FIT AND WELL? HEALTH AND HEALTH CARE

Introduction

Health care has consistently been identified by the Northern Ireland public as one of the most important social policy areas and its top priority for spending. This chapter looks at the health of the population in Northern Ireland and at the main health challenges.

In general the health of the Northern Ireland population has been improving as evidenced by increasing life expectancy and, in recent years, some reduction in death rates from the major killers such as heart disease, cancers and respiratory conditions. However, preventable conditions continue to be a significant cause of death and many of these conditions impact disproportionately on lower socio-economic groups.

The majority of people assess their health as ‘good’. Almost two out of three respondents (63%) in the 2005/06 Northern Ireland Health and Well-being Survey said that their health had been ‘good’ in the previous 12 months, 23% commented that it had been ‘fairly good’ and 15% said it was ‘not good’. Overall 36% of men and 40% of women indicated that they have a long-standing illness. This proportion increased with age. In the 16-24 age group 12% of men and 14% of women had a long standing illness in comparison with 68% of men and 70% of women aged 75 and over. Ten per cent had been told by a doctor that they were suffering from asthma and 6% from angina.

Life expectancy has increased consistently and at 76.2 years for men and 81.2 years for women[1], life expectancy in Northern Ireland is generally in line with the average for the UK and higher than in Scotland. However, when we look at disability-free life expectancy – in other words the proportion of your life you are expected to spend free from disability or chronic illness - Northern Ireland fares worst of all regions in the UK. So, while the average male in the UK can expect to have 62.3 years of disability free life, it is only 59.7 for a man in Northern Ireland. Wales (60.6 years) and Scotland (61.0) fare better. Women in Northern Ireland are also less likely to stay healthy as they get older, with only 60.3 years of disability free life expectancy compared to a UK average of 63.9. This is two years less than the next worst region, Wales, where a woman can expect 62.2 years of disability free life.

There is a considerable difference in life expectancy between those living in the most deprived parts of Northern Ireland and those living in the more affluent parts of the region. In the most deprived areas, life expectancy for men is 72.1 years, which is more than 4 years less than for men in non-deprived areas. Women in deprived areas have more than 2.5 years less life expectancy in comparison to women in non-deprived areas.[2]

Northern Ireland fares badly compared to other countries of the UK in relation to a number of diseases and illnesses. In comparison with England and Wales, Northern Ireland has higher

mortality rates for circulatory diseases (9% higher), respiratory diseases (28% higher), and injuries/poisonings (23% higher). The proportion of Northern Ireland's population that has diabetes is estimated at 5.4%, compared to 3% in Britain. These are all diseases that are closely related to deprivation.

Northern Ireland also has the highest female incidence rate for colorectal cancer (19% above the UK average) and the second highest male incidence rates for lung cancer (1% above UK average) and colorectal cancer (14% above the UK average)[3].

There is much concern throughout the UK about the growing levels of obesity and the impact on the future health of the population. The 2005/06 Health and Well-being Survey estimated obesity levels using the Body Mass Index, which is calculated from a person's height and weight. Overall, three out of five adults measured were either overweight or obese. About one in three was overweight and one in four obese. Men were more likely (64%) than women (54%) to be either overweight or obese. Obesity was most common amongst the middle aged. However, 29% of young men aged 16-24 and 32% of young women were either overweight or obese. Data on childhood obesity in Primary 1 pupils (age 4-5 years) reports that 5.2 % of children were obese and 15.7% were overweight[4].

Mental Health Issues

Levels of mental ill-health in Northern Ireland are higher than elsewhere in the UK or Ireland. The Department of Health, Social Services and Public Safety (DHSSPS) estimates that prevalence figures for mental health problems in Northern Ireland are 25% higher than in England. The number of people in Northern Ireland receiving Disability Living Allowance (DLA) for mental health reasons in 2006 was 2.9% of the total adult population. This is three times the comparable figure for GB (0.9 per cent) and has more than doubled since 1998, when 1.2% of the total adult population received DLA for mental health reasons.[5] Other evidence, that suggests a growth in the extent of mental ill-health in Northern Ireland, is the 33% rise in the number of anti-depressant prescription items issued in the five years from 2000, to 1.4 million in 2005, equivalent to 0.75 prescription items per head.[6]

Findings from the 2005/06 Health and Well-being Survey show that 19% of all people aged 16 and over showed signs of a possible mental health problem such as depression, by scoring highly on a General Health Questionnaire (GHQ). Women were more likely to show signs of a possible mental health problem (21%) than men (16%). This is a better picture than that previously painted by the 2002 Health and Lifestyle Survey conducted by the Health Promotion Agency. It found that a quarter of respondents (23% of men and 26% of women) showed signs of a possible mental health problem by scoring highly on a GHQ. Those with no qualifications and those on a low weekly household income were more likely to show signs of mental health issues. Depression and anxiety were greatest in the 35-54 and 55-69 year age groups.

A Northern Ireland Audit Office Report[7] on absence because of sickness in the Civil Service found that stress-related illness accounts for almost one in three work days lost through illness. Stress is now known to impact on physical health, especially on heart disease and diabetes.

There is a growing body of evidence to suggest that high levels of mental ill-health are significantly related to the conflict, including the psychological distress suffered by those who appeared resilient during the conflict. Variation in intensity of political violence between different areas of Northern Ireland has been linked to area differences in the level of psychological disorder.[8] People in poorer households were found to be more likely to suffer significant health stresses and also more likely to have borne the brunt of "the Troubles."

Another factor which should be taken into account in discussions of poorer mental health in Northern Ireland is that services have been significantly less developed. The Bamford Review of Mental Health and Learning Disability established in 2002 identified major deficits with regard to policy and provision and made over 700 recommendations. Lack of development in relation to community mental health services and poor services for children and adolescents were highlighted. The government's planned response to the review is set out in a consultative document published in 2008.[9]

Structure of Health Care Services in Northern Ireland

As in the rest of the UK, the National Health Service was established in Northern Ireland in 1948. There has always been some policy and structural divergence across the jurisdictions of the UK but the introduction of devolution in 1998 has resulted in governments in England, Scotland, Wales and Northern Ireland having more discretion over significant aspects of health policy. Historical differences with regard to the Northern Ireland system include the structural integration of health and social care in Northern Ireland in 1973. This resulted in the removal of social services from local government and health and social care being administered by four integrated health and social services boards.

The structure of health and social services in Northern Ireland has been under examination since 2000 when a fundamental review of the system of public administration was announced. However, decisions and the implementation of various proposals were delayed by the intermittent nature of devolution. Final decisions regarding the structure were published in 2008 and include:

- A Regional Health and Social Care Board
- A Regional Agency for Public Health and Social Well being
- 5 integrated Health and Social Care Trusts with 5 Local Commissioning Groups
- 1 Patient and Client Council

The new structure in Northern Ireland is more centralised than in Scotland or Wales where, post devolution, there was a strong emphasis on localism. The restructuring in Northern Ireland significantly reduces the number of health and social care delivery trusts. The five Trusts established under the restructuring serve large populations and are among the largest health related Trusts in the United Kingdom. Wales, with a population of 2.9 million compared to 1.7 million in Northern Ireland, has sixty bodies to carry out the same functions as seven bodies in Northern Ireland.

In addition to structural differences, there are a number of other areas where there is divergence across the UK. These include different entitlement to some NHS services. A number of examples are provided in the table below.

Table 1: Examples of Differences in Entitlement to Health and Social Care Services across the UK

	Prescriptions	Dental check	Eye tests	Personal Care
Northern Ireland	From 1 Jan 2009 reduced to £3 per prescription. Free from 1 April 2010	Means tested + free to under 18 and in Full time education women who are pregnant and had a child in the previous 12 months	Means Tested but free to people over 60 and those with certain medical conditions	Means tested
Scotland	To be abolished by 2011	Free	Free	Free in nursing and domiciliary settings
Wales	Free to all	Free to under 25s and over 60s	Means tested but free to people over 60 and those with certain medical conditions	Means tested
England	Means tested with exemptions	Means tested + free to under 18s, women who are pregnant and have a child under 18	Means tested but free to people over 60 and those with certain medical conditions	Means tested

Expenditure on Health and Social Care in Northern Ireland

Expenditure on health and social services in Northern Ireland has almost doubled since the turn of the century, from approaching £2,000 million p.a. in 1999/2000 to almost £4,000 million in 2007/08. Since the 1990s per capita spending on health and social services in Northern Ireland has been higher per head of population than in England but has been lower than Scotland for some time. In recent years, however, the spend per head gap with England has narrowed and now has dropped below Wales, as well as Scotland.

In 2004, Professor John Appleby was asked to review the future resource requirements for health and social care in Northern Ireland and examine whether resources could be used more effectively.[10] Using Needs and Effectiveness Evaluation data he reported that in 2003/04:

- Hospital activity per member of staff was 19% **lower** than the UK average;
- Hospital activity per pound of health spend was 9% **lower** than the UK average;
- Hospital activity per available bed was 26% **lower** than in England;
- The unit cost of procedures was 9% **higher** in Northern Ireland than England with day case unit costs 9% **lower** and elective inpatient unit costs 12.6% **higher**;
- There were significant variations in unit costs between hospitals;
- Day case rates were **higher** than the UK average and had risen significantly since 1990/91;
- Average unit prescribing costs were nearly 30% higher in Northern Ireland than in England, though lower than Wales.

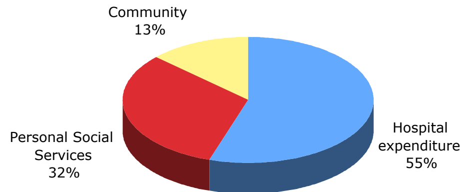
Table 2: Expenditure on health and personal social services per head of population

	£ per head
Northern Ireland	2,096
England	1,915
Wales	2,109
Scotland	2,313

Source: HM Treasury, Public Expenditure Statistical Analyses Data (2008)

NHS expenditure for the devolved jurisdictions is determined by a ‘block grant’ for each which incorporates funding for health services. The allocation of this is at the discretion of the Northern Ireland Executive. In 2006/07 spending on health and social care in Northern Ireland totalled £3.8 billion.

Figure 1 Health and Social Care spending in Northern Ireland 2006/07



Within programmes of care spending on hospital and residential services continues to be high relative to other provisions. Out of £629 million spent on elderly care in 2006/07, £171.2 million went on nursing homes (quarter of total spending on elderly care), £79.7 million on residential homes and £121.9 million on domiciliary care. In relation to mental health services, half of the £191 million total was spent on hospital setting care.

Analysis of Trust expenditure for 2006/07 shows that the amount allocated to health promotion and disease prevention, while increasing, is still relatively small compared to other Programmes of Care. In fact Health Promotion and Disease Prevention and Primary Health and Adult Community Programmes of Care combined account for only 4.4% of total expenditure of Trusts, despite the prevalence of CHD, mental illness, diabetes etc.

Hospital Care

In 2007/08, over half a million (538,552) inpatients were treated in Northern Ireland hospitals. Of these 69% were inpatients and the remainder were treated as day cases. On a number of ‘efficiency’ measures Northern Ireland has improved. Since 2002/03, the number of patients treated in hospitals as day cases has increased by 21.6%.

There were 7,873 beds available across Northern Ireland in 2007/08; this is a 5.2% decrease in the average number of available beds in 2002/03. In the course of the latest year for which figures are available, 2006/07 to 2007/08, there was a decrease of 2.2%. The average length of time spent in hospital (excluding day cases) was 6.4 days compared to 7.8 days in 2002/03. Another measure of efficiency is throughput, that is the number of admissions treated in each available bed. This has increased by 19.4% between 2002/03 and 2007/08.[11]

The 2005 Appleby Report found that waiting times for in- and out-patient appointments in Northern Ireland were the worst in the UK, with considerable variation between trusts. These figures have since improved. Cutting NHS waiting lists has been a policy priority for the NHS in England since 1997 and strategies to reduce waiting times have included performance

targets and strong sanctions for failure to meet these. Historically Northern Ireland has had some of the longest waiting times in the UK for in-patient and out-patient care. In 2005, one in ten of the population was waiting to attend a first out-patient appointment but this figure has fallen steadily. Non-emergency admissions to hospitals had fallen steadily from mid 1990s and continued to fall between 2005 and 2008. In 2005, during a period of Direct Rule, the Minister of Health set out a package of reform to reduce waiting lists, including significantly more challenging targets. Hospital Statistics published by DHSSPS show reductions in hospital waiting lists for both in-patient and out-patient treatment.

Table 3: In-patient Waiting Lists 2005-2008

	Dec 05	Dec 06	Dec 07	Dec 08	% change Dec 05 and Dec 08
Ordinary Admissions	17,145	14,373	12,813	11,962	-30.2%
Day Case Admissions	27,595	25,879	24,950	24,938	-9.6%

In 2008 new targets were set for waiting times. From April 2008 no patient was to wait more than 21 weeks for in-patient or daycare treatment. From March 2009 the target is 13 weeks. In December 2008 4,370 people were waiting more than 13 weeks, with 161 waiting more than 21 weeks.

Table 4: Number of People Waiting for First Out-Patient Appointment 2005-2008

	Dec 05	Dec 06	Dec 07	Dec 08	% Change Dec 05-Dec 08
First Out-Patient Appointment	180,063	154,607	73,637	68,734	-61.8%

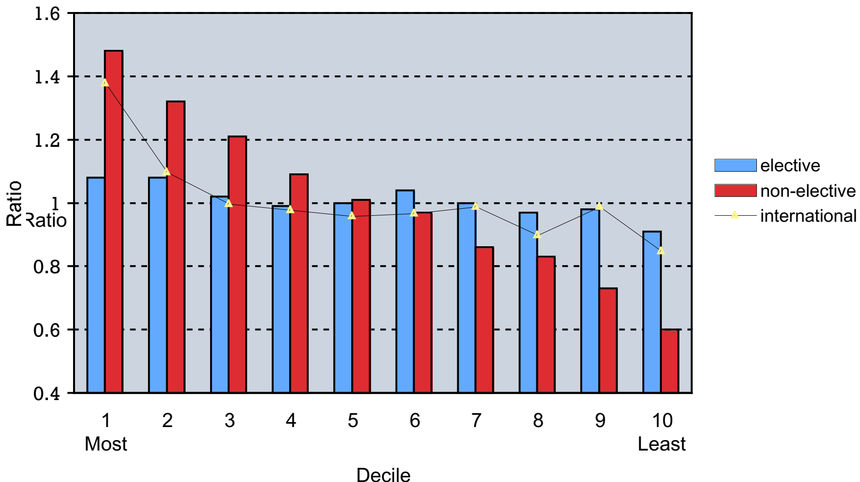
Outpatient waiting times have been similarly reduced. By April 2008 no patient was to wait more than 13 weeks for their first out-patient appointment, reducing to 8 weeks by March 2009. In December 2008 the number of patients waiting more than 9 weeks for their first out-patient appointment was 5,831, 8.5% of the total number of people waiting.

In order to effect this dramatic reduction in waiting times, there has been a significant investment surrounding buying-in capacity from the private sector. So, for example, in reply to a written question in June 2008 (AQW 8293/08), Minister McGimpsey revealed that the Western Health and Social Care Trust (WHSCT) had referred 2,884 patients to the North West Independent Hospital (NWIH) in 2007/08. Of these, 2,091 had had surgery and the total cost to the taxpayer amounted to £5.3 million. This was almost double the amount spent by the WHSCT in 2006/07 when it sent 2,130 patients to the NWIH, 1,389 of whom had surgery, at an overall cost to the taxpayer of £2.7 million.

Access To and Use of Health Care Services

A report for the Belfast Health and Social Care Trust[12] looked at differences in the way that people in more deprived parts of Northern Ireland use hospital services, compared to those from better-off areas. It found that in the nine year period up to 2006/07, a person in the most deprived tenth of the region was almost two thirds more likely to have been treated as a patient than a person in the least deprived tenth. The figures also show that that while someone in the most deprived tenth is 17% more likely than a person in the most affluent tenth to be admitted to hospital on an elective basis, they are 132% more likely to be admitted on a non-elective basis. Figure 2 shows the actual number of elective and non-elective cardiology patients from each tenth of the population, from the most economically deprived to the least, divided by the number that would be expected to be admitted to hospital. A value greater than one indicates an above average use. As can be seen, people living in the most deprived tenth are more than twice as likely as those in the least deprived tenth to need non-elective admission to hospital for cardiology treatment.

Figure 2: Standardised ratios for elective and non-elective cardiology patients, and patients receiving interventional cardiology, by economic deprivation decile for the period 1998/99 - 2006/07



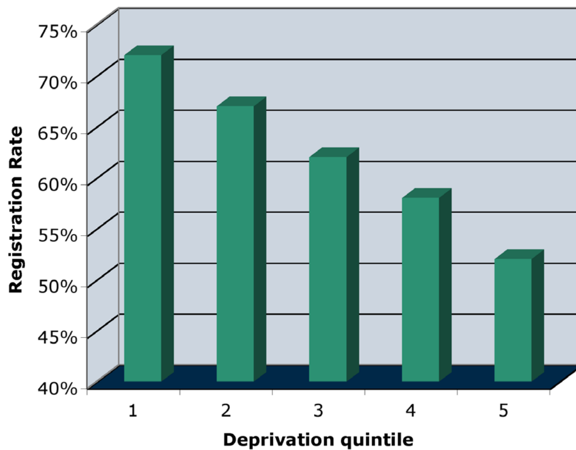
Source: Bates (2008), A report on patterns and trends in the use of hospital services in Northern Ireland.

There are also issues with regard to dental services. In June 2006, Central Services Agency figures show that there are 4.59 practising principal dentists[1] registered to provide Health Service dental treatment per 10,000 head of population[2] in Northern Ireland. This compares with 5.57 dentists per 10,000 people in Scotland. The problems in accessing NHS dentists

faced in some areas is reflected in the numbers of people registered with a dentist in Northern Ireland, which has dropped from 913,303 in 2006 to 862,864 at a time when the population was growing, although within the UK Northern Ireland has the second highest percentage of population registered with an NHS dentist. People living in poverty or in a deprived area are less likely to be registered with a dentist and more likely to have serious oral health problems because of a lack of preventative care.

In recent years there has been considerable focus on the growing number of people unable to get dental treatment on the NHS and the impact of this in terms of equity and oral health issues. The Oral Health Strategy for Northern Ireland published in 2007 provides information about the state of the region's oral health; it indicates that rates of registration with a dentist vary by age, social class and geographical area. There is a marked dip in registration at age 18 when free universal care ceases. While registration rates increase up to age 40, it then dips again – but without recovery after age 40. Figure 3 shows registration rates by deprivation quintile for 3-5 year-old children in Northern Ireland. Although dental care is free to children, just over half the children in the most deprived areas are registered with a dentist, compared to almost three quarters of children in the least deprived areas. Children living in the most deprived wards in Northern Ireland are twice as likely to have dental decay as children from the most affluent wards. Furthermore, in 2003, 8,000 Northern Ireland children attended hospital for dental treatment under general anaesthetic; this is the highest per capita rate of general anaesthetic for dental reasons in Europe.

Figure 3: Registration rates by deprivation quintile for 3-5 year-old children in Northern Ireland

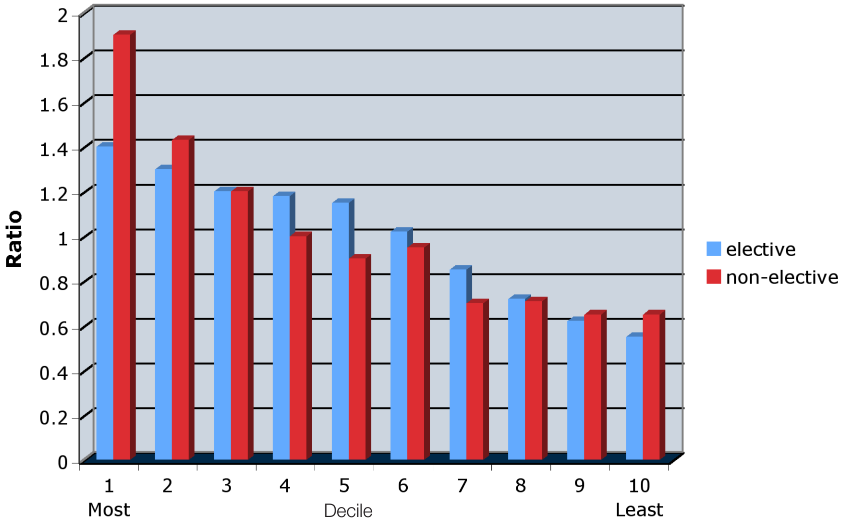


Source: DHSSPS, 2007, Oral Health Strategy for Northern Ireland.

A similar picture emerges in relation to adults. As figure 4 shows, people from the most deprived areas are two and a half times more likely to require hospital dental services than

those living in the more affluent areas, and almost three times more likely to need non-elective dental treatment in a hospital setting.

Figure 4: Standardised ratios for elective and non-elective dentistry patients, by enonomic deprivation decile, for the period 1998/99 - 2006/07



Source: Bates (2008), A report on patterns and trends in the use of hospital services in Northern Ireland

Key Policy Challenges

This chapter has considered the state of the Northern Ireland population's health and explored trends in health care expenditure. On a number of measures Northern Ireland appears to be achieving greater cost efficiency and waiting times, in particular, have been significantly reduced. The recent restructuring of health and social care has reduced the number of health and social care bodies and resulted in a more centralised system.

Many of the challenges facing Northern Ireland relate to public health policy. This includes the need to increase healthy life expectancy, reduce obesity, achieve substantive improvements in mental health and reduce the incidence of a range preventable diseases and conditions. An overarching theme is the persistence of inequalities within the population in relation to health outcomes and access to health services.

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