



*Celebrating 21 years  
Working together for a healthier Belfast*

## **Response to Northern Ireland Multiple Deprivation Measure 2009 consultation NISRA**

5 November 2009

Belfast Healthy Cities welcomes the opportunity to comment on the process to update the NIMDM.

Belfast Healthy Cities is a partnership organization working to improve the health and wellbeing of people in Belfast, through intersectoral collaboration. The partnership consists of key public and voluntary sector agencies, including the Public Health Agency, Belfast City Council, Belfast HSC Trust, Northern Ireland Housing Executive, Planning Service, Bryson Group, Ulster Cancer Foundation and Queen's University of Belfast. Belfast is also a leading member of the WHO European Healthy Cities Network, which currently has over 80 member cities across Europe and co-ordinates work on the common core themes WHO sets for the Network.

Our aim is to integrate health, health equity and wellbeing in all local policies. This follows from the Healthy Cities approach to health, which defines health broadly as the outcome of physical and social living conditions and therefore the responsibility of all sectors.

A key role for Belfast Healthy Cities' office is to provide and share evidence that supports this aim, as well as develop tools that organizations can use to integrate health into their strategy and action. In this role, Belfast Healthy Cities has been at the forefront of collating data relevant to the wider, social determinants of health. Belfast Healthy Cities published the first comprehensive health profile for Belfast in 1998 and followed this up with an overview of change over the decade in 2008. We also developed the original Investing for Health Eastern Area Indicators, which were intended to monitor progress on the public health strategy Investing for Health and were adopted as the regional Investing for Health indicators now collected by NISRA.

## **Comment on the 2009 update of the 2005 NIMDM**

Belfast Healthy Cities acknowledges that the 2009 NIMDM is intended to be an update of the 2005 NIMDM, rather than a full review. We believe that this is appropriate and indeed offers an important opportunity to review change over the period. This will fill a considerable gap, as all deprivation measures developed for Northern Ireland to date have been based on different methodologies, and therefore not been comparable.

Meanwhile, comparability is very important in order to assess whether policies and intervention measures are having an impact in terms of tackling deprivation and inequalities in health, and in what areas. Deprivation data can help do this, and an indication of change over time is particularly important now for two key reasons. Firstly, tackling deprivation is an aim of the Programme for Government and the new Public Health Agency has an explicit aim to tackle inequalities in health. Secondly, in a toughening economic climate evidence of effective interventions is crucial.

We also note that the methodology used is the same as that used in England and Wales. This is another advantage, in that it allows as close comparison as is possible between the jurisdictions.

On this basis, we believe that the current approach taken, limited to updating indicators where necessary, is appropriate. Indeed, Belfast Healthy Cities would urge that priority is given to enabling comparison with the 2005 NIMDM. The proposed amendments, such as including housing benefit or mental health inpatient stays, are in the main positive in terms of better capturing the full extent of deprivation. However, Belfast Healthy Cities would suggest that consideration be given to establishing two 2009 measures – one which is broadly comparable with 2005, and one which incorporates the amendments.

### **Issues for future review**

For a more far reaching review, the consultation document raises a number of issues. Deprivation indices are important in guiding public funding decisions, and therefore it is crucial that the indicators used to establish the indices cover all important aspects and forms of deprivation. In this regard, the current NIMDM indicator and data set has scope for improvement.

However, to ensure comparability over time and across regions, it would be important to undertake any review as a UK wide project with new measures adopted across as much of the UK as possible. In Northern Ireland, collaboration with Central Statistics Office and other stakeholders in the Republic of Ireland would also be important to establish the potential for linkable measures, which have particular relevance in border areas.

We will present our comments and suggestions separately for each domain.

## **Income Deprivation Domain**

The domain, as constituted at present, focuses exclusively on people reliant on benefits, and is well placed to capture the most severe income deprivation. However, it includes no reference to people in employment but on low incomes, the so called 'working poor'. This is a major omission, since at a UK level it has been estimated the working poor constitute up to half of all low income households.

Belfast Healthy Cities appreciates the difficulties in obtaining tax credits data from the Department of Work and Pensions. However, it is crucial that the data embargo is resolved as tax credits data are likely the best proxy for a count of the working poor available without resorting to data modeling, which we agree is problematic in a composite measure generally based on administrative data. Housing Benefit is not a good substitute, as tax credits are counted as income and therefore may push a low income household out of housing benefit eligibility.

Belfast Healthy Cities believes specific indicators focused on children are of great importance and utility, as deprivation in childhood is strongly correlated with poor health and wellbeing in later life, as well as a prolonged cycle of deprivation. Measures focused on adults may also not benefit children equally, for a number of reasons (most importantly, statistical measures often assume equitable sharing of any gains within families, which may not take place). A child centred measure is important to highlight any discrepancies of this type.

Income deprivation can be considered the most important marker of multiple deprivation and is therefore the minimum measure required. However, Belfast Healthy Cities suggest consideration be given to developing a bespoke MDM for children, which would significantly help in developing and targeting interventions at children in greatest need of support.

## **Health Deprivation and Disability Domain**

We appreciate the effort to reduce reliance on the Census, as its data date relatively quickly. However, we are somewhat concerned that the measure relies heavily on benefit data, as there may be area based differences in tendency to claim especially disability related benefits. Similarly, prescription habits related to mood and anxiety disorders may differ between GPs for a number of reasons. It would be helpful to know what work has been undertaken to estimate the size, if any, of such effects.

Belfast Healthy Cities would suggest that for a more fundamental review of the deprivation measures post 2011, opportunities are explored to utilize a greater range of information from the GP Quality and Outcomes Framework. This would allow identification of all cases with key conditions of interest, regardless of benefit uptake behaviour. It could also contribute to the mental health indicator. We acknowledge that the Framework was developed primarily for resource allocation and the statistical

products it yields remain a work in progress, but would suggest that by 2011 the quality of the data will have improved sufficiently to support an analysis of this kind.

We support the inclusion of the low birth weight and children's dental extraction indicators. As noted in the consultation document, they are markers of childhood deprivation, which have implications throughout the lifecourse.

We are less certain about the proposed addition of a mental health inpatient stay indicator. While this in principle would improve the robustness of the measure, in practice surrounding the data are issues about service availability and accessibility. This is of particular importance in relation to mental health services due to the limited capacity in Northern Ireland; in general, evidence indicates that those in most need of a service are often least likely to receive it due to issues of accessibility, which in themselves are tangled up with deprivation. For example, research by Belfast HSC Trust indicated that people from more deprived areas were more likely to need, but less likely to get specialist care than people from less deprived areas.

### **Education, Skills and Training Deprivation domain**

Belfast Healthy Cities broadly agrees with the indicators proposed in this domain. We also agree with the reweighting, as this again gives greater weight to children.

We would welcome clarification, however, on the proposed methods to apportion school level aggregates for Key Stage 2 and 3 assessments to areas. It is important to note that many schools have wide catchment areas, and therefore clarification is needed especially on how results from such 'geographically mixed' schools are apportioned.

### **Proximity to Services domain**

Belfast Healthy Cities would welcome clarification on what the core purpose of this domain is. On their own, each proposed indicator is relevant and reflects an aspect of deprivation; however, when combined the domain with its general reference to 'services' appears to lack a well defined, clear purpose. It would appear helpful to prioritise the indicators based on evidence of how they relate to deprivation, and weight them accordingly.

We would also stress that proximity may have little to do with accessibility, which is the key issue related to deprivation. For example, older people may be unable to walk even short distances; this highlights the relative nature of 'proximity'. This measure also ignores the presence of barriers such as busy roads, or indeed interface areas, as well as issues such as cost and quality, which are key to the concept of accessibility. In relation to health care, accessibility may be affected by issues of knowledge and information, and in some cases by attitudes within the service itself. We would recommend that longer term, work is undertaken to develop more accessibility focused indicators for this domain.

A particular concern related to this domain is the lack of transport data. Transport is crucial for accessing services, especially in the Northern Irish context with a large rural area. Lack of suitable transport is a key form of deprivation which may serve to limit people's life spheres as well as definitions of proximity and locality, and it is a significant limitation that this now ends up ignored due to lack of data. Belfast Healthy Cities would recommend that NISRA seek collaboration with the Department for Regional Development and Translink, to improve the availability of transport data.

In relation to the above, Belfast Healthy Cities would welcome clarification of whether travel times refer to motorized and/or non motorized travel. People affected by higher levels of deprivation are less likely to own a car than others, and therefore the method and definition used to establish proximity are important.

Regarding the proposed indicators, Belfast Healthy Cities is not convinced that the general services indicator is sufficiently specific to be included. While access to the types of establishment proposed to be included is related to wellbeing, they appear relatively weakly related to the type of deprivation focused on in other domains.

We would suggest that the food shop indicator focus on supermarkets and larger food stores but not convenience stores. The latter typically carry a limited range, often concentrated on less healthy food and at premium prices, which means that reliance on convenience stores often contributes to the poor diet associated with deprivation and poor health. Including these in the food indicator would mask this effect and reduce its utility.

We would agree that Council leisure centres should be included, as they are often the most affordable option for organized sports or leisure activities such as swimming. Access to such opportunities, meanwhile, is important for health and wellbeing. However, we are disappointed that no indicator for access to open space is proposed.

Open space offers opportunities for free and/or unsupervised physical activity, which is essential especially for children and young people from low income backgrounds. There is evidence that the visual amenity alone has positive impacts on health and wellbeing, while open green space also offers opportunities for social interaction and mental recreation. Open space is, furthermore, in itself often a marker of affluence, while lack of open space is typically associated with inner cities or social housing estates. Belfast Healthy Cities would suggest that ways of including an open space measure are explored for this update, and that development of a standardized open space indicator is given priority in a future review.

### **Living Environment domain**

In relation to the housing indicators, Belfast Healthy Cities agrees with the proposed amendments. We would also suggest that while accidents in the home have a deprivation dimension, they do not necessarily reflect housing quality, as they often

are related to behaviours (eg. scalding from hot baths, DIY accidents or accidental poisoning due to inappropriate storage of toxic substances or medicines). Therefore, the Housing Health and Safety Rating, which focuses on design related hazards, would appear a better indicator also over the longer term.

The outdoor environment sub domain is an important element of this domain, as it influences how an area is perceived, both by people living in it and others. This, in turn, will affect mental wellbeing and negative perceptions can directly lead to stress and ill health. Belfast Healthy Cities would recommend that longer term, options for strengthening this sub domain are explored. Relevant indicators could include availability and quality of open space, safety (see below) and an indicator of social capital or social cohesion in the area. Data on the latter is currently collected as part of the Continuous Household Survey, but we do appreciate the sample size is currently not large enough for robust small area modeling.

### **Crime and Disorder domain**

Belfast Healthy Cities broadly agrees with the indicators proposed for this domain.

We appreciate the issues regarding sample sizes of the Crime Survey and DPP surveys. However, longer term we believe it would be important to incorporate a measure of how safe people feel in an area. This is directly related to the other currently proposed indicators, but also incorporates an element of people's perceptions and lived experience.

While perceptions do not always reflect the statistical figures, as noted above they remain important as they influence people's daily lives and choices. For example, people are less likely to be physically active in an area they feel is unsafe, and a perceived lack of safety can directly lead to stress and ill health.

Belfast Healthy Cities would also recommend that the crime indicators included are kept under review. In particular, it is important to collate evidence of the types of areas where specific crimes are most prevalent. For example, vehicle crime or burglary might move to occur in less disadvantaged areas as loot values may be higher, although we are aware this is not the case at present.