Dr Ziglio: No, that is just my bias. *[Laughter.]*

Mr Dunne: Fair enough. Good.

What about funding? The argument is that there is not enough budget, yet we spend about £4·6 billion on health in Northern Ireland. Many argue that we spend enough but do not manage it properly. Is that the key to success? Is it about trying to manage resources more effectively and efficiently? You obviously want to see more going into prevention and education. Is that vital for that to succeed and for trying to address inequalities?

Dr Ziglio: We should have a whole day for this big issue. In a nutshell, first, we are a part of the world where there are not perhaps as much resource as some people would like, but there are resources. I am dealing with countries that spend $50 per capita on health.

Secondly, you are hinting at whether we can do more with what we have. Doing more with what we have also means that, in the way in which we analyse it, we need to judge the performance of the health system or the impact of the financial, technological and human resources on health equity. It should somehow benefit everyone in the same way, but, at the same time, some people who are worse off have an acceleration of their health status in comparison. Otherwise, you would still have a big gap. We can do much more on that issue with what we have. That is also why I humbly suggest that we need to monitor not just access but treatment and outcomes.

Thirdly, in many European countries, we will expect more money for our sector. Mind you, a number of countries in Europe are going to do that because they do not actually have the big problems that we have. The budgets of Turkey and Azerbaijan are almost double, because, fortunately for them, the economic recession is not a big issue. In other countries, we cannot expect there to be a big increase in the next 10 years. It might be that we need to see which kind of mobilisation of resources we can do. That is why I was pushing — it is my bias, for which I apologise — the fact that we need to think more about development. There are still a lot of financial resources that we in the health sector could somehow try to utilise.

You are very good in this part of the world with the structural funds. Are you satisfied with your work in that area? What part of that could have been utilised to create good news for the health sector? I do not remember the data right now, but 80% of all that money goes into infrastructure, which is OK. The money that is channelled into health is also our own responsibility. How do we do a good job? It goes mainly into buildings, maintenance, refurbishment and things like that. Perhaps we need that in some countries, but we could still do a better job. Resources could be mobilised through partnerships with other sectors or through utilising resources that come from the EU through those kinds of structural funds or cohesion funds. We are not really used to doing that. Other sectors do that better than us, so we should learn from what they do.

You have to package it within a development. Otherwise, the door is closed. You cannot go to the structural funds for some of the health issues, because you will be met with a no.

The Chairperson: There are a number of things happening in the Department and there are policies, such as Fit and Well and Transforming your Care and even, indeed, the review of public administration, which is being done by another Department.

We have a sizeable budget, but a sizeable percentage of that budget is spent on wages over which you have no control. A number of stakeholders are also involved in the whole issue of health, social services and public safety, and that needs to be managed properly. So, the Committee is trying to get to the very bottom. We have been told that over £10 million a day is spent on health, and we are trying to find out where that £10 million is being spent. You still cannot follow the actual pound, and we are doing a bit of work on following that pound. That work is ongoing. However, parallel to that, we also want to look at health inequalities.

We are not a Committee that is shy and will not challenge other Departments — we have done that with regard to the issue of suicide and self-harm. Suicide and self-harm is not solely an issue for the Department of Health. Other Departments have a role to play, and we have done that as a Committee.

We are being proactive, in the sense that we are looking outside our box. If we believe that we need to challenge, criticise or commend another Department for its role that helps us do our job, we will do that. Today was very useful. It allowed us to look outside of that. However, I cannot let today go without asking a question, but you might not have the answer. About three years ago, the World Health Organization (WHO) put out a statement that is still interesting in this day and age. It said that women are still dying in the world because men are in charge. Are health inequalities an issue because men are still in charge? I thought that it was a very stark statement coming from an organisation like yours. Is there a need to change, considering that 51% of the world population is made up of women?

Mr McDevitt: That would be post-feminist and post-patriarchy, Chair, yes. *[Laughter.]*

The Chairperson: Putting out that statement three years ago would have been an issue. We are 10 years on from Investing for Health, and —

Mr McDevitt: We all support your area, if it is OK? She is right.

The Chairperson: The reason I said that is that when I referred to it in a debate in here, people did not believe me. I cannot miss the opportunity to ask your opinion on it.

Dr Ziglio: For those of you who do not know, the WHO is a technical agency affiliated to the United Nations. The countries pay a fee to be members. The director general is a women from Hong Kong, China, and the European region is headed by Ms Zsuzsanna Jakab, who is really committed to that policy. She really gets the countries involved. It is not easy to get a policy like this. It is very ambitious and very inspirational. At the end of the day, all the signs and the evidence can be there and it is technically OK, but, at the end of the day, it is a political document, so it is not easy.

I have a question for you, if I may? In the area of health inequality, I can see some strange things happening in the countries. You have your Fit and Well strategy. In my view, it is an interesting document. Personally, I would like Slovenia and Scotland to utilise your document — a country that tries so hard to put some priority in place on the issue of health inequalities. The way in which you approach health inequalities here is mainly geographical, rather than looking at social classes and so on.

Do you have an example here to avoid the following kind of crazy situation that I see in Europe? It is like this: there is an area that is very deprived. You can expect that health inequalities there are very high. It has very bad data to a certain extent: unemployment, education and so on. You want policy to put more priorities in that area. That makes sense. However, there is a tendency, mainly from the local politicians — I am sorry; I am not diplomatic, as you can see. *[Laughter.]* Local politicians, on the one hand, say, "That is OK; it is good that more resources will come in." However, they are not so happy to show their success. Why? Because, if they show that success, they will have less money. So we are caught into a kind of situation, in some European countries, where basically we want to

show success, but that success is not good news, to a certain extent. So, we need to change the mentality, because if you do not do that, you will create dependency. The last thing our communities and cities want is to become dependent.

Do you find that your mechanism of implementation — how you do this — avoids this strange dysfunctional behaviour that you have?

The Chairperson: I will allow members to answer for themselves. I do not, because I do not like it. I am very proud of where I live, and of the fact that I represent where I live. I am proud for my family.

To take that one step further, the media has a part to play in that. We notice how quickly and easily the media — whether it is a local paper or the radio and TV — prefer a bad news story to a good news story. Some of that is to blame, too. It is the "broken window" syndrome. The more you tell people that they are this or that, the more they start to believe it.

So it is a partnership approach. I think that the MLAs who are here are all very keen to promote the good stuff that comes out of our constituencies. It is a level of how we get others to buy in and say that our constituencies are good and the people are good, hardworking and decent. We have our problems, but we work very hard to deal with it — *[Inaudible due to mobile phone interference.]*

Mr McDevitt: Chair, I think that Erio raises a very important point. Often, a Government funds a crisis response, so a crisis response needs a crisis to generate the income. I think that we are as guilty here, as anywhere else in the European Union, of sometimes building responses around crises and magnifying the crises or adding on bits to them. That is not just in health policy. It is a problem that we have struggled with in funding our transition towards peace in interface areas. You need to ask yourself a basic question: does the funding perpetuate the problem, or does it deal with it? Sometimes, it is perpetuating the problem, if we are frank and honest about it.

I think that the other problem that we have here is that we are very siloed. We are very good at writing good strategies but very bad at living them. The Minister of Health has very little authority beyond the Department of Health. You will find that he or she — whoever it may be, it does not matter who the individual is — goes looking for other parties to make strategic investments in health, they will not do it.

That then creates a culture in health that is about getting stuff in to do stuff that health can do, which, oftentimes, means spending money not quite in the best or right way. If you look at the proportion of our Budget that we spend on public health, that is the real giveaway: it is miniscule and it is not going to go up. The only way it would go up is if we started using education interventions, social development interventions, economic development interventions and some cohesion funding, to be able to increase it.

You are very right to challenge us in that way, and we know that is a problem. We do.

Mr Wells: Apologies; I am sorry that I could not be here for all of your presentation. It is a very great honour for this Committee to have such an expert giving evidence.

I think we are unlikely to be in a position where the problem that you outlined would arise, because we are well behind the rest of Europe, in my opinion, in tackling this issue. We have only had a Public Health Agency for three or four years, and we are only now beginning to take this issue really seriously. We have not yet cracked the really hard core areas; for instance, 31% of our manual labourers smoke, and we have a huge obesity problem. I would love to think we could have the problem of being so successful that we had to hand money back, or of finding it more difficult to claim money for health, but I am afraid that I think that that would be many years down the line. I think the Department is beginning to get quite professional and well organised on this.

Like Conall, unfortunately I think we need to be placing far more emphasis on money in the public health agenda, but I think that is unlikely in the present situation. I do not think that, in my lifetime, we will have an issue with being so successful in our public health agenda that we are forced to hand money back, or not get any extra resources. If only that was the case. There are many indicators that Northern Ireland, has real problems ahead in this field. We all agree that early interventions are absolutely essential, but that is a very long-term process and will not produce a quick hit, as we would say. We will not get a return from that for many years to come. The recession, which has of course

hit all of Europe, has not helped. If only we were facing that problem. I do not think that we are immediately, but hopefully we will someday.

Dr Ziglio: Thank you. First, it was a pleasure and an honour for me to be here with you, the people that are at the forefront of the issue. This issue of the silos is something I see a lot. I have seen some innovation, but I would like the next time I am here to see 10 examples like Slovenia. I was thinking about something that is the — *[Inaudible.]* — like Northern Ireland, I would have perhaps three.

This has opened up an opportunity for a new kind of co-operation among countries. I tell my organisation that, to implement a policy such as Health 2020, we need to open up different ways of co-operation, and that will also be very pragmatic in producing the kind of know-how that we have, and to move a little bit away from this silos mentality. We will be delighted to see how the reality of Northern Ireland can be; perhaps you can discuss with us the kind of co-operation you want.

You are a credible country in Europe. In that regard, we tend to get good examples from Scandinavian countries and so on that have a lot of stability and not so many social or economic issues. That is good, but it is very difficult for me to be credible when I go to some other countries to use an example from Sweden and Norway and so on. I have an example from a country that has suffered and that did not get everything so easy in life. The kind of situation we find in Europe with these new countries, because there have been 21 new countries in Europe since 1990, is that some of them have come out of conflict with a lot of problems. Information that they can relate to is very good. I think you are very credible on things.

I also think that you have a lot of talents in this country. There is talent in this country. The quality of your resources in many areas is really good. Perhaps you do not see that because you are from here, but when I come here, I see these developments. On the other hand, I agree with Jim, we are dealing with issues that are very complex. You have been brave to put the issues of health inequities in your strategy; not just to suggest a rationalisation of hospitals or of primary health care. It is a big issue, and you do your work right because we need to address this issue. Yes, it will take time. It will probably take time. However, I think that for a country like yours and of that size, it would be good if people working in public health find a way of sitting at the table where decisions are made about the country's development. It is a big issue. That is what will make the changes that we need.

The Chairperson: One of the positives that has come out of the Committee looking at health inequalities is the fact that the Minister has agreed to hold off on publishing until we come back after Christmas. That may be a sign of the genuine partnership approach between a Committee, a Minister and a Department. It is better than us publishing what we believe after the strategy has been put in place. I do not think that you will get any argument between us and the Department about that. There is no division. We know that we need to tackle health inequalities. It is probably just about the way that that is gone about and how we get to that stage. That is one the of the positives of the exercise that we are doing.

This session was very useful. I apologise that, as there are other Committees going on, members have had come to in and out to make quorums. On behalf of the Committee, I thank you for giving up your time. I know that you came over for another reason and we piggybacked on that. It was very useful, so thank you very much. Joan, thank you for allowing us to have him.

Ms Devlin: Thanks. It was a good opportunity.