



A Report for  
the Centre for Cross Border Studies

# Cross-border Co-operation in Health Services in Ireland

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# CROSS-BORDER CO-OPERATION IN HEALTH SERVICES IN IRELAND

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## About the Centre for Cross Border Studies

**The Centre for Cross Border Studies**, based in Armagh, was set up in September 1999 to research and develop co-operation across the Irish border in education, health, business, public administration, communications and a range of other practical areas. It is a joint initiative by Queen's University Belfast, Dublin City University and the Workers Educational Association (Northern Ireland), and is financed by the EU Special Support Programme for Peace and Reconciliation. Between March and May 2001 the Centre will publish research reports on cross-border telecommunications, cross-border health services, all-Ireland co-operation to tackle disadvantage in education, North-South EU funding programmes and a number of other areas of practical North-South co-operation.

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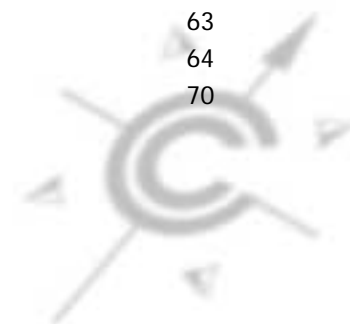


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# Executive Summary

## Introduction

THIS report, commissioned by the Centre for Cross Border Studies in Armagh, outlines the past, present and the potential for future co-operation in health services across the Irish border. It focuses on cross-border initiatives with the greatest potential for future development and makes recommendations on how co-operation might be upgraded and made more effective both on a cross-border and all-island basis.

Over a 12 month period - between March 2000 and March 2001 - relevant policy documents, evaluation reports and published Irish and European cross-border literature were reviewed and a series of semi-structured interviews were held with senior key informants throughout Ireland. In July 2000 the Centre for Cross Border Studies was commissioned by the most important existing cross-border initiative, Co-operation and Working Together (CAWT), to conduct a separate but complementary evaluation of the CAWT organisation. The findings of that five-month evaluation have been used to inform this research.

In November 2000, senior policy-makers and practitioners came together for a study day in Armagh organised by the Centre to discuss the preliminary findings of both this study and the CAWT evaluation.

The report begins by comparing the structure and policy of health services in both jurisdictions, and looking at the European context. The findings of the study are then presented under five thematic headings:

- the need for co-operation;
- the economics of co-operation;
- past and current co-operation, much of it in the context of CAWT;
- ways in which co-operation can be enhanced in the future, and
- barriers to co-operation and how to overcome them.

Finally a series of recommendations are outlined to aid the development of co-operation both at a local cross-border level and at a wider all-island level.

## Findings

There are important differences between the two health systems in Ireland in relation to policy, structures, coverage and funding. These include the existence of universal coverage and the purchaser-provider split in Northern Ireland. Despite these differences, the two systems have common core principles, face common health and service problems, and there are similar approaches to tackling issues.



## Executive Summary

Despite recent judgements in the European Court, EU law at present has little relevance to cross-border health care in Ireland other than in relation to mutual recognition of health professionals and specialist training.

Interviewees saw considerable advantage to be gained from cross-border co-operation in health services. We have identified a number of major themes running through our respondents' views:

- collaboration will address the relative disadvantage of border areas
- the border region is a 'natural' geographic area
- there are benefits from planning health care on an all-Ireland basis
- threats to health do not respect political or other boundaries
- cross-border collaboration will bring a faster response in an emergency
- patient benefits will accrue from exchanging good practice.

In addition, it is suggested that the benefits of enhanced co-operation would enable the pooling of expertise and the development of critical mass and economies of scale in areas such as education, manpower planning, and health technology assessment.

Many of these points have considerable merit. However initial comparative analyses of mortality and utilisation data conducted for this study failed to confirm that there are particular problems of unmet need for hospital services in border areas.

As far as the economics of cross border co-operation are concerned, such initiatives provide an opportunity to enhance the services provided to populations either in the vicinity of the border, or more widely, by increasing 'critical mass' to justify concentration. Evidence that this will produce benefits attendant on exploitation of economies of scale in the acute sector is not strong, and is counterbalanced by good evidence of decay in utilisation of a service as the distance from it increases. Evidence of a relationship between volume and outcome is mixed. The argument that services must be centralised in the interests of quality - given opportunities for more imaginative patterns of service delivery and the observed distance-decay problem - is not supported. However where excess capacity is clearly evident on both sides of the border, rationalisation may improve effectiveness, reduce costs and not necessarily adversely affect access.

North-South co-operation in health care can take a number of forms:

- training/professional development
- purchasing or commissioning services from the other jurisdiction
- joint service development
- research and policy work.

## Executive Summary

Analyses of hospital episode data in the two jurisdictions have indicated that cross-border flows for inpatient services currently amount to between 0.1% and 0.3% of overall caseloads.

A number of barriers to cross-border co-operation have been identified:

- Developing services at one site may mean discontinuing/reducing services at another. This is particularly difficult when two jurisdictions are involved.
- There are legislative differences regarding eligibility for services and licensing of products.
- Separate bodies are responsible for professional registration.
- There are differences in pay scales, conditions of employment, job descriptions and tenure of office.
- Medical defence insurance is operated by private providers in the Republic but by health authorities in Northern Ireland.
- Undergraduate and postgraduate training is organised and accredited by different bodies in the two jurisdictions and in many cases reciprocal recognition does not exist
- The two jurisdictions have different funding arrangements.
- Transaction costs and currency fluctuations are a problem.
- The two jurisdictions have different clinical/professional standards, protocols, guidelines and audit procedures.
- Hospitals have tertiary level services provided within their own jurisdictions making it difficult to refer patients to a hospital across the border.
- There are differences in the public/private mix and in insurance coverage outside a patient's area of domicile.

### Recommendations

Both at an overall strategic and an individual project level, greater clarity is needed about the objectives of improving cross-border co-operation and the obstacles that stand in the way of achieving that improvement. Clear statements should be made about existing problems and how they can be ameliorated through closer cross-border working.

Although the above obstacles are in the main not insurmountable, unless they are tackled they have the potential greatly to inhibit the scope of cross-border working. This would suggest that concerted efforts are required to identify and dismantle such potential barriers, where this is feasible and appropriate.



## Executive Summary

There should be a thorough assessment of the potential for co-operation in relation to tertiary referral services including:

- transplantation services (heart/lung and other)
- paediatric cardiac surgery
- collaboration between specialist units in Northern Ireland and the Republic.

There should be an assessment of how co-operation in emergency services close to the border might be enhanced.

The two Departments should consider commissioning more joint studies in the five areas identified in the Belfast Agreement.

There should be much greater collaboration on the island in relation to evaluation and research, particularly on projects comparing the effectiveness of the two health care systems. Consideration should also be given to developing formal and reciprocal arrangements for peer review and audit.

Provided barriers can be overcome, there is considerable scope for an expansion of activities such as staff secondments, exchanges and development, and joint training programmes.

There should be much greater co-operation in the field of public health, particularly in joint health promotion campaigns.

There should be greater co-operation in the field of emerging health technology, and consideration should be given to the establishment of an all-Ireland capacity in Health Technology Assessment.

Consideration should also be given to:

- including a cross-border element in all service reviews in either jurisdiction
- involving clinicians and hospital/trust managers at an early stage in relevant studies
- subjecting cross-border proposals to cost-benefit analysis
- economic research, for example on the potential for economies of scale on an all-Ireland basis.

## Executive Summary

Clearer objectives for Co-operation and Working Together (CAWT) are required, such as:

- to overcome disadvantage in terms of particular documented levels of unmet need in border areas
- to plan more effectively for 'natural' cross-border catchment areas
- to learn about the effectiveness of different responses to common problems.

There is a major opportunity for CAWT to influence the developing all-Ireland agenda, both by feeding its experience to the two Departments of Health and/or the North-South Ministerial Council and by undertaking work on behalf of them.

CAWT has the potential to become an exemplar of good practice, for example in relation to the assessment of health care needs and opportunity costs.

CAWT studies should be commissioned into:

- the effects of population sparsity and remoteness
- morbidity and other population characteristics
- unmet need in rural areas
- distance from facilities
- the determinants of utilisation in border areas
- the potential for economies of scale locally
- efficiency and equity issues
- baseline levels of provision, any spare capacity and the scope for expansion
- the political/service impact of losing services.

There should be more input from public health professionals to the work of CAWT, for example in relation to needs assessment or to planning/specifying co-operation initiatives.

The future success of CAWT might be assessed in part in the light of how well its work has influenced board purchasing strategies. Trusts should be involved more extensively and more attention should be paid to communication and dissemination.

CAWT has been very dependent on EU grant funding. Some projects have lapsed after such funding expires, irrespective of their outcomes. A limited amount of funding has been made available from the budgets of the individual boards. Clarity is needed about the priority boards place on funding cross-border work. However the wealth of experience of cross-border working that has been developed within CAWT could be used to drive the implementation of cross-border services.





## Introduction and aims of research

### 1.1 Introduction

THE research documented in this report is one of a number of studies commissioned by the Centre for Cross Border Studies in pursuit of its role to undertake research and develop co-operation across the Irish border in a range of practical areas including education, health, business, public administration and communications.

The main aims of the study were as follows:

- to investigate the current state of cross-border relations in the field of health services;
- to identify any barriers, gaps, opportunities and challenges in relation to enhanced cross-border co-operation; and
- to formulate detailed proposals for upgrading co-operation and enhancing its effectiveness.

The project has aimed to cover the full range of health services, including general medical/primary care, inpatient and out-patient, and community care services. As well as investigating the current extent of cross-border co-operation, an attempt was made to identify examples of past co-operation. For these and for current areas an assessment was made of how successful they have been. The work is placed in the context of developing relationships in Ireland and also in a wider European context.

The project also set out to:

- distil available evidence on effectiveness by examining evaluative reports and other data from informants
- incorporate a preliminary assessment of the economic potential of cross-border co-operation
- assess the opportunity for further co-operation by analysing hospital episode data and other statistical material
- examine potential practical, political and professional barriers to co-operation
- consider ways of enhancing co-operation and making it more effective.

There are a number of areas of co-operation that it has not been possible to cover in any detail in this report. These include Information and Communication Technology (which we suggest would warrant a full study on its own), nursing, professional development and training, and public health.



# Introduction and aims of research

## 1.2 Structure of the report

Chapter Two outlines the approach taken to this review of cross-border co-operation in health services and the methods used. This is followed in Chapter Three with a review of the context for cross-border co-operation in order to identify the benefits and feasibility of co-operation within current policy frameworks in the two jurisdictions and the broader European context. In addition, common issues are identified, along with differences that have the potential to hinder co-operation. In Chapters Four to Seven the findings of the study are presented under four themes: the need for co-operation, the economics of co-operation, the current status of co-operation, and ways in which co-operation can be enhanced in the future. Chapter Eight considers barriers to co-operation and how they might be overcome and Chapter Nine presents the overall findings and recommendations of the study.

## 1.3 Intended readership

We hope this report will be of value to anyone with an interest in the history and potential for development of cross-border co-operation in health care in Ireland, whether from a social policy, political science or health management perspective.

## 2.1 Scope

TRAFFIC across the Irish border in health services can be the result of an emergency, where the condition concerned arises during a visit to the other jurisdiction, or on a planned basis with prior authorisation by the authority normally responsible for the individual's care. There is also a long-established practice of residents of the Republic of Ireland accessing care in Northern Ireland through the use of an "accommodation address". By its very nature such traffic is very difficult to quantify, but may be substantial. Patients paying privately for care also cross the border in both directions for elective surgery, for example hip replacements. Although the study covers the full range of publicly-funded emergency and elective services, the focus has been mainly on planned, pre-authorised treatment. Although, as indicated above, we have covered co-operation across the spectrum of health services, we have concentrated our attention on major strategic initiatives with the greatest potential for further development.

## 2.2 Data sources

The study drew upon three main sources. Semi-structured interviews using a schedule of questions (see Appendix 1) were conducted with a purposively selected sample of key informants, identified on account either of their position as stakeholders or of their ability to provide a specific perspective on the issues being examined (see Appendix 2). The interviews were transcribed in full and subjected to content analysis using a qualitative computer package.

Policy documents and, where possible, evaluative reports were also identified, drawing extensively on material identified by key informants (see Appendix 3). Finally, relevant published literature on topics such as the configuration of health services or cross-border care in Europe was identified from standard bibliographic databases.

## 2.3 Key tasks

One key task of the research was to identify areas of current co-operation and areas where co-operation has been attempted in the past. This was further explored by eliciting views and, importantly, any evidence about how useful the co-operation had been and also what further potential respondents perceived there to be. Copies of evaluation reports along with data on costs, numbers of patients treated, results of satisfaction surveys etc were requested, and a second key task was to examine these to identify any reliable evidence of effectiveness and cost-effectiveness. Because of its importance as the most significant existing cross-border network, there was a particular emphasis on the Co-operation



## Methods

and Working Together (CAWT) projects and we have drawn on the report of an evaluation of CAWT<sup>2</sup> undertaken by two of the authors of this report (Patricia Clarke and Jim Jamison) following a commission by the CAWT Management Board. Representatives of community/watchdog organisations such as the Health and Social Services Councils in Northern Ireland were also interviewed. In the course of the interviews the key informants were asked for their views about gaps in and barriers to co-operation across the range of health services, and how these might be overcome.

### 2.4 Hospital care

In relation to hospital services, the potential for cross-border flows exists at two levels. Over short distances, people living in the vicinity of the border can access services fairly readily in the other jurisdiction; more distally, those living throughout the area of one jurisdiction may travel for specialist care in the other jurisdiction. Statistical data known as 'hospital episodes' are routinely collected by the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland and the Economic and Social Research Institute (ESRI) in the Republic. These are computerised records giving demographic, administrative and basic clinical data in respect of each spell of inpatient treatment. Thus a third key task was to analyse these in conjunction with routinely available demographic data to map utilisation on both sides of the border and establish whether there was evidence of unmet need for such services.

### 2.5 Other levels of care

The potential for cross-border patient flows for primary and community care may be greater for those living close to the border. There is also likely to be scope for cross-border collaboration in relation to activities such as the planning and management of services, research and training/professional development. Although it was not possible to undertake a detailed examination of each of these, we have attempted to document the existing state of co-operation, make a judgement about how successful it has been, and suggest whether and how it could be built upon.

### 2.6 Economic dimension

Ultimately any proposals for changes in how health services are organised and delivered on the island of Ireland should be subject to economic appraisal. This would allow an assessment of the implications for costs, cost-effectiveness and/or access associated with greater co-operation. (It should be noted in this context that the "costs" concerned may include political and organisational changes as well as financial.) It must also be recognised in this context that what is

## Methods

considered to be a tolerable cost or an unacceptable level of service will depend heavily upon the observer's perspective. Another cost could be reduced local access to services because of the development of regional specialist centres - so while the quality of services may be improved, there is a trade-off with local access. The scope of the study has not permitted such a detailed appraisal, but it has been possible to incorporate a preliminary economic assessment of potential for co-operation.

### 2.7 Other key tasks

These were as follows:

- To examine potential barriers arising from the different legislative bases and entitlement provisions in the two jurisdictions, including the potential for, and the barriers to, co-operation across EU boundaries.
- To investigate the strength of apprehensions or concerns on the part of potential patients.
- To seek from those involved with pilot initiatives experiences of the strength of such obstacles, and to identify proven strategies for dealing with them.
- To consider possible ways of upgrading co-operation and making it more effective.
- To make a broad estimate of potential cost savings attendant on greater co-operation.

### 2.8 Study day

A North-South Health Services Study Day was held in November 2000 at which the preliminary findings of this study and the evaluation of CAWT were presented to over 50 senior managers and policy-makers from both jurisdictions. Those present were given the opportunity to discuss and elaborate on issues which had been identified throughout the interview series.





### 3.1 A comparative review of health systems and policy in Northern Ireland and the Republic of Ireland

THE purpose of this chapter is to place cross-border co-operation in health care in the context of local and national policy and the broader European context. This helps to set the scene for the following chapters, which explore the views of respondents involved in the study. It draws on a range of key documents in both jurisdictions to examine commonalities and differences in the principles underpinning health service planning and provision and to identify issues of common concern or references to the need for co-operation.

#### Health systems

A comprehensive range of health and personal social services in Northern Ireland are available largely free of charge on the same basis as in Great Britain. The NHS Reforms of the early 1990s led to the establishment of the public contract model<sup>3</sup> and separation of responsibility for planning and purchasing from the provision of health services. Overall policy, regional planning and resource allocation functions are exercised by the Department of Health, Social Services and Public Safety. There are four Health and Social Services Boards (the Eastern, Northern, Southern, and Western) which are responsible for assessing the needs of their populations and commissioning integrated health and social care from 19 providers, the Health and Social Services (HSS) Trusts. Many GP practices also have commissioning powers, although GP fundholding is to cease with effect from April 2002. There are four Health and Social Services Councils which provide oversight on behalf of consumers and the general public.

In contrast the Republic of Ireland has a mixed public/private health care system. About 35% of the population, in the lowest income groups, are eligible for the full range of services free of charge (Category I\*). The remainder (in Category II) pay directly for primary care services and have entitlement to a bed in a public ward of a hospital, subject to a *per diem* charge. Private insurers must offer policies on the basis of open enrolment, lifetime cover and community rating. 43% of the population are privately insured with VHI or BUPA to cover for co-payment expenses in ambulatory and in-patient care and for services provided in private hospitals. Health insurance premiums are tax deductible at the standard tax rate.

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\* Defined as "persons who are unable without due hardship to arrange general practitioner services for themselves and their dependants". The Health Boards fix income guidelines to help in deciding on applications for medical cards.



## The context for cross-border co-operation

Health care is administered through seven Health Boards, with both purchaser and provider functions, and the recently established Eastern Regional Health Authority (ERHA). The ERHA covers the more densely populated eastern region comprising counties Dublin, Wicklow and Kildare. Its responsibilities include strategic planning and commissioning and funding of services through service agreements with its three Area Health Boards, the voluntary hospitals and other voluntary agencies in the region. The Department of Health and Children is responsible for policy and overall service planning. The ERHA and the Health Boards serve populations of between 200,000 and 1.3 million; each has its own Chief Executive Officer, and their management boards comprise elected local representatives, a few ministerial nominees, and employee representatives.

Financing of the health system is mainly from public sources (about 80%); around 13% is financed through co-payments for services. The main share of public funding is raised by general taxation and a specific health contribution of 1.25% of gross income for all of the population except those in Category I.

There are 2,500 private beds in private hospitals and, of 12,300 acute beds in the public sector, 2,500 are designated for use by private patients.

### Comparisons

Despite the differences in structure and funding mechanisms, the two systems suffer from similar problems in the form of waiting lists, staff shortages particularly in nursing, and constant media scrutiny.

Although the Republic does not have a policy favouring concentration of hospital services, several respondents there were of the view that services were inefficient, with resources spread thinly across too many hospitals. A number of interviewees stated that the Irish system was four to six years behind the UK in relation to clinical audit, performance management, accountability and clinical governance. In the community, there were seen to be problems in that GPs and public health nurses did not work very closely together. However there was considerable optimism about the prospect of substantial additional resources being made available for health services over the next few years. Respondents in Northern Ireland also made reference to these plans for greater investment in the Republic, at times with more than a trace of envy.

### Service comparisons

Health and social services in both Northern Ireland and the Republic are integrated. When provision in the two jurisdictions is compared, Northern Ireland seems to have greater investment in primary/community care.

## The context for cross-border co-operation

Some recent comparative data (1999) are given in the following table:

Service per 1000 population	Northern Ireland	Republic of Ireland
Acute beds	3.1	3.1
All discharges	199.0	148.3
Day cases	66.5	64.5
A&E attendances	393.9	329.2
O-p attendances	848.5	531.9
Consultants	0.179	0.315
Total medical & dental staff	1.5	1.3
Nursing etc	8.7	7.5
Scientific, PAMs etc	2.4	2.0
All direct Health and Community Health Services care staff	12.5	10.8
Management & support staff	9.2	7.3
Total HCHS staff	21.7	18.1
GPs	0.63	0.45
Population/GP	1597	2202
Nursing home beds age >75	111.2	40.4 (est.)
Residential places age >75	55.3	6.9 (est.)
Total care home places age>75	166.5	47.3 (est.)
Home help recipients age >75	309.8	112.9
Meals recipients age >75	47.6	75.7

**Sources:** Department of Health and Children and  
Department of Health, Social Services and Public Safety

Compared with the Republic, Northern Ireland has (per capita):

- 38% more GPs
- 43% fewer consultants
- about the same number of acute beds
- over three times as many residential/nursing home beds
- nearly three times as much home help provision
- 63% as much meals on wheels provision.

### Review of policy documents

This section presents a review of relevant recent policy documents from the two jurisdictions. The purpose is to identify similarities and differences in policy, thinking, values and approaches with a view to identifying areas where there is potential for co-operation.



## The context for cross-border co-operation

### Republic of Ireland

#### *Shaping a healthier future: A strategy for effective healthcare in the 1990s. Department of Health (1994)*

The main theme of the 1994 health strategy document, issued by Mr Brendan Howlin, Minister for Health in the previous "rainbow coalition" in the Republic, was to reorientate the system towards improving the effectiveness of health and personal social services:

- prevention, treatment and care services were to be more clearly focused on improvements in health status and the quality of life - with increased emphasis on the appropriateness of care;
- management and organisational structures would provide more decision-making and accountability at regional level, allied to better performance measurement;
- there was to be greater sensitivity to the rights of consumers, responsiveness of services, equity and quality of service - and enabling providers to move in this direction.

Among the weaknesses identified in the system were the following:

- insufficient attention paid to tackling the causes of premature mortality;
- waiting times for services too long;
- inadequate linkages between complementary services;
- community-based services not yet well enough developed to substitute for institutional care;
- management and organisational structures needed to be updated.

The stated underlying principles are equity, accountability and quality of service. The health and personal social services are directed towards prevention, treatment and continuing care.

Themes in the new organisational structures include: separating policy from operational management; improving decision-making, information and evaluation; enhancing accountability; integrating services; and improving the effectiveness of representation of the interests of individuals within the structure. New roles were outlined for the Department and the Health Boards.

The strategy document also states that Regional Public Health Departments should be established to undertake research and surveillance, provide advice on preventative programmes, and participate in identifying national targets and indicators and in monitoring and evaluating the outcomes of health services.

## The context for cross-border co-operation

At the end of the document there is a section on the 'wider dimension' covering: the multi-sectoral dimension; the European Union dimension; the World Health Organisation dimension; and, ultimately, North/South co-operation. In this final paragraph it is stated that such co-operation is an important element and there are significant benefits in the area of joint purchasing and in the provision of services at a supra-regional level.

"Co-operation is also of obvious value in relation to joint approaches to health promotion. Important initiatives have been taken in this area in the fields of immunisation, lifestyle, alcohol programmes and AIDS. There is a continuing exchange of information on topics such as smoking, fitness and health, cancer education, cancer screening and mental health legislation. North/South co-operation was an important dimension to the celebration of the European Year of Older People. Apart from the above initiatives, which mainly centre on the Department of Health in the Republic of Ireland and the Department of Health and Social Services in Northern Ireland, there is also co-operation at the level of the individual health board. This is particularly the case with adjoining boards (the North-Eastern and North-Western Health Boards in the Republic, and the Southern and Western Health and Social Service Boards in Northern Ireland). The potential for further co-operation, both centrally and at board level, will be fully explored."  
(p75)

This statement is placed at the end of the four-year action plan, which was written in 1994. This suggests there should have been significant work undertaken on behalf of the Department to explore fully the potential for further co-operation, and this should have culminated in some sort of report by the end of 1998. This has not happened at national level although, as our findings indicate, the two 'border Boards' in the Republic of Ireland have been exploring the potential for co-operation through the medium of the CAWT initiative and have been involved in various initiatives in partnership with their Northern Ireland counterparts.

The other observation about this statement is that it is focused clearly on the potential benefits of co-operation on an all-Ireland basis. It does not refer to the disadvantage which, it is often maintained, the existence of the border creates for those living adjacent to it by virtue of their distance from facilities in their own jurisdiction (see *Chapter Four*). It also omits to mention any special initiatives that might be required to ensure that such people enjoy the same benefits from health services as others in the Republic of Ireland. In addition, no reference is made to the relationship between North and South in the main body of the report or of the impact of the border on health services and health status for those living in border areas. However, it does highlight issues such as inequalities in health and equity in the provision of services as key issues for the health strategy.

## The context for cross-border co-operation

### ***The National Health Promotion Strategy (2000-2005)***

This strategy outlines “the broad policy framework through which the strategic objectives aimed at promoting a holistic approach to health promotion can be advanced”. The strategy document begins by outlining the major determinants of health and speaks about the development of health promotion internationally and in Ireland. Cross-border co-operation is included in a section entitled “Irish Developments”. It is reported that over the preceding five years there had been “an excellent working relationship” between the Health Promotion Agency of Northern Ireland, the Health Promotion Unit (Department of Health and Children) in the Republic, and the regional health promotion departments in all health boards. This was supported in interviews with key players in the health promotion area. It is suggested that the explicit inclusion of health as an area for co-operation in the Good Friday Agreement provides an opportunity to develop a strategic approach to health promotion and primary care initiatives on an all-island basis. The strategy notes several joint initiatives that have been identified in the areas of research, the exchange of information on best practice, professional training and public information campaigns. The report goes on to state that:

“strengthening cross-border co-operation will ensure that meaningful and sustainable health promotion initiatives are developed on an all-island basis” (p15).

### ***Working for Health and Wellbeing: Strategy Statement 1998-2001. Department of Health and Children (1998)***

This strategy statement outlines the Department’s mission and high level and divisional objectives within the current environment of the health sector and its role with its ‘partners’ in planning and delivering health services. Key themes in the Department’s mission are: partnership and co-operation; protecting, promoting and restoring health and well-being; and effective planning, management and delivery of health and personal social services to achieve measurable health and social gain and provide the optimum return on resources. These themes are then reflected in the high level objectives, which emphasise partnership, strategic development, accountability, quality and effectiveness, and a customer service ethos. The statement also identifies the principal challenges facing health and personal social services, including:

- growing consumer demands and expectations;
- specific issues arising relating to food safety, environmental health, drug abuse, and the safety of blood products;
- the need to reduce waiting times;
- increasing complexity of services and the diversity of skills required to deliver them;
- meeting the demands of the expenditure review programme;

## The context for cross-border co-operation

- pressures on expenditure from medical technology;
- ethical issues such as reproductive medicine and equity in health outcomes;
- changing demographic profiles;
- pressure to expand the remit of health and personal social services;
- the need for close inter-sectoral co-operation to achieve health and social gain;
- the need to improve data systems, analysis, evaluation and performance measurement;
- public concern regarding child protection; and
- continuing pressure to distribute finite resources available in an equitable, cost-effective and efficient manner.

The strategy statement makes reference to several recent reforms in the health sector or public service generally that have significantly impacted on the health sector. Included is the Health (Amendment) (No.3) Act 1996, which it states has tackled some of the weaknesses of the system such as lack of clarity about the respective roles of the Department and the health boards, and accountability arrangements. It is also reported that health boards are working more closely together on issues of national importance. Two examples given are the establishment of the Health Services Employers Agency and the strengthening of arrangements for co-ordinated materials management across the system as a whole.

Although one of the divisional objectives for the Health Insurance and International Division is to “promote further North/South co-operation in health matters”, there is no explicit mention of cross-border co-operation. Nonetheless this report identifies similar issues to those facing health services in Northern Ireland, as outlined in the next section.

### **Northern Ireland**

#### ***Fit for the Future (1999)***

This is a consultation paper, issued by the then Minister, Mr John McFall MP, prior to the establishment of the devolved Executive. It outlines the options available to tailor the principles contained in the British Government’s vision for the NHS in England to take account of the integrated system of Health and Personal Social Services (HPSS) in Northern Ireland. In doing so, it states that the seven principles of the HPSS, to be built on, are:

- equity;
- the promotion of health and well being;
- the emphasis not just on treating people who are ill but improving health overall and reducing inequalities in health and well being;



## The context for cross-border co-operation

- quality;
- a local focus;
- partnership;
- efficiency;
- openness and accountability.

In the consultation paper, targets are set to demonstrate the Government's commitment to improving the HPSS, relating to:

- improving access to specialist cancer services;
- reducing hospital waiting lists;
- ensuring that patients and clients benefit from improvements in information and information technology.

Several specific objectives for change are outlined:

- More co-operation between HPSS organisations.
- Ending unfairness due to the internal market and GP Fundholding.
- Ending fragmentation in the present configuration of services.
- More local commissioning involving all GPs and other primary care providers.
- Ending inefficiency, instability and secrecy and reducing bureaucracy.

There is no specific mention of cross-border working or co-operation in this document.

### ***Investing for Health: A Consultation Paper (2000)***

This document outlines proposals for a "cross-cutting strategic approach to improving health and reducing health inequalities" for public consultation. The paper (the strategy) is prefaced by the First Minister and the Deputy First Minister. The approach adopted was cross-departmental, involving senior officials from each department working together as the Ministerial Group on Public Health. The introductory sections highlight that Northern Ireland has some of the worst health outcomes in Europe in terms of premature mortality and chronic pain and suffering, and that there is a clear relationship between health and social and economic inequalities. The report explores the determinants of health, how health in Northern Ireland compares with that of other countries, and the main causes of death.

When health comparisons are made with a number of other European countries, the Republic of Ireland is included as one of these, but in other cases comparisons are made with England and Scotland only. Nonetheless, the Republic of Ireland and Northern Ireland exhibit the same top three causes of premature mortality - cardiovascular disease, cancer and accidents. Suicide is also a particular issue for both jurisdictions. The report also includes some details of long-standing sickness and disability in Northern Ireland. Inequalities are explored in terms of

## The context for cross-border co-operation

differences in life expectancy by deprivation category and social class, inequalities that relate to children, such as differences in accident rates, and oral health and deprivation. Other areas explored are teenage pregnancy rates, older people living alone, differences between men and women and in ethnic minorities, and geographical differences (focusing on those council districts with the highest death rates).

The consultation paper identifies a set of principles and values to guide action. The strategy aims to improve health and reduce inequalities. The approach proposed goes beyond traditional approaches to health protection and health education and is not confined to the professional disciplines of public health medicine, health promotion and environmental health. Three values are identified to be adopted in the strategy:

- health is a fundamental human right;
- policy should actively pursue equity and social inclusion;
- individuals, interest groups and local communities should be involved fully in decision-making on matters relating to health.

Further on it is stated that the strategy will build on the value of equal rights to health, to health services and to health information.

The policy context outlined in the paper is interesting and positions the strategy within international developments (the work of WHO and *Health 21*), the EU Public Health Strategy, public health strategies in other countries and policy changes in Northern Ireland. Included in the section on public health strategies in other countries is the work going on in Scotland, Wales and England, and the Irish Government's *National Health Promotion Strategy (2000)*. In terms of policy developments in Northern Ireland, the report notes that much of the action outlined in the five priority areas identified in the Northern Ireland Executive's draft *Programme for Government* will contribute directly to strengthening the determinants of health. Other key developments in policy identified that will impact on health are:

- The *New Targeting Social Need* initiative aimed at tackling poverty and social inclusion;
- *Promoting Social Inclusion* - inter-departmental action on meeting the needs of ethnic minority groups, teenage pregnancy and parenthood, making public services more accessible and services for Travellers;
- *Equality schemes* - required of all departments and most public agencies. The report states that although these requirements are not aimed directly at inequalities in health status or the determinants of health, it is expected that they will complement and reinforce the strategy process by mainstreaming equality considerations across the public sector with an indirect impact on inequalities in health.



## The context for cross-border co-operation

- *The Human Rights Act* came into force in October 2000, requiring public authorities to respect the fundamental rights set out in the European Convention on Human Rights. While these include social, economic and educational rights, they do not include health as a human right.<sup>4</sup>
- *Key policy* areas impacting on health directly and contributing to creating conditions that make it easier for people to lead healthy lives are identified, including:
  - increasing commitment to tackling the root causes of ill-health through *interagency approaches* - such as the Ministerial Group on Public Health;
  - special initiatives already underway to *break down obstacles* - healthy cities, health action zones, etc;
  - *new initiatives* planned - after school clubs and healthy living centres;
  - the forthcoming *Regional Development Strategy* - the impact of spatial planning on health and wellbeing and promoting social, economic and environmental approaches to planning;
  - The Department of Environment is to lead the development of a *Strategy for Sustainable Development*, in collaboration with other departments, aimed at ensuring that development meets current needs but does not compromise the ability of future generations to meet their own needs.

While the paper's discussion of policy issues acknowledges that similar work is going on in the Republic of Ireland, it makes no reference to the benefits of co-operation, or to the needs of people living in the border regions. In addition, policy appears still to be very much influenced by current thinking and developments in England, Scotland and Wales.

The penultimate section of the report (section 11) outlines the potential for North/South, East/West and international joint working. The rationale outlined is that the societies involved face similar challenges and that it is sensible to share ideas and experiences, that resources can be pooled and that it is important to ensure that the services benefit from new discoveries. Views are invited on new ways to develop North/South, East/West and international partnerships. In the section on North/South co-operation it is stated that the Belfast Agreement provides new and special arrangements for co-operation and gives details of the North/South Ministerial Council (NSMC) and the establishment of the six cross-border implementation bodies, including the Food Safety Promotion Board.

It also outlines the work of the Institute of Public Health in Ireland in promoting North/South co-operation in public health and proposes that it should expand its role in a number of ways. The paper also notes that Co-operation and Working Together (CAWT), with financial support from the European Union, involves adjacent health boards working together across the border. It is also noted that European and other international funding is also being used to support voluntary and community groups in cross-border working. The authors anticipate that there may be scope to draw on funding from the new European Union 'Peace Two'

## The context for cross-border co-operation

Programme for specified cross-border purposes over the coming years. It also notes that another area to be addressed is the development of common data systems to allow meaningful comparisons to be made on a North/South basis.

### 3.2 The European dimension

Health care had a negligible role in the original European Communities, being limited primarily to occupational health services provided to workers in the coal, steel and atomic energy industries who lived in one country but worked in another. Since then successive treaties, most recently at Maastricht<sup>5</sup> and Amsterdam<sup>6</sup>, have placed health policy firmly on the European agenda. This has been reinforced by successive rulings of the European Court of Justice<sup>7</sup>. In the present context, the most important conclusions are that national rules that make provision of health services between countries more difficult than within a country are unlawful<sup>8</sup> and cost containment cannot be used to justify barriers to free movement of goods and services<sup>9</sup>.

Until recently, there was a consensus that scope for treatment received by EU citizens in another Member State, outside specific bilateral agreements, was limited. Provisions covered migrant workers (E106), emergency care for those temporarily abroad (E111) and pre-authorised cross-border care (E112). Two recent Court rulings have been interpreted by many commentators as extending the competence of European law in the field of health care and, specifically, constraining the ability of those paying for care to specify where that care is provided.<sup>10</sup> These two rulings established a precedent by which patients going abroad for treatment would not need prior authorisation and would be reimbursed in line with rates applying in their home country.

In the first case (Dekker)<sup>11</sup>, a health insurance fund in Luxembourg refused to reimburse one of its insureds for the cost of spectacles purchased in Belgium on a prescription issued by an optician in Luxembourg. The fund argued that they had the right to decide in advance<sup>12</sup> whether or not to approve the purchase, while the purchaser argued that this was a violation of the principle of free movement of goods. The Court ruled that refusal to reimburse a good purchased in another Member State was contrary to the provisions covering free movement of goods in the Treaty of European Union. In the second case (Kohl)<sup>13</sup>, another citizen of Luxembourg requested prior authorisation from the sickness fund for orthodontic treatment for his daughter in Germany. This was refused because the treatment was not urgent and care was available and adequate in Luxembourg. This view was initially upheld by a Luxembourg Court, arguing that national measures to control health expenditure must be taken into consideration. The European Court subsequently ruled that purely economic aims cannot overrule the fundamental principle of free movement of services.



## The context for cross-border co-operation

Although widely cited, these rulings are often misunderstood and it is necessary to study the wording of the judgements in detail. A key issue is whether health care is a “service” within the context of the treaties. Previous rulings in the field of education had implied that health care was unlikely to be considered a “service” where it is provided within the framework of a national system, although where it is privately provided and separate from the national system, as in the provision of abortion services by the private sector in the United Kingdom, it may be a service. This distinction is important because any action that makes provision of a service more difficult between member states than within them is illegal. Although formally this does not require that services provided in another country must be reimbursed by health funds, not reimbursing them will *de facto* make obtaining them more difficult. However in the Kohll case the Court ruled that an orthodontist worked “outside any hospital infrastructure” and so was considered to provide a service.

Since the Kohll ruling several other cases have been considered by the Court, although final judgements are still awaited. On the basis of preliminary opinions, however, it seems that the Kohll and Dekker rulings will be even more limited than was initially thought. The Court seems to be differentiating between those systems, such as that in Luxembourg, where services are paid for by the patient and then reimbursed, and others where the provider is paid directly by a health authority or insurer. It appears that rulings related to the former will not apply to the latter. Thus these rulings may have very limited applicability to the situation in Ireland.

### How much movement of patients takes place

The scale of cross-border flows within Europe is difficult to quantify. Some countries, especially those with funding based on general taxation such as the United Kingdom, do not have effective systems to measure it. In addition, several countries have bilateral agreements that predated European provisions, such as that between Ireland and the United Kingdom. A further problem arises from the use of ‘accommodation addresses’, where someone normally resident in one jurisdiction is recorded as living with friends or family in a different jurisdiction. As noted earlier, this is believed to be common in relation to the border between Ireland and Northern Ireland. Finally, much health care in countries other than where one is resident will be paid for directly or with reimbursement from travel insurance.

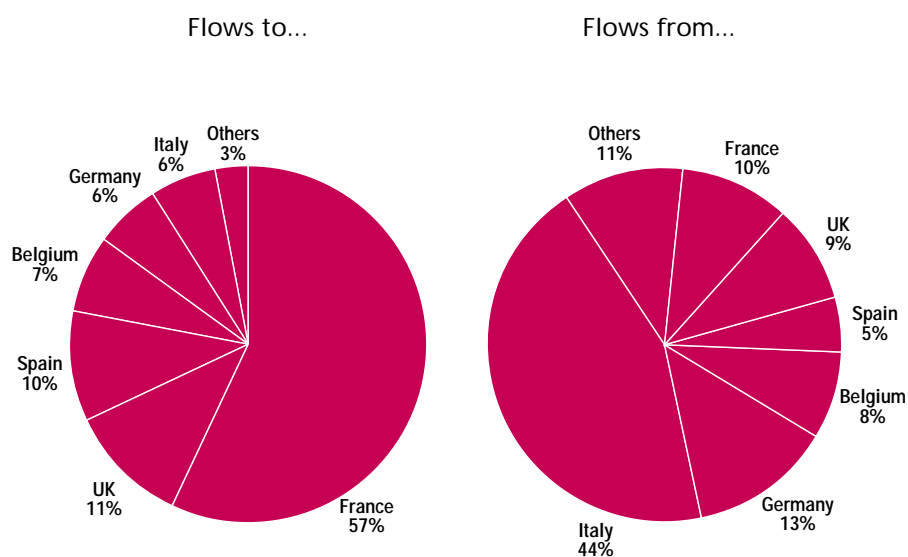
Data on officially recorded flows using the E111 and related systems have been assembled by Hermesse et al <sup>14</sup> (Figure 1). In summary, this shows that the largest flows within Europe are between France and Italy, an observation that has been attributed to the perceived poor quality of some health care in the latter country.

## The context for cross-border co-operation

However the overall volume of traffic is very low. Even in settings where geography and administrative factors facilitate movement, such as the Euregio Meuse-Rhine\*, patients from other countries were found to make up no more than 2% of the case load in any of the hospitals involved<sup>15</sup>. The factors either encouraging or inhibiting movement were largely self-evident, such as distance, language, the presence or absence of direct patient charges, and bureaucratic ease or lack thereof.

Cross-border movement of patients might be expected to be significant for those who live in one country but work in another, but even here it is relatively small. Calman and colleagues have explored the reasons for this in interviews with cross-border workers in France and Belgium.<sup>16</sup> Again the factors involved were intuitive. Incentives to travel included: lack of appropriate facilities in one's home state; ease of systems for reimbursement; referral by a doctor; reputation of providers; proximity of facilities to the workplace; and access to services at the workplace. Barriers included: satisfaction with facilities in one's home state; distance of facilities from the workplace; linguistic barriers; non-referral by doctors; and unfamiliarity with the health care or reimbursement system in the neighbouring state.

**Figure 1** Cross border flows of patients in Europe, E111 and E112 combined, 1988



\* This region brings together the German city of Aachen, the Dutch city of Maastricht, and the Belgian city of Liege.

## The context for cross-border co-operation

### Implications of European law

Although the EU Treaties do make provision for cross-border patient flows, in practice they have had relatively little impact on the delivery of health care elsewhere in Europe. Where movement does take place it has tended to be within informal or bilateral arrangements, and it has also been of low volume. Obviously some of the barriers that exist elsewhere, particularly differences in language, are not a problem in Ireland. Others, such as distance, clearly are.

A number of our interviewees had the impression that the Dekker and Kohll cases had important consequences for health care in Ireland. Our view is that European law, even after the recent Court rulings, would seem to have few direct implications for cross-border health care. There are, however, some indirect implications. For example, the provisions on mutual recognition of health professionals and specialist training mean that those working in the health services in both countries must meet certain standards, although arguably the close links between the British and Irish Royal Colleges and other professional bodies have ensured this anyway. Conversely, Ireland's membership of the European Monetary Union system means that the two currencies are no longer linked, introducing an element of risk into any contractual arrangements.

### 3.3 Summary

It would seem that despite the differences in structure, coverage and funding identified above, the two systems have common core principles and there are similar approaches to tackling issues. For example, in relation to health promotion, the two jurisdictions have similar poor population health outcomes when compared to the rest of the European Union. Their top causes of premature mortality are the same - cardiovascular disease, cancer, accidents and suicide. There are other similarities including risk factors and determinants of health. This is one area where according to several respondents a considerable amount of work has been carried out on a partnership basis.

The main differences include structures and funding, including universal coverage and the purchaser-provider split in Northern Ireland. Policy in Northern Ireland has also usually derived from a Department of Health (London) model.

While many interviewees looked to recent European Court judgements as a means of addressing the issues they face, it is unlikely that it will have much direct relevance. EU law has relatively few implications for cross-border health care in Ireland other than those in relation to mutual recognition of health professionals and specialist training. Perhaps the most important factor related to the EU is that Ireland's membership of the European Monetary Union system means that the two currencies are no longer fixed, introducing an element of risk into any contractual arrangements.

## The need for co-operation

### 4.1 Introduction

ONE of the key aims of this research was to explore the potential for cross-border co-operation in health services in terms of the practical benefits to patients in both jurisdictions, for health services as a whole, and in terms of economic and other considerations.

### 4.2 Views of respondents

The findings from interviews across the range of respondents were, first and foremost, that there is seen to be considerable advantage to be gained from cross-border co-operation in the planning and provision of health services. Many different reasons were given but it has been possible to distil a number of major themes which appear to have to a greater or lesser extent provided the basis for such views.

- *Addressing the relative disadvantage of border areas*  
Firstly, there is a widespread perception that the environs of the border are disadvantaged on account of their peripherality, sparsity of population and rurality, and that the region should benefit from positive discrimination in terms of funding to redress this disadvantage. This perception has been reinforced by the fact that it has been possible to use the argument about disadvantage to secure European Union funding to undertake work that would not have been funded outside the border region.
- *The border region as a natural geographic area*  
The argument is also commonly made that if the border had not been in existence for the past 80 years, health services would have developed in more appropriate ways around a "natural" area/population base. The fact that this has not happened has had damaging consequences, the most obvious example being north Donegal and particularly the Inishowen peninsula, which is part of the North Western Health Board (NWHB) area although it forms a natural geographical unit with the northern part of the Western Health and Social Services (WHSSB) area. Instead there now exist two separate catchment populations, neither of which (it is widely believed) has the critical volume required to justify locally delivered health services. Ultimately it should be possible for people in Donegal to use hospital services in Derry and Belfast in the same way as they would access those in the Republic, and to access local primary/community services in the other jurisdiction. Much private sector activity in this area operates without regard to the border.

## The need for co-operation

One respondent from a border Health Board in the Republic of Ireland envisaged a situation where his population might use services in Belfast in the same way as those in the South. This “seamless service” would mean that people in the border areas would no longer be disadvantaged. In his view Northern Ireland represents the best opportunity to secure/guarantee services for his population.

Other points made by respondents in support of this argument were:

- It is possible to access private treatment in the other jurisdiction, so why not public health services?
- Many specialist hospital services for populations in the North Eastern Health Board (NEHB) area and North Western Health Board (NWHB) area are located in Dublin, leaving local services underdeveloped. This brings opportunities to access those in Northern Ireland.
- From time to time there may be opportunities to purchase specific services in the other jurisdiction (eg MRI scanning) to reduce waiting lists.

- *Ireland as a geographical unit*

An extension of the second theme is that, although Northern Ireland and the Republic of Ireland may not have a large enough population on their own to support certain specialist supra-regional hospital services, there may be a sufficient population on the island as a whole to sustain such services.

- *Threats to health do not respect boundaries*

A number of respondents made the point that as air and water do not respect political boundaries there is an obvious need for public health co-operation, for example in relation to preventing the spread of communicable diseases. Equally because of genetic and lifestyle similarities, the populations on the two sides of the border are similarly predisposed to non-communicable diseases, in particular cancer and cardio-vascular disease. It should be possible to combat such diseases more effectively on an all-Ireland basis.

- *Speed and distance*

If an accident occurs close to the border it may make sense to take casualties to the nearest hospital with an accident and emergency unit, whether or not it is in the same jurisdiction.

- *Exchanging good practice*

There was thought to be considerable scope for joint training schemes, professional contact and beneficial sharing of good practice both in managerial and professional terms. Contact is already being developed through meetings between chief officers and others. A related argument derives from the very existence of two separate but adjoining health systems

## The need for co-operation

on the island. This gives rise to the expectation that there may be much to be gained from the sharing of ideas and learning, in particular in relation to strategies to enhance quality. Inevitably, because of differences in policy and funding levels, services are at different stages of development in the two health systems, and it may make sense to extend coverage of the more developed service to the adjoining jurisdiction rather than to wait for indigenous development to occur. One example of this is the breast cancer screening programme which is much more advanced in the North, and for some Southern patients it is also more geographically convenient to avail of services in Northern Ireland.

There exist then several distinct philosophical bases for cross-border co-operation in health services. While it could reasonably be said that this has not led to any major conflict to date, as future opportunities for co-operation are identified it would be beneficial to have greater clarity about their respective importance. We will return to examine these broad themes later in the report.

### 4.3 Unmet need in border areas

It has been suggested that people living in the vicinity of the border are materially disadvantaged on account of low levels of economic activity, rurality and geographical isolation. A comprehensive analysis of spatial deprivation in Ireland<sup>17</sup>, undertaken by a cross-border team of researchers and drawing on previous work in both jurisdictions<sup>18 19</sup>, lends weight to this view, with deprivation in border areas particularly evident with regard to age dependency and unemployment. As need for health services is highly correlated with material deprivation, it is likely that people living in border areas will have higher than average health needs. A study of perinatal mortality<sup>20</sup> also suggested higher mortality rates in border areas.

In the absence of readily available indicators of morbidity at population level, a widely used proxy is the Standardised Mortality Ratio, or SMR. SMRs are the ratio of actual to expected mortality in populations once differences in their age and sex structure have been corrected for. Tables 4.1 and 4.2 show SMRs for Northern Ireland and the Republic respectively. It should be noted that because different standard populations have been used these are not comparable across the two jurisdictions.



## The need for co-operation

**Table 4.1** Standardised mortality ratios by district council, N Ireland (1988-94)

<b>Derry</b>	112.9	Antrim	98.2
<b>Strabane</b>	108.0	Larne	98.0
<b>Dungannon</b>	107.5	Coleraine	97.2
Belfast	105.8	Ballymena	96.0
<b>Armagh</b>	104.7	Banbridge	95.8
<b>Limavady</b>	104.5	Newtownabbey	95.4
Moyle	102.6	Ballymoney	95.1
<b>Newry and Mourne</b>	102.3	Ards	94.4
<b>Omagh</b>	101.9	Castlereagh	92.6
<b>Craigavon</b>	101.7	Lisburn	92.3
<b>Fermanagh</b>	101.5	Cookstown	91.1
Down	101.2	Magherafelt	90.3
Carrickfergus	99.7	North Down	87.1

**Source:** Northern Ireland Statistics and Research Agency

**Table 4.2** Standardised mortality ratios by health board, Republic of Ireland, 1993-97

Eastern	97.7
Midland	103.8
Mid-Western	102.6
<b>North-Eastern</b>	97.9
<b>North-Western</b>	99.5
South-Eastern	102.2
Southern	103.4
Western	97.0

**Source:** Age-standardised mortality rates from Central Statistics Office, Dublin

In Northern Ireland the district councils along the border (Derry, Strabane, Omagh, Fermanagh, Dungannon, Armagh, and Newry and Mourne) all have mortality rates that are higher than average. All but one of the other councils making up the Western and Southern HSS Boards (Limavady and Craigavon, the exception being Banbridge) also have higher than average rates. However the two border boards in the Republic (the North Eastern and North Western) have lower than average rates.

## The need for co-operation

It is also held that people in border areas are disadvantaged in terms of their access to and utilisation of health services. In an attempt to explore this in relation to hospital services, we examined data on acute hospitalisation rates (inpatient and day cases) by health board of residence. These were supplied by the Regional Information Branch, Department of Health, Social Services and Public Safety and the Information Management Unit, Department of Health and Children. The rates were age-standardised using the European Standard Population. Cases with a psychiatric illness or pregnancy-related diagnosis were excluded. The information is presented in Table 4.3.

**Table 4.3** Standardised hospitalisation rates by health board of residence (per 1,000 resident population)

<b>Northern Ireland (HSS Boards) 1998-99</b>	
Eastern	203.1
Northern	199.8
Southern	207.7
Western	209.5
<b>Average Northern Ireland</b>	<b>204.5</b>
<b>Republic of Ireland (health boards) 1998</b>	
Eastern	170.2
Midland	222.5
Mid-Western	179.4
North-Eastern	214.4
North-Western	212.4
South-Eastern	208.3
Southern	184.9
Western	198.0
<b>Average Republic of Ireland</b>	<b>189.1</b>

Comparisons **between** Northern Ireland and the Republic should be treated with caution because of the possibility of differences in coverage and definitions. For that reason we will concentrate on differences **within** the two jurisdictions. The first thing to be noted is that the variability in hospitalisation rates is much less within Northern Ireland than in the Republic. This may be because the operation of a capitation-based funding formula in the former jurisdiction, allied with the fact that HSS Boards are funded for the services consumed by their populations rather than for the services they provide, has brought about a greater degree of uniformity in provision and utilisation.



## The need for co-operation

*Prima facie* there is no evidence from these data of under-utilisation of acute hospital services on the part of populations close to the border in either jurisdiction. If anything, utilisation in the Southern and Western Boards in Northern Ireland and the North Eastern and North Western Boards in the Republic of Ireland is higher than in other Boards. However these figures do not take account of differences in population need (other than those represented by differences in the age structure of the population).

No data exist on the relationship between population characteristics and need for hospital services in the Republic of Ireland. However in Northern Ireland funding for acute hospital services is distributed across the four health boards using a formula<sup>21</sup> that relates need to utilisation at small area level. It is possible to use this formula to weight the boards' populations to reflect their relative need for acute hospital services. This produces board-specific hospitalisation rates that are needs-adjusted as well as being age-standardised. The results are shown in Table 4.4.

**Table 4.4** Standardised and needs-adjusted hospitalisation rates by HSS board of residence in Northern Ireland (per 1,000 resident population)

Northern Ireland (HSS Boards) 1998-99	
Eastern	204.4
Northern	207.1
Southern	203.5
Western	200.4
<b>Average Northern Ireland</b>	<b>204.5</b>

The Western and Southern Board populations are now shown to have slightly less hospital utilisation (relative to Northern Ireland as a whole) than the needs of their population would indicate. Although the differences are marginal and may simply be attributable to the rate at which those boards are moving towards their capitation share of overall resources, they may nevertheless merit further investigation to see whether the existence of the border (or the distance from facilities in Belfast) is restricting access to and suppressing utilisation of services.

In the absence of a formula relating population characteristics to hospital utilisation in the Republic of Ireland it is not possible to be definitive about whether uptake of hospital services in the border boards is equitable. It is also not possible to say whether there are particular problems of unmet need for community and other non-acute services in border areas.

## The need for co-operation

### 4.4 Conclusion

Interviewees saw considerable advantage to be gained from cross-border co-operation in health services. We have identified a number of major themes running through our respondents' views.

Comparative analyses of mortality and utilisation data have failed to confirm that there are particular problems of unmet need for hospital services in border areas. However it should be noted that there is the possibility that needs are being met at additional cost to the patient, for example in terms of travel to hospital.





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## 5.1 Introduction

MOST health systems aim to improve the health of their populations, and this is identified as a key goal for health systems by the WHO in its 2000 World Health Report. In Ireland this applies to the two Departments (and also to the CAWT organisation). However in practice success in this regard is very difficult to establish. This is because the relationship between health status and the provision or uptake of health care is extremely complex and poorly understood. The degree to which an individual's recovery or lack of it can be attributed to the treatment he or she receives can be difficult to ascertain. Similarly, the extent to which the health of a population can be ascribed to the health care system they use as distinct from biological endowments, lifestyle or living standards is often unclear without resort to complex epidemiological analysis and even then the results are subject to many caveats. The corollary of this is that production relationships in health care should not be viewed as deterministic. Estimated functions (even those estimated on the basis of accurate data) may have low predictive power. By the same token, relationships observed in different contexts may give apparently conflicting results and thus an ambiguous impression of underlying relationships - at what level of provision is outcome optimised, at what level of operations are scale economies exhausted, and so on. It is important that these facts be borne in mind in any investigation of the relationship between health and health care and in any review of such investigations conducted by others.

It is also important to recall that cross-border co-operation can take a variety of forms. This can include greater provision for information exchange, joint training, mutual recognition of professional qualifications, arrangements for insurance coverage and harmonisation of policies. All of these may well bring tangible benefits to populations in the two jurisdictions. In as much as none of these is likely to affect the location of services, however, they are unlikely to encounter the same degree of opposition as co-operation aimed at improving efficiency that does involve the rationalisation of service provision. Similarly, it is unlikely that they will be as costly to effect as (say) the relocation of hospital services from one location to another or even cross-border contracting. Because of this, it is unlikely that the benefits from co-operation of the types listed need be as demonstrable nor as closely scrutinised as that for rationalisation of services to convince policy makers of their merit. In light of this it is appropriate to concentrate in the following discussion on evidence relating to service rationalisation.

## 5.2 The issues

Cross border co-operation presents the opportunity to concentrate or rationalise services, or more formally in economic terms, to adjust the ratio of care centres to care users. This can be achieved in three ways:



## The economics of cross border co-operation

- by reducing the number of discrete patient populations that use existing service providers i.e. amalgamating patient populations and thus increasing the number of potential patients for existing care centres;
- by reducing the number of care centres for existing patient populations i.e. concentrating service provision on fewer sites and thus increasing the number of potential users for each of those that remain; or
- by a combination of reducing the number of user populations and the number of service providers.

Adjusting this ratio may facilitate

- the removal of any excess capacity in service provision in the two jurisdictions;
- the exploitation of economies of scale and scope in the use of existing technology;
- the deployment of new technologies in an all-Ireland context that would be uneconomic to deploy independently in either one;
- the development of increased proficiency among those experiencing greater patient throughputs, and thus increased effectiveness;
- the creation of a more rewarding environment for practitioners and thus improvements to staff morale, retention and recruitment.

Concentrating services in this way may, however, bring adverse effects. These might include:

- reduced access, utilisation and hence effectiveness of care, especially for economically disadvantaged groups;
- increased monopoly power among remaining service providers, with adverse consequences for their efficiency;
- the generation of transaction costs;
- contradiction of broader policy objectives such as rural development, which themselves may be related to health.

There is some literature regarding issues such as economies of scale, access and effectiveness. However, for other issues (for example, staff recruitment and retention, consistency with broader policy objectives) the literature could generously be described as emerging. While there is a literature on monopoly power, transaction costs, the removal of excess capacity and the deployment of new technology, its findings are very much context specific. What can be inferred from these for the Irish situation is unclear and no discussion of these is planned. In what follows, literature that may shed light on the subject of Irish cross border co-operation is discussed.

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### 5.3 Economies of scale and scope

Economies of scale refer to situations in which cost per unit output falls as the scale of activity increases. They are associated with what economists refer to as the “long run” i.e. the time period over which all factors of production are variable. Examples of scale economies may include the ability to spread administrative costs over a larger number of cases, the ability to hold proportionately less services in reserve and still meet unusual peaks in demand, and the ability to obtain more favourable terms through bulk buying. Economies of scope refer to situations in which cost per unit of output is lower where services are produced together than when they are produced separately. Examples of this might include situations where equipment or expertise is shared between services, as in maternity and neonatal care.

While over 100 studies have been published relating to economies of scale or scope in health care provision, the quality of these has often been poor.<sup>22</sup> In consequence inferences drawn from them must be treated with caution. A consensus appears to exist that economies of scale are exploited at quite modest levels of operation (around 100 to 200 beds)<sup>23,24,25,26,27</sup>, followed by a plateau (up to around 600 beds)<sup>28,29,30</sup> and subsequent diseconomies at the over 600 bed level. This is supported by a number of studies using a variety of techniques. It is unclear from the reported analyses what monies may arise from concentration of services in units of “optimal size”. What effect (if any) such concentration may have on broader policy objectives is also unknown. That any moves towards concentration of services should coincide with opportunities for new capital projects or service upgrades (as a way of minimising the disruptive effects of closing units) has been recommended.<sup>31</sup>

No reliable evidence as to the existence or nature of economies of scope is considered to exist. The consensus among those working in this area is that, given that scale economies are exploited at quite low levels of operation, the burden of proof as to the advantages of any concentration should lie with those proposing this change. Where there is clear evidence of excess capacity this should be less problematic.

### 5.4 Access to care and concentration of services

Concentrating service provision on fewer sites brings with it the risk of adversely affecting patient access.<sup>32</sup> There are three ways in which this may occur. First, as distance increases so the opportunity cost of consulting the primary carer (usually the GP) increases and with it the willingness of the patient to do so may decline. (This may be particularly evident among the economically disadvantaged and those in rural areas where the transport infrastructure is poor.) This reduces access to the primary carer and reduces the probability of timely referral to



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the secondary carer. Second, as distance to secondary care facilities from the GP increases, so the willingness of the primary carer to refer the patient on may decrease - the GP acting as the agent of the patient and responding to perceived increased costs of travel to secondary care as they imagine the patient would. Third, as distance to the secondary care provider increases, so the willingness of the patient to comply with the GP referral may decline, again related to the opportunity costs of access.

Evidence of distance-decay in respect of primary care, accident and emergency and screening services does exist<sup>33,34,35</sup>, with the study of emergency care having been conducted in Northern Ireland. For primary care even apparently quite small distances can be a major deterrent. In one study, for example, women living over two miles from their GP were found not to consult at all,<sup>34</sup> while in other studies those living more than half a mile away tended to consult much less.<sup>33</sup> Where the perceived benefits of care are less (e.g. in respect of screening services as opposed to curative and palliative services)<sup>36</sup>, or the social costs of access are higher (e.g. not having access to a same sex practitioner)<sup>37</sup>, utilisation rates have also been found to be adversely affected. Among those using primary care services it has also been found that those living at greater distance tend to present later and with more serious symptoms than those living closer to health care facilities.<sup>38</sup> Similarly, in relation to Accident and Emergency and screening services, a reduction in utilisation associated with decreased access has been observed.<sup>35</sup>

In secondary care similar distance-decay effects have been observed, though the relationship does vary between services. For example, in relation to CABG and heart disease some studies have found no evidence of distance decay.<sup>39</sup> That where decay is observed it is associated with a reluctance to refer as well as a reluctance to seek referral has also been established. A small number of studies in respect of specific services report a relationship between distance and mortality.

### 5.5 Volume of activity and health care quality

A key issue in any discussion of service centralisation associated with opportunities for greater co-operation concerns the relationship between patient volume and outcome.<sup>22</sup> The arguments of many policy makers regarding the concentration of services - which greater co-operation could facilitate - are based upon a supposed link between volume and proficiency and volume and training.

Establishing a link between patient volume and outcome is complicated by the need to control for confounding variables. For example, as hospital size increases so too may the complexity of the cases it deals with. As volume increases so average outcomes may appear to deteriorate because of this. Outcomes attained must therefore be adjusted for any case mix effect if the relationship between outcome and volume is to be accurately assessed. Similarly, the socio-economic

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characteristics of the referred population may impact upon outcome and these should also be controlled for. For example, the two-year mortality rate for a given procedure may differ quite widely depending on the circumstances into which patients are discharged (and indeed the 30 day mortality rate reflects more the discharge policy of the hospital than the quality of the care it provides). It must also be conceded that in many cases outcomes other than death may be required to measure outcome accurately.

Bearing these major caveats in mind, there is some evidence - where case mix has been accounted for - that higher volume hospitals have superior outcomes for certain procedures than lower volume ones. What constitutes high and low here unfortunately varies between procedures, thus complicating the task of making general statements about volume and outcome. For CABG, paediatric heart surgery, intestinal operations and neonatal intensive care, among others, evidence of a volume-outcome relationship was found to exist.<sup>22</sup> For other services, for example adult intensive care, trauma care (including that of a tertiary trauma unit dealing with injuries incurred with blunt instruments) and stomach cancer, among others, evidence supporting such a relationship was not found.<sup>22</sup> Moreover the direction of causality is not clear from those studies where a positive correlation was found. Thus, whether higher volume units give better outcomes or better outcome units attract more work is not clear.

There may be specialties or procedures where neither Northern Ireland nor the Republic has sufficient population on its own to provide a 'critical mass' that would justify the maintenance of a service (on either economic or clinical grounds), but where one could be justified for the island as a whole. This is likely to apply particularly to organ transplantation services.

The British Transplant Society has recommended that **renal transplantation units** should generally serve a population of at least 2 million. This would imply that Northern Ireland alone would be unable to sustain a transplant centre (though one is located at the Belfast City Hospital). On an all-Ireland basis this is an area where co-operation could sustain more than one unit effectively. A Working Party to Review Organ Transplantation recommended in January 1999 that the Belfast unit should explore links with Donegal to expand its population base.

In relation to **liver transplantation**, the British Transplant Service has recommended a minimum of 50 transplants per year in a unit for it to be cost-effective and for skills to be maintained. Currently no unit in Northern Ireland undertakes this volume of work: there are around 670 transplants in the United Kingdom annually. It is unlikely that there would be sufficient demand except on an all-Ireland basis to sustain this volume of work.



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Only 31 **pancreas transplants** are performed annually in the United Kingdom. These are often as part of a multiple organ transplant, performed within renal transplant units. It is unlikely that Ireland could provide adequate throughput to justify this service.

There are nine units carrying out **intra-thoracic transplantation** (heart/heart and lung) in Great Britain. A total of 266 heart, 45 heart and lung and 103 lung transplants were undertaken in 1997. No guidance on recommended throughput has been given but on a population basis there might just be adequate workload for a unit serving the whole of Ireland.

For **paediatric transplantation**, the overall volume in the United Kingdom is small and activity is concentrated largely at Great Ormond Street. It is unlikely that even on an all-Ireland basis adequate throughput would be generated to sustain a unit.

Finally, a report on **treatment for cleft lip/palate** was completed in 1998 and may, in consequence, be slightly out of date. At that time there were 57 UK centres providing services in this area, one of which was at the Royal Group of Hospitals in Belfast. The study group recommended that services be concentrated on 8-15 sites for the UK as a whole. Based on their criteria there would not be a centre located in Northern Ireland. On an all-Ireland basis there may however be sufficient workload to warrant a centre.

A second report on **specialist services** detailed what these are and where they are provided. By definition these are rare diseases/illnesses. None of the designated units are located in Northern Ireland and even on an all-Ireland basis it seems unlikely - no actual criteria are given - that there would be sufficient throughput based on current technologies to warrant the establishment of a unit.

### 5.6 Summary

Cross-border co-operation provides an opportunity to enhance the services provided to populations either in the vicinity of the border, or more widely by increasing 'critical mass' to justify concentration. Evidence that this will produce benefits attendant on exploitation of economies of scale in the acute sector is not strong. Economies appear to be exhausted at quite low levels of activity (around 200 beds). What savings might be associated with moving toward this level of activity are unclear. Were this to provide a premise for centralisation, it should be counterbalanced by evidence of decay in utilisation of a service as the distance from it increases. Such evidence relates to primary care as well as secondary care of a diagnostic and screening nature. The relationship has been noted as stronger among those in rural communities and may be particularly strong among the economically disadvantaged. Evidence of a relationship between volume and outcome is mixed. The argument that services must be centralised in the interests

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of quality - given opportunities for more imaginative patterns of service delivery and the observed distance-decay problem - is not supported. However where excess capacity is clearly evident on both sides of the border, rationalisation may improve effectiveness, reduce costs and not necessarily adversely affect access.

The above discussion has focused on the expensive acute hospital sector. It should be noted that there are many other areas where beneficial co-operation may be possible at little cost and with major potential benefits. These include areas of information sharing, issuing of common policy statements and health promotion initiatives to maximise their effect, and the joint training of staff.





## Current and past co-operation

### 6.1 Introduction

HAVING outlined the case for cross-border co-operation in Chapter Four and explored the economic issues in Chapter Five, we now trace the development of co-operation initiatives over recent years. The information in this chapter has been derived from the interviews and from documentary material. A number of key events in the development of closer working between Ministers and health service managers North and South are discussed and several types of cross-border co-operation are identified, including:

- purchasing of services from the other jurisdiction
- joint service development
- public health and health promotion
- co-operation in training/professional development
- research and policy work.

### 6.2 History of co-operation

Cross-border co-operation in the health field has actually existed for many years and, in some cases, pre-dates partition. The main bodies concerned with specialist medical training operate on an all-Ireland basis: the Royal College of Physicians of Ireland and the Royal College of Surgeons of Ireland. In recent years both Royal Colleges have had presidents from Northern Ireland.

At a political level, developments in cross-border co-operation started after the Sunningdale Agreement in 1973. There was however very little progress until the 1985 Anglo-Irish Agreement, since when there have been regular bilateral ministerial/ departmental meetings to discuss the potential for co-operation. Developments at a political level have been complemented by efforts locally and these are encouraged by both governments.

As far as the provision of services is concerned, it was reported to us that the implementation of the NHS Reforms in Northern Ireland from 1993 had brought about considerable changes in attitudes, not least on the part of the new HSS Trusts. Whereas prior to 1993 it was possible to access services informally in the other jurisdiction, arrangements then became much more formal with treatment having to be provided under contract or by means of an 'extra-contractual referral'.

On the other hand, the implementation of the reforms and the emergence of the purchaser-provider split brought with it new opportunities for cross-border co-operation. Among these were a number of intermittent contracting initiatives: for example in the mid-1990s the Royal Group of Hospitals in Belfast entered into an arrangement with the Southern Health Board in the Republic



## Current and past co-operation

of Ireland to provide hip replacements in order to reduce the numbers waiting for surgery. For a variety of reasons, including distance and apprehensions about security, such initiatives have only been partly successful and none has developed into a continuing arrangement.

Prior to the NHS Reforms the structure and organisation of services were similar North and South, with health boards responsible for both commissioning and provision. Implementation of the reforms led to divergence in the organisation and delivery of services. We were told that at that time health service managers in Northern Ireland had relayed their experiences and this had informed policy decisions in the Republic of Ireland.

Other prime examples of co-operation in the mid to late 1990s included the provision of emergency assistance by health professionals from the Republic, the most recent example of which was following the bombing at Omagh in 1998.

### **Good Friday Agreement**

The first formal government commitment to work towards specific objectives in relation to cross-border co-operation was in the Good Friday Agreement of 1998. This included provision for the establishment of a North-South "Implementation Body" in the health field, the Food Safety Promotion Board (FSPB). The FSPB was formally launched at a bilateral meeting on 3 November 2000. It has the following functions:

- promotion of food safety
- research into food safety
- communication of food alerts
- surveillance of foodborne diseases
- promotion of scientific co-operation and linkages between laboratories
- development of cost-effective facilities for specialist laboratory testing.

The body is located in Cork. One of its first initiatives is an all-Ireland advertising campaign on the importance of food safety using television, direct mail and in-store promotions.

The Agreement also recognised health as one of six fields for co-operation to be overseen by the North-South Ministerial Council (NSMC). Five specific areas for co-operation were identified: accident and emergency services, major emergency planning, cancer research, health promotion and high technology equipment. Although any further proposed areas for development through this channel would require to be agreed by the North-South Ministerial Council as a whole, we were informed that co-operation is being discussed in other areas outside the NSMC format. (Examples of this include the development of child abuse guidelines, research, meetings between the Chief Medical Officers and Chief

## Current and past co-operation

Nursing Officers and the Institute of Public Health.) Our interviewees advised us of progress to date in relation to the five specific areas for co-operation as follows:

### **Accident and Emergency Services**

The two Departments are interpreting accident and emergency services very broadly: unusually, the term is being taken to cover all acute hospital services. Following the bilateral meeting on 3 November 2000, the CAWT organisation was to be asked to make further proposals for developing local collaborative projects. A Regional Hospital Services Group has been asked to “scope” arrangements for co-operation in relation to renal transplantation and radiotherapy services.

### **Ambulance Services, Emergency Planning, High Technology Equipment**

We were informed that joint working groups were being formed in each of these areas. The Department of Health, Social Services and Public Safety has not publicly disclosed the membership of these groups.

### **Health Promotion**

A joint information/publicity campaign on folic acid by the Health Promotion Agency in Northern Ireland and the Health Promotion Group in the Republic was launched at the bilateral Ministerial meeting in November 2000.

### **Progress reported at Ministerial meetings**

We examined press releases from the joint Ministerial meetings held since February 1998 and a summary is included in Appendix 4.

## **6.3 Co-operation and Working Together (CAWT)**

The CAWT\* initiative began in 1992 with the Ballyconnell Agreement between the North Eastern and North Western Health Boards (NEHB and NWHB) in the Republic of Ireland and the Southern and Western Health and Social Services Boards (SHSSB and WHSSB) in Northern Ireland. Recognising that these four boards embrace the whole of the land boundary between the Republic of Ireland and Northern Ireland and that they share a common demographic profile and challenges, several primary objectives were agreed. These were aimed at “identifying and exploiting opportunities to work together to improve the health and social well-being of their resident population”. In 1998 following the implementation of the NHS Reforms in Northern

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\*Co-operation And Working Together for Health Gain and Social Well-being.



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Ireland, this agreement was reviewed to include the seven newly formed trusts in the border region. The CAWT process was endorsed officially by both Ministers and both Departments of Health. In the minutes of the joint ministerial meetings held in February 1998 and in May 1999 the two Ministers are reported as having examined the current CAWT strategy and expressed their appreciation for the valuable work being undertaken at local level. They are also reported as requesting to be kept regularly advised about future activities.

The CAWT Management Board comprises the four Board chief executives, the four Board chairmen, a Trust chief executive and a Trust chairman from Northern Ireland. The two key linkage mechanisms are the Secretariat and the Central Resource Unit, which support and co-ordinate the work of CAWT from the management board through to the sub-groups. There is a nominated Secretariat person with responsibility for CAWT within each health board. The current support for the Central Resource Unit, the main infrastructure of CAWT, comes from the EU Peace and Reconciliation Programme, with the individual boards now beginning to absorb the cost of their own Secretariat officer. There is also a Finance Forum which comprises the Board chief finance officers, with facilitation by a part-time finance officer. There are currently five part-time posts and 2 full-time posts within CAWT.

A strategic plan, *CAWT: The Bridge to the Future. Strategic Plan 1998 - 2001*, was constructed following a workshop of the Management Board and the Secretariat which identified a strategic context and agenda for CAWT into the Millennium. A revised CAWT strategy is now being developed.

A number of projects, including principally the Primary Care Project, have also attracted EU Peace and Reconciliation funding. Between October 1996 and December 2000 CAWT attracted over £5 million in funding under Measures 3.3a and 3.3b (Co-operation between Public Bodies) of this programme. Details of funding by project (from both EU and board sources) are given in Appendix 5.

Recently, a new scheme has been introduced, the "Creative Cross Border Project", involving the allocation of small amounts of money (up to £3000) to stimulate cross-border work. Ten small projects have been funded in such areas as mental health, elderly, health promotion, physical disability, learning disability, family and child care and primary care.

CAWT functions primarily through eight subgroups: health promotion, human resources, information technology, family and child care, learning disabilities, acute services, public health and primary care. Some projects are bilateral and some involve three or all four Health Boards. Progress in a subgroup often depends on the motivation and energy of individuals working within it. The Secretariat meets once or twice a month and there are also meetings with representatives of the subgroups all together. The work of each subgroup as outlined in CAWT annual reports (1997, 1998 and 1999) is here considered in turn.

## Current and past co-operation

### Health Promotion Sub-group

The CAWT annual reports refer to considerable development in the work of the health promotion subgroup over the period documented. In 1997 terms of reference were agreed and these were followed up in 1998 with an operational plan. In addition the group was extended in 1997 to reflect changing arrangements in Northern Ireland and the development of the purchaser/provider split.

There was a focus on three particular themes after 1997: mental health promotion, accident prevention and drug education/awareness for young people. In 1997 it was reported that a *joint mental health promotion* conference had been held, opened by the two Ministers, and that work was also continuing in relation to evidence-based research. EU Peace and Reconciliation funding was secured in partnership with the Mental Health Association of Ireland and the Northern Ireland Mental Health Association for a two-year action research project aimed at encouraging positive mental health and reducing the suicide rate amongst men aged 15-30 years in the Finn/Derg valley area on the Donegal-Tyrone border, entitled 'Men in Crisis'. In 1998 it was reported that phase one, comprising a literature review and focus groups, was underway. In 1999 it was reported that, drawing on the findings of phase one, work had progressed in several areas including:

- setting up a mental health module for fourth year pupils at two post primary schools
- providing feedback of the findings to the community through an information meeting, information leaflets and a press release.

A *drug awareness project* began in 1998 as a one-year initiative to explore the information and educational needs of young people (11-13 years) and to develop materials to meet these needs. This was funded in the Republic of Ireland through EU Peace and Reconciliation monies but disseminated throughout the CAWT region. A key feature of the project was consultation through a methodology known as "Planning for Real", involving detailed local level consultation with young people, their parents, teachers, voluntary organisations and service providers. It was reported that the analysis would be used to inform the development of drug education programmes in all four health board areas. This project is not mentioned in the 1999 annual report.

A further initiative, known as the *Community Childhood Accident Prevention Project*, was aimed at home accident prevention through the involvement of trained peer educators with families of children under five years living in areas of disadvantage in all four Boards. Phase One of this project began in Donegal and Derry in 1995 and a survey in 1998 reportedly found parents very satisfied with it. The project was extended to Drogheda and Newry (Phase Two) in 1997 and



## Current and past co-operation

an evaluation commenced in May 1999. It is reported that phase two was well received by those working in the area of prevention. It was intended that the project would be mainstreamed into health promotion after 1999. The findings of an internal evaluation of this project recorded significant improvements in knowledge, attitude and reported behaviour at the Donegal site.

Other developments in health promotion include the following:

- *Prescribed drug compliance* - it was reported in 1997 that a project was under way with a range of health personnel from the NEHB and NWHB and the WHSSB, involving the collation and analysis of data from pharmacists. It was intended that in 1998 appropriate education strategies would be put in place.
- *Conferences* were held as follows:
  - 1997 Promoting Positive Mental Health (NEHB and SHSSB)
  - 1998 Promoting Mental Health in the Workplace
  - 1999 Clearing the Air - Smoking in Young PeopleOut of these came presentations of projects and results at various national and international conferences.
- *Networking, sharing information, discussions on evidence-based practice*  
Evidence- based health promotions - smoking cessation.
- *Joint meetings* - between Southern and Western HSS Board Drugs Co-ordination teams and their counterparts in the NW and NEHBs, and a one day event.

### Primary Care Sub-group

The three CAWT annual reports suggest that there were considerable developments in the work of this sub-group over the period concerned. It is referred to as the General Practice Sub-group in 1997 and then the Primary Care Sub-group in 1998. There is also the sense of a widening of the remit of the sub-group over that period, beginning initially with eight general practices and five projects and culminating in a briefing paper to the CAWT Management Board in September 1997.

EU Peace and Reconciliation funding was obtained for a project between the NWHB and the WHSSB. This began in October 1998 and focused on services development, practice organisation, community pharmacy, information technology, and the establishment of a cross-border practice in the Ballybofey - Stranorlar area. The latter project involves the building of a dedicated premises, sharing good practice on both sides of the border and the joint development of primary care, practice nurse and receptionist training. Another project proposed between Lifford and Strabane has not taken off.

## Current and past co-operation

In June 1999 the initiative was extended to all four boards as the 'Developing Primary Care Across Borders and Boundaries' project. Its aims were to improve primary care for people resident in border areas by enhancing the quality of care provided, raising levels of communication/teamworking and improving standards and facilities available to deliver services. It was reported that the lessons learned from the various stages of development had been used to inform the development of "an excellent framework for developing primary care in the border areas and the wider CAWT region" (CAWT annual report 1999, p5). Several key objectives were identified for each of the five areas for phases two (April 1998 - May 1999) and three (June 1999 - June 2000). The work in phase three was to involve a particular focus on the identification of the needs of border communities and ways in which providers can work together to address these needs. Initially work was to focus on the Belcoo and Blacklion area of Fermanagh and Cavan and a partnership was established between the University of Ulster (Coleraine) and the National University of Ireland (Maynooth) to conduct the study. It was reported that the primary care sub-group had received significant support from other primary care professionals and staff, who were also feeding into the development of primary care projects.

In September 2000 the NEHB established a general practice out-of-hours co-operative for its 200 GPs. As with primary care co-operatives elsewhere, this involves members of the public ringing a central number to access a doctor. Depending on the urgency of the patient's condition, he/she either receives telephone advice or a home visit or is invited to attend the centre. The viability of organizing a cross border out-of-hours initiative between this service in the NEHB and an equivalent established service in the SHSSB is now being considered, with patients able to access a GP regardless of jurisdiction. A feasibility study of all the legal, professional, administrative and financial issues which would allow patients to have access to the nearest out-of-hours services, whether in the North or the South, is being conducted by the University of Ulster at Coleraine. This study is due to be completed in 2001.

### **Acute Services Sub-group**

Co-operation in the acute hospital sector appears to have developed more recently than either primary care or health promotion. The CAWT annual report records no formal meetings taking place in 1997. However it is reported that members of the acute services groups "continued to promote the CAWT agenda" in informal contacts on the development of acute services strategy documents, including the development of a cancer strategy, and in developing cross-border relationships between several hospitals in the four boards. It is suggested that, because of the differences in structures in the two jurisdictions, the Acute Services Sub-group had not been able to work in the same way as the other sub-groups. Accordingly service enhancements were pursued directly between the health boards in the Republic and Northern Ireland health and social services (HSS)



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trusts, with CAWT taking on an “umbrella role”. There are five such hospital trusts bordering the Republic of Ireland and one region-wide trust (the Northern Ireland Ambulance Service Trust), and by 1999 joint projects had been set up between Health Boards in the Republic and five of these trusts, as follows:

1. *Craigavon Hospital Trust and the NEHB* were the first to discuss the potential for working together. (In fact these discussions were initiated outside CAWT.) Out of those discussions came the Cross Border Acute Services Project (C-BAP), which again secured EU Peace and Reconciliation funding. C-BAP is also reported to have resulted in a high level of co-operation and co-ordination across a range of acute areas such as dermatology, telemedicine, pathology, radiology and nurse training and education. Significant progress was made on the development of shared dermatology services in Monaghan, Dundalk, Newry and Armagh, including the joint appointment of a registrar in dermatology. 211 dermatology patients from Northern Ireland and 196 from the Republic were seen on an out-patient basis and this is reported as having ended the waiting list. This initiative was subjected to formal evaluation by the University of Ulster<sup>40</sup>. In the evaluation report it is suggested that the creation of this joint, albeit temporary, post had caused concern at Department level, both North and South. The project has now come to an end, with the view that it would have been better to have appointed a consultant. The service did not fit in with any existing system, North or South. Staffing, structural and accreditation difficulties have militated against the extension of what was a successful project.

2. *Triangle Study*

A three-way partnership involving the NEHB, the NWHB and Sperrin Lakeland HSS Trust conducted a feasibility study into co-operation in acute hospital services in the “mid-border” areas of Cavan, Fermanagh, Leitrim, Monaghan, Sligo and Tyrone. Six major areas have been identified for cross-border co-operation:

- networked health service education and research network (ERNET)
- joint in-service education programme (for qualified nurses)
- integration of emergency planning to provide a regional response
- renal information system, which will support clinical audit and lead to quality improvement
- mobile MRI
- regional pathology standardisation forum

‘Meaningful’ discussions are now reported to be taking place between senior management of the NWHB, the NEHB and the Sperrin Lakeland HSS Trust with a view to progressing these areas.

## Current and past co-operation

Other co-operative areas in acute care included the sharing of information on Y2K computer systems so that each system could act as a 'back-up' to its neighbour. In addition, Sligo General Hospital provided back-up support for trauma patients from the west Fermanagh area.

### 3. *Altnagelvin HSS Trust/Letterkenny General Hospital*

A feasibility study began in 1999 and reported in August 2000. The group identified four major areas for joint working over a 12-18 month period:

- cardiac catheterisation
- oral and maxillo facial surgery services
- neo-natal intensive care
- rehabilitation service for brain injured patients

The four identified areas are now being considered by steering groups established with high-level representation from both hospitals. Also highlighted as possible areas to be considered within a five year period are breast screening, dexta scanning, MRI services, nuclear medicine, registrar rotation, oncology services, cytology, PACS in radiology, ICU services, lithotripsy service and electronic storage of records.

One of the most valuable contributions of the Letterkenny/Altnagelvin partnership has been the documentation of constraints/barriers which have a detrimental effect on partnership working. Discussions within CAWT have confirmed that these 13 documented constraints/limitations (see Appendix 6) are common to the entire CAWT region.

### 4. *Renal Dialysis Project*

Under the auspices of CAWT, the NEHB and Newry and Mourne Trust have formed an alliance to enable patients from Dundalk to avail of essential renal dialysis treatment in Daisy Hill hospital in Newry. Since 1998 consultant-led renal dialysis clinics have been held in Daisy Hill hospital three times a week. In the Republic, patients from north Louth who needed this dialysis treatment used to travel twice a week to one of the main hospitals in Dublin (either Beaumont Hospital or the Mater Hospital). Over 750 dialysis treatments have now been carried out on NEHB patients in Newry. Patients have reported a real improvement in their quality of life as they no longer have to spend two days every week travelling to and from Dublin



## Current and past co-operation

### 5. *Ambulance Services Project*

A joint project between the NEHB and the Northern Ireland Ambulance Trust Board was set up in 1998 aimed at:

- establishing a training facility in the border region to deal with major incident planning and response;
- appointing a co-ordinator for the programme;
- developing a programme to enable services to respond rapidly and effectively to major incident calls;
- training appropriate personnel as instructors in the programme, who could then commence training programmes for personnel working in adjoining border areas;
- developing community information packs.

It is reported that the lessons learned from this project had been shared with other boards and trusts in the CAWT region. It is also reported that the findings would feed into the work of the Northern Ireland Review Group on Ambulance Services. In 1999 a major incident exercise was carried out in the Cooley mountains which involved observers from both sides of the border. A video and report have been produced following the exercise and the project has been evaluated. In addition it is reported that members of the Northern Ireland Review Group met with the NEHB and the NWHB to exchange views on the future development of services.

### **Learning Disability Sub-group**

A “flexi-worker” family support project was initiated in 1997 with the support of EU Peace and Reconciliation monies. This involved the sub-group in the learning disability field overseeing the direct provision and purchase of domiciliary care for clients, their families and carers. The project was implemented in 1998 and an internal evaluation was carried out in 1999. Difficulties in developing co-operation arising from differences in infrastructure and legislation between the two jurisdictions are reported in the evaluation.

The sub-group identified two additional projects as priority topics : a) the development of a cross-border multi-agency approach to training in the area of protection of vulnerable adults from abuse; and b) the development of a cross-border resource centre for persons with a disability. The sub-group was unsuccessful in attracting EU funding for this work but it was reported that it would consider other ways in which the projects could be progressed. During 1999 32 professionals from the four border boards and representatives from the statutory and independent sectors attended a *Prevention is Better than Cure* workshop focusing on the areas of personal relationships and protecting vulnerable adults from abuse.

## Current and past co-operation

It is also reported by CAWT that a considerable amount of information sharing and forming of local networks has taken place, including a network developing an integrated approach to meet the needs of children with autism. Several workshops and networking events had taken place and a cross-border conference was planned.

### Family and Child Care Sub-group

Discussions between service providers in the area of family and child health appear to have begun at an early stage and by 1997 the group had obtained funding for two projects. The first of these, *Protecting Children with a Disability*, was aimed at providing children with a disability with protection from potential abuse through a comprehensive strategy targeting the environment, home, schools, clubs and carers. This was to “build on” work existing in the area both in Northern Ireland and the Republic. The project also involved the appointment of two project officers, one from each jurisdiction, and the development and piloting of materials in each board area. In 1999 it was reported that teachers in the WHSSB and the NWHB had come together to develop a framework for protecting children with disabilities from sexual abuse. In the NWHB training for carers had taken place and an advice booklet for parents was being produced

The second project, *Parenting Initiatives in the Community*, was to establish a number of parenting programmes across the four boards. The project was to identify parenting needs in specific localities and set up schemes to address those needs over a specific timescale. By 1999 it was reported that 11 parenting groups had been established across the four pilot sites involved, parenting education programmes were being evaluated and additional groups being set up.

The implementation of a third initiative in the NWHB, *The Preventative Community Youth Project*, is reported in the 1999 annual report. Targeted at young people aged between 10 and 18 perceived by referral agencies to be “in need” and at risk of being received into welfare or custodial care, the project incorporated two approaches. The first involved encouraging the young people concerned to take responsibility for their actions and to effect positive change in their lives. It was reported that this approach had received very positive feedback in its evaluation and that a cross-border link had been established between the NWHB and Foyle HSS Trust. The second approach targets families in crisis and trained family support workers visit homes twice a week to assist parents in household management and child care. This was also evaluated in March 2000 and both aspects of the project were due to end in 1999/2000.

It is reported that the work of the group has focused on these three areas but that over time networks had been developed and the group would continue to explore other areas of potential joint working.



## Current and past co-operation

### **Mental Health Sub-group**

Mental health is included in the CAWT annual report for the first time in 1999 as a separate entity. It is reported that cross-border co-operation continued to expand in the area in 1999 and that, in addition to mental health promotion projects, significant progress was made in two other areas: cognitive therapy training for nurses from the NWHB and WHSSB, and an outreach support and employment project in the Melvin area. Plans are being laid to establish a formal mental health sub-group.

### **Public Health Sub-group**

Reported advances in the public health area in 1997 were limited to the joint exploration of issues and problems of common interest. There was a particular emphasis on the role of health boards in the area of communicable diseases, and on sharing experiences and best practice in the area of medical admissions. In 1998 it was reported that the sub-group had a role in identifying and prioritising needs to inform CAWT's service plan. In 1999 it was reported that the sub-group had been very active in promoting a range of research projects relevant to health issues in the CAWT region, the first of which was a three-year project on the management of patients with breast cancer. It was also reported that other initiatives were under way focusing on pre-hospital emergency care, suicide, traumatic brain injury and coronary heart disease.

### **Information Technology Sub-group**

The IT sub-group met twice in 1997 and a significant amount of progress is reported on a CAWT-funded project to enable e-mail communication between the four boards; this had been completed in three of the four boards by the end of 1997. The work of the sub-group also included the review of the CAWT directory and allocating an e-mail address for each person listed in it. Additional work carried out by the sub-group in 1998 included developing a website for CAWT, supporting the primary care and other projects, and sharing information and expertise. In 1999 it was reported that work continued on developing a CAWT internal communication system and developing the website. It was also reported that a cost-benefit analysis was carried out of video conferencing.

### **Human Resources Sub-group**

In 1997 it was reported that the human resources sub-group had begun to implement the recommendations in the report *A Study of Cross Border Recruitment and Selection Practices*. Training was organised on a partnership basis across boards on best practice in this area and the development of recruitment strategies. Examples of joint training in 1998 included two one-day conferences on the influence of the EU on human resource issues and health and safety, and a major initiative on the training of domiciliary carers between the NWHB and the WHSSB.

## Current and past co-operation

In 1998, the purchaser/provider split was reported as a particular challenge to the sub-group in identifying common needs and areas for mutual co-operation. Nonetheless the sub-group continued to review its priorities for action, its role within the CAWT corporate support structure and in relation to strategic issues for CAWT boards. In 1999 the focus was on strengthening collaboration between personnel departments and staff in the four boards; developing a strategic view of human resource developments in the region and Europe; developing and planning a collaborative response to changes impacting on the CAWT partnership, and supporting the CAWT infrastructure in human resource matters. It was also reported that the sub-group was working on the equivalence of qualifications, advertising, application forms, contracts of employment, selection process and induction within the partnership.

### CAWT evaluation

The recent evaluation of CAWT by the Centre for Cross Border Studies, which was commissioned by the CAWT Management Board, found that its main focus had been on enabling senior management from the member boards to work together in potentially beneficial areas. There had been an attempt to encompass as many areas of health care as possible and to build as many networks as possible. Ultimately the goal had been to “change the culture” of planners, commissioners and providers by encouraging them to look beyond their own borders. The main objective of CAWT continues to be the improvement of health and social well being of the resident population in the border region. There appeared to have been only a limited effort to look systematically at the particular problems confronting the border region within a health context and to assess how CAWT could help in addressing them. Nevertheless CAWT was found to have made progress in reaching all of its key objectives over the evaluation period (1992-2000).

The work of CAWT has been mostly project-focused, very diverse and very dependent on EU grant funding. The envisaged model of cross-border service development has yet to be tested, with the majority of projects concentrating on issues of training and education as distinct from service delivery. Few projects have involved patients on a cross-border basis.

Discussions with respondents have shown that in the past the perceived success of CAWT project work has been judged in two quite different ways:

- the success of the project in terms of its value in improving the health and wellbeing of the resident population
- the value of what has been achieved in terms of peace and reconciliation.

A summary of respondents' views of CAWT is included as Appendix 7.



## Current and past co-operation

The judgement of what constitutes project success within CAWT has changed with the different stages of development. While establishing contact and exchanging information was once regarded as a successful outcome, this is no longer deemed sufficient, with respondents now coming to expect more than projects for projects' sake. It would be fair to say that because CAWT had to avoid being seen as threatening in the past, it had to develop cautiously. With the new post-Belfast Agreement institutional arrangements for cross-border co-operation in Ireland, the expectations for the organisation to deliver may be greater in future.

During discussions respondents highlighted a number of projects which they believed had made a valuable contribution to cross-border health care. Those projects where individual patient benefits are evident were given the highest priority. Two good examples of patient-centred projects are the C-BAP Dermatology Project, which reduced out-patient dermatology waiting lists, and the Renal Dialysis Project, where access to treatment was improved for people in north Louth (NEHB).

The Letterkenny/Altnagelvin feasibility study was frequently cited as a good example of collaborative cross-border working in terms of the consultative approach it took to identifying potential areas for collaboration and for its documentation of constraints to partnership working.

In addition, the recently initiated GP Out-of-hours Project was seen as a pivotal piece of work because of the expectation that it would address identified cross-border barriers such as registration of professionals, insurance cover and GP referrals between different health sectors.

Within the project work there has been a concentration on education and training with a large exchange of information across the border. Within each health sector (with the exception of public health) at least one conference or workshop is held every year where approaches to work are exchanged, practice models are reviewed and joint training is delivered. Within the sub-groups, in particular the Health Promotion Sub-group, members exchange information on current UK and Irish national schemes and campaigns. Members of the professions allied to medicine (PAMs) have developed joint approaches in professional development using examples from both jurisdictions as case studies. Following this, networks have been established at ground level which have allowed co-operation to develop outside CAWT. Relevant examples include the extension of critical and surgical nursing cover at Craigavon Area HSS Trust to Monaghan hospital during the 1998 nurses strike, and the sharing of Y2K plans in the north west region to act as potential back-up in the event of a Millennium computer failure.

## Current and past co-operation

Respondents have expressed the view that there have been benefits for the individual boards which have not necessitated a cross-border movement of patients. It could be hypothesised that professionals who have undertaken cross-border training will have improved their skills and patients should benefit as a result. In addition there is evidence that those involved in certain specialties, for instance health promotion, are now considering alternative approaches to tackling problems within their own boards which have not been considered previously.

Nonetheless the impact of these approaches and the improvements in skills as a result of cross-border training remain to be tested. The very limited evaluation of training initiatives which has occurred appears to have been restricted to monitoring the uptake of available training places, assessing the inter-disciplinary mix of trainees and general feedback on the course. There are notable exceptions to this, such as the accreditation of courses within the Primary Care project.

The CAWT evaluation also identified a number of major issues for the future:

- There was scope for improvement in **communication and dissemination**
- There is considerable scope for **developing CAWT's current cross-border remit** which would benefit from increased infrastructural support and research studies
- There was no real evidence of **mainstreaming**: CAWT work did not appear to be integral to individual boards' service plans or performance management processes
- There is a **hidden commitment** from the boards in terms of people's time
- With the emerging **all-Ireland agenda**, there is a need to clarify whether CAWT should concentrate on cross-border health issues (i.e. restricted to the border region) or should evolve to look at broader all-Ireland issues
- **A population needs assessment** could provide a clearer focus on health within the CAWT region
- There are a number of options for the future **funding** of CAWT. These are explored in Chapter Nine.

### 6.4 Institute of Public Health in Ireland

Plans for the establishment of an all-Ireland institute of public health were announced following the February 1998 ministerial meeting. At that time the Institute of Public Health in Ireland (IPHI) was envisaged as a resource centre providing advice to the two Departments of Health on issues affecting public health. Its role was to be concerned with disease surveillance, development of information systems, research, education and training. In May 1999 it was announced that the IPHI was now operational and its offices were located at the Royal College of



## Current and past co-operation

Physicians in Dublin. Several respondents welcomed the setting up of the IPHI, stressing that public health and health promotion are the most obvious areas for cross-border co-operation, in that they can capture the public's imagination and deal with the same preventable diseases suffered throughout the island.

Since its establishment the IPHI has organised a number of conferences on topics such as health inequalities and partnership working. Respondents were generally positive about the potential contribution that the Institute could make. There was a degree of understanding that a new entity such as this takes time to find a settled role for itself and hopes were expressed about it making a considerable impact in the future. The suggestion has recently been made that the Institute should assume a role akin to that of a 'public health observatory' for the island. The DHSSPS Consultation Paper, "Investing for Health" (November 2000) proposed that the Institute should enhance its capacity to include:

- comparative monitoring of trends in health, the determinants of health, and health inequalities North and South, and relative to other EU countries
- highlighting of new areas of concern as they emerge
- advising on the methodology for health and health equity assessments
- disseminating throughout Ireland information from international research and experience.

### 6.5 Other areas of co-operation

#### Specialist hospital services

At least one Board in the border area has contracted recently with the Mater Hospital in Belfast for the provision of ophthalmology services. This is an example of the kind of arrangement that can sometimes be made with clear benefits in terms of speedier treatment for patients on a waiting list.

#### Extent of cross-border patient flow

As can be seen from Table 6.1, approximately 1,300 - 1,400 people from the Republic use hospital services each year in Northern Ireland. (This excludes those using accommodation addresses.) This figure represents 0.3% of all patients treated. Table 6.2 shows that the number of people from Northern Ireland who are treated in the Republic is even less, representing 0.13% of all patients treated.

## Current and past co-operation

**Table 6.1**

	Total inpatients and day cases treated in Northern Ireland	Patients from Republic of Ireland 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

Source: DHSSPS

**Table 6.2**

	Total inpatients and day cases treated in Republic of Ireland	Patients from Northern Ireland treated in Republic of Ireland	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

Source: ESRI

A number of respondents mentioned the potential for co-operation in supra-regional or national specialties such as liver and heart/lung transplantation, and paediatric cardiac surgery. However one senior interviewee in N. Ireland was cautious, saying that in most of these cases consultants in Northern Ireland had become accustomed to referring their patients to colleagues in England with whom they may have trained and in whom they have confidence. There are also potential funding difficulties, in that for most of these procedures the authorities in Northern Ireland would have to pay for treatment provided in the Republic whereas in some cases treatment may be available without charge in England. (It should however be noted that increasingly NHS Trusts in England have been expecting payment for Extra-Contractual Referrals from Northern Ireland).

Other opportunities include technologies that have not yet been introduced into Ireland such as PET (Positron Emission Tomography) scanners where we were told that DHSSPS was commissioning some work on the scope for co-operation. However it was recognised that every large teaching hospital (on the island) would want to be the site.



## Current and past co-operation

### Cancer research and treatment

Both jurisdictions are in the process of developing their cancer services. Following the Campbell Report in Northern Ireland there is a well-developed strategy for concentrating cancer services. In the Republic of Ireland a similar, although perhaps not so radical, approach has been developed through the National Cancer Forum. This takes account of the much greater prevalence of private practice in that jurisdiction, and the fact that it is less possible to take a prescriptive approach in relation to centralisation and specialisation.

Against this background, a memorandum of understanding has been signed between the Republic, Northern Ireland and the National Institutes of Health (on behalf of the US National Cancer Institute) in the United States on a common approach to a number of issues relating to cancer research and registration. There are three elements to this:

- The underpinning and co-ordination of the two existing cancer registries on the island.
- Scholar exchange where people from a range of professional and scientific backgrounds spend a short period of time at the National Cancer Institute to learn about scientific methods including how to organise cancer trials.
- The establishment of three-year cancer epidemiology fellowships for scientists from North and South, one year of which will be spent at the National Cancer Institute, one year in the Republic of Ireland and one year in Belfast.

A next step envisaged is to develop a process whereby hospitals providing cancer services throughout the island would be linked to the National Cancer Institute for the purpose of carrying out clinical trials on new modes of therapy and new drugs. A number of tripartite meetings have been held to push this forward. A major cancer conference was held in Belfast in October 1999 to introduce these new arrangements to those involved in cancer treatment and research throughout the island.

One area of co-operation in the cancer field that is regarded as a success is breast screening. There has been a comprehensive screening programme for breast cancer in Northern Ireland for 11 years. The Republic of Ireland has been able to learn from the experience of Northern Ireland in establishing their own programme in recent years. They were able to look and see what things merited particular attention and what things Northern Ireland would do differently if they were doing it again. There is continuing contact and liaison in relation to quality assurance programme.

## Current and past co-operation

These changes are expected to lead to improvements in cancer care for two reasons. One is the opportunity to learn from the USA, where outcomes of cancer care are much better than in Ireland, although much of this may reflect the vastly greater funding available, but also, and more importantly, because more patients will be entered into clinical trials.

### *Cancer Services in Letterkenny*

An arrangement has been entered into between the NWHB and the Belfast City Hospital whereby Donegal patients suffering from cancer will receive specialist treatment in Belfast rather than having to travel to Dublin. Over 120 patients each year are expected to travel to Belfast for radiotherapy and extensive chemotherapy, while lower level chemotherapy and any other services will be provided locally. A consultant is to be appointed with a commitment in Belfast on a one day a week basis to manage Donegal patients. More importantly this consultant will work within a larger group of consultants in Northern Ireland and it is expected that this will bring benefits for him/her and for patients in Donegal.

### **Training and professional co-operation**

#### *Medicine*

Despite their all-Ireland remit, in practical terms the Royal College of Physicians and the Royal College of Surgeons in Ireland are only able to organise training within the Republic. Training in Northern Ireland is organised in association with the UK Colleges because they are the bodies responsible for providing accreditation. Postgraduate specialisation in the Republic of Ireland is recognised in the UK. There is a specific system of exchange of trainees in the area of paediatric surgery, with the training periods recognised in both jurisdictions for the purpose of accreditation.

Attempts have been made to construct joint training programmes for other specialties, and there have been limited successes despite difficulties in relation to insurance, medical/legal cover and accreditation. These attempts have concentrated on specialties where it was difficult to maintain a training programme in one jurisdiction, such as neurosurgery and paediatric surgery.

#### *Nursing*

Initiatives in the nursing field have included:

- Nurses from the Republic taking up distance learning opportunities at the University of Ulster
- A joint conference in Dublin on "Celebrating Nursing"
- A joint nursing meeting on public health
- Joint research fellowships



## Current and past co-operation

- Post-registration nurse training - with senior departmental officials suggesting the possibility of running specialist courses such as paediatric intensive care in alternative years, North and South, where there may not be sufficient candidates in each jurisdiction to justify a separate course there every year
- A clinical project on continence care funded by the EU run from Foyle HSS Trust
- The UK Central Council and the National Board for Northern Ireland have co-operated with An Bord Altranais on exchanges and educational standards.

### *Other*

The chief executive officers of the health boards in both jurisdictions meet at least twice a year to discuss matters of common interest. The meetings have a formal agenda and papers are delivered from both sides on issues of the day. There is however no secretariat and no capacity to commission studies or gather further information on particular topics. This means there is no structured mechanism to facilitate learning from different experiences. There is also a public health directors' forum that meets regularly.

### **Public health/health promotion**

There have been good relationships for some years between the Health Promotion Agency in Northern Ireland and the Health Promotion Unit (part of the Department of Health and Children) in the Republic. They met about twice a year to keep in touch and share experiences and models of good practice. In 1999 this developed into a more serious dialogue, also involving the DHSSPS and the Institute of Public Health, with the objective of identifying a joint programme of health promotion activity. A number of possibilities were discussed including smoking among schoolchildren and nutrition. Ultimately a decision was taken to run an all-Ireland campaign on folic acid using materials that had been developed by the Health Promotion Agency. This was launched by the two Ministers in November 2000.

Other initiatives under way or under consideration include an inventory and needs assessment of training opportunities for people working in health promotion, research into health and lifestyle on an all-Ireland basis, a joint initiative on workplace health promotion and an anti-smoking initiative.

A number of respondents said that public health and preventive health and health promotion were probably the most immediate way of co-operating and working together because they are the things that are most likely to capture people's imagination, and because of the fact that people throughout the island

## Current and past co-operation

suffer from the same preventable diseases. One example often mentioned was cardiovascular disease where both the Republic of Ireland and the UK have national strategies.

### **Policy and planning co-operation**

There has been virtually no cross-border co-operation at a policy level in relation to health services. This applies also to strategic planning: for example the major hospital planning exercises undertaken by all four HSS Boards in Northern Ireland in recent years did not take account of cross-border possibilities. Similarly service reviews, such as for cancer screening and cervical cytology, have not had a cross-border dimension.

Recently however the Acute Hospitals Review Group, established by the Minister of Health, Social Services and Public Safety in Northern Ireland under the chairmanship of Dr Maurice Hayes (incidentally a member of the Irish Senate), has been asked to have regard to the potential for co-operation with other hospitals on the island.

A recent strategic review of ambulance services had a cross-border element in terms of co-operation, not joint development. The possibility of sharing training and communications has been mooted. One reported obstacle is the different stage of development of the trained paramedic and the provision of pre-hospital care in the two jurisdictions. As noted in Section 6.2, a joint working group on ambulance services has recently been set up under the North-South Ministerial Council (health sector).

### **Public health nursing**

There have been a number of co-operation initiatives in relation to public health nursing, including research on the contribution of nurses to public health. One difficulty is in relation to terminology: in Northern Ireland there is a tendency to think of public health as the preserve of health visitors, while in the Republic of Ireland all community nurses are designated public health nurses. One objective of the research referred to above has been to arrive at a consensus definition of public health nursing. There have also been discussions with the IPHI about a nursing contribution to the Institute.

### **Research**

The Health Research Board (HRB) in the Republic of Ireland and the HPSS Research and Development Office in Northern Ireland have introduced a grant funding scheme for cross-border research. The purpose of the scheme is to stimulate co-operation between research investigators in the two jurisdictions by making grant support available for joint health research projects of a high quality.



## Current and past co-operation

The HRB provides up to a maximum of IRE40,000 pa for the Republic of Ireland partner and the HPSS Research and Development Office provides up to a maximum of Stg£40,000 pa for the Northern Ireland partner. Awards may be used for research scholars, small items of equipment, consumables and travel. Awards are conditional on the HRB and the Research and Development Office being satisfied that the project is genuinely collaborative with the partners providing complementary skills. Applications are assessed both on the quality of the research proposed and the quality of the cross-border collaboration.

Although all areas of health and biomedical research are eligible, almost all the awards made to date have been in biomedical research (see Appendix 8).

### Telemedicine

In the early 1990s Belfast City Hospital (BCH) was the first hospital in the UK and Ireland to use telephonic transmission of electrocardiographs (ECGs) to GPs. A cross-border example of this, a link-up based on the remote diagnosis by BCH of heart patients in University Hospital Cork, was widely publicised in the summer of 2000.

In a chapter in a recent report for the Centre for Cross Border Studies on cross-border telecom technologies<sup>41</sup>, Geraldine McParland, principal cardiac clinical scientific officer at Belfast City Hospital, explained how patient care could be improved and money saved by developing such telecardiology services throughout the island of Ireland. This form of telemedicine, using modems and e-mail, can speed up diagnosis and treatment in remote areas; offer heart scans to patients in smaller hospitals; link local hospitals with central hospitals in order to remotely monitor and analyse patients' heart signals; and remotely monitor pacemakers and cardiac defibrillators.

## 6.6 Evaluation/success/benefits

There has been little external evaluation of cross-border projects. Exceptions to this are CAWT's C-BAP and Primary Care projects. C-BAP was evaluated by the University of Ulster and the Primary Care project by the National University of Ireland Galway. As noted in Chapter Two, an evaluation of CAWT itself has just been completed by the Centre for Cross Border Studies in Armagh. However project work has produced a number of useful internal reports such as the acute feasibility studies.

The majority of CAWT's EU funded project work has been completed or is due to be completed within the next twelve months. There are currently a large number of CAWT evaluations which are due for completion (e.g. Family and Child Care Sub-group projects). It is important that an evaluation is conducted on each of these individual pieces of work so that the lessons learnt can be assimilated and

## Current and past co-operation

disseminated. All CAWT project groups are required to provide evaluation plans and projected outcomes from which an assessment of the work can be completed. However, the extent to which these plans are integrated into the projects' day-to-day working appears to be limited.

Currently the monitoring and evaluation of CAWT's work is undertaken through procedures which have been established as a direct result of securing EU funding. It is accepted that these internal procedures are constantly developing over time. Clarity is needed to identify how CAWT's work fits into the broader peace and reconciliation agenda of the EU and the two governments. It is not clear, when CAWT is setting out the projected outcomes of its work, to what extent these are informed by peace and reconciliation and/or health objectives.

The responsibility for producing evaluations of the project work has been allocated to the individual sub-groups. The CAWT evaluation has suggested that this activity could be co-ordinated through the CAWT Resource Unit so that the quality of all evaluative work can be maintained to a certain standard and that official guidance on deadlines can be established and monitored. In addition, CAWT should play an enhanced supportive role in ensuring that the people who are completing these evaluations either have the skills or access to the skills to complete this work expeditiously.

The primary care project, 'Developing Primary Care Across Borders and Boundaries', is an example of how monitoring and evaluation can be used to progress and enhance cross-border co-operative working. This project has been guided by an external quality assurance team in order to maintain a focus in accordance with the health strategies of both jurisdictions. The membership of this quality assurance team includes academic units in both jurisdictions and an international expert. Respondents have found the guidance of this team particularly useful in maintaining the focus of the work, providing a structure for progress and for documenting every aspect of their approach.

The inclusion of a body such as a quality assurance team or an academic institute to enhance performance management should be considered for all CAWT work in the future. Performance management has been highlighted by the National Health Service (NHS) in Great Britain (e.g. *A First Class Service*, NHS Executive, 1998) and the Department of Health and Children in Ireland as a means of improving the quality of care.





## Scope for further co-operation

### 7.1 Views of respondents

As we noted earlier, our respondents were optimistic about the scope for further co-operation, particularly in the changed political climate that now exists. The areas most often mentioned as having particular potential were in primary/community care and acute hospital services.

#### Primary/community care

A number of respondents were enthusiastic about the possibilities of developing co-operative arrangements in primary and community care, mainly developing from the planned CAWT pilot out-of-hours arrangements. There was a strong feeling that if GP and associated services could be provided in a seamless way across the border that would improve relationships and open the way for further co-operation, particularly in relation to hospital services. Repeated reference was made to the particular problems of the Carlingford peninsula and the fact that Blacklion in Co Cavan was nearer to a hospital in Enniskillen than to one in Cavan.

This enthusiasm derives from the feasibility study on the possibility of GPs in Donegal and Cavan/Monaghan participating in, or sharing cover with, the out-of-hours co-operatives in Northern Ireland. That might bring about a geographical realignment in the co-operatives, because they are currently designed around centres like Enniskillen or Strabane, when in fact they should maybe be centred in Ballyshannon to serve the whole region. The aim would be that regardless of which side of the border they were on, a patient would be served by his or her closest centre.

As far as community services are concerned, there was a view among respondents that once relationships have been established it should be possible for a community-based worker (e.g. health visitor or social worker) who cannot get to his or her client on a particular day to ask a counterpart working close by in the other jurisdiction to call in when in the vicinity.

Reference was also made to the potential of social care projects such as that between Castlefinn in Co Donegal and Castleberg in Co Tyrone in relation to the needs of elderly people living in isolated rural communities. There was a view that social programmes may have more to offer at present than more ambitious and visible projects in the acute sector.



## Scope for further co-operation

### **Acute hospital services**

There was also optimism about further potential in respect of hospital services in the border region, with the four CAWT Boards pooling resources to create sufficient “critical mass” to sustain local provision. The example often cited was the North Western Health Board with its low population density and high dependency, with the highest number of medical cardholders and a lot of deprivation. The NWHB has been endeavouring to develop two centres (in Letterkenny and Sligo) but neither may be viable in its own right in the medium term. However if Letterkenny Hospital coupled itself with Altnagelvin and Sligo was aligned with hospitals in West Mayo, Cavan and Enniskillen, that might contribute to the viability of the hospitals concerned. This is very much in keeping with the Republic of Ireland’s general approach to sustaining acute hospital services in rural areas, i.e. grouping small hospitals together. It is not however a concept that to date has found very much favour north of the border. There are benefits to be gained from sharing information about different approaches to hospital rationalisation: for example, about the hospital networks in the Republic, with Cavan and Monaghan hospitals being really one hospital on two sites and three hospitals in Louth networked together.

A number of potential co-operative initiatives have been suggested by the Letterkenny/Altnagelvin feasibility study and the Triangle feasibility study. These include cardiac catheterisation, MRI, ophthalmology, services for patients with brain injury, visual imaging, electronic storage of records and emergency planning.

### **Public health**

We referred in Section 6.4 to the establishment of the Institute of Public Health in Ireland. A number of respondents indicated that the biggest opportunity for co-operation on the island lay in the field of public health. In implementing public health strategies, evaluating their impact, in trying to add value to whatever is being done in one jurisdiction, there is a real benefit to working on an all-Ireland basis. It could be something as simple as working together on vaccination programmes because of the cross-border influence of the mass media. Alternatively, it could involve major programmes to tackle heart disease or cancers.

There is also huge scope for research on the differences in delivery of primary care services and the pattern of utilisation of health care North and South.

There are important issues here about the balance of effort in the field of public health, with the responsibilities of the various agencies being carefully defined.

## Scope for further co-operation

### Other areas for co-operation

Examples of other potential areas of co-operation mentioned by respondents were:

- In the event of an outbreak of infection in operating theatres in one jurisdiction it would be useful to be able to transfer patients to the other
- There are potential economies of scale and effort in joint approaches to manpower planning, and in the sharing of experience, information and knowledge generally
- There are benefits to be gained from co-operating in professional education; it is easier to create a critical mass, and people are transferable across the border in the event of shortages
- It would be beneficial to pool scarce professional expertise, for example in relation to specialised needs assessment exercises, in both health and social care
- a joint production centre for catering.

### 7.2 Health technology assessment

Reports from the Analysis of Scientific and Technical Evaluations of Health Interventions in the European Union (ASTEC) for both parts of Ireland have recently been completed<sup>42,43</sup>. These report on the current status of health technology assessment (HTA) in the two jurisdictions, the need for such work and barriers to it. The two reports identify common difficulties in the conduct of HTA in the two jurisdictions. These include small populations that make the maintenance of separate HTA infrastructures expensive. At the same time, however, simply adopting research generated elsewhere is less than satisfactory: for example findings may not apply to the Irish contexts (because of differences in service structure and scale, population characteristics or costing of inputs). Similarly the fact that areas of high priority for HTA in Ireland may be of lower priority in those areas where research is generated could prove problematic.

For these reasons both reports argue in favour of the development of expertise in this area and imply that cross border co-operation may provide a means of overcoming issues of expense and key skills shortage.

The establishment of a focus for health technology assessment in Ireland could provide a means of unifying the fragmented research potential that currently exists and meeting the needs for information in this area. Information deficits could be identified and studies pertinent to Irish needs undertaken or commissioned without duplication of effort.



## Scope for further co-operation

Such an initiative represents one area where co-operation could take place at relatively little expense and with tangible benefits for populations on the two parts of the island. This does seem to be an area that warrants further investigation.

### 7.3 Conclusion

The views of respondents suggest that there is scope for the further development of cross-border co-operation in health services in an attempt to provide a more “seamless” service and to provide the critical mass required to develop specialist services and sustain acute services. In addition, it is suggested that the benefits of enhanced co-operation would enable the pooling of expertise, the development of critical mass and economies of scale in other areas such as education, manpower planning, and health technology assessment.

## Barriers to co-operation and how they might be overcome

### 8.1 Introduction

HAVING explored the need for and the potential benefits of cross-border co-operation in previous chapters, we now consider the challenges faced by health service planners and managers in preparing for and putting in place cross-border initiatives, and also the barriers that may prevent co-operation being enhanced further. This was a key objective of the research and the findings are examined in this chapter.

It might be worth reiterating at this point in the report that people were generally enthusiastic and keen to do what they could to ensure that benefits to patients from cross-border co-operation could be realised. (This is reflected in Chapters Six and Seven in the range of current or past initiatives and respondents' views about future scope.) Potential barriers to co-operation identified in interviews and supported in documentary reviews related to policy differences, funding issues (including transaction costs), reciprocation, public acceptance, professional accreditation and insurance.

These issues are discussed in turn in the following sections.

### 8.2 Policy and structural differences

In Chapter Three it was noted that there were significant differences between the two jurisdictions in terms of health services policy and funding/structural arrangements. One important example of this is in the acute hospital sector, where policy in Northern Ireland favours concentration of inpatient care on a smaller number of sites as a means of sustaining services and enhancing quality. Assuming that the trend towards concentration is maintained, it is likely that before too long commissioners in Northern Ireland will only contract with provider units that meet certain minimum standards in terms of specialty mix, case load, consultant cover etc. In such circumstances it would be difficult to justify making exceptions for hospitals in the Republic.

In addition, several respondents identified issues relating to differences in the structures and systems in the two jurisdictions, which pose problems in co-operative working. The health system in Northern Ireland, as outlined in Chapter Three, is based on the purchaser/provider split, meaning that each HSS board has a clear responsibility for planning services to meet the assessed needs of its population and for commissioning the services required through contracts with providers. Thus any negotiation to purchase services takes place with the relevant provider (usually an HSS Trust in N. Ireland).

## Barriers to co-operation and how they might be overcome

In contrast, it is the health boards in the Republic of Ireland which would be involved in agreements to purchase services and thus the relationship here would be with hospital or community trusts in Northern Ireland, rather than with their counterparts in one of the four health boards. While this might seem appropriate, given the purchaser/provider relationship in Northern Ireland, issues do arise particularly in relation to funding (as discussed in the following section).

Other differences between the two systems include the following:

- GPs in the Republic are outside the public service net and direct payments are required from those patients not covered by medical cards (approximately 67% of the population). In contrast, people living in Northern Ireland have free unlimited access to a (named) GP and services are funded through the public system, largely on a capitation basis. In the event that practices on the two sides of the border decide to share out-of-hours services, with a GP in one jurisdiction seeing (or providing telephone advice to) patients from the other, arrangements will be required that take account of such differences in entitlements and reimbursement arrangements.
- In Northern Ireland a comprehensive range of after-care and preventive facilities in the community (district nursing, health visiting, community midwifery, and personal social services such as home help) are available to all. As we noted in Chapter 3, many of these services do not exist in the Republic or are organised differently. For example, there may be restricted entitlement to public services or services may be provided by the private or voluntary sector. In developing cross-border working, consideration will need to be given to the implications of such differences, including issues of equity. There may also be complications in organising aftercare and follow-up for a person having treatment in the other jurisdiction.
- There are differences in prescription and medication charges in the two jurisdictions and in entitlements. There are also issues about the legality of a prescription written in one jurisdiction and filled in another.
- There are difficulties relating to professional registration and insurance cover. For example, medical practitioners working across the two jurisdictions, as in joint appointments, would require separate insurance cover in each jurisdiction (two policies). Another example relates to nurses working on a cross-border basis who would be required to register both with the UKCC in Northern Ireland and An Bord Altranais in the Republic, and to incur two registration fees.

The general opinion among respondents was that the difficulties posed by such differences are not insurmountable, particularly in light of the positive attitudes to co-operation that exist. However they do add to the number of issues that have to be addressed when setting up cross-border arrangements for health services. The difficulty and expense of resolving them might need to be weighed against the potential benefits of further co-operation.

## Barriers to co-operation and how they might be overcome

### 8.3 Funding issues

#### The purchaser-provider split

In Chapter Three we discussed the consequences of EU membership for the resourcing of health care. Prior to the introduction of the purchaser-provider split in Northern Ireland, funds generally did not change hands for cross-border treatment because the costs involved were set off against one another on a 'knock for knock' basis. Under current arrangements providers have to charge purchasers in the Republic of Ireland the same as they would those in Northern Ireland.

One further complication is that health boards in the Republic are funded for the services provided within their area rather than for the needs of their resident population. This means that it is difficult for them to shift funds from a provider in the Republic to one in the North. On the face of it this makes decisions on the part of boards in the Republic to commission services from Northern Ireland providers more difficult.

To illustrate this with an example, the North Western Health Board (NWHB) does not control the funding that Dublin hospitals receive for services provided to its population. That means that although it might make sense for the patients concerned to be treated in centres in Northern Ireland, the board cannot readily switch the resources concerned from Dublin to Belfast. On the face of it this represents a considerable obstacle to the development of a 'cross-border health economy'. However the Department of Health and Children in the Republic makes available additional monies each year for 'external hospital services' and boards make bids for additional resources for specific developments. These funds are held by the programme manager in the board concerned and are used to buy services outside the board's area, whether in the Republic, in Northern Ireland or elsewhere, where there is not a service available locally. For example, the NWHB has earmarked some of this additional funding to purchase cancer services from Belfast City Hospital. (It is perhaps notable that the board felt it necessary to secure the support of their local TDs before deciding to spend this money in Belfast.)

It should also be noted that, rather than just distributing a block allocation to providers, the new Eastern Regional Health Authority will operate by specifying what is required and the standard to which it will be provided. If such arrangements were to be implemented generally in the Republic of Ireland, they would provide for service or contractual arrangements to be developed that would facilitate cross-border contracting.

In theory, funding mechanisms in Northern Ireland should make cross-border co-operation in health care easier. However some of our respondents indicated that the purchaser-provider split



## Barriers to co-operation and how they might be overcome

might militate against true partnership working because if a trust had not involved its 'parent' board in discussions the revenue or capital implications of any developments might not be met. There have been cases where a trust in Northern Ireland has signed up for a project without knowing whether the board concerned was going to approve it. Also boards in Northern Ireland are often linked into arrangements in Great Britain that are difficult to get out of for financial or professional reasons.

Again, in theory, it should be possible for insurance companies and other third-party payers in the Republic to contract with trusts in Northern Ireland to provide treatment to their members. We were told however that there had been major difficulties in persuading the VHI to recognise hospitals in Northern Ireland for reimbursement purposes. However another respondent indicated that people in one of the top two schemes in the VHI had a choice of accessing services in the North. (In fact the VHI offers five plans, A to E, in increasing order of expense. Plan E covers treatment at Daisy Hill Hospital in Newry; the only other Northern Ireland hospital covered is the North-West Independent Clinic in Ballykelly).

As far as the future is concerned, there were indications that funding arrangements should not constrain cross-border co-operation provided developments are planned in advance. Top slicing of resources at department level might be a possibility as a tangible expression of political intent and accountability. This would mean a jointly agreed budget, joint responsibility and overt political decisions. One possibility mentioned was that the two governments might establish a fund specifically for cross-border health initiatives. A potential danger of that approach is that cross-border co-operation would be 'privileged' and would not have to compete on an equal basis for funds with other service developments.

Another recurring issue was whether EU funding should be used to subsidise services, or be merely for pump priming or start-up costs (including capital). The potential role of the European Investment Bank as a source of low cost capital financing has not been explored, although this would also require consideration of what powers hospitals and others would be given to borrow.

### **Transaction costs**

Transaction costs were discussed in Chapter Five, and a number of respondents referred to them as a potential barrier to co-operation. These are the costs involved in negotiating, administering and monitoring service contracts between a commissioner and a provider. Depending on the type and size of contract, such costs can be disproportionately large and act as a real disincentive to cross-border co-operation. Even in a jurisdiction like Northern Ireland with a well-established purchaser-provider system and mechanisms for commissioning services, commissioners (and providers) prefer to have the vast bulk of their expenditure on a predictable, fixed recurrent basis. Commissioners in Northern Ireland that we

## Barriers to co-operation and how they might be overcome

spoke to said even if they found a hospital in the Republic of Ireland that was able to do, for example, hip replacements more economically and speedily than Musgrave Park\*, there is still the problem of running such a contract with limited financial capacity. There is also an expectation that health boards will support the fixed costs of an elective orthopaedic surgery service in Northern Ireland. This means that if a commissioner is moving business from one provider to another, it is not possible to withdraw the fixed costs, only the variable ones. Although in theory it should be possible for providers in the Republic of Ireland to charge marginal cost if they have spare capacity, the experience of commissioners in Northern Ireland is that they often seek to recover the full costs of treatment.

### 8.4 Reciprocation

A number of important issues arose in relation to cross-border patient flows.

More than one respondent in the Republic of Ireland noted that area-type hospitals or sub-regional hospitals in Northern Ireland were much better developed than their equivalents across the border. 'Bread-and-butter' acute specialties in the Republic are relatively well dispersed, but regional and national specialties are often based in Dublin, although there are ambitions on the part of both the NEHB and NWHB to be self-sufficient in regional specialty services.

A strong view was expressed by respondents in the Republic, particularly in the north west, to the effect that co-operation should not be seen as a "one-way street", with patients and resources flowing from South to North, possibly to prop up services that might be under threat of closure. At the same time it must be said that most (although not all) respondents in the North saw the opportunities for patients flowing into Northern Ireland hospitals more clearly than traffic in the other direction. In fact a senior officer in one of the Northern Ireland boards indicated a reluctance to commission acute services from hospitals in the Republic of Ireland as things stand. The same officer did however add that this did not mean that they would not be happy to commission a range of services in the context of a rapid development (as seems likely) of health services in the Republic.

One senior health board officer in the Republic acknowledged that it was unlikely that specialist services could be developed in the Southern border area which would be used by Northern Ireland people to the same extent as Donegal people travelling into Northern Ireland. In his view this meant that unless circumstances changed radically there would probably never be full reciprocation.

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\*The regional specialist elective orthopaedic centre in Belfast



## Barriers to co-operation and how they might be overcome

While many respondents in Northern Ireland were sensitive to this 'one-way traffic' issue, others expressed the view that it seemed to be fairly acceptable to people in the Republic of Ireland to come to the North for treatment, or indeed to England. There was a widespread acknowledgement that people in Northern Ireland would be more resistant to being told that the only place that they could receive a particular treatment was in the Republic. There was a common view in both jurisdictions that for co-operation to work effectively with full clinical and political support it must involve reciprocal movement.

The tension between a desire for greater co-operation and a concern not to lose local services is perhaps seen most clearly in the north west, where in order to secure full involvement of clinical and other interests a number of conditions have been applied to any future co-operation between Letterkenny and Altnagelvin:

- No proposal would undermine the services currently being provided in either hospital
- The overall objective is to "bring services back" from Dublin to the north west or retain existing services in the north west
- Co-operation should be confined to services that a particular hospital could not see itself providing in 5-10 years. Letterkenny is most definitely not interested in a purchaser/provider relationship with Altnagelvin as the main provider.

Clearly such conditions place real constraints on developments that might be justifiable in pure 'patient benefit' terms.

One approach to resolving such issues has been to appoint a consultant with a cross-border commitment in a specialty such as oncology or cardiology. That means that it is possible to demonstrate that there can be improvements on both sides of the border (a 'win-win solution').

An example of this is the arrangement between Letterkenny Hospital and the Belfast City Hospital (BCH) in relation to cancer services. This is a different model from that in Northern Ireland, where there is a cancer centre in Belfast and four cancer units, one for every 300,000 population. The oncologists in a cancer unit will manage their patients locally but those who need to go to the cancer centre in Belfast will be managed by specialists there. In contrast, the oncologist in Letterkenny will spend a day or so per week in Belfast. Whenever a patient is transferred, it will be under the directional control of a consultant in Belfast although the Letterkenny consultant will accompany the patient and will provide some input to the treatment received.

## Barriers to co-operation and how they might be overcome

It is suggested that such an arrangement might be more attractive for a potential consultant oncologist than the model in Northern Ireland whereby he or she will be part of a local oncology team but would not be part of the central team at the BCH.

Interviewees in Letterkenny suggest that if they wanted to access a service in Altnagelvin that was under threat of being withdrawn to Belfast they would not want merely to act as purchasers of such a service. However they would be happy to work with Altnagelvin with a view to developing a long-term structural relationship by making a joint appointment or appointing someone who would be part of a three or four person team.

This appears to open up the possibility of a different kind of reciprocity, not at individual hospital level, but rather at system level. The argument is made that if such a relationship can be developed between Donegal and Derry, there is a potentially equivalent situation involving Enniskillen, Cavan, Monaghan and Sligo and that hospital services could be planned with 'gains' for the two jurisdictions being balanced against each other.

It is important however to recall that hospital planning in rural areas is often rightly seen as a 'zero-sum game', with rationalisation almost always resulting in a diminution of services on one site to provide for investment on another. There is often keen, not to say bitter, rivalry between hospitals and communities even in the same jurisdiction. It seems unlikely that controversy surrounding such decisions would be any the less if there was a threat of services being reduced or subject to unwelcome change as part of a plan that would see improvements in the other jurisdiction.

### 8.5 Public acceptance

In the paragraph above we touched on the difficulty of securing public acceptance of changes in hospital services on a cross-border basis. Although there are likely to be fewer problems in relation to individuals, it cannot be assumed that there would be universal acceptance of having to cross the border to receive treatment. Any initiative that would restrict the availability of certain services in such a way would need to be explained in advance and, if necessary, formally consulted upon.

### 8.6 Professional accreditation

As the report of the Altnagelvin/Letterkenny project noted, registration/accreditation of nursing, medical and PAMs staff is carried out in the two jurisdictions by separate bodies which often have different sets of requirements. This can seriously



## Barriers to co-operation and how they might be overcome

inhibit joint appointments, staff rotations/placements and cross covering. Also undergraduate and postgraduate training is organised and accredited by different bodies in the two jurisdictions, and in many cases reciprocal recognition does not exist, inhibiting partnership training programmes.

### 8.7 Insurance

The Altnagelvin/Letterkenny report also pointed out that medical defence insurance, which is operated by private providers in the Republic of Ireland, is operated by health and social services boards in Northern Ireland, making it difficult to enter into cross cover arrangements at a senior medical level.

### 8.8 Competing pressures

One issue raised by respondents was that although people are generally very keen to do what they can to bring about improvements in services through cross-border co-operation, their allocation to work in this area tends to be in addition to the work that they are normally required to do. This arose particularly in the work of the CAWT initiative but also in regard to civil servants in the two departments. It is suggested that health service staff are already very pressed in terms of their commitments without the additional burden of project work relating to cross-border co-operation, and that such work should really be allocated additional resources. This might include, for example, freeing up some of a manager's time specifically for work on such projects.

### 8.9 Political context

Perhaps the most significant factor likely to influence cross-border co-operation in health care in future is the overall political context. It is notable that in the recent past the pace of developments, particularly (but not exclusively) at departmental level, has been closely related to the state of relationships in a broad political sense. If the arrangements put in place following the Good Friday Agreement can be sustained and built upon it is likely that, as in many other spheres of life, cross-border and all-Ireland working will become an increasingly accepted and natural part of the way things are done on the island.

### 8.10 Conclusion

A number of barriers to cross-border co-operation are identified in the findings, which - although not insurmountable - if tackled have the potential to enhance the scope of cross-border working. This would suggest that in addition to the current project-based approach and possibly future service-based approaches, an

## Barriers to co-operation and how they might be overcome

additional concerted effort is required to identify and dismantle potential barriers to enhanced co-operation, where this is feasible and appropriate. Where this is not feasible, guidance could be developed to enable those planning services to deal with such barriers. For example:

- It might be possible to devise joint or reciprocal arrangements be put in place for professional insurance and accreditation
- Protocols/guidelines might be developed for the arrangement of aftercare for someone receiving care in the other jurisdiction, and for GP cover between jurisdictions
- It might be possible to resolve the problem of transaction costs by devising a system of rolling contracts.





## Findings and recommendations

### 9.1 Introduction

THE purpose of this chapter is to distil the material in previous chapters into a set of overall findings from the study and to present some recommendations for future action by the two Departments of Health and by health service planners and commissioners in the two jurisdictions.

### 9.2 Achievements to date

In assessing progress to date it is important to recall that only 15 years ago cross-border co-operation in health care on the island of Ireland was almost non-existent, apart from isolated ventures involving small numbers of patients travelling for treatments only available in one jurisdiction. There were periodic meetings of Ministers that invariably resulted in agreement about the potential for further co-operation, but no facilitating structures existed and the key personnel on the two sides of the border were virtually unknown to one another.

Since then much has been achieved, not least in terms of improving relationships, building networks and sharing experience and best practice between health service managers and practitioners in the two jurisdictions. This is often described as 'preparing the ground' for future, more substantive co-operation initiatives. There has been a great deal of 'behind-the-scenes' activity (most of it sponsored by CAWT) involving committees, feasibility studies etc.

Despite this, the current level of co-operation involving patient cross-border services is still quite limited; very few patients have crossed the border for treatment and there has been almost no joint service development. Although those who have been closely involved with co-operation initiatives such as CAWT are generally enthusiastic, there is evidence of a lack of widespread knowledge and ownership of them, notably on the part of HSS Trusts in Northern Ireland.

Sometimes the impression is given that the establishment of cross-border links or the acquisition of funds is regarded as an achievement in its own right.

Progress in relation to the five areas for co-operation identified in the Belfast Agreement has also been limited, possibly because of competing demands on the time of the small numbers of departmental staff involved.

### 9.3 Benefits

This section sets out to summarise what have been the real benefits of co-operation initiatives to date and for whom. As we noted above, because of the multiple influences on the health status of an individual or a population, it is often very difficult



## Findings and recommendations

to isolate the contribution of a particular episode of health care. For that reason any attempt to measure the 'outcome' of a particular cross-border initiative in terms of health gain is almost certainly doomed to failure. There is a danger then of interpreting the absence of evidence about an effect on health as evidence of an absence of such effect.

Nevertheless it should have been possible to establish what the impact has been of those initiatives that have involved patients, if only in terms of readier access and reductions in waiting lists.

### CAWT

The potential benefits of cross-border co-operation in health care were set out most clearly in the objectives that the CAWT organisation set for itself at the outset. These were:

- Improving population health and social well-being
- Exploiting opportunities for co-operation in planning and providing services
- Taking up available funding from EU or other third parties
- Involving other public sector bodies in joint initiatives
- Assisting border areas in overcoming problems arising from isolation
- Exploiting opportunities for joint working or sharing of resources where these would be of mutual advantage.

Most of these objectives have been fulfilled to some extent, apart from the first one (which, as we noted above, is virtually impossible to measure). The remainder are mostly about process. A detailed assessment of achievements is included as Appendix 9.

As noted above, the main objective of CAWT is to improve the health and social well-being of its resident population. However the shortlisting criteria for the Letterkenny/Altnagelvin project clearly state that any proposed collaborative developments regarding the two hospitals should not impact negatively on existing services at each hospital. There is a danger that if restrictive approaches to co-operation are adopted opportunities for the improvement of patient care may be lost.

A great deal has also been achieved by CAWT in terms of improved relationships. Considerable credit is due to those who conceived and pioneered the initiative in an often adverse political climate. Attitudes to CAWT are generally very positive and there is optimism about future potential.

Actual cross-border involvement of patients has, however, so far been limited although there have been notable successes, for example in relation to patients from north Louth receiving renal dialysis in Newry.

## Findings and recommendations

A key question is the extent to which such developments can be attributed to the creation of CAWT. Unfortunately, this question is impossible to answer with certainty although the existence of CAWT does appear to have enabled these initiatives to develop more effectively.

Some evaluation of implemented projects has taken place but the focus has been on process and, to a lesser extent, benefits to patients, rather than the advantages of a co-operative approach over other approaches. A greater focus on what has been value-added by co-operative working would have identified lessons that could be applied in future projects.

The creation of a separate body such as CAWT has certain advantages, one of which is the existence of an identifiable focus of responsibility for taking forward co-operation initiatives in the border area. It also has an important disadvantage in that it can be seen as distant from the mainstream activities of the agencies involved in routine health care. Thus there is little evidence that individual health boards have 'adopted' developments which have been pump primed by CAWT. The work of CAWT has been largely project driven and would benefit from a greater emphasis on population needs assessment. It is noted that needs assessment is an area where significant future development is required in health services as a whole, and that the ability to develop a comprehensive needs assessment for the CAWT region is limited by the lack of appropriate data and poor data systems in general. It has also been suggested that because of the reliance on EU funding, the quality of the proposal for a particular project was perhaps more important than the priority of the need being addressed. However there are some examples of project elements that were mainstreamed such as primary care training.

Similarly there is very little evidence of ownership of CAWT beyond the 'inner circle'. Input from other disciplines within health boards has also been limited, and there is little evidence that co-operation has become embedded in the routine business of boards. This is reflected in strategy and policy documents from each jurisdiction, as highlighted in Chapter Three, and also when one examines the annual plans and contract statements of boards and trusts.

Most of the co-operation projects that have occurred over the last five years have been under the auspices of CAWT. In addition to these there have been isolated contracting initiatives for elective surgery that have undoubtedly benefited patients on a waiting list.



## Findings and recommendations

### 9.4 Critical factors

Where innovation has occurred, several factors have been important. The first set relate to the identification and definition of a problem, most often in relation to an unmet clinical need. The second set relate to mechanisms that will enable the innovation to take place.

One of these mechanisms is an institutional structure. CAWT would appear to fulfil this role but, as we indicate above, it is not clear whether it was absolutely necessary for change to take place. A second is resources. In theory designated resources should not be needed since, if the agencies concerned identify an unmet need, then they should consider a cross-border solution in the same way that they might do with a single jurisdiction solution. In practice, however, the availability of additional resources, such as those provided from the European Union, is clearly a stimulus to co-operation.

Finally, it is necessary for obstacles to be removed. In the past, deeply held views about the other jurisdiction, combined with an aversion by politicians to taking risks that they associated with co-operation, acted as strong barriers to collaboration. These appear to have disappeared to a considerable extent. However fears may also exist at the level of institutions, in which staff may be concerned about threats to their continued employment. Thus it is preferable to identify programmes that can be seen to bring benefits to all concerned.

There are, however, some important potential obstacles as identified in Chapter Eight. These include different funding arrangements, entitlements, levels of baseline provision, structures/accountability, entrenched professional attitudes, professional accreditation and medical insurance. However the problems that arise are not insurmountable and there is scope for the two Departments of Health to work together to develop creative approaches to addressing them. It is further suggested that in order to further enhance the potential for co-operation, a systematic and co-operative approach is required to identify the range of such obstacles and consider longer-term solutions to address them.

### 9.5 Future potential and possible stumbling blocks

We found a great deal of optimism and enthusiasm on both sides of the border about the potential for further co-operation. It is however important to consider how well founded such views are, and what the scope is for real patient benefits. In Chapter Four we identified a number of important themes running through the views of respondents about the potential for co-operation. In a number of cases, widely held views do not seem to be supported by evidence. In the following paragraphs we seek to separate the myths from the facts.

## Findings and recommendations

### **Will cross-border collaboration address the relative disadvantage of border areas?**

We have been unable to confirm the now common assertion that the border areas have particular problems of unmet need, and it is notable that there was no mention of such problems in strategy documents in either jurisdiction until quite recently. (This does not of course mean that unmet need does not exist.) There also appears to have been no systematic assessment of the extent to which cross-border co-operation could meet unmet population needs or provide services more effectively than at present.

### **Is the border region a 'natural' geographic area?**

Similarly, the optimism in both jurisdictions about the potential of cross-border co-operation to help maintain local hospital services by creating a critical mass of population appears to be largely unfounded. Current health policy, for example in respect of hospital services, differs across the two jurisdictions, although these differences largely seem to have been ignored or discounted by those pursuing opportunities for co-operation. Unlike in Northern Ireland, the Republic of Ireland has no policy favouring centralisation. If this difference persists, it may prove to be a barrier to further co-operation as the pattern of services diverges. HSS boards in Northern Ireland might be unable to refer patients to hospitals in the Republic of Ireland that did not meet their proxy 'quality' standards. There is concern, particularly on the part of respondents in the Republic of Ireland, about co-operation being a "one-way street" - patients travelling into the North for treatment with no matching traffic in the other direction. Hospital rationalisation is often a 'zero-sum game', and it seems unlikely that public opinion in either jurisdiction would countenance the effective transfer of services to the other.

### **Are there benefits from planning health care on an all-Ireland basis?**

There appears to be little or no evidence in support of economic arguments about economies of scale arising from developing specialist services to serve the population of the island. Nevertheless there may be scope for joint initiatives in a small number of specialties such as heart and lung transplantation, liver transplantation and paediatric cardiac surgery.

### **Threats to health do not respect boundaries**

This is possibly the area where there is most scope to benefit from collaboration. There are shared threats to health across the island in the forms of both communicable and (particularly) non-communicable disease. There is considerable scope for action on a joint basis to combat these, including joint health promotion campaigns. This is a field where the barriers to co-operation are few and the potential benefits are substantial.



## Findings and recommendations

### **Will cross-border collaboration bring a faster response in an emergency?**

There are obvious potential benefits to be derived from facilitating cross-border movement of patients and/or emergency services. In reality, however, the sparseness of population in the vicinity of the border means that the number of patients involved is likely to be quite small.

### **Exchanging good practice**

This is another area in which benefits may be substantial. As we noted above, the existence of two separate health systems on the island itself provides an opportunity for comparing the effectiveness of different responses to similar problems, and exchanging 'good practice' generally. It is important to be aware that in many cases proper evaluation will be required to establish what is actually 'good' and what is 'bad' practice. It is, however, important to ensure that comparison of experiences in the two jurisdictions does not preclude looking further afield, to other parts of Europe, where the levels of health achieved are often much better than in either part of Ireland.

There are considerable opportunities for useful research comparing different ways of tackling problems common to the two jurisdictions. However almost all the research funded to date under the joint Department of Health, Social Services and Public Safety Research and Development Office/Health Research Board scheme has been in the biomedical field, and as such does not appear to take advantage of these opportunities.

### **Do we need new structures?**

Questions have been raised about how much further co-operation can go with existing structures, i.e. in the absence of an all-Ireland implementation body for health services. At the same time the issue was raised of whether CAWT should maintain its focus in the border region or should become a vehicle for cross border co-operation between the Southern and Northern health services generally. The overall consensus among our respondents was that for the moment it would seem sensible for CAWT to confine its sphere of interest to the four border boards since by adopting a wider focus the emphasis on co-operation on the ground could be lost. Our view is that there is considerable scope for improvements in working arrangements using the existing structures.

## Findings and recommendations

### 9.6 Recommendations for the future

#### Overall recommendations

Both at an overall strategic and an individual project level, greater clarity is needed about the objectives of improving cross-border co-operation and the obstacles that stand in the way of achieving that improvement. Clear statements should be made about existing problems and how they can be ameliorated through closer cross-border working.

There should be a thorough assessment of the potential for co-operation in relation to tertiary referral services including:

- transplantation services (heart/lung and other)
- paediatric cardiac surgery
- collaboration between specialist units in Northern Ireland and the Republic.

There should be an assessment of how co-operation in emergency services close to the border might be enhanced.

In order to expedite progress, the two Departments should consider commissioning joint studies in the five areas identified in the Belfast Agreement. CAWT and the Centre for Cross Border Studies should be seen as organisations potentially capable of undertaking studies of this nature.

There should be much greater collaboration on the island in relation to evaluation and research. In any future cross-border scheme for research into health and social services priority should be given to projects comparing the effectiveness of the two systems. As well as research, consideration should be given to developing formal and reciprocal arrangements for peer review and audit.

There is considerable scope for an expansion of activities such as staff secondments, exchanges and development, and joint training programmes. There should be much greater co-operation in the field of public health, in particular joint health promotion campaigns.

There should be greater co-operation in the field of emerging health technology, and consideration should be given to the establishment of an all-Ireland capacity in health technology assessment.



## Findings and recommendations

Consideration should also be given to:

- putting arrangements in place to resolve 'barrier' issues such as structures/accountability, professional accreditation and medical insurance
- involving clinicians and hospital/trust managers at an early stage in relevant studies
- subjecting proposals to cost-benefit analysis
- including a cross-border element in all service reviews in either jurisdiction
- economic research, for example on the potential for economies of scale.

### Recommendations - CAWT

Clarity is needed to identify how CAWT's work fits into the broader peace and reconciliation agenda of the EU and the two governments.

Clearer objectives for CAWT are required, such as:

- to overcome disadvantage in terms of particular documented levels of unmet need in border areas
- to plan more effectively for 'natural' cross border catchment areas
- to learn about the effectiveness of different responses to common problems.

Evaluation and monitoring should be standardised across all CAWT sub-groups.

Consideration should be given to assigning a quality assurance team to all projects.

There is a major opportunity for CAWT to influence the developing all-Ireland agenda, both by feeding experience to the two Departments of Health and the North-South Ministerial Council and by undertaking work on behalf of them.

In order to take full advantage of the opportunities and to meet enhanced expectations, careful thought is required as to structures and processes. The staffing of the CAWT Resource Unit may need to be reviewed. CAWT has the potential to become an exemplar of good practice, for example in relation to the assessment of health care needs and opportunity costs. Studies should be commissioned into:

- the effects of population sparsity and remoteness
- morbidity and other population characteristics
- unmet need in rural areas
- distance from facilities
- the determinants of utilisation in border areas
- the potential for economies of scale
- efficiency and equity issues

## Findings and recommendations

- baseline levels of provision, any spare capacity and the scope for expansion
- the political/service impact of losing services.

In order to provide a clearer focus on health, there should be greater emphasis on population needs assessment. There should be more input from public health professionals to the work of CAWT, for example in relation to needs assessment or to planning/specifying co-operation initiatives. A greater focus on health and on needs assessment would provide more of a sense of strategic direction, and less impression of developments being opportunistic or the work of CAWT being project-led.

Project objectives/performance indicators should be established in advance and progress measured against these. These should provide a means of justifying staff time spent on projects.

The future success of CAWT might be assessed in part in the light of how well its work has influenced board purchasing strategies. Agreed criteria need to be developed for prioritising possible initiatives. Trusts should be involved more extensively and more attention should be paid to communication and dissemination.

CAWT has been very dependent on EU grant funding. Some projects have lapsed after such funding expires, irrespective of their outcomes. Funding has sometimes not been available to carry forward successful elements of a project on a more structured basis.

A limited amount of funding has been made available from the budgets of the individual boards. It is not clear whether this is because boards see cross-border work as meriting low priority compared with other pressures. An open discussion on the possibilities and constraints of allocating individual board money to cross-border co-operation needs to take place.

There are number of possible options which can be considered in relation to future funding:

- **Continuing to seek EU funding**

This would mean applying to the Peace II and INTERREG III Programmes for funds to support individual projects until 2005. In order to qualify for such funding there will be a requirement to show sustainability. This will normally mean that successful projects will be 'mainstreamed'. Another possible source of EU funding for CAWT would be to seek a loan from the European Investment Bank.



## Findings and recommendations

- **Becoming an EU Intermediary Funding Body**

This would mean securing an allocation of block funding from either Peace II or INTERREG III. CAWT would then select projects and distribute funds to voluntary and community organisations in the health and social services area operating in the border region. However following discussions with the EU Special Programmes Body and the two Departments of Health a decision has been taken not to pursue this option.

- **Seeking an allocation from the two Departments or the NSMC (theme funding)**

This would involve securing a budget from the two governments to focus on large areas of work (e.g. cardiovascular disease). One possibility would be to attract funding from the North-South Ministerial Council (NSMC) to work with the five areas prioritised for cross-border co-operation.

- **Seeking an allocation from the health boards concerned**

While boards do have a hidden commitment to cross-border working in terms of officials' time, there has been no attempt to establish a cross-border fund by the four boards. It may be that there are legal impediments to this, or it may be a reflection of the lack of commitment to cross-border working as a funding priority within boards.

- **Research funding**

It would be possible for CAWT to apply for research funding, in collaboration with academic institutes, from research bodies in Ireland, the UK and Europe. However this could only cover the costs of evaluation, and not project costs themselves.

The following were areas interviewees were asked about:

- 1) *Current state of cross-border co-operation*
  - a) stance/views on cross-border co-operation
    - (i) benefits
    - (ii) feasibility
  - b) developments over recent years
  - c) examples
    - (i) ask to provide examples
    - (ii) ask re: areas identified in research proposal - prompt with list
  - d) arrangements for review/evaluation of value for money impact and benefits of services (e.g. are cross-border arrangements more cost-effective than alternatives?)
- 2) *Barriers, gaps, opportunities and challenges*
  - a) gaps and opportunities
    - (i) areas yet to be explored
    - (ii) potential benefits
    - (iii) why not yet pursued
    - (iv) likelihood that they will be pursued in the future
    - (v) approaches to identifying opportunities and evaluating effectiveness
  - b) barriers and challenges
    - (i) to co-operation and to increased co-operation
    - (ii) once opportunities are identified
    - (iii) implementation
    - (iv) evaluation
- 3) *Proposals to upgrade co-operation and to enhance its effectiveness*
  - (i) views on potential
  - (ii) ideas on how it can be achieved
  - (iii) examples of good practice
- 4) *Key documents and anyone else we should talk to*



### Northern Ireland

Dr Joe Hendron, Chairman of the Health, Social Services and Public Safety Committee in the Northern Ireland Assembly  
Dr Brian Gaffney, Chief Executive, Health Promotion Agency

#### Department of Health, Social Services and Public Safety

Mr Clive Gowdy, Permanent Secretary  
Dr Henrietta Campbell, Chief Medical Officer  
Miss Judith Hill, Chief Nursing Officer  
Mr Don Hill, Deputy Secretary  
Mr Brian Grzymek, Director of Secondary Care  
Dr Bill Smith, Assistant Secretary  
Mr Norman Lunn, Assistant Secretary

#### HSS Boards

Dr Paula Kilbane, Chief Executive, Eastern Health and Social Services Board  
Mr Tom Frawley, Chief Executive, Western Health and Social Services Board and Director General, CAWT (now Northern Ireland Ombudsman)  
Mr Stuart MacDonnell, Chief Executive, Northern Health and Social Services Board  
Mr Brendan Cunningham, Chief Executive, Southern Health and Social Services Board

#### HSS Trusts

Mr Quentin Coey, Chief Executive, Belfast City Hospital HSS Trust  
Mr John Templeton, Chief Executive, Craigavon Area Hospital HSS Trust  
Mr Raymond McCartney, Deputy Chief Executive, Altnagelvin Hospital HSS Trust  
Mr William McKee and Mr Hugh McCaughey, Chief Executive and Director of Contracting, Royal Group of Hospitals HSS Trust  
Mr Eric Bowyer, Chief Executive, Newry and Mourne HSS Trust

#### HSS Councils

Mr Brian Coulter and Ms Jane Graham, Chairman and Chief Officer of the Eastern Health and Social Services Council  
Mr Seamus Magee, Chief Officer of the Southern Health and Social Services Council  
Mr Frank Hughes and Mr Stanley Millar, Chairman and Chief Officer of the Western Health and Social Services Council

## List of those interviewed

### Republic of Ireland

Mr Batt O’Keeffe, Chair, Joint Committee on Health and Children  
Dr Ruth Barrington, Chief Executive Officer, Health Research Board  
Dr Jane Wilde, Executive Director, Institute of Public Health in Ireland

#### Department of Health

Mr Michael Kelly, Secretary General  
Dr James Kiely, Chief Medical Officer  
Ms Peta Taaffe, Chief Nursing Officer  
Mr Joseph Cregan, Principal, Health Insurance and International Unit  
Mr Chris Fitzgerald, Principal, Health Promotion Unit

#### Health Boards

Mr Pat Harvey, Chief Executive Officer, North Western Health Board  
Mr Paul Robinson, Chief Executive Officer, North Eastern Health Board  
Mr Donal O’Shea, Chief Executive Officer, Eastern Regional Health Authority  
Mr Denis Doherty, Chief Executive Officer, Midland Health Board, and Director, Office for Health Management  
Mr Tadhg O’Brien, Director of Primary Care, North Eastern Health Board  
Ms Cara O’Neill, Service Plan Co-ordinator, North Western Health Board

#### Hospitals

Mr Christopher Lyons, General Manager, Letterkenny General Hospital  
Mr Paul McLoone, General Manager, Sligo General Hospital  
Mr Gerry Lynch, Director of Finance, The Adelaide and Meath Hospital, Dublin, (incorporating the National Children’s Hospital)



North/South Study of MRSA in Ireland, 1999	Department of Health and Children, July 2000
Local Authority Cross-Border Networks: and North-South Co-operation	Jonathan Greer, University of Ulster, <i>Administration</i> Spring 2000 (Vol.48 No.1)
Memorandum of Understanding on Cancer Services	Department of Health and Children; Department of Health, Social Services and Public Safety; National Cancer Institute. Sept/Oct 1999
Triangle Project - A feasibility project into acute service provision	Sperrin Lakeland HSS Trust, 8 Sept 2000
North East Doctor on Call	NEHB, Sept 2000 (leaflet)
CAWT Annual Reports 1997, 1998, 1999	CAWT, various
Needs Assessment on Joint Areas of Working	CAWT, late 2000
Audit of CAWT Financial Arrangements for 1998/99	SHHSB, November 1999
Performance Measurement in the Health Sector	M Butler, CPMR, 2000
Service Planning in the Health Sector	M Butler, R Boyle, CPMR, 2000
Working for health and well-being: Strategy Statement 1998-2001	Department of Health and Children, 1998
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Cross-border health care: meeting the acute health care needs of a rural population	D McKee, 1998
Altnagelvin/Letterkenny Partnership Project Report	Letterkenny General Hospital and Altnagelvin Hospitals, August 2000
European Journal of Public Health - supplement on cross-border health care	EUPHA, Sept 1997
Community Childhood Accident Prevention Project	CAWT, 2000

## Documentary Material

Laying Foundations: Cross-Border Co-operation in Health - CBAP Evaluation Report	A Hayes, D Birrell, A M Gray, University of Ulster, 2000
Strategic Plan 2000-2003 and Workplan 2000	Institute of Public Health in Ireland, 1999
Partnership Framework: A Model for Partnerships in Health	Institute of Public Health in Ireland, 2001
The family health nurse: Context, conceptual framework and curriculum	WHO Europe, 2000
Report on the All-Ireland Public Health Nursing Network Workshop, Newry	C Mason/H McKenna, 1999
The Amsterdam Treaty and the future of European health services	M McKee, J Health Serv Res Policy, April 1998
The Influence of European Law on National Health Policy	M McKee, E Mossialos, P Belcher. J Eur Sol Policy, 1996
White Paper on Private Health Insurance	Department of Health and Children, 1999
North-South co-operation in acute health care - an idea whose time has come?	D McKee, J Irish Colleges Physicians Surgeons, July 1999
Building the Way Forward in Primary Care: A Consultation Paper	Department of Health, Social Services and Public Safety, December 2000
Long-stay Activity Statistics 1996	Department of Health and Children
Investing for Health: A Consultation Paper	Department of Health, Social Services and Public Safety, November 2000
Putting it Right - the Case for Change in N Ireland's Hospital Service	Department of Health, Social Services and Public Safety, 1999
OECD Economic Surveys 1996-97: Ireland - the Health System	Organisation for Economic Co-operation and Development



## Progress reported at North-South meetings between Health Ministers

## Appendix 4

An examination of press releases from joint ministerial meetings in February 1998 and May 1999 produced the following:

- 1) *February 1998* - Satisfactory progress was reported on the implementation of the two patient-centred **Cancer Strategies** and it was suggested that the two ministers were exploring the scope for closer co-operation in the delivery of certain aspects of specialised cancer care.

*May 1999* - Much the same report as before with the rider that Ministers were looking forward to new initiatives starting to make a positive impact.

- 2) *February 1998* - Reference was made to the establishment of the **Food Safety Authority of Ireland** from January 1, 1998 as a corporate body, which would be established later that year following passage of relevant legislation. The importance of the new body working in co-operation with the Food Safety Authority in Northern Ireland was noted by the Northern Irish Minister.

*May 1999* - The establishment of the **Food Safety Promotion Board** as a joint North/South Implementation Body as a follow up to the Good Friday Agreement. Its responsibilities were to include research, surveillance of food-borne disease, and the promotion of food safety. The Northern Ireland Minister, Mr McFall, commented on the continuing close liaison between officials over practical arrangements for setting up of the Board, and the 'special focus' required on its relationship with the UK Food Standards Agency and Food Safety Authority of Ireland. The Irish Minister, Mr Cowen, referred to the new implementation body complementing existing bodies North and South.

- 3) *February 1998* - Mr McFall was reported as having briefed Mr Cowen on the recently launched **Strategy for Health and Wellbeing for Northern Ireland**, and noting similarities with **Republic of Ireland Health Strategy**. Mr McFall expected it would provide a further basis for future sharing of information and actions directed at achieving optimal health on an all-island basis. He also outlined plans for publication of a consultation document on the future organisational infrastructure of the Northern Ireland health service.

*May 1999* - The Ministers were very pleased to note that the field of health promotion provided valuable opportunities for cross-border action and co-operation. A close working relationship had been established between the Health Promotion Unit (Republic of Ireland) and the Health Promotion Agency (Northern Ireland) and this was set to continue to mutual benefit.

## Progress reported at North-South meetings between Health Ministers

- 4) *February 1998* - The Ministers exchanged information on other areas of mutual interest, which they expected would lead to further scope for joint action and co-operation in the future. These included child health and surveillance of communicable diseases.

### **North-South Ministerial Council**

The first meeting of the North-South Ministerial Council Sectoral Group on Food Safety Promotion and Health took place on 4 February 2000. This was the first official meeting between the Northern Health Minister, Bairbre de Brún, and the Irish Government's Minister for Health and Children, Micheál Martin. Sir Reg Empey also attended the meeting.

The meeting dealt with issues relating to the Food Safety Promotion Board and with health, which is one of the six areas of co-operation under the Good Friday Agreement. Ministers discussed issues in the area of health that have been identified for improved co-ordination and co-operation. These are accident and emergency planning and major emergencies; co-operation on high technology equipment, cancer research and health promotion. The Ministers noted the examples of effective co-operation taking place in these areas but agreed that there was much more that could be achieved. The incidence of heart disease and cancer in both parts of the island was identified as being unacceptably high and it was agreed that much could be done in jointly promoting healthier lifestyles.

It was agreed that Department of Health, Social Services and Public Safety and Department of Health and Children officials would prepare papers for the next meeting setting out how common work in each of the five areas for co-operation might be taken forward.

The Council received a verbal report from Martin Higgins, interim Chief Executive of the Food Safety Promotion Board (FSPR). Commenting on the inaugural meeting of the Board, also held on 4 February, Ms de Brún said: "The Council looks forward to working closely with the Food Safety Promotion Board. Food Safety is an important issue for us all and is a topic that can be tackled on an all island basis."

Ms de Brún continued: "Overall this has been a very positive start to what I hope will bring mutual and tangible benefits in the areas of health and food safety to patients and clients throughout Ireland."



## Progress reported at North-South meetings between Health Ministers

The second meeting of the NSMC in health sectoral format took place on 4 July 2000. It was attended by Bairbre de Brún and Dermot Nesbitt from the North and Micheál Martin and junior health minister Dr Tom Moffat from the South. The Council received a detailed oral report from Dr Thomas Quigley of the FSPB. This dealt with management and staffing structures and was approved, in principle, by the Council.

A progress report was presented on the five areas for North-South co-operation. The Council focused particularly on cancer research and health promotion. It was agreed that proposals for decision in a number of the areas for co-operation would be put to the Council at its next meeting.

There was an oral presentation from Dr Jane Wilde, Director of the Institute of Public Health in Ireland, and the Council paid tribute to the work of the Institute.

A North/South bilateral ministerial meeting on Food Safety and Health outside the formal framework of the NSMC was held on 3 November 2000 involving Ms Bairbre de Brún and Mr Micheál Martin. The meeting was also attended by Deputy First Minister Mr Séamus Mallon and Dr Tom Moffatt.

Ministers received a progress report on the work of the FSPB from the interim Chief Executive, Mr Martin Higgins. Amongst the programmes being developed by the FSPB is a major television advertising campaign that will extend into other marketing channels such as direct mail and in-store promotions. The FSPB was formally launched following the meeting and will be located in Cork.

### *Co-operation and Working Together (CAWT)*

The Ministers received a presentation on the work of CAWT from the Director, Mr Paul Robinson and the Principal Executive Officer, Ms Frances Reynolds. The Ministers paid tribute to the important contribution made to North-South co-operation by CAWT since its inauguration in 1992.

### *Areas for Co-operation in Health*

Ministers discussed progress in establishing co-operation under the five areas for co-operation. They endorsed the following:

- with regard to accident and emergency services, CAWT to make further proposals for developing local collaborative projects
- the Regional Hospital Services Group to initiate work immediately on scoping the development of collaborative arrangements covering renal transplantation and radiotherapy services
- the establishment of working groups on ambulance services and emergency planning

## Progress reported at North-South meetings between Health Ministers

- the establishment of a joint High Technology Assessment Group to draw up protocols for the assessment/evaluation of emerging new technology.

Commenting on the Tripartite Agreement on Cancer between Ireland and the USA, Ms de Brún stated: "This is an important opportunity to improve cancer research in Ireland and is of benefit to the whole island."

### *Folic Acid*

Launching a joint campaign on Folic Acid the Ministers stated: "This a solid demonstration of co-operation which will be of mutual benefit to everyone North and South." The Ministers emphasised the real and important impact which this campaign can have on the incidence of neural tube defects, such as spina bifida, through encouraging women intending pregnancy to take folic acid.



**EU SPECIAL SUPPORT PROGRAMME FOR PEACE AND RECONCILIATION  
FUNDED PROJECTS**

REF	PROJECT NAME	ROI (IR€)	NI (Stg€)
EU 1/PR 596	Child Accident Prevention Programme Phase 1	152,000	152,000
EU 11/PR 664	Cross Border Flexi Workers	37,500	37,500
EU 13/PR 665	CAWT Support Phase 1	110,500	110,500
EU 8/PR 668	Protecting Children with a Disability	55,500	55,500
EU 10/PR 666	Parenting Initiatives	69,625	69,500
EU 68/PR 1344	Primary Care Phase 1	422,664	237,336
EU 62	Drug Awareness	133,333	0
EU 65/PR 210	Imp. Health in Border Regions/ Craigavon Phase 1	204,125	233,333
EU 51/PR 853	Ambulance Training	177,000	167,000
EU 14	Community Youth	219,000	0
EU101	CCAPP Phase 2	76,866	128,739
EU113	CAWT Phase 2	234,839	255,453
EU168	Primary Care 2	279,495	361,567
EU165	Improving Health In Border Areas 2	120,787	107,500
EU167	Cognitive Therapy	59,245	82,472
EU161	CAWTAS	28,089	25,000
EU160	AGH/Letterkenny	34,832	31,000
EU114	Melvin Mental Health	235,393	212,571
EU118	Letterkenny Cancer Services	524,345	95,300
<b>TOTALS</b>		<b>3,175,138</b>	<b>2,362,271</b>

## CAWT funding

### CAWT BOARD FUNDING FOR PROJECTS

REF	PROJECT NAME	ROI (IR£)	NI (Stg£)
EU1	CCAPP Phase1	53,624	47,748
EU 11	Flexi Worker Project	128,143	126,257
EU 13	CAWT Support Unit Phase 1	33,332	45,211
	Recruitment Practices Research Project		
	GIS Systems		
	Child Care Legislation Comparison Project		
	Learning Disabilities Needs Assessment Project		
	Social Deprivation Research Project		
	A total of £30,000 was allocated to the		
	5 research projects above	15,000	15,000
	Primary Care Project	60,000	0
	Breast Cancer Audit	36,418	33,697
	<b>TOTALS</b>	<b>326,517</b>	<b>267,913</b>

Note: these costs do not include the costs borne by all boards/trusts in respect of the continued work of the sub groups and the support of these sub groups



## Summary of constraints to cross border partnership working from the Altnagelvin/Letterkenny partnership report

## Appendix 6

- Hospitals tend to work as self-contained units and are seen to operate, in some instances, in competition to one another. Developing services at one site may mean discontinuing/reducing services at another. The latter, even within one jurisdiction, is difficult, but when it crosses jurisdictions it is even more difficult.
- Legislation differences regarding eligibility for services, the special licensing of products (radioisotopes supplies), the transport and disposal of wastes (nuclear) and employment legislation can have serious impact on partnership working.
- Registration of nursing, medical and professionals allied to medicine is carried out in both jurisdictions by separate bodies who often have different sets of requirements. This can seriously inhibit joint appointments, staff rotations/placements and cross covering.
- Administrative differences in terms of pay scales, conditions of employment, job descriptions and tenure of office make it difficult to have joint recruitment drives, sharing of staff pools, staff placements/rotations and joint appointments.
- Medical defence insurance, which is operated by private providers in the Republic of Ireland, is operated by health authorities in Northern Ireland, making it difficult to enter into cross cover arrangements at a senior medical level.
- Undergraduate and postgraduate training is organised and accredited by different bodies in both jurisdictions, and in many cases reciprocal recognition does not exist, inhibiting partnership training programmes.
- Funding arrangements in both jurisdictions are quite different and can provide a barrier to partnership working.
- Currency fluctuations (Estg/Epunt) of up to 40p can seriously undermine cost proposals.
- Standards, protocols, guidelines and audit procedures vary considerably between both jurisdictions and can inhibit partnership working.
- Both hospitals have tertiary level services provided within their own jurisdictions making it difficult to refer patients from one hospital to another.
- Service users, for political/cultural reasons, may be reluctant to avail of services in another jurisdiction although such services are provided to the nearest point of delivery.

## Summary of constraints to cross border partnership working from the Altnagelvin/Letterkenny partnership report

- The public/private mix of service provision is quite different in both areas, and insurance providers do not always offer the same cover to patients availing of services outside their area of domicile.
- Finally, there is staff willingness to facilitate and co-operate with new arrangements to the extent that allows health professionals to move from one hospital to another to deliver a service.

Although these constraints are quite significant, they should not be viewed as unsurmountable barriers but as challenges and opportunities to overcome in the interests of the population served.



The majority of views of CAWT respondents was generally positive in nature and referred mostly to the development of understanding between those involved in the planning and delivery of health services on both sides of the border and the development of cross-border networks. Views also related to the structure of CAWT and its role in promoting change. In summary, respondents reported that:

- The Ballyconnell agreement which led to CAWT brought about a significant change in the way that board members looked at cross-border co-operation. The involvement of board chairmen is particularly important.
- Much of what has happened would not have occurred without CAWT. The existence of CAWT has brought about a familiarity with services on the other side of the border so that when an opportunity emerges it is possible to make contact with the appropriate people in the other jurisdiction.
- CAWT formalised the co-operation that was already in existence. Instead of looking at practical co-operation along the border strip, the emphasis is now on looking at the one million people who live on either side of the border and asking what can be done collectively for them that will be more effective than doing it in separate jurisdictions.
- CAWT has been opportunistic in identifying potential areas and exploiting them.
- There is a good management structure. The CAWT management board meets about three to four times a year and there is a lot of feedback from the various projects. The chief executive officers meet as a group first and put together the main report with the secretariat prior to the management board meeting. CAWT really took off with the appointment of the full time administrator working alongside the director-general.
- Throughout there has been very encouraging support from the North's Department of Health and Social Services, the various ministers and ultimately even from John Major when he was Prime Minister.
- Much encouragement and moral support came from Brussels and this was seen as at least as important as the financial support.
- Experiences gained in CAWT were also made available to other boards in the two jurisdictions.
- Now that relationships have been built boards are putting increasing amounts of their own resources into CAWT.

Nonetheless there were also references to difficulties experienced when submitting proposals: for example, one person's experience of submitting proposals to CAWT is that it can take a long time for them to be processed, resulting in a loss of impetus and enthusiasm on the part of professionals. It was also suggested that to date CAWT has been driven by specific projects and needed to take on a broader role in joint working. It was suggested too that there has been little joint development except in dermatology. It was reported that some real barriers such as professional registration exist and it will take a dedicated project to bring about change, but CAWT has prepared the ground. One weakness is that there is only one representative from the HSS trusts in

## Summary of CAWT respondents' views

Northern Ireland on the CAWT management board. There is very little contact between CAWT and the other trusts in the border region. There were also several views on how CAWT should be developed in the future:

- Most respondents felt that CAWT should be allowed to continue concentrating on co-operation in the vicinity of the border, with all-Ireland developments being looked after at a different level. Their view was that the strength of CAWT lies in the familiarity that has been built up with services and personnel on the two sides of the border. The type of co-operation that might be developed involving Belfast and Dublin would be quite different from that close to the border.
- There needs to be a more strategic approach involving identifying needs, and setting priorities. The directors of public health need to be more closely involved.
- The move should be away from project-based work towards direct provision of services across the border.
- A joint executive is being established to provide a vehicle for agreed action on the part of the health boards in the Republic. It was suggested that if some health services were organised on an all-Ireland basis this or a similar body would have a wider remit and there might be no need for CAWT.



1999	Dr Peter Maxwell, Belfast City Hospital. Professor Hugh Brady and Dr Mc Carthy, Mater Hospital Dublin. Identification of susceptibility genes for progressive renal disease by combined genotyping for single nucleotide polymorphisms and analysis of differential gene expression.	3 years £30K
	Professor Roy McClelland, The Queen's University of Belfast. Dr Kevin Malone, Mater Hospital Dublin The Ireland North/South, Urban/Rural Epidemiologic (INSURE) Collaborative Project on Suicidal Behaviour in Major Psychiatric Disorders.	2 years £53K
	Professor David Marsh, The Queen's University of Belfast. Dr Alun Carr and Dr Pancred, University College Dublin. Novel tissue-engineering approaches to bone graft.	2 years £61K
2000	Dr. Aaron Maule, The Queen's University of Belfast. Professor John Dalton, Dublin City University. The role of peptidases in the regulation of neurotransmission signalling in the parasitic helminths <i>Fasciola hepatica</i> and <i>Schistosoma mansoni</i> .	3 years £97K
	Professor Mark Pallen, The Queen's University of Belfast. Professor Timothy Foster, Moyne Institute, Trinity College Dublin. Exploiting the genome sequences of <i>Staphylococcus aureus</i> .	3 years £110K
	Dr. Stuart Elborn, Belfast City Hospital. Dr Claire O' Connor, University College Dublin. Evaluation of the contribution of a polymorphism in the $\alpha$ 1-proteinase inhibitor gene to pulmonary disease in Cystic Fibrosis.	3 years £111K
	Dr. Tracy Robson, Lecturer, University of Ulster. Dr Mark Lawlor and Professor Hollywood, St. James Hospital Dublin Selective Activation of Transgenes to enhance radiotherapy in prostate cancer	3 years £110K

# CAWT - assessment of achievements against objectives Appendix 9

Primary Objectives	Achievements
<p>The improvement of health and social well-being of their resident population</p>	<p>Improvements in health and social well-being are impossible to measure.</p> <p>Respondents feel that work to date has built a strong foundation from which health will be improved in the longer term. They also believe that by improving training of staff through cross-border links the population will eventually benefit by receiving better care.</p> <p>Models of best practice have been identified in both jurisdictions.</p> <p>There has been a great exchange of ideas on a cross-border basis.</p> <p>“CAWT may appear to be unproductive time but one cannot buy trust”.</p> <p>There should be a greater emphasis on patient needs assessment.</p>
<p>The exploitation of opportunities for co-operation in the planning and provision of services</p>	<p>The <i>planning aspect</i> is best established in individual feasibility studies. One limitation of CAWT's work is that it lacks a overall strategic direction which is grounded in the policies of both jurisdictions. However, there are exceptions such as the Primary Care Project.</p> <p><i>Provision of services</i> to patients on a cross-border basis has been limited to dermatology clinics and renal dialysis treatment. There is a query over how involved CAWT was in establishing this work.</p> <p>Other work has centred on the development of protocols, training methods or research models.</p>



## CAWT - assessment of achievements against objectives

Primary Objectives	Achievements
The take-up of funding which may be available under the European Union or from outside parties	<p>CAWT has been successful in attracting over £5 million in EU funding to its health agenda. It is doubtful if this money would have been attracted to the region without CAWT's overseeing role.</p> <p>There has been no funding from other sources and only limited allocations from individual boards. However there is a hidden commitment from CAWT in terms of allocating people's time and resources.</p>
The involvement of other public sector bodies in joint initiatives where this would help fulfil CAWT's primary objectives	<p>There has been some involvement of other public sector bodies through building the Stranorlar-Ballybofey Primary Care Centre with cross-border usage and through the Family and Child Care sub-group.</p> <p>Most external partnerships have been developed with the community and voluntary agencies.</p>
To assist border areas in overcoming the special development problems arising from their relative isolation within national economies and within the European Union as a whole, through the promotion of government and EU awareness of and support for this process	<p>Relationships have been developed with the new North/South structures.</p> <p>The Departments of Health in both jurisdictions should be made more aware of CAWT's progress.</p> <p>The EU funded projects have raised the awareness of the health-related problems of the Irish border region at a European level.</p> <p>CAWT should share its experience of cross-border co-operation with other EU border regions.</p>
The exploitation of all opportunities for joint working or sharing of resources where these would be of mutual advantage	<p>CAWT has been very active in establishing joint training days and conferences, and exchanging information (e.g. email systems)</p> <p>A joint consultant dermatology post was not filled due to difficulties (instead it was conducted using outreach clinics staffed by specialists).</p> <p>Secondments of staff on a cross-border basis are beginning to happen.</p>

**Source:** From concept to realisation: an evaluation of CAWT, Patricia Clarke and Jim Jamison, Centre for Cross Border Studies, December 2000

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## Notes



## Notes



The Centre for Cross Border Studies, based in Armagh, was set up in September 1999 to research and develop co-operation across the Irish border in education, health, business, public administration, communications and a range of other practical areas. It is a joint initiative by Queen's University Belfast, Dublin City University and the Workers Educational Association (Northern Ireland), and is financed by the EU Special Support Programme for Peace and Reconciliation. Between March and May 2001 the Centre will publish research reports on cross-border telecommunications, cross-border health services, all-Ireland co-operation to tackle disadvantage in education, North-South EU funding programmes and a number of other areas of practical North-South co-operation.

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