

24th March 2005

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Thank you for the opportunity to comment on The Regional Strategy document
“ A Healthier Future”. Attached are comments on behalf of The Royal Hospitals.

W.S. McKee
Chief Executive

Enc

A Healthier Future

A concerted opportunity to reflect on longer term societal issues which affect health rarely becomes available – shorter term considerations are usually dominant. We welcome the release of the consultation document “A Healthier Future” as a stimulus to reflection and debate. We hope that this process will lead towards a longer term strategy to raise health standards and reduce health inequalities.

1 A vision, a strategy, or a framework?

“A Healthier Future” is variously described as a vision, as a regional strategy, and as a framework. There are distinctions, usefully set out in the “Strategy Survival Guide” (Prime Minister’s Strategy Unit, 2004). The Guide emphasised the need for:

- clarity and understanding about the problem
- research and analysis
- consideration of a broad range of possible solutions
- analysis of choices and trade-offs
- appraisal of a narrower range of options
- selection of a coherent set of solutions (in contrast to a “scattergun” approach), consistent with agreed principles and evaluation criteria
- engagement with stakeholders throughout the process.

“A Healthier Future” is a useful starting point, but there is still some way to go, particularly in terms of consideration of a broad range of possible long term solutions, the analysis of choices and trade-offs, and the engagement of stakeholders.

Conscious of the wider social aspects of these choices, trade-offs, and potential solutions, there is a strong argument that the process should have the endorsement of the Secretary of State (in the absence of a devolved administration). We are mindful that the early Programmes for Government adopted by the Northern Ireland Executive has a cross-cutting strand entitled “Working for a healthier people”; and that the “Investing for Health” strategy had initial endorsement from the First and Deputy First Ministers.

A twenty year perspective offers ample opportunity to question many of our orthodox assumptions, and to consider wider issues of public interest.

2 Health and health inequalities

2.1 Wider considerations

“A Healthier Future” points out that our health standards are often lower than in other regions of the United Kingdom and in Europe; and some health inequalities in Northern Ireland are briefly acknowledged. We agree on both points, but there are wider considerations, such as:

1. What importance should be attached to issues of health and health inequalities? Which aspects of health and health inequalities are of greatest importance to us, and why?
2. What weight should we attach to the health of future generations, perhaps not yet born? The answer may in turn affect the weight we give to environmental issues, and to other issues of sustainability.
3. What considerations should be given to the health of people outside Northern Ireland – particularly people who experience even lower standards of health? We already know that we are not isolated from international events, but this consideration brings in wider issues of our role in a global society.

Consideration of wider issues of this type, in a way which fully involves stakeholders, seems to be in keeping with the section of the “Strategy Survival Guide” relating to “articulating the vision”. It could also dovetail with consultative aspects of a full equality impact assessment, developing the perfunctory section in the current consultation document.

2.2 Poor health, and health differentials

Though the section of “A Healthier Future” entitled “Investing for health and wellbeing” acknowledges that low income, education, unemployment and poor housing contribute both to poor health and health differentials, the section is weighted towards control of lifestyle behaviour, such as smoking, drinking and eating. With the exception of a reference to accidents, the health outcome targets set out on page 13 of “A Healthier Future” all relate to lifestyle factors.

“Investing for Health” made the point, strongly, that social and economic issues must be addressed to improve health standards and reduce inequalities; the Black and Acheson reports in England made similar points; as did “Working together for a healthier Scotland” (Scottish Office, 1998):

“Simply addressing disease and lifestyle cannot deliver what is needed. The first part of a cohesive strategy for a healthier, more equitable Scotland must be to counter the life circumstances which can give rise to poor health, and foster those which generate good health. These include a job, a home, a good education and an attractive environment.”

“A Healthier Future” includes a quotation from the WHO World Health Report 2002, referring to the disease burden in industrialised countries linked to tobacco, alcohol, blood pressure or cholesterol (or their combination). It is interesting that the Report went on to distinguish both distal and proximal causes of disease, commenting that the “distribution of risks across levels of poverty as measured in this report, both within and between regions, suggests they are likely to explain a large proportion of current inequalities in healthy life expectancy”.

Data on healthy life expectancy is not yet readily available in Northern Ireland. Data for England, recently published by the Office of National Statistics in the Health Statistics Quarterly, showed that men in the most affluent tenth of electoral wards could expect to enjoy *17 more years* in good health, compared to men in the most deprived tenth of wards (the gap in life expectancy was smaller, a 6 year gap). There is no reason to believe that the situation is any better in Northern Ireland.

We will need to become more accustomed to setting targets specifically aimed at closing these gaps. In England, Health of the Population PSA targets (2005-8) include some in relation to smoking, heart disease, stroke and cancer explicitly aimed at narrowing societal gaps – we should do likewise. We also need active programmes to meet agreed targets – it is unfortunate that some modest targets in “Investing for Health” for the period up to 2010 have been reduced or deferred, with no obvious explanation.

2.3 The potential role for public services

The HPSS can of course help to raise health standards by providing treatment and care. We should acknowledge that we can also cause harm to our patients (the WHO World Health Report 2002 also referred to studies showing that 10% of patients may experience measurable harm in acute care hospitals in the United Kingdom). The point we want to emphasise, though, is that the introductory section of “A Healthier Future” should go further, recognising that the HPSS is the largest source of employment in Northern Ireland, and the largest sector of public expenditure. The way we carry out our functions, as public bodies, has health consequences for our staff, their families, and in wider society – and often there are differential impacts. We could enlarge on the wider ramifications of this point, but it may suffice to refer you to a couple of publications - “Claiming the health dividend; unleashing the benefits of NHS spending” (A Coote, King’s Fund 2002); and “Work, stress and health: the Whitehall II study” (Council of Civil Service Unions/Cabinet Office 2004). “Improving the prospects of people living in multiple deprivation in England” (Prime Minister’s Strategy Unit, 2005) refers to work being undertaken within the NHS both to help tackle local unemployment, and to strengthen local economies through procurement practices.

These points are relevant to most public bodies; and “A Healthier Future” does acknowledge some aspects of the crucial role for other government departments in achieving health goals. We welcome the introduction of health impact assessment procedures. There would be merit in substantially expanding Section 1(iv) of “A Healthier Future”, which deals with these crucial partnerships across government – references to issues of education, employment, environment and social development all merit substantial development.

3 The future need for health and social care

“A Healthier Future” sets out one vision of our society in 2025; a society with a higher proportion of elderly people, with more people experiencing age-related chronic diseases; a society which may have a greater gap between the rich and poor; a society with a greater burden of mental illhealth; a society at greater risk of both terrorist and disease-related global threats; a society where technological advances and consumerism will have stimulated new demands for treatment. “A Healthier Future” attempts to model the potential impact of varying changes in lifestyle behaviour; but other choices and trade-offs were not considered.

These issues are ripe for discussion with wider stakeholders, discussion about the type of society we want in future. We may prefer to work towards a society which will be more equitable, and more proactive in relation to reducing global threats, than envisaged in “A Healthier Future”. There may be other factors we should take into account – a greater emphasis on environmental considerations, for example. We may prefer to spend more of our public money on creating a healthier and inclusive society, to avoid the disease consequences associated with the type of society anticipated in “A Healthier Future”. These potential choices and trade-offs, of crucial significance in our society, should be acknowledged and widely discussed – “A Healthier Future” would be doing a disservice if it pre-empted such discussions.

We would, nevertheless, concur that it is reasonable to forecast that the Northern Ireland population will have expanded by 2025; that it will be more cosmopolitan; and that the proportion of elderly people will have increased. However, the incidence of chronic disease and the associated need for care could be influenced by government policy.

“A Healthier Future” acknowledges that there is substantial unmet demand for healthcare; delays for outpatient appointments and elective admissions must rank amongst the worst in Europe. There are other subtler aspects of unmet need, reflected for example in low utilisation of specialist hospital services by certain groups in our society – we should be aiming, during the next twenty years, to identify and address these differential patterns of unmet need.

4 The future provision of health and social care

“A Healthier Future” repeats the mantra that in ten or twenty years time the health of the people in Northern Ireland will be amongst the best in Europe. We favour a challenging but more realistic target – that health standards here should compare well to regions of comparable wealth and income, and that the social gradient in health standards will have been substantially reduced. Earlier in this letter we have referred to factors which lead to illhealth; we now turn to the delivery of health and social care to those who are ill.

Many patients and clients receive excellent health and social care. Unfortunately, some patients do not. For various reasons some people are

less likely to go to their GP when ill, or they present at a later stage of their illness. Some patients and clients (particularly those who experience wider social disadvantage) have continued difficulty in accessing and using health and social care services, with the result that diagnosis, treatment and care are delayed or disrupted, potentially with permanent adverse consequences. When patients and clients receive services, these services are not always well coordinated, or adjusted to reflect the diverse needs of patients, unfortunately, variations in the standards of services also occur. In addition to the problems experienced by patients and clients, there are associated difficulties for their carers and families.

As “A Healthier Future” sets out, a recent survey indicated that many people in Northern Ireland are satisfied with our services. We need to be careful, though, that we take account of different experiences of patients in different strata of our society, and in some circumstances the potential impact of depressed expectations. The research paper, “Satisfaction and expectations: attitudes to public services in deprived areas” (B Duffy, Centre for Analysis of Social Exclusion, LSE 2000), may be helpful. There is a growing recognition that satisfaction surveys can produce positive but bland responses – again, see “Community care: asking the users” (G Wilson, published by Chapman and Hall, 1995). At the Royal Hospitals, we are beginning to focus our own survey work more on objective patient experiences, rather than simply on indicators of satisfaction (working with the Picker Institute).

From a service supply perspective, there are many reasons to be proud of our performance, while at the same time recognising the scope for further improvement. We are very proud of the commitment and dedication of staff, and their eagerness to find ways to improve services. Within wider system constraints, the performance of staff is often admirable. We are aware, though, of some shortcomings in our current services, and areas of vulnerability. We have grouped these supply side issues for convenience into issues of resource allocation and resource application.

4.1 The allocation of resources

The UK spends a smaller proportion of GDP on health and social care than most other developed countries (taking into account both public and private sector expenditure). This might be justifiable if health standards in the UK already compared favourably to other countries. This is not the case; nor is there a higher level of expenditure on other social programmes with beneficial health consequences. It is not surprising that patients and clients experience problems in accessing and using our services, if these services are chronically under-resourced.

The Barnett formula shapes the allocation of resources to the four regions in the UK. Northern Ireland receives a population-based proportion of changes in planned spending on comparable services in England, England and Wales or Great Britain, as appropriate. We are concerned that the Barnett formula does not reflect different patterns of need – we anticipate that a switch to a needs-based funding model would benefit the HPSS.

Within Northern Ireland, we have already expressed concern that the HPSS capitation funding formula does not take adequate account of unmet need; and, in the acute sector, that proximity to death is a stronger driver of resource utilisation than age. We continue to argue that the costs of tertiary hospitals (and the Royal Hospitals in particular) fall too heavily on the local community, drawing on recent comparable work in Scotland.

“A Healthier Future” should address these issues of resource allocation, again taking account of issues of choice and trade-offs; otherwise the vision will simply be a dream.

4.2 The application of resources

We fully agree with “A Healthier Future” that we must make our services “patient and client-centred”, that this is one way of making our services more responsive to the diverse needs of each person. We also fully support proposals to achieve better integration of our public services, and more narrowly the integration of our health and social services.

“A Healthier Future” could usefully put a greater emphasis on the potential benefits from patient and community involvement – involvement which can range from information sharing, to joint decision-making, to concordant working. Hopefully inadvertently, the summary of “advantages of engagement” set out in “A Healthier Future” is patronising in tone – that individuals “feel better when they have been listened to”; that they are more likely to complete treatment “if they feel a sense of ownership”; and that “effective public engagement can help to create a better understanding of the complexities involved in managing our services”. A more humble approach would reverse the thinking – more public engagement will help us to learn, to interpret our responsibilities more widely, and to respond to the complex needs of patients, clients and our society. Incidentally, the list of groups set out in “A Healthier Future” which has difficulties engaging with HPSS services should be lengthened to include people living in poverty; and those with potential literacy problems (perhaps 20% of our adult population).

We agree with many proposals set out in “A Healthier Future” for reforming the HPSS. Some of these reforms are overdue. There is now a real prospect that the English model, involving a much greater role for privately provided (but still publicly funded) services will be adopted in Northern Ireland – a process which rapidly becomes irreversible, given the terms of the General Agreement on Trade in Services, to which the UK is a signatory.

In the absence of a devolved administration, we need to move quickly to strengthen strategic leadership and service integration within the HPSS, finding pragmatic mechanisms to overcome the drawbacks of our excessively fragmented organisational structures. We certainly welcome the Review of Public Administration. We hope that new organisational structures will eventually integrate HPSS organisations, and encompass primary care (with one organisation covering all of Belfast). In the meantime, we need to press

on with reforming the HPSS, challenging the existing organisational rigidities more effectively than in the past.

The HPSS will of course need to modernise its infrastructure, and take advantage of clinical and technological advances. We welcome initiatives which will strengthen workforce planning, staff development, and partnership working. We have referred earlier to the need for additional resources within the HPSS – these would be among the areas for additional investment, over and beyond the levels envisaged by “A Healthier Future”.

Throughout this letter, we have been conscious of the twenty year time horizon for “A Healthier Future”, and the opportunity to consider wider societal issues, choices and trade-offs. The HPSS is at a critical juncture – we need more resources, but at the same time we must raise our performance, and become more responsive to the needs of our patients, clients and our society. We have highlighted only a small number of issues, and we are uncomfortably aware that there are many other issues raised by “A Healthier Future” which are of great importance. Nevertheless, we hope that you will find our comments helpful.