

Acknowledgements

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EXECUTIVE SUMMARY

The Co-operation and Working Together (CAWT) organisation was initiated in 1992 when the North East Health Board (NEHB) and North West Health Board (NWHB) from the Republic of Ireland and the Western Health and Social Services Board (WHSSB) and Southern Health and Social Services Board (SHSSB) from Northern Ireland signed the Ballyconnell Agreement committing them to co-operation to improve the health and social well-being of their resident populations. The four CAWT Boards embrace the whole of the land boundary between the Republic of Ireland and Northern Ireland, serve a population of over one million people and account for 25% of the total land area of the island of Ireland.

This report highlights the main findings of an evaluation conducted by the Centre for Cross Border Studies at the request of the CAWT Management Board.

Over a four month period (August–December 2000) a series of interviews were held with 30 key personnel. Within the time constraints of the evaluation period, every effort was made to include representation from all health sectors and all partner organisations. Where further detail was required, telephone interviews were conducted. A separate and complementary study had already been commissioned by the Centre for Cross Border Studies concerning the issue of all-Ireland co-operation in health services and was being carried out by a team led by Dr Jim Jamison. This work also involved a series of interviews with key personnel within CAWT. The findings of that study have been used to inform this evaluation.

Members of the evaluation team observed CAWT proceedings at a range of meetings throughout the evaluation period: management board, secretariat, sub-group and project group. All available CAWT documentation was reviewed including annual reports, strategic plans and project documentation. A North-South Health Services Study Day was held in November 2000 at which the preliminary findings of the evaluation were presented to members of CAWT who were given the opportunity to respond and to elaborate on issues which had been identified throughout the interview series. This study day was an integral part of the evaluation and offered CAWT the opportunity to contribute positively to the final recommendations.

This report begins by setting out the context of cross-border co-operation in Ireland and introducing the main players: the North/South Ministerial Council, the cross-border EU funders and the local authority cross-border networks. This evaluation is being prepared at a time when CAWT is actively considering its future role. Changes in the North-South political structure brought about by the Good Friday Agreement have afforded CAWT a platform from which to influence the cross-border health agenda. CAWT is seeking long-term funding solutions which would allow it to evolve beyond the constraints of a narrow project focus. In addition, CAWT will also be hoping to attract new EU funding from either/ or both the Peace II Programme and the INTERREG III Programme.

Following a general introduction to the structure and growth of CAWT since its conception, the work of each CAWT sub-group is examined in terms of its structure, process, output, main achievements and main issues. Particular attention is given to examining the working structures of CAWT in terms of how the organisation is both led and supported by its member boards and trusts. The overall CAWT focus and approach to cross-border co-operation is scanned. Finally the broader European context is outlined.

The main focus of CAWT to date has been on providing a forum through which senior management from the member boards can work together on charting future developments in mutually beneficial areas. In so doing, this approach has tried to encompass as many areas of

health care as possible and to build as many networks as possible. Ultimately the goal has been to change the culture of planners, commissioners and providers 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 populations in the border region.

The work of CAWT has been mostly project-focused, very diverse and heavily dependent on EU grant funding. The CAWT model of cross-border service development has yet to be tested, with the majority of projects concentrating on issues of training and education as opposed to service delivery. Few projects have involved patients on a cross-border basis, although in the ones that have patient benefits can be seen in the reduction of waiting lists for out-patient dermatology in the Craigavon/Armagh/Dundalk region and improving access to renal dialysis treatment for patients in the Dundalk area.

At a corporate level, the structures of the organisation are stable, yet there is a need to develop greater ownership of CAWT. The Resource Unit plays a central role in maintaining balance between the partners and in maintaining the momentum of the sub-groups. The Secretariat works well because of the seniority of members who typically have direct links to the board CEOs. However the Secretariat is stretched by a very heavy workload. The working process is flexible (not overly bureaucratic), yet very time-intensive. The financial management structure is well developed. More effort should be made actively to engage the trusts under the over-arching CAWT umbrella. The Secretariat accounts for a relatively small amount of funding. However the opportunity costs of the involvement of fairly senior board staff in CAWT activities are substantial. Ultimately the cost of that involvement should be gauged against the benefits for patients and clients.

The conclusions and recommendations are presented as the main contributions that CAWT has made to the overall cross-border health agenda and the main issues that need to be addressed to optimise CAWT's future potential. A series of recommendations are outlined to help CAWT develop into the future. While there are specific issues around communication, dissemination and evaluation which need to be addressed, there are also proposals made for ensuring that valuable lessons on cross-border co-operation are not forgotten.

Both at an overall strategic and an individual project level, greater clarity is needed about the objectives of improving co-operation and the obstacles to be overcome in achieving that improvement. A clear statement should be made about existing problems and how they can be ameliorated through closer cross-border working. Clarity is also needed to identify how CAWT's work fits into the broader peace and reconciliation agenda of the EU and the two governments, perhaps through its work in helping to overcome 'people to people' barriers in the health sector. It is recommended that a revised CAWT strategy should include clear statements on CAWT's objectives, existing cross-border problems and the interaction between health objectives and peace and reconciliation objectives. There could be instances where co-operation in the development of services would lead to sustainable, mutual benefits in improving the health of the CAWT population. Care needs to be taken that restrictions intended to protect existing services do not impede the possibility of future co-operation which could lead to benefits for the overall health of the population. A strong view was expressed by respondents from the Republic of Ireland, particularly in the North-West, to the effect that co-operation should not be seen as a one-way street in terms of patients and resources flowing from the South to the North. There needs to be open discussions around acceptable development criteria and documentation of these criteria needs to take place.

In order to provide a clearer focus on health there should be a greater emphasis on population needs assessment. This would provide more of a sense of strategic direction, and less impression

of developments being opportunistic. Greater involvement of the public health sub-group would be gained through the undertaking of such an assessment with structured plans on how this information would be used to plan CAWT's future agenda. It is noted that needs assessment is an area where significant further development is required in health services as a whole and the ability to develop a comprehensive needs assessment for the CAWT region may be limited by the lack of appropriate data and poor data systems in general.

It is recommended that CAWT proactively support the more inclusive involvement of Trusts in Northern Ireland and encourage the greater contribution of Information Technology, Human Resources and Public Health sub-groups to the CAWT programme. The current practice of timetabling structured meetings between CAWT representatives, Secretariat members and CEO in the NEHB has proved to be an efficient means of effecting progress and acknowledging and supporting staff contributions. It is recommended that all Boards and Trusts develop in this manner.

At present the evaluation and monitoring of CAWT's work is co-ordinated by the individual sub-groups. In order to standardise this work across the entire organisation it is recommended that guidelines on the expected standard and format of CAWT work be established. In addition, consideration should be given to assigning a quality assurance team to all projects. The quality assurance team involved in the primary care project has proved to be very beneficial in maintaining the focus on the cross-border aspects of the work and ensuring that the development is aligned to the policies of both jurisdictions. Enthusiasm about future potential for cross-border working needs to be backed up careful research. It is recognised that CAWT has already established short-term links with several universities. The development of on-going relationships would provide support for CAWT decision-making and would lend credibility to CAWT's stance in influencing the emerging all-Ireland agenda. It is recommended that CAWT develop a mutually beneficial research programme with academic institutes and policy institutes.

The new North-South political arrangements provide an excellent opportunity to build on CAWT's foundation but the expectations of what CAWT can do will be greater. In order to take full advantage of the opportunities and to meet enhanced expectations, it is recommended that the staffing of the central executive be reviewed to provide both greater support for the existing Secretariat members and to facilitate the move towards developing an on-line communications culture. CAWT is actively seen to be improving its external relationships. However, while both departments of health have officially endorsed CAWT, there does not appear to be a broad insight into CAWT workings or relevance within the Departments. A closer relationship and improved communication channels need to be developed between CAWT and the two health departments. Consideration should be given to establishing joint CAWT-health department meetings to discuss how cross-border and all-Ireland co-operation agendas can symbiotically develop. CAWT has a valuable role to play in influencing the emerging all-Ireland agenda by proposing work which could be undertaken in collaboration with the new North-South structures and highlighting any staffing, structural and accreditation difficulties encountered in pursuing the CAWT agenda. Finally, the CAWT Resource Unit appears to be acting as a central information point on matters relating to cross-border co-operation on the ground in Ireland. An up-to-date (on-line) repository of CAWT documentation and other relevant documentation should be held at the CAWT resource unit.

An additional part to the evaluation is an examination of the European health agenda. This section outlines how this agenda has developed within European law and illustrates the implementation of EU law with practical examples of current cross-border co-operation between health services. The European picture can be seen as a resource which CAWT can learn from and use to develop its own cross-border co-operation.

This work has been completed by Dr Patricia Clarke, Research Officer, Centre for Cross Border Studies in collaboration with Dr Jim Jamison, former Director of the Health and Social Care Research Unit, Queens University of Belfast.

PART I THE IRISH CONTEXT

1. THE EVALUATION

Following a tender process and presentation, the Centre for Cross Border Studies was commissioned by the Co-operation And Working Together (CAWT) Management Board to undertake an evaluation of the organisation.

1.1 Approach

During the period of August – December 2000, an evaluation of Co-operation And Working Together (CAWT) process addressed three main issues:

- CAWT's progress, highlighting the main achievements and potential areas for improvement. Particular emphasis was paid to the issues of accountability and effectiveness.
- The extent to which co-operation has been embedded into mainstream health care
- The future context of co-operation with respect to the European agenda and the implications for CAWT when EU project funding potentially ends in 2006.

1.2 Methodology

A separate and complementary study had already been commissioned by the Centre for Cross Border Studies concerning the issue of All-Ireland co-operation. This work also involved a series of interviews with key personnel within CAWT. The findings of this work have been used to inform this evaluation.

A variety of methods were used to gain an in-depth understanding of CAWT.

- Members of the evaluation team observed CAWT proceedings at a range of meetings throughout the evaluation period: Management Board, Secretariat, Sub-group (Health Promotion, Human Resources, Family and Child care) and Project group (Primary Care project team and Craigavon Acute Project review meeting (CBAP)). Every effort was made to attend meetings at different levels of the organisation.
- Semi-structured interviews were conducted with key personnel (See Appendix A for details). Within the time constraints of the evaluation every effort was made to include representation from all health sectors and all partner organisations (see Figure 1 below). Where further detail was required, telephone interviews were conducted.
- All available CAWT documentation was reviewed including annual reports, strategic plans and project documentation. (See Appendix B for details)
- A North-South Health Services Study Day was held at which the preliminary findings of the evaluation were presented to members of CAWT who were given the opportunity to respond and to elaborate on issues which had been identified throughout the interview series. This study day was an integral part of the evaluation and allowed CAWT to positively contribute to the final recommendations. Details of this day are outlined in the Appendix C.
- Throughout the period of the evaluation, contact was maintained with the CAWT Principal Executive Officer.

Figure 1. Evaluation interviews by sector and organisation.

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2. THE CROSS-BORDER APPROACH

2.1 North/South relationships

2.1.1 North-South Ministerial Council

North-South co-operation has been placed on a new basis under the provisions of the multi-party agreement reached in Belfast on 10th April 1998 – known as the Good Friday Agreement. The North-South provisions of the Agreement provided for the setting up of the North-South Ministerial Council (NSMC) and outlined a new institutional framework and context within which co-operation between the two parts of the island is now being taken forward.

The Agreement identifies six new cross-border Implementation Bodies: Trade & Business Development, Inland Waterways, Aquaculture and Marine Matters, Special EU Programmes, Food Safety and Language (Irish and Ulster Scots).

In addition, six areas have been agreed for co-operation through existing bodies in each jurisdiction: transport, agriculture, education, health, environment and tourism. Within health, the priority areas for co-operation are: A&E Services, major emergency planning, high technology equipment, cancer research and health promotion.

As a result of the devolving of power on Thursday 2nd December 1999, the Northern Ireland Assembly and its Executive Committee of Ministers came into existence, and the North/South Ministerial Council and the North/South Implementation Bodies became fully functional institutions.

The North-South Ministerial Council is the main co-ordinating body for co-operation between the two jurisdictions of Ireland. It is composed of representatives appointed by the Northern Ireland Executive and the Irish government.

The main purpose of the NSMC is to:

- bring together those with executive responsibilities
- promote consultation, co-operation and action within the island
- direct the work of the six Implementation Bodies
- oversee the six areas for enhanced co-operation

The Council currently meet twice a year, and in sectoral formats on a frequent and regular basis. The Council has a joint secretariat and joint funding and all decisions in the Council are by agreement between the two sides. In all functions, whether advisory or implementary, the council is fully accountable to the Northern Ireland Executive and the Irish government.

Within the Northern Ireland Executive's Draft Programme for Government North-South co-operation has been transcribed into actions and targets. Regarding the health agenda, immediate priority is being given to advancing the five priority areas identified by the North South Ministerial Council and supporting the work of the North/South Food Safety Promotion Board. Another relevant short-term practical action is the commissioning of a cross-cutting study on barriers to North-South mobility and living/working.

2.1.2 The Common Chapter

Contained within the Northern Ireland Structural Funds Plan (2000-2006) and the National Development Plan for the Republic of Ireland (2000-2006) is a Common Chapter designed to recognise the benefits that can be achieved for the whole of the island of Ireland through closer co-operation. This Common Chapter provides a framework for increased co-operation between economies and across all sectors for the period 2000-2006, where it is identified as appropriate and mutually beneficial to do so.

Within the health sub-section of the Common Chapter, reference is made to the considerable scope to co-operate in the provision of required services on a partnership basis. This co-operation is to include extension and development of the CAWT mechanism in relation to ambulance cover and joint training; and the sharing of emergency admissions where hospitals are under pressure. The successful relationship between the Department of Health and Social Services (DHSS) and the Departments for Social Community and Family Affairs (DSCFA) was noted. In addition, the potential to progress the five identified priority areas under the direction of the NSMC was acknowledged.

A Special EU Programmes Body, one of the North-South Implementation Bodies set up under the Good Friday Agreement, will monitor and promote the implementation of the Common Chapter

2.1.3 The Institute of Public Health

One of the first cross-border bodies to be established in the wake of the Good Friday Agreement was the Institute of Public Health in Ireland. The four main functions of the Institute are:

- Disease surveillance and development of information services
- Research
- Education and training
- Providing advice on public health issues

A report by a working group of the two Chief Medical Officers (CMOs) in 1996 stated that public health research was fragmented and that a new all-Ireland institute could bring together bodies from the North and the South to co-operate on research matters. The report recommended that the Institute engage in epidemiology and health service research, co-ordinate research, make research proposals and commission and/or conduct research. The CMOs working group found that the fragmented nature of the public health professions made it particularly difficult to achieve effective planning and co-ordination of services to address the needs of the population.

The key role of the Institute was to provide an infrastructure for the development of co-ordinated action in key areas of public health interest. As the Institute develops its unique role working across professions, sectors, organisations, boundaries and jurisdictions, it will aim to develop a broad coalition for public health across the island of Ireland.

The Institute of Public Health has hosted a number of conferences during 2000 to boost health partnerships north and south of the border.

2.1.4 Food Safety Promotion Board

The Food Safety Promotion Board (FSPB) is one of six North/South Implementation Bodies established under the Good Friday Agreement. The main functions of the board throughout the island of Ireland are:

- promotion of food safety
- food safety research
- communication of food alerts
- surveillance of food borne disease
- promotion of scientific co-operation and laboratory linkages
- development of cost effective facilities for specialist laboratory testing

The FSPB has no enforcement function. Its main role is to ensure that appropriate mechanisms are in place to respond effectively to emergencies as they arise. Among the programmes currently being developed is a major television advertising campaign that will extend into other marketing channels such as direct mail and in-store promotions. The board, which is located in Cork, was officially launched in November 2000 following the North/South bilateral ministerial meeting.

2.2 European funding

North-South co-operation is particularly important as regards European Structural Funds. While the INTERREG programme specifically promotes cross-border development there are also important North/South dimensions to the EU Special Support Programme for Peace and Reconciliation (1995-1999) and the Peace II (2000-2004) programmes. The Special EU Programmes Body (mentioned earlier), working with lead departments North and South, will advance the Peace II programme and all of the Community Initiatives.

2.2.1 The INTERREG Programme

The accession of Ireland and the UK to the European Community in 1973 created new opportunities for inter-state and cross-border co-operation. However, it was the preparation for the Single European Market (1992) which provided the greatest stimulus for cross-border co-operation.

The European Commission approved, under the INTERREG I Community Initiative (1991-1993), a programme designed to support cross-border co-operation and economic development in Ireland and Northern Ireland. (The main objective of INTERREG is to "strengthen economic and social cohesion in the European Union by promoting cross-border, transnational and interregional co-operation and balanced development of the European Union territory.")

The successor programme, INTERREG II (1994-1999), built on the achievements of the previous programme in order to adopt a sustained approach to tackling the development problems affecting the area. The creation and development of networks of cross-border co-operation between local authorities, chambers of commerce, educational institutions, voluntary and community sector organisations was promoted.

A new INTERREG III programme is now being proposed, of which strand A relates to 'promoting integrated regional development' across land boundaries. Both Ireland/ Northern Ireland INTERREG I and II Programmes were delivered through the medium of joint departmental working groups, drawn from the relevant sectoral governmental departments, North and South. The guidelines for the INTERREG III programme for Ireland/Northern Ireland (2000-2006) call for a wider participation at all levels of the Programme, including 'institutional' partners from national, regional and local authorities, but also economic and social partners and other relevant competent bodies.

Within INTERREG IIIA, health will be identified as a priority area for funding.

2.2.2 The EUSSPPR and Peace II

The EU Special Support Programme for Peace and Reconciliation (EUSSPPR) comprises a cross-border sub-programme focused on business and cultural linkages, infrastructure, co-operation between public bodies and cross-border reconciliation. A unique feature of the programme is the use of non-government intermediary bodies to deliver aspects of the programme.

The Peace II Programme is similar to its predecessor the EUSSPPR in that it includes all of Northern Ireland and the Border Counties of Ireland within its remit.

The Peace II operational programme was forwarded jointly by the two administrations to the European Commission in early April 2000. It was declared admissible by the European Commission and negotiations on the draft operational programme are on-going. The five priorities for the new Peace programme are:

- Economic renewal
- Social integration, inclusion and reconciliation
- Locally based regeneration and development strategies
- Outward and forward-looking region and
- Cross-border co-operation

The focus of the programme in the Border Counties of Ireland is on targeted groups who have been particularly affected by the 'Troubles'.

2.3 Other relevant players

2.3.1 Border Corridor Groups

The Border Corridor is made-up of seventeen local authority districts in Ireland and Northern Ireland which adjoin or are adjacent to the Ireland/Northern Ireland border. In order to provide a strategic dimension to ongoing co-operation within the border area, Local Authorities on both sides of the border developed cross-border co-operation networks as follows:

- In 1975 the North West Regional Cross-Border Group (NWRCBG) was established. It comprises Derry City Council, Donegal County Council, Limavady Borough Council and Strabane District Council.
- In 1976 the East Border Region Committee (EBRC) was established. It comprises Newry & Mourne District Council, Down District Council, Banbridge District Council, Louth County Council and Monaghan County Council.
- In 1995 the Irish Central Border Area Network (ICBAN) was established. It comprises Armagh City & District Council, Cavan County Council, Donegal County Council, Dungannon District Council, Fermanagh District Council, Leitrim County Council, Monaghan County Council, Omagh County Council and Sligo County Council.

The networks have facilitated a wide range of cross-border projects and provided the basis for contact and co-operation between their respective authorities, both at elected member and officer levels. With the encouragement of both governments, the European Commission and the respective local authorities, the networks are co-ordinating strategy and project development under INTERREG II. Each network has developed a cross-border Integrated Area Plan for their region, as well as developing an overall Border Corridor Strategy for the new INTERREG III programme.

The key elements of the joint approach are broadly as follows:

- The creation of an overall Border Corridor Strategy
- The implementation of that overall strategy on a common basis by the three Border Corridor Groups
- Co-operation between the Groups on cross-border issues
- Widening the basis of the existing cross-border co-operation bodies to include social partnership representation; and

- The creation of an independent but close working relationship between the Border Corridor Groups and the two Governments.

This strategy sets out a vision for the development of the Border Corridor as a distinctive region. It also presents proposals to increase local involvement and control over European Structural Funds for the Border Corridor by means of an overall Border Corridor Strategy, principally implemented through sub-regional Integrated Area Plans.

Within all three integrated area plans there exists an 'inclusive' theme which refers to the need to address uncoordinated health actions, community cohesion and childcare.

2.3.2 LACE-TAP (Linkage Assistance and Co-operation for the European Border Regions – Technical Assistance and Promotion)

LACE-TAP is a measure implemented by the Association of European Border Regions (AEBR) to provide technical assistance and foster cross-border co-operation for the regions in and around the European Union. The main aims of the LACE-TAP office in Monaghan are:

- To promote the development of cross-border co-operation throughout the European Union
- To facilitate the effective and regionally specific implementation of INTERREG IIA and IIIA
- To establish local/regional cross-border structures and organisations
- To strengthen networking between border/ cross-border regions
- Facilitate the transfer of information, best practice and expertise in the field of cross-border co-operation

LACE-TAP supports and facilitates cross-border co-operation through actively exchanging information and experience throughout the EU, crystallising best practice, transferring experience and producing European-wide publications promoting best practice.

The LACE-TAP Office is funded in part (60%) by AEBR, through DGXVI of the European Commission, and the remainder (40%) equally by Co-operation Ireland and the three cross-border local authority networks. These regional stakeholders are actively involved in the work of the LACE-TAP office through a steering committee and participation in specific activities. The LACE-TAP measure, which began in 1996, is intended to accompany INTERREG IIA until the completion of its implementation in 2001 and to include the preparation and introduction of INTERREG IIIA.

PART II CO-OPERATION AND WORKING TOGETHER

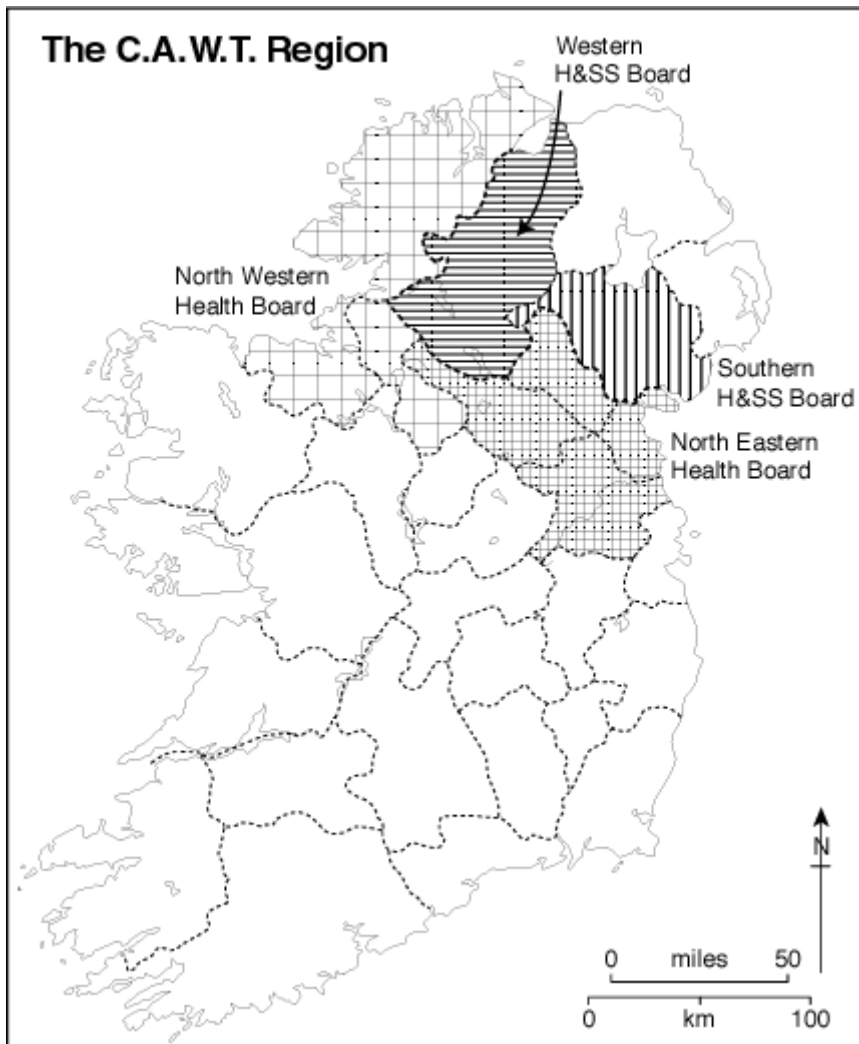
3. INTRODUCING CAWT

The Co-operation and Working Together (CAWT) initiative was officially started in 1992 when the North East Health Board (NEHB) and North West Health Board (NWHB) from the Republic of Ireland and the Western Health and Social Services Board (WHSSB) and Southern Health and Social Services Board (SHSSB) from Northern Ireland signed the Ballyconnell Agreement (Appendix D) committing them to co-operation to improve the health and social wellbeing of their resident populations. Subsequently, this agreement was reviewed to include the seven newly formed Northern Ireland Trusts in the border region; Altnagelvin Hospital HSS Trust, Armagh and Dungannon HSS Trusts, Craigavon Area Hospital Group HSS Trust, Craigavon and Banbridge Community HSS trusts, Foyle HSS Community Trusts, Newry and Mourne HSS Trusts, Sperrin Lakeland HSC Trust. Spontaneous cross-border work did exist during the 1980s. However the Chief Executive Officers (CEOs) of the border boards were aware that relationships needed to be formalised in order to harness the potential of the opportunities presented by the EU. Official endorsement for the CAWT process has subsequently been given at a national level by both Ministers for Health and Departments of Health, in Northern Ireland and the Republic of Ireland.

3.1 CAWT Region

The four CAWT Boards embrace the whole of the land boundary between the Republic of Ireland and Northern Ireland, serve a population of over one million people and account for 25% of the total land area of the island of Ireland.

Figure 2 below shows the Board boundaries of the CAWT region.



More specifically, the CAWT region comprises:

- The Western Health and Social Services Board, covering the District Council areas of Limavady, Strabane, Omagh and Fermanagh;
- The Southern Health and Social Services Board, covering the District Council areas of Newry and Mourne, Armagh, Dungannon, Banbridge and Craigavon;
- The North Western Health Board, encompassing counties Donegal, Sligo and Leitrim; and
- The North Eastern Health Board, covering counties Cavan, Louth and Meath and Monaghan.

The border between Northern Ireland and the Republic was established eighty years ago, creating a frontier of 450km. Like many internal EU borders, the Irish border region exhibits most of the problems and disadvantages associated with peripherality from political and economic decision-making (unequal and poorly integrated development, and mismatches in organisational responsibility and competencies). When combined with the associated problems of rurality (poverty, deprivation and weak infrastructure, and an ageing population) and intensified by the consequences of 30 years of politically motivated violence, the Irish border region shows most of the characteristics of economic and social deprivation. It is virtually certain that the existence of the border has aggravated many of the general problems associated with the region or has at

least prevented the optimal solution to these problems being pursued. It is considered that significant unrealised potential has been linked to the pattern of 'back to back' development in both jurisdictions.

3.2 CAWT organisational profile

The current CAWT structure is shown below in **Figure 3.**

Co-operation and Working Together: Organisational Profile

The CAWT Management Board comprises the Chief Executive Officer (CEO) and the Chairman of each of the four Health Boards and one CEO and Chairman representing the HSS Trusts in Northern Ireland. The Board, which meets on a quarterly basis, is the main decision-making forum for CAWT. Typically, the format of the meeting allows for two presentations to be given on a relevant aspect of CAWT work by members of the sub-groups or project group.

The CAWT Finance Forum comprises either the Director or Assistant Director of Finance from each of the four Boards. The Forum oversees the operational plans and the financial budget of the project groups. Meetings are held quarterly with the Finance/Projects Officer who acts as a link between the project groups and the financial personnel in each board. A quarterly financial update is presented to the Management Board.

The CAWT Secretariat comprises of senior (director/assistant director level) representatives from each of the four boards alongside a full-time Principal Executive Office and an Administrator and a part-time Finance/Project officer who are based in a CAWT Resource Unit in Derry. The four board representatives cover the speciality areas of finance, primary care, personnel and hospital administration. The role of the Secretariat is to support and co-ordinate the work of CAWT through the subgroups and the Management Board. They meet regularly on a monthly basis. Originally, each CAWT sub-group comprised senior (director/assistant director level) representatives from all of the four boards. Some of the CAWT subgroups have since adapted their membership to suit their emerging needs. The Health Promotion subgroup membership also includes public health representation from both jurisdictions. The Human Resources subgroup comprises director level representation from five Northern Ireland trusts alongside the two health boards in Republic of Ireland. Typically, the subgroups meet on average every three to four months.

In addition to the subgroup, Secretariat, Management Board, and Finance Forum meetings, which take place within CAWT, there are numerous project meetings which occur on a regular basis.

3.3 CAWT primary objectives

The primary objectives for CAWT were identified as:

- The improvement of health and social well-being of its resident population
- The exploitation of opportunities for the co-operation in the planning and provision of services
- The take-up of funding which may be available under the European Union or from other third parties
- The involvement of other public sector bodies in joint initiatives where this would help fulfil CAWT's primary objective
- To assist border areas in overcoming the special development problems arising from their relative isolation in natural economies and within the European Union as a whole, through the promotion of government and European awareness of and support for this process

- The exploitation of all opportunities for joint working or sharing of resources where these would be of mutual advantage

3.4 CAWT phases of development

In general, the development of CAWT can be seen in three phases. Throughout the following sub-section the general approach to work within each of these phases is examined. This is followed later in the report by an in-depth examination of each of the health sector areas.

3.4.1 Phase I (1992 – 1995)

Following the commitment of the four boards (NEHB, NWHB, SHSSB and WHSSB) to work co-operatively to improve the health and social well-being of their resident populations a Steering Committee was established to develop an agenda for action. This committee included the four CEOs from the respective Boards and a nominated part-time Secretariat member from each Board. The role of the Secretariat was to support the CAWT activity. The initial period was concerned with building an architectural platform for the future. Four subgroups were established with representation from each of the four partner Boards:

- Information Technology (IT) subgroup
- Human Resources (HR) subgroup
- Health Promotion subgroup and
- Social Deprivation subgroup

The Secretariat kept in contact with each of the subgroups and reported on progress to the Steering Committee. (The work of these subgroups will be examined in greater detail later in this report.)

The main focus was on establishing relationships and trust between the different partners at senior level. But applying for EU money also became a great focus of energy. This was at a time when boards were operating within tight financial circumstances, so being able to apply for and attract EU money was very welcome. Project work concentrated on the more amenable areas of co-operation, particularly Health Promotion and Social Deprivation. The third focus was on bringing the 'non-professional' groups of IT and HR together, through project working, to develop common themes. Although project work was completed in these functional areas, the broad base of secondments from boards and exchange programmes between boards and trusts has never materialised. However, there have been some exceptions such as the exchange of staff within the Triangle project and the secondment of a public health specialist registrar from the NWHB to the WHSSB.

3.4.2 Phase II (1995 – 1998)

With the securing of EU funding, organisational structures and process were put in place to support the work of CAWT. The Steering Committee was reformed as the Management Board to include the chairmen of the respective boards and representation from the newly formed trusts in Northern Ireland (a CEO and chairman). The original Secretariat was re-formed to include one representative from each board (part-time), an executive officer(full-time) and an administrator (full-time) and a finance/project support post (part-time). Organisational practices and protocols were also put in place to facilitate efficient and cost-effective cross-border co-operation. A strategic plan for the period 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.

The securing of new EU funding from the EU Special Support Programme (EUSPPR) saw CAWT beginning to address the areas of acute and primary care. These areas were felt to have the greatest potential for cross-border co-operation but also the greatest potential for political reaction. The project work brought people together to gain a better understanding of their professional inhibitions and political difficulties.

3.4.3 Phase III (1999 onwards)

Phases I and II established the identity of CAWT with the external key players, such as the Departments of Health, in the health field. It was felt by many respondents that the time had come to stop seeing CAWT merely as a flag of convenience to attract EU money and to move towards seeing it rather as the right way of working because the populations would benefit.

There have been a number of key elements to CAWT of late:

- In terms of internal process, a seminar entitled 'Making Connections' was held in June 2000 which brought together 65 key players from the CAWT region to design the process by which projects for the next tranche of EU funding would be selected. Concerns were expressed about focusing overly on specific projects since that might give CAWT too narrow a focus which could raise mainstreaming and sustainability questions. It was agreed that it would be useful to identify broader health themes rather than specific projects and that in seeking EU funds the possibility of accessing a block allocation would be considered through becoming an intermediary funding body, which distributes EU funding to smaller NGO bodies under the EUSPPR. Discussions have been held with the EU Special Programmes Body and representatives from the two Departments regarding the possibility of becoming an intermediary funding body.
 - A new concept of allocating small amounts of money (< £3000) to stimulate cross-border work was introduced. Under the Creative Cross Border Project ten small cross-border projects have been funded (see Appendix E). This programme has been well received by members of the subgroups
 - In addition, changes in the North-South political structure brought about by the Good Friday Agreement have afforded CAWT a platform from which to influence the cross-border health agenda. In recent months, presentations have been given to the two Permanent Secretaries and to a bilateral meeting of the Health Ministers. Joint press statements from the two Ministers have reiterated their support to developing CAWT as an organisation which works on the ground. Bairbre de Brún, Health Minister for Northern Ireland has been quoted as saying "CAWT is clearly a good concept which is hampered by constraints".
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4. CAWT HEALTH SUBGROUPS

4.1 Acute Services

Structure

The Acute Services subgroup was established in 1994 with representatives from the four original boards. However after initial enthusiastic meetings, problems arose due to the:

- lack of representative membership from purchasers and providers in the North
- differences between the two hospital systems in terms of management and financial arrangements
- difficulties of working co-operatively with hospitals which were competitors within their individual structures

In order to overcome these problems, a natural process evolved whereby trusts from the North started to interact directly with health boards from the South.

Initially independent of CAWT, Craigavon Area Hospital Health and Social Services (HSS) Trust set up a joint working group with the NEHB to examine the potential for cross-border working. This direct arrangement between the trust and the NEHB was seen to establish good relationships. Under the encouragement of the Management Board, similar groups were established between the NEHB and NWHB and their corresponding trusts in the North. There are now three main acute working groups under the CAWT umbrella.

1. The Cross Border Acute Project (C-BAP) which includes Craigavon Area Hospital, Daisy Hill Hospital in Newry and hospitals in Dundalk and Drogheda in the NEHB.
2. The Letterkenny/Altnagelvin Partnership project which includes Letterkenny Hospital in the NWHB and Altnagelvin Hospital in the WHSSB
3. The Triangle Partnership project which includes acute hospitals in Fermanagh, Tyrone, Cavan/ Monaghan, Sligo and Leitrim.

All of these groups have senior management representation from all disciplines and joint project management from both jurisdictions. However the three projects are very different in scale, a characteristic that could possibly be a reflection of their maturity. The Cross-Border Acute Project (C-BAP) is a major initiative involving a variety of co-operative ventures (see below) while the other two projects are feasibility studies identifying areas in which it would be useful to establish such co-operative ventures.

Two other projects, the Emergency Planning Project and the Renal Dialysis Project, have emerged out of identified need. The Emergency Planning Project was born out of the aftermath of the Omagh bombing. The Renal Dialysis Project has been spearheaded by an enthusiastic practitioner supported by a partnership of boards and trusts from both sides of the border. While CAWT was not the instigating factor in either of these projects the cross-border networks which have been established as a direct result of CAWT have helped to establish and guide both projects.

Process

Figure 4 Acute Services Projects

Project	Area	Timescale	Total expenditure
C-BAP Phase I and II	Craigavon/ Drogheda/ Dundalk/Monaghan/ Cavan	Phase II 12months 1998/99	Phase I £437,450 Phase II £215,000
Triangle Phase II Feasibility Study	Omagh/ Enniskillen/ Cavan/ Sligo	9 months 1999	£50,000
Letterkenny/Altnagelvin feasibility study	Letterkenny/Altnagelvin	12 months 1999	£62,000

Project 1 Cross Border Acute Project (C-BAP)

The Cross Border Acute Services Project (C-BAP) involves a partnership between the NEHB and the Craigavon Area Hospital HSS Trust. In Phase II the project expanded to include Daisy Hill hospital in Newry. Co-operation involves a number of initiatives, such as:

- shared dermatology services with outreach clinics in Newry, Armagh and Dundalk and Monaghan which has resulted in a reduction of out-patient waiting lists from one year to approximately three weeks
- a feasibility study into telemedicine links between hospitals in Craigavon, Dundalk and Drogheda
- cross-border pathology steering groups
- electronic linkages between laboratories
- cross-border co-operation in nursing training and education
- staff exchange visits and programmes in radiology and nursing

Three conferences were held under the C-BAP project with approximately 1000 staff attending. Senior managers from the NEHB and the trust also took part in a management development programme. The outcomes of these conferences and training have not been documented. However as a result of the networks which have been established, further co-operative ventures such as the development of nurse-led dermatology clinics between Craigavon and Monaghan hospitals and staff exchanges in the areas of radiology, pathology, renal dialysis and nursing have happened. In addition, Craigavon Area Hospital HSS Trust provided emergency CSSD services to Monaghan hospital for a period of two weeks during the nursing strike in the Republic.

Project 2: Letterkenny/Altnagelvin Feasibility Study

The Letterkenny/Altnagelvin group undertook an examination of the potential for collaboration, co-operation and working together to improve the health and social well-being of the North-West border region. Essentially this region includes the catchment areas of Altnagelvin and Letterkenny hospitals. Specifically an attempt was made to identify areas of service provision that could be developed or enhanced based on a partnership approach between the two hospitals. This approach was based on the recognition that by working together both hospitals might be able to take advantage of economies of scale in a cost-effective manner to further develop current services, and/or to develop new services.

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

Other areas which were highlighted as possible joint working areas to be considered within a five year period include 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. The four identified areas are now being considered by steering groups established with high-level representation from both hospitals.

One of the most valuable contributions of the Letterkenny/Altnagelvin partnership has been the documentation of constraints/barriers which have a serious detrimental effect on partnership working. Discussions within CAWT have emphasised that these 13 documented constraints/limitations (see Appendix F) are common to the entire CAWT region. This report is refreshing in that it attempts to document the current needs of the catchment population and to systematically address those needs.

Project 3: Triangle Study

A three-way partnership between the NEBH, the NWHB and Sperrin Lakeland HSS Trust conducted a feasibility study into co-operation in acute hospitals services in mid-border areas of Cavan, Fermanagh, Leitrim and Sligo. 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 said 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. 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.

Project 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 in the NEHB to avail of their 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 the 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. Patients have reported a real improvement in their quality of life as they no longer have to spend two long days every week travelling to and from Dublin city.

Project 5: Emergency Planning project

The emergency planning project was born out of the aftermath of the Omagh bombing. While there was a good spontaneous response from hospitals in the Republic when the bomb exploded, the intention was to establish formal structures in future that would be implemented in the event of another disaster in any part of the country. This work engaged the Northern Ireland Ambulance Service, the only region-wide trust, with the NEHB. The project involved joint training at operational and control level, the development of joint protocols to aid a co-ordinated approach to major incidents and examination of the feasibility of a joint radio link to facilitate cross-border communication. However following a 'major incident' exercise in the Cooley mountains, the momentum was lost and this work did not continue after the project funding (£344K) ceased in June 1999.

This project group did play a part in informing the recently published strategic review of the Northern Ireland Ambulance Service. One of the recommendations of this review is that a cross-border working group be established between border ambulance services to look at issues at both a strategic and operational level, and that this group should have appropriate representation at departmental level to ensure that any proposed developments are implemented. In addition, CAWT has also been asked to contribute to a current, more restricted review of the ambulance service in the Republic and to provide details of its work for consideration by the newly formed North/South emergency planning working group (established as one of the North-South Ministerial Councils five health co-operation areas).

Output

The acute sector areas have been well documented with two feasibility reports and an evaluation of the C-BAP Phase I completed with Phase II evaluation underway. The two feasibility studies have engaged practitioners, planners, and management in a wide, consultative effort and have identified short-term and long-term co-operative ventures. In addition, the Letterkenny/Altnagelvin study has compiled a list of barriers/constraints to future development. The partnerships between two SHSSB trusts and the NEHB have developed to provide cross-border patient dermatology and renal services.

Main achievements

- Joint appointment of a dermatology clinician.
- Demonstrated willingness of patients to avail of cross-border services shown by dermatology patients and renal dialysis patients.
- Clear patient benefits have been demonstrated. There has been a reduction in the dermatology out-patient waiting lists from one year to approximately three weeks. Access to renal dialysis treatment for patients from Dundalk (NEHB) has been greatly improved.
- Greater understanding of different systems and barriers.
- There has been a concentration on education, joint training and raising awareness of differing protocols between staff North and South.

Main issues

- Level of CAWT involvement. CAWT was not involved in the initial stages of the C-BAP project but was useful in terms of financial monitoring and project management at a later stage of C-BAP development.
- There has been a lack of co-ordinated strategic planning. This has led to difficulties with some of the trusts who were on the fringes of the project.
- There has been a lack of mainstreaming. The extension of successful work has been impeded by staffing, structural and accreditation difficulties. This raises the problem of dealing with patient expectations.
- Reciprocal arrangement and two-way traffic. There is a concern that there will be an unbalanced flow of patients from the South to the North which would be unacceptable.

4.2 Primary Care

Structure

The initial meetings of the primary care sub-group, which was established in 1994, involved the exchange of information between the representatives from the individual boards on their different methods of working and different policies. With the funding of the first primary care project, the sub-group took on the role of a project management board.

Process

Project One: Developing Primary Care Across Borders and Boundaries

The primary care project 'Developing Primary Care Across Borders and Boundaries' is examining the development of primary care across a series of key priority areas in a phased approach. This work has been well-resourced, with funding (£976K) secured under the EUSPPR with approved match funding from the host governments. Phase 1 identified common themes and potential areas for joint working between the four boards. The key priority areas are outlined below:

- Services Development – focusing on nursing needs, skills, protocols and cross-border co-operation
- Practice Organisation – focusing on practice managers/ team building
- Community Pharmacy – focusing on the role in general and specifically in relation to asthma/ head lice
- Information Technology – cross-border multi-disciplinary long-term training, CAWT primary care web page
- Practice Premises - a new health centre was constructed at Ballybofey/ Stranorlar which could be used by the communities on both sites of the border
- Quality Assurance Team - external team of people to direct progress

Phase 2 (February 1998 – May 1999) used an action-centred approach to implement the findings of the studies from the initial phase thereby beginning the process of improving primary care services for the border populations.

Phase 3 involves identifying the health and social care needs of isolated cross-border communities and examining ways in which authorities in the region could work together to improve care for people in those communities. A health needs assessment exercise is currently being completed in the Belcoo and Blacklion area by the University of Ulster at Coleraine and National University of Ireland Maynooth. A working group has been established to guide the research process which incorporates the local community, health and social care professionals working in the area. The needs assessment aims to engage a natural cross-border population

centred on a local community to find out what people in that area expect from health and social services. It also expects to identify and involve other stakeholders in the area to define needs for health and social care in the local community and where possible meet the immediate needs within the health and social care resources currently available.

Project Two: Cross Border Out-of-Hours Study

GPs working co-operatively outside of working hours to provide emergency cover for their combined area is a well-established practice in Northern Ireland. Recently, GP out-of-hours services have also started to develop in the Republic of Ireland – the NEHB officially launched such a service in September 2000.

The Primary Care sub-group has started to consider the viability of organising a cross-border out-of-hours service between the four boards. The biggest demand for the GP out-of-hours services has come from the smaller towns and rural areas so it is a particular problem for the border region. In some locations along the border the distance that a patient may have to travel to see a doctor out-of-hours is significant. If the patient was free to travel across the border to see a GP, the travel distance, depending on location, could be reduced considerably. For example, currently a patient in Blacklion (Republic of Ireland) must travel to Cavan to see a GP out of hours (35 miles) even though there is a GP out-of-hour service offered significantly closer (7 miles) in Enniskillen for patients in Northern Ireland.

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 feasibility study is due to be completed in early 2001.

This project is seen as a pivotal piece of work. In order to work it will need to address all the identified cross-border barriers in terms of registration of professionals, insurance cover and GP referrals between different health sectors.

Output

This work is well resourced and timely in terms of policy direction of the Departments of Health, both North and South. Under the guidance of a quality assurance team the work is reflective of mainstream policy in both jurisdictions. The links with academic units (National University of Ireland Maynooth and University of Ulster at Coleraine) should serve to establish its credibility alongside the establishment of course accreditation. The findings in the key priority areas have been well documented and a tender to externally evaluate the 'Developing Primary Care Across Borders and Boundaries' project has been circulated.

Achievements

- There has been an in-depth programme of training in information technology, communications, skills enhancement and service sharing.
- The work is well grounded in the policies of both jurisdictions and is guided by an external quality assurance team.
- The work is well-documented and the group have now asked academic units from the North and the South to tender for an external evaluation.
- There is active community and statutory body involvement in assessing the perceived needs of the population of Belcoo and Blacklion.
- The work has been multi-disciplinary in nature and has involved a mix of practitioners from various levels of primary care.
- The work is very focused with good management structures.
- Efforts have been made to facilitate a continuation strategy by 'skilling' staff in permanent positions to oversee the implementation of findings and by allocating responsibility for maintaining the infrastructure (eg. email communications) beyond the life of the project.

Issues

- The expectations of the local population may need to be controlled following the outcome of the needs assessment in Belcoo and Blacklion.

4.3 Family and Child care

Structure

Initially the Family and Child Care sub-group formed part of the Social Deprivation sub-group. However, as the programme of work within this area developed Family and Child Care became a separate sub-group.

Feasibility study

A feasibility study, commissioned by the Social Deprivation sub-group in 1996, on the levels of social deprivation in the border area and containing an assessment of service needs, identified significant differences in the type of information held and the diverse arrangements for collating and analysing data between both jurisdictions. It was felt that opportunities for co-operation in this field of health care existed in a number of areas:

- professional education and development
- inter-professional and interagency work
- investigation of cases of suspected child abuse and neglect
- development of community-based family support options in both urban and rural settings
- provisions for special needs groups
- Evaluation of specific service provision, measuring outcomes and effectiveness of family and child care services.

A comparative study of the legislative base was commissioned from the Centre for Child Care Research, Queen's University Belfast and the Children's Centre, Trinity College Dublin. The focus of the study was the Children (NI) Order 1995 and the Child Care Act 1991 in the Republic. Despite the fundamental differences between the two legislations, the commonalties in terms of intent were found to be striking.

Process

The Family and Child Care sub-group attracted EU funding for the three projects which became the main focus of its work:

Project 1: Protecting Children with a Disability

The Protecting Children with a Disability project (£111K) piloted training programmes to protect children with a disability by applying the child protection approach to the specific protection needs of children with a disability.

Initially the project worked on a bi-lateral basis, SHSSB/NEHB and WHSSB/NWHB, before expanding to introduce the package to all four Boards. Following a scoping study, a multi-disciplinary reference group for the project was established. The project was established on the principle that the empowerment of key players such as parents, carers, teachers and children themselves is the best way to protect a child with a disability.

In the WHSSB and the NWHB teachers have come together as a group to develop a framework for protecting children with disabilities from abuse. In the NWHB training for carers has taken place in both residential and community settings and an advice booklet is now being produced. In the SHSSB and the NEHB teaching resources for adolescents, involving teaching staff from Special Schools, have been developed alongside a programme on awareness raising. This work

has led to changes in attitude and practices, which should reduce the potential for abuse and create more confident and self-aware children.

Project 2: Parenting Initiatives in Communities

The 'Parenting Initiative in the Community' project (£139k) completed a mapping exercise of existing provision and identified four pilot sites in south Armagh, north Louth, south Fermanagh and north Leitrim. In each of these pilot sites local committees have been established to try and identify the needs of parents.

This project aims to develop and implement effective parenting programmes across the CAWT region. The project will then build on the experiences of the four boards in developing and running parenting schemes. It aims to identify parenting needs in specified localities, set up schemes to address these needs over a specified timescale, and report on the lessons learnt from the experience. This is a unique approach in that it provides an opportunity to test out and develop approaches to parenting programmes in the future. Eleven parenting groups were established. Four initial sites were identified in south Armagh, north Louth, south Fermanagh and north Leitrim. Local committees have been established in each area and the particular needs of the parents are now being identified by the local committees/agency groupings. Approximately 500 parents have participated in parenting education programmes undertaken by these groups over a two-year period. A wide range of facilitators from the statutory, voluntary and community sectors have been utilised for the project and parents have participated in groups in the other jurisdictions ensuring constant cross-border traffic.

Project 3: Preventative Community Youth Project

The Preventative Community Youth project (£219k), which involves two pilot youth strategy interventions in the NWHB, has used service providers from Northern Ireland. The first intervention was the Extern West Youth Support Programme which brought together twenty-two young people aged 10-18 years perceived by referral agencies as being 'in need' and at risk of being received into welfare or custodial care. Young people were encouraged to take responsibility for their actions and were empowered to effect positive change in their lives. The second intervention, The Partnership Care West Family Support Programme, targets families in crisis with children aged 10-18 years. Trained family support workers visit homes twice a week to assist parents in household management and child care. Quarterly reviews are held in family homes with young people, their parents, social workers and family support workers to discuss progress and amend the care plans where necessary. Support is provided until the family crisis has passed. An evaluation by the NWHB Public Health Department is currently underway.

Cross Border Rural Day Care Action Research Project

In addition to the three projects funded under the CAWT umbrella, the sub-group has worked closely on this voluntary sector-led project, with two of the working group members serving on the management board of the project. The Cross Border Rural Day Care Project aims to undertake an in-depth analysis of the day care needs of children, parents and employers in specified rural areas which span the border. INTERREG funding was agreed to undertake the research and to evaluate pilots of innovative approaches to meeting day care needs in six key areas.

Alongside the project work, consideration has been given to areas of work where the jurisdictions can successfully co-operate without encountering legal and administrative barriers. Such work includes reviewing work cases when lessons of practice need to be established.

Output

Evaluations of all three studies are now due and are scheduled to be completed by January 2001.

Achievements

- All three projects have established networks across the four boards, involving other agencies and services, both statutory and voluntary, which impact on the projects.
- All projects serve to establish models of best practice which are not confined to a cross-border situation.
- Changes in attitude and practice have been found in the Protecting Children with a Disability Project.
- The work has engaged a wide range of people from the local communities.

Issues

- All pilot sites appear to operate on a separate basis with findings being implemented separately in each board.
- The networks between WHSSB and NWHB proved valuable in counselling patients in the aftermath of the Omagh bombing. Immediately following the bombing, Letterkenny and Sligo general hospitals in the NWHB treated patients not directly involved in the bombing to relieve pressure on the Omagh hospital. The NWHB then offered counselling support for victims and relatives of the tragedy.

4.4 Learning Disability

Structure

The Learning Disability sub-group was one of two sub-groups initially established under the Social Deprivation umbrella (the other being Family and Child Care sub-group). However as the programme of work developed Learning Disability became a separate sub-group.

Process

The initial remit of this group was to review the legislation in both jurisdictions concerning social services/social care. Academic institutes in Belfast (Queens University Belfast) and Dublin (Trinity College Dublin) were commissioned to undertake a review of the legislation for all four boards and this work was presented and discussed at a conference in March 1996.

Flexi-Worker Scheme

After securing EU money (£75K), the group concentrated on their main project the Flexi-Worker Scheme. This scheme pilots different carer approaches to the support of persons with learning disabilities in their homes in each of the four CAWT Boards. The pilot areas differ in terms of training, models for carers, models of intervention and the level of providers who are providing carer support.

Initial plans to function as an integrated cross-border project were shelved after differences in the police vetting systems and remuneration systems between the North and the South were deemed too great. Instead the WHSSB bought individual packages of care. SHSSB bought some packages of care and also employed some staff directly. The NEHB set up a contract with Rehab to provide the care and the NWHB provided the care directly through their home help system. An evaluation of this work is due.

Two additional projects were identified as priorities by the sub-group and were submitted for EU funding:

- A cross-border training programme for the prevention of abuse of vulnerable adults.
- The development of an integrated cross-border resource centre for people with disability.

Although unsuccessful in attracting funding the group is still actively pursuing this agenda by sharing information and developing localised networks between the boards. For example, a partnership of health care workers, local community groups and statutory bodies is currently planning the development of a cross-border, local day centre in the south Tyrone and north Monaghan area.

Each year the group hosts a conference under an agreed priority theme. During 1999 the '*Prevention is Better than Cure*' workshop saw 32 professionals from across the four boards and representatives from the statutory and independent sectors focus on the areas of personal relationships and the protection of vulnerable adults from abuse. This workshop concluded that there was a need for further training on a multi-disciplinary and cross-agency basis and also highlighted the dearth of locally-based research.

Output

A review of the legislative documentation has been produced. An evaluation of the Flexi-worker scheme is due.

Achievements

- The group have shown themselves to be able to adapt their work to overcome the legislative and administrative difficulties of cross-border working (e.g. the Flexi-Worker Scheme)
- Very strong local cross-border networks have been established.
- The absence of (and need for) local research on this area has been identified.

4.5 Health Promotion

Structure

The Health Promotion sub-group was one of the first sub-groups to be established and it comprises a sector of people who are used to working together on a cross-disciplinary, co-operative basis. The sub-group membership has widened to include public health input.

Process

The Health Promotion sub-group has undertaken a large programme of work involving four main projects.

Project 1: Community Childhood Accident Prevention Programme

The Community Childhood Accident Prevention Programme (CCAPP) explored the use of layworkers to promote child safety with families of children under five who live in areas of high deprivation. Different experiences were found in each of the four pilot sites. The project (£700k+) ran for a five year period (1995-1999) and has involved all four CAWT boards. Initially two sites were established in rural Donegal and inner city Derry. While the work proved successful in Donegal, with over 80% uptake of safety club places and easy recruitment of staff, it proved equally unsuccessful in Derry, with very little community interest and difficulties in recruiting staff. The evaluation concluded that the variation in the uptake of the project across the sites was determined by the dynamics that existed within each community. Where the community was stable and open the introduction of the scheme was comparatively straightforward. However where there was tension or conflict, it seemed that the community could not make the necessary commitment.

In Phase two, sites were established in Newry and Drogheda. Newry proved to be a similar experience to Donegal while Drogheda proved to be relatively similar to Derry. From a research perspective, the CCAPP project has increased the knowledge base in the field of child injury reduction in areas of deprivation. Across the four sites, approximately 1500 families have been involved in the scheme and 120 of these have completed a four-session first-aid course. In the

Donegal site, significant improvements in knowledge, attitude and reported behaviour were recorded.

Project 2: Drug Awareness Project

The Drugs Awareness Project, which finished in April 1999, aimed to provide drugs awareness in the 11-14 year age group in the NEHB and the NWHB. This work was only funded in the Republic (£133k) but under the guidance of the CAWT Health Promotion Group the resulting training and policy development has been disseminated to the other CAWT regions. This project adapted a 'Planning for Real' approach which has been used by local authorities in Great Britain to engage local communities in the planning of services. The project team has consulted with young people, their parents, teachers, voluntary organisations and service providers.

Regular joint meetings have been held between the Southern and Western drug co-ordinating teams in Northern Ireland and their NWHB and NEHB counterparts to exchange information, develop new materials and debate the latest updates and drug developments. This is a good example of how lessons learnt can be disseminated more broadly.

Project 3: Young Men and Positive Mental Health

The Young Men and Positive Mental Health project was led by two partners from the voluntary sector, the Mental Health Association of Ireland and the Northern Ireland Mental Health Association, in conjunction with the NWHB and the WHSSB. It is a two-year action research project aimed at addressing the specific mental health needs of men aged 15-30 living in the Finn/ Derg Valley area.

Stage one of the project has involved an extensive literature review around two areas: community attitudes regarding the mental health needs of young men and the mental health needs of young men living in rural areas. In addition, focus groups made up of local young men and centering on discussion of topics raised by this research are being used to define areas of concern.

During stage two of the work information gained is being disseminated among groups in the community who work with young men. Two post-primary schools on each side of the border were contacted and the principals agreed to timetable a mental health module for fourth year students for one term. Training for teachers and outside facilitators was held in 1999. An information evening was held where the purpose and findings of the research were fed back to the community.

Project 4: Prescribed Drug Compliance Rates among the Elderly

GPs and Pharmacists are investigating the underlying reasons for non-compliance with drug prescription in order to develop appropriate educational strategies to improve compliance rates among the elderly. Data being collected by 10 community pharmacists in each of the participating boards is being used to establish compliance rates among elderly patients on long-term prescribed drugs. Preliminary findings suggest that only 42.4% of participants currently complete their prescription.

The Health Promotion sub-group has hosted three cross-border conferences on the theme of positive mental health. These conferences have identified professional training needs, which have been circulated to service managers in the CAWT region. In addition, the sub-group has co-hosted a conference on smoking with the Irish Cancer Society and Ulster Cancer Foundations. The sub-group actively exchanges information on national and regional strategies and methodologies, typically by presenting relevant work at their sub-group meetings. In addition, the sub-group tries to ensure that their individual board health promotion work is co-ordinated.

Output

Evaluation reports on the CCAP Project and the Drugs Awareness Project have been produced. The initial findings of projects have been disseminated widely with relevant professional bodies

(e.g. drug co-ordination teams, North and South). Each year, the group produces a widely requested 'Year Planner' which highlights key health promotion dates in the North and the South.

Achievements

The group is very active and its achievements are spread over a wide base of work, most notably;

- The partnership approach has included a wide range of community, voluntary and statutory groups.
- The CCAP Project has added to the research base on child injury prevention in areas of social deprivation.
- Lessons from the CCAP project regarding the state of readiness of communities to engage in this work will be useful to plan other interventions.
- Changes in attitudes (and practice) have been recorded in the CCAP Project.
- Findings of work are being widely disseminated to academic and professional practitioners. For example a presentation on the CCAP Project was given at the World Accident Prevention Conference which was held in Delhi during February 2000 and the findings of the Drug Awareness project have been debated with drug co-ordinating teams from the North and the South.

Issues

- The lack of mainstream funding has meant that CCAPP work has ceased when the project funding ran out.

4.6 Other sub-groups

There are a number of sub-groups which have supported the work of CAWT. These sectors are outlined below:

4.6.1 Information Technology (IT)

In March 1996, the IT Subgroup completed a six-month feasibility study into Geographical Information Systems (GIS), a software tool capable of mapping demographic data. This work arose out of a common need across the board areas to understand the complexities and costs of these GIS systems before any resources were committed to their use. As a result, links with other GIS users in academic institutes have been established and individual boards have since purchased stand-alone systems. This technology has been used to identify possible areas where interventions could be implemented. For example, the selection of Belcoo and Blacklion as a possible site where the community needs assessment exercise in the primary care project 'Developing Primary Care Across Borders and Boundaries' was facilitated by GIS technology.

With the health IT strategy for Northern Ireland centralised in Belfast through the Department of Health, it was difficult to work on a cross-border basis. Instead the IT group has concentrated on sharing expertise and developing an internal communications system. An internal email system was established with funding from the Management Board (£20.5K) and a CAWT directory has been produced. A three-month study of the costs and benefits of using videoconferencing and teleconferencing equipment to facilitate meetings was conducted.

Westcare Business Services, the support services organisation for the WHSSB, assisted the NWHB with the provision of information technology application training. The health boards in the South (NWHB and NEHB) have exchanged information concerning their procurement of a new payroll system with their neighbours in the North.

4.6.2 Human Resources

The Human Resource sub-group has concentrated on developing joint training and recruitment strategies. It has completed a comprehensive review of human resource (HR) practice relating to recruitment and selection procedures, which is a useful reference document. It has also held two one-day conferences:

- 'Managing Health and Safety in the Healthcare Service', which looked at the legislative developments in Europe and the need to develop a safety culture.
- 'EU and its influence on Human Resource Issues', which explored how employment/human resource issues are addressed by the European Union.

In addition, the sub-group has supported the training of staff for CAWT projects. One example of this was the training of domiciliary workers undertaken in the NWHB and NEHB for the Flexi-Workers Scheme.

Recently the sub-group has reformed into a strategy group and established three operational groups on: recruitment, training and development, and health and safety. In practical terms, the sub-group is now addressing models for secondments of staff, management development training, which to-date has been lacking in CAWT, and a range of other useful areas.

4.6.3 Public Health

The work of the Public Health sub-group has been cross-disciplinary, contributing to the work of the Primary Care and Health Promotion sub-groups. A programme of joint training on communicable disease is planned for 2000. CAWT has already identified the need for this group to develop a profile of CAWT population needs and priority development areas. In addition, this role of the sub-group may need to be re-established in terms of its relationship with the two new North-South structures - the Institute of Public Health in Ireland and the Food Safety Promotion Board. There is a lack of public health input in CAWT.

4.6.4 Mental Health

One area of work which has developed without the establishment of a sub-group is that of mental health. CAWT has been involved in two mental health projects.

- The Cognitive Therapy Project (January 1999-March 2000) has involved training nurses from WHSSB and NWHB in cognitive therapy skills. Forty nurses were trained at basic level and ten at advanced level. This training course was accredited by Queens University Belfast.
- The Melvin Project is a partnership between Sperrin Lakeland Trust, Action Mental Health a Northern Ireland regional voluntary organisation, and the NWHB. It is based at the Erne Gateway Centre and is targeted at people recovering from mental health problems in the Lough Melvin area of County Fermanagh. The project was developed in response to research that highlighted how people with mental health problems in this area were unable to access a range of services, mostly due to transport difficulties. Some of the options available within the project are work-based training, development of key skills and training for jobs.

Evaluations on both of these projects are now due. Mental health has been identified as a priority topic for both jurisdictions and it is proposed that a mental health sub-group be formed during 2001 to facilitate the broad area of work that is developing in this sector.

Issues

- The Information Technology, Human Resource and Public Health sub-groups have not been fully integrated into the working of CAWT and as such have not had any major influence on the CAWT programme.
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5. CAWT STRUCTURE

5.1 Leadership

Involvement in the CAWT Executive Board requires a high level of commitment from individual members. This is particularly true of the post of Director General (DG). Originally this position rested with the Chief Executive/General Manager of one of the Northern Boards (firstly with the SHSSB and then the WHSSB) but it has recently moved to the NEHB. It has also now been agreed that the post of DG will rotate on a biennial basis so that each Board can actively contribute to chairing the Executive Board. Respondents have cited these new arrangements as significant in terms of 'deepening' the ownership of CAWT at a senior management level. While a network of relationships has been established at this senior level, there is evidence that the Executive Board's effectiveness as a decision-making forum may need to be strengthened. Respondents felt that due to pressures of time at Executive Board meetings it was sometimes impossible to debate issues fully. This was a particular problem with regard to policy issues and the future direction of CAWT. Bearing in mind that cross-border co-operation is a very small part of the overall workload of the members of the Management Board it may be useful to convene a planning/priority committee so that the ground part of such debates can be thoroughly prepared and discussed prior to the quarterly meetings.

"CAWT doesn't get disproportionately less time than anything else does but is probably not getting anything like the attention it deserves".

5.2 Engagement of Trusts

While the Health and Social Services Trusts in Northern Ireland are actively involved in some cross-border projects (e.g. in the Acute Sector Projects) they do not appear to be truly engaged in the CAWT process. Efforts to involve the trusts following the purchaser/provider split saw a representative trust CEO and Chairman join the Management Board. However, this is generally regarded as being a token effort and not a true involvement in the CAWT structure. The role of this representative has not been clearly defined and this has led to some confusion over the process of raising trust awareness - one example being the allocation of responsibility for circulating the minutes of the Management Board meetings to the other trust CEOs and chairmen.

It is strongly felt that the change in health care structures in Northern Ireland has not facilitated cross-border working. The priority for trusts has been to ensure viability and stability within the Northern Ireland system rather than to explore new areas of working, such as cross-border co-operation.

British government reforms of the early 1990's led to a separation of the purchasing and providing roles within the national health care (NHS) system. As commissioners and purchasers, boards are required to plan, secure and pay for the services needed to meet the health and social care needs of their populations. Health trusts became managerially responsible for the delivery of health services and although they control their own budgets they are accountable to the Health and Social Services Executive. Respondents from the South have experienced difficulties in working co-operatively within a sometimes conflicting environment involving both boards and trusts. CAWT could possibly facilitate the smoother implementation of cross-border practice within the current health care system. By discussing cross-border working practices under a CAWT agenda, the trusts and the boards from Northern Ireland can legitimately be involved from the start of new developments and thus any conflicts (which arise due to their purchaser/provider roles) can be resolved at an early stage.

Equally there is evidence of problems which have arisen when CAWT in its co-ordinating role has not been involved in the initial set-up of a project. This is true of the cross-border dermatology

work which affected the waiting lists and procedures within a single trust which was not aware of the new practice until it was implemented and was therefore unable to plan for the change. In addition, CAWTs short-term project-based approach has proved a problem for trusts, particularly in managing patient and staff expectations. This is particularly true of the Dermatology Project. The new arrangements did result in reductions in out-patient waiting lists, however a series of staffing, structural and accreditation difficulties have militated against the extension of the project. Staff and patients must now return to the less efficient procedures in place before the cross-border initiative.

5.3 Resource Unit/Secretariat

The CAWT Secretariat, essentially a very small working group of five part-time and two-full time posts, are pivotal to the functioning of the CAWT process. Their success can be attributed to a number of factors. Firstly, the seniority of these staff has allowed direct contact to take place with their respective CEOs. Secondly, the involvement of Secretariat members on different CAWT sub-groups and project management groups facilitates the smooth linkage of the different levels of the CAWT structure.

The Secretariat acts as a reminder of cross-border working as a viable working option. The full-time Executive Officer and the designated Secretariat are a point of reference for people to get involved in such working. There is a strong feeling among CAWT members that without the focus the Secretariat has brought, cross-border working would still not be considered as an option by many board managers and other service professionals.

In the past the work of the Secretariat has 'legitimised' the organisation by raising awareness of the organisation's cross-border vision and agenda with relevant partners outside CAWT.

Respondents felt that only because these relationships have been established it is now possible to implement effective working on the ground.

Another contribution of the Resource Unit has been the provision of a central information point through which information and support can be obtained by both health and social services professionals, community organisations and agencies involved in the promotion of cross-border working. Acting as a central corporate focal point, the Unit aims to co-ordinate co-operative work across the region, supporting existing relationships and promoting good practice.

It was felt by many respondents that while cross-border work has to be generically built into the system, not all cross-border work needs to be directed through the CAWT Resource Unit and the Secretariat. For the system to function effectively, the Secretariat should be developing links with their senior staff, giving them support so that they can develop relationships with their cross-border counterparts. Respondents felt that keeping the Secretariat involved in all decision-making is not appropriate in the long-term. Eventually, the Resource Unit will act as a backup system, promoting the processes which need to be integrated into the core plans of the boards and the trusts.

Interestingly, the Resource Unit provides an opportunity to observe the attitudes and behaviours of people from both sides of the border working together to achieve a common goal. With the changing attitude towards cross-border (and indeed cross-board) working practices, the Resource Unit has a wealth of experience to contribute to the agenda.

5.4 Process of support

In theory, the ongoing work of the Secretariat has been concerned with directing and supporting the CAWT sub-groups. However, in reality, they have acted as a information channel connecting the management board with the work of the subgroups. Originally, there was an effort to assign responsibility for sub-programmes to individual Secretariat members in order to ensure optimal cross-border support. This process has never materialised and was actively discouraged due to the time pressures such a commitment would entail. Instead, Secretariat members have adopted

a more flexible process, adapting their supportive roles as effectively as possible within their individual board commitments. In essence this has meant that different support procedures have developed within different boards.

Within the NEHB, the CEO, the Secretariat member and all of the board's sub-group members meet quarterly to discuss progress and relevant issues prior to the Management Board meeting. Within the other three boards the individual sub-group representatives do not meet formally under the CAWT banner.

The WHSSB has a two-pronged approach. The WHSSB Secretariat member meets regularly with the key people who are responsible for the planning of services within the board and trusts. Support for sub-groups within this board is greatly assisted by the presence of the CAWT Resource Unit in Derry, and sub-group members contact this unit directly for advice or help. The SHSSB Secretariat member plays a key role in representing the board's interests at the Secretariat. No regular meetings are held with sub-group representatives, but due to established in-board relationships informal contact is maintained and the Secretariat member is 'seen to be there if needed'. However, concerns are typically directed through the chairs of the sub-groups as opposed to through the Secretariat member.

Within the NWHB, the Secretariat member is actively involved in some of the CAWT projects within his Board. These relationships allow for information on the ground to be relayed through to the Board CEO. No regular meetings are held with all of the CAWT sub-group representatives, but the Secretariat member can be contacted directly for advice and information on cross-border co-operation.

The current procedure in the NEHB of timetabling a regular meeting of all CAWT representatives has proved to be an effective way of raising the profile of CAWT within the board and in disseminating and communicating information on the different strands of cross-border practice. It allows for mixing of different groups of health professionals, who may not normally work together in a board capacity, to cross-fertilise ideas and contribute new solutions and approaches. It also focuses the board's overall contribution to the CAWT agenda and allows the CEO to gain a direct insight into the working procedures prior to Management Board meetings. NEHB respondents felt that their time was more productively spent attending these meetings, and this was proportional to the old procedures.

The procedures in the other boards appear to be effective for the majority for of sub-groups. However there are instances where sub-groups do not feel included in the wider CAWT agenda. This is particularly true of the functional sub-groups (e.g. IT) which often need to contribute on a cross-disciplinary basis. In addition, those CAWT representatives who meet on an organised basis within their individual boards have cited the usefulness of cross-disciplinary meetings as a means of recognising their contribution.

5.5 Financial management and control

CAWT established a structured financial management system to account for the funding attracted from the EU Special Support Programme for Peace and Reconciliation. The original procedures provided for the designated CAWT finance representatives in the WHSSB and the NWHB to be responsible for the proper disbursement of EU funds channelled to these boards from the sponsoring department (i.e. Department of Health and Social Services (DHSS) in Northern Ireland and Department of Foreign Affairs (DFA) in the Republic of Ireland). It was recognised that with the potential expansion of projects under the auspices of CAWT even strict accountability procedures were needed.

In May 1997 the Management Board approved new financial procedures which saw the appointment of a part-time finance manager to act as a link between the project groups and the financial personnel in each board. The WHSSB and the NWHB continue to act as 'banker boards' channelling funds to spending organisations and claiming and drawing down funds from the funding departments. A Finance Forum now oversees the operational plans and the financial

budget of the project groups. Details of the CAWT financial procedures are contained in Appendix G.

The CAWT Finance Manager and the Finance Forum meet quarterly to consider the performance of projects from a financial perspective and to present formal progress reports to the CAWT Management Board. Quarterly financial reports and claims for funding are also presented to the funding departments in both jurisdictions (i.e. the DHSS in Northern Ireland and the DFA in the Republic of Ireland).

The part-time Finance/Project Officer post has proved to be very effective in establishing the credibility of CAWT financial management. In 1999 the Head of Ireland Audit Services of SHSSB carried out an audit of CAWT's financial arrangements on behalf of the Finance Forum and concluded that the financial arrangements provided adequate controls. DHSS Northern Ireland (Internal Audit) carried out a detailed examination of payments in connection with two projects and no irregularities were reported. In 2000 there were two further audits, one by the EU Regulations Unit, Dublin and the other by the Northern Ireland Audit Office. Both were happy with the financial procedures and controls.

There is some concern that in the future, as the CAWT workload inevitably expands, the accounting for individual projects will require a proportional increase in financial support as each new piece of work will demand an individual set of accounts and procedures. In order to counter-balance this, it may be necessary for CAWT to concentrate its efforts on a small number of large projects.

5.6 CAWT people

The initial formalisation of CAWT was driven by individual personalities and until relatively recently it has depended on individual energy. Because of the small nature of CAWT, personalities play a major part in its effectiveness. Considerable credit is due to those who conceived and pioneered the initiative in an often adverse political climate.

People appear to derive a great sense of enjoyment in conducting their cross-border work. Respondents have expressed the view that CAWT opens up new ways of working and allows them to contribute to the health of their region in new and innovative ways through which they can see obvious benefits for individual patients (e.g. the renal dialysis programme).

At the project level, working within CAWT is seen as a positive career advancement move. Professionals who have become engaged have seen the potential and appreciate the value of working in a cross-border way. The overall consensus among those who have been involved is that the networks which have been developed are genuine.

"CAWT provides a framework for co-operation which is enhanced because of the time, space and resources to test out new ideas".

There is a sense of enthusiasm for cross-border working. This is underlined by the fact that in many instances CAWT work is done on a voluntary basis – as an addition to a person's normal job.

A lot of CAWT projects have engaged community and voluntary groups from the local communities on a cross-border basis. The involvement of local communities in helping to tackle the root causes of social deprivation, social exclusion and poor health has been identified as a priority for mainstream health provision in both jurisdictions.

5.7 Overview

Considerable credit is due to those who conceived and pioneered the CAWT initiative in an often adverse political climate. At a corporate level, the structures of the organisation are stable, yet there is a need to develop greater ownership of CAWT. The Resource Unit plays a central role in maintaining balance between the partners and in maintaining the momentum of the sub-groups. The Secretariat works well because of the seniority of members who typically have direct links to

the board CEOs. However the Secretariat are stretched by a very heavy workload. The working process is flexible (not overly bureaucratic) yet very time-intensive. The financial management structure is well developed. More effort should be made to actively engage the trusts under the over-arching CAWT umbrella.

The Secretariat accounts for a relatively small amount of funding. However the opportunity costs of the involvement of fairly senior board staff in CAWT activities are substantial. Ultimately the cost of that involvement should be gauged against the benefits for patients and clients.

6. CAWT PROGRAMME

6.1 Focus

The main focus of CAWT to date has been on providing a forum through which senior management from the member boards can work together on charting future developments in mutually beneficial areas. In so doing, this approach has tried to encompass as many areas of health care as possible and to build as many networks as possible. Ultimately the goal has been to change the culture of planners, commissioners and providers to look beyond their own borders.

There appears to have been only a limited effort to look systematically at problems which may confront the border region (such as economic and social deprivation, an ageing population, distance from main tertiary centres, the lack of locally-delivered health services) within a health context and to review the extent to which CAWT can help in addressing these issues. However, through discussions with respondents it has been possible to identify three major perspectives which appear to have to a greater or lesser extent provided the ideological basis for CAWT.

1. Disadvantage in terms of needs and funding

Firstly, there is a widespread perception that the CAWT region is disadvantaged on account of its peripherality, sparsity of population and rurality, and that the region should benefit from positive discrimination in terms of funding projects to redress this disadvantage. It has been possible to use this argument about disadvantage to secure funding to undertake work that might not necessarily have been funded outside the border region .

2. Natural geographic areas/catchment area

The argument is also commonly made that if the border had not been in existence for the past 80 years, services would have developed in different ways around a "natural" area/ population base. This has not happened in either jurisdiction as a direct result of the existence of the border, the most obvious example being north Donegal and in particular the Inishowen peninsula being part of the NWHB while geographically it should be aligned with the northern part of the WHSSB area. Instead there now exist two separate catchment area populations and neither of which have the critical volume to justify locally delivered health services.

3. Separate systems

Another persuasive argument in favour of cross-border co-operation derives from the very existence of two separate but adjoining health systems on the island. This gives rise to the expectation that there may be a lot to be gained from the sharing of ideas and learning, approaches to 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 happen. 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 the North. It would seem a logical and natural solution to adapt both services to the benefit of the patient.

There exist then three distinct philosophical bases for the existence of CAWT (and one might say for cross-border co-operation in health services generally). 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.

6.2 Project prioritisation and selection

Traditionally the proposal of projects for funding has involved members of the different sub-groups preparing detailed outlines of proposed work with the help of their respective Secretariat member. The Secretariat members and the Executive Officer would then in turn discuss the proposals with the respective board CEOs before they are brought to the Management Board meeting for approval. This procedure has proved to be very time consuming for the individual sub-groups and recently a new system has been proposed.

During June 2000 a seminar, entitled 'Making Connections', brought together sixty-five key players from the CAWT region to influence the future direction of CAWT. Following presentations on current CAWT initiatives and future EU funding programmes, participants were set a number of tasks:

- to devise a list of themes or projects which could be submitted for EU funding.
- to identify areas for joint working within existing budgets and
- to design the process by which proposals might be submitted and selected.

A further workshop, entitled 'Identifying Key Projects', was held in July 2000 to refine these project prioritisation and selection procedures. Participants included a single key representative from each board or trust, the chairs of the sub-groups and the CAWT secretariat. Working in small groups, 70 potential pieces of work were identified. After a brief explanation of each area, all attendees were then given the opportunity to vote for these work projects and to suggest whether they should be progressed through internal funding or by applying for EU funding. Currently the Secretariat is preparing a priority listing of these projects for Management Board review. This process has been a concerted effort to include more people in the selection procedure, to reduce the amount of time spent by sub-groups in preparing proposals and to provide an opportunity for sub-groups to interact and exchange experiences with each other. Within CAWT there now exists a number of criteria lists to aid the process of prioritising and selecting potential projects:

1. CAWT criteria for selection of project proposals (developed June 2000).
2. A set of shortlisting criteria used by the Letterkenny/Altnagelvin feasibility study to identify projects for joint development in the immediate future (developed August 2000).
3. A set of considerations for planning cross-border projects suggested by the Health Promotion sub-group.

All of these criteria are outlined below.

While the criteria of the Health Promotion sub-group appear to reflect the needs of the patient, those of the Acute Services sub-group appear to be mainly organisation-based. While the criteria do appear to be largely justifiable there is no documented evidence within CAWT as to the extent to which these selection criteria are actually being used to select projects (see 8.3 below).

6.3 Programme of work

The work of CAWT has been mostly project-focused, very diverse and heavily dependent on EU grant funding. The CAWT model of cross-border service development has yet to be tested with the majority of projects concentrating on issues of training and education as opposed to service delivery. Few projects have involved patients on a cross-border basis, although for those that have patient benefits can be seen in terms of reducing the waiting lists for out-patient dermatology in the Craigavon/Armagh/Dundalk region and improving access to renal dialysis treatment for patients in the Dundalk area.

Discussions with respondents have shown that the perceived success of CAWT project work is judged in two very different ways:

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

The judgement of project success has changed with the different stages of CAWT 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. With the new post Good Friday Agreement institutional arrangements for cross-border co-operation in Ireland, the expectations for CAWT to deliver may now be even greater.

During discussions respondents highlighted a number of projects which they believe to have made a valuable contribution to cross-border health care. Those projects where individual patient benefits can be seen were given the highest priority. Two good examples of patient-centred projects are the Dermatology Project which reduced waiting lists for out-patient dermatology appointments 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 is seen as a pivotal piece of work because it will address all the identified cross-border barriers in terms of registration of professionals, insurance cover and GP referrals between different health sectors.

6.4 Education and training

Within the project work there has been a concentration on education and training with a large exchange of information across the border. Each health sector (with the exception of public health) hosts at least one conference or workshop 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. Professionals allied to medicine (PAMs) have developed joint education approaches in professional development using examples from both jurisdictions as case studies. As a consequence of these events, 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.

6.5 Individual board benefits

While the core concept of CAWT has evolved around effective working together across the border, 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 as such the patients within their individual Boards should benefit. In addition there is evidence that those involved in certain specialities, 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 limited evaluation of training initiatives which have occurred appears to have been restricted to monitoring the uptake of available training places, assessment of the inter-disciplinary mix of trainees and general feedback on the course. There are notable exceptions such as the accreditation of courses within the Primary Care project and the Cognitive Therapy project.

6.6 Joint appointment/training

There appears to be some potential for joint cross-border appointments, training and/or secondments which could address issues of recruitment and retention of staff in the border regions (which has become a major issue in certain disciplines in the South particularly in nursing).

The possibility of undertaking professional training which includes working in both jurisdictions is already being tested within the north-west region. A public health specialist registrar from the NWHB is now seconded to work in the WHSSB for 18 months as part of her specialist training. There was a pragmatic need to get training within another region and Derry was the obvious place to go. It meant not having to relocate and was also seen as an opportunity to experience the working of the National Health Service (NHS). The health boards provided the financial arrangements with the NWHB continuing to pay the registrar's salary and the WHSSB reimbursing the NWHB for her work. The Faculty of Public Health Medicine organised the training.

While there were some administrative and attitudinal issues encountered in establishing this arrangement (which were eventually sorted by the respective CEOs), the integration of this specialist into the team in the Northern jurisdiction has not been a problem. There does appear to be potential around such arrangements particularly when one jurisdiction may be unable to attract highly skilled staff while the adjoining region may have available staff who do not wish to relocate. A reciprocal arrangement will shortly be in place where the NWHB will offer an allocation of places on their Management Development Training Course to members of the WHSSB.

Following plans to develop a shared dermatology service in Craigavon Area Hospital HSS Trust with outreach clinics in Newry, Armagh, Dundalk and Monaghan, the appointment of a joint dermatology consultant was sought. Despite several attempts, no applications were ever received for this post: however there were two expressions of interest at the registrar level. Even after an assistant specialist agreed to accept the post in the Monaghan outreach clinic it was reported that there was a further delay while insurance and indemnity cover was sought in the Republic of Ireland. These commitments are decided upon by the Department of Health and Children in consultation with its health advisory body, Comhairle na nOspideal, in Dublin which determines the numbers and types of consultant appointments and oversees the rationalisation of medical services. In the Dermatology Project evaluation report it is suggested that the creation of this joint, albeit temporary, post had caused a lot of concern at Department level, both North and South.

6.7 Monitoring and evaluation

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 disseminated. All 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 day-to-day working appears to be limited. There are obvious exceptions such as the primary care project 'Developing Primary Care Across Borders and Boundaries'.

Currently the monitoring and evaluation of CAWTs work is done through procedures which have been established as a direct result of securing EU funding. 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. This activity should 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 a 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. By focusing all of the sub-groups to achieve a high standard of documentation and evaluation the benefits of working on a cross-border basis should be more readily understood. The facilitating role of the Resource Unit should ensure that better horizontal learning of lessons will be undertaken.

The primary care project, Developing Primary Care Across Borders and Boundaries, is a clear example of how monitoring and evaluation can be used to progress and enhance cross-border co-operative working. The 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 management structure of this project showing the input of the quality assurance team is outlined in Appendix H. A tender for an external evaluation of this project has recently been issued. The external evaluation is being completed with a view to increasing the credibility of this work outside CAWT.

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.

PART III CONCLUSIONS AND RECOMMENDATIONS

7. MAIN CONTRIBUTIONS

7.1 Improved relationships

A large number of health personnel in the CAWT boards are now more familiar with their counterparts in the other jurisdiction. A network of contacts has been established throughout the CAWT region and further beyond. In many cases people are no longer working 'back-to-back' and there is confidence that "joint development will now happen because of those personal contacts". CAWT has played a valuable role in establishing these networks, particularly at a senior level. It is accepted that a joint vision for the provision of health care in the region has still not been achieved but respondents feel this would have been unrealistic within such a short time span. However CAWT does now offer a vehicle for such a cross-border vision and in the words of one respondent has already begun to do so through the "first meaningful discussions entered into between trusts in Northern Ireland and the boards in the Republic". CAWT has succeeded in building social capital in the form of trust and through routinising interaction with health personnel from both sides of the border.

7.2 Inclusive debate

There are certain projects, such as the acute sector feasibility studies, which do not necessarily need dedicated funding but demand co-operation for shared development. While it is generally accepted that in the longer term this co-operation may well have happened irrespective of CAWT, it is equally accepted that CAWT networks have helped this process to happen more effectively and efficiently. CAWT consultations have allowed debate to take place around a range of sensitive issues with all of the relevant partners. In essence this has allowed collaborators to become more comfortable with potentially reactive concepts in terms of identifying the benefits that can accrue which may not be immediately relevant and accepting ownership of the process at a very early stage. One example given the proposed development of a CATH lab facility in Altnagelvin hospital which would serve the joint population of the north west region. This proposal might be viewed as favouring the WHSSB institution, but an equally valid view is that it would allow the soon to be appointed NWHB cardiologist at Letterkenny to proactively manage his/her own patients while utilising existing spare capacity in Altnagelvin.

7.3 Attraction of EU funding (outcomes not yet available)

While the region is able to avail of EU funding because of the problems caused by the border, CAWT has facilitated the securing of this funding. It is accepted that a limited amount of this money would probably have been secured irrespective of CAWT. However, this process has been greatly assisted by the CAWT focus on introducing potential partners, assisting groups to complete funding proposals and providing a central information point for the four boards. This additional money has been particularly significant in times when health budgets were tight and the priority for funding prevention and promotion areas may not have been high. In total, CAWT has attracted over £5 million in EU funding to the border region. Care should be given to emphasise that the securing of such funding should not be portrayed as an achievement in itself. The emphasis should rest on the outcomes achieved as a result of the investment of these funds for the health benefit of the population. Only the completion of CAWT projects and the assessment of outcomes will show the true benefits of this scheme.

7.4 Pool of experience

Considerable experience has been built up regarding both the barriers/ constraints to cross-border working and the possible solutions needed to overcome them. The feasibility studies, in particular the Letterkenny/Altnagelvin Partnership Project 2000, have documented the current constraints to cross-border partnerships. Looking across the health sectors, a number of the projects have experience of adapting their original approach to overcome legislative or administrative barriers. A particular example of this is the Flexi-Worker Scheme run under the direction of the Learning Disability sub-group, where different vetting procedures necessitated the establishment of 'mirror sites' under joint management and with cross-border training. While it is accepted that changes to legislation and the harmonisation of registration arrangements will need to be addressed at a government level, it is possible that CAWT can offer potential solutions to overcoming barriers in order to implement services on the ground.

Importantly, CAWT is a vehicle through which problems and constraints to cross-border working can be highlighted. Many respondents feel that potentially CAWT has a far greater role than the one it currently plays in terms of informing the health agenda at an all-island level. To date this is an emerging agenda. In fairness to CAWT it had to be seen as unthreatening in the past and thus had to move quite slowly and cautiously. However, a body like CAWT, which looks at both the hospital service and the mental health and social services on a cross-border basis and which involves the people who are actually engaged in the community, is in an excellent position to identify and put forward proposals for future development.

8. MAJOR ISSUES

There are many issues that have been identified throughout discussions which need to be addressed by CAWT, and indeed some of which are already being addressed.

8.1 Communication/dissemination

At the moment, beyond the central core of people (Management Board and Secretariat) there appears to be a lack of knowledge about CAWT processes and procedures. In addition, as the CAWT workload increases there will be a need to communicate progress to senior management in a simple and effective way. Video-conferencing and teleconferencing should be incorporated into working arrangements now that cross-border relationships have been built – this should also facilitate more structured meetings. There is an urgent need to review the working and use of CAWT internal email systems to ensure that people have access to electronic communication. There is also a need for a regular newsletter/update which could be circulated electronically within CAWT. It is recognised that CAWT has actively begun to address these issues since the commencement of this evaluation with the establishment of a pilot Communications Officer position.

8.2 Mainstreaming

There is a need for CAWT work to be considered in the context of individual board strategies and not as something separate. At the moment CAWT work is not integral to the individual boards' service plans or performance management processes. There is very little evidence of mainstreaming in process, thinking and management and effectively projects have been bolted on to existing systems.

There is no particular evidence of project mainstreaming (e.g. Dermatology Project has been discontinued) but there is some limited evidence that boards are beginning to fund the Secretariat and developing infrastructural resources with people who have been trained to use them e.g. networked GP practices. In addition, some of the lessons learnt through cross-border working have been incorporated into individual board practice (e.g. CCAP project and the establishment of safety officer posts). There is evidence that the boards in the South, which have recently received a rise in health budget funding, would be willing to pump prime /seed fund services but need to get matching funding from the boards in the North.

There is a hidden commitment from the Boards in terms of people's time. The nature of CAWT is that it involves a lot of travel and meetings and represents a heavy commitment of people's time.

8.3 Institution focus

The main objective of CAWT is to improve the health and social well-being of its resident population. The shortlisting criteria for Letterkenny/Altnagelvin 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.

8.4 Evolving all-Ireland health agenda

The changing political climate has highlighted the need to clarify the focus of CAWT's work with regard to whether it should concentrate on cross-border health issues (i.e. restricted to the border region) or should evolve to look at broader all-Ireland issues. It is felt that cross-border co-operation and all-Ireland co-operation on health are not "two prongs of the same fork" but involve two different agendas, albeit overlapping agendas.

On the one hand contributing to an emerging all-Ireland agenda could lead to neglecting the border region. On the other hand by maintaining the focus on a region which may be overlooked in the bigger picture, CAWT may at the same time lose the potential to influence future developments between the Departments of Health, North and South, which will impact on the border region.

The overall consensus is that for the moment it would seem sensible for CAWT to remain within the four border boards since by adopting a wider focus the emphasis on co-operation on the ground may be diminished. Respondents strongly feel that the scope for cross-border co-operation is far from maximised and CAWT should continue to operate in the same vein. One possible solution to enable CAWT to maintain its regional focus but still influence the emerging all-Ireland agenda would be to develop closer, structured relationships with officials in both health departments. This structure should facilitate a two-way exchange of information and ideas, highlight work that needs to be undertaken to overcome obstacles and aid the symbiotic development of both the cross-border and all-Ireland agendas.

8.5 Funding issues

CAWT has been heavily dependent on EU grant funding for most of its projects. This has meant many projects have lapsed after such funding has expired, irrespective of their outcomes. One example of this was the emergency planning work carried out in partnership with the Northern Ireland Ambulance Trust. Funding has not been available to carry forward successful elements of a project on a more structured basis. Another problem is that such grant funding is rigidly project-specific, making it impossible to move funding from one related project to another. A limited amount of funding (approximately £500K) has been made available from the budgets of the individual boards over the past 8 year period. An open discussion on the possibilities and constraints of allocating individual board money to cross-border co-operation has not yet taken place. This is an area that needs to be explored in greater detail. Appendix J contains a breakdown of funding received by CAWT for the period 1992 – 2000.

There is some concern among respondents that while it is beneficial to attract funding which raises the profile of CAWT, it is difficult in these circumstances to avoid funding becoming a main focus. There are number of possible options which CAWT can consider in applying for future funding.

Option1: Individual project funding

One option would be to continue applying for funding for individual projects. In the past CAWT has submitted applications for EU funding which have been prioritised by the two Departments of Health. 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 the EU Special Support Programme for Peace and Reconciliation. It is probable that EU funds will be available from the Peace II and INTERREG III Programmes to support projects until 2006.

This option would constitute a continuation of CAWT's existing funding procedures. The structures and reporting mechanisms for interacting with the EU Peace and Reconciliation Programme are already established within the organisation. However, this study has already highlighted weaknesses with this approach such as sustainability (e.g. emergency planning work), mainstreaming (e.g. Dermatology Project) and the lack of a clear exit strategy (e.g. Community Childhood Accident Prevention Programme).

Generally, respondents would welcome the chance of funding to pilot new cross-border initiatives. However there is some concern that applying for individual project funding, which can be very time consuming, may detract from CAWT's main focus of cross-border co-operation.

Option2: CAWT as an Intermediary Funding Body

Another option, which CAWT has recently considered, is the securing of an allocation of block funding from either the Peace II or the INTERREG III Programmes. By doing so CAWT would have to function as an Intermediary Funding Body, in a similar way to groups such as Co-operation Ireland, selecting projects to fund and distributing funds in the health and social services area to voluntary and community organisations in the border region.

Following discussions held with the EU Special Programmes Body and the Departments of Health, North and South, it was decided against pursuing this option. There was some concern expressed by respondents that becoming an allocator of funds would change both the way CAWT worked and the way that CAWT was perceived by people in the community. Some respondents were uncomfortable with this prospect as they felt that the responsibility of accounting for the funds and justifying their selection process within the community would preoccupy a large amount of CAWT energy.

Option 3: Theme funding

Another viable option for CAWT is to secure money from the governments of both jurisdictions 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 through existing bodies in each jurisdiction. These priority areas are accident and emergency services, major emergency planning, high technology equipment, cancer research and health promotion.

While CAWT's programme of cross-border health work is wider than the current remit of the NSMC, these five areas do cover a large section of the current CAWT workload. It would be expected that CAWT would still be capable of pursuing its wider agenda in conjunction with the health work of the North/South structures.

CAWT has developed a reputation with both governments as a body which is engaged in the community and is thus in a good position to identify and put forward cross-border health proposals. In the Northern Ireland Assembly in June 2000, the Minister for Health, Social Services and Public Safety, Ms Bairbre de Brún, said that CAWT had been asked to conduct a study scoping the potential for cross-border local and sub-regional acute services.

Engaging with the new North-South structures on a more formal basis would not only integrate CAWT into the health strategies and policies of both jurisdictions but would also force the issues of sustainability and mainstreaming to be addressed.

Option 4: Funding from within individual board budgets

Currently only a limited amount of cross-border health co-operation is funded through the budgets of the individual boards. An open discussion is needed around the possibility of money being allocated within the budgets of individual boards to meet population needs which can be better addressed on a cross-border basis. While boards do have a hidden commitment to cross-border working in terms of allocating officials' time, there has been no attempt to establish a dedicated cross-border fund by the four boards. It may be that there are legal impediments to establishing such a funding mechanism which need to be addressed. Also, the inflexible nature of allocating money from individual budgets, where money may have already been earmarked for specific purposes, to new ventures has been cited as a contributing factor. However it may also be a reflection of the lack of commitment to cross-border working as a funding priority within the board budgets.

In the Republic of Ireland the main funding for voluntary social service organisations is through Section 65 grants. Under this section of the Irish Health Act (1953) grants can be paid by the health boards to voluntary organisations in respect of 'services similar or ancillary to a service

which the health board may provide'. There is similar funding available for voluntary groups within Northern Ireland such as National Lottery funding. It should be ascertained whether such grants can be paid to voluntary groups working in partnership with CAWT.

Option 5: Research funding

It is possible for CAWT to apply for research funding, in collaboration with academic institutes, from research bodies in Ireland, the UK and Europe.

In 1999, the Health Research Board in the Republic of Ireland started a North/South grant scheme to stimulate co-operation between researchers in the two jurisdictions and awarded funding for three co-operative studies. From 2000 onwards, this North/South scheme is being run on a matching funds basis with the Northern Ireland Department of Health's Research and Development Office.

It would also be possible for CAWT to apply for research funding through European programmes such as the current EU Fifth Framework Programme. This programme has been conceived to respond to the major socio-economic challenges facing Europe. It focuses on a limited number of research areas combining technological, industrial, economic, social and cultural aspects. Two programmes within the current framework have calls for proposals with health as a key action and/or as a generic research activity:

- Quality of Life and Management of Living Resources Programme

Specific key areas mentioned include: food, nutrition and health; control of infectious disease, and the ageing population and disabilities. Public health and health services research (including drug-related problems) is cited as a generic research activity.

- Creating a user-friendly information society (IST) Programme

Two specific health topics which are eligible for funding here are: the use of advanced telemedicine service and health network applications to support health professionals, continuity of care and health service management; and the use of intelligent systems which would allow citizens to assume greater participation and responsibility for their own health. Creating stronger links with academic institutions would be beneficial to CAWT both in terms of developing research skills and disseminating its work to a wider audience. Working within the European Framework Programme would help CAWT to become more familiar with European issues and to develop relationships with other European border regions. (Part IV later in this report deals specifically with the European health agenda).

9. ASSESSMENT of ACHIEVEMENTS against OBJECTIVES

<i>Primary Objectives</i>	Achievements
The improvement of health and social well-being of their resident population	<p>Improvements in health and social well-being are virtually 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 in their individual areas.</p> <p>Models of best practice have been identified in the both jurisdictions. There has been a great exchange of ideas on a cross-border basis. There should be a greater emphasis on patient needs assessment.</p> <p>"CAWT may appear to be unproductive time but one cannot buy trust".</p>
The exploitation of opportunities for co-operation in the planning and provision of services	<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>
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 most notably through building the Stranorlar-Ballybofey Primary Care Centre with cross-border usage and though the Family and Child Care sub-group.</p> <p>Most external partnerships have been developed with the</p>

	community and voluntary agencies.
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>

10. RECOMMENDATIONS FOR THE FUTURE

10.1 Review of existing CAWT Strategy

The Making Connections workshop and the follow-up seminar were a welcome step in gathering the collective views of CAWT. These views are now being used to review CAWT's existing strategy with direction from senior management. Both at an overall strategic and an individual project level, greater clarity is needed about the objectives of improving co-operation and the obstacles to be overcome in achieving that improvement. One objective might be to overcome disadvantage in terms of particular documented levels of unmet need in border areas. Others might be to plan more effectively for 'natural' cross border catchment areas or to learn about the effectiveness of different responses to common problems. Where the achievement of goals and objectives is outside the direct control of CAWT; intermediary objectives should be set. A clear statement should be made about existing problems and how they can be ameliorated through closer cross-border working. Clarity is also needed to identify how CAWT's work fits into the broader peace and reconciliation agenda of the EU and the two governments, perhaps through its work on helping to overcome 'people to people' barriers in the health sector.

- **A revised CAWT Strategic Strategy should include clear statements on CAWT's objectives, existing cross-border problems and the interaction between the objectives of the health and peace and reconciliation agenda.**

10.2 Structure and Processes

The new North-South political arrangements provide an opportunity to build on the valuable foundation created by CAWT. It is likely that in a more propitious political climate expectations of what CAWT can do will be greater. In order to take full advantage of the opportunities and meet enhanced expectations, careful thought is required as to structures and processes. The staffing of the central executive (Resource Unit/ Secretariat) may need to be strengthened. One possible option would be to create two bilateral positions to support the existing Secretariat members. These positions would be joint appointments between the SHSSB in partnership with the NEHB and the NWHB in partnership with the WHSSB. In addition to supporting the existing Secretariat staff their brief could be expanded to include the wider European picture in terms of the specific commonalities and differences between the jurisdictions in the region.

In addition, the appointment of an Information Technology/ Communications officer within the Central Resource Unit may be necessary to facilitate the move towards greater communications (both external and internal) and in particular to facilitate a culture of on-line communications. It is recognised that during this evaluation a pilot communications officer post has been established with a view to developing a CAWT communications strategy.

- **The staffing of the central executive (Resource Unit/ Secretariat) may need to be strengthened.**

10.3 Research

It is recognised that CAWT has already established links with academic institutions such as the University of Ulster, the National University of Ireland Maynooth and the Centre for Cross Border Studies. However, the development of on-going relationships would provide support for CAWT decision making and would lend credibility to CAWT's stance in influencing the future cross-border/All-Ireland agenda. One possibility would be to develop a CAWT register of researchers

interested in health and cross-border work from which it could access expertise when needed. Establishing such relationships would also help CAWT to developing its own research and monitoring expertise to support its internal systems. Enthusiasm about future potential needs to be backed up by careful studies of:

Population sparsity and remoteness

Morbidity and other population characteristics

Unmet need in rural areas

Distance from facilities on either side of the border

The determinants of utilisation in border areas

The potential for economies of scale

Baseline levels of provision in the two jurisdictions, any spare capacity and the scope for expansion

The political/service impact of losing services, given that it will often be a 'zero sum' game

- **CAWT should develop research in conjunction with academic and policy institutes.**

10.4 Population needs assessment

In order to provide a clearer focus on health, there should be greater emphasis on population needs assessment. This might involve the lead being taken at board level rather than hospital/trust level. Ideally 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. It is noted that needs assessment is an area where significant further development is required in health services as a whole and that the ability to develop a comprehensive needs assessment for the CAWT region may be limited by the lack of appropriate data and poor data systems in general. However a greater degree of reliance on needs assessment would provide more of a sense of strategic direction, and less impression of developments being opportunistic. CAWT has the potential to become an exemplar of good practice, for example in relation to needs assessment and the assessment of opportunity costs. 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.

- **A population needs assessment for the CAWT region needs to be undertaken**

10.5 Developing relationships

CAWT is actively seen to be improving both its external and internal relationships. However with the greater potential for accelerating and extending cross-border co-operation afforded by the North-South institutions a greater two-way exchange of information is needed between the two Health Departments and CAWT. Although both Departments of Health have officially endorsed

CAWT, there does not appear to be a broad insight into CAWT workings or relevance within the Departments. A closer relationship and improved communication channels need to be developed between CAWT and the two health departments.

- **Consideration should be given to establishing joint CAWT - health department meetings to discuss how cross-border and All-Ireland co-operation agendas can symbiotically develop.**

The existing practice within the NEHB of holding structured meetings involving CAWT representatives, Secretariat members and CEO appears to be an efficient means of effecting progress and acknowledging and supporting staff contributions. The timetabling of such meetings appears to be time-efficient in that it relieves the necessity to hold ad hoc meetings with individual CAWT representatives. It also promotes horizontal learning across different disciplines. All Boards should look forward to developing in this manner.

- **Consideration should be given to timetabling structured meetings between CAWT representatives, Secretariat members and CEOs of the individual Boards and Trusts.**

10.6 Communication and Dissemination

Within Ireland, the CAWT Resource Unit appears to be acting as a central information point on matters relating to cross-border co-operation on the ground. A reference library of all CAWT documentation (including project documentation and sub-group minutes) and all relevant cross-border health matters should be established in the CAWT Resource Unit. Where possible, this information should be made available over the Internet so that the chain of information does not depend on the availability of a limited number of staff. The existence of CAWT should be actively promoted via the Internet and particular emphasis should be given to exchanging experience with other border regions.

- **An up-to-date (on-line) repository of CAWT documentation and other relevant documentation should be held at the CAWT Resource Unit.**

In addition, it may be appropriate to re-audit the existing use of the CAWT email system to identify any gaps in its use and to establish the need for further updates and training programmes. Every effort should be made to encourage CAWT staff to use the on-line system for routine CAWT business and queries. Regular CAWT news bulletins could easily be circulated to all CAWT members through the existing email system and on-line discussion forums could be established on the CAWT website. The single greatest difficulty associated with working on a cross-border basis was cited as the time spent travelling to meet with partners. The current CAWT practice of familiarisation and training of staff in the use of teleconferencing and/or videoconferencing with the view to facilitating remote meetings should be encouraged.

- **Internal and external communications systems such as the use of teleconferencing and videoconferencing should be strengthened.**

10.7 The relationship between CAWT and an all-Ireland health agenda

There is a major opportunity for CAWT to influence the developing all-Ireland health agenda, both by feeding experience to the two Departments/North South Ministerial Council and by undertaking work commissioned by them. Careful consideration is required as to the role of

CAWT in the future, including whether it should have an all-Ireland remit and whether it should become a funding body.

- **A strong relationship needs to be established with the NSMC in order to influence the health co-operation agenda. CAWT should proactively approach the NSMC, either directly or in partnership with an academic unit, with proposals for funding cross-border research.**

The importance of CAWT experience in providing cross-border solutions on the ground should not be underestimated. CAWT now has a greater opportunity alongside the responsibility to highlight the need for continuation of successful cross-border work.

- **Good cross-border models identified by CAWT (e.g. Dermatology Project), which have been discontinued due to staffing, structural and accreditation difficulties, should be brought to the attention of the North/South health ministerial meetings and other relevant bodies.**

10.8 Developing services

There could be instances where co-operation in the development of services would lead to sustainable, mutual benefits in improving the health of the CAWT population.

- **Care needs to be taken that restrictions intended to protect existing services do not impede the possibility of future co-operation which could lead to benefits for the overall health of the population.**

10.9 Reciprocal arrangements

A strong view was expressed by respondents from the Republic of Ireland, particularly in the North West, to the effect that co-operation should not be seen as a one-way street in terms of patients and resources flowing from South to North. At the same time most respondents (though not all) in the North saw the opportunities for patients flowing in to Northern Ireland hospitals more clearly than those that would have involved traffic in the other direction.

- **There needs to be open discussion around acceptable development criteria and documentation of these criteria needs to take place.**

10.10 Engaging Trusts and sub-groups

CAWT has made efforts to adapt to the changing structure of the health service in Northern Ireland however there is still significant scope to involve Trusts more extensively. While Trusts have been involved directly in the Cross-Border Acute Services Project they are not actively engaged in the overall CAWT organisation. The role and responsibility of the Trust representative on the CAWT Management Board needs to be clarified. The circulation of the minutes of Management Board meetings needs to be extended to all Trusts. Following the renewed interest in cross-border health co-operation since the establishment of the North-South institutions it may be appropriate for CAWT to meet with the senior managers of the respective Trusts to rekindle their cross-border relationship.

- **Trusts should be proactively involved in the CAWT strategic approach.**

In terms of developing the potential contributions of CAWT sub-groups the Information Technology(IT) and Human Resources(HR) sub-groups may benefit from structured Secretariat support to improve their awareness of the overall CAWT picture. (Indeed the HR sub-group does appear to have benefited from having a Secretariat member as chair of sub-group). All future proposals should be asked to specify where they have considered these disciplines (IT and HR) within their plans. Greater involvement of the public health sub-group would be gained through the undertaking of a population needs assessment with structured plans on how this information would be used to plan CAWT's agenda.

- **CAWT should proactively support the more inclusive involvement of IT, HR and Public Health sub-groups within the CAWT agenda.**

10.11 Evaluation and monitoring

Evaluation and monitoring of CAWT work should be standardised across all CAWT sub-groups. Currently the practice of evaluating and monitoring existing work appears to be of varying standard across the organisation. This practice could be facilitated by centrally co-ordinating this activity through the CAWT Resource Unit. The Resource Unit in turn should be provided with access to expert skills and advice on establishing and maintaining such a programme of work. Guidelines on the expected standard and format of CAWT work as well as recommendations for dissemination of preliminary findings in a timely fashion across other CAWT projects should be established. In addition, a system for highlighting the need for improved skills to achieve these standards at an early stage in the work should be implemented.

- **A template for project evaluations should be developed.**

10.12 Quality Assurance

The Quality Assurance Team involved in the Primary Care project has proved to be very beneficial in terms of maintaining the focus on the cross-border element of the work and providing structure to project outputs. This successful practice could be extended to include all CAWT projects as the costs involved were minimal.

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

PART IV THE WIDER EUROPEAN PICTURE

11. THE EUROPEAN APPROACH

A logical approach to cross-border co-operation is that of mutual recognition, which is already employed by the European Union (EU). This approach by-passes the administrative problems of harmonising diverse standards by mutual recognition of those standards. Since both the United Kingdom and the Republic of Ireland are part of the EU, the mutual recognition approach can be used as a basis for encouraging North-South (cross-border) policy co-ordination.

11.1 European Law

A European legislative framework has been agreed by the Member States. Typically, directives are used to agree a general intention that the Commission wishes to pursue and these are enacted through national laws in a way that is appropriate to the circumstances of each country. There have been a series of European Treaties through the years which have slowly been developing the competence of the European Union (EU) in the field of health. There are also a number of implications for health deriving from the interpretation of EU law concerning areas which have nothing to do with health. Examples of these include the Protection of Employment Directive, which has had a major impact on contracting procedures and the Working Hours Directive.

The EU is fundamentally about free movement of four things: goods, personnel, services and capital. Although health is not actually mentioned directly as part of fundamental EU policies, all of these issues, to some extent, are influenced and have an influence on health:

- free movement of goods e.g. pharmaceuticals
- free movement of persons e.g. patients and health professionals
- free movement of services e.g. health services
- free movement of capital, (to a lesser extent).

In general the role of the EU in influencing cross-border health care has been very limited. However, there is a vast contribution that the European dimension can add to the debate on the future of health care systems and European law does have something to say about health. Originally, EU public health was largely dominated by occupational health, beginning with the European Coal and Steel Treaty in 1951. Health emerged as a specific issue in the 1985 Single European Act, which said "the Commission would take a high level of protection as a basis for its proposals in a whole range of areas." In practice this meant that when the Commission takes action it should look to the implications for health. Countries originally signed up to this Act believing it to be an innocuous statement. However it was used as a lever by France and The Netherlands to develop the EU competency in health - specifically the 'Europe Against Cancer' and 'Europe Against Aids' programmes. Concerns about the use of this Act to direct the European health agenda saw the Principle of Rome evoked. This Principle restricts the ability of the European Commission (EC) to act only in certain circumstances and health was relegated back to a subsidiary topic.

The signing of the 1993 Treaty of Maastricht was recognition that there were public health problems which needed to be acted on by the European Union although this was restricted to specific areas such as 'prevention', 'major health scourges' and 'drug dependence'. Article 129 of the Maastricht Treaty states that "health protection requirements shall form a constituent part of the EU's other policies". In effect this means that the EU has to check that proposals for new

policies (in any field) do not have an adverse impact on health or create conditions that undermine the promotion of health.

To date six separate 'vertical' health programmes on AIDS and other communicable diseases, cancer, drug dependence, health promotion, and more recently health monitoring have been pursued by the Commission.

More recently (May 2000) the European Commission agreed to adopt a package of public health measures, designed to implement the provisions of the Treaty to strengthen the health protection of the European Community's population ². The package of measures consists of two main strands:

- A proposal for a new public health action programme, which will run for six years with a total budget of 300 million euros. The programme will focus on three main areas of action:
 - 0. The development of a comprehensive health information system.
 - 0. The development of mechanisms to respond to major health threats including a rapid reaction capability.
 - 0. Tackling of health determinants which will seek to reduce the high levels of premature deaths and illness in the EU.
- A Communication on the Community Health Strategy, which presents for the first time an overall strategic approach to health by the EU in light of:
 - 0. The expectation of the public that the EU should act to ensure that their health is protected.
 - 0. The strengthening of the European Commission's obligation in relation to public health.
 - 0. The emergence of new health challenges and priorities, especially related to the enlargement of the EU, increased demands on health services and demographic change.

In addition, a new mechanism, the Health Forum, is being established to give the public health community throughout the EU an opportunity to play a role in the development of health policy.

11.2 Free movement of people, patients and services

Originally EU directives were passed for individual health professionals (e.g. doctors, nurses, dentists, pharmacists) before finally a general system directive was passed which covered all other health professionals. In the Irish context, these directives did not have much impact because there was already a long established tradition of movement between the Irish and British jurisdictions. While theorised movement was possible throughout Europe, in many cases national requirements have been put in place (e.g. nurses moving to Germany being required to have psychiatric examination and chest x-rays) which are restrictive.

The free movement of patients is covered by a number of directives. Under EU legislation there are four sets of circumstances in which a resident of one member state can claim entitlement to health care in another;

- where emergency treatment is necessary during a temporary stay (e.g. tourists)
- for 'frontier workers'
- in the case of visits specifically for medical treatment not readily available at home
- for students.

(Dialysis patients are covered because you cannot have free movement unless there are arrangements for you to get dialysis elsewhere.)

11.2.1 Case Studies: Decker and Kohll

In April 1998, two landmark rulings by the European Court of Justice in Luxembourg were hailed as the first steps towards much closer European health care integration. Until these rulings reimbursement for reciprocal medical care between Member States had hinged on individuals having to get prior authorisation from their health authority or insurance fund. By suggesting that health care should be freely available across borders without restrictions, the ruling clashed with the principle of subsidiarity.

These rulings do not mean that national insurers are now required to reimburse people for treatment they receive elsewhere. Firstly, the treatment has to be offered on a transnational basis, otherwise it comes under national law and not European law. Secondly, it was the act of 'not reimbursing' for the treatment which was the deciding factor in making the provision of the clinical service more difficult. Thirdly, the treatment needs to be classified as a service – in the Kohll case the orthodontist treatment was classified as a service because it was provided outside the hospital infrastructure.

Therefore the key question, for which there is no black or white answer, is '**Are health services 'services'?**' The answer is **yes** if they are provided privately – the classic Irish example being the advertising of abortion clinics. The Irish Government's efforts to preclude Irish magazines from taking advertisements for abortion services offered in England was over-ruled because this was deemed a service and the Irish government was unable to hinder free movement. But the answer is **no** if the services are part of an organised national system and are not provided in return for remuneration – an obvious example being the provision of free National Health Service care in the UK.

One of the concerns leading from these rulings was the extent to which opening up health care markets could leave a country vulnerable to people coming in from outside and demanding to be treated on an equal basis as a member of that health system. The defence in the Decker and Kohll cases established legitimate blocks to the provision of free services. If allowing free movement of services would either undermine the financial basis for a social security system or health system, or its ability to provide care to a whole country population then it was deemed legitimate not to authorise treatment. (The view was taken that the provision of orthodontic services did not contravene either of these situations.)

The major impact of these rulings was in reminding Member States that the health care system is not excluded from the application of EU law.

11.3 Level of cross-border movement in Europe

It is particularly difficult to measure the flow of people across European borders for health care as there are no proper systems for recording such data. It is believed that people are moving to some extent but that most countries are actually having no gain or loss, and the impact on individual hospitals is minimal. One exception to this rule is the relationship between Italy and France, where Italians are more likely to go to France for private health care, a process mostly caused by the fairly widespread dissatisfaction with the Italian health care system.

One region in Europe which has a strong record of studying cross-border health co-operation is that of the Euregio Meuse-Rhine region. This region covers areas of Belgium, Germany and the Netherlands, centred on the cities of Maastricht, Aachen and Liege, and is ideally situated to encourage cross-border health care. It is one of 40 Euregios in the European Union and covers a population of 3.7 million people.

Figure 8. The Euregio Meuse-Rhine region



11.3.1 Case Study. Euregio Meuse-Rhine region^{3 4 5}

Phase 1

An early study of the Euregio Meuse-Rhine region attempted to record the extent to which cross-border health care takes place in practice and the factors that influence such behaviour. This work was grounded in a detailed analytical description of the health care indicators and the hospital financing systems for the three relevant member states. Findings showed a low volume of cross-border health care, accounting for less than 1% of total hospital admissions. Factors that influenced whether patients would seek treatment abroad included relative distance compared with national facilities, language, patient charges, and the conditions of health insurance that specifically facilitated care abroad.

Phase 2

On behalf of the European Commission, a cross-border Health Care Project was undertaken to explore how citizens living in the Euregio Meuse-Rhine region could potentially obtain access to health services in the members states of Belgium, Germany and The Netherlands. While the main part of this work focused on practical issues of cross-border health care, the rights of patients to receive cross-border care were also addressed.

The programme is a well informed, patient-centred attempt to improve patient access to cross-border health care in the region. Although the most of the co-operative work has involved regional and not national governments, administrative procedures and covenants have been sought from the respective governments to enable health insurers and providers to work on a cross-border basis.

Information

Three relevant sources of information were used:

0. A detailed picture of the legal systems (national and international) in the region was undertaken.
0. Questionnaire surveys were conducted with patients and those people registered with insurers relating to the main proposed sub-projects.
0. The project is being conducted as a form of action-research with a strong component for creating and strengthening health care alliances. Every effort was made to involve health care practitioners, hospitals and governmental and non-governmental authorities in these alliances. As a result of these strong alliances initial work was undertaken by both providers and health insurers.

- Providers have initiated strong pilot projects to reduce patient waiting lists in the areas of ophthalmology and orthopaedics.
- Health insurers have started initiatives to reduce barriers for patients, like creating the possibility of a flexible application of the existing administrative procedures in order to access cross-border care.

Sub-programme structure

The programme was divided into several sub-programmes which would run over a two and a half year period.

Sub-programme 1:

With help from the competent authorities, the participating hospitals comprehensively documented the existing level of cross-border patient care in traumatology, ambulance care and emergency care.

Sub-programme 2:

An existing programme in the Netherlands, the "Zorg op Maat" programme, was experimenting with the pre-authorisation of patients to receive care in a neighbouring country. This work has now been extended to cover the three Member States within the Euregio Meuse-Rhine region and is being monitored closely by the Dutch Research Institute, NZi.

Sub-programme 3:

The similarities and differences in the health insurance schemes of the different countries are being documented.

Sub-programme 4:

Possibilities for cross-border care based on reciprocity are being investigated. High care technologies are being made accessible for patients from all parts of the participating countries (i.e. not restricted to those patients in the border region). Current examples of this process are oncology treatment for children, kidney dialysis and rehabilitation facilities. An analysis of differences in regulation, financing and quality of medical devices in the three countries is being performed. Health insurers appear to be particularly interested in purchasing medical equipment in other participating countries which their insured persons can then access for treatment.

Sub-programme 5:

Efforts are being made to make the systems of co-payments, which have to be paid by patients crossing the borders in the Euregio, more transparent. The programme has stimulated insurers to develop lists of contracted or preferred providers and prices for co-payments of health care.

The patient

One of the main priorities of the programme is to strengthen the position of the patient in gaining access to health care. It was realised that the rights of patients to receive cross-border care was contained in the interpretation of existing laws and regulations of the participating countries and the EU, which govern the actions of patients, health care providers, governments and third-party payers. The overriding focus to all of this work was the patient's right to benefit from a supply of health care facilities anywhere in the region. Despite this principle, a sense of realism that not all patients' expectations could be completely met was maintained.

Within each health care system of the Euregio Member States, rules have been developed to limit coverage for services under public or private insurance. These rules are based on 'screening criteria' or 'referral criteria' which are dependent on relevant clinical findings. Patients who wish to obtain services but have failed to meet the relevant criteria of the insurer in their own member state generally have to do so at their own expense. Within the context of this study a general set of new procedures has been developed to aid the cross-border flow of patients.

Conclusions

The new cross-border health alliances in the Euregio Meuse-Rhine region have resulted in improved opportunities for patients to access a greater range of health care facilities. Alliances between health care insurers and providers have been approved and facilitated by the different governmental organisations. The interpretation of laws on the authorisation of cross-border health care was different between participating countries but tensions were reduced by agreeing uniform procedures. This work is regarded as a practical first step to realising patients' rights to access optimal health care service.

Throughout Europe, it is estimated that the total cross-border patient movement, which occurs mainly in the border regions, is very limited, at 0.2 percent of total patient health care (ref. European Health Forum Gastein, July 2000)

Even for transfrontier workers - those people who live in one country and work in another and under the Treaty they have the right to seek health care in the country in which they work - there does not appear to be very much cross-border movement. Some of the identified incentives for transfrontier workers seeking treatment are obvious and include: systems for reimbursement; referral mechanisms in place; the providers are perceived to be better; the facilities are near to their workplace.

In Ireland there is also a long-established practice of residents of one jurisdiction accessing care in the other through the use of an "accommodation address". Evidence⁶ suggests this is not insignificant, particularly in border areas and that such 'informal' activity may well outweigh the 'formal' traffic.

11.4 Local and regional co-operation in Europe

In an effort to transform the borders from lines dividing societies into zones of intensive co-operation and the European Union established the "Euroregions".

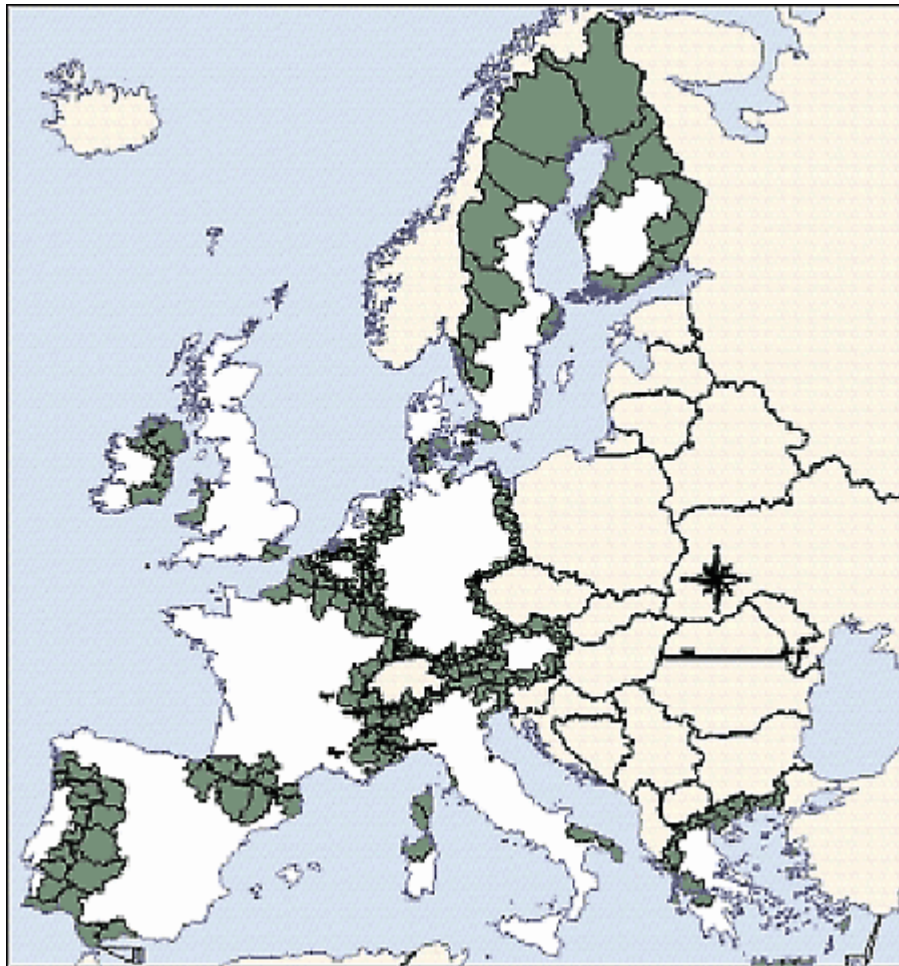


Figure 9. Map of the Euroregions

The main objective of the euroregions is to develop and to promote further co-operation and enhance positive regional integration through a variety of regional and cross-border activities. In the majority of cases there appears to be a concentration on the harmonisation of the infrastructure and economic development programmes of the regions. However, in some instances specific committees have been established to deal with the health and social aspects of co-operation. **Indeed, it is thought that the** concept of cross-border co-operation originated in 1958 following a **medical emergency incident in the Dutch-German border region**. A young Dutch man suffering from internal bleeding died during a lengthy ambulance journey (over 100km) to the nearest hospital in his country. There was a hospital less than a kilometre across the German border where he could have been treated and may have survived. As a result the Euregio was established on the Dutch-German border. From this beginning, the Euroregion concept slowly spread across the borders of western Europe. **Since then INTERREG Euroregions have been established at most of the internal and external borders of the European Union.**

11.4.1 Positioning CAWT within the euroregions

It may be beneficial to establish the position of CAWT within the overall context of the Euroregions to assist CAWT in gauging the usefulness of establishing contact with other relevant organisations. The cross-border regions across Europe can be crudely categorised into three phases of development:

1. Those regions that are more economically developed with common internal EU borders and common rural border problems (e.g. the Euregio),
2. Those with internal or external border regions of the European Union that have significant cross-border economic and administrative problems (e.g. Republic of Ireland-Northern Ireland), and
3. The external border regions of the European Union.

11.4.1.1 Well-established regions

These Euroregions extend from the Pyrenees to Northern Europe. Their prime distinguishing feature is that the countries are long-standing EU members whose cross-border co-operation developed very early. The countries also share a large densely populated land mass with long borders (<3000 kilometres). The main priorities for these regions have been economic co-operation and tourism, followed by employment and the environment. Transport and infrastructure have not yet featured prominently in cross-border co-operation. Health and social wellbeing is featured on the agenda of regions in this area most notably in the German-Dutch border region, Euregio, where co-operation first began (see case study in section 11.3 of this report).

All the regions have cross-border structures and operate on the basis of cross-border joint strategies and programmes. The governmental structures along these mutual borders vary widely with parallel discrepancies in efficiency. For example, along the German-Danish border the Danish counties enjoy a considerable degree of autonomy while the various entities on the German side have not yet combined into a regional association. By comparison, regions on the Belgian-Dutch border are fast developing cross-border structures with equal responsibilities. Regions on the German-Dutch border have developed furthest, with solid foundations laid down by international agreement, well-defined structures, and some integration already underway. Powers to carry through programmes and projects, in particular with EU grant aid, have been vested in the regional level to a very marked degree.

11.4.1.2 Developing regions

There are six major European border regions in this category:

- The border of Ireland (the northern counties) and Northern Ireland (excluding Belfast).
- The region of the Spanish-Portuguese border where Portugal's provinces of El Norte, Centro, Alentejo and Algarve meet Spain's provinces of Galicia, Castilla y Leon, Extremadura and Andalusia.
- The border of France and Italy.
- The border of Corsica and Sardinia.
- The border of Greece, in particular regions adjoining Bulgaria, the former Yugoslavia and Albania.
- The borders of the German Lander of Mecklenburg-West Pomerania, Brandenburg and Saxony.

Although cross-border co-operation in these regions is a relatively recent development phenomenon (typically beginning in the early 1990's) they have made surprising progress in cross-border co-operation most notably in cross border infrastructure, agriculture, forestry, fisheries and tourism. The general problem in these countries has been not the lack of ideas or initiatives, but political or jurisdictional problems in translating them into concrete action. The CAWT organisation is placed within this category of development even though the formal cross-border structures to develop North-South relations have only been put in place in recent years.

11.4.1.3 External borders of Europe

The third category contains regions along the external borders of Europe. Co-operation across the European Union's external borders is particularly uneven with many of the regions having had to contend with rapid change in the neighbouring border regions. The regions have been developing programmes of cross-border co-operation since the early 1980s. Most are bilateral agreements and they include associations such as the Constance Council (an institution created for co-operation at the Euroregion council level), the Working Community of Alpine Regions, the Working Community of Regions of the Eastern Alps, or the CONTRAO. Perhaps most important developments are the cross-border (and even pan-European) associations and the setting up development finance by drawing on a combination of EU resources and aid programmes (such as INTERREG and PHARE, a programme created and funded by the EC to support reforms and changes in Central Europe). One example of such co-operation is the Carpathian Euroregion Association and its common initiative embracing the border regions of Poland, Slovakia, Ukraine and Hungary.

11.4.2 Developing CAWT in Europe

It is generally accepted that Euroregions can only function as 'bridges' of communication if they succeed in building social capital in the form of trust and through routinising interaction. This is something that CAWT has successfully achieved within the field of health care. It is clearly evident from discussions with members at all levels of the organisation that cross-border co-operation is now becoming a generic part of the opportune appraisal.

While published cross-border health co-operation appears to be limited to the Euregio region, it is expected that in the well-established euroregions that co-operative health work does exist which has not yet been published in main stream literature. There is considerable scope for CAWT in proactively approaching the other Euroregions in order to exchange experiences and information. Outlined below are known websites of euroregions and umbrella organisations. Each of these websites contains local and regional contact details for cross-border structures and committees within their euroregion. It is recommended that CAWT establish contact with each of these euroregions in order to develop mutually beneficial relationships. It may be that those well-established regions have better developed cross-border health structures and may be able to contribute more to the CAWT agenda. Alternatively, the experience of CAWT may be more valuable to those regions which are in the same phase of development as itself.

Aside from the published health work of the Euregio region it appears to be extremely difficult to source practical examples of other cross-border health work in Europe. As was noted at the recent conference (*Challenge and Change for Health Care conference, Dublin 17-18 January 2001*) arising out of the Cross-Border Acute Project, it would be beneficial to convene a meeting of representatives from all active cross-border health organisations within Europe to exchange information on practice and policies and to develop an overall picture of cross-border health care.

11.4.2.1 European networks & contacts

Outlined below are the known website addresses of other euroregions. These websites typically give a broad overview of the region and the programme of work undertaken and provide contact details for each of the cross-border structures involved. Rather than reproduce them within the confines of this report, the website address is given as a point of reference.

European cross-border region	Website (maintained by the Euroregions)
EUREGIO	http://www.euregio.nl
EUREGIO Wattenmeer	http://cwss.www.de/
Benelux-Middengebied	http://www.gomantwerpen.be/nederlands/diensten/2igres.html
Ems-Dollart Region	http://www.edr.org/
EUREGIO Rhein-Waal	http://www.EUREGIO.org/default/default.cfm
EUREGIO Maas-Rhein	http://www.EUREGIO.net/nederlands/EUREGIO/index.html
EUREGIO rhein-maas-nord	http://www.EUREGIO-rmn.de/
EUREGIO Scheldemond	http://www.euregio.scheldemond.be
saar lor lux	http://www.etat.lu/MAT/
PAMINA	http://www.pamina.com/
Regio Bodensee	http://www.de1.emb.net/ibk/regio.html
Regionalverband Mittlerer Oberrhein	http://www.region-karlsruhe.de/promo/rvmo.html
RegioTriRhena	http://www.trirhena.com/Ger/Main.htm
Regio Basiliensis	http://www.regbas.ch/home.cfm
Freiburger Regio-Gesellschaft	http://www.rrz-freiburg.de/regio-gesellschaft/
Euroregion Pomerania	http://www.pomerania.net/index1.html
Euroregion Elbe/Labe	http://www.oberelbe.de/euroregion/struktur.htm
Euroregion Erzgebirge	http://www.mumost.cz/deutsch/mesto/euroregion/obsah.htm

Euroegio Pro Europa Viadrina	http://www.slubice.gorzow.pl/deutsch/pro-eur.htm
Euroregion Egrensis	http://www.landkreis-greiz.de/eureg.htm
Euroregion Spree Neisse Bober	http://www.wtcbb.de/WirtschaftBb/NachbarPolen/Euroregion.html
Euroregion Neisse	http://www.htw-zittau.de/ebz
Euroregion Nisa	http://www.euroregion-nisa.cz
Euroregion Bayerischer Wald/Böhmerwald	http://www.ooenet.at/EUREGIO/
EUREGIO Inn-Salzach	http://www.inn-salzach-EUREGIO.de
EUREGIO Zugspitze-Wetterstein-Karwendel	http://www.gaponline.de/landkreis/EUREGIO/
EUREGIO Weinviertel-Südmähren-Westslovaeki	http://www.EUREGIO-weinviertel.org
EUREGIO-Waldviertel-Südschechien	http://www.wvnet.at
EUREGIO Burgenland	http://www.burgenland.at
EUREGIO Insubrica	http://www.regioinsubrica.org
Comunidade de Trabalho Galicia-Norte de Portugal	http://www.galicia-nortep.org
Carpathian Euroregion	http://www.carpathian.euroregion.org/
EUREGIO Helsinki-Tallinn	http://www.EUREGIO-heltal.org
Euroregion Niemen	http://www1.omnitel.net/euroreg_nemunas/
Euroregion Bug	http://chelm.uw.gov.pl/e_eurobug.html
EUREGIO Baltyk	http://www.Eurobalt.org
EUREGIO Danube-Drava-Save	http://www.pbkik.hu/ddsz/angol/index.htm
Euroregion DMTC/DKMT	http://www.euroregion-dkmt.freehosting.net/welcome.html
Euroregion Saule	http://geluva.siauliai.aps.lt/saula_fr.htm

Euroregion Bile-Biele Karpaty	http://geluva.siauliai.aps.lt/saula_fr.htm
Eurégio West/Nyugat-Pannónia	http://www.neumann-haz.hu/digital/educatio/1997osz/studies/3suli-za/3suli-za.html
Euroregion Tatry	http://www.euroregion-tatry.sk/
Euregio Glacensis	http://www.euro-glacensis.cz/er/p_index.htm
Euroregion Bile-Biele Karpaty	http://geluva.siauliai.aps.lt/saula_fr.htm
Euroregion Tatry	http://www.euroregion-tatry.sk/
Euregio Glacensis	http://www.euro-glacensis.cz/er/p_index.htm

11.5 Other relevant European organisations

Outlined below are a number of other health organisations/ programmes which are active within Europe and are particularly worthy of mention.

11.5.1 The World Health Organisation(WHO)

The World Health Organisation published a comparative study of national health care systems in June 2000 ⁷.

Since 1980, the 51 countries of the WHO's European Region have embraced a common policy framework for health development which sets clear targets and outlines strategies that can be used to turn national policies into practical operational programmes at local level. In September 1998 the WHO Regional Committee for Europe approved an updated policy framework, Health 21, as the agenda until 2005. The Health 21 policy's framework is outlined as:

1 goal	1. To achieve full health potential for all people in the region
2 aims	<ol style="list-style-type: none"> 1. To promote and protect people's health throughout their lives 2. To reduce the incidence of main diseases and injuries and alleviate the suffering they cause
3 basic values	<p><i>Ethical foundation</i></p> <ol style="list-style-type: none"> 1. Health as a fundamental human right 2. Equity in health and solidarity in action 3. Participation and accountability for continued health development

4 main strategies	<i>Actions which drive the implementation</i> <ol style="list-style-type: none"> 1. Scientific 2. Economic 3. Social 4. Political sustainability
21 targets	<i>Benchmarks against which to measure progress in addressing the needs of the region</i>

11.5.2 European Observatory for Health Care Systems

Officially established in June 1998, the Observatory is a partnership between six organisations:

- World Health Organisation Regional Office for Europe
- Government of Norway
- Government of Spain
- European Investment Bank
- World Bank
- London School of Economics and Political Science
- London School of Hygiene and Tropical Medicine

Its principal aim is to promote the development of evidence-based health policy. The objective is to support policy-makers in formulating strategies for developing their national systems and to aid international agencies in providing consultation and development services to governments. To fulfil these objectives, the Observatory has developed a work programme that centres on four basic functions: monitoring and information, analysis, dissemination and training. Country-specific and topic-specific information on health systems and reform developments across Europe are provided through a series of profiles called Health Care Systems in Transition (HiTs) and secondly through periodic studies of sub-regions. The Observatory brings together basic science and practical policies in analysing major health care system topics such as the hospital-community interface and the future role of contracting. Central to the Observatory's wide dissemination policy is their newsletter, book series, web site (<http://www.observatory.dk>), and conference/meeting programme. As well as acting as a source for good educational materials, the Observatory offers a programme of short-term fellowships for key national policy-makers.

11.5.3 eEurope – An Information Society for All Action Plan

(http://europa.eu.int/comm/information_society/eeurope/documentation)

In June 2000 the European Council endorsed the eEurope action plan which aims to bring Europe on-line and to exploit its strong position in the new global digital economy. The Health Online action contained in the plan underlines the strategic importance of full exploitation of new information technologies in the health field. The identification and dissemination of best practices and the joint development of relevant benchmarking criteria for 'eHealth' will be undertaken within the context of improving public health, preventing human illness and diseases, and minimising sources of danger to human health.

Health Online sets out four areas of activity:

1. Best practices in eHealth will be identified and disseminated, in order to assist purchasing departments in decision-making.
2. A set of quality criteria for health web sites will be developed to boost consumer confidence in the use of such sites and to foster best practice in the development of sites.
3. A series of data networks will be established which will facilitate the sharing of technology, application and production assessment in order to help informed purchasing and European level quality assurance.
4. A communication on the legal aspects of eHealth will be drafted which will clarify the existing EU legislation impacting on eHealth (concerning fears around data production)

11.6 Recommendations

Europe certainly does not create any significant barriers to cross-border co-operation and health. There are a number of opportunities which exist through the implementation of EU directives although these opportunities may be over-stated. However, there are very positive benefits to looking at issues within a wider European programme:

- It goes beyond the constraints of Ireland, North and South, to a common agenda.
- It expands the mutual learning from European countries.
- It demands a search for solutions that have been adopted across borders elsewhere in Europe, taking account that some of them may be of limited value.

However, the main agenda to facilitate cross-border co-operation needs is the identification of problems and constraints for which Europe can help to find practical solutions.

- **It is recommended that CAWT proactively develop links with its cross-border neighbours within Europe to exchange information on practices and policies.**

APPENDICES

APPENDIX A CAWT KEY INTERVIEWS

CAWT Evaluation Interview Schedule

Monday 11th September	Mr Brendan Cunningham
Wednesday 13th September	Mr Tom Daly, Ms Mary Corrigan, Mr Paul Maguire
Thursday 14th September	Dr Colin Hamilton, Mrs Frances Mc Laughlin, Ms Frances Mc Reynolds, Ms Oonagh Carson, Ms Wendy Mc Laughlin
Monday 18th September	Mrs Madeline Coulter
Tuesday 19th September	Mr Martin Sweeney
Wednesday 20th September	C- BAP Project group
Thursday 21st September	Professor Martin Mc Kee
Monday 25th September	Dr Sean Denyer, Mr Eric Bowyer
Thursday 28th September	Health Promotion Subgroup
Tuesday 3rd October	Mr Pat Harvey
Wednesday 4th October	Dr Anne Maire Telford
Thursday 5th October	Ms Eithne O'Sullivan
Tuesday 10th October	Human Resources sub-group, Ms Nuala Sheerin
Thursday 12th October	Mr Tom Frawley
Friday 13th October	Mr Tadhg O'Brien
Wednesday 18th October	Mr Paul Robinson
Friday 27th October	Ms Val O' Kelly, Family & Child Care sub-group
Tuesday 31st October	Ms Lynn Donnelly
Wednesday 1st November	Mr Eugene Gallagher
Monday 6th November	Mr Barney McNeany
Tuesday 7th November	Mr William Gillespie

CAWT DIRECTORY

<i>GROUP TITLE</i>	<i>NAME</i>	<i>POSITION</i>	<i>HEALTH AUTHORITY</i>
Management Board	Bowyer, Mr Eric	Chief Executive	Newry and Mourne Trust
Management Board	Bradley, Mr John	Chairman	Western Health and Social Services Board
Management Board	Cunningham, Mr Brendan	Chief Executive Officer	Southern Health and Social Services Board
Management Board	Dolan, Dr Hugh	Chairman	North Eastern Health Board
Management Board	Frawley, Mr Tom (Dir. Gen.)	General Manager	Western Health and Social Services Board
Management Board	Gillespie, Mr William	Chairman	Southern Health and Social Services Board
Management Board	Harvey, Mr Pat	Chief Executive Officer	North Western Health Board
Management Board	McGlinchey, Cllr Bernard	Chairman	North Western Health Board
Management Board	Robinson, Mr Paul	Chief Executive Officer	North Eastern Health Board
Management Board	Scott, Mr Richard	Chairman	Western Health and Social Services Board
Secretariat	Coulter, Mrs Madeline	Assistant Director of Finance	Southern Health and Social Services Board
Secretariat	Maguire, Mr Paul	Assistant Hospital Administrator	North Western Health Board
Secretariat	McReynolds, Ms Frances (Chair)	CAWT Executive Officer	CAWT Resource Unit
Secretariat	O'Brien, Mr Tadhg	Director of Primary Care	North Eastern Health Board
Secretariat	Sheerin, Ms Nuala	Director of Personnel	Foyle Health and Social Services Trust
Finance	McLaughlin, Mrs Frances	CAWT Finance/Project Manager	CAWT Resource Unit
Finance Forum	Baker, Mr Brian	Assistant Director of Finance	Western Health and Social Services Board
Finance Forum	McKeever, Mr Sean	Director of Finance and Contracting	Southern Health and Social Services Board
Finance Forum	O hAodha, Mr Seoirse (Chair)	Chief Finance Officer	North Eastern Health Board
Finance Forum	Travers, Mr Anthony	Director of Finance	North Western Health Board
Acute Services	Corrigan, Dr Diane	Consultant Public Health Medicine	Southern Health and Social Services Board
Acute Services	Gaughan, Mr Pat	Programme Manager Acute Hospitals	North Western Health Board

Acute Services	Hamilton, Dr Colin (Chair)	Consultant Public Health Medicine	Western Health and Social Services Board
Acute Services	McNeany, Mr Barney	General Manager	North Eastern Health Board
Family/Child Care	Bolton, Mr David	Director of Community Care	Western Health and Social Services Board
Family/Child Care	Boyle, Mr Louis	Director of Child and Family Care	Southern Health and Social Services Board
Family/Child Care	Doherty, Ms Nuala	Director of Child Care Services	North Eastern Health Board
Family/Child Care	O'Kelly, Ms Val (Acting Chair)	Child Care Manager	North Western Health Board
General Practice	Gallagher, Mr Eugene (Chair)	Administrator Family Practice Services Unit	Western Health and Social Services Board
General Practice	Kelly, Mr Tom (Chair)	General Manager	North Western Health Board
General Practice	Gillen, Dr Uel	Senior Primary Care Medical Advisor	Southern Health and Social Services Board
General Practice	O'Brien, Mr Tadhg	Director of Primary Care	North Eastern Health Board
Health Promotion	Doherty, Dr Lorraine	Consultant in Public Health Medicine	Southern Health and Social Services Board
Health Promotion	Donnelly, Mrs Lyn	Health Promotion Commissioner	Southern Health and Social Services Board
Health Promotion	Eldin, Dr Nazih (Chair)	Health Promotion Officer	North Eastern Health Board
Health Promotion	Howell, Dr Fenton	Specialist in Public Health	North Eastern Health Board
Health Promotion	Hyland, Ms Bernie	Health Promotion Officer	North Western Health Board
Health Promotion	Jain, Ms Carrie	Health Promotion Manager	Western Health and Social Services Board
Health Promotion	O'Boyle, Ms Paula	Health Promotion Commissioner	Western Health and Social Services Board
Health Promotion	O'Brien, Mr Tadhg	Director of Primary Care	North Eastern Health Board
Health Promotion	Smithson, Dr Richard	Consultant Public Health Medicine	Western Health and Social Services Board
Health Promotion	Teahan, Ms Breda	Area Health Promotion Manager	Southern Health and Social Services Board
Human Resources	Doherty, Mr Manus	Director of Personnel	Altnagelvin Hospitals Trust
Human Resources	Donaghy, Mr Kieran	Director of Human Resources	Craigavon and Banbridge Trust
Human Resources	Ferris, Mr Mervyn	Director of Personnel	Newry and Mourne Health and Social Services Trust
Human Resources	McLaughlin, Mr Gerry	Director of Human Resources and Operational Services	Sperrin Lakeland Trust
Human Resources	Murphy, Mr Willie	Acting Personnel Officer	North Western Health Board
Human Resources	Sheerin, Ms Nuala (Chair)	Director of Personnel	Foyle Health and Social Services Trust
Human Resources	Walsh, Mr Larry	Prog. Mgr, Community Services and Continuing Care	North Eastern Health Board

Info. Technology	Alderdice, Mr Geoff	IT Officer	Southern Health and Social Services Board
Info. Technology	Corrigan, Mrs Mary (Chair)	Senior Executive Officer	North Western Health Board
Info. Technology	Doherty, Ms Roisin	Senior Systems Analyst	North Eastern Health Board
Info. Technology	Harrigan, Mr Colm	Information Technology Manager	Western Health and Social Services Board
Learning Disability	Gillen, Ms Aisling	Service Manager for Learning Disabilities	North Western Health Board
Learning Disability	Kinsella, Mr Leo	Regional Manager – Disabilities	North Eastern Health Board
Learning Disability	Simpson, Mr Jim	Service Planner Mental Handicap	Western Health and Social Services Board
Learning Disability	Sweeney, Mr Martin (Chair)	Assistant Director Disability Services	Armagh and Dungannon Trust
Public Health	Corcoran, Dr Rosaleen	Director of Public Health and Planning	North Eastern Health Board
Public Health	Denyer, Dr Sean (Chair)	Director of Public Health	North Western Health Board
Public Health	McConnell, Dr Bill	Director of Public Health	Western Health and Social Services Board
Public Health	Telford, Dr Anne Marie	Director of Public Health	Southern Health and Social Services Board

APPENDIX B CAWT DOCUMENTATION AVAILABLE FOR REVIEW

CAWT – CONSULTED DOCUMENTS *(list of documents available for review*)*

CAWT

- Co-operation and Working Together for Health Gain and Social Well Being, *CAWT Annual Report*, 1999
- Co-operation and Working Together for Health Gain and Social Well Being, *CAWT Annual Report*, 1998
- Co-operation and Working Together for Health Gain and Social Well Being, *CAWT Annual Report*, 1997
- Co-operation and Working Together for Health Gain and Social Well Being, *Annual Report*, 1996
- Co-operation and Working Together for Health Gain and Social Wellbeing, *Annual Report*, 1994
- Co-operation and Working Together, Moving to the Millennium, *Service Priorities for 2000 – 2001*
- Co-operation and Working Together for Health Gain and Social Well Being in Border Areas, *Making Connections Seminar Report*, 8 June 2000
- CAWT Workshop, *Identifying Key Projects*, 28 July 2000, a follow up to 'Making Connections' Seminar
- Co-operation and Working Together, *CAWT: The Bridge to the Future. Strategic Plan 1998 – 2001*, July 1997

PRIMARY CARE PROJECT

- CAWT – Primary Care, *Cross-Border Needs Assessment Project*
- CAWT Primary Care Development Project, *Education, Training and Development for Practice Managers/Administrative & Clerical Personnel*

- *Information Technology, Evaluation of Training Programme: Phase 2*, Fergal Durey, IT Facilitator, April 1998
- CAWT Primary Care Development Project, Training Programme for Information Technology and Management, Fergal Durey/Josephine Flynn, CAWT Facilitators
- Personal Professional Portfolio for Practice Managers & Administrative & Clerical Staff
- CAWT Primary Care Development Project, *Training and Development for Primary Care Nurses*, Final Report – Phase Two, Oonagh Carson – Services Division
- Health Fair Ballybofey, Public Consultation
- CAWT Primary Care Development Project, *Community Development Workshop*, Final Report – Phase Two
- Co-operation and Working Together, *Project Initiation Document*
- Patient Participation in Primary Care, *Report on Research Methods*
- *Outline of Management Training Needs for Primary Care*
- *Teambuilding Evaluation Workshop Report*
- *Analysis of Core Competencies and Training Needs of Practice Manager/Senior Receptionists*
- CAWT Primary Care Development Project, *Community Pharmacy: Outline of suggested Pilot Projects*, Valerie Scott
- Community Pharmacy, *Teambuilding Final Report*
- Cross Border Pharmacy Group, *Final Report* (Phase Two)
- CAWT Primary Care Development Project, *Chronic Disease Management Protocols*, Final Report – Phase Two
- CAWT Primary Care Development Project, *Hypertension Management*, Final Report Phase Two, Oonagh Carson – Services Development

ACUTE SERVICES

- *Developing A Cross-Border Ambulance Response To Major Incidents*, Draft, A Cross-Border Training Initiative of The Northern Ireland Ambulance Service and The North Eastern Health Board Ambulance Service With The Support of Co-operation and Working Together
- Altnagelvin/Letterkenny Partnership Project, *Project Report*, August 2000
- Triangle Project, *A feasibility study into acute service provision*, 8 September 2000
- Hayes, A., Birrell, D. & Gray, A.M., *Laying Foundations: Cross-Border Co-operation in Health. The Cross-Border Acute Project*, University of Ulster, 2000

HEALTH PROMOTION

- Young People Alcohol & Drugs Project, *Exploring the Promotion of Non-use of Alcohol and Drugs in the 11-13 Year Old Age Group*, 2000
- CAWT Drug Compliance Study, *Summary of Results*
- Co-operation and Working Together, *Community Childhood Accident Prevention Project, Using Home Visitors to Promote Child Safety in Deprived Areas*, Cathy Mullan & Dr Richard Smithson, 2000

INFORMATION TECHNOLOGY

- *Videoconferencing Project for CAWT*

HUMAN RESOURCES

- Co-operation and Working Together, Human Resources Project, *A study of cross border recruitment and selection practices*

*report title as given.

APPENDIX C NORTH SOUTH HEALTH SERVICES STUDY DAY **PROGRAMME**

PART I: CO-OPERATION AND WORKING TOGETHER

10:15 Introduction

Dr Maurice Hayes, former Permanent Secretary of DHSS, Northern Ireland and Chair of Northern Ireland Acute Hospital Review

10:30 Co-operation and Working together for Health Gain and Social Well Being. C.A.W.T. and Beyond: Main Evaluation findings

Dr Jim Jamison, former Director of Health and Social Care Research Unit, QUB and Dr Patricia Clarke, Research Officer, Centre for Cross Border Studies, Armagh

11:00 Refreshments

11:30 CAWT Evaluation: Discussion groups

12:30 Lunch

PART II – ALL-IRELAND CO-OPERATION

13:40 Opening

Mr Andy Pollak, Director, Centre for Cross Border Studies, Armagh

13:45 Introduction

Dr Maurice Hayes, former Permanent Secretary of DHSS, Northern Ireland and Chair of Northern Ireland Acute Hospital Review

13:50 An investigation of the current extent of cross-border co-operation in the full range of health services, identifying past co-operation and opportunities for future co-operation.

Dr Jim Jamison, former Director of Health and Social Care Research Unit, QUB

14:10 All-Ireland Co-operation: Discussion groups

15:10 Refreshments

15:40 Potential for, and barriers to, health co-operation across European boundaries

Professor Martin McKee, Professor of European Public Health, London School of Hygiene and Tropical Medicine/ Research Director, European Observatory on Health Care Systems

16:10 Final discussion (chaired by Dr Hayes)

16:30 Close

Participants

Mr Roy Alexander

Sectoral Manager, North-South Ministerial Council

Ms Mary Bergin

Sectoral Officer, North-South Ministerial Council

Mr Eric Bowyer	Chief Executive, Newry and Mourne Health and Social Services Trust
Mr John Bradley	Chairman, Western Health and Social Services Board
Ms Michelle Butler	Institute of Public Administration
Dr Patricia Clarke	Research Officer, Centre for Cross Border Studies
Dr Eibhlín Connolly	Deputy Chief Medical Officer, Department of Health and Children
Ms Madeline Coulter	Assistant Director of Finance, Southern Health and Social Services Board
Mr Joseph Cregan	Principal Officer, Secondary Care Division, Department of Health and Children
Mr Brendan Cunningham	Chief Executive Officer, Southern Health and Social Services Board
Mr Tom Daly	Regional Development/European Officer, North Western Health Board
Dr Lorraine Doherty	Consultant in Public Health Medicine, Southern Health and Social Services Board
Mr Kieran Doherty	General Manager, Community Services, North Western Health Board
Mr Colm Donaghy	Director of Planning, Southern Health and Social Services Board
Mr William Dukelow	Principal Officer, Department of Health and Social Services
Mr Tom Frawley	Office of the Ombudsman
Dr Kenneth Fullerton	Medical Director, Belfast City Hospital Trust
Mr Brian Grzymek	Assistant Secretary, Department of Health and Social Services
Ms Pat Haines	Director of Planning, Belfast City Hospital Trust
Ms Janet Hall	Communications Co-ordinator, CAWT
Ms Amanda Hayes	Researcher, University of Ulster at Coleraine
Senator Maurice Hayes	Chair of Northern Ireland Acute Hospitals Review
Ms Mairéad Hughes	Administrator, Centre for Cross Border Studies
Dr Jim Jamison	Former Director, Health and Social Care Research Unit, Queen's University Belfast
Dr Phil Jennings	Specialist in Public Health, Midland Health Board
Deputy Cecilia Keaveney	Oireachtas Committee on Health and Children
Mr Colm Keenan	Principal Officer, International Unit, Department of Health and Children
Mr Martin Kelly	Director of Planning and Information, Craigavon and Banbridge Community HSS Trust
Mr Norman Lunn	Assistant Secretary, Department of Health and Social Services
Mr Stephen Lyndsay	Chief Executive Officer, Western Health and Social Services Board
Mr Dick Mackenzie	Joint Secretary, North-South Ministerial Council
Mr Seamus Magee	Southern Health Council
Mr Paul Maguire	Assistant Hospital Administrator, North Western Health Board
Dr Miriam McCarthy	Senior Medical Officer, Department of Health and Social Services
Mr Edmond McClean	Director of Strategic Planning and Commissioning, Northern Health and Social Services Board
Mr William McKee	Chief Executive, Royal Group of Hospitals Trust
Professor Martin McKee	Professor of European Public Health, London School of Hygiene and Tropical Medicine
Mr Sean McKeever	Director of Finance, Southern Health and Social Services Board
Ms Frances McLaughlin	Finance/Project Manager, CAWT
Mr Kenny McMahon	Director of Operations, Northern Ireland Ambulance Service
Deputy Liz McManus	Spokesperson on Health, Labour Party
Mr Fergus McQuillan	Member, Western Health and Social Services Council
Ms Frances McReynolds	Principal Executive Officer, CAWT
Mr Seoirse O hAodha	Finance Officer, North Eastern Health Board
Mr Tadhg O'Brien	Director of Primary Care, North Eastern Health Board
Mr Tim O' Conner	Joint Secretary, North-South Ministerial Council

Mr Connor O'Malley	Sectoral Manager, North-South Ministerial Council
Dr Ciaran O'Neill	School of Public Policy, Economics and Law, University of Ulster at Jordanstown
Mr Ambrose Owens	Office of the Permanent Secretary, Department of Health and Social Services
Mr Andy Pollak	Director, Centre for Cross Border Studies
Mr Paul Robinson	Chief Executive Officer, North Eastern Health Board
Mr Francis Rogers	General Manager, General Hospital Sligo, North Western Health Board
Ms Nuala Sheerin	Director of Personnel, Foyle Health and Social Services Trust
Mr Paul Simpson	Deputy Secretary, Department of Health and Social Services
Ms Breda Teahan	Area Health Promotion Manager, Armagh and Dungannon Health and Social Services T.
Dr Anne-Marie Telford	Director of Public Health, Southern Health and Social Services Board
Mr Larry Walsh	Assistant Chief Executive Officer, Governance and Planning, North Eastern Health Board
Dr Jane Wilde	Director, Institute of Public Health in Ireland
Mr Robin Wilson	Director, Democratic Dialogue

APPENDIX D THE BALLYCONNELL AGREEMENT (revised)

THE BALLYCONNELL AGREEMENT 9th October 1998

The Ballyconnell Agreement was made in July 1992 between the North Eastern and North Western Health Boards, in the Republic of Ireland, and the Southern and Western Health and Social Services Boards, in Northern Ireland. It is reviewed at each CAWT Annual General Meeting and has been revised since 1992 to take account of relevant changes to CAWT's operation. It is now being revised to take account of the Purchaser/Provider split within Northern Ireland, where the Northern Ireland Health and Social Services Boards have been reorganised into Commissioner Boards and Provider Trusts which now exist as separate statutory agencies within the original functional areas of the WHSSB and the SHSSB. This agreement will continue to be revised in the context of the reorganisation of Health Service structures.

- i. This agreement is made between the North Eastern and North Western Health Boards, in the Republic of Ireland, and the Southern and Western Health and Social Services Boards and the Craigavon Area, Craigavon and Banbridge Community, Newry and Mourne, Armagh and Dungannon, Altnagelvin Hospitals, Sperrin Lakeland and Foyle Health and Social Services Trusts in Northern Ireland. The four Boards embrace the whole of the land boundary between the Republic and the United Kingdom. Between them, they

- comprise a population of one million - 21% of that of the island - and some 25% of the land area.
- ii. Health Boards in the Republic, and the Health and Social Services Boards and Trusts in Northern Ireland have as their primary aim the improvement of the health and social well-being of their resident populations. In the European context, they are unique in covering almost the entire range of health and personal social services
 - iii. The four Boards and seven Trusts are anxious to exploit opportunities for co-operation in the planning and provision of services which will improve the health and social well-being of their resident populations and to take advantage of funding which may be available from the European Union or other third parties. They would also wish to involve other public sector bodies in joint initiatives where this would fulfil their primary objective.
 - iv. The Boards and Trusts are particularly conscious of the desire of the British and Irish Governments, and of the European Commission, to promote such co-operation and to assist border areas in overcoming the special development problems arising from their relative isolation within national economies and within the Union as a whole. The Boards will, therefore, promote Government and European Union (EU) awareness and support for this agreement.
 - v. The opportunities which exist for co-operation will not be limited to those where the EU or third party funding may be available and the Boards and Trusts will explore all opportunities for joint working or sharing of resources where these are of mutual advantage.
 - vi. Within the European context, there are various aspects of Commission policy where opportunities exist for joint working and financial assistance. It is considered that there are many opportunities of joint working which will be of mutual benefit and which will come within the ambit of EU directives.
 - vii. It is agreed that the Chief Officers and Chairpersons of the four Boards and one nominated and agreed Chief Executive Officer and one Chairperson to represent the Trusts will meet as a Steering Group at quarterly intervals to consider proposals for joint working, to receive reports on existing projects and to review the extent and effectiveness of collaborative working arrangements.
 - viii. A joint Secretariat comprises two officers nominated by the Boards and Trusts in Northern Ireland (one for each of the Southern and Western Health and Social Services Board areas) and two officers nominated by the Boards in the Republic of Ireland (one each for the North Western and North Eastern Boards). This Secretariat is led by an Executive Officer appointed by CAWT. CAWT is also supported by finance/ project expertise and a corporate service structure as agreed by the Management Board. The Secretariat will meet regularly with the objective of developing proposals and related projects for consideration by the Management Board. The Secretariat will also take forward agreed projects. The Secretariat will be expected to develop a detailed knowledge of EU structures and legislation. It must also be familiar with the structures and responsibilities of both Government policies for the development of services and for the encouragement of co-operation and joint service provision. Members will also be expected to develop a knowledge of other funding opportunities.
 - ix. Officers appointed to the Secretariat will be expected to understand and contribute to the longer term development of services and improvement of the health and social statues of the catchment population. Where the Secretariat finds it necessary or appropriate, it can draw on other resources within the Boards or elsewhere. It may also recommend the appointment of ad hoc groups to investigate, develop proposals and take forward particular areas of work. The Secretariat will report to each meeting of the Management Board.

- x. A spring meeting will be held each year to review the Agreement, take stock and assess progress. An annual report will be produced each Summer by the Secretariat, for approval of the Management Board.
- xi. Every second year, at the spring meeting, a Director General will be appointed or re-appointed from the Chief Officers on the Management Board. The term of office for the Director General will be two years.

APPENDIX E CREATIVE CROSS BORDER PROJECTS



cooperation and working together
for health gain and social well being in border areas

CREATIVE CROSS BORDER PROJECTS

<i>No</i>	<i>GROUP</i>	<i>PROJECT</i>	<i>COST</i>
1.	Family & Child Care	Seminar to provide initial and unique opportunity for planners, information support staff and social work managers to focus on information in Family and Child Care Services	£3,000
2.	Health Promotion	Needs assessment of the Lesbian, Gay, Bi-sexual and Transgender (LGBT) Community in Derry and Inishowen.	£3,000
3.	Health Promotion	Drug Misuse Training for youth workers in the Newry & Mourne and NEHB area.	£3,000
4.	Learning Disability	Training event planned by the Learning Disability Sub-Group entitled The Ageing Service-User for Alzheimer's, Downs Syndrome population	£2,750
5.	Learning Disability	Independent Travel/Road Safety Training Programme over a two-month time frame using a test group of clients from Derry, Tyrone and Donegal border region.	£3,000
6.	Mental	Development of an information leaflet to provide information on suicide awareness for	£1,000

	Health	the public. Will lead to an all Ireland production.	
7.	Mental Health	Seminar to identify existing models of co-operation in mental health and inform the development of a network of cross border practitioners and voluntary agencies in mental health.	£3,000
8.	Older People	Reminiscence project between Day Centres in Lifford and Strabane.	£2,000
9.	Physical Disability	Re-education of Walking, e.g. children with cerebral palsy, spina bifida. Two day theory and skills based workshop for 14 qualified physiotherapists working with children and young people with special needs.	£1,500
10.	Primary Care	Development of an information system across WHSSB and NWHB to collect comparative information on dental epidemiology, oral health promotion and dental treatments etc.	£2,900
		<i>TOTAL</i>	£25,150

APPENDIX F LETTERKENNY/ALTNAGELVIN PARTNERSHIP PROJECT

Altnagelvin/Letterkenny Partnership Project Report August 2000

Constraints to Cross Border Partnership Working

- 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 waste (nuclear) and employment legislation can have serious impact on partnership working
- Registration of nursing, medical and professionals allied to medicine are 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
- Under- and post-graduate 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 is quite different and can provide a barrier to partnership working.
- Currency fluctuations (£stg. / £punt) 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
- 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's 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 services

APPENDIX G CAWT FINANCE PROCEDURES

SUMMARY OF CAWT FINANCE PROCEDURES

1. Projects designed by Project Group supported by CAWT Finance Manager.
2. Projects submitted to Management Board for approval.
3. Projects approved by Management Board submitted to EU and/or other funding decision makers.
4. If a project is successful in attracting funding, the Project Group agrees a detailed operational plan and financial budget with the CAWT Executive Officer and the CAWT Finance Manager. Operational Plans and Financial Budgets are submitted to the Management Board and Finance Forum for approval.
5. The agreed financial budget will include details of the expenditure approved to be incurred by each participating Board/Organisation and this information will be notified to each participating Board's/Organisation's Director of Finance by the CAWT Finance Manager.
6. Approved expenditure actually incurred is claimed by the relevant organisation through the relevant Project Chair/Project Manager. (Each project is supported by a designated finance support person).
7. The Project Chair forwards approved claims and monitoring returns in respect of expenditure to the CAWT Finance Manager. Claims from organisations in respect of approved expenditure to Project Chairs will be in the format approved. Claims from Project Chairs to the CAWT Finance Manager will be in the format approved.
8. The CAWT Finance Manager co-ordinates claims in respect of all Projects and informs the "Banker Boards" how expenditure is to be reimbursed.
9. Banker Boards reimburse expenditure to relevant participating organisations.
nb: The CAWT Finance Manager claims reimbursement of expenditure from the Government Funding Departments.
10. Banker Boards are reimbursed by Funding Departments.
11. CAWT income and expenditure will be accounted for in the statutory accounts of the participating organisations.

APPENDIX H PRIMARY CARE PROJECT ORGANISATION STRUCTURE

APPENDIX J CAWT FUNDING (EU and BOARD)

EU SPECIAL SUPPORT PROGRAMME FOR PEACE & RECONCILIATION FUNDED PROJECTS

REF	PROJECT NAME	TOTAL FUNDS £/IR£
EU 1/PR 596	Child Accident Prevention Prog Phase 1	304000
EU 11/PR 664	Cross Border Flexi Workers	75000
EU 13/PR 665	CAWT Support Phase 1	221000
EU 8/PR 668	Protecting Children with a disability	111000
EU 10/ PR 666	Parenting Initiatives	139125
EU 68/PR 1344	Primary Care Phase 1	660000
EU 62	Drug Awareness	133333
EU 65/PR 210	Imp. Health in Border Regions./Craigavon Phase 1	437458
EU 51/PR 853	Ambulance Training	344000

EU 14	Community Youth	219000
EU101	CCAPP Phase 2	205605
EU113	CAWT Phase 2	490292
EU168	Primary Care 2	641062
EU165	Improving Health In Border Areas 2	228287
EU167	Cognitive Therapy	141717
EU161	CAWTAS	53089
EU160	AGH/Letterkenny	65832
EU114	Melvin Mental Hth.	447964
EU118	Letterkenny Cancer Services	619645
TOTALS		5537409

Note the above figures are based on Sterling and IR£ being added together.

BOARD FUNDING FOR PROJECTS

REF	PROJECT NAME	TOTAL FUNDS £/IR£
EU1	CCAPP Phase1	101372
EU 11	Flexi Worker Project	254400

EU 13	CAWT Support Unit Phase 1	73666
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Recruitment Practices Research Project

GIS Systems

Child Care Legislation Comparison Project

Learning Disabilities Needs Assessment Project

Social Deprivation Research Project

A total of £30000 was allocated to the above 5 research projects.	30000
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Primary Care Project Out-of-hours	60000
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TOTAL	519438
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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.

REFERENCES

- ¹ The Border Region Submission regarding Structural and Cohesion Fund Assisted Operations 2000-2006.
- ² Commission of the European Communities. *Commission communication on the framework for action in the field of public health*. Brussels: EC, 1993 (COM ((3)559 final of 24 November 1993.)
- ³ *Cross-border health care within the European Community*. Brussels: Commission of the European Community, Directorate General V, 1991
- ⁴ Starmans, B., Leidl, R. & Rhodes, G. *A comparative study on cross-border hospital care in the Euregio Meuse-Rhine*. European Journal of Public Health 1997,7(suppl); 33-41
- ⁵ Herbert, E.M.G. & Hermans, A.E., *Cross-border Alliances in Health Care: International Co-operation between Health Insurers and Providers in the Euregio Meuse-Rhine*. Croatian Medical Journal, March 1999. Vol 42, No. 2.
- ⁶ Mulholland CW, O'Reilly D and Browne S (1996). Cross-border flows. A report to the Southern and Western Health and Social Services Boards. Health and Social Care Research Unit, The Queen's University of Belfast.
- ⁷ World Health organisation. *World Health Report 2000 – Health systems: improving performance*. Geneva: World Health Organisation, 2000).