



Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

**Departmental Briefing on the Review of
Investing for Health**

21 January 2010

NORTHERN IRELAND ASSEMBLY

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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
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey

Witnesses:

Dr Naresh Chada)	
Mr Andrew Elliott)	Department of Health, Social Services and Public Safety
Dr Liz Mitchell)	
Mr Rob Phipps)	

The Chairperson (Mr Wells):

We now move on to a briefing from departmental officials on the review of the Investing for Health strategy. I refer Committee members to their folders in which the Committee staff have provided some good background material on this important issue.

The Department of Health, Social Services and Public Safety (DHSSPS) was unable to provide its briefing paper to the Committee until late on Tuesday, which was quite disappointing given that several weeks' notification had been given. That briefing paper was e-mailed to all

members when it was received, and you should have a copy with you. Hard copies are also available.

I welcome the departmental officials, most of whom are extremely well known to the Committee: Dr Liz Mitchell, the deputy chief medical officer; Mr Andrew Elliott, the director of population health; Dr Naresh Chada, a senior medical officer; and Mr Rob Phipps, who is head of the health development policy in the population health directorate. All the witnesses have appeared before the Committee in the past in various guises, so nothing should be new to them. I ask the witnesses to make a 10-minute presentation and to leave themselves available for any questions that members may have.

Dr Liz Mitchell (Department of Health, Social Services and Public Safety):

I begin by apologising for the delay in forwarding the written evidence to the Committee.

The purpose of our presentation today is to outline the process of progressing the review of the Investing for Health strategy, to update the Committee on the progress that has been made to date and to outline plans for future policy work.

Minister McGimpsey wrote to the Committee on 24 June 2009 describing the approach that the Department would take with the review and to outline its terms of reference. At that time, the Department promised to update the Committee on the progress of the review, which is why we have been invited to give evidence today. I thank the Committee for its continued interest.

I will begin by setting the scene and by detailing the background, context and purpose of the review and, I hope, its outcomes. I will then hand over to Andrew, who will cover the process, timing, methodology, update and future direction of the review. All the officials present today are happy to respond to questions from members.

Many members are probably familiar with the background to ‘Investing for Health’. It was published in 2002 and is Northern Ireland’s 10-year public health strategy and was developed by the cross-departmental ministerial group on public health following extensive public consultation. It was agreed by all the Ministers in the Executive at that time, and it has a preface by the then First Minister and Deputy First Minister with a comment that “all Ministers are committed to it”. Therefore, importantly, the strategy is not primarily a Department of Health, Social Services and

Public Safety strategy but has the focus of achieving the vision of a healthy society in Northern Ireland. That vision is about the prevention of ill health and reducing health inequalities in society rather than a strategy for treatment and care. That requires an emphasis on tackling the wider determinants of health, which means that all Departments must sign up to it and be engaged with it.

It is an overarching strategic framework that has two principal goals: to improve the health and well-being of people in Northern Ireland; and to reduce health inequalities. It sets seven objectives to reflect the cross-cutting nature of the strategy, including action on poverty; education and skills; mental health and well-being; the living and working environment; neighbourhoods and the wider environment; accidental injuries and deaths; and healthier choices.

Effective partnership working and collaboration at governmental, regional and local levels are critical for the achievement of the strategy's goals and objectives. The strategy led to the establishment of four local cross-sectoral Investing for Health partnerships in each of the legacy health and social services boards. Their role was to identify and act on local priorities, in line with the strategic objectives of Investing for Health.

The review of the strategy has been deferred because of the review of public administration (RPA) and, in particular, the timetable for health and social care reform. We considered it important to secure the focus and attention of key stakeholders, which would not be fully possible at a time of major structural reorganisation. The review is timely and takes place in the context of the new structures, particularly the new Public Health Agency. In that respect, learning from the review will come at an opportune time to influence the forward strategies of those new organisations and for that body and the other partner organisations to build on what has been effective.

It is also critical that we take into account work that has been done elsewhere, in particular the 'Strategic Review of Health Inequalities in England post-2010', which was led by the eminent public health expert Sir Michael Marmot and is due to publish its report in February 2010. That report will be timely in influencing our way forward.

It is also important, given the cross-cutting nature of Investing for Health, to acknowledge the interaction with other developments in government policies and strategies. We believe that there

will be major opportunities at local level with the reform of local government, and the education sector in particular, as those are our key local partners.

The review is a high-level strategic exercise, given that the framework is overarching. Its purpose is to assess and capture the strategy's impact to date; to consider how resources are deployed across a range of settings; and to make recommendations for any changes that could improve progress towards its goals. The terms of reference have been copied to members with the evidence paper, and they were drawn up with the support of a small group of colleagues from the health and community and voluntary sectors. They were considered and agreed by the ministerial group on public health.

It is envisaged that the review outcomes will include learning and recommendations that can be considered and actioned in the short term for the remainder of the strategy until 2012 — for example, ways to refocus efforts, taking the new organisational structures into account. It is also anticipated that there will be longer-term recommendations that will provide a foundation for policy development work, which will result in a successful public health strategy to take us forward from 2012.

I will ask Andrew to provide further detail on the progress to date and outline how we will progress issues.

Mr Andrew Elliott (Department of Health, Social Services and Public Safety):

I will take a little bit of time to outline how the review is working. The Investing for Health strategy received widespread acclaim when it was first published in 2002. The sophistication of the document, given the cross-cutting approach of government and the contribution that it can make to health and well-being, made it a groundbreaking piece of work at the time. That approach has now spread more widely and is reflected in Sir Michael Marmot's work for the World Health Organization (WHO). As a strategy, it was a leader in its time.

However, we wanted an independent review to consider the strategy carefully. Although the strategy is clearly focused on the social determinants of health, for instance, we wanted to ensure that it is the right strategy for today and for the structures that are in place in Northern Ireland. We also wanted to benchmark against best practice in other places where there is an equally, or even more, sophisticated approach to health improvement.

Therefore, we held a tender process, and an external consultancy, FGS McClure Watters, won the contract. It is not working on it in isolation; it is supported by a professional public health expert, Professor David Hunter from Durham University. They commenced the work in July 2009. Their work is being directed and monitored by a cross-sectoral steering group that is co-chaired by Dr Mitchell and Mr Eddie Rooney, who is the chief executive of the Public Health Agency. They will report on the review to the ministerial group on public health.

Membership of the steering group includes representation from local government, the community and voluntary sector, other public health experts and a spread of disciplines from the constituent parts of the new health and social care system. An expert panel is also in place to advise the review when appropriate. Three eminent public health experts who have widespread expertise have agreed to consider the review outcomes and to provide commentary. They are Martin McKee, who is the professor of European public health at the London School of Hygiene and Tropical Medicine and is widely regarded internationally; Dr Gabriel Scally, who is the regional director of public health in the South West Strategic Health Authority in England; and Professor Corey Keyes from Emory University in Atlanta, who focuses on the area of mental resilience and well-being and how one ensures a flourishing, rather than a languishing, population, which is so important to mental and physical health and well-being. It is anticipated that a draft report will be provided to the steering group by the end of February 2010 and a final report by the end of April 2010. Therefore, more information will be available soon.

The written evidence paper provides an outline of the key stages of work that are being taken forward. There is desk research to examine the background rationale for the Investing for Health strategy and the current strategic context within which it is working. Furthermore, a statistical review is ongoing, which is assessing the impact, considering key statistics and identifying trends. Consultation and identifying how to learn from the past are also important aspects of the work. It is not a widespread public consultation, but it does focus on identifying and interviewing key stakeholders on the strategy; its performance and relevance; leadership; accountability; and the effectiveness of its structures and resources and how effectively those resources are being used.

The review will examine the structures that were used locally and at Northern Ireland level to deliver the Investing for Health strategy in order to identify learning. In particular, it will examine the effectiveness of the ministerial group on public health. It will take into account the

changes that have occurred through the recent reforms and changes to the structures of the health and social care system, under the review of public administration.

With regard to benchmarking, the review will consider three regions: the north-east of England and its public health strategy; Sweden; and Australia. Australia has a long history of utilising evaluation and evidence to guide decision-making in the area, and Sweden has a decentralised healthcare system and a cross-governmental approach to tackling health inequalities.

The review will examine and analyse value for money. It will examine the economy, efficiency and effectiveness of the strategy, as one would expect. It is also important that it considers how to present and report on the work that it has done. That will ensure that the work is transparent and widely communicated so that people will understand what is needed for the future.

At this stage of the project, we do not want to report any firm findings or recommendations, but it is scheduled to report on time, with all the key tasks under way but not yet completed. At the most recent steering group meeting, initial comments were made that supported the Investing for Health strategy. There is good buy-in for the strategy across the community, good engagement at community level on health improvement, and good ownership of the actions across a range of sectors. That bears out our experience in working the strategy, and we see that as well. It is good across the sectors of government.

Although the statistical review shows that some targets have not been met, there are general signs of an improving trend in a range of cross-cutting indicators. As a result, we hope that we can find ways to improve how quickly we can move targets forward in the future.

There are lessons to be learned about better connectivity and communication between the structures. The written evidence paper highlights the fact that the review has already brought into focus a number of challenges and opportunities in addressing public health issues. It is envisaged that the outcome will be a number of short- and long-term recommendations, the implications of which will need to be fully considered with the ministerial group on public health and by the Department and partner organisations. Any short-term actions can then be agreed and, I hope, implemented quickly. It is anticipated that any longer-term recommendations will provide a

starting point for the development of a successor to Investing for Health, which will be in place by April 2012. That process will be informed by the review's findings and any further structural and contextual developments that may take place in the meantime.

Through the process of developing a successor strategy, in which we hope that the Committee will be heavily involved, we expect widespread stakeholder engagement and significant opportunities for public consultation. That is an important opportunity to build on and improve a powerful and important strategy for all of government. The return on that can be much greater than that which comes from improving health and well-being: it can permeate all aspects of public policy.

The Chairperson:

Do any other members of the delegation wish to say anything?

Mr A Elliott:

We are happy to move to questions.

The Chairperson:

I notice that the Deputy Chairperson was writing furiously throughout your presentation, so expect some stiff questions from her. I will start the ball rolling with some softer questions, before other members move in for the kill, so to speak.

As you know, the Committee published a report on obesity and has discussed the trends in alcohol abuse, both of which are strong determinants in public health. The statistics seem to be moving totally against the Department. If the information that was given to us on obesity, particularly in lower socio-economic groups, is anything to go by, we are facing chaos by 2050 with the number of people who will have type 2 diabetes, certain cancers and heart conditions. The level of alcohol abuse in poorer parts of Northern Ireland is also quite frightening, and we still face the desperate difficulty of trying to reduce the percentage of manual labourers who smoke. Am I right to think that the Department's task has, in fact, become more rather than less difficult in the past eight years?

Dr Mitchell:

I will kick off, and my other colleagues will respond after that. You are absolutely right about the

fact that the Department faces major challenges, but so do our colleagues across the rest of the UK and in many parts of the world, particularly in respect of obesity trends and alcohol abuse. Certain major secular trends and forces are working to worsen the health of the population, and we need to take significant stock of that. Naresh will talk specifically about diabetes, and Rob will talk about alcohol abuse. Obviously, Investing for Health is an overarching strategy, and other work that underpins specific issues is ongoing.

Dr Naresh Chada (Department of Health, Social Services and Public Safety):

Chairperson, you highlighted the important link between obesity and diabetes. The Department has focused on those issues for some time, and we have always taken a multi-strand approach. First, we need to use the public health measures that are required and outlined by strategies such as Investing for Health. Secondly, we need to consider how to tackle diabetes from an obesity perspective, ensuring that patients have access to high-quality services and are given enough information and education.

The fact that the issues of alcohol and obesity have been raised shows that the DHSSPS cannot tackle those issues on its own; there must be co-operation with other Departments. The Investing for Health strategy shows how the health of the population has improved over the past six or seven years since its inception, but it also shows that the gaps are widening. It also shows that we face many challenges in trying to ensure a cross-sectoral approach to tackling those issues. Health is not the only factor that influences them.

Mr Rob Phipps (Department of Health, Social Services and Public Safety):

Next week, colleagues and I will return to the Committee to discuss the inquiry into obesity, so I will say much more than about the obesity situation. The Department is working to develop a strategic approach to tackle obesity. The Committee's report refers to the "obesogenic environment", which means exactly that: it concerns not only health but planning issues and people's social psychology. We understand that, and the better our grasp of it, the better placed we are to initiate partnership and cross-sectoral approaches.

You spoke of a gap with regard to alcohol abuse. The incidence of binge drinking in Northern Ireland is diminishing per head of population. Statistics on binge drinking show that achievement. When I say that, people look at me in disbelief, but the absolute facts and our research indicate, through two surveys that were undertaken in the past six or seven years, that

there has been a reduction in the proportion of the population that binge drinks. However —

The Chairperson:

I would love to bring you to Downpatrick on a Saturday night.

Mr Phipps:

I appreciate that people's own experiences may put a different perspective on the issue, but those are the figures that we have. That is my information. The level of alcohol misuse in Northern Ireland among young people is diminishing. We now have a smaller proportion of young people getting drunk. What one sees may not necessarily represent the full picture. Obviously, young people are getting drunk, and we are concerned about it. We have specifically targeted young people and have developed a young people's drinking action plan to address the issue. However, to pick up on Dr Mitchell's point, one of the key issues related to alcohol is its affordability. That is clearly not just a health issue: it is to do with the whole mechanism of pricing and promotions. We are examining that issue with our colleagues in other Departments and watching to see what happens.

The Chairperson:

Mr Gardiner is interested in this point, and because it is directly related to what you are saying, I will let him in ahead of the Deputy Chairperson.

Mr Gardiner:

Will you give us a breakdown of the age groups about which you are speaking? You talk about "young people". Do you mean people up to the age of 21?

Mr Phipps:

No; I mean people up to the age of 18. The minimum age for purchasing alcohol is 18, so that is how we defined "young people". However, there is always a crossover. If we target 16- and 17-year-olds, the material produced will be read by older people anyway. To a certain extent, there tends to be a crossover at the cusp of any target group. However, the key target with respect to young people is the 12- to 17-year-olds, especially in a school setting. I can provide more information about the issue. We have an action plan, and I am happy to share it with members.

Mr Gardiner:

It would be helpful to see the age brackets and find out where the problem comes from. We point the finger at young people, but they may not be responsible. It may be adults, who are supposed to be more mature. Let us see that.

Mr Phipps:

I am more than happy to explain exactly what we are doing and the progress we are making.

The Chairperson:

I will be fascinated to see statistics that show that teenage binge drinking is diminishing. As a constituency representative, the single largest volume of complaints that I receive are those that relate to antisocial activity caused by binge drinking.

Mr Phipps:

We are also aware of that issue. Members may have heard of the “night-time economy” — people coming out late at night. We are considering that issue. We are not complacent about it. We want to try more specific targeting about the entire population’s drinking habits rather than concentrating on binge drinking. That is what we should be doing: taking a more population-based approach and targeting all drinkers not just binge drinkers.

Mr Gardiner:

I fully support that.

Mr Phipps:

We are taking that approach.

Mr A Elliott:

We recognise that alcohol abuse remains an extremely serious problem. The fact that we are perhaps having some success according to the indicators does not mean that we do not still have a serious problem to deal with in our streets, towns and cities. There are some fundamental issues about the misuse of substances generally and, to some extent, the misuse of food — our dietary habits, and so on — that still remain to be tackled. If our overarching strategy can be more sophisticated, it may mean that some of the most successful interventions to change those issues may not be the interventions that seem most obvious. We will have to consider the whole life

cycle and the impact of parents on their children's behaviour. Many issues play into that. Around the world, people are finding more effective interventions that work; we need to capture those, which is why we are reviewing the strategy.

Dr Mitchell:

I will reinforce what Rob and Andrew said: we are all aware that the problem is not only heavy drinkers and binge drinking but the general increase in levels of alcohol consumption across society. That is important, and we see it reflected in hospital admissions with chronic liver disease and in the increasing need for liver transplantations. There are big issues that we definitely must examine.

You mentioned the issue of tobacco and smoking levels among manual workers. The Department is developing a new action plan that will specifically consider what more can be done about that. There have been some improvements in the levels of smoking across the population as a whole, but there is still a question about what we can do about particular groups. How can we stop young people smoking? Members will be aware of the work on vending machines and other issues such as that. What can we do to push down the levels of smoking among manual workers?

The Chairperson:

There was a specific target for the level of smoking among manual workers that the Department was supposed to address, but that level has not shifted at all. It is depressingly high. What worries me is that there is an inexorable link between socio-economic and income backgrounds and health; Investing for Health is quite clear on that. There are not too many QCs, consultants or business executives with the range of health problems that are to be found in poor, working-class estates in parts of Northern Ireland.

Of course, since 'Investing for Health' was published, there has been a major economic downturn. It worries me that there may be a set of factors over which the Department has absolutely no control. The Department was not responsible for the problems with Lehman Brothers. We will not blame the Minister for that; some might try, but he was not responsible. The Department is not responsible for what has happened, yet there is a tide moving against it that puts more and more people onto income support and lower incomes. That inevitably leads to a deterioration of public health standards. How on earth can any Department stem that tide?

Dr Mitchell:

You are absolutely right; those are serious issues for all of us collectively in Northern Ireland. Obviously, it is not an issue only here. We referred to the work that Michael Marmot has been doing with the Department of Health in England. Previously, he worked with the WHO on the Commission on Social Determinants of Health. Important learning is coming out of that. Much evidence from around the world indicates that, if measures can be put in place to support children and their parents in the earliest years of life, that reaps benefits across a range of issues, including lifestyle and antisocial and criminal behaviour. That new evidence is much stronger than the evidence that was available at the time when 'Investing for Health' was published.

The Chairperson:

Are you aware of the Nuffield Trust report, 'Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution', that was published on 20 January 2010? It may be unfair to ask you about that this afternoon.

Dr Mitchell:

I am aware of it, but I have not read the report. I heard the media coverage.

The Chairperson:

I have read a summary, although I have not had a chance to read the full report. It clearly has implications for your review work. To be fair, the only question that we should be asking is whether that report will be taken into account. I assume that any relevant material will be fully considered.

Dr Mitchell:

Yes, indeed. As Andrew mentioned, a wide range of desk research has been undertaken. We refer the team to any relevant and important documents not only from Northern Ireland but from wider afield. They can certainly take that report into account.

The Chairperson:

It does not make pleasant reading on the Northern Ireland situation. On many basic targets, our performance is poorer than GB's.

Dr Mitchell:

That report relates to 2006, and, since then, there have been major initiatives, particularly on waiting times and waiting lists. Perhaps some of those comparisons are not as up to date as they might be.

The Chairperson:

Furthermore, a significant reduction in funding for the Department has been announced, and, if I am being realistic and there is a change of government, it does not require a soothsayer to say that much more significant cuts are highly likely. Are you building the fact that you may not have the resources that you expected into the review to produce a strategy to meet the considerable demand that you outlined?

Dr Mitchell:

We are all extremely mindful of the challenging economic and fiscal circumstances into which we are moving, particularly after this comprehensive spending review (CSR) period, when, probably under a different Administration, we will move into another CSR, so we expect challenges ahead and, bearing that in mind, we are emphasising what lies ahead to consultants.

The Chairperson:

The steam has stopped rising from the Deputy Chairperson's pen, so I shall give her the opportunity to quiz you.

Mrs O'Neill:

A lot of mind-reading is going on around this table, and one of my first questions was to be about how the review is being dictated by budgetary constraints.

I thought that you were coming here today to give us the final report, so, on reading the papers in preparation for this meeting, I was disappointed to discover that you would not be doing so. I thank you for the update on progress, but, after such a long review and given how eagerly we have been waiting for the final report, I am disappointed. Are you on target to produce the draft report by the end of February 2010?

Mr A Elliott:

We are on track to have something in the public domain by the end of April 2010. There is also

scope for us to make useful changes to the strategy. From what we have seen in light of international evidence, by the time we meet again to talk about the review of Investing for Health, we will be able to draw the Committee's attention to issues that we need to pick up on.

It is important, however, that whatever resources are available at the time are deployed in the most valuable and useful way. We must make good use of resources by working out which areas will give the greatest return on investment, and there is potential for generating some useful material in that regard. For example, I have had the opportunity to see some of the ongoing work for Sir Michael Marmot's report, which will make interesting reading for the Committee, because some powerful stuff is beginning to shape up for it, particularly on tackling health inequalities, which is our big challenge. We continue to extend the lifespan of males and females in Northern Ireland, but the big difficulty is in reducing the differentials between those who have more disadvantaged lives and those who have wealthier lives. Some important points will arise on that subject.

Mrs O'Neill:

No one would disagree that the Investing for Health strategy is as relevant today as it was in 2002. However, unless we tackle the root causes of ill health, we will have to look into the problem again and again. We have to tackle the socio-economic and physical factors, because they are strong determinants of ill health. Consider the fact that this statistic is still relevant: if a child lives in a deprived area, he or she is four times more likely to have tooth decay. We need to get to the bottom of such matters, which is why the Investing for Health strategy is still relevant today. The strategy is, of course, eight years old, and it needs to be reviewed and updated. At the time, the strategy was cutting edge and innovative, so we want to retain that momentum, and the review will help to do that.

The focus of Investing for Health — tackling the root causes of ill health — should mean that, throughout people's lives, they will be less dependent on acute services and long-term healthcare. Do you agree that tackling the root causes of ill health through the Investing for Health strategy will lead not only to improved outcomes for individuals but to improved outcomes for the public purse? If we tackle those problems at their root, we will not face them down the line. Much of the focus on budget cuts centres on acute services and demand. Eight years after the strategy was published, the main focus is not on primary or community care but acute services.

Dr Mitchell:

That is a challenge that we always face, and that was highlighted at the time. As we move into a challenging economic environment, it is important that we do not lose focus on tackling upstream issues because of short-term expediency. We are all aware of acute service pressures. Long waiting lists, for example, feature heavily in the public and the media. Some issues are, perhaps, less visible, and there is less of a public outcry about them. However, they are equally important.

You are absolutely right; if we could invest more money in some upstream issues, it will have benefits for the Department and across the education sector because people will be more fit to work. They will be ready for the rest of their lives and will be less dependent on health, social care and other support systems throughout their life course. We must avoid the temptation to reduce spending at the cost of other matters.

Dr Chada:

I agree with Dr Mitchell. I am sure that members will remember the excellent Wanless report that was produced in the early part of the last decade. It spoke passionately about a population being fully engaged in public health issues. The report powerfully made the economic health argument for investing in public health. We have now come to a juncture at which we are in obvious economic difficulties, and we will not be as replete with resources as we have been in the past. An investment in public health has to be seen as a necessity rather than a luxurious add-on.

Mrs O'Neill:

The Public Health Agency will be important if we are to educate, and start talking to, people on the ground. The agency has been tied up with swine flu since its inception, but we need to move on and focus on Investing for Health and tackling root causes.

The written evidence paper refers to the challenges that are posed to the review about attributing outcomes to interventions. How do you get round that or measure it? I understand where you are coming from, but you are saying that you cannot always say that one issue was the direct result of another issue in the DHSSPS.

Dr Mitchell:

I will invite Andrew or Rob to answer that question. As we said, that is a challenge. The issue is cross-sectoral so it is difficult to determine whether a problem was the result of something that

the DHSSPS or the Department of Education did.

Mr Phipps:

On some of the issues, there is a collective responsibility — perhaps that is too strong a term. If one measures what one does, one can model the process having an impact on behaviour. A classic example is behaviour concerning tobacco, smoking or alcohol. Providing information, increasing a young person's knowledge and informing their attitudes should impact on behaviour. Therefore, the difference can be measured. If it can be shown that knowledge is increasing or attitudes are changing positively, that work could be measured and could, therefore, be an indicator of how behaviour also changes.

It is a case of measuring what is done and showing how everything fits together. The fact that it is so wide has always been a classic issue for us. Increasingly, however, we understand the process. Depending on where the input is, one can measure that and show a change and an impact. To a certain extent, the approach that we are increasingly taking is to be able to measure the individual inputs and setting a target against that, as well as the overarching behaviour target at the end if it is a lifestyle issue.

Mr A Elliott:

That is an important question. We must recognise the fact that we have a population of just over 1.5 million. To carry out the kind of thorough analysis that would be needed to calculate every intervention would be beyond us.

An important aspect of a complex strategy such as Investing for Health is examining the evidence base from larger populations elsewhere, working out what works effectively and faithfully reproducing that in Northern Ireland. That will always be an important area for attention in this type of work.

Ms S Ramsey:

It is hard to go back to Investing for Health without looking at the Programme for Government and the statistics that are being submitted by other Departments, be they Health, Education or whatever.

I have a series of questions, one of which relates to what the Deputy Chairperson and the

Chairperson touched on earlier, which concerns an earlier Committee discussion, when you were in the Public Gallery, on the recent announcement about budget cuts. At the time of its publication, 'Investing for Health' was considered one of the most radical Health Service documents ever. Everyone agreed, and it was embraced to take us forward and be proactive in dealing with health issues and inequalities. The revised spending plan is based on current difficulties and on hard decisions that need to be made. If there is no revised spending plan — the Chairperson said that we will not receive it until March — how can you be proactive in the review of Investing for Health if you do not know what your budget will be? It strikes me that you cannot plan a strategy.

Considering the recent DFP statement, have you looked at other Departments' revised spending plans? If you have not, my contribution to lifting people out of fuel poverty would be to put any further strategies onto their fires because they will not have an impact. There is no point in having strategies unless we have a way to achieve them.

Before Christmas, I put questions to all Ministers on Investing for Health. Several stated that they had no direct targets as a result of the strategy, but they went on to tell me what they were doing. I have to give some Departments credit for that. The Minister for Social Development stated that her Department's targets related to reducing levels of fuel poverty, but that related to 2004. Has this been reviewed in the ministerial group on public health? It strikes me that the ministerial group is working, but where do those strategies fit in with Investing for Health? Where do the strategies for obesity, alcohol, drugs, suicide and domestic violence fit in? They are vital to Investing for Health.

Do you believe that other Departments are as committed to the proactive approach to Investing for Health as the DHSSPS is, or is there a barrier? Investing for Health and other commitments do not seem to be real in some Departments. On the issue of children and young people, figures on unallocated cases — such as children in care and children at risk — have increased, but the budget has been reduced. How can you have an impact on that?

The review is important because the strategy is eight years old. However, I am cynical about outcomes, given the budget cuts and other Departments' revised plans. Where does that sit with Programme for Government commitments? One identifies the other.

The Chairperson:

Sue, are you going to move on to another question? I do not mind your asking a lot of questions, but I would like you to do so in small chunks if possible. We have time left, so I will let you come back and ask your next series of questions.

Ms S Ramsey:

I am conscious that we cannot ask questions about Investing for Health without going into the statistics that Departments produce, and it is important that we cut through all of this. It is a great document, but that is all it is: a document.

Dr Mitchell:

Sue asked how we plan without knowing our budget. The review will lead to work that will develop a successor strategy. A completely new strategy must be in place from 2012. We hope to take into account changes that occur during the final couple of years of the current strategy, particularly the formation of the new organisations.

The Deputy Chairperson mentioned the Public Health Agency, which is an important new organisation that will, once it gets through the swine flu outbreak, turn its attention to this matter. It will consider how it works with local government and with the education sector at a local level to make changes. We can use the current resources better, and we will work with the Public Health Agency to ensure that that happens.

Sue mentioned the benefits of examining other Departments' revised plans; that is an extremely good point. We need to take note of that suggestion and act on it. All our strategies, such as the tobacco action plan and the drugs and alcohol strategies, fit within the context of trying to realise and meet the objectives of Investing for Health and the values and principles therein. We must try to tackle those inequalities while improving overall levels of health.

Do I believe that other Departments are as committed as the DHSSPS? Ms Ramsey referred to the Programme for Government, which focuses on the economy. We need to ensure that everyone recognises that a healthy, vibrant and fit population is an important part of a strong, vibrant economy. I hope that the next Programme for Government recognises that link more clearly. That would help to point up why all Departments must be equally committed. As Sue knows, those Departments made a commitment, and they all signed up to the strategy initially. I

hope that we can re-energise and raise that commitment to those levels again.

Mr A Elliott:

Given that resources are likely to be severely constrained, it is slightly reassuring that, when Departments work together to deliver improved health and well-being for the population and reduce health inequalities, it will also serve to achieve other targets and objectives in other Departments. For example, when I work with the Department of Education on issues about people's emotional health and well-being, that Department knows that, if those initiatives and strategies work, its educational outcomes will improve in addition to the benefit that the DHSSPS receives in tackling health inequalities. Children will come to school ready to learn.

Similarly, through neighbourhood renewal, if we adjust the resources to tackle health inequalities properly, it will help the Department for Social Development to achieve its other objectives in that area. When resources are tight, cross-departmental working is vulnerable. However, as Liz said, Investing for Health brings much to the table and facilitates the achievement of other objectives, including the competitiveness of the economy. People must continue to think long term and continue to sell that message after the review of Investing for Health.

Mr Phipps:

Each Department has been asked to respond to the review through a detailed list of questions. I agree with Liz; the Programme for Government may offer an opportunity to share targets. There are some shared targets at the moment, but there may be scope for more. We now have about 18 months to develop the next stage forward. Thereafter, we will know what resources are available, and we can then discuss the issue with other Departments. The development will be a consultative process anyway.

Mr McCallister:

In his response to Sue, Andrew mentioned long-term thinking and how other Departments have a buy-in because they recognise the advantage in meeting some of their targets. In our experience, most Departments seem to be worried about getting through the current financial year and possibly the next one. Most are a long way from thinking about the long term, and they would be doing well even to be thinking about the medium term. That provides evidence to this Committee that other Departments are not taking the issue as seriously as we would like them to, which is a

huge worry. To follow on from Sue's point, I do not know whether other Departments recognise that investing money now will enable them to reap huge benefits further down the road, which would be particularly useful as we move into an extremely tight fiscal cycle.

Mr A Elliott:

We asked that the review re-examine the ministerial group on public health and the higher-level structures to determine whether we can make improvements and increase the level of buy-in from the Executive. In the Governments of some countries, all Ministers regard themselves as the health Minister, and they say as much. That is significant, because far more can be achieved with a healthy and vibrant population than with one that is languishing.

Ms S Ramsey:

I want to put on record that I am not knocking the Investing for Health strategy or the theory behind it; it is a radical document. However, we need to be realistic about whether it is working. You are 100% right: nine out of 10 of the causes of health inequalities have nothing to do with health. Health inequalities are more to do with social housing, unemployment, living conditions and other such issues.

It is not always necessary to throw money at the Department of Health, Social Services and Public Safety, because other factors come into play. John is right that, if we are talking about a collective approach, the Programme for Government is vital. The programme does not necessarily have to be the main theme; to resolve the issues, we need an economy that is working. However, it is vital to get all Ministers on board.

Mrs McGill:

Thank you for your briefing. When the deputy Chairperson asked when the report will be published, he was told that a draft report is due to be published at the end of February 2010. Did you also say that the Committee will have sight of that draft report? A draft report was presented to another Committee, of which I am also a member, before the final report was published. The Chairperson of that Committee is here today and had asked for that draft, which I found helpful. That Committee agreed to have sight of the draft report and to pick up on some of the relevant issues as part of its input into the final report.

I am from west Tyrone, and I live in the west. Later, the Committee will be briefed about the

hospital situation. In the west, that situation is evolving, with the new enhanced hospital that I hope will open in Omagh and a new hospital in the south-west. You will have some idea of the new strategy's contents. Has it taken into account the regional disparities in healthcare, particularly in the west?

Mr A Elliott:

In answer to your first question, the steering group was set up to oversee and work with the consultants. We expect the draft report to go to the steering group in February. It was not even supposed to be distributed more widely within the Department. We will bring the final version to the Minister and the Committee by April 2010. I stress that it is not a new strategy: it is a review report on which our Department will be able to build and work with other Departments to create a new strategy. A great deal of work will follow from the review report.

Mrs McGill:

Other members, and indeed the Chairperson, may not agree that it is a good idea, but I think that it would be helpful for the Committee to have sight of the draft.

Mr A Elliott:

We are not trying to hide anything, but it may not be a good use of the Committee's time to see the draft at an early stage because it may be subject to factual changes. When those changes have been made, we will be more than happy to come back to talk to you about how the report is shaping up and discuss what it is likely to contain. We have no reason to withhold information, but we would rather come back with a more presentable version.

Mrs McGill:

Given that the report is overdue, it is my personal view that it would be helpful for the Committee to receive the draft now.

The Chairperson:

The Committee should give some thought to the stage at which it wants to be brought into the consultation process. I do not think that it would be useful for individual members to be involved, but the Committee might want to be involved. We can consider such involvement when we get down to dealing with the issue.

Mr A Elliott:

Investing for Health is an important strategy, and, in the development of a strategy of any kind, the Government are encouraged to ensure that they take account of the rural/urban differences that exist in society. The delivery of a strategy may be subtly different in the west than it is around Belfast, for example, and we must consider that as part of the development of a new strategy. The review may highlight some of those issues, because it will include consultation with people from the various Investing for Health partnerships, some of which are more rural than others. I cannot say how significant those findings will be, but, coming from a rural background in the west myself, I am sympathetic to your point.

Mrs McGill:

There will be a massive gap in the review should it fail to pick up on that point, but you said that you are not in a position to say whether that will be the case. The review's terms of reference include tackling health inequalities but do not emphasise the urban/rural issue. I would like there to have been more emphasis on the east-west divide that you outlined and for which the evidence exists. Not to highlight that the strategy has not been delivered in the way that it should have been would represent a significant gap in the review.

Mr A Elliott:

The Public Health Agency has a powerful role in the structures that have been designed and put in place to deliver and commission health services. That includes a powerful role in local commissioning, which is designed to shape services to suit the particular locality in which they will be delivered, and health improvement will be an important dimension of that. Therefore, even aside from the review, having the right services for the right locality is an important issue, and we will want to rural proof a new strategy.

Dr Mitchell:

We envisage the Public Health Agency working closely with local government and district councils, so that it can shape services to suit the people who live in a particular locality. There is evidence that people in rural areas have better health than people in some urban areas. However, we must take the important rural issues into account.

Mrs McGill:

The Noble index shows that a big chunk of the area that I represent is deprived. However, I do

not want to make the mistake of saying that rural equals deprived, because I am making a slightly different point.

The Chairperson:

In the next session, we will receive evidence from Mr Evan Bates. In the past, one of the points that he has made very strongly is that the disparity in service provision is more pronounced between east and west than between rural and urban areas. Some worrying statistics have emerged from that, including the fact that those who live in the west are more likely than their counterparts in the east to undergo emergency rather than routine operations. Thus, while people with certain conditions who live in Belfast or north Down undergo routine operations, those who live west of the Bann are more likely to undergo emergency operations. The report also highlighted the fact that the further one travels from the eastern seaboard, the higher the incidences of hysterectomies and gynaecological procedures become.

All of that suggests that someone living in a rural area of Craigavad or Cultra may not be particularly deprived, whereas someone who lives in an urban setting in Strabane or Enniskillen may have much poorer health outcomes. That is not entirely explained by the economics of the situation, but by the provision on the ground. We will question Mr Bates on that issue later, but has the Department examined whether health outcomes in certain areas depend on a postcode lottery rather than on income?

Dr Mitchell:

The Department studies inequalities across a range of issues including services, service access, travel times, the east-west split and the Section 75 groups, including those from ethnic minorities and those with learning disabilities. The Department tries to examine the issue from all angles and to capture the gamut of indicators — for, example, by examining mortality and morbidity rates on a council-by-council basis — rather than focusing on socio-economic inequalities.

The Chairperson:

Do your findings reveal that the health outcomes of those who live outside the eastern seaboard are likely to be poorer not because of their income but because of where they live?

Dr Mitchell:

There are differences in mortality by council area, but people living in Belfast or Derry will do

worse according to some of the other indicators. Therefore, it is difficult to provide a snapshot. There are so many indicators that we could discuss that it would probably take an entire meeting to examine the inequalities and what they show.

The Chairperson:

I want to make you aware that the Committee will ask you for an update on swine flu shortly. We have not yet received the weekly update, and it would be interesting to find out where we stand on that.

Before that, I have a question about the monitoring and evaluation of the strategy's outcomes, which, since its inception eight years ago in 2002, have not been particularly scientific. Why has the Department not placed more emphasis on monitoring how successful it has been so far?

Dr Mitchell:

The Department has developed quite sophisticated monitoring at a local level through the Northern Ireland Neighbourhood Information Service (NINIS), which allows people to find out what is happening in their own communities

Mr Phipps:

As Dr Mitchell said, the outcomes and indicators evolve as the Department becomes more sophisticated. For example, NINIS provides health indicators at a local level, and the Department is increasingly able to obtain more information in that manner.

We now have a regional Public Health Agency, which covers all of Northern Ireland, the four legacy boards and the trusts. The Department is trying to establish who is doing the work and at what level they measure it. In the past, it was difficult to source that level of information. With the introduction of NINIS, the Department is able to drill down and obtain that information and is, therefore, better placed to establish various forms of monitoring. The review will reflect that the Department is now in a better position to monitor than when the strategy was devised. The statistical review, which forms part of the overall review, will examine those figures.

Mr A Elliott:

The Department monitors the key public service agreement (PSA) targets that are associated with the strategy. That monitoring is interdepartmental, so we pull people from other Departments

into the room to assess progress. If targets are not being achieved, questions are asked about how we can do better in future.

Investing for Health is an overarching strategy that has spawned a huge amount of further work, including work on the development of detailed and specific strategies in areas such as suicide prevention, sexual health and mental health promotion. It also includes the important piece of work that was carried out on smoking legislation, the development of a new strategic framework for alcohol and drugs, and so on. Therefore, Investing for Health is not a stand-alone strategy with which nothing happened after it was written. In the intervening period, a massive amount of work has been taken forward on specific areas that are relevant to the strategy.

The Chairperson:

You may be aware that the Committee gave you its full backing on the reduction in the display of tobacco products, including in vending machines. That will, I hope, be a concrete measure towards achieving targets on that vexed issue.

Thank you for your evidence on the important matter of the Investing for Health strategy. While Dr Mitchell is here, it is too good an opportunity not to find out the latest situation on swine flu. The statistics have been encouraging, and I hope to hear of a similar trend this week.

Dr Mitchell:

This week, GP consultations on flu and flu-like illness decreased by 36%, and the number of out-of-hours calls also decreased. In the past week, only one person has been hospitalised as a result of confirmed swine flu, and the number of antivirals issued has continued to decrease. All of the indices are, therefore, going in the right direction. The number of cases of the respiratory syncytial virus (RSV), which also causes respiratory and flu-like symptoms, particularly in the younger age groups, has decreased significantly this week, which is the third consecutive week that it has fallen.

I am pleased to say that we have received reports that more than 250,000 people have been vaccinated against swine flu. We continue to make progress on vaccinating children from the age of six months to five years, and that programme is ongoing.

The Chairperson:

Have there been any further deaths?

Dr Mitchell:

There have been no further deaths in the past week.

The Chairperson:

That is excellent news.

Mr Gardiner:

Have the weather conditions had any effect?

Dr Mitchell:

Many people have asked me whether the cold snap had any impact. If people are huddled together indoors because of cold weather, the risk of transmitting infections can increase. However, clear bright weather and sunlight can reduce or kill viruses, and it is, therefore, a mixed blessing. During the cold snap, travel was restricted, and I suspect that people were less likely to go out and mix. Those two factors may have lessened the spread of the virus.

Mr Gardiner:

I thought that the frost and the snow would have reduced its spread.

Dr Mitchell:

The evidence is that ultraviolet light is particularly good at killing viruses. Clear, bright spells, as opposed to damp and fuggy weather, can better limit the spread of a virus.

The Chairperson:

You said that 250,000 people have been vaccinated. At the turn of the year, 200,000 people had been vaccinated, so the rate of vaccination is slowing down. Are we getting to the stage at which everyone who wanted the vaccine has received it or is due to receive it as part of the programme of vaccination?

Dr Mitchell:

Most of the phase 1 priority groups had been vaccinated by December 2009. We are now

concentrating mainly on those aged between six months and five years. The level of swine flu in the community is decreasing, so people are not as anxious to come forward for vaccination. The high level of vaccination marks a significant achievement, and, given that we only started the vaccination programme on 21 October 2009, we have immunised a huge number of people.

The Chairperson:

Thank you. The fact that you were able to answer those questions with only five minutes' warning demonstrates that you have your finger on the pulse. We are grateful for that, and we appreciate your ability to pull those figures out of the top of your head so quickly. As I said before, the Department has done an excellent job on swine flu. The fact that it is under control and all the statistics are moving in the right direction shows that the Department took the correct decisions. It is incumbent on the Committee to register that good news, and I hope that those trends will continue. I thank the witnesses for that update and for the other information in their submission to the Committee.