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Collaborating on Healthcare on an All-Island Basis: A Scoping Study*

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ABSTRACT

Over the past two decades health has been identified as a key area for increased cross-border working on the island of Ireland. To date though, the approach has been minimalist and often project specific. The global pandemic, the continuing fallout from Brexit and the establishment of the Shared Island initiative have pushed the broad issue of healthcare cooperation up the policy agenda.

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**The author would like to dedicate this paper to the late Professor Jim Dornan, whose unfailing wisdom, advice and support was invaluable.

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Theoretically, closer cooperation could deliver economies of scale, value for money, opportunities for clinical specialisation, and facilitate the sharing of knowledge. However, despite its obvious potential and policy significance, cross-border collaboration in healthcare has been the subject of remarkably little research attention. This small-scale qualitative study is based on in-depth interviews with 49 individuals with expertise and experience in this area. From these interviews six broad themes emerged: support for collaboration, lack of strategic direction, knowledge sharing, Covid-19, data and opportunities for future cooperation. Given the similar social, economic and political pressures faced by both healthcare systems, it is concluded that leveraging the strengths from cross-border collaboration should be a policy priority.

INTRODUCTION

Over the past two decades cross-border cooperation on the island of Ireland has been evolving, largely due to EU policies and commitments contained in the Good Friday Agreement (hereafter, 'the Agreement'). In recent years, however, the issue has been catapulted up the political agenda. The increased impetus can be explained by a number of factors including the course of the Brexit process, the broad impacts of the Covid-19 pandemic, and the Irish government's Shared Island initiative. A period of unprecedented change has raised a myriad of issues around the nature and extent of current cooperation and possible areas of greater collaboration. The focus on opportunities for all-island collaboration reflects priorities for both the administrations, in Northern Ireland and Ireland. It is relevant for the Northern Ireland 'New Decade, New Approach' deal, which includes a focus on delivering what matters to citizens: better public services, a stronger economy and a fairer society; and the Irish government's 2020 Programme for Government, a key pillar of which is the concept of a Shared Island.

Within these debates there is a general recognition that healthcare offers significant potential for increased cooperation; consequently, it is a focus for the Shared Island initiative.[1] Theoretically, closer cooperation could deliver economies of scale, value for money, opportunities for clinical specialisation and the sharing of knowledge. This type of collaborative activity would

[1] Sheelah Connolly, Maev-Ann Wren, Aoife Brick and Ciarán O'Neill, 'Primary Care: Ireland and Northern Ireland', *Paper 2* of *Scoping papers for research on 'The economic and social opportunities from increased cooperation on the shared island'*, ESRI Survey and Statistical Report Series Number 106, May 2021.

particularly benefit communities that straddle the border where services are often difficult to access. While on paper the benefits of collaboration are obvious, creating this dynamic across the two jurisdictions of this island is challenging and not supported by extensive evidence or research. Significantly, the regular and repeated calls for further collaboration and cooperation have not been accompanied by detailed plans, feasibility studies or robust data to support an all-island approach. Statements by political parties and policymakers urging improved cross-border working are expressed in general, and at times vague terms. While there are some examples of cooperation in health services between Ireland and Northern Ireland,[2] to date the approach has been minimalist and often project specific. Aside from the notable exceptions of the Congenital Heart Disease Network and the North West Cancer Centre at Altnagelvin, and cooperation on access in border regions, there is relatively little strategic activity in this key policy area.

Recent major policy reviews on both sides of the border have paid scant regard to this issue. There are major structural and financial differences between the health systems in Northern Ireland and Ireland. However, they share similar core principles and values and face similar social, economic and political pressures.[3] To a large extent the two systems have common core principles and have adopted similar approaches to tackling issues. Key challenges include an ageing and growing population, evolving healthcare needs, workforce planning, rising costs associated with medical technology and increasing expectations. With regard to access to primary care across Europe, both Ireland and Northern Ireland perform relatively poorly.[4] The main causes of premature deaths are the same: cardiovascular disease, cancer, accidents and suicide.

Given the shared health challenges faced by each jurisdiction, and the dominance of healthcare in the policy agenda, the dearth of research and knowledge in cross-border health is remarkable. While the lack of priority and absence of strategic planning may be partly explained by the political sensitivities of all-island working, particularly for unionists, it does not fully explain why the potential benefits and barriers have not been the focus of substantial research attention. The lack of comparable data and robust information on both systems and their respective outcomes for

[2] Andy Pollak, 'Whatever happened to north-south co-operation?' *Belfast Telegraph*, 1 February 2019.

[3] Michelle Butler and Jim Jamison, *Removing the barriers: an initial report on the potential for cross-border hospital services* (Centre for Cross-Border Studies, Armagh, 2007); Patricia Clarke, *Mental health: The case for a cross-jurisdictional approach combining policy and research efforts on the island of Ireland* (Centre for Cross Border Studies, Armagh, 2009).

[4] Connolly *et al.*, 'Primary Care: Ireland and Northern Ireland'.

the populations they serve has enabled a general lack of understanding and misrepresentation. Analysis of the potential to improve health outcomes and ensure greater access to healthcare across the jurisdictions is under-developed.

Overview of both systems

There are two distinct healthcare systems on the island of Ireland, with significant differences in structures, access, funding and health policy.[5] They provide services to a population of approximately seven million people and are funded predominately through the tax system. In Northern Ireland a universal healthcare system operates through primary, community and hospital care, free at the point of access. This is often referred to as 'the NHS', but unlike the British system, Northern Ireland has an integrated system of health and social care. Theoretically, this should ensure the seamless delivery of care, but in reality, social care has been completely overshadowed by a focus on hospital-based health.[6] Health and social care are fully devolved to Northern Ireland, however, policy innovation is somewhat limited.[7]

By contrast, Ireland operates a healthcare system which is a mix of public and private provision. In this two-tier system, approximately one third of the Irish population have a means-tested medical card, which gives them access to healthcare for free, while 46.2% of the population have private medical insurance. There are charges for many services that are 'free' in the north: a GP appointment currently costs around €60, a visit to the Emergency Department costs €100, and prescription costs are also paid for directly by the patient. The fact that a substantial proportion of the population pay in full for GP visits, instead of it being free or largely subsidised, makes Ireland an outlier in the European Union.[8] It remains unclear to what extent free access to GPs leads to better health outcomes for patients. Charges deter and are designed to reduce unnecessary visits, however, there are also concerns that

[5] Deirdre Heenan, 'Cross-border cooperation health in Ireland', *Irish Studies in International Affairs: ARINS* 32 (2) (2021), 117–36.

[6] Deirdre Heenan and Derek Birrell, *The integration of health and social care in the UK* (London, 2018).

[7] Chris Ham *et al.*, 'Integrated care in Northern Ireland, Scotland and Wales: lessons for England' (The King's Fund, London, 2013). Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf (3 July 2021).

[8] Seamus McGuinness and Adele Bergin, 'The political economy of a Northern Ireland border poll', *Cambridge Journal of Economics* 44 (4) (2020), 781–812; Connolly *et al.*, 'Primary Care: Ireland and Northern Ireland'.

charges for visits to the GP prevent people from access to appropriate treatment. Adele Bergin and Seamus McGuinness[9] noted in a recent study that there were 3.3 active physicians per 1,000 population in Ireland, compared to 2.1 in Northern Ireland; however, conversely, the number of hospital beds was marginally higher in Northern Ireland at 3.1 per 1,000 population compared to 3.0 in the south.

Providing healthcare services accounts for one of the largest allocations of public funding on both sides of the Irish border and concerns over the efficiency and effectiveness of these systems are perennial. In Northern Ireland's 2018–2019 budget of £13 billion, £5.6 billion was allocated to health alone (44%) for a population of 1.8 million people. In 2019–20 it was £6.12 billion and the latest budget for 2020–21 is £6.45 billion. This compares to the HSE's budget of €17 billion for 2018–2019, for a population of 4.9 million, and €20.6 billion for 2021. While Northern Ireland's health spending per person has been slightly higher than in Ireland, currently the two are almost identical, with Ireland spending €4,204 per person in 2021 and Northern Ireland spending the equivalent of €4,182.[10]

Prior to the emergence of the global pandemic in 2019, the health and social care system in Northern Ireland was already in crisis. Stretched to its limits, struggling to cope with record levels of demand, soaring costs and missed targets. The situation for elective care waits was particularly poor relative to other regions of the UK. Figures for June 2021 revealed that the waiting list for planned admission to hospital or a first outpatient appointment had reached almost 450,000, equivalent to almost a quarter of the population. In England, where services have also been hit hard by the pandemic, the waiting list was equivalent to just 9% of the population.[11] Significantly, most of those waiting in Northern Ireland have been waiting over a year, a problem which was supposed to have been entirely eliminated. The global pandemic has increased pressure on waiting times everywhere, but in Northern Ireland long waits have been the reality for almost a decade. In a number of specialisms such as orthopaedics, neurology and rheumatology, typical waiting

[9] Adele Bergin and Seamus McGuinness, 'Who is better off? Measuring cross-border differences in living standards, opportunities and quality of life on the island of Ireland', *Irish Studies in International Affairs: ARINS* 32 (2) (2021), 143–60.

[10] *The Journal.ie*, 'How two different, expensive healthcare systems on this island have managed to (occasionally) work well together', 27 March 2021.

[11] Mark Dayan and Deirdre Heenan, 'Change or collapse: lessons from the drive to reform health and social care in Northern Ireland' (Nuffield Trust, London, 2019). Available at: https://www.nuffieldtrust.org.uk/files/2019-07/nuffield-trust-change-or-collapse-web-final.pdf (3 July 2021).

times are now five or six years for an 'urgent' initial consultation, followed by a further lengthy wait for treatment.

Analysis by McGuinness and Bergin[12] suggests that the gap between the Irish and UK health systems has narrowed, perhaps as a consequence of increasingly high levels of per capita health expenditure by the Irish government and the negative impacts of a decade of austerity policies in the UK. Despite the differences in structure and funding mechanisms, the two systems suffer from similar problems in the form of waiting lists, staff shortages, lack of focus on prevention and resources spread thinly across too many hospitals.

Policy context

The need for reform of the healthcare system has been acknowledged both north and south of the border. The Sláintecare report and the Bengoa report have highlighted the need for a systemic healthcare reform, one which reorientates the health system towards prevention and increased community care.[13] The Sláintecare report, for example, recommended the introduction of universal GP and primary care, reducing or removing out-of-pocket fees and substantially increasing public healthcare expenditure and capacity in a tax-funded system. In Northern Ireland, the respected Spanish healthcare leader Rafa Bengoa led a landmark review of healthcare for the Stormont government, laying out a plan for reform. Five years after his ambitious blueprint, little progress has been made on implementing his recommendations.

Political context

To date cross-border collaboration in healthcare has been driven by political commitments, availability of EU funding, partnership working (particularly in border areas) and personal relationships. In 2006, a British-Irish Intergovernmental Conference recommended exploring the opportunities for planning and delivering all-island health services. It suggested that strategic cooperation could address fragmentation, deliver efficiencies, improve access to services and ensure better outcomes.[14] A series of other plans and

[12] McGuinness and Bergin, 'The political economy of a Northern Ireland border poll'.
[13] Rafa Bengoa *et al.*, *Systems, not structures: Changing health and social care* (Belfast: Expert Panel Report, 2016); Houses of the Oireachtas Committee on the Future of Healthcare, *Sláintecare Report* (Dublin, 2017).
[14] British-Irish Intergovernmental Conference (B-IIGC), 'Comprehensive study on the all-island economy' (Dublin and Belfast: Department of Foreign Affairs/Northern Ireland Office, 2006).

reports called for a strategic framework to cultivate a common approach, but they did not result in major policy changes. In the mid-2000s a report commissioned by the departments of health, north and south, noted that by working together to address major health issues, 'significant additional benefits to the population of each jurisdiction can be achieved, which could not be achieved by each system working in isolation'.[15] However, as Andy Pollak[16] noted, Michael McGimpsey, then Northern Ireland's health minister, refused to publish the report as he was reportedly upset about the level of funding his department received. The report was eventually published three years later by his successor.

In post-Brexit politics in Ireland, both north and south, there is a renewed interest in the opportunities and barriers to an all-island healthcare system. For instance, in a plethora of debates and presentations on the constitutional future of this island, healthcare has emerged as a key issue. Access to the UK National Health Service (NHS) could be a key factor preventing voters in Northern Ireland from supporting a united Ireland.[17] In a 2019 Northern Ireland Life and Times Survey,[18] respondents were asked whether the two different healthcare systems would influence their vote in a referendum on a united Ireland. Overall, 52% said that it would discourage them from voting for a united Ireland.

The way in which healthcare features prominently in discussion on the possibility of constitutional change reflects its obvious importance for people, but also a relative lack of evidence-based analysis and debate on how the two systems compare and interact, both today and into the future under a range of scenarios.

In the north there is a prevailing view that the southern healthcare system is inferior and expensive for the individual, including paying fees for GP appointments, prescriptions and hospital services. However, as Bergin and McGuinness[19] note, a broad comparative health analysis between the two jurisdictions reveals a somewhat mixed set of results. The southern system

[15] Department of Health and Children (Ireland) and Department of Health, Social Services, & Public Safety (Northern Ireland), *North-South Feasibility Study* (2009), p 2. Available at: https://assets.gov.ie/16548/fe0b2a751e67497c9086bc06f22d39ae.pdf (5 July 2021).

[16] Andy Pollak, 'Northern intransigence and southern indifference: north-south cooperation since the Belfast Agreement', in Niall Ó Dochartaigh, Katy Hayward and Elizabeth Meehan (eds), *Dynamics of political change in Ireland: making and breaking a divided island* (London, 2017).

[17] McGuinness and Bergin, 'The political economy of a Northern Ireland border poll'.

[18] Northern Ireland Life and Times Survey, Political Attitudes Module, ARK, Belfast, 2019.

[19] Bergin and McGuinness, 'Who is better off?'

does have up-front charges; but it also contains checks and balances to ensure that healthcare remains free at the point of use for the most vulnerable in society. The priorities set out in Sláintecare have the potential to increase universal access to primary care for a significant proportion of the population in the near future.

Cooperation and Working Together (CAWT)

CAWT is a cross-border initiative established in 1992 as a response to a mutual recognition that the border area in both jurisdictions shared specific problems such as poverty and isolation. The CAWT partnership geography spans the entire border region, accounts for 25% of the total area of the island of Ireland and has a population of 1.6 million. Prior to this, collaboration in the area of health and social care was practically non-existent. CAWT is not a policy-making organisation, but it works to support the priorities of both health departments.

The project designs practical and innovative solutions to the health and social care needs of the border region. This valuable EU investment, through the INTERREG VA health theme, and amounting to a total of €36 million across all projects for all areas, has provided the CAWT partners with a unique opportunity to further intensify and embed cross-border health and social care activity. Various services have been established through INTERREG VA funding and rolled out by CAWT, including the Multiple Adverse Childhood Experiences programme, which secured €5.01 million, and the Acute Hospitals Services project 'Connecting Services, Citizens and Communities', which secured €10 million.

The CAWT partnership has reiterated a belief and optimism that any post-Brexit agreements will not impede these now firmly established existing cross-border and all-island health and social care arrangements and future developments. CAWT is currently consulting with its partners in relation to the new EU Peace Plus Programme, which has a budget of approximately €80m to support health and wellbeing across the statutory, community and voluntary sectors from 2022–2027. The new programme is a further endorsement of the importance placed on cross-border collaboration in healthcare by the governments of the UK and Ireland. Given the success of CAWT's work to date, there is considerable merit in assessing the scope for further integration in wider policies and strategies.

North-South Ministerial Council (NSMC)

Health is an established area of north-south cooperation. The North-South Ministerial Council (NSMC), which was established under Strand Two of the 1998 Agreement, brings together the two governments in Ireland to 'develop consultation, cooperation and action within the island of Ireland', and has health as one of the six agreed areas of collaboration. Health ministers formally engage on cross-border matters of mutual benefit under the auspices of the NSMC.

To date north-south cooperation in health and social care services has largely focused on addressing needs in the border counties. However, in more recent times there have been calls for collaboration on a wider range of issues, including health promotion, emergency planning, data collection and analysis, mental health and social care. For example, tackling health inequalities is a major common challenge in Ireland and has been identified as an important priority in both jurisdictions.

Intergovernmental agreements

Significantly for the post-Brexit context, many cross-border initiatives are not reliant on EU law, albeit EU policy and the Single Market have been important facilitators of cooperation. For example, the All-Island Congenital Heart Disease Network and the North-West Cancer Centre at Altnagelvin are based on intergovernmental agreements between the respective health departments north and south, underpinned by service level agreements, which continue to operate post-Brexit.

Covid-19

The issue of cross-border health in Ireland came into sharp relief during Covid-19 with a focus on how health policies in the two jurisdictions fundamentally differed.[20] While the geography of the island suggested that it was ideally placed to adopt an all-island collaborative approach to tackle this global health emergency, the reality was somewhat different.[21] The global pandemic revealed the fragmented nature of cross-border cooperation on healthcare.

[20] Deirdre Heenan, 'Healthy co-dependencies: co-ordination across the border in response to Covid-19 and beyond Brexit', *Journal of Cross Border Studies in Ireland* 15 (2020), 73–86.
[21] Martin Unfried and Anthony Soares, *Briefing Paper. Approaches to the Covid-19 pandemic: bordering on (non) co-operation* (Centre for Cross Border Studies, Armagh, 2020).

As the island of Ireland is a Single Epidemiological Unit (SEU) for disease control relating to animal health, it seemed that similar practical considerations could pertain to the spread of human diseases such as Covid-19. In April 2019 the health departments in Northern Ireland and Ireland signed a Memorandum of Understanding (MoU) to underpin and strengthen north-south joint working. This committed 'to promote cooperation and collaboration in response to the Covid-19 pandemic'.[22] In particular the departments committed to working together on a number of key areas including, modelling the spread and impact of Covid-19, the sharing of information and the development of public health messages.

Alongside this, it was announced that the chief medical officers of Northern Ireland and Ireland agreed to hold a weekly teleconference to update each other on the situation in their respective areas and 'ensure mutual ongoing understanding'. Significantly, with reference to the development of public health responses, the MoU also states that: 'Consideration will be given to the potential impact of measures adopted in one jurisdiction on the other, recognising that the introduction of such measures may differ, reflecting differences in Covid-19 transmission at different stages of the public health response'. In effect though, this MoU acknowledged that the island of Ireland was administered as two separate epidemiological units in responding to the pandemic. Despite repeated assertions that the 'virus recognised no borders', the responses to the global emergency demonstrated a shortfall in meaningful cooperation. Lockdown measures were introduced at different times, in varying ways, there were limitations on data sharing, and there was no all-island public health messaging.

Cross-Border Health Directive (CBHD)

The CBHD allows EU patients to arrange health treatment in most other European countries and claim back some costs. Reimbursement is considered for both private and state-funded treatments. More than £50m was spent reimbursing CBHD patients on both sides of the Irish border over the past five years. In 2020, 98% of the 7,850 cases (including multiple cases for patients) involving the CBHD accessed by Irish patients in the UK were in

[22] Department of Health, Ireland, and the Department of Health, Northern Ireland, 'Memorandum of Understanding (MoU) Covid-19 response: Public health co-operation on an all-Ireland basis between Department of Health, Ireland (and its agencies) and the Department of Health, Northern Ireland (and its agencies)', 7 April 2020, available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/MOU-NI-RoI-Covid-19.pdf) (3 July 2021).

Northern Ireland. The scheme was especially popular among cataract patients in Ireland, about 2,000 of whom travelled to Belfast on so-called 'cataract buses' to access eye surgery in private clinics.[23]

In 2020 the Health and Social Care Board in Northern Ireland spent £6 million reimbursing 1,300 Northern Ireland patients for CBHD treatments in EU states, including Ireland. Since 1 January 2021, as a direct consequence of the UK's withdrawal from the EU, the CBHD no longer applies to the UK. In January 2021 a temporary Northern Ireland Planned Healthcare Scheme was put in place to manage the transition period. In June 2021, the north's health minister Robin Swann announced plans to replicate the replacement scheme established by the Irish government.

AIMS OF THIS STUDY

The aims of this research are threefold:

- Assess attitudes towards cross-border collaboration in healthcare.
- Identify key issues in this policy area.
- Provide insights to inform future policy directions.

Methods

This small-scale scoping exercise was commissioned by the Shared Island unit of the Department of the Taoiseach and is hosted on the Analysing and Researching Ireland North and South (ARINS) project website. It is based on a qualitative study involving semi-structured interviews with 49 individuals with a particular interest in cross-border working in healthcare. The participants were purposively sampled and included academics, clinical consultants, policy experts and senior managers in this broad policy area. This group of information-rich respondents were articulate and willing to reflect on their views and experience of cross-border working and the potential for increased integration. A short interview guide with five open-ended questions was used to facilitate greater consistency in the data and enable participants to discuss their experiences and perceptions. The questions emerged from a review of the existing literature on collaboration in healthcare. They broadly explored

[23] Ian Youngman, 'Cross border Ireland/UK healthcare post-Brexit', *LaingBuisson*, 31 March 2021. Available at: https://www.laingbuissonnews.com/imtj/news-imtj/cross-border-ireland-uk-healthcare-post-brexit/ (3 July 2021).

the views/stance, experiences, opportunities and challenges of working on an all-island basis, while the methodology included a mix of one-to-one interviews and small group interviews. All interviews were undertaken by the author and given the Covid-19 restrictions all were undertaken virtually. These interviews were recorded and transcribed verbatim. The data created was subjected to a rigorous, iterative process of thematic analysis to identify emergent themes and illustrative comments. As recommended by Yvonna Lincoln and Egon Guba,[24] this process was followed by a peer debriefing to provide an external check on the research process, to increase credibility and as a means to check interpretations from the raw data. The findings are presented under six sub-sections; 1. Support for cross border health, 2. Lack of an over-arching strategy, 3. Sharing knowledge, 4. Covid-19, 5. Data and 6. Areas for future cooperation. The interviewees (see Appendix 1) were categorised follows:

- Consultants: 9
- Academics: 11
- Policymakers : 5
- Leaders in the voluntary sector: 4
- Representatives of professional bodies: 10
- Others: 10

1. Support for cross-border health

A key theme to emerge from this research was overwhelming support for increasing collaboration in the area of healthcare—it was described as 'logical', 'a no-brainer', something that 'made sense' and a 'medical imperative'. Collaboration and cooperation were described as the 'lifeblood' of healthcare. A more joined-up approach was described as having the potential to 'transform' and 'revolutionise' healthcare:

> On every level it makes sense to develop a more unified approach to common issues, I mean why would you not?

For many, the fact that healthcare providers on both sides of the border were facing almost identical challenges provided an unassailable case for an all-island approach:

[24] Yvonna Lincoln and Egon Guba, *Naturalistic inquiry* (Beverly Hills, California, 1985).

> All of the key challenges pertaining to both health services have common characteristics, these include; an aging population, poor access to services in rural areas, poor infrastructure and inability to attract, recruit and retain specialist staff. An all-island approach to resolving some of the requirements is needed, for example, organ transplantation could be more effectively undertaken using the skill-sets that exist and these services brought together to enable sustainability.

Many of the participants reflected on the enormous potential in looking beyond the border to develop 'world-class' services rather than automatically looking beyond this island for 'expert' healthcare services. There was a general belief that leveraging the existing knowledge and expertise is not as effective as it could be.

Alongside this support and appetite for further and deeper integration was a frustration at what was termed the 'heel dragging' and general lack of momentum around building meaningful alliances around healthcare. It was suggested that 'despite the rhetoric' this issue was continually 'kicked down the road' and was not viewed as a sufficient priority by either administration:

> The issue is raised on a regular basis, everyone agrees it makes sense, agrees about the need to make it happen. Nothing happens and then a year or two later we meet and repeat the whole process. It is exhausting and depressing in equal measure.

A clinician working south of the border explained cross-border working as follows:

> Every now and again, working across the border becomes flavour of the month. There is a surge, momentum and then it just falls off the radar. People quickly realise that expending large amounts of time and energy on this is pointless. We can't make it happen without political support and that just never materialises.

There was an acknowledgement that the politics of this island made the practicalities of collaboration and further integration problematic. A voluntary sector manager working on an all-island basis suggested that her organisation had pursued collaboration because there were obvious mutual symmetries. She noted though that innovation and creativity were more difficult for

government departments and that perhaps initial work should be concentrated in the third sector:

> For us it just made sense. The wider issues of logistics followed that decision. I understand though that working within government structures and systems may seriously hinder any moves to even explore these issues. I think a space for this work and developing ideas is urgently required and maybe it should start in our sector.

Given the political sensitivities associated with all-island approaches, it was suggested that involving regional academic, clinical and economic institutions could provide appropriate 'political cover' and support, if required. Many respondents expressed a view that if there was robust evidence to illustrate the mutual benefits to support collaboration, then political reticence would eventually subside or 'melt away'. Despite a plethora of cross-border health initiatives and projects, follow-up action was described as too-often inadequate. Meaningful cross-border working requires sustained coordinated responses at the regional, national, and most importantly, local levels:

> There is a belief that there would be a lot of problems with engendering the political will to make such an arrangement work, whereas I've probably taken the attitude to sidestep the politicians; let's appeal to the people directly, see if they like a new vision that could be presented to them.

A number of interviewees stated a belief that governments were simply paying 'lip service' to cooperation, with a far greater focus on budgetary pressures, and the prioritisation of other issues. It was suggested that if decision-makers were serious about meaningful collaboration, then the current scale and pace of change required a radical rethink with more momentum and leadership:

> Harmonisation of services to date has been dead slow and stop; if we continue at this pace it will never happen. Change in a complex, multi-layered system under constant media scrutiny is challenging and difficult. Without leadership and political will, it is impossible.

> We have an unparalleled opportunity to provide equal care in every corner by imagining healthcare provision without a political border, but it needs impetus and urgency.

In terms of the benefits of collaboration, it was suggested that healthcare systems both north and south needed to change culture and also actively seek to change patients' expectations of how and where care was delivered. A new model could well be based around centres of excellence, but this would require a number of clinical and administrative imperatives. Rather than seek to have services in every town, there should be consolidation of resources. This would afford advantages to healthcare providers and the populations that they serve. Concerted action could make this happen and dramatically enhance the depth and breadth of healthcare services. This type of working would enable institutions to take advantage of a wealth of opportunities presented by new technologies and simultaneously address financial constraints.

A consultant who had been involved in cross-border collaborations and had worked across the world suggested collaboration presented a wealth of opportunities, but it needed to be supported by vision and leadership:

> Centres of excellence across the world have become a byword for world-class care. Ireland north and south has resources spread too thinly and people don't expect to travel for care. In Vancouver people routinely travel 800 miles plus to see a specialist. They do it willingly as they know they will get the best treatment. We have to change the mindset.

These sentiments were echoed by a former commissioner of services in the north:

> Healthcare should be housed in specialist centres; the cost of running multiple sites is colossal and actually delivers poor outcomes. We are a relatively small island with a small population and we simply can't support this model. Also, think of how recruitment could be revolutionised if we could attract and retain specialists from across the globe. Not just clinicians but administrators skilled in new technologies.

The ability to recruit and retain staff was highlighted as an important issue by many of the respondents. It was reported that some small hospitals, particularly those outside Belfast and Dublin, had difficulties in attracting and paying for specialist staff. Organisational design and the way in which resources are allocated was described as outdated and 'no longer fit for purpose'.

This was explained by a professional body representative:

> The way it works at the minute is bits of care are taken from a whole raft of departments and they come together to deliver to the patient. Care is fragmented and could be dispersed on different sites. All-island collaboration in key areas would enable pooling of resources, deliver efficiencies and fundamentally address the issues with vacancies and the fact that we don't have a system that attracts and retains the high-flyers.

A consultant who had worked in Derry referred to 'toothbrush' consultants. Staff who came but had no intention of staying for the long-term. Posts were viewed as a stop gap until better opportunities emerged.

There was strong support for the view that specialist cross-border teams in areas such as orthopaedics, oncology and bariatric surgery could bring vital economies of scale, reduce costs and deliver better outcomes.

2. Lack of an overarching strategy

The absence of an overarching framework for cross-border interventions was described as a significant obstacle to developing and sustaining initiatives. It was suggested that this type of working was not sufficiently supported by health departments. Collaboration was not an overarching policy priority and therefore not systematically built into decision-making. The nature and extent of all-island healthcare was described as ultimately a political decision driven by the wider political landscape, and cross-border working had to be actively supported at ministerial level on both sides of the border.

A policymaker summarised the situation as follows:

> There are willing partners and delivery agents, but without a powerful conduit we are just whistling in the wind.

Another reiterated:

> The organisational, political, legal and regulatory challenges are just too daunting for most people. They just get burnt out. We need robust structures to support this work.

It was suggested that meaningful long-term collaboration would remain a 'pipe-dream' if it was not supported by a strategic framework agreed by both jurisdictions. Participants suggested that the absence of a strategy had contributed to an inability to build capacity and effectively collaborate. Without a firm policy commitment many individuals and groups were discouraged from committing their time and energies. As one member of a professional body commented, working in this uncertain context was counter-intuitive:

> I mean we used to build houses without foundations, we don't do that anymore. We can't build without the substructure.

It was reported that given the number of actors involved in the design and delivery of healthcare, a lack of coordination led to a patchwork of activities that were fragmented and therefore of limited effectiveness. This lack of strategic oversight was widely commented on:

> We have been plagued by short-term thinking. No long-term vision or commitments/ collaboration with any underpinning.

> Short-term projects and no foundations, no strategy and systems that oil the wheels of bureaucracy rather than stop them turning.

> For me the key issue in north-south collaboration at the minute is that it is completely piecemeal. It will never flourish or get anywhere while it sits outside the mainstream. There are very committed individuals and groups, but they are marginal.

The lack of an overarching framework has also meant confusion about what exactly was meant by all-island health or cross-border health. Many respondents commented on a need for clarity on these issues. Generally, cross-border healthcare was understood to mean initiatives designed to

address particular issues within a specific geographical area around the border. All-island healthcare was different and involved healthcare systems and strategies designed to meet the needs of the whole population of the island; however, the terms were used interchangeably:

> We need to have a conversation about all-island healthcare, what it is. For me an all-island system involves a radical rethink, whereas cross-border healthcare is an entirely different proposition.

> The question is, are we in the business of transformation to improve outcomes for the population as a whole or is this about identifying projects and working with two separate systems that don't really align or interface.

Significantly, it was stressed by a number of respondents that this strategic vision did not have to be a detailed costed plan with timelines, and in many ways an overarching commitment to agreed principles would be an important step. A consultant explained that for him this could be an agreed focus and direction of travel:

> For me, focus should be on simple principles of added value, things that a larger health service serving 7 million people can provide.

A number of respondents suggested that any major initiative in healthcare on the island should be assessed against a number of agreed economic and healthcare objectives and this would help to ensure that services were aligned, and synergies identified in a systematic way. A framework could also provide clarity about roles and responsibilities:

> I would suggest we should/could be encouraging the introduction of an agreed MoU that would demand that any new services being considered by either current health service should be tested in an all-Ireland context to determine if there were clinical and fiscal benefits to a harmonised approach.

A former senior policymaker from the north stressed that if all-island working was to develop and flourish then some formal commitment to this way of

working should be agreed and signed up to at the highest level. Interestingly, he and a number of respondents claimed that those involved in the design and delivery of healthcare in the north lacked the confidence required to fully engage across the border in a meaningful way. There was a reticence around cooperation in some areas as it de facto meant being reliant on engagement with a different system:

> There has to be some form of commitment at a senior level, as some people are genuinely frightened at the prospect of increased cooperation, but they know that it makes sense. It's not just politics but also size. We need a high-level agreement on key principles, or framework.

Current systems and structures frequently do not reward or recognise working across boundaries and this was identified as a demotivating factor. Issues in terms of rewards were less about financial incentives and more related to time pressures and commitments. It was suggested that where projects had been successful, they were often driven by committed individuals who had invested significant amounts of time and personal energies to ensure that desired objectives were achieved. This was described as unsustainable and meant that projects were often relatively small and time limited. Appropriate tools and strategic support are required for individuals or groups wishing to collaborate across borders in this complex, evolving landscape. Without a formal cross-border framework, developments and initiatives fell by the wayside when personnel moved on. This shortcoming was reflected on by a number of respondents:

> We have flagship projects, but they wouldn't have happened without the grit and determination of a handful of visionaries. That is just not sustainable, it has to be facilitated and supported at the highest level.

> In my experience, where initiatives have been successful, they have been dependent on one or two determined, committed individuals who won't take no for an answer. Working in this way can be a long, lonely road and most people simply don't have the bandwidth required.

Collaboration enabled people to work together to tackle a common problem and generated excitement and energy. Networks were identified as a useful way of leveraging support outside a formal hierarchical chain of command. The All-Island Congenital Heart Disease Network was described as a powerful example of a cooperative structure where interconnected people had coalesced around a particular challenge. This network was described as an exemplar, as it facilitated innovation, created social capital, momentum and delivered substantial improvements. However, there was no 'one size fits all' for networks and they were described as 'tricky', 'difficult to get off the ground', 'hard to sell' and 'unwieldy'. Establishing a credible, cohesive network was challenging in the often frantic healthcare environment. A healthcare leader highlighted the opportunities presented by networks but also cautioned against this type of intervention being viewed as a panacea:

> You don't need to convince me about the merits of networks. We have an example of a world-class network on this island. This has allowed change to happen effectively, harnessed the power of connections and developed and delivered a shared vision. It can be tough going though, with many bumps along the way. This worked in children's cardiac care, it might not be suitable for other specialties. It is a tool in the armoury of cooperation rather than the answer.

Many of those who had experience of working in cross-border initiatives were highly critical of the bureaucracy and administrative processes associated with this cooperation. Individuals felt over-burdened, overwhelmed by onerous processes. There was a realisation of the need to meet legal requirements regarding information and data; however, this was described as inefficient and ineffective.

This was reflected on by a clinician with extensive experience in cross-border working:

> I would characterise the experience as like pushing water up a hill. There were multiple requests for the same information, it was unclear who was doing what. To be honest it felt like somebody was making it up as they went along.

A member of a professional body also stressed the lack of clear systems and burdensome bureaucracy:

> If all-island systems are to be developed then to be honest it would need to be made much simpler, more streamlined and we would need to get rid of the huge chunks of pointless processes. If it adds no value, then people start to get disincentivised.

A policy professional with considerable experience of cross-border working suggested that the establishment of a strategic body was required. This could be charged with analysing and reviewing proposed all-island projects against a range of agreed parameters:

> It is my view that health and social care should be added to the current six north-south bodies, e.g. Waterways Ireland, Safefood, etc, all operating on an all-island basis and under the overall policy direction of the North-South Ministerial Council, with clear accountability lines back to the Council and to the Oireachtas and the Northern Ireland Assembly.

The onerous bureaucracy associated with working across organisational boundaries was also described as stifling innovation and creativity. Given the development of digital interfaces, there was a belief that these processes could be dramatically reduced and streamlined to facilitate rather than hinder collaboration.

3. Sharing knowledge

Alongside this lack of a strategic vision was the concern about the absence of a vehicle or unit where knowledge and best practice could be developed and disseminated. Current information on cross-border initiatives was described as often dated, incomplete and difficult to access. If professionals were actively and visibly engaged in this area of practice, they could become important advocates or champions. This would allow individuals to develop more collective efficacy. Furthermore, while a number of respondents had ideas for innovation, they were unclear as to how this would or should be progressed, and this was described as 'demotivating'.

Working across borders was not a simple endeavour and was often in addition to the 'day job', therefore, a place to discuss synergies and goals would be highly valued. Those who had been involved in similar initiatives both nationally and internationally could mentor and support others.

An academic explained what he thought was required:

> What we are missing is a vehicle, a forum for all-island collaboration. This would facilitate the alignment of priorities, reviewing of priorities, enhance knowledge, forge links and strengthen networks and foster partnerships at all levels.

There was unanimous support for the work and achievements of CAWT, but a belief that their work had not been adequately disseminated or mainstreamed. There were mixed opinions on having a stand-alone initiative for cross-border interventions. On the one hand, this longstanding project was much valued as it provided much needed space for innovation and creativity. On the other hand, the existence of a stand-alone initiative let both governments 'off the hook' from taking ownership of this policy area and driving progress:

> CAWT has been outstanding and has pushed this whole agenda. But in some respects, it can feel that they have cornered the market in collaboration and there is no need or space for anyone else. Both governments can point to it as evidence that they are interested in collaboration, but it sits outside the mainstream.

Dialogue, the sharing of data and good practice was described as fundamental to high-quality collaboration across the island. However, the absence of a forum to develop relationships and share good practice and learning was identified as a significant obstacle to cross-border working. This was described as a 'serious shortcoming' and a 'major hindrance' to building capacity and exchanging knowledge. While online communities of practice were valued, it was suggested that these virtual platforms were no substitutes for face-to-face engagement. Building a community of stakeholders required a multi-faceted approach centred around building relationships. There was a strong consensus that the organisation culture in health departments did not nurture a culture of sharing ideas or information. This issue was reflected upon by both clinicians and those charged with developing policy:

> Working together to address mutual issues can harness good ideas and allow the sharing of knowledge and ideas. You couldn't really argue against it. In reality it's a minefield. Where do you go? How do you begin to get an idea of the research that is already underway?

A number of respondents reflected on the hierarchal structure of health and social care in Northern Ireland, which they did not associate with openness and transparency. It was suggested that there were systemic issues that mitigated against working across borders and taking an all-island approach.

Support for a strategic commitment to exploring the potential and possible opportunities presented by an all-island approach to healthcare was often in the context of raising standards and professional development. Pooling resources and knowledge could develop expertise and many respondents suggested that health authorities on both sides of the border should have an aim to be world-leading. A perceived poverty of ambition was described as a barrier to developing services. It was suggested that many specialisms could only be viable on the island if they were assessed on an all-island basis. A consultant who had been instrumental in campaigning for and delivering the all-island paediatric cardiac surgical network reflected:

> The development of an all-island network has raised standards of care in both north and south and in my opinion is a win-win. All of the children on the island have benefitted as have clinicians. Rather than focusing on the hurdles, and there are many, we need to keep a focus on outcomes. Prior to this we were sending children to Birmingham and London as it was the way things were always done. It was far from straightforward but there is no doubt that expertise was enhanced when teams were amalgamated.

Others also commented on this successful initiative:

> Prior to this extraordinary collaboration, to access cardiac surgery Northern Ireland parents had to travel to Great Britain with their child, often spending weeks and months in hotels in London and Birmingham. It would be impossible to quantify the additional emotional, psychological and financial costs to the whole family.

The importance of sharing the learning from successful case studies of cross-border working was repeatedly highlighted. Those who had been personally involved with projects had important insights and it was described as 'crucial' and 'critical' that the learning was shared and disseminated. Why was all-island cardiac surgery a success? What were the critical factors? How important was political support? What were the key drivers?

The need for an infrastructure to support all-island research was identified as a significant issue in relation to sharing knowledge and good practice. There was agreement that not having a platform to discuss innovations and new technologies was a serious weakness. Those working in the broad area of healthcare had a limited knowledge of emerging initiatives, which led to duplication and gaps.

4. Covid-19

Unsurprisingly, the importance of learning from Covid-19, in particular realising the benefits of treating Ireland as a single geographical unit, was a recurrent theme in this research. There was a consensus that the global pandemic exposed serious weaknesses in public health across the island. Conversely though, there was agreement that the crisis uncovered a level of ingenuity and resilience that had hitherto been unimaginable. Leaders demonstrated agility, flexibility and adaptability in response to Covid-19. Services were radically reshaped and new technologies were embraced. The importance of holding on to these gains and building on them in terms of collaboration and all-island approaches was emphasised by healthcare leaders on both sides of the border:

> We have to learn the positive lessons from the pandemic, how we use and embrace technology, how to communicate with patients, in fact how to communicate, mobilise our collective strengths and stop silo working.

> It should be very possible to introduce change on the back of the fertile health provision ground created by the pandemic. We can reshape our ideas and think big, don't ask why, ask why not.

One academic commented that Covid-19 had reinforced partnership working and demonstrated that effective healthcare depended on collaborations between the NHS, universities, businesses and the community and that these must be maintained and nurtured. Investing in multi-disciplinary partnerships to build capacity in healthcare was described as a priority:

> We can't go back to our old ways of working. We have to stop working in silos and see the bigger picture. The bigger picture here is an all-island approach. We need to collect the evidence and data and secure the best outcomes for the whole population.

Another respondent suggested that this post-pandemic period offered a once-in-a-lifetime opportunity to harness the goodwill and support for healthcare and transform how services are designed and delivered:

> The healthcare systems on both sides of the border were facing unprecedented challenges but politicians were willing to kick the difficult decisions down the road. We are now at a crossroads. Do we revert back to limping from one crisis to another or work collectively to ensure better outcomes?
>
> There has never been a more opportune moment for transformational change, the public are already convinced about the benefits of using our advantages as one geographical unit. It is incumbent on politicians to build on this goodwill and press for meaningful change.

Before Covid-19, hospitals and care providers actively pursued technological innovations to improve productivity and organisational agility; however, responses to the global pandemic have accelerated the pace and scale of infrastructural change. Forward-looking healthcare providers should capitalise on the opportunities presented by these seismic shifts to fundamentally change how and where services are provided. Established norms can be swept away in the quest for the provision of optimal care.

5. Data

Data and information sharing issues were raised by the majority of respondents in this study. There was a consensus that data infrastructure was a particular weakness of healthcare organisations. Participants from both sides of the border described data systems as 'an embarrassment', 'antiquated', 'cumbersome'. Information management was described as 'crucial' if health data systems were to optimise the opportunities to derive meaningful information. The efficient management and analysis of data was described as a 'game changer'. The issue was not simply that healthcare organisations across the island do not share data but that neither system has developed an efficient system. Sharing data effectively across the border was described as unrealistic when healthcare systems were unable to communicate internally across different sites. This was reflected upon by a number of participants:

> I think it is extraordinary that in this day and age we don't have universal electronic patient records. Clinicians don't have automatic access to patients' full medical records. How can you really talk about coordinating care without this essential building block?

> The key is data and digital platforms. You can dramatically reduce paperwork, reduce human errors, improve coordination, improve productivity and improve practices. Progress in this area is glacial. We still dictate letters, I mean be realistic.

> An all-island approach in terms of data could be viewed as ensuring that significant decisions about population health are informed by data and trends, which can only be a good thing. However, I think there is a need to reflect and take stock of both systems. What do we do well, what is a problem? The sharing of GP records could be a game changer but the bureaucracy around it is mind-blowing.

Others commented that policymakers acknowledged the fundamental importance of information but appeared unwilling to invest appropriate resources on world-class data systems. It was expressed that both healthcare systems

wanted data management 'on the cheap' and investment in the requisite expertise was needed. The lack of reliable information mitigated against identifying trends, scenario planning, economic modelling, determining best practice and making informed policy decisions. The need for ambitious reform in data collection and sharing was highlighted by policymakers, academics and clinicians.

A clinician commented on the need to share information as a prerequisite to ensuring the design and delivery of better services:

> If we could confirm identification and share registration, we could provide much better service and streamline care. We tend not to share data apart from ad hoc events.

Respondents stressed the importance of data being presented in standard accessible formats to enable sharing within and across jurisdictions. It was impossible to speak in a common healthcare language as there were no agreed standards or formats. There was an urgent need for the quality of information to be improved. A general lack of data literacy was highlighted by a number of respondents, who decried the dearth of health economists and stressed 'serious' limitations around the use of data, both north and south. Databases were described as 'contorted', with many policymakers and politicians failing to use data to predict trends. Organisations tended to focus solely on their own needs rather than consider how data could inform wider interventions. While interviewees acknowledged that there were shortcomings around data collection and analysis, it was also suggested that there was no culture of data and information sharing across the border. Interviewees stated data-sharing agreements were limited and there was no single interface to access and compare this information.

Waiting lists were referred to by a number of respondents in the context of data management. It was suggested that waiting lists north and south provided a good example of how information and data were not fully utilised; the problems underpinning the waiting lists were not fully understood. Consequently, those charged with dealing with this issue were working 'in the dark' or with 'one hand tied behind their backs'. Health and social care trusts could not hope to address waiting lists without reliable, detailed, up-to-date information.

> The whole system needs a review and I've no doubt that it is the same in the south as it is here. If we are serious about improving health outcomes, and addressing inequalities across the island, then we must start here. I've no doubt that it's the poorest, with lower educational qualifications, that are waiting longest.
>
> For me it's as simple as this. Problems with waiting lists north and south can only be understood and addressed by taking a whole systems approach. We can't even begin to do that without information, and we don't have it. How can you drive up productivity if you don't really know where the problems are, never mind what is causing them?

There was some frustration about what was described as late adoption to digitally enabled technology, which could go some way to addressing issues. It was suggested that health literacy north and south was relatively poor and that healthcare providers could not hope to empower people if they did not have access to information. The transparency and accessibility of data were recurring themes in this research. Respondents, regardless of professional background, suggested that there was an urgent need to address what was termed 'the information and data deficit'. Terms such as 'co-production', 'patient-centred care' and 'self-directed care' were described as meaningless when not accompanied by policies to democratise data.

> We've been talking for years about prevention and targeting issues that are coming down the tracks, such as obesity and diabetes. How can that happen without giving people the information that they need. Explaining and empowering, giving hope and control.

The fact that the population was increasingly using mobile devices such as smartphones, smartwatches and laptops was described as an opportunity to use data and innovate around healthcare delivery. Mobile platforms had the potential to improve healthcare dramatically by enhancing communication between patients and their healthcare providers.

> Systems that effectively address the access and communication systems could also address learned helplessness and start to empower people. We need to challenge the old paternalistic ideas. We need to use the data that people now collect as a matter of routine on their devices.

A consultant and academic working in the area of mobile health hubs described how the possibilities in this area of healthcare would be 'transformational', if appropriate data systems were developed. GPs and other professionals could utilise a wide range of information to understand patients' real time health status. Investment in this area was described as essential in order to achieve these objectives and harness the potential offered by a growing amount of data. Patients and healthcare systems produce huge amounts of data and this can be difficult to manage, but it offers enormous potential.

The implications of General Data Protection Regulation (GDPR) were raised by many respondents in the context of data and information sharing. GDPR was adopted by the European Parliament in 2016 and is broadly a regulation that requires businesses to protect the personal data of EU citizens for transactions that occur within EU member states. This directive, and compliance with it, has been the subject of much debate as concepts such as 'reasonable' levels of protection remain open to interpretation. GDPR has greatly increased the scope of data protection laws and imposed increased obligations on anyone handling personal data across the EU. While GDPR applies to all sectors, it has particular significance for the healthcare sector, in its widest sense. Given the volume of sensitive data generated by patient care and health research, these strengthened rules have had a considerable impact. As the UK has now left the EU there was expressed considerable concern and uncertainty on the implications of one part of the island being covered by GDPR and another now potentially seeing these requirements change over time.

6. Areas for future cooperation

There was unanimous agreement that specialisation of a range of services had the potential to improve patient outcomes and support the development of high-level clinical skills. Working as a single island with a population of approximately seven million people would allow the safe and sustainable

development of services that were currently not viable in separate jurisdictions. Areas identified as having potential for future collaboration were generally high-volume interventions such as orthopaedics, or niche areas that required specialist skills, such as rare diseases. Unsurprisingly, respondents typically highlighted their own areas of expertise and the opportunities they presented. These included developing specialties in areas such as liver and heart/lung transplantation, cardiovascular health, organ disease, dialysis, early years, children's cancer services, perinatal mental health and eating disorders.

There was a strong belief that despite statements to the contrary, the two administrations are not primed to systematically explore synergies and possible collaboration on the island. The current fragmented approach has prevailed in the face of what were described bluntly as opportunities to 'transform lives', 'radically improve quality of life' or to provide 'viable sustainable services' despite what were described as obvious savings and benefits of investing in the development of more all-island services.

A consultant in the north suggested that commissioning further specialist services on an all-island basis was currently afforded a low priority, as it was complicated.

> The reality is, in terms of commissioning in the north, there are already well-worn paths for commissioning specialist services in England and little appetite or incentive for exploring all-island alternatives. Why bother if you don't have to?

An individual working in the area of cancer care expressed his frustration that the vision of no child in Ireland facing cancer alone was 'sadly not the case' under the current fragmented system. In reality, you could live two minutes from the border and not have the same access to children's cancer care services. This was described as 'inexcusable'.

While in terms of areas with potential for future or further collaboration, a wide range of specialisms was mentioned. However, it was notable that mental health was identified by the majority of participants as an area that presented significant opportunities to achieve mutual benefits. Despite high levels of poor mental health, and difficulties associated with accessing services, it was reported that levels of collaboration, particularly in terms of shared knowledge, were relatively low.

One academic stressed a number of important dimensions that could be explored:

> Mental health is one area that should have an all-island philosophy, there are no borders in terms of mental illness. I think if this was a flagship policy area where there was an agreement that we would really focus on sharing knowledge and sharing strategies, there could be a sea change.

A practitioner working in the area of mental health reflected on the possibilities for gaining a better understanding of issues around young people and poor mental health and how this could represent a valuable investment in the future:

> Many young people across this island are in mental distress and we don't understand the reasons or how to effectively deal with it. It's extraordinary that we have the most connected generation ever and yet the loneliest. Sharing knowledge and information, and gaining understanding, is a vital step forward.

The possibilities presented by digital intervention to improve access to mental health services were identified as a key area for further research and development:

> We could enter a new era of care in mental health if we developed a one-island approach to designing and delivering interventions. If you were supported by an online intervention, then it wouldn't matter where it was based. Derry or Limerick, what would it matter.

The potential to improve the targeting of services was also mentioned by a number of respondents:

> Mental health services could be designed and delivered through a blended approach, face-to-face and online. This would free up clinicians' time to deal with the more complex difficult cases, but also really allow people to self-manage and access their own care.

> It is high time that we addressed the reluctance to invest in first-class digital interventions that can transform mental health services. What we have is a service not fit for purpose, with huge swathes of the country having no access to services. This is not foisting people off on the cheap but using technology to address need effectively.

It was further suggested that working collaboratively on a north-south basis had the potential to reduce suicides and tackle self-harm. The recent publication of a new ten-year Mental Health Strategy in Northern Ireland was warmly welcomed; however, it was noted that cross-border collaboration was not mentioned in the strategy. This was described as symptomatic of the approach to the design and delivery of care that prevails on this island.

CONCLUSIONS

There is a range of common challenges surrounding healthcare on the island of Ireland, but important opportunities have emerged to collaborate on tackling issues of mutual concern, which will bring benefits to both jurisdictions. Current challenges include: reducing health inequalities, enhancing the quality and sustainability of services, developing evidence-based responses, meeting expectations of a growing and ageing population, and addressing relatively high levels of mental ill-health.

Over the past two decades there has been a consistent commitment at both ministerial and departmental levels in both jurisdictions to collaborate on issues where there are mutual benefits to be gained. There is a recognition of the opportunities in healthcare to design and deliver services that efficiently utilise resources to enhance the health and well-being of both populations. In the future, healthcare interventions will have to utilise technological advancements to enhance productivity, develop centres of excellence and empower people to effectively manage their own healthcare.

All-island approaches have the potential to address some of the current issues and ensure that Ireland as a whole is well placed to deal with future challenges. This joint approach involves both working within current structures and developing new all-island structures. Participants in this study were overwhelmingly positive about the opportunities presented by developing deeper and further integration. A consensus existed around an

unassailable case for assessing key aspects of future healthcare provision through an all-island lens.

There has been, however, frustration around a perceived lack of impetus for this type of working, despite its obvious benefits. Notwithstanding the political sensitivities associated with an all-island approach, there was a strong view that there should be a relentless focus on achieving better health outcomes for patients. It was reported that without a framework and vision for collaboration, interventions would remain fragmented and piecemeal. Robust mechanisms and policies are needed to tackle systemic and complex healthcare challenges, assess potential economies of scale and support the work of clinical staff with scarce specialist skills. Given the similar health challenges faced by each jurisdiction, working collaboratively in order to maximise the potential for service planning and delivery should be a policy priority.

APPENDIX 1

Interviewees

Alexander, Philip: Chief Executive, Cancer Fund for Children, Belfast.
Appleby, John: Director of Research and Chief Economist, Nuffield Trust, London.
Babington, David: Chief Executive, Action Mental Health, Belfast.
Bengoa, Rafael: Professor, Chair of the Bengoa Review.
Birrell, Derek: Professor, Social Policy, Ulster University.
Bjourson, Tony: Professor of Genomics, Ulster University.
Black, Tom: GP, Chair of British Medical Association, NI.
Burns, Harry: Professor of Global Public Health, University of Strathclyde.
Casey, Frank: Professor, Consultant Paediatric Cardiologist, Belfast Health and Social Care Trust.
Compton, John: Former Chief Executive of the Health and Social Care Board.
Connolly, Susan: Consultant Cardiologist, Western Health and Social Care Trust.
Cross, Judith: Head of Policy and Committee Services, British Medical Association, NI.
Cullen, Pat: Acting Chief Executive and General Secretary of the Royal College of Nursing.
Devlin, Rita: Associate Director of Professional Practice, Royal College of Nursing.
Doherty, Michael: Dr, Vice Chair of Royal College of Psychiatrists, NI.
Dorman, Laurence: Dr, Chair of the Royal College of General Practitioners.
Dornan, Jim: (deceased) Professor in Foetal Medicine, Queen's University Belfast.
Farrell, Anne-Maree: Professor, Edinburgh Law School.
Ferguson, Mark: Professor, Director General, Science Foundation Ireland.
Fogarty, Damian: Consultant Nephrologist, Belfast Health and Social Care Trust.
Glasby, Jon: Professor, Department of Social Work and Social Care, University of Birmingham.
Henderson, Donall: Chief Executive, Foyle Hospice, Derry.
Kane, Joseph: Dr, Clinical Lecturer Queen's University Belfast, and Royal College of Psychiatrists, NI.
Knape, John: Dr, Head of Communications, Royal College of Nursing, Belfast.

Magahy, Laura: Executive Director, Sláintecare.
Matthews, Anne: Professor at the School of Nursing, Dublin City University.
McCrory, Bernie: Chief Executive, Cooperation and Working Together (CAWT), Derry.
McElherron, Lisa: Group Director of insight and engagement, Inspire Mental Health, Belfast.
McGinnity, Martin: Professor of Computer Science, Ulster University.
McIntyre, Gina: Chief Executive of Special EU Programmes Body.
McLaughlin, Jim: Professor, School of Engineering, Ulster University.
Morrow, Sharon: Director, All-Island Congenital Heart Disease Network.
Mulvenna, Maurice: Professor of Computer Science, Ulster University.
Nethercott, Raymond: Paediatrician, Western Health and Social Care Trust.
O'Connor, Anthony: Professor, Consultant Gastroenterologist, Tallaght Hospital.
O'Hagan, Len: Dr, Chair of the All-Island Congenital Heart Disease Network.
O'Neill, Ciaran: Professor, School of Medicine, Dentistry and Biomedical Sciences, Queen's University Belfast.
O'Neill, Francis: Dr, Senior Lecturer in Psychiatry, Queen's University Belfast and Royal College of Psychiatrists, NI.
O'Neill, Siobhan: Professor of Mental Health Sciences, Ulster University and Interim NI Mental Health Champion.
O'Sullivan, Barry: Professor of Computer Science, University College Cork.
Peace, Aaron: Consultant Cardiologist, Western Health and Social Care Trust, Derry.
Quinn, Michael: Head of Clinical Information, Health and Social Care Board, Belfast.
Regan, Mark: CEO, Kingsbridge Private Hospital, Belfast.
Scally, Gabriel: Professor, President of Epidemiology and Public Health, Royal Society of Medicine.
Shrime, Mark: O'Brien Chair of Global Surgery, Royal College of Surgeons in Ireland.
Soares, Anthony: Dr, Director Centre for Cross Border Studies, Armagh.
Taylor, Mark: Consultant Hepatobiliary and Pancreatic Surgeon, Director of Royal College of Surgeons, Belfast.
Walker, Rhoda: Chair, Northern Ireland Rare Disease Partnership, Belfast.
Wilson, Richard: Dr, Chair of Royal College of Psychiatrists, NI.