Attitudes to the development of cross-border health services: The case of GP Out-Of-Hours services

Research report prepared for the Co-operation and Working Together GP Out-Of-Hours Project Board

by

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EXECUTIVE SUMMARY

Most patients prefer to be treated as near as possible to where they live, close to their relatives, in a system they are familiar with, with providers who speak their language, where they know what they can ask for and what they expect to receive. Going abroad is almost never the first option, but is rather the result of specific circumstances.

Europe for Patients Study, Rosenmöller et al., Eds. (2006).

Patient mobility has emerged as a key policy issue both from a European and all-island perspective in recent years.

Co-operation and Working Together (CAWT), a partnership of health Boards and Trusts in the Irish border region, is leading the development of cross-border co-operation in health on the island of Ireland. In 2001 the CAWT Primary Care Sub Group investigated the logic and benefits of providing GP Out-Of-Hours services[1] on a cross-border basis. A feasibility study (Moore et. al., 2001) found that:

- Approximately 70,000 people across the length of the border are closer to GP Out-Of-Hours services in the other jurisdiction
- Over 70% of this population live in areas which can be classed as socially deprived
- If the patient were free to travel across the border to see a GP for urgent Out-Of-Hours treatment then the travel distance could be considerably reduced

The study concluded that such a service would have great potential to increase access to primary health care for residents of the border region.

In 2005 CAWT secured funding from the EU Interreg IIIa programme to develop two pilot areas along the border where patients would be given the choice of accessing closer GP Out-of-Hours cross-border services or using the existing service in his/her own jurisdiction. In the first pilot area patients in the Republic of Ireland (Donegal) would be given access to a GP Out-Of-Hours centre in Northern Ireland (Derry). In the second pilot area patients in Northern Ireland (South Armagh) would be given access to a GP Out-of-Hours centre in the Republic of Ireland (North Monaghan). Each pilot area would have approximately 13,000 residents.

The Centre for Cross Border Studies was commissioned to research the views of people living or working with communities in the border region on the planning, development and use of cross-border health services and in particular on the planned cross-border GP Out-of-Hours service. The views of the main political parties were also sought. The research was conducted over a 5-month period from April–August 2006 prior to the planned implementation of the pilot cross-border GP Out-Of-Hours service. This is the first study to look at public attitudes to the development of cross-border health services on the island of Ireland and should be read as a starting point for developing more in-depth, rigorous research on this subject..

The research reviews the legal, policy and pragmatic experience of providing health care across other EU borders and draws on two major reports published during 2006, the Framework 6 Europe for Patients Case Study book (Rosenmoller et. al., 2006) and the policy brief on cross-border health

[1] GP Out-of-Hours services are health services provided to people when their own General Practitioner/medical centre is closed, that is, in the evenings and during the night from 6.00pm to 8.00am, at weekends and over public holidays.

care in Europe produced by the European Observatory on Health Systems and Policies (Bertinato et. al., 2006).

Mobility in an EU context

The debate on mobility of patients is linked to a wide set of issues about the future of European health systems. Recent discussions have highlighted a range of ways in which European collaboration can bring concrete benefits to the effectiveness and efficiency of health services across Europe (Bertinato et. al., 2006). This includes collaboration to make better use of resources, developing a better understanding of the rights and duties of patients, sharing spare capacity between systems, mobility of health professionals, identifying and networking European centres of reference, and coordinating assessments of new health technologies. It also covers improving information and knowledge about health systems to provide a better basis for identifying best practice, and ensuring universal access to high quality services.

Recent judgments[2] by the European Court of Justice have established important principles for cross-border co-operation in health but offered very little detail of what patient mobility in the EU meant in practice. Within the EU national governments have retained the responsibility for organising health and social care within their own borders. However a series of EU directives and frameworks on mobility of professionals, data protection, sharing of confidential information and eHealth all facilitate cross-border co-operation in health.

There is a long tradition of co-operating in health across other EU border regions. Recognising that these practical experiences in delivering health care across borders are still fairly unknown the European Commission has funded a three year Evaluation of Cross-Border Regions in the European Union (Euregio) project under its Public Health Programme[3] and the previously mentioned Framework 6 Europe for Patients Project[4]. The in-depth case studies detailed under these projects have highlighted examples of integrated cross-border health zones on the border regions of France and Belgium and Netherland, Belguim and Germany; the first joint hospital on the French-Spanish border; the electronic international health insurance card in the border region of Germany and the Netherlands; contracting arrangements under which Maltese patients are treated in the UK and UK patients were treated in Belgium, a Euregio Internet portal which provides cross-border health-related information for patients; and Belgian and Dutch patients who can access GP care up to 25 km across the border.

These case studies show how the experience of developing health co-operation across other EU borders is very similar to that on the island of Ireland. Typically health co-operation has emerged as a bottom-up process based on local agreements between providers and purchasers, often within a broader framework of cross-border co-operation and often supported by EU (Interreg or Peace) funding programmes. There are clear examples of projects in Belgium, France and Slovenia providing pragmatic solutions to specific local problems but experiencing problems once the exchange of patients takes place, often because of a lack of a sound legal basis. Difficulties also relate to the development of shared approaches to quality assurance, continuity of care, information sharing, or compliance with regulatory systems. The development of cross-border health services on the island of Ireland should build on the practical experience of other European border regions and on the renewed interest in the European Commission on facilitating health care across borders.

[2] (See in particular the Kohll judgement, Case C-155/96 of 28.04.98, ECR 1998 p. I-1931; Smits et Peerbooms judgement, Case C-157/99 of 12.07.01, ECR 2001 p. I-05473 ; Vanbraekel judgement, Case C-368/98 of 12.07.01, ECR 2001 p. I-05363, Inizan judgement, Case C-56/01 of 23.10.03, not yet published; Leichtle judgement, Case 8/02 of 18.3.04, not yet published.).
[3] See http://www.loegd.nrw.de
[4] See http://www.europe4patients.org

In September 2006 the European Commission launched a 4-month public consultation to support co-operation between the health systems of the Member States and to provide certainty over the application of Community law to health services and healthcare. The public feedback will be used to inform an EU Commission's 2007 Annual Policy Strategy on developing an EU framework for safe, high quality and efficient health services.

Mobility in an all-island context

In an all-island context mobility has been the focus of a comprehensive study by the North South Ministerial Council, the intergovernmental framework under which co-operation in health is being developed. The final report (PricewaterhouseCoopers and Indecon 2001) from this study highlighted the difference in primary care access North and South of the border and reviewed the arrangements which facilitate mobility on the island. Four recommendations were made which concerned conducting a series of feasibility studies permitting frontier workers to access health services at their nearest hospital; encouraging an increased number of hospitals in the North to accept Southern health insurance, and raising awareness of the E128 form for seconded or posted workers through proactive employer contact. The report also called for an objective source of information designed to inform individuals considering a move to either jurisdiction about the changes in their healthcare entitlements.

Despite the enduring enthusiasm for co-operation in health services found in previous research (Jamison et al., 2001 and Jamison et al, 2006) [5], the mobility of patients and professional on the island has remained at a low level. Approximately 16, 000 patients have received treatment in the other jurisdiction over the seven year period from 1996-2003 either under individual contracting arrangements or through the newly established National Treatment Purchase Fund in the South.

The public's willingness to use health services across borders is reflected in the fact that 1,262,705 European Health Insurance Cards[6] were issued in the South and 359,061 in the North since the launch of the scheme in May 2004 – equating to one in every four people living on the island applying for EU 'occasional' health cover.

There is anecdotal evidence of large undocumented movements of patients crossing the Irish border for health care. In 2000 there were an estimated 18,000 EU frontier workers who commuted across the Irish border to work in the other jurisdiction and who could legitimately use the health services in both jurisdictions. However the experience of this group of health services users or indeed the unofficial large number of health service users in the South who use an 'accommodation address' in the North to access services illegitimately has never been officially researched. A brief comparison of the current population and GP registration statistics[7] for the two health boards adjoining the border in Northern Ireland shows over 46,000 patients currently registered with GP practices over and above the official population of these regions.

The views of the border communities

The findings of this research are based on a series of four public meetings and a survey of 107 community groups living in or working with the border community. The high response rate achieved for the survey (79 %) is indicative of the public interest in health issues.

[5] Interviews conducted as part of Centre for Cross Border Studies research in 2001 and undated under the Europe for Patients Study in 2004.
[6] From June 2004 the EU simplified procedures for patients, providers and administrations by launching a European Health Insurance Card which replaced all existing paper forms required for occasional health treatment when in another Member State (E111, E110, E119, E128).
[7] Sourced from the Department of Health, Social Services and Public Safety, Northern Ireland

Over 95% of organisations supported the development of the cross-border GP Out-of-Hours service, and the development of cross-border health services in general. In essence they have provided CAWT with a strong mandate to implement this cross-border service on their behalf. This support is evident within the two pilot areas of Donegal/ Derry and South Armagh/ Monaghan and further afield. The border communities would like reassurance that this development of more effective and efficient GP Out-of-Hours health services in the region will be given due priority over any legal, political and financial concerns which may arise.

As is the experience of other EU border regions, people consulted in the Irish border region place a great importance on accessing information. At all stages of this research the border communities expressed a desire to contribute to the debate on cross-border health services. In particular questions were raised on the cost implications, the administrative procedures involved, the monitoring arrangements, their rights and entitlements to access, and the integration of cross-border care into existing arrangements for secondary services. There is a clear need to familiarise the wider border communities with the details of the planned cross-border service and of cross-border health co-operation in general. The majority of organisations consulted as part of this research were unfamiliar with the work of CAWT and only 20% of organisations were aware of their EU rights and entitlements to health care.

In addition, the border communities expressed a desire to be kept informed of how successfully the service is operating once it begins, how many people access care on a cross-border basis; what patients experience is of using the new service, and what indicators are being used to judge the success of the pilot service. The development of a GP Out-Of-Hours website would allow members of the public and health professionals alike to easily access information on the plans for the service, familiarise themselves with the operationalisation of the system and view regularly up-dated and transparent information on the monitoring and use of the service.

The Inishowen community in the South (North Donegal) highlighted the fact that they access information on health issues primarily through the media in Northern Ireland. It is important that any publicity for the service is generated through media on both sides of the border in each pilot area. Promotional material should also be channeled through established and trusted organisations within the pilot areas from where patients will originate. This should include distributing leaflets through GP practices and religious establishments, and via children at local schools. Using this approach, the publicity for the service will be focused on users of existing public services (education and health) within the area they normally reside, eliminating those groups who reside on one side of the border but continue to use the health services in the other jurisdiction.

Perceived differences in the quality of the health systems, North and South, could be a critical factor in determining the use of the cross-border GP Out-of-Hours service. The National Health Service in the North has an excellent reputation for delivering high quality health care. The Irish health system has recently had extended bad publicity surrounding patient experiences in Monaghan/ Cavan, Louth and Drogheda hospitals. During this research individuals from the South have referred to the hospital situation in the South as being “dangerous” and “run-down”. Patients originating in the South appear to feel safe in accessing health care within the North and have asked few questions concerning onwards referral to hospitals or social services. There appears to be an underlying acceptance among Southern patients that any services they access in the North will be of high quality. In contrast individuals in the North have repeatedly enquired about the arrangements for onward referral to hospital care (in emergency cases), mental health services or social services (in cases of suspected abuse). For Northern patients the fear of being referred to a hospital in the Southern border region may be a critical factor in using the cross-border GP Out-of-Hours service.

The financial arrangements of the cross-border GP Out-of-Hours service are vitally important to patients residing in the South. Discussions held as part of this research have highlighted the current practice of people living in the Southern border counties registering as private patients with NHS GPs in the North. Allowing for the euro-sterling exchange rate, this care is delivered at a considerably reduced rate compared to the rate they pay for equivalent care with Southern GPs. Discussions have also highlighted the growing number of Southern patients who are traveling to the North to access private health services from dentists and opticians. It is clear that private fee-paying patients from the South will travel across the border to the North for routine care if the price is right. By highlighting different arrangements for accessing care, this cross-border service could open up the possibility of a competitive market for primary care services along the border region. The cost of accessing the GP Out-Of-Hours service will be closely monitored by patients based in the South who pay for health care within their own jurisdiction. Questions will be raised about any discrepancy with charges paid for existing services within jurisdictions. For instance, if private patients from the South can access GP services during the day (9am-5pm) at a lower cost in the North than they do in their own jurisdiction should they also be able to access GP Out-Of-Hours services cheaper in the North? The cross-border service needs to be recognised by private health insurers who offer healthcare plans with medical cover for GP costs.

The effect that the cross-border GP Out-Of-Hours service would have on existing local services was raised at public meetings in both Donegal and South Armagh and by organisations who responded to the survey. Any development of the cross-border GP Out-of-Hours service must be sensitive to this issue. Rather than imposing conditions on the development of cross-border services, it would be more prudent to reassure the communities that all patients will be treated equally on the basis of clinical need rather than residency; that the patient flow will happen in both directions; and that the new service is one which is being specifically developed for the border region (North and South) rather than utilising spare capacity on one side or the other.

Research findings suggest that the number of residents living in the Southern border counties who use the NHS in Northern Ireland without incurring charges is growing. Other EU border regions such as France-Belgium or France-Switzerland have put in place bilateral agreements to include access for dependents of frontier workers. By legitimising this group of 'frontier families' in the Irish border region any cross-border service would reflect a truer picture of frontier families living and working in this region. A second group of cross-border users who could be legitmised are those people who retire to live in the South after paying NHS contributions throughout their working life in the North. This group has been recognised as a key group of cross-border health users within the France-Belgium border region who should be given dual access to both health systems. Any cross-border service whose projected use is calculated on the basis of the number of Southern residents within a specified distance from the border will need to be mindful that some of these residents have already found an alternative means of accessing healthcare in the North.

The views of political parties

During August and September 2006 the health spokesperson for each political parties on the island, along with 2 independent politicians representing the border region, were contacted to provide their views on the development of cross-border health services and on the cross-border GP Out-of-Hours Service in particular. In total nine responses were received. These included the Democratic Unionist Parties (DUP), Independent representative for West Tyrone, Sinn Fein, Social Democratic Labour Party (SDLP) and Ulster Unionist Party (UUP) in the North and Fine Gael, Independent representative for Cavan-Monaghan and Sinn Fein in the South.

It is notable that the cross-border co-operation in health has not become a matter of public controversy across the border or across the "religious divide" as have suggestions for cross-border working in other fields.

All of the politicians were supportive of developing health services which would provide the optimum care for patients, recognising that at times this may mean accessing services in the other jurisdiction. While Fianna Fail or Labour parties did not reply their joint pursuit of cross-border approaches to health care under the radiotherapy initiative which will see Donegal patients being granted access to facilities in Belfast has been documented elsewhere in the media[8].

The DUP expressed concerns about cross-border co-operation which is politically driven but stated that their ultimate approach is to take all of the opportunities available to develop better health services. This need to put patients before politics was a sentiment referred to by all the Northern parties. Indeed, any disappointment over patients traveling abroad to receive health care in Scotland, Dublin or EU was viewed as an indictment of the current state of health service in the North rather than displeasure about cross-border arrangements.

The main concerns regarding cross-border co-operation in health come from outside the Northern Ireland Unionist parties. The slow pace/ delays in developing the GP Out-of-Hours service, which was first proposed five years earlier, was often mentioned. In general disappointment was expressed at the failure of both Health Departments to seriously engage in joint planning or services delivery and some respondents outlined the ambiguous attitude to cross-border co-operation in health care as it currently exists referring to CAWT as a 'convenient label for reassuring people of government's commitment to cross-border working'. By ignoring CAWT when developing health policy both governments are felt to be effectively disregarding the practical benefits that cross-border co-operation could bring and shirking their responsibilities to the border community. While accepting that current co-operation is confined to piloting arrangements and testing possible scenarios there was also a concern expressed over the length of time needed before successful approaches become accepted practice. The identification of a future role for smaller regional hospital in the border regions was particularly mentioned as a key area for co-operation.

It is clear that many politicians are already familiar and engaged in key practical arrangements which see patients and professionals crossing the border for health care. Interestingly, a number of the political spokespersons for health are also qualified health professionals (general practice, social work and nursing), some of whom have practiced in both jurisdictions on the island.
Indeed discussions with politicians highlighted health as an area of co-operation which is not politically driven and showed a broad willingness to look imaginatively at joint health initiatives on an all-island basis.

Summary

In both jurisdictions on the island of Ireland there are major current or proposed plans for organisational change which provide a focus on strengthening of primary care. Separate policy reports from the Department of Health Social Services and Public Safety, Northern Ireland ('Building the Way Forward in Primary Care') and the Department of Health and Children, Ireland ('Primary Care: A New Direction') outline the better outcomes, improved health status and increased cost effectiveness which a properly integrated primary care service could deliver. There is indeed considerable logic in thinking that the entrance point to the system is the obvious place where improved co-ordination should take place. This is also true for health care delivery on a cross-border basis.

The planned GP Out-of-Hours service is one example of practical cross-border co-operation addressing all of the critical factors needed for successful collaboration. It is first and foremost

[8] For example, Donegal Democrat Thursday 20 July 2006, 'Donegal to get first cross-border GP service'.

based on providing patient choice and addressing clinical needs by recognising the unique circumstances that exist in the Irish border region, where 70,000 patients who may need access to primary care outside normal hours would be better served in the other jurisdiction. It is supported by politicians and border communities. It is well-resourced and is built on a platform of collaborative primary care expertise developed under the auspices of CAWT over a 10 period. It is systematically finding solutions to a range of administrative obstacles to co-operation. A six month pilot service is expected to see approximately 400 patients from Donegal and South Armagh crossing the border for GP Out-of-Hours treatment in the other jurisdiction.

As patients cross the border between the North and the South they simultaneously cross from one health system into another which can have important impacts for the individual systems involved beyond the cross-border dimension. The successful implementation of the cross-border GP Out-of-Hours service could play an important role in directing future health service delivery on the island.

1. THE CROSS-BORDER GP OUT-OF-HOURS PROJECT

Co-operation and Working Together (CAWT), a partnership of health Boards and Trusts in the Irish border region, is leading the development of cross-border co-operation in health on the island of Ireland. In 2001 the Co-operation and Working Together (CAWT) Primary Care Sub Group investigated the logic and benefits of providing GP Out-Of-Hours services on a cross-border basis. A feasibility study (Moore et. al., 2001) found that:

- Approximately 70,000 people across the length of the border are closer to GP Out-Of-Hours services in the other jurisdiction
- Over 70% of this population live in areas which can be classed as socially deprived
- If the patient were free to travel across the border to see a GP for urgent Out-Of-Hours treatment then the travel distance could be considerably reduced

The study concluded that such a service would have great potential to increase access to primary health care for residents of the border region.

In 2005 CAWT secured funding from the EU Interreg IIIa programme to test the recommendations of the feasibility study by developing two pilot areas along the border where patients would be given the choice of accessing closer cross-border services or using the existing service in his/her own jurisdiction. In the first pilot area patients in the Republic of Ireland (Donegal) would be given access to a GP Out-Of-Hours centre in Northern Ireland (Derry). In the second pilot area patients in Northern Ireland (South Armagh) would be given access to a GP Out-of-Hours centre in the Republic of Ireland (North Monaghan). Each pilot area would have approximately 13,000 residents.

The first phase of the project has focused on testing a range of geographical, technical, professional, pharmaceutical and financial issues which were identified within the feasibility study. In May 2006 CAWT was still working to resolve a number of remaining issues concerning:

- dual medical registration of GPs with the UK General Medical Council and the Irish Medical Council
- the introduction of a UK Primary Medical Services Performers List in Northern Ireland
- medical indemnity cover for GPs practicing in two jurisdictions
- the design of a technical interface between the Patient Information Systems (ADASTRA) and the Geographical Information System which would identify eligible patients
- protocols for data protection and processing/ triaging patient calls
- financial arrangements within Northern Ireland medical centres to accept patient payments
- alternative arrangements for dispensing drugs which currently must be licensed in the dispensing jurisdiction
- impacts on secondary ambulance and hospital services and
- referral protocols to respond to potential social care/ mental health issues

The cross-border GP Out-of-Hours service will be piloted in the Donegal/ Derry area from late 2006 but will not commence in the South Armagh/ North Monaghan pilot area until Spring 2007. This rescheduling is necessary due to timescales in developing legal solutions for some of the issues mentioned above. Approximately 400 patients are expected to cross the border for GP Out-of-Hours treatment during the six month pilot phase[9].

[9] Expected use of the cross-border service was discussed at the recent Manahealth/ CAWT European Professional Seminar held in Carlingford, Co. Louth on 15-16 May 2006.

2. OVERVIEW OF RESEARCH

The Centre for Cross Border Studies was commissioned by CAWT to conduct a small scale research study that would assess the level of need and the attitudes of people living in the two identified pilot areas (Donegal and South Armagh) to using GP Out-of-Hours services on the other side of the border. The specific objectives of this research are to:

- Conduct a literature review which identifies and outlines examples of good practice relating to cross-border primary care and GP Out-of-Hours services and highlights key emerging themes relevant to the Northern Ireland/ Republic of Ireland cross-border GP Out-of-Hours pilot study

- Engage with the community groups living along the border to examine:
  (a) the levels of interest and willingness of people to avail of health services in the other jurisdiction
  (b) perceptions among local communities of GP Out-of-Hours services across the border
  (d) identify perceived or real barriers to patients travelling to the other jurisdiction

- Draft a report which outlines the perceptions and attitudes of people living in the border area to choosing the option of accessing GP Out-of-Hours services in the opposite jurisdiction

- Make recommendations which will inform the CAWT GP Out-of-Hours Project Board in planning and provision of services.

The research was conducted over a 5-month period from April–August 2006 prior to the planned implementation of the pilot cross-border GP Out-Of-Hours service. The community engagement focused primarily on the two pilot areas, namely East Donegal and South Armagh, but also included a survey of community groups living or working with communities in the border region.

3. THE LEGAL ASPECTS, POLICY AGENDA AND PRACTICAL EXPERIENCE OF PATIENT MOBILITY

Most patients prefer to be treated as near as possible to where they live, close to their relatives, in a system they are familiar with, with providers who speak their language, where they know what they can ask for and what they expect to receive. Going abroad is almost never the first option, but is rather the result of specific circumstances.

Europe for Patients Study, (Rosenmöller et al., Eds.2006)

Patient mobility has emerged as a key issue on the policy agenda within the European Union in recent years. Since 1998, when the European Court of Justice applied the fundamental principles of free movement of services and goods to health care, health policy-makers have increasingly been urged to reflect on how EU Community Law interacts with the management of national health systems. The tasks of organising and monitoring health care delivery, ensuring its funding through social security schemes or taxation, as well as safeguarding the health of the population, remain a national competence. However health systems and health policies across the EU are becoming more interconnected, driven by the marked increase in mobility within Europe. The growth in budget airlines allows a growing number of people to take several holidays abroad each year or to commute weekly between work and home in different countries. An increasing number of retired people have decided to spend their retirement in warmer climates or retire to their original country of birth. Since May 2004 people from the ten new Member States have been moving to Ireland, the United Kingdom and Sweden. A greater number of people are now using facilities serving border regions. People are now being sent abroad by their own health authorities because the treatment is unavailable at home or because there would be an 'undue' delay in obtaining it.

The debate on mobility of patients is linked to a wider set of issues about the future of European health systems. Recent discussions have highlighted a range of ways in which European collaboration can bring concrete benefits to the effectiveness and efficiency of health services across Europe (Bertinato et. al., 2006). This includes collaboration to make better use of resources, developing a better understanding of the rights and duties of patients, sharing spare capacity between systems, mobility of health professionals, identifying and networking European centres of reference, and coordinating assessments of new health technologies. It also covers improving information and knowledge about health systems to provide a better basis for identifying best practice, and ensuring universal access to high quality services.

In developing the cross-border GP Out-of-Hours service it is important to review the legal, policy and pragmatic experience of providing health care across other EU borders.

3.1 THE EUROPEAN LEGAL FRAMEWORK

In the past the role of the EU in influencing cross-border health care has been restricted by the territoriality principle under which national governments have retained responsibility for organising their systems of social security and health care. Derogations from this territoriality principle were gradually introduced to deal with professional mobility. Through bilateral agreements, immediate health cover was guaranteed to migrant and frontier workers. The legal framework for health in the European Union is provided by the European Commission Treaties (Rome, Maastricht, Amsterdam and Nice) and case law from the European Court of Justice.

3.1.1 Coordination of social security

European regulations 1408/71 and 574/72, which coordinate the social security of Member States, have created specific laws in the case of mobility linked to work, study, change of residence and tourism. Developed under the 'free movement of persons' concept, these laws provide access to cross-border care including:

- Emergency care in the event of an illness arising during a visit abroad
- 'Necessary' care in the event of residence abroad for an unspecified period of time
- Care authorised beforehand by the authority normally responsible for the individual's health care.

From June 2004 the EU simplified procedures for patients, providers and administrations by launching a European Health Insurance Card which replaced all existing paper forms required for occasional health treatment when in another Member State (E111, E110, E119, E128). A summary of forms used in relation to entitlements to health services under EU regulations is listed in Appendix A.

3.1.2 Judgments by the European Court of Justice

In a series of judgments in recent years[10], the European Court of Justice has confirmed that patients have, in certain cases, the right to access healthcare products and services in other Member States with the costs being covered by their own health system. The Court has begun to define the limits of this right, recognising the need for conditions that will enable the Member States to plan for the provision of health services, avoid undermining the finances of the social security system and control costs. These judgements established important principles for cross-border co-operation in health, but offered very little detail of what patient mobility in the European Union meant in practice (Busse, 2002).

These judgments have wide-ranging implications for the health systems of the Member States as they were not based on the fundamental principle of free movement of persons but, rather, free movement of goods and services as set out in articles 30 and 49–50 of the EC Treaty. In February 2006 health professionals throughout the EU successfully lobbied to exclude health from the updated EU Directive on Services in the Internal Market despite the requests of patient associations for health to be included.

3.1.3 Other relevant directives and frameworks

There are other directives and frameworks which facilitate cross-border co-operation in health. Mobility of health professionals between countries is facilitated by European rules on the recognition of professional qualifications, and the possibility of developing automatic recognition for some health professions is currently being explored.

Issues about data protection and the sharing of confidential data between EU Member States are specifically covered by Directive 95/46/EC (OJ L 281 of 23/11/1995) on the protection of individuals with regard to the processing of personal data and on the free movement of such data. Under this directive health data may be processed in situations where it is required for the purposes of preventive medicine, medical diagnosis, the provision of treatment or the management of health care services.

An eHealth action plan has been developed within the framework of a European eHealth Area for using information and communication technologies to help improve access, quality and effectiveness for health services across the European Union.

3.2 THE EUROPEAN POLICY AGENDA

In order to address mobility issues, the European Commission invited ministers from the Member States and representatives of civil society to take part in a high-level process of reflection on patient mobility and health care developments in the European Union. The report agreed by the reflection process at its final meeting on 8 December 2003 makes nineteen recommendations across five main areas:

[10] (See in particular the Kohll judgement, Case C-155/96 of 28.04.98, ECR 1998 p. I-1931; Smits et Peerbooms judgement, Case C-157/99 of 12.07.01, ECR 2001 p. I-05473 ; Vanbraekel judgement, Case C-368/98 of 12.07.01, ECR 2001 p. I-05363, Inizan judgement, Case C-56/01 of 23.10.03, not yet published; Leichtle judgement, Case 8/02 of 18.3.04, not yet published.).

- European co-operation to enable better use of resources
- Information requirements for patients, professionals and policy makers
- Access to and quality of care
- Reconciling national objectives with European obligations
- Health and the European Union's Cohesion and Structural Funds

The European Commission responded with a policy paper (EU Commission, 2004) and the creation of the High Level Group on Health Services and Medical Care which developed a permanent mechanism at EU level to support European co-operation in health care, to monitor the impact of the EU on health systems, and to bring forward any appropriate proposals.

In September 2006 the European Commission launched a 4-month public consultation to support co-operation between the health systems of the Member States and to provide certainty over the application of Community law to health services and healthcare. The public feedback will be used to inform an EU Commission's 2007 Annual Policy Strategy on developing an EU framework for safe, high quality and efficient health services.

3.3 PRAGMATIC CO-OPERATION ACROSS NATIONAL BORDERS

Border regions account for approximately 15% of European Union territory and 10% of its population. Binational agreements have emerged as one of the main tools for developing co-operation within border regions. One the first agreements to be signed between neighbouring countries was the health convention of 12 January 1881, between Belgium and France, revised on 25 October 1910, which "authorised Belgian doctors of medicine, surgery and childbirth established in the Belgian districts bordering France to practise their art in the same way and to the same extent in any neighbouring French district, in which there is no doctor residing" and vice versa (Coheur, 2001).

Cross-border co-operation in the health sector has a long tradition in some countries of the European Union. However practical experiences in delivering across borders are still fairly unknown. Recognising this, the European Commission has funded a three year Evaluation of Cross-Border Regions in the European Union (EUREGIO)[11] project under its Public Health Programme. The main aims are to give an overview of cross-border activities, identify good practice models, encourage the exchange of experiences and information between health care actors, and generate hypotheses on promoting and hindering factors of successful projects. The focus is on projects and initiatives with direct influence on patient mobility and cross border patient flow.

Under the EUREGIO public health project, a written survey was carried out among 53 INTERREG IIIA Secretariats as well as among more than 60 Euregios and working associations along the internal and external borders of the old EU Member States. This survey has provided a comprehensive overview of more than 300 cross-border health-related projects in the individual border regions. In January 2006 more than 100 participants attended a workshop in Germany where they heard presentations on 40 selected projects (see Appendix B) and discussed recommendations for the promotion of cross-border co-operation in health care.

A second project, the EU Sixth Framework-funded Europe for Patients[12] research project, involves research institutes in Britain, Spain, France, Belgium, Slovenia, Estonia and Ireland examining the ability of patients across the EU to benefit from the cross-border health care advantages created by an increasingly integrated Europe. The overall project is examining legal frameworks at both national and European level with a focus on recent European jurisprudence, contracting for health services across borders, and systems for ensuring the quality of care provided across borders.

[11] See http://www.loegd.nrw.de
[12] See http://www.europeforpatiients.org

An additional strand of this work looks at what is happening on the ground, by means of a series of detailed case studies on cross-border care. These include arrangements spanning new and old Member States (Slovenia/Austria, Estonia/Finland); the response to the needs of long-term residents (Spain); the situation wherein purchasers in one country contract with providers in another (United Kingdom, the Netherlands, Belgium); mass tourism (Veneto region); sharing capacity and the use of centres of excellence (Malta); cross-border hospital co-operation (France); cross-border contracting (Germany); and the particular situation on the island of Ireland in which arrangements between the Republic of Ireland and Northern Ireland combine health co-operation with the promotion of peace and reconciliation. Since February 2004 the Centre for Cross Border Studies has been involved in the Europe for Patients project as the Irish partner.

These case studies show how the experience of developing health co-operation across other EU borders is very similar to that on the island of Ireland. Typically health co-operation has emerged as a bottom-up process based on local agreements between providers and purchasers, often within a broader framework of cross-border co-operation and often supported by EU (INTERREG or Peace) funding programmes. There are clear examples of projects in Belgium, France and Slovenia providing pragmatic solutions to specific local problems but experiencing problems once the exchange of patients takes place, often because of a lack of a sound legal basis. Difficulties also relate to the development of shared approaches to quality assurance, continuity of care, information sharing, or compliance with regulatory systems.

Outlined below are some examples of key co-operations involving EU countries which have been driven by agreements across national borders and are examined in detail under the EUREGIO and Europe for Patients projects. Many of these examples have EU–wide implications and transferable learning which could be applied to the development of the cross-border GP Out-Of-Hours service.

3.3.1 The first official integrated health zone

Thierache is a region located across the French-Belgian border, covering an area of 2800km^2 with a population of 146,000 people (100,000 on the French side and 46,000 on the Belgian side). Thierache provided an ideal setting for developing co-operation. The area is characterised by poor health infrastructure, equipment and transportation links but with strong cross-border connections. Health co-operation began in the mid-1990s, based on the idea of an integrated network between eight relatively small hospitals (seven in France and one in Belgium).

A European Economic Interest Grouping[13] (EEIG) was created to identify common needs and promote joint projects and complementary initiatives, to develop formal agreements and to act with a single voice for the cross-border region. A range of practical initiatives have been developed including: joint emergency departments (ambulances and rescue teams); an image transmission network/ image bank for teleradiology and neurosurgery allowing for joint diagnostic and expertise sharing; equipment sharing (scanners, dialysis, echo doppler); and the exchange of professionals and collaboration in other areas such as cardiology, surgery, endocrinology, nuclear medicine, vascular surgery, paediatrics, gynaecology, etc. Many of these initiatives have been supported by different INTERREG programmes and include the referral of patients and the sharing of medical duties in several disciplines by professionals from both sides of the border. The crucial role of European funds in implementing innovative and practical health activities and officialising partnerships at European level has been widely acclaimed (Bassi, 2002).

This practical co-operation has been complemented by the introduction of a financial tool. The 'Transcard' project extends the coverage of the French and Belgian insurance funds in the Thierache zone to either side of the border, thus allowing patients to use facilities available on both sides of it.

[13] European Regulation No. 2137/85 of 25 July 1985. The EEIG was designed in 1985 to structure economic interests from two or more Member States but appears to be a legal instrument that is particularly suited to multilateral co-operation in the health sector.

Two positive evaluations conducted in 2003 and 2004[14] outlined the success in establishing the first official integrated health zone in Europe. Further activities are planned, including joint recruitment of doctors and joint purchasing of medical equipment through partnerships with local authorities. There are plans to extend the Transcard project to cover the entire French-Belgian border, corresponding to a population of 250,000 inhabitants.

In June 1999 the Franco-Belgian Observatory in Health was created to improve access to health care for border populations, develop an integrated approach to health across the border and achieve economies of scale.

3.3.2 The first cross-border hospital

The first ever hospital to be planned, managed and funded jointly by two countries is now being established on the border of France and Spain. Divided by the Pyrenees Treaty in 1659, the Cerdanya mountain region has two communities which are historically, socially and culturally very close, sharing a common language, Catalan. The main hospital is in Puigcerda on the Spanish side, one km from the French border. It is under private management and has all the basic services. On the French side there are only general practitioners, specialists and some convalescence and rehabilitation facilities. From the mountain plateau access to the nearest French hospitals (in Perpignan) with surgery and obstetric care is difficult and slow. Emergency services, very frequently needed in this area with high tourism rates in both summer and winter, are not adequately covered. This has led the French authorities in the 1990s to develop initiatives with the Spanish hospital in Puigcerda, with the aim of improving services to their citizens. Since then the number of French patients visiting Puigcerda hospital has steadily increased and co-operation has intensified. The project is now creating a new hospital for the entire territory which will employ staff and treat patients from both sides of the border. Investment support will come from Catalonia, France and the European Union. There are still several issues needing to be resolved including the institutional and legal nature, the legal basis for co-operation, national planning schemes, labour laws, professional training, and organisational issues. A particular challenge is the issuing and nature of birth certificates for new-born babies.

3.3.3 Patient choice as a driver

In 2004 the European Commissioner for Health Care, David Byrne, called Euregio Meuse Rhine a model in Europe for cross-border health care. This Euregio has been involved in numerous EU INTERREG projects, many driven by the desire to provide patients with the choice of accessing health care across borders.

Since 2000 the (I)ZOM (International) Zorp op MAAT 'Treatment According to Needs' programme has allowed patients from the Euregio Meuse-Rhine, covering parts of the Netherlands, Belgium and Germany, to receive predefined treatments across borders by allowing unconditional approval from the health insurances for a time period of up to 12 months (Cartonensis et. al., 2002). This treatment includes free access to GP consultations, hospitalisation (including chronic diseases and follow-up) treatment, and provision of pharmaceuticals on the other side of the border. This process was initiated by health insurers and heath providers (physicians' organisation, pharmacists' organisations and hospitals) and in a second stage received support from public authorities of the involved countries (Coheur et. al., 2004). These contracts are based on an interpretation of European Court of Justice rulings that care provided abroad should be under the same terms and conditions as that provided domestically. Thus a Dutch provider contracting with a German insurance fund is expected to apply German quality standards and vice versa. Between 2000 and 2004 over 7000 patients took the opportunity to be treated in the neighbouring country as part of this programme (Schemken, 2005).

The European Union has continued to fund co-operation in health under an INTERREG III Cross-Border Care programme which addressed quality, cost, safety and care issues in the areas of cancer, chronic disease, hereditary metabolic disease, medical aids, ambulance assistance, and the combating

[14] Annual evaluation, Transcard, CPAM de Maubeuge/ St Quentin

of bacterial risks, including antibiotic resistance (MRSA), in the regions hospitals. This programme officially ended in March 2006.

3.3.4 The first electronic international health insurance card

A key issue for patients accessing health care across borders is that of continuity of care. In developing co-operation in border regions between Germany and the Netherlands AOK-Rheinland, a German insurance fund, and CZ Actief, a leading Dutch health insurance fund, have worked closely with general practitioners, specialists, hospital and pharmacies from both sides of the border to provide medical care to the border population that is delivered in a timely manner close to home (as developed under the IZOM project), with the additional objective of reducing waiting times and simplifying administrative procedures. In 2000 they implemented the first electronic international health insurance card in Europe, the *GesundheitsCard international(GCi)*. Using this card within the entire region, irrespective of which side of the border they reside, patients can now gain access to any specialist treatment, supply of medication and any hospital treatment necessary in connection with specialist therapy. Special agreements have been reached on determining measures of data protection and liability rules. In 2004 this pioneering work won the prestigious German Janssen-Cilag Future Prize which "honors persons, organisations and mechanisms which improve health care with socially effective innovations". Since 2000 over 25,000 *GCi* cards have been issued to patients on the German-Dutch border region. It is now planned to expand the more developed *GesundheitsCard Europa(GCE)* to other European countries such as Austria, Spain, Portugal and Italy.

3.3.5 Building expertise within the UK National Health Service

The United Kingdom has experience both of sending National Health Service (NHS) patients abroad for treatment and receiving patients from other EU countries for treatment.

In the past NHS patients have been sent to Europe for simple elective surgery procedures such as knee and hip replacements, hernia and cataract procedures under such initiatives as the Treating Patients Overseas project(UK Department of Health, 2002)[15] and the London Patient Choice (2000-2004)[16] project. From January 2002 to May 2004 872 NHS patients were treated in hospitals in France and Belgium. Patients who accepted the offer of overseas treatment attended an 'overseas assessment clinic' - an out-patients consultation at their local hospital trust where they met the medical team from the overseas hospital. Quality of care was ensured through the assessment of the hospitals abroad based on strict qualification requirements, the detailed description of treatments included in the contracts, and by defining procedures, clinical services, performance standards and discharge criteria[17]. This NHS principle of exporting domestic standards through bureaucratic assessment procedures frustrated several Belgian providers to the point that they withdrew from the process. Indeed the NHS experience of sending patients abroad to tackle waiting lists was short-lived.

There are other examples within the UK of health professionals from other EU countries being contracted to see NHS patients. For instance, some English hospitals currently contract surgical teams from Germany to perform large numbers of non-urgent surgeries in England over the weekend in an attempt to reduce waiting lists. In addition, the Southern Health and Social Service Board in Northern Ireland bringing over Polish GPs to provide weekend GP Out-Of-Hours cover in the Northern border counties.

[15] UK Department of Health. Evaluation of Treating Patients Overseas. Final report. York Health Economics Consortium 2002.
[16] http://www.londonchoice.nhs.uk/about-programmeoverview.php.
[17] A Framework for Cross-Border Patient Mobility and Exchange of Experience in the Field of Healthcare between Belgium and England. Common framework between the Department of Health (England) represented by John Hutton (Minister of State for Health) and Belgium, represented by Josef Tavernier (Minister for Public Health) and Frank Vandenbroucke (Minister for Social Affairs and Pensions), Brussels, 3 February 2003.

There are also instances where EU patients from abroad are sent to the United Kingdom, particularly London, for treatment. A 30 year old bilateral health care agreement between the UK and Malta provides for the referral of a quota of Maltese patients for NHS treatment in 25 Centres of Excellence within, or close to, London. The profile of cases that are currently accepted for treatment in the UK consists mainly of bone marrow transplants, liver transplants, complex major spinal surgery, pediatric cardiac surgery, maxillofacial surgery and specialist pediatric cases, particularly endocrinology, gastroenterology and neurology. These cases (approximately 300 every year) all exhibit the features of high cost and low patient volumes.

3.3.6 The key role of information provision

More effort needs to be invested in developing patient access to relevant information. Concerning the double-access eligibility of frontier workers (i.e. access to services both in the country of residence and in the country of work), a survey (Calnan et. al., 1998) conducted on the French-Belgian border in 1994-95 produced evidence that awareness of the arrangements for double access to health care was limited. Approximately one-fifth of frontier workers from both countries were unaware that this option was available.

The Europe for Patients project highlighted the importance that patients place on access to information at all stages in obtaining care. This is particularly great before they cross borders for care, with questions about the available options for care, their rights and entitlements, cost implications, administrative procedures involved, transport arrangements, and management before and after the main treatment. During their stay they seek information on their progress in a language that they can understand. After discharge they seek information on follow-up arrangements. There are examples of where information initiatives have been successfully established to address patient's information needs. For instance, the Euregio Internet portal (http://www.euregiogesundheitsportal.de) for health-related information and exchange targets healthcare professionals and citizens in the border regions of Euregio Meuse-Rhine, Rhine-Meuse-Nord and Rhine-Waal, including parts of Belgium, Germany and the Netherlands. A second example is that of the German and Dutch insurance funds which in 1995 established a joint customer service office near the Dutch-German border where a high proportion of cross-border commuters live.

3.3.7 The influential role of doctors

A survey (IZOM, 2002) of 1,406 insured persons from the Meuse-Rhine region highlighted the influential role of doctors in the distribution of information on accessing cross-border care and in advising their patients on where to be treated. Recommendations included placing leaflets in GPs waiting rooms and establishing interactive online information systems for border regions where doctors, patients, insuring bodies and hospitals could gain access to all of the relevant information they require on cross-border care protocols, content of treatment, preventative and post operative care, referral etc. This survey also rated the factors which encourage people to access cross-border care. Surprisingly, patients prioritised their relationships with the medical profession ('The care is more appropriate to my own situation') and the attention they received ('My health problem is treated with greater attention') over shorter waiting times and proximity of care.

A survey of the experience and attitudes of the Estonian population regarding health treatment abroad (Praxis, 2004) also stressed the key role played by doctors/ family practitioners in overcoming a key obstacle to cross-border co-operation, that of a lack of adequate, validated information for patients on their rights and opportunities regarding care in another country.

3.3.8 Primary care delivery across borders

There are some examples of cross-border care provided by GPs across national borders. For Belgian citizens living close to the border the so-called 15/ 25 km rule applies, in which health insurers will automatically apply a E112[18] scheme for those patients who are living within 15 km of the national

[18] An E112 scheme covers patients who obtain prior authorisation for medical treatment in another Member State paid for by their usual health authority.

border and who apply for care with a health care provider that is no more than 25 km across the border.[19] This is a special regulation enacted by Belgian national law.

The Dutch Health Insurance Act provides for a system of benefit-in-kind. In this context, the Dutch health insurance funds can enter into contracts with individual medical practitioners who are paid directly by the funds without any financial involvement on the part of the patient. In the Netherlands it is also possible for the insurance funds to contract a provider in another country to provide treatment which makes it possible for Dutch patients to receive care abroad. One leading Dutch health insurance fund, CZ Actief, currently has contracts with 35 GPs in the Belgian border region who provide treatment for approximately 500 Dutch patients. In February 2006 the insurance fund proposed to extend its contract with Belgian GPs so that all Dutch patients living close to the border would have the choice of being treated by a GP in Belgium without paying any more[20]. Conditions of this arrangement are that the Belgian GP practice must be situated within 15km of the Dutch border, unless it already has the minimum number of 50 insured patients from the Netherlands. At the request of its members the insurance fund also intends to make this GP cover available in the evenings, at night and at weekends.

In the special cases of frontier workers between France and Belgium and between France and Switzerland, simultaneous double access to health care both in their state of residence and in the state in which they work has been extended by bilateral agreements to family members.

In April 2005 the idea of considering available primary care resources across the border was supported by the French Minister of Health, Mr Xavier Bertrand, who announced that patients living in border regions will be able to register, as their attending physician, with a doctor from another country of the European Union, under the same conditions as for a French doctor".[21]

[19] Rijksinstituut voor Ziekte en Invaliditeitsverzekering (4 February 1983). Omzendbrief V.I. nr. 83/54.)
[20] Interview with Meuse-Rhine Journal
[21] AFP press release April 2005 and interview with Le Monde newspaper 13 April 2005.

4. DEVELOPING EXPERIENCE ON THE ISLAND OF IRELAND

A study of cross-border co-operation on the island (Jamison et. al., 2001) found a great deal of enthusiasm for co-operation in health services, both in the vicinity of the border and at all-island level. This enthusiasm was once again evident in 2004 during interviews conducted under the Europe for Patients project. Since the signing of the 1998 Good Friday Agreement politicians, senior civil servants, health service managers, health professionals and others have made speeches, attended conferences, sought election, attended meetings, written and read papers and reports, and funded initiatives all aimed at facilitating and encouraging co-operation across the Irish border. CAWT, a partnership of Health Boards and Trusts has continued to lead the development of cross-border co-operation in health. CAWT has secured approximately €19 million in EU Peace and INTERREG funding over the past 10 years to implement 78 cross-border health activities in areas such as cognitive therapy, suicide behaviour, road safety, sex offenders, fostering care, health impact assessment training, care of diabetes and emergency planning. The initial cross-border health arrangements on the island were funded by the EU Peace Programme. However recent co-operation has been primarily funded under the EU INTERREG Programme.

4.1 NORTH/SOUTH MINISTERIAL COUNCIL OBSTACLES TO MOBILITY REPORT

Health is one of the areas agreed for co-operation under the 1998 Good Friday Agreement. Common policies and approaches are agreed within the framework of the North/ South Ministerial Council (NSMC) but implemented separately in each jurisdiction. Five specific areas for co-operation in health were identified: accident and emergency planning, major emergency planning, procurement of high technology equipment, cancer research and health promotion.

During 2000 the NSMC established a Cross-Border Steering Group of senior civil servants to report on removing barriers to mobility on the island of Ireland. In November 2001 the NSMC published the Obstacles to Mobility report (PricewaterhouseCoopers/ Indecon, 2001) which includes a section on current health practice on the island of Ireland and its implication for mobility of patients.

This report highlights the differences in primary care access North and South of the border and reviews the arrangements which promote mobility on the island. In the North there is a comprehensive range of health and personal social services which are largely available free of charge through the National Health Service to residents. An individual who lives in the North, irrespective of salary earned, has access to free GP visits and relevant cheaper prescriptions (a prescription charge is currently fixed at £6.40 per item). In the South there is a mixed public/private healthcare system. A medical card, which entitles holders to eligibility for free health care, is available to those receiving welfare payments, low earners, all persons aged 70 or over (regardless of income) and those with certain long-term or severe illnesses. Those on slightly higher incomes are eligible for a GP Visit Card which entitles the holder to free GP visits only. People who do not qualify for a medical card pay for some health care services. Such patients are charged approximately €40 for a GP visit and €55 for a GP Out-of-Hours visit. In-patient or day services at a hospital costs €60 per day up to a maximum of €600 per year. Those who do not qualify for a Medical or GP Visit Card can also be charged €60 for a visit to an accident and emergency department (only once per year) if the patient has not been referred by a GP. Under the Drugs Payment Scheme, no person or family unit should ever have to pay more than €85 per calendar month for approved prescribed drugs and medicines. In 2006 approximately 28% of the population are entitled to a medical card and have completely free health care and approximately 48% have private health insurance with either VHI, BUPA Ireland or VIVAS Health which allows them to avoid long waiting lists for major treatment. Five hospitals in the North currently accept Southern health insurance.

The NSMC Obstacles to Mobility report highlighted EU regulations for frontier workers and 'posted' workers that encourage mobility between the two jurisdictions of Ireland but warned of gaps in awareness. An individual living in the South and working in the North has the EU status of frontier worker and is therefore automatically entitled to a medical card in the South linked to his/ her

residency, without a means test, and entitlement to healthcare in the North through the payment of national insurance contributions. Similarly, an individual who lives in the North and commutes to work on a daily or weekly basis in the South will continue to be able to access healthcare in the North, as the NHS entitlement is linked to residency.

However the report was very superficial in its conclusion that "for individuals who commute to work on a daily/weekly basis outside their jurisdiction, entitlement to such health care is not such a major issue". A Southern–based frontier worker who pays the equivalent national insurance contributions as a resident in the North can access care through the NHS but, unlike the resident in the North, his/ her children cannot use the NHS service and on retirement he/ she will lose all entitlement to NHS care. Southern–based frontier workers tend to be recorded under their Northern work addresses within NHS information systems which do not allow the recording of patient addresses without postcodes. There is no consistent recording of details of Northern-based frontier workers. This makes it impossible to access any statistics on this mobile population.

Through the E128 scheme 'posted workers' and their dependants who accompany them abroad can access full health cover. The entitlement is for an initial period of 12 months with potential extension up to 24 months and prior authorisation is not necessary. So if an individual is relocated by his/her employer from the North to the South (or vice versa) and he/she and their dependants move to live in the other jurisdiction for the period of the posting, they will be able to access full medical treatment whether or not it is of an emergency nature i.e. free GP access and prescriptions, and free public hospital treatment for any condition.

The report warned of gaps in awareness about the eligibility of frontier workers and posted workers for medical treatment through EU regulations. A series of four health recommendations were made aimed at removing obstacles to patient mobility on the island. These recommendations concerned conducting a series of feasibility studies permitting frontier workers to access health services at their nearest hospital; encouraging an increased number of hospitals in the North to accept Southern health insurance, and raising awareness of the E128 form for seconded or posted workers through proactive employer contact. The report also called for an objective source of information designed to inform individuals considering a move to either jurisdiction about the changes in their healthcare entitlements. None of these recommendations appear to have been implemented over the past five year period.

4.2 EXTENT OF PATIENT MOBILITY ON THE ISLAND

In 2004 research under the Europe for Patients project showed that patients and professional mobility on the island has remained at a low level. Data on the cross-border movement of patients provided by the two Departments of Health, North and South, and the Economic and Social Research Institute in the South is used to establish the extent of patient mobility and how it has changed in recent times. From Tables 1 and 2 below it can readily be seen that there has been some increase in patients from the Republic of Ireland treated in Northern Ireland, but no increase in the other direction. The numbers overall remain very small.

Table 1 Patient flows into Northern Ireland

	Total inpatients and day cases treated in Northern Ireland	Patients from Republic treated in Northern Ireland	Patients from Republic of Ireland as percentage of total
1996/97	436,164	1,330	0.30
1997/98	450,417	1,438	0.32
1998/99	473,600	1,328	0.28
N.B. DATA BELOW EXCLUDE REGULAR DAY/NIGHT ATTENDERS			
2000/01	429,985	1,708	0.40
2001/02	435,072	1,636	0.38
2002/03	445,263	1,722	0.39

Source: Department of Health, Social Services and Public Safety

Table 2 Patient flows into the Republic of Ireland

	Total inpatients and day cases treated in the Republic of Ireland	Patients from Northern Ireland treated in the Republic	Patients from Northern Ireland as percentage of total
1997	679,214	915	0.13
1998	696,723	920	0.13
1999	758,149	995	0.13
2000	798,620	974	0.12
2001	857,270	1069	0.12
2002	891,312	902	0.11

Source: Economic and Social Research Institute

As expected most of the cross-border discharges were from hospitals in the former Eastern Health Board area (which includes Dublin), or those close to the border (formerly the North Eastern and North Western Boards) in the South, and Altnagelvin (Derry), Daisy Hill (Newry) and Erne (Enniskillen) in the North.

One of the most useful examples of cooperation has involved contracting (by the health boards in the North and the National Treatment Purchase Fund (NTPF) in the South) for elective surgery to reduce waiting lists within each jurisdiction. In Northern Ireland such initiatives are invariably of short duration because of concerns on the part of the boards that they should be investing resources to maintain the services in their own jurisdiction rather than exporting them. An early example is that of the arrangement between the Royal Group of Hospitals in Belfast and the Southern Health Board (now an area of the Health Service Executive) in the Republic of Ireland (covering the area around Cork) to provide hip replacements in order to reduce the waiting lists. There are still intermittent initiatives in which health boards in Northern Ireland contract with hospitals in the South, usually employing one-off funds made available by the Department to reduce waiting lists. Another example is the provision of ophthalmic services to patients from the old North Eastern Board (now HSE North Eastern area) in the Republic by the Mater Hospital in Belfast. Looking within the border region there has been a number of temporary contracting arrangements developed under the auspices of CAWT. These include a neonatal intensive care service provided under contract from Altnagelvin (North) to premature/ sick babies from Letterkenny (South); patients who had been waiting for hernia surgery for more than 18 months at Craigavon Area Hospital (North) being treated at Monaghan General Hospital (South), and haemodialysis provided in Daisy Hill, Newry (North) to a small number of people from the Dundalk area (South).

The establishment of the Irish National Treatment Purchase Fund (NTPF) enables the health services in the Republic of Ireland to arrange and purchase treatment for qualifying patients in hospitals in Northern Ireland and the wider UK. Examples of treatments covered under the NTPF are cataracts, varicose veins, hernias, gall bladders, prostate, tonsils, plastic surgery, cardiac surgery, hip and knee operations. About 1000 patients, mostly from Donegal but some from Dublin and elsewhere in the South, have been treated in a private hospital near Derry in the North and approximately 600 patients have traveled to England.

Despite the low patient mobility statistics, there are large undocumented movements of patients crossing the Irish border. In 2000 there were an estimated 18,000 EU frontier workers who commuted across the Irish border to work in the other jurisdiction and who could legitimately use the health services in both jurisdictions. However the experience of this group of health services users or indeed the unofficial large number of health service users in the South who use an ‘accommodation address’ in the North to access services illegitimately has never been officially researched. A brief comparison

of the current population and GP registration statistics[22] for the two health boards adjoining the border in Northern Ireland shows over 46,000 patients currently registered with GP practices over and above the official population of these regions. Ironically one could say that these statistics provide proof of the willingness of patients to avail of cross-border health services. The public's willingness to use services across borders is also reflected in the fact that 1,262,705 European Health Insurance Cards were issued in the South and 359,061 in the North since the launch of the scheme in May 2004 – equating to one in every four people living on the island.

4.3 IMPROVING CO-ORDINATION THROUGH PRIMARY CARE

There is considerable agreement that a strong primary care system is the linchpin of effective health care delivery (Mc Gregor, 2006). In both jurisdictions on the island of Ireland there are major current or proposed plans for organisational change which provide a focus on strengthening of primary care. Separate policy reports from the Department of Health Social Services and Public Safety, Northern Ireland ('Building the Way Forward in Primary Care') and the Department of Health and Children, Ireland ('Primary Care: A New Direction') outline the better outcomes, improved health status and increased cost effectiveness which a properly integrated primary care service could deliver. There is indeed considerable logic in thinking that the entrance point to the system is the obvious place where improved co-ordination should take place. This is also true for health care delivery on a cross-border basis.

The in-depth case studies detailed under the Europe for Patients project[23] and the Evaluation of Cross-Border Regions in the European Union project[24] have highlighted examples of cross-border practices in guaranteeing consent and data protection, moving of patients and health care providers, reconciling different medicine formularies across national boundaries, and agreeing protocols for pre- and post-intervention care within the country of origin between the referring and host institutions.

The cross-border GP Out-of-Hours service is based on the desire to offer patients in the Irish border region the choice of receiving the same quality care closer to home and as quickly as possible by attending a GP Out-of-Hours centre across the border. This initiative has already received support form politicians and health professionals. This research documents the views of people living in or working with border communities on using health services across the border and in particular their willingness to support CAWT in its efforts.

[22] Sourced from the Department of Health, Social Services and Public Safety, Northern Ireland
[23] http://www.europeforpatients.org
[24] http://www.loegd.nrw.de

5. ENGAGING THE COMMUNITY

This research shows that people living in the border region are overwhelming supportive of the cross-border GP Out-Of-Hours service. The findings are outlined below primarily in terms of their facilitation and participation at public meetings which were held in the Donegal and Armagh pilot areas.

The tender submission outlined the role of the Centre for Cross Border Studies in organising and facilitating two focus groups, one in each pilot area, where up to 20 key people would receive a presentation from the GP Out-Of-Hours project team and partake in a facilitated discussion, led by the Centre, on the main issues of this research. In practice a different design was taken to engaging the two communities. In Donegal the public meeting was advertised in the local and regional media by the research team. In the South Armagh area the research team engaged a prominent and respected group within the community to recruit local people to attend three public meetings. In total 50 members of the border community attended these public meetings. In both areas people highlighted the difficulties in getting people to attend public meetings and suggested that key people in the community typically attend such events and feed back to the rest of the community. There was a concern that the turnout would not be used as a reflection of the willingness of the community to use the planned service. As is typical within the health sector there was a large gender imbalance with only four men attending the public meetings.

Details of the public meetings in the two pilot areas were also circulated via the Community Exchange online bulletin, a monthly e-mail bulletin moderated by a steering group of volunteers from the Combat Poverty Agency, Models Research, the Public Communications Centre and the Women's Resource and Development Agency (Belfast). This email bulletin is distributed to over 1000 groups and individuals involved or interested in the work of community and voluntary organisations on the island. Dedicated project pages, incorporating a feedback form, were established on the Centre for Cross Border Studies website at www.crossborder.ie.

The Centre was also invited to talk to the participants on the Community Health Action and INformation (CHAIN) course aimed at people who wish to become active in organising collective action in their community. This course was organised in Armagh by the 'Beyond Borders – Community Well-being' project from the Cross Border Centre for Community Development in Dundalk Institute of Technology and seeks to build community infrastructure in the border region.

Finally, the Centre drew on the findings of a further research project which has been actively researching family support needs in the Inishowen area using survey and focus group methods.

5.1 PILOT AREA 1

DONEGAL /DERRY (direction of patient movement from South to North)
Muff Primary School, 30 May 2006

In February 2004, the Irish Draft Regional Planning Guidelines identified Muff, along with a number of other border villages, as an area integral to the Letterkenny-Derry gateway [25] and one which would be expected to support growing local infrastructure and service needs.

Muff is a border village situated in County Donegal along the banks of Lough Foyle. In recent years the character of the village has changed significantly due to considerable economic and residential growth influenced by the proximity of Derry (4km) and the border with Northern Ireland. The

[25] The 2002 Irish National Spatial Strategy is a twenty-year planning framework designed to deliver more balanced social, economic and physical development between regions. Part of this strategy identifies Letterkenny as a shared gateway with Derry City which prioritises the area for inward investment and is designed to 'strengthen the area economically, infrastructurally and socially'.

population of the village has grown by 131% (to 773) over the six year period 1996-2002. The majority of new residents have moved across the border from Derry but continue to work and socialise in the Derry area. In 2004 an estimated 100,000 people resided within 10 miles of the village.

People living in Donegal often refer to their county as 'the forgotten county', a place which has been overlooked by government investment. Within Donegal the people of Inishowen refer to themselves as the 'forgotten province'. This label was infamously justified in 2004 when 100, 000 copies of a government-issued map of Ireland showing Inishowen as being part of Northern Ireland was circulated throughout the 10 EU accession countries.

An interdepartmental group has been sitting in the Republic since the end of 2005 looking specifically at initiatives for County Donegal. In July 2006 the Minister for Enterprise Trade and Employment, Micheál Martin, published the first report of this group which places a renewed emphasis on cross border co-operation. A joint communiqué from the British-Irish Intergovernmental Conference on 2 May 2006 contained a commitment that the two Governments would work together to explore ways to maximise the potential of the North West Region. The Conference approved a new Cross Border North West Gateway initiative which includes an objective to provide better coordination of public services, including health.

5.1.1 Arrangements

Within the Donegal/ Derry pilot area a public meeting was organised in Muff Primary School at 7:30pm on Tuesday 30 May 2006. An earlier arrangement to hold this meeting in Newtowncunningham where the community infrastructure and facilities were considered to be stronger was reversed as the scheduled updating of the GIS-led selection of pilot areas suggested that this electoral ward may be dropped or marginalised in the pilot service. The village of Muff was selected as a more appropriate venue as it was more central to the GP Out-Of-Hours pilot area and its closeness to the border dictated a growing cross-border community.

Details of the meeting were publicised on Inishowen Community Radio (interview and notice-board), Highland Radio, and the Derry Journal and it was either publicly announced or listed in the bulletins of all Church of Ireland, Catholic and Presbyterian services in the pilot area. While it was listed in the Quigley Point Notes, disappointingly it was omitted from the Muff Notes due to an administrative error. Two key community groups in Donegal, the Donegal Workers Co-operative and Newtowncunningham Development Association, circulated an email to their members informing them of the meeting.

5.1.2 Discussion: Muff Primary School

The group strongly supported the cross-border GP Out-Of-Hours service and cited examples of having to drive long distances with sick relatives and experience long delays to access GP Out-of-Hours care within their own jurisdiction.

The immediate discussion centered on the financial arrangements for the planned service. In particular the group requested clarification on whether providers in the North would accept euro payments; how the exchange rate would be established; whether the cost would be the equivalent of the current charge by GP Out-of-Hours in the South; if prescription charges would be included, and if the visit necessitated onwards referral to hospital, what the procedures would be for paying hospital bills.

Further discussions of the group were concerned with the operating details of the new service in terms of the exact physical location; the nature of the questions which the patient would be asked when calling the GP Out-of-Hours phone number; whether the patient would be allowed to choose where he/she wanted to be treated before the call was prioritized, and if patients would be allowed to walk in off the street.

Clarity was sought on a number of issues such as the passing of information on the patient's visit to their GP across the border; support for the initiative by the two Health Departments, North and South; the protection of local services; and the publicizing of the service.

Recognising that the service was being initially offered as a 6-month pilot, the group were keen to establish what would happen after this period and whether the numbers of patients using the service would be used as an indicator of success. The willingness of people to use the service was not questioned as people are already used to paying for GP Out-of-Hours service. The present situation in Muff regarding access to primary care is considered very unsatisfactory with a single GP practicing in the village for 3 hours one morning every week. The group reflected that the projected use of the system will be affected by the number of people who are currently using accommodation addresses in the North to access NHS services for free. Such people will not use a legitimate cross-border service because of the cost implications and for fear of exposing themselves.

One member of the group who was living in Muff and working in Derry described her current problems with accessing GP services for her children during the day. Both her children attend a nursery close to her workplace in Derry but as dependents of a frontier worker they are not allowed to access GP care in Derry. If her children become sick during the day (which frequently happens) she has to take them on a 40-mile round trip from Derry to see a GP in Buncrana. Co. Donegal. Another group member highlighted current cross-border practice whereby Southern residents can register with GPs in the North as private patients and currently pay £20 per visit as opposed to €50 per visit for a Southern GP.

The discussion inevitably moved to address the huge differences in health systems, North and South, and the group welcomed the fact that this service would bring the two health systems sharply into focus. The group expressed their desire for further cross-border services in the border area and for objective information on their current EU entitlements to use such services. In particular they welcomed any information on access for frontier workers and their children.

Further issues that were raised included the need for a debate on all-island health insurance cover, and the need to widen the debate on cross-border services beyond Letterkenny-Derry to include access to services in Belfast.

Finally, the group reflected on the fact that this service would be a natural extension to the existing practice in Inishowen whereby people are already accessing information on health issues and voluntary health services in the North through the network of women's group and the "excellent" Derry Well Women Clinic. Referring to Inishowen as the forgotten province, one member stated:

> *"The North has always accommodated people from Inishowen and people from Inishowen look North for health. Typically one-third of all participants at Derry Well Women workshops and information sessions come from the Inishowen area"*

5.1.3 Inishowen Family Support Needs Assessment Research Project

A comprehensive study of the quality, range and scope of family support services in Inishowen, commissioned jointly by the Donegal County Childcare Committee and the North Western Health Service Executive, will be published in Autumn 2006. This research, which will inform the production of a three-year action plan for a multi-agency implementation in the Inishowen region, includes an initial survey and a series of in-depth focus groups with families living in the area. The research findings provide a good insight into the psyche of the Inishowen community as regards cross-border service development.

For instance, the research shows that a lot of the current service needs for the Inishowen community (such as shopping and socialising) are met in Northern Ireland, and that the community would welcome the opportunity to access health services across the border, particularly as they feel that the

route from Inishowen into Derry is much better served by public transport than routes within Donegal. Furthermore the Inishowen community believes that Northern Ireland has always offered them a way of accessing broader parenting advice.

This family needs assessment research points to a growing number of residents who have moved from Northern Ireland to Inishowen but are continuing to access public services, such as health and education, across the border though the use of an 'accommodation address'. The 'indigenous community' in Inishowen is concerned that the past advantages of living in a close-knit community are being dissipated by new members who are not integrating into their local society yet are putting additional pressures on infrastructure within the area. Specifically, those involved in the focus groups referred to the "secretive nature of cross-border arrangements and entitlements" and highlighted instances where even the health service providers themselves were not aware of service level agreements to share services and information on sexually transmitted diseases across the border.

Discussions with the researchers suggest that the cross-border GP Out-Of-Hours service should be specifically targeted at vulnerable groups such as the elderly who are less likely to be Northern-focused. In addition, the service should be advertised to people who use existing public services within the Inishowen area, for instance through the local schools, since resident families who continue to use Northern education and health services will not use a cross-border service for which they would have to pay.

5.2 PILOT AREA 2
SOUTH ARMAGH/ NORTH MONAGHAN (direction of patient movement from North to South)

5.2.1 Arrangements
Within the South Armagh/ Monaghan pilot area the Centre identified and recruited a number of key community organisations which act as 'gatekeepers' to the local community and could facilitate engagement with it. The Women and Family Health Initiative, alongside the Rural Health Initiative and Sure Start South Armagh, have registered their support for the planned GP Out-of-Hours service and played a central role in informing the local community of this research and in organising and advertised details of the planned public meetings within the area.

The *Women and Family Health Initiative,* led by Una Walsh, has a strong reputation as a key player in community development within the South Armagh region. It is an umbrella group of women-focused, community, voluntary and development organisations based in the rural area of South Armagh whose aim is to promote, develop and support community-based health projects, with the realisation that targeting women will positively impact on individual families and communities at large. It is one of four core projects which have been granted long-term support under the Southern Health and Social Services Board 'Investing for Health' partnership and has previously been involved in the 'Across Boundaries, Across Borders, Across Disabilities' CAWT INTERREG IIIA specialist cross-border training event, which aimed to inform front line staff about the needs of service users and offer them an in-depth insight into specific sensory impairments and hidden disabilities.

The Rural Health Partnership, led by Teresa Nugent, was established in March 2000 as a pilot project to improve and sustain the quality of life for men and women who experience mental health problems in the South Armagh area. It provides opportunities for social interaction and access to training and education and seeks to reduce the stigma associated with mental illness by integrating people with mental health problems into social, educational, training and employment opportunities in their own communities. Teresa is Chairperson of Cullyhanna Woman's Group, a founder member and Director of the Women and Family Health Initiative, and represents the Cullyhanna Women's Group and the Rural Health Partnership on various committees and networks within the Newry and Mourne area.

Sure Start South Armagh has been operational since June 2004, and covers the electoral wards of Camlough, Crossmaglen, Newtownhamilton and Creggan. The project delivers a range of family-friendly, responsive support services which are available to everyone living in the target area with children under 4 years. Services on offer include family support, health visiting, health promotion, midwife assistance, mobile crèche, and speech and language therapy. The Sure Start Management Board is a multi-agency and multi-disciplinary collective of individuals from the following agencies: NIPPA – the Early Years Organisation, Newry and Mourne Health and Social Services Trust, DELTA (Developing Everyone's Learning & Thinking Abilities) Community Parenting programme, Barnardos, Women and Family Health Initiative and the South Armagh Rural Women's Network.

The partnership of these three key organisations arranged a series of three public meetings within the South Armagh area:

Crossmaglen Community Centre	14 June (morning)
Wald Centre Cullyhanna	15 June (evening)
Lír House, Newtownhamilton	21 June (morning)

They distributed 2000 flyers through local community groups, primary schools and religious meetings in the pilot area, inviting people to attend the public meetings or to contact the Centre for Cross Border Studies with their comments on the cross-border GP Out-of-Hours Project. Details of the meetings were announced in the local press two weeks running prior to the meetings.

5.2.2 Discussion: Crossmaglen Community Centre, Crossmaglen, 14 June 2006 [in association with SureStart]

Crossmaglen is the largest town in South Armagh and is situated approximately 3 miles north of the border with the Republic of Ireland and 14 miles southwest of Newry City. In the past Crossmaglen has been described as a "southern town that had the border laid down on the wrong side of it[26]".

The discussions of the small group focused on the issue of proximity to the border, the perceived poorer services in the South Armagh area (with all services being concentrated in Newry away from the immediate border area) and the futility of not being allowed to use public services across the border. There was a strong sense that the service would be popular in the Crossmaglen area given both its proximity to Castleblayney and the fact that the Crossmaglen community regularly shop and socialise there.

Two main concerns were raised. Firstly the group sought reassurance that their use of the cross-border GP Out-Of-Hours services would not have a cost implication. Secondly the group was concerned that the delay in implementing the service on the South Armagh pilot site (6-month delay) could mean that the service would never get off the ground.

Overall the group was unaware of their EU rights and entitlements to health care. Those who were familiar with the E111 form were confused about where the E111 stopped and this new service started.

5.2.3 Discussion: Wald Centre, Cullyhanna, 15 June 2006 [in association with Cullyhanna Women's Group]

Cullyhanna is a small village in County Armagh on the road between Newtownhamilton and Crossmaglen. There was a broad welcome for the cross-border service given the issue of proximity to Castleblayney (9.6 miles). There was some concern expressed that the implementation of the service had been delayed 6 months until Spring 2006. The group was keen to establish what levels of support for the cross-border service existed among politicians and health professionals, including the GP Out-Of-Hours staff in Castleblaney, and whether progress could be further delayed by any of these groups despite the strong support of the South Armagh community.

[26] Belfast journalist, Malachi O'Doherty

The group voiced concern at the lack of community involvement in the planning stages of the service, particularly given the excellent reputation of the Southern Health and Social Services Board in involving the community in past health service development within their area. While accepting that the CAWT group did include a patient representative, prior to this meeting the group was not aware of the plans for establishing this service which has been developing over a number of years.

A lengthy discussion opened up on what patients could expect when using the cross-border GP Out-of-Hours service and how the new service would differ from the service currently delivered in the North. In particular the group raised questions about changes to the current telephone assessment; whether the patient would be able to make a choice to go North or South after being informed about the waiting times in each practice, and the dispensing of prescriptions scripted in the South.

This discussion led onto the precedents that this initiative might have for other health services in the border areas (such as mental health or disability services). It was accepted that CAWT was developing a unique system which would allow patients to cross the border for routine care, but the group felt that other services such as access to GP care across the border during working hours should be quickly built on the momentum of this work.

A number of key other concerns were raised. There was a fear that resources might be diverted from existing services to this new cross-border service. There was apprehension that the quality of the service delivered in the South would not be assured. It was emphasised that the service was built on the need for patient choice and stressed that the new service would be closely monitored and would include an integrated complaints procedure. As in the earlier Crossmaglen meeting, reassurance was sought that using the service in the South would not incur a charge. Another major point of discussion was that of continuity of care, with the majority of the group expressing the desire to be referred onto secondary hospital services within their own jurisdiction (Daisy Hill Hospital, Newry) rather than to a hospital in the southern border region (Louth General Hospital).

The final point stressed was that the implementation of the new service should be widely publicised in the usual manner (local press, radio and perhaps television) but also through more effective routes such as using local GPs and their surgeries, sending mail-outs to homes through local schools, and recruiting key stakeholders within the community to spread the message.

5.2.4 Discussion: Lir House, Newtownhamilton, 21 June 2006 [in association with SureStart]

Newtownhamilton is a small village in South Armagh approximately 10 miles from the border. The group strongly welcomed the planned service and the opportunity to discuss their needs before the service was implemented. The initial discussion focused on the limited amount of health care currently provided on a cross-border basis despite the high levels of cross-border mobility which exist within the region. Several of the group made the point that there was pressure on optician and dental services in Northern border towns as patients from the South took advantage of cheaper Northern prices for private health care.

The discussion focused in on how the cross-border GP Out-Of-Hours service would differ from the current Northern-based service once it crossed the border. People stressed the need to familiarise the community with simple issues such as directions to the Castleblaney GP Out-of-Hours centre. The group sought clarification that they would not have to pay for accessing the service in Castleblaney.

There was some debate on whether GP services were being abused in the North because they were free. It was a recognised practice that people who lived in the South accessed GP services in the North using ‘accommodation addresses’. The opinion of the group was that these ‘illegal users’ of the Northern system would not use the planned service as they were currently accessing it free.

Other concerns expressed included which hospital patients would be sent to if the GP Out-of-Hours visit turned into an emergency referral; whether the patient choice element of the cross-border service

would be removed in time, and whether the protocols for quality monitoring or onward referral (for example in reporting abuse cases) would follow best practice on one or the other side of the border.

In the context of differences between the Irish health system and the NHS health system, there was some discussion about the variety of prices charged by GPs in the South. Given that the cross-border service would contrast sharply the high cost of accessing services by people living in the South relative to the free service experienced by those living in the North, the group empathised with the people living in the North Monaghan region and expected some degree of reservation by Southern health providers.

A common thread throughout discussions was the current information deficit on EU rights and entitlements to cross-border health care, and the confusion over the E111 form and what it qualified people for.

5.3 OVERVIEW

There is unanimous support for the introduction of the cross-border GP Out-of-Hours service in both pilot areas and many people have sought to congratulate those behind this initiative for their clear vision and enthusiasm. It was agreed that the cross-border service would be particularly important for those people who care for children and elderly relatives. The communities in both areas have sought reassurance that they would receive an equally high standard of service (i.e. equivalent treatment) when using the cross-border service. The quality of the discussion at these events was consistently high and a number of key questions were raised including:

- When would the cross-border service commence and how long would it continue for?
- Would the successful implementation of the cross-border GP Out-Of-Hours service set a precedent for the cross-border delivery of other services, such as mental health services and disability services?
- Would the implementation of the cross-border service eventually see the patient choice element removed so that patients would have to access GP Out-of-Hours across the border?
- Would the service undermine the local existing service in any way or improve the quality of the existing service?
- Would the implementation of the cross-border service be closely monitored and incorporate an official complaints procedure?
- Why has there not been a more structured involvement of the local community in the planning stages?
- Could GPs or other health professionals delay the implementation of the cross-border service even if the community supported it?
- In what way would the cross-border service differ to the existing, familiar service?

There were different concerns raised in both pilot areas which are reflective of the different health systems which operate on either side of the border. For instance, in South Armagh there is a major concern over possible GP Out-of-Hours referrals to secondary hospital services, with people expressing a clear preference to be sent back to Daisy Hill Hospital, Newry rather than be admitted to a hospital in the Southern border region. In contrast, the most important issues for people living in Donegal appear to concern the financial arrangements.

6. SURVEY OF COMMUNITY GROUPS

A key strength of the Centre for Cross Border Studies is its strong network of contacts within the border region and beyond. These networks are facilitated by two information systems held within the Centre. Firstly, Border Ireland, [27] an online cross-border information system, currently stores the contact details of community and voluntary organisations in the border region. Secondly, the Centre has its own Contact Management System which stores information on 'clients' of the Centre and people who have expressed an interest in cross-border co-operation.

The Centre wrote to 107 community organisations that were either active in the border region or working with border communities informing them that it was conducting research into their views on the cross-border GP Out-of-Hours service which was being developed by CAWT. Each organisation was sent brief details of the cross-border GP Out-of-Hours project and asked to complete and return a short survey questionnaire (see Appendix C). Organisations were directed to the Centre's website (www.crossborder.ie) where they could find further information, complete an online version of the survey or provide additional feedback on any of the key issues.

This survey addressed the strategic views of communities on both sides of the border on cross-border health service issues. Feedback was received from 85 community organisations spread along the entire border region on the planning, development and use of cross-border health services. In addition CAWT circulated the survey questionnaire to the Western Community Networks which resulted in a further 10 organisations providing feedback. Details of all responding organisations, which cover a wide range of sectors and geographical areas, are listed in Appendix D.

CAWT is not a well-recognised organisation within the border region. Only forty percent of community organisations operating in the border region had heard of CAWT and less than 30% of organisations were familiar with any work that involved CAWT. In one sense this lack of recognition would be expected as CAWT operates as a virtual organisation with the majority of its work being undertaken by personnel within the Health Service Executive in the South and the National Health Service in the North.

Furthermore in developing the cross-border service CAWT should be mindful of the fact that not everyone has used the GP Out-of-Hours service – only 75% of organisations were familiar with the service within their own jurisdiction. There is a low level of awareness of EU rights and entitlements to health care and no objective source of information which people can consult. Only 20% of organisations said that they were familiar with EU entitlements on health care.

6.1 SUPPORT FOR THE CROSS-BORDER GP OUT-OF HOURS SERVICE

Over 95% of organisations supported the development of the cross-border GP Out-of-Hours service, and the development of cross-border health services in general, and felt that this service would be well-used by those living in the border region.

"People should be able to access medical help as close to their home as possible, no matter where they live on the island of Ireland".

"Cross border work has a potential impact on access, geographically and financially, for all groups."

"We believe it to be vital to continue to develop services and facilities which cater for the community on both sides of the border."

[27] See http://www.borderireland.info for a searchable database of all cross-border activities and publications on the island of Ireland since the early 1980's

"This is very important work in developing an all-island network and a cross-border network of health services. "

"This planned service will have the support of the entire community as it is equally applicable to all people living within the community."

6.2 EXTRAPOLATING THE LEARNING

The need for such a cross-border service in other parts of the border region beyond the two pilot areas was highlighted, as was the wish that the learning behind the establishment and implementation of this cross-border service would be used to facilitate access to further health services on a cross-border basis.

"A great idea. Maybe we will learn from one another to improve our health services."

"This creative and innovative approach to providing health provision throughout the CAWT region has to be a methodology which is allowed to develop to address the huge disparity/ barriers which thousands of people experience in the border corridor region."

"I think this is a brilliant service-should have been done years ago. Hopefully it will motivate other affected areas to move in the same direction - ie banking, education & taxes."

"There is a major need for such a service on the Blackwater Valley/ Clogher Valley/ Blackwater catchment strategy section of ICBAN."

"All services should be thinking on an all-Ireland basis".

6.3 REASONS FOR USING THE SERVICE

The main reasons cited for using the cross-border GP Out-of-Hours service include being able to access services as close to home as possible; having a back-up service when services on one side of the border are not easily available, and choosing to go where the best quality service is delivered. In particular Southern organisations referred to their desire to access the Northern health system which they considered to be of better quality than the service in their own jurisdiction.

"I think cross-border health care can only enhance services in the southern end of the border."

"Northern Ireland is ten minutes from us. In the event of no local G.P available it would be great to go North".

Where I live in Monaghan, if you become ill there is a good chance your life could be in danger!! That's reality."

6.4 TARGETING VULNERABLE GROUPS

A number of organisations specifically mentioned the benefits that this cross-border service would bring to the most vulnerable sections of the border community-the very young and the very old.

"As a worker who sees daily the appalling lack of services for older people on both sides of the border (I live in the North and work in South), I fully support this work. In my opinion the health systems in the border region needs drastic re-organising to be of any benefit."

"In rural areas having to drive many miles for out of hours services may be difficult, particularly if there are young children at home-it makes sense to use the nearest available service regardless of

which side of the border it is on. The people I work with would do that. The older people I work with also say they don't like to have to drive too far at night."

6.5 A DEVELOPING 'BORDER' COMMUNITY?

The feedback clearly shows the border communities moving beyond the concept of working on a cross-border basis to learn from each other to more advanced concepts. Suggestions include the realignment of existing health boards to cover a cross-border catchment area which would be large enough to sustain services in the border region, and the belief that communities on both sides of the border should pool resources to provide more effective and cost efficient services.

"Spatial delivery of essential health services does not require us to respect administrative boundaries."

"Health Boards should be re-aligned, i.e. Derry/Tyrone/Donegal functioning as one organisation that ignores the border but has a large enough population to sustain a decent and effective health service."

"Services should be planned on a cross-border basis if they are more effective."

"My son attends the Royal in Belfast for a heart condition. We are a small island, so use the resources more effectively to improve health care please."

"The need to provide an efficient and cost-conscious service, I believe, means that there must be a greater co-operation on the use of services."

"Health services are best situated and shaped so that access in all forms is maximized for the whole community – the continuing formal existence of a supposed border should not be any kind of a factor in providing an inclusive, joined-up range of health or other services".

6.6 RESERVATIONS

Two organisations expressed reservations about the cross-border development of health services, suggesting that cross-border services would justify the downgrading of local services on either side of the border, and that the existing use of NHS services by people living in the South using accommodation addresses needs to be halted before cross-border services developed.

"Already people in South of Ireland are accessing GPs in border practices to access free services. As they are not paying taxes in NI this is not acceptable. If there is a cross-border service this needs to be addressed."

One organisation referred to the development of services which would be more beneficial to people from the Republic of Ireland.

".. proposal would be more beneficial to persons living in the Republic of Ireland and might constitute a drain on the already overstretched resources in the North"

One organisation raised the issue of poor cross-border transportation which could hinder people from using the service even if it was located closer to where they lived.

"Would transport be available for cross-border services, as the cross-border transport links are currently very bad in our area?"

In addition four organisations felt that they needed further information on CAWT before they could support the development.

7. DISCUSSIONS WITH POLITICIANS

Public concern about the state of health care and support for all-island health development such as the cross-border GP Out-of-Hours services is not enough to move this issue forward by itself. It is unrealistic to expect public opinion, on its own, to reach some new tipping point that will create a tidal wave for cross-border health planning and delivery.

The state of the health care system remains one of the forefronts of debate in politics, North and South and political support for developing cross-border health arrangements has been apparent in successive years. However in the past this support does not appear to have been sufficiently translated into the sense of urgent commitment and political leadership needed to accelerate, what many see as, a somewhat slow and ponderous process[28]. Indeed a clear message from the health departments in 2000[29] was that the amount that could be achieved and the timescales for progress, depended primarily on political leadership, and on putting sufficient resources, both money and people, behind that leadership.

On both parts of the island the maxim of former US House Speaker Tip O' Neill that 'all politics is local' can be strongly applied to the health sector where elected representatives are sometimes seen to be too responsive to their constituencies and therefore unwilling to show leadership in the wider public interest. One example often quoted is the failure to address the issue of acute-hospital rationalisation[30].

For health to compete more effectively with other issues on the agenda, it will take leadership in the form of visible politicians willing to champion the issue, and the media attention that follows. During August and September 2006 the health spokesperson (see Appendix E for details) for each political parties on the island, along with 2 independent politicians representing the border region, were contacted to provide their views on the development of cross-border health services and on the cross-border GP Out-of-Hours Service in particular. Initial contact was made by letter with follow-up contact by phone.

In total nine responses were received. These included the Democratic Unionist Parties (DUP), Independent representative for West Tyrone, Sinn Fein, Social Democratic Labour Party (SDLP) and Ulster Unionist Party (UUP) in the North and Fine Gael, Independent representative for Cavan-Monaghan and Sinn Fein in the South.

7.1 UNDISPUTED POLITICAL SUPPORT

It is notable that the cross-border co-operation in health has not become a matter of public controversy across the border or across the "religious divide" as have suggestions for cross-border working in other fields.

All of the Northern political representatives replied to the request for feedback and all were supportive of developing health services which would provide the optimum care for patients, recognising that at times this may mean accessing services in the other jurisdiction.

Three responses (Fine Gael, Sinn Fein and Independent) were elicited in the South which were all supportive of developing cross-border health services. While Fianna Fail or Labour parties did not reply their joint pursuit of cross-border approaches to health care under the radiotherapy initiative

[28] Discussion at 2006 Sinn Fein conference, Newry.
[29] Launch of Co-operation and Working Together Evaluation in Armagh in 2000.
[30] Wilford, R. and Wilson R. (March 2002) Nations and Regions: The Dynamics of Devolution. Quarterly Monitoring Programme NI.

which will see Donegal patients being granted access to facilities in Belfast has been documented in the media[31].

While the DUP have concerns about cross-border co-operation which is politically driven the ultimate approach is to take all of the opportunities available to develop better health services.

"There are concerns about cross-border co-operation which is politically driven. But on a day-to-day service, where co-operation is mutually beneficial, we do not have a huge population on the island so we need to take all opportunities to develop better health services" (DUP)

Fine Gael spoke of developing health services in natural hinterlands and made particular reference to delivering cross-border services in local border regions which are more familiar with cross-border mobility issues.

"Supportive of developing health services in natural hinterlands"(Fine Gael)

The independent political representatives are very clear about the rationale for co-operation citing issues such as the small, mobile population living on the island who should have the right to choose where their health care is delivered and the primacy of health access over politics.

"Cross-border co-operation is the future" (Independent)

"People don't care where the service is provided (North or South) as long as they can access it" (Independent)

The SDLP referred to the North-South Makes Sense document which outlines the role joint strategic planning could play in ensuring that the best possible use is made of resources and that a first class service is provided to all.

"The CAWT partnership illustrates the benefits that can be achieved for people living in the border region by collaborative working between health and social care organizations on a cross-border basis".(SDLP)

Sinn Fein have a keen interest in the proposed GP Out-of-Hours service and have had meetings with Co-operation and Working Together to discussion plans and progress. The party have called for health planning at all levels to be on an all-Ireland basis and expressed its disappointment at the failure of both Health Departments to seriously engage in joint planning or services delivery.

"We view healthcare provision as a matter devoid of borders and have called for health planning at all levels on an all-Ireland basis".(Sinn Fein)

The UUP are supportive of any practical co-operation which improves the provision of care for patients and their families. Any disappointment over patients traveling abroad to receive health care in Scotland, Dublin or EU is viewed as an indictment of the current state of health service in the North rather than displeasure on cross-border arrangements. It was recognised that the co-operation between Dublin and Belfast was allowing people to access services that they needed.

"Patients must be first. We are supportive of any practical co-operation which sees better treatment being provided for patients" (UUP)

7.2 UNDERCURRENT OF CONCERNS

The main concerns regarding cross-border co-operation in health come from outside the Northern Ireland Unionist parties who viewed health as an area of co-operation which is not politically driven.

The slow pace/ delays in developing the GP Out-of-Hours service, which was first proposed five years earlier, was often mentioned. On a note of caution some politicians seemed to be unaware of the major geographical, technical, professional, pharmaceutical and financial issues which have needed to be resolved in order to implement the cross-border GP Out-of-Hours service stating that there were

[31] For example, Donegal Democrat Thursday 20 July 2006, 'Donegal to get first cross-border GP service'.

"little problems which could be solved". This void between ideology and practicality may lead to impatience in terms of timescales.

Disappointment was expressed at the failure of both Health Departments to seriously engage in joint planning or services delivery and some respondents outlined the ambiguous attitude to cross-border co-operation in health care as it currently exists. In particular it was the guarded view of one respondent that CAWT provides a convenient label for reassuring people of government's commitment to cross-border working. By ignoring CAWT when developing health policy both governments are seen to be effectively disregarding the practical benefits that cross-border co-operation could bring and shirking their responsibilities to the border community.

While accepting that current co-operation is confined to piloting arrangements and testing possible scenarios there was also a concern expressed over the length of time needed before successful approaches become accepted practice. With particular reference to the border counties a call was made to focus on potential roles for smaller regional hospitals in the current rationalisation climate. For instance, a successful cross-border partnership saw Monaghan (South) provide hernia operations and ENT services for patients from Craigavon (North). While this approach cleared the Northern waiting list and was deemed successful it was not continued and was felt to call into question the model of developing cross-border co-operation.

There was a further call for a value-for-money assessment of health activities which would judge the effectiveness of past and current cross-border co-operation.

"If governments were serious about developing the best services for patients then they should include the option of cross-border co-operation in all service delivery"

7.3 ACTIVE ENGAGEMENT IN ALL-ISLAND HEALTH ISSUES

It is clear that many politicians are already familiar and engaged in key practical arrangements which see patients and professionals crossing the border for health care. For instance, the UUP is currently involved in finalising arrangements for an all-island helicopter emergency service (HEMS) with financial support from a charitable donor and the offer of free landing services at Belfast airport (the Royal hospital in Belfast does not have a helipad). Northern Ireland remains the only part of the NHS which does not have HEMS cover and it makes sense to develop this service on an all-island basis. Other respondents outlined their involvement in discussions concerning pediatric hospital services, radiotherapy services, ENT services and cross-border contracting for elective surgery.

Interestingly, a number of the political spokespersons for health are also qualified health professionals (general practice, social work and nursing), some of whom have practiced in both jurisdictions on the island. This training and experience should provide a clear and realistic insight into the practicalities of delivering services and a vested interest in delivered cross-border care when it is clearly the best option available for patients. Indeed, health should be a key area for imaginative cross-border planning for the future.

Indeed discussions with politicians showed a willingness to look imaginatively at joint health initiatives on an all-island basis.

8. IMPROVING THE CROSS-BORDER GP OUT-OF-HOURS SERVICE: FINAL DISCUSSIONS AND RECOMMENDATIONS

Speaking at the MacGill Summer School in Donegal in July 2006, the Secretary of State for Northern Ireland, Peter Hain, called for "deeper North-South co-operation which is practical rather than constitutional" and made specific reference to "patients crossing the border to get treatment where it makes medical sense to do so"[32].

The cross-border GP Out-Of-Hours service recognises the unique circumstances that exist in the Irish border region, where 70,000 patients who may need access to primary care outside normal hours would be better served in the other jurisdiction. It is a perfect example of practical cross-border co-operation. The border communities overwhelmingly supported the work of CAWT in developing this cross-border service. A series of recommendations are outlined which could help to improve the delivery of this service.

8.1 A COMMUNITY MANDATE

The border communities are very supportive of the cross-border GP Out-of-Hours service. In essence they are providing CAWT with a strong mandate to implement this cross-border service on their behalf. This support is evident within the two pilot areas of Donegal/ Derry and South Armagh/ Monaghan and further afield. The border communities would like reassurance that this development of more effective and efficient health services in the region will be given due priority over any legal, political and financial concerns which may arise.

Recommendation 1: CAWT should continue to plan and implement the cross-border GP Out-Of-Hours service with the strong support of the border communities.

8.2 INFORMATION FOR PATIENTS, POLITICIANS AND HEALTH PROFESSIONALS

As is the experience of other EU border regions, patients within the Irish border region place a great importance on accessing information. At all stages of this research the border communities expressed a desire to contribute to the debate on cross-border health services. In particular questions were raised on the cost implications, the administrative procedures involved, the monitoring arrangements, their rights and entitlements to access, and the integration of cross-border care into existing arrangements for secondary services. There is a clear need to familiarise the wider border communities with the details of the planned cross-border service. One suggested way of keeping the communities abreast of developments was to circulate a leaflet within the two pilot areas answering all the questions raised during the public meetings. This would be particularly useful in the South Armagh/ North Monaghan pilot area where the implementation of the service has been postponed until Spring 2006.

Recommendation 2: CAWT should develop and distribute a leaflet for patients on the cross-border GP Out-Of-Hours service which answers all of the questions raised during this research.

In addition, the border communities expressed a desire to be kept informed of how successfully the service is operating once it begins, how many people access care on a cross-border basis; what patients experience is of using the new service, and what indicators are being used to judge the success of the pilot service. The development of a GP Out-Of-Hours website would allow members of the public and health professionals alike to easily access information on the plans for the service, familiarise themselves with the operationalisation of the system and view regularly up-dated and transparent information on the monitoring and use of the service. Any website should incorporate Web 2.0

[32] John Hume lecture. Macgill summer school, Donegal, 16 July 2006

technologies such as blogs and RSS feeds which would promote an interactive debate with the border community on their needs for further cross-border health services. This web service should emulate best practice by the Meuse-Rhine Euregio in establishing an Internet portal for health-related information and exchange.

Recommendation 3: CAWT should establish an online health-related information and exchange website for both people living in the border region and health professionals alike with particular relevance to the cross-border GP Out-Of-Hours service.

8.3 USING ADVOCATES WITHIN THE COMMUNITY

The border communities stressed the need to publicise the cross-border service widely and effectively. GPs currently practicing within the border region are respected members of the community and, as in other EU border regions, they should be recruited to advise their patients on the use of the cross-border GP Out-of-Hours service. The broad support of all political parties should be harnessed to campaign for the implementation of the service.

There are strong community infrastructures on both sides of the border, with long established community voices in South Armagh such as the Women and Family Health Initiative and emerging community health advocates in Donegal such as the Voice of Older People in Donegal and the Donegal Action for Cancer Care (DACC). It is important to recruit the help of umbrella groups in delivering the cross-border service which is built on patient choice and responsive to patients needs.

CAWT should work with key advocates within the community who act as gatekeepers and advisers to the local community. These advocates must have access to up-to-date accurate information on the service and, whenever relevant, should be included as patient representatives on the GP Out-of-Hours planning group. It was acknowledged that CAWT had reserved places for patient representatives at the planning table but had been unsuccessful in recruiting active participants.

Recommendation 4: CAWT should consider recruiting GPs, politicians and key community representatives to advise people living in the border region about the cross-border GP Out-of-Hours service. In addition, CAWT should engage patient representatives from the two pilot areas to sit on the CAWT planning board.

8.4 PUBLICISING THE SERVICE

The Inishowen community highlighted the fact that they access information on health issues primarily through the Northern media. It is important that any publicity for the service is generated through media on both sides of the border in each pilot area. Promotional material should also be channeled through established and trusted organisations within the pilot areas from where patients will originate. This should include distributing leaflets through GP practices and religious establishments, and via children at local schools. Using this approach, the publicity for the service will be focused on users of existing public services (education and health) within the area they normally reside, eliminating those groups who reside on one side of the border but continue to use the health services in the other jurisdiction.

Recommendation 5: The services should be widely publicised in the traditional media on both sides of the border in each pilot area and should target users of existing public services in the immediate area where patients will originate.

8.5 INTEGRATION OF CROSS-BORDER GP OUT-OF-HOURS SERVICE INTO THE WIDER HEALTH SYSTEMS

Perceived differences in the quality of the health systems, North and South, could be a critical factor in determining the use of the cross-border GP Out-of-Hours service. The National Health Service in the North has an excellent reputation for delivering high quality health care. The Irish health system has recently had extended bad publicity surrounding patient experiences in Monaghan/ Cavan, Louth and Drogheda hospitals. During this research individuals from the South have referred to the hospital situation in the South as being "dangerous" and "run-down". Patients originating in the South appear to feel safe in accessing health care within the North and have asked few questions concerning onwards referral to hospitals or social services. There appears to be an underlying acceptance among Southern patients that any services they access in the North will be of better quality.

In contrast individuals in the North have repeatedly enquired about the arrangements for onward referral to hospital care (in emergency cases), mental health services or social services (in cases of suspected abuse). For Northern patients the fear of being referred to a hospital in the Southern border region may be a critical factor in using the cross-border GP Out-of-Hours service.

Recommendation 6: The development of the service needs to be transparent about referral practices onto secondary care (hospital) or social care services (abuse, mental health services), and to dispel any myths which distort the perception of existing services on either side of the border. CAWT should strive to publicise patients' positive experiences of using the cross-border service in a timely and regular manner.

8.6 FINANCIAL ARRANGEMENTS

The financial arrangements of the cross-border GP Out-of-Hours service are vitally important to patients residing in the South. Discussions held as part of this research have highlighted the current practice of people living in the Southern border counties registering as private patients with NHS GPs in the North. Allowing for the euro-sterling exchange rate, this care is delivered at a considerably reduced rate compared to the rate they pay for equivalent care with Southern GPs. Discussions have also highlighted the growing number of Southern patients who are traveling to the North to access private health services from dentists and opticians. It is clear that private fee-paying patients from the South will travel across the border to the North for routine care if the price is right. By highlighting different arrangements for accessing care, this cross-border service could open up the possibility of a competitive market for primary care services along the border region. The cost of accessing the GP Out-Of-Hours service will be closely monitored by patients based in the South who pay for health care within their own jurisdiction. Questions will be raised about any discrepancy with charges paid for existing services within jurisdictions. For instance, if private patients from the South can access GP services during the day (9am-5pm) at a lower cost in the North than they do in their own jurisdiction should they also be able to access GP Out-Of-Hours services cheaper in the North? The cross-border service needs to be recognised by private health insurers who offer healthcare plans with medical cover for GP costs.

Recommendation 7: The cost of accessing the cross-border GP Out-Of-Hours services should be very transparent. Any cost incentives for patients should be highlighted and the cross-border service should be recognized by private health insurance schemes

8.7 LEARNING FROM THE EXPERIENCE OF OTHER EU REGIONS

The in-depth case studies detailed under the Europe for Patients project[33] and the Evaluation of Cross-Border Regions in the European Union project[34] have highlighted examples of cross-border practices in guaranteeing consent and data protection; moving of patients as well as health care providers;

[33] http://www.europeforpatients.org
[34] http://www.loegd.nrw.de

prescribing medicines across national boundaries, and agreeing protocols for pre- and post-intervention care within the country of origin between the referring and host institutions.

The development of cross-border health services on the island of Ireland should build on the experience of other European border regions. Both Belgium and the Netherlands allow patients to access GP care across their national borders and France has expressed an interest in doing so. It is important that CAWT develop links with these European initiatives.

Recommendation 8: CAWT should explore the possibility of forging closer links with other European border regions which are delivering health services on a cross-border basis, and transfer any learning to the island of Ireland situation.

8.8 PROTECTING THE EXISTING LOCAL SERVICES

In the past there has been a concerted effort to sell non-threatening cross-border co-operation which is sensitive to the feelings of the Irish border communities. A formal agreement on the development of co-operation for acute services between the North Western Health Board (now HSE North West area), the managers of Letterkenny General Hospital, and Altnagelvin Health and Social Services Trust, contained a number of conditions governing any cooperation between the two hospitals including:

- no proposal would undermine the services currently being provided in either hospital; and
- co-operation should be confined to services that a particular hospital could not see itself providing in 5 to 10 years.

These conditions were thought to be necessary because of concerns on the part of politicians and professional staff that Letterkenny General Hospital could otherwise lose out to its dominant neighbour.

In resolving current health provision issues for County Donegal, the role of cross-border co-operation has been much debated by groups such as the Donegal Action for Cancer Care (DACC). While health consultants in Donegal have expressed a preference to link Donegal cancer treatment services with Galway, the Health Service Executive led by Irish Minister for Health, Mary Harney, is actively promoting the idea of stronger cross-border co-operation with Derry and Belfast. The voice of the local community, Donegal Action for Cancer Care (DACC), has raised questions about the difficulties of accessing care in Altnagelvin Hospital in Derry (4 miles across the border) given that sharing services across jurisdictions has proved so difficult in the past. In vocalising his reservations, the DACC co-chairman, Mr John Quinn, stated that while Donegal patients may be able to access spare capacity in Northern Ireland, they would essentially be 'second-best patients' within a system which would always look after its own first.

The effect that the cross-border GP Out-Of-Hours service would have on existing local services was raised at public meetings in both Donegal and South Armagh and by organisations who responded to the survey. Any development of the cross-border GP Out-of-Hours service must be sensitive to this issue. Rather than imposing conditions on the development of cross-border services, it would be more prudent to reassure the communities that all patients will be treated equally on the basis of clinical need rather than residency; that the patient flow will happen in both directions; and that the new service is one which is being specifically developed for the border region (North and South) rather than utilising spare capacity.

Recommendation 9: CAWT should stress that the cross-border GP Out-Of-Hours service is one which is built on patient choice and not on utilising spare capacity; that it is supported by local and national health professionals, and that all patients will be treated equally on the basis of their clinical need.

8.9 RECOGNISING EXISTING CROSS-BORDER MOBILITY PRACTICES AND PROBLEMS

There appears to be a growing number of residents living in the Southern border counties who use the NHS in Northern Ireland without incurring charges. Any cross-border service whose projected use is

calculated on the basis of the number of Southern residents within a specified distance from the border will need to be mindful that some of these residents have already found an alternative means of accessing healthcare in the North.

The majority of these residents come from two groups - related to frontier workers and those who have moved from Northern Ireland to reside in the Republic of Ireland. Southern frontier workers have legal access to services in the North under EU regulations but their dependants do not. Many frontier workers feel this is extremely unfair. They contribute national health insurance contributions from their salaries in exactly the same way as people who live in the North yet, unlike their Northern fellow-workers, their health coverage does not extend to their children. In effect families are being divided by the border, with the parents choosing to use the services in the North and their children having to use the health service in the South. This creates the extreme example whereby a female frontier worker who lives in the South can give birth to her baby in a Northern hospital but on discharge from hospital that baby can no longer be treated alongside his/ her mother and must receive any postnatal care in the South.

Efforts should be made to recognise such frontier workers using the NHS health system by facilitating them to register under their southern addresses – this way it would be easier to monitor their use of NHS services, to identify any distinct needs they may have, and to differentiate them from other groups who access the NHS without any legitimate basis. Other EU border regions such as France-Belgium or France-Switzerland have put in place bilateral agreements to include access for dependents of frontier workers. By legitimising this group of 'frontier families' in the Irish border region any cross-border service would reflect a truer picture of frontier families living and working in this region.

A second group of cross-border users who could be legitmised are those people who retire to live in the South after paying NHS contributions throughout their working life in the North. This group has been recognised as a key group of cross-border health users within the France-Belgium border region who should be given dual access to both health systems.

The planning of any cross-border service needs to recognise that cross-border patient mobility does exist at present, albeit below the radar. These existing cross-border patients are not from one homogeneous group but have varying degrees of legitimacy to dual health service access. Thought should be given to granting dual access to the children of frontier workers and to people who retire to live on the opposite side of the border.

Recommendation 10: In developing the cross–border GP Out-Of-Hours service CAWT should account for the existing forms of patient mobility with the border region. In terms of facilitating the long-term development of cross-border health provision CAWT could lobby both governments to recognise the rights of access for children of frontier workers and retired people.

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APPENDIX A

Summary of forms used in relation to Entitlements to Health Services under EU Regulations

E001: Form E001 is a general form used by a Member State to request general information on applications, transmit information, or to request forms from another European Economic Area country.

E101: This form is used by people who are posted to work in another Member State but continue to receive salary from their usual country of residence and to pay their social insurance contributions to the Member State that they are posted to.

E103: This form is issued by the Department of Social, Community and Family Affairs in cases where people who are posted to work in another Member State wish to opt for the health services of that Member State.

E104: This form is a record of a person's insurance contributions in a Member State.

E105: This form records benefits due because of incapacity for work.

E106: This is a certificate of entitlement to sickness/maternity benefits in kind for persons going to live in another Member State. When the E106 is registered the person and registered dependants can receive medical treatment on the same basis as an insured person of the Member State of residence.

E107: This is an application for a certificate of entitlement to benefits. This is normally issued by the Health Authority of the other Member State in the case of persons who become ill while on a temporary stay in another Member State and do not have form E111. Form E107 is issued by the Health Authority and is really an application for and E111 or in some cases E106 or E123.

E108: Form E108 is issued by the relevant authority of a Member State to notify another Member State of the suspension or withdrawal of the right to benefits and cancels the previously registered "E" form with effect from a specific date.

E109: Form E109 is a certificate of registration for the dependants only of an employed/self-employed person who resides in a Member State. It entitles the holder to sickness/maternity benefits. Form E109 is issued for a limited period, i.e. 12 months.

E111: Form E111 provides entitlements to immediate necessary medical and dental treatment during a temporary stay in an EU Member State on the same basis as if the person was an insured resident of that Member State.

E112: Form E112 provides for entitlement to medical treatment in another Member State if the person is authorised to go temporarily to another Member State for the purpose of receiving specific medical treatment, which is not available in their own Member State.

E113: Form E113 is notification from a Member State that a person who is insured under one Member State legislation has been admitted or discharged from hospital in another Member State. This form is used in cases where the actual cost of medical treatment is reimbursed by one Member State to another.

E114: Form E114 is used in cases where major benefits are provided in another Member State, e.g. artificial limbs, prostheses etc.

E115: Claim for cash benefits for incapacity for work (Transfer of sickness or maternity benefits from one country to another).

E116: Medical report relating to incapacity for work (Transfer of medical details from one country to another).

E117: Granting of case benefits for incapacity for work. (Acknowledgement of putting sickness or maternity benefits into payment from one country to another).

E118: Notification of non-recognition or end of incapacity for work - (Notification of a final certificate on a claim, from one country to another).

E119: Form E119 provides income maintenance, treatment and other benefits to persons and their dependants in receipt of unemployment benefit in their country of residence who go to another Member State looking for work.

E120: Certificate of entitlement for pension claimants and member of their family. Similar to E106 but applies to pension claimants who are awaiting a decision on the granting of a pension.

E121: E121 is a certificate of entitlement to medical benefits for a pensioner and dependants resident in another Member State.

E123: Form E123 is a certificate of entitlement to treatment for industrial injury or industrial disease.

E124: Claim for a death grant.

E125: Form E125 is an individual statement of the costs of the medical treatment a person has received in another Member State. It is used by the Member State to claim the costs of medical treatment where there is an agreement between two Member State to reimburse the actual costs involved.

E126: If a person becomes ill while on a temporary visit to another Member State and does not have Form E111, he/she is liable for the cost of any treatment received. Form E126 is a request from sickness insurance institution in that Member State to the person's normal country of residence to consider if a refund of medical expenses is appropriate to a person who was charged for treatment.

E128: Form E128 is issued to students and posted workers and certifies entitlements to the full range of healthcare in the country of posting or study. The E128 does not need to be registered in the country of posting or study but is presented at the time treatment is required.

APPENDIX B

Workshop "Cross-Border Activities – Good Practice for Better Health"
Posters of the Projects presented at the workshop in Bielefeld, Jan. 20-21, 2006
Working Group "Patient Mobility"

- Boundless patient treatment in the Euregio Rhein-Waal
- (Integration) Zorg op Maat – (I)ZOM
- Transparency in the cross-border aids supply structures
- Crossborder dental care
- healthregio
- Euregio Health Portal
- Health Card international – GCi
- Contracting Belgian Health Care

Working Group "Hospitals, Health Care Provision"

- Pain Cultures, Methods of preventing and relieving pain in the Northern Region
- Standardization of Treatment in patients presenting HIV, HVC, HVB and other infectious pathologies
- Cross-Border Hospital Cerdanya and Capcir
- Sharing the expertise of three health networks to the benefit of cancer patients
- Quality Circle of Hospitals in the Euregion Meuse – Rhine
- Chronos: an education in chronic psychiatry
- Implementation of a MRSA protocol in cross border hospitals
- State-of-the-Art Medicine along the Borders of Europe
- Cross-border collaboration between the hospitals: Academisch Ziekenhuis Maastricht (NL) and Algemeen Ziekenhuis Vesalius (AZV) in Tongeren (B)

Working Group "Public Health"

- German-Dutch Alliance of Help for the Addicted
- Alcoholismo - Prevention and treatment of alcoholism
- Epi-Rhin – A Transborder Reporting Scheme for Communicable Diseases
- Health Protection – A New Challenge
- Spatial risk assessment for Lyme borreliosis and tick-borne encephalitis (TBE) in the trans-border area between Italy and Slovenia: preliminary results
- Disasters management – SAGEC
- EUMED: Cross-border emergency medical assistance in the Meuse-Rhine Euroregion

Working Group "Prevention in Childhood and Adolescence"

- Cross-border Network for the primary prevention of drug addiction in the Euroregion Pomerania
- The Class Moves!
- Health and Activity in Schools
- Cross-border cooperation in the Euregion Meuse-Rhine to decrease risky behaviour by adolescents
- From Drug Route to Therapy Chain
- Psychosocial Well-being of Children and Youth in the Arctic
- Unlimited Help for Self-Management of Children and Teenagers with Asthma Bronchiale

Working Group "IT Employment, Knowledge, Human Resources"

- POMERANIA Telemedicine network
- Crossborder telematics in laboratory medicine in the "Euregio Bodensee"
- Telemedicine in North-West Russia
- Pathology across the Rhine
- Telemedical auditing in reconstructive oral and maxillofacial surgery
- Collaborative Tele-Neurology
- A Network of Professionals in Rheumatology and Rheuma-Orthopaedics
- Cross-border cooperation in the care training Bavaria – Bohemia

APPENDIX C

your voice your views

The Centre for Cross Border Studies

Community attitudes to cross-border health services

Politicians and health professionals have identified health as a key area for cross-border co-operation. The two health systems (National Health Services in the North and Irish Health Service in the South) share common core principles, face similar health and service problems, and have adopted similar approaches to tackling issues. However there is little evidence of joined-up cross-border development either in current health system reforms which are developing in parallel in both parts of the island or in practical service delivery.

Among the notably exceptions is the planned cross-border GP Out-of-Hours service*. Earlier research identified approximately 70,000 people across the length of the border who live closer to a GP out-of-hours services in the other jurisdiction. Co-operation and Working Together (CAWT), a partnership of border Health Boards and Trusts, is working to resolve a range of geographical, technical, professional and financial issues which would improve access to primary care services for people living in the border region.

From Autumn 2006 it is hoped to run a cross-border pilot scheme which will allow people living in East Donegal to access GP-Out-of-Hours services in Derry/ Londonderry. A similar pilot scheme in the mid-border region will allow people in South Armagh to access services across the border in North Monaghan is planned from Spring 2007.

The Centre for Cross Border Studies is documenting the views of people living in or working with border communities on using health services across the border.

TELL US WHAT YOU THINK

Please contact us to register your support or your concerns by:

- Completing this short **questionnaire**
- Attending one of the **public meetings** organised in your area
- Logging on to **www.borderireland.info**
- Contacting Patricia Clarke by phone at **028 3751 1559**, by email at **patricia.clarke@qub.ac.uk** or by writing to the **Centre for Cross Border Studies, 39 Abbey St, Armagh BT61 7EB**

*GP Out-of-Hours services are health services provided to people when their own General Practitioner/medical centre is closed, that is, in the evenings and during the night from 6.00pm to 8.00am, at weekends and over public holidays.

INTERREG IIIA

CAWT cooperation and working together

YOUR VOICE YOUR VIEWS

Attitudes to cross-border health services

Please complete this short questionnaire and return it to the Centre at:
Fax: 028 3751 1721 (North) or 048 3751 1721(South)
Post: Centre for Cross Border Studies, 39 Abbey Street, Armagh BT61 7EB.
Email: patricia.clarke@qub.ac.uk
Phone:028 3751 1559 (North) or 048 3751 1559 (South)

Your views will be used to inform a report on community attitudes to cross-border health service development. Would you like to receive a copy of the completed report? □ *Yes*

1. **Name** _____
2. **Email address**_____
3. **Name of organisation** _____
4. **What geographical region does your group cover?**
   _____
5. **Are you currently involved in cross-border cooperation?** □ Yes □ No
   *If yes, please give details*_____
   _____
   _____
   _____
6. **Are you familiar with the work of Co-operation and Working Together (CAWT) organisation?** □ Yes □ No
   *If yes, please give details*_____
   _____
   _____
   _____
7. **Are you familiar with the entitlements of people who live on one side of the border and work on the other side of the border to access health services in both jurisdictions?** □ Yes □ No
8. **Are you familiar with the GP Out-of-Hours service**
   in your own area? □ Yes □ No
   across the border? □ Yes □ No

In your opinion,

9. Should people <u>plan</u> future changes to the health services on an all-island basis?

□ Yes □ No □ Don't Know

10. Should people be able to <u>access</u> health services across the border?

□ Yes □ No □ Don't Know

11. Would you be willing to cross the border to <u>use</u> health services?

□ Yes □ No □ Don't Know

12. What health services could be beneficially offered on a cross-border basis?

(Please tick all that apply)

□ Cancer care
□ Coronary Heart disease care
□ Suicide prevention
□ GP services
□ Emergency Ambulance care
□ A&E
□ Other (please give details) _____
□ Hospital services
□ Community Pharmacy
□ Chronic care (e.g. diabetes, asthma)
□ Mental Health
□ Health Promotion
□ Specialist surgery

13. Do you support the CAWT development of a cross-border GP Out-of-Hours service?

□ Yes □ No □ Don't Know

14. Do you think people living in the border region would use such a service?

□ Yes □ No □ Don't Know

15. For what groups of people do you think a cross-border GP Out-of-Hours service would be particularly beneficial?

□ Yes □ No □ Don't Know

16. Do you think people living in the border region would use such a service?

□ Yes □ No □ Don't Know

17. For what groups of people do you think a cross-border GP Out-of-Hours service would be particularly beneficial?

(Please tick all that apply)

□ Women
□ Infants
□ Young People
□ Other (please give details) _____
□ People with Disabilities
□ Ethnic and Immigrant Groups
□ Carers

Please add any further comments you have on developing mutually beneficial cross-border health services

_____
_____
_____
_____

Thank you for taking the time to complete the questionnaire.

APPENDIX D

Community organisations that have provided feedback as part of the survey are outlined below:

Community Organisations
Ageing Well Roe Valley
Atlantic View Community Development Project
Ballymagroarty Hazelbank Community Partnership
Bee Park Resource Centre Ltd
Beyond Borders
Blackwater Valley (Errigal Truagh & Aughnacloy)
Blayney Blades
Border Action
Castleblayney Arts and Community Development Co Ltd
Cavan Community IT Skills Project
Cavan Partnership Co Ltd
Clara Development Committee
Clones Failte
Clones Regeneration Partnership
Comhairle
Communities Connect-Louth Leader
Community Connections
Community Connections Community Development Programme
Community Creations
County Leitrim Partnership
County Monaghan Citizens Information Service
County Monaghan Community Network
County Monaghan Partnership
Cox's Demesne Youth & Community Project
Deirdre Fullerton Research and Consultancy
Dergfinn Partnership
Derry and Raphoe Action
Derry Healthy Cities
Derry Well Woman
Donegal Town Community of Chamber
Drogheda Partnership
Drum Development Association
Dundalk Counselling Centre
Dundalk Resource Centre for the Unemployed
Dunfield Football Club
East Border Region Committee
Errigal Truagh Parish (R.C.)
Errigal Truagh Special Needs Committee
EXPAC- Ex Prisoners Assistance Committee
Family Support Services
Feile Chamlocha
Fermanagh -University Partnership Board

Community Organisations
Fermanagh Rural Community Network
Foroíge
Foyle Down Syndrome Trust
Freelance Community Facilitator - Newry and Mourne District
Freelance voluntary and community sector (Dublin South)
Garil Triucha (GAA)
Health Services Executive North West
Inishowen Community Radio (ICRFM)
Inishowen Partnership Company
Kilty Cashel Project
Macra na Feirme
Meitheal Forbartha na Gaeltachta Teoranta (Leader)
Mental Health Ireland/ St Davnet's Hospital
Migrant Rights Centre, Ireland
Mind the Gap /Community Workers Co-operative
Monaghan Youth Federation
Muirhevnamor Community Youth Project
Multiple Sclerosis Society
NcompasS/ British Council
Newry and Mourne Trust
Newry and District Confederation of Community Groups (10 groups)
Newry and Mourne Leader
Northern Ireland Chest Heart Stroke Association
North Leitrim Men's Group
North West Community Network
Oak Healthy Living Centre (Erne East Community Partnership Ltd)
Peace and Reconciliation Group
Royal National Institute for the Deaf
Rural Community Network
Rural Health Partnership
SAVER/NAVER
Serenity Active Retirement Cross Border Group
Sligo Institute of Technology
South Armagh Tourism Initiative
STEER Mental Health
Strabane Farmers Forum
Strabane/Lifford Development Commission
Sure Start South Armagh
Synergy Multiculturalism Initiative
Truagh and Aughnacloy Heritage Committee
Truagh Community Games
Truagh Development Partnership
Ulster Community Investment Trust Ltd
Western Health Action Zone
Women and Family Health Initiative

APPENDIX E

Political spokesperson for health who were asked to contribute their views on the development and planning of health services on an all-island basis.

Dr Jerry Cowley TD, Independent
Brian Lenihan TD, Minister of State for the Department of Health and Children, Fianna Fail
John Gormley TD, Green Party
Liz Mc Manus TD, Labour
Carmel Hanna MLA SDLP
John O Dowd MLA and Caoimhghin O Caolain TD, Sinn Fein
Dr Kieran Deeney MLA, Independent
Dr Liam Twomey TD, Fine Gael
Paudge Connolly TD, Independent
Rev Dr Robert Coulter MLA, UUP
Iris Robinson MP (and Dr Philip Weir, policy adviser), DUP