Northern Ireland Assembly

Committee for Education

OFFICIAL REPORT (Hansard)

Period Products (Free Provision) Bill: Department of Health

20 January 2022

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Chris Lyttle (Chairperson)
Mr Pat Sheehan (Deputy Chairperson)
Ms Nicola Brogan
Mr Robbie Butler
Mr Justin McNulty
Mr Robin Newton

Witnesses:
Dr Tomas Adell Department of Health

Please note that proceedings at the start of the meeting were not recorded, owing to technical difficulties.

Dr Tomas Adell (Department of Health): *(Continuing)*

Clause 1 creates a duty on the Department of Health to provide free period products universally across Northern Ireland, and clause 2 creates a duty to create regulations that specify public service bodies, including health and social care trusts and the Health and Social Care Board (HSCB).

The Department of Health supports the objectives and overall intent of the Bill. The concept is important. However, while we can all agree that the lack of access to period products can have significant physical and mental health impacts, period products are not classified as healthcare products because menstruation does not generally require health treatment nor is it preventable. The fact that the lack of period products can cause health issues does not make it an underlying or a direct healthcare issue. Parallels can be drawn with other areas that cause health issues, such as social deprivation, fuel poverty and homelessness. Although those are all hugely important issues for health inequalities and outcomes, they are not, in themselves, health issues. While the Bill has very good intentions and will, undoubtedly, help those who need it, we believe that it should be considered as an issue of gender equality, poverty or social justice rather than a healthcare issue. It is, therefore, the view of the Department that the duty in clause 1 should not be on the Department of Health. Again, that does not take away anything from the importance of the Bill or the good that it will do.

The letter from Minister Swann to the Committee made a number of comments on specific clauses. I will mention a few that we found particularly important. The general duty in clause 1 and the more specific duty in clause 2 include a number of factors that have to be taken into account, such as dignity, accessibility, choice and differently able people. The view of the Department is that that is a good way of expressing how products should be provided and is a pragmatic way of ensuring that products are available where they are needed. More specific requirements, such as the requirement to

have products available in toilet cubicles or specified areas, could be difficult to accommodate, considering the wide variety of locations where products would be provided. For example, purely from a healthcare perspective, in a mental health or learning disability hospital, regard would have to be paid to patient safety, where the lack of understanding of the product may cause risks. Those would need to be managed, which would be difficult if they were available in all toilets. That, obviously, would not be a problem in, for example, further education settings, so a differential approach would be useful. We fully support the aspects of dignity, accessibility and choice and the need to consult on those things.

Clause 2 provides a duty to create regulations to specify public service bodies with requirements, including trusts, the HSCB and educational settings. The HSCB is not a public-facing body and is due to close on 31 March. Therefore, the most prudent approach would be to remove the HSCB. We are also a bit concerned about the inclusion of absolute requirements relating to health and social care trusts. As drafted, the requirements would include the Northern Ireland Ambulance Service Health and Social Care Trust. We understand that that might not be intentional, but it may cause some logistical challenges. We also do not necessarily see the difference between a health and social care trust and other public-facing bodies, even those within the Department of Health's remit. The wide inclusion of all trusts might cause technical and administrative challenges. It is, obviously, possible to overcome those challenges, but it might be more appropriate to treat the trusts the same as all other arm's-length bodies in the Department and wider government rather than specifically mentioning them. That might provide better outcomes for the overall provisions.

As we noted in our written response, the overall timeline to commence the Bill within two years is very much manageable, and other timelines should match that. The commencement powers in clause 9 should probably match the Department's duty in clause 1. That would make the policy and implementation work more efficient and effective.

The Bill will have financial implications. It is difficult to assess the total cost of the Bill, as that will be heavily dependent on the price per product, the total uptake and the delivery method. It is estimated that approximately 109 million products are used in Northern Ireland each year, so even a small variation in cost could have significant cost consequences. Experience from other jurisdictions shows that the cost-per-product range can be huge. In some areas, it has been from 4p per product to 49p per product, depending mostly on how the products were procured rather than on the products themselves. At 4p per product and with a 5% uptake, the total cost of the products would be about £200,000. That is obviously not a huge cost, but, at 49p per product and with a 20% uptake, the total cost would be about £10 million. That would pose significant challenges. The Department believes that the most reasonable expectation for public procurement across the whole of Northern Ireland would be about 9p per product with an uptake of about 20%. That would mean a product cost of approximately £2 million per year. That, of course, assumes that we use low-cost products that are not reusable. With reusable products, the cost could increase significantly.

In addition, departmental staff would be needed to develop the overall policy and guidance. We would need procurement, and we would need logistical networks. Good distribution channels would also be needed. If we used existing networks to get the product across the whole of Northern Ireland — for example, community pharmacists are one of the few networks available to the Department of Health — a low estimate would be that it would cost at least £1 million per year. The total cost would therefore be at least £3 million per year but with much uncertainty over the total implications.

If the duty in clause 1 remained with the Department of Health, we would need to reduce other spending to fund it. That should be seen in the context of the challenging financial situation in which the draft Budget is not sufficient to cover existing demands across the Health and Social Care (HSC) system. If implemented, sufficient funding would therefore be required for the duty, or other healthcare areas would have to be reduced.

The Department supports the principle of the Bill, although we believe that the duty in clause 1 should not be on the Department of Health. I thank you for the opportunity to provide opening remarks. I am happy to take any questions that you might have.

The Chairperson (Mr Lyttle): Thanks for that, Tomas. I must say at the outset that your genuine and full apology for the lateness of your papers was entirely refreshing and unique. I am not being facetious; I am grateful for it.

Your acknowledgement of the unacceptable status quo of the lack of period product provision is also important, but, thereafter, you raise a couple of fundamental problems for the Bill, particularly the

Department of Health's assessment that it is not its statutory duty to roll out the provisions of the Bill as per clause 1, which is obviously significant. I presume that members will want to get into that with you in a bit more detail. I realise that we are extremely tight for time today, so I am keen to bring other members in straight away. Thank you for that clear, understandable briefing, Dr Adell; I appreciate it. I might not agree with the substance of it and may need to challenge that, but I appreciate your presentation today.

Mr Sheehan: Thank you, Dr Adell, for your presentation. I certainly agree with your comment that this is a gender equality issue; there is absolutely no doubt about that. In conversations with witnesses who have appeared before the Committee, the point has been well made that no one would think of not placing toilet paper in toilets or of charging for toilet paper. That should be the case for period products.

I want to drill down into the costs that you mentioned. If I am right, you suggest that it could cost anywhere between £200,000 and £1 million, and you mentioned a figure of £3 million. What did that relate to?

Dr Adell: We estimate the product cost to be between £200,000 and £10 million, depending on cost. We do not think that it will be as high as £10 million. A reasonable product cost would be in the region of £2 million, if there is about a 20% uptake and a cost of 9p per product. There will be other costs, such as logistical and administrative costs that we estimate to be at least £1 million a year. Again, there is a lot of uncertainty, because it depends on the delivery methods, the logistical system and the outcome of the procurement exercise. That is our best estimate at this point.

Mr Sheehan: Why is there such a wide difference in cost?

Dr Adell: We looked at costs in other jurisdictions in their procurement exercises: they ranged from about 4p per product to 49p per product. That is a huge range. The difficulty is that, because we have not procured products on this scale across Northern Ireland before, it is hard to know where in that range the cost will be. The best estimate that we could come up with is around 9p per product, and, with 20% uptake, that will be about a £2 million cost per year for the products alone.

Mr Sheehan: When doing your comparative analysis, what other jurisdictions did you look at?

Dr Adell: We were speaking extensively with Scotland and looking at the cost of products in pilots across England. Scotland went through a procurement exercise recently, so it has a fairly good indication of what it might cost per product. There is huge variation in Scotland.

Mr Sheehan: Thanks for that. Those are all the questions that I have.

Mr Newton: As before, I just seek information about the potential budget, but the questions asked by the Deputy Chair have steered me in the right direction. That information will no doubt come out at a later stage. Thank you to our witness this morning.

Mr Butler: Tomas, I echo the words of the Chair about the refreshing opening statements that you made. I hope that you were not just prepping us, softening us up and trying to be the good guy. The submission is honest, and we appreciate that. The Committee will agree that the very fact that you are here today indicates that this item should have been with the Committee for Health as opposed to the Committee for Education, although we have a part to play in it, and that is a given because we want to establish good legislation that sees the products available and free to young women, young girls and those who menstruate.

With that in mind, can we expand a little, Dr Adell, on gender equality and the poverty and dignity issues? Looking at the Bill and the *[Inaudible]* changed or effected to redress or refocus it, this is really a cross-departmental issue. When we look at gender equality, poverty issues and dignity, those are really issues for the Department for Communities; when we look at the provision in schools, it is for the Department of Education; and, when we look at health facilities, it is your Department. This is a Bill that everybody wants to see through. The points from Pat, the Chair and Robin are well made. In your estimation — I know that you are not a Bills expert — does the Bill have enough scope that that can be addressed and that it can be more of a cross-departmental Bill?

Dr Adell: The Bill is fairly well drafted. It is not a bad Bill in itself. The issue that we have is the designation of the Department of Health as the Department with universal power. If you place a universal duty on a Department, it needs to sit with a specific Department, otherwise it would cause too much confusion. It is undoubtedly a cross-departmental issue, and the Department of Health undoubtedly has a huge input to make. There is no question about that, and we are not arguing about it. However, we argue that the universal duty should sit better in relation to poverty or social justice, because that is really what the Bill is tackling. It is not dealing with a healthcare issue, even though it has healthcare consequences, and that is a problem. If it had not been the end of the mandate, my recommendation probably would have been that we should take a step back and sit down across government to figure out the best way of doing this. It would be unhelpful for me to say that to you now, because —

Mr Butler: We are where we are.

Dr Adell: — we do not have time to do that. My honest opinion would have been, "Let's take a step back. Let's sit down and talk about where we can get the best result to take this through". Again, that is not realistic at this point.

Mr Butler: I think that the Deputy Chair picked up on this when he was asking you about the financials and how you modelled. That was useful, and we have not been able to get to this stage with anybody we have talked to. There has been a general gist that people were looking at what the costs have been in Scotland, but that breakdown of price per product is incredible when you look at the variance between 4p and 49p and, obviously, the difference between £200,000 a year and £10 million a year. That should sharpen our focus on the need to make sure that the cost burden is shared. We are well versed in the tremendous pressures that will come on health and education in particular.

Thank you for your presentation. It is nice to see a commitment from the Department of Health with regard to what you will do. We can see a little light at the end of the tunnel with this, and you have helped to flesh out a bit of direction for the Committee. Thank you, Dr Adell.

The Chairperson (Mr Lyttle): Dr Adell, before I bring in Justin McNulty MLA, I expect that the Committee will want to interrogate the assertion that this is not a healthcare issue. It would be helpful if you could say more about that, in that it is argued, widely at times, that menstruation is a public health and human rights issue. For anyone who would challenge your view that it is not a public health issue and would put to you that it is a public health issue, can you respond to that in more detail, please?

Dr Adell: Of course. First, I am not disagreeing with the human rights aspect. Human rights is an important issue across all Departments and something that we all take seriously. When it comes to public health and healthcare issues, the general position that we take on products is that, if the product is used for something that is not treatment and is not preventable, it is not a healthcare issue. There are a range of issues that are helpful and useful that are not healthcare products. For example, food supplements are useful for our well-being, but they are not a healthcare product.

Also, there are many things that cause us healthcare issues. Most things in society impact on our health, but that does not make them healthcare issues. That is a very important distinction for us to draw because otherwise we would, arguably, be responsible for everything in society. Whilst we want to be involved in those things, that would make the position of the Department untenable. A good example is homelessness. Homelessness has huge consequences for physical and mental health, and, in my previous role in mental health in the Department, I was heavily involved with the work of the Department for Communities on homelessness. It is right that the Department is involved in that work, but it is also right that we were not leading on that work. We also know that social deprivation is one of the biggest reasons for and causes of health inequalities. That does not mean that social deprivation is a healthcare issue; it is a societal issue that is taken forward through poverty strategies, inclusion strategies and similar. In that sense, period products sit in that category as something that is important for health but is not a health issue itself.

The Chairperson (Mr Lyttle): OK. The Committee will need to reflect on that and, I imagine, potentially return to the Department of Health about it. We will consider this an opening exchange with you in that regard.

Mr McNulty: Tomas, thank you very much for your informative presentation. Does your mind boggle, Tomas, that this legislation is only being brought forward in the year 2022?

Dr Adell: It is not right for me to make political comments. However, I consider that free period products is a very important issue and will have good effects on the public who need to use them.

Mr McNulty: That is my next question. What do you see as the positives of the legislation?

Dr Adell: They are huge. We all know the negative consequences for those who do not have access to such products. The statistics on educational underachievement are shocking. The impact on physical and mental health is huge. As I said before, I have been involved with mental health in the Department for quite a few years, and I know that this causes massive mental health issues. Undoubtedly, this is an issue that will have positive health consequences.

Mr McNulty: Excellent. Other questions that I wanted to ask have already been asked. I am very much in Pat's corner on the equality issue. It is fantastic that, at long last, this is being addressed. Doctor, thank you very much for your detailed and informative presentation.

The Chairperson (Mr Lyttle): Thanks for that, Justin.

Dr Adell, it is obviously an extremely significant intervention to say that the Department on which the sponsor chose to place the duty of universal provision should not be chosen. Have you had any engagement with the Bill sponsor in that regard? You suggest that substantive engagement, the like of which might not be possible at this stage of the mandate, would have been ideal. Have you had any engagement with the Bill sponsor at this stage?

Dr Adell: I have not had that engagement. I was only brought in to work on the Bill at the start of this year, so I have really only had two weeks to look at it. I have had to focus on understanding the Bill and the consequences that it will have. Unfortunately, I have not had the time to engage as I would wish in normal circumstances.

The Chairperson (Mr Lyttle): Has the Department engaged with the Bill sponsor?

Dr Adell: Not as far as I am aware. As, I am sure, you are aware, the Department is under some pressure at the moment, with most of our work focusing on the COVID response.

The Chairperson (Mr Lyttle): OK. Can you recommend another Department on which that duty should be placed?

Dr Adell: I must apologise in advance. I am not sure that it is right for me, as a civil servant, to recommend how the Executive should operate. There has to be Executive agreement on what Department should lead on this.

The Chairperson (Mr Lyttle): You must have an opinion, though, because you have said that it should not be the Department of Health. You have suggested that the matter engages more closely with issues of social deprivation, gender equality, poverty and social justice.

Dr Adell: Those topics are the responsibility of the Department of Justice and the Executive Office. If they are the relevant issues, that is where the policy should sit. I must say, though, that it is a cross-departmental issue, so there needs to be cross-departmental working. However, it is not right that the Department of Health should have the lead in implementing this.

The Chairperson (Mr Lyttle): One imagines that those issues engage directly with the remit of the Department for Communities.

Dr Adell: The Department for Communities has a huge part to play in this, absolutely.

The Chairperson (Mr Lyttle): And, obviously, given the significance for educational institutions, the Department of Education should be involved. I am concerned. We started well, Dr Adell, but I have seen important provisions fall between the stools of cross-departmental cooperation too often during my time in office. I am really concerned for the sponsor of the Bill as well. Time is not our friend in overcoming such a fundamental intervention. I do not mean to be personally critical towards you in any way, obviously, but the Department's assertion that the Department specified as being responsible

for the duty of universal provision is not the appropriate one is extremely significant. Is it fair to say that?

Dr Adell: Yes. I can only apologise for the lateness of our response. I wish I had been able to bring it forward sooner. As I said, if we had had more time in the Department to sit down and have good conversations about it, it probably could have worked out without too much difficulty. It is difficult to do that at the end of January, given both the COVID pressures and the large amount of legislation going through the Assembly at the moment.

The Chairperson (Mr Lyttle): It is not an insurmountable problem but one that has a time challenge.

I know that you touched on some of the other issues. You acknowledged plenty of the Bill's positive aspects. Are there any other key problems that we need to face up to in order to overcome those, other than the specification that the Department of Health has the statutory duty for universal provision?

Dr Adell: We mention a few technical things in the letter. Fundamentally, it is a fairly well drafted Bill. It is not a bad Bill at all from a technical perspective. We like the fact that it gives wide freedoms on how we do it in practice, because that makes it workable. Tight controls over specifics would have made it difficult.

The Chairperson (Mr Lyttle): OK. Well, that is positive. Departments do not always advise us that private Members' Bills have been well drafted. There are plenty of positives to work on.

Dr Adell, I do not think that I have anyone else to bring in at this stage. I am really grateful for your engagement today. We can reflect on your contribution and how we can help the Bill sponsor to engage with you and the Department in order to see in what way the Bill can be amended or refined and whether there are aspects of it that are more deliverable in advance of the end of the mandate than the ones that, you have suggested, may need more work at this stage. Are you happy for us to come back to you, if necessary?

Dr Adell: Of course. Our job is to support the Department and support you to make the right decisions.

The Chairperson (Mr Lyttle): OK. There is very clear consensus on the need for delivery of the purpose and principles of the Bill, so it is incumbent on us all to work together to advance that as far as we absolutely can. That is coming through clearly from you today as well, Dr Adell. I appreciate that.

Dr Adell: Absolutely.

The Chairperson (Mr Lyttle): Thanks very much for your time today.

Dr Adell: Thank you.