

# Health Systems in Transition: the Northern Ireland report

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**This report was prepared as part of  
the forthcoming United Kingdom HiT**



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## Preface

**T**he Health Systems in Transition profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

Health Systems in Transition profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe Health for All database, national

statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) health data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The Health Systems in Transition profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals. Comments and suggestions for the further development and improvement of the Health Systems in Transition series are most welcome and can be sent to: [info@obs.euro.who.int](mailto:info@obs.euro.who.int).

Health Systems in Transition profiles and Health Systems in Transition summaries are available on the Observatory's web site at [www.euro.who.int/observatory](http://www.euro.who.int/observatory). A glossary of terms used in the profiles can be found at the following web page: [www.euro.who.int/observatory/Glossary/Toppage](http://www.euro.who.int/observatory/Glossary/Toppage).



## Acknowledgements

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The current series of Health Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science and the London School of Hygiene and Tropical Medicine.

The Observatory team working on the Health Systems in Transition profiles is led by Josep Figueras, Director, and Elias Mossialos, Co-Director, and by Reinhard Busse, Martin McKee and Richard Saltman, Heads of the Research Hubs. Technical coordination is led by Susanne Grosse-Tebbe.

Giovanna Ceroni managed the production and copy-editing, with help from Nicole Satterley and with the support of Shirley and Johannes Frederiksen (layout). Administrative support for preparing the Health System profile on Northern Ireland was undertaken by Caroline White.

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# 1 Introduction and historical background

## 1.1 Overview of the health system

In general Northern Ireland has prospered over the past ten years with increases in manufacturing exports, a reduction in unemployment and an economy that is growing faster than other parts of the United Kingdom. In terms of health care, Northern Ireland is unique within the United Kingdom in that health and personal social services are integrated under the umbrella of the Health and Personal Social Services (HPSS). This section provides a brief overview of how the service has evolved.

### **Past**

From the instigation of the NHS in 1948 until 1974, the Northern Ireland health services were administered in a tripartite system with different structures for hospitals, general practice and public health. In 1974 four health and social services boards – eastern, western, northern and southern were established to administer health and social services, including public health. GPs remained, and still do, independent contractors. Northern Ireland followed the 1991 changes in the health service with the introduction of health and social services trusts, with the four boards becoming commissioners of services.

### **Present**

There are currently four health boards, 19 health and social services trusts, 15 local health and social care groups and four health and social services councils which are involved in the commissioning and provision of health and social services. These bodies are responsible to the Minister for Health, Social Services and Public Safety.

As regards funding of the health service, Northern Ireland receives a block grant, which ministers then distribute among the various government programmes according to their own priorities. In 2004/2005 the Department of Health, Personal Social Services and Public Safety received an allocation of £3.2 billion. The Department of Finance and Personnel (DFP) Minister also commissioned an Independent Health Review in December 2004, to consider funding, use of resources and performance management. Professor John Appleby submitted his findings in August 2005 (see Chapter 4 for more details of this report).

### **Future**

In November 2005, the Secretary of State for Northern Ireland announced a radical restructure of public administration structures within the province. The number of public bodies will be reduced significantly with the aim of making the public sector more streamlined and economically efficient. The impact on health and social care will be significant. The number of public bodies in relation to health will be reduced from 47 to 18 over the next few years (see Chapter 2). All public sectors including local government and education are entering a similar period of transition.

## **1.2 Geography and sociodemography**

The island of Ireland is situated in the Atlantic Ocean, west of Britain. Northern Ireland is situated in the north-eastern corner of Ireland and comprises the six counties of Antrim, Armagh, Derry, Down, Fermanagh and Tyrone. Belfast is the capital city. In the 2001 Census the population within the city limits (Belfast Urban Area) was 276 459, while 579 276 people live in the Greater Belfast Area or Belfast Metropolitan Urban Area. There are four other cities in the country: Armagh, Derry, Lisburn and Newry.

In the past, as well as ship-building, Northern Ireland was noted for both agriculture and manufacturing. While Northern Irish manufacturing has declined in recent years agriculture continues to contribute significantly to the economic output. In 2000, agriculture accounted for 2.4% of economic output, compared to 1% in the United Kingdom as a whole.

As with all developed economies, services account for the majority of employment and output. The public sector accounts for 63% of the economy of Northern Ireland, which is substantially higher than in other parts of the United Kingdom. In the year to June 2005, 30% of the workforce was working in the public sector. This compares to 20% in England for the same time period.

Northern Ireland has a population of just over 1.6 million (2001 Census). Compared with the rest of the United Kingdom, Northern Ireland has the youngest population with 24% being under the age of 16 as compared to 20% in the United Kingdom as a whole.

### 1.3 Political context

Northern Ireland came into existence as a result of a campaign for Irish Home Rule which started in the 1870s. At that time the whole island of Ireland was governed by Britain. After a number of political and often violent campaigns, including the Easter Rising of 1916, the Government of Ireland Act 1920 divided Ireland into two areas. The intention was that both areas would have limited governing powers but remain within the United Kingdom. Only Northern Ireland took up the offer, and King George V opened the first Northern Ireland Parliament in Belfast in 1921. This semiautonomous government was suspended in 1972 after three years of sectarian violence between Protestants and Catholics. Northern Ireland was then governed directly from London after an attempt to return certain powers to an elected assembly in Belfast.

The Northern Ireland Office (NIO) was created in 1972 after the Northern Ireland Government was dissolved because of the security situation. The current Secretary of State for Northern Ireland is the most recent of 15 British cabinet ministers who have headed the NIO. The Secretary of State has responsibility for the government of Northern Ireland and the representation of Northern Ireland's interests in the United Kingdom Cabinet.

The NIO, through the Secretary of State, retains responsibility for Northern Ireland's constitutional and security issues; however, economic and social matters, including health, became the responsibility of the Northern Ireland executive during devolution.

As a result of the Belfast Agreement, commonly known as the "Good Friday" Agreement, a new coalition government was formed on 2 December 1999. The British Government formally transferred governing power to the Northern Irish Parliament. David Trimble, Protestant leader of the Ulster Unionist Party (UUP) and winner of the 1998 Nobel Peace Prize, became first minister of the Northern Ireland Executive, established by the Northern Ireland Act 1998. The executive consists of a first minister who heads it and various ministers with individual portfolios and remits. Ten government departments were established – one being the Department of Health, Personal Social Services and Public Safety. The executive is elected by the Northern Ireland Assembly.

The Assembly has a single legislative chamber consisting of 108 proportionally representative elected members. The Government has been suspended four times since 1999; it has remained suspended since 14 October 2002. Negotiations to reinstate the Assembly commenced in March 2003; however, to date, this has not yet happened.

As a result of the partial devolution of power, Northern Ireland has the ability to devise its own systems. Even under direct rule, when ministers are from outside Northern Ireland, the administrative structures, including the Civil Service, remain distinct; therefore policies from the Department of Health in London do not automatically apply to Northern Ireland.

As the island of Ireland is governed by two separate bodies, services and systems that would naturally have been developed on an all-Ireland basis are not, although in recent years there has been an increase in cross border initiatives (see Chapter 6).

### **“The troubles”**

The 30 years from 1968 onwards, commonly referred to as “the troubles”, were a period of prolonged violence and civil unrest in Northern Ireland. This violence has had a direct impact on certain aspects of life within the country, most notably the security response and the conduct of politics.

During the last 30 years Northern Ireland has experienced a series of social and economic problems which are either directly or indirectly associated with the conflict. Symptoms of these problems include pockets of severe deprivation, long-term unemployment, economic inactivity and a legacy of poor mental and physical health. The health service has always been and continues to be involved in dealing with the consequences of violence.

### **Section 75 legislation**

The Northern Ireland Act of 1998 which translated many aspects of the “Good Friday” Agreement into law has, under section 75, the duty to “promote equality of opportunity”. This is why it is sometimes referred to as section 75 or the Statutory Duty.

These new duties require public authorities to promote equality of opportunity and good relations. The Northern Ireland Act grew out of attempts to make the earlier non-statutory Policy Appraisal and Fair Treatment (PAFT) guidelines legally binding.

The Equality Commission has been given the role of overseeing and guiding the implementation of this legislation. The Commission has produced guidelines

for each public authority to develop an Equality Scheme by which they would systematically implement their Statutory Duty. This involves checking all of their written and unwritten policies to ensure that they do not discriminate against any of the nine designated categories, and a commitment to train staff on equality issues. At each stage of the process there is an obligation to consult with the general public.

Section 75 of the Northern Ireland Act 1998 requires public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity:

- a) between persons of different religious beliefs, political opinion, racial group, age, marital status or sexual orientation;
- b) between men and women generally;
- c) between persons with a disability and persons without;
- d) between persons with dependents and persons without.

A public authority is also required, in carrying out its functions, to have due regard to the desirability of promoting good relations between persons of a different religious belief, political opinion or racial group.

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

In the absence of a functioning Northern Ireland Assembly, responsibility for the administration and management of health-related matters has returned to the Northern Ireland Office. The Department of Health, Social Services and Public Safety administers:

- health and personal social services, which includes policy and legislation for hospitals, family practitioner services, community health and personal social services;
- public health, which covers responsibility for policy and legislation to promote and protect the health and well-being of the population;
- public safety which encompasses responsibility for the policy and legislation for the fire authority, food safety and emergency planning.

This department is organized under the Permanent Secretary into several groups, namely the Planning and Resources Group, Strategic Planning and Modernization Group, Primary, Secondary and Community Care Group, and five professional groups (Medicine, Nursing, Pharmacy, Social Care and Dental).

The Department currently receives funding in the region of £3.2 billion (2004/2005) of which the majority is allocated to health and personal social services.

## 1.4 Economic context

The Northern Ireland economy is at present performing reasonably well in the context of a global slowdown. Northern Ireland's gross domestic product (GDP) had the largest increase between 1990 and 1999 of all the United Kingdom countries, growing 1% per annum faster than the United Kingdom during this period. The economic growth forecast had increased to 3% in 2004, matching that of England, and was projected to grow by another 0.5% to 3.5% in 2005.

Unemployment in Northern Ireland is currently at its lowest level in almost 20 years. It fell from 16.8% in 1986 to 4.6% in the final quarter of 2005. Northern Ireland now has a lower unemployment rate than the United Kingdom average of 5.0%. It is also considerably lower than the European Union (EU) average (8.5%) for the same period.

Traditionally, there has always been higher levels of unemployment within the Catholic community than the Protestant community. This situation has been addressed to a large extent by the introduction in 1976 of the Fair Employment Act.

The proportion of women in the workforce is also growing rapidly. Most people in Northern Ireland are employed in the areas of service, manufacturing and health and social work.

## 1.5 Health status

As Table 1.1 below suggests, life expectancy continues to increase and in 2002–2004 was 75.88 and 80.58 for males and females, respectively.

The crude birth rate has fallen by almost one-third in the past 15 years, with infant mortality rates also continuing to fall – reaching an all time low of 4.6 in 2002 before rising again to 5.3 in 2003 (Table 1.2).

In terms of adult mortality, heart disease and cancer continue to be the major causes of death, with lifestyle issues such as smoking, poor diet and lack of exercise being major contributors. Age standardized mortality rates per 100 000 population are around 2.4% higher than for the United Kingdom as a whole. Overall mortality in Northern Ireland has been falling. Between 1996 and 2001, death rates have fallen by nearly 14%, which is faster than for the United Kingdom (9%).

**Table 1.1** Expectation of life at birth, 1900–2004

| Period    | Life expectancy at birth |        |
|-----------|--------------------------|--------|
|           | Male                     | Female |
| 1900–1902 | 47.1                     | 46.7   |
| 1925–1949 | 55.4                     | 56.1   |
| 1950–1974 | 65.5                     | 68.8   |
| 1975–1984 | 67.5                     | 73.8   |
| 1985–1994 | 70.9                     | 77.1   |
| 1995–1996 | 73.8                     | 79.2   |
| 1997–1998 | 74.3                     | 79.5   |
| 1999–2001 | 74.8                     | 79.8   |
| 2000–2002 | 75.2                     | 80.1   |
| 2001–2003 | 75.6                     | 80.4   |
| 2002–2004 | 75.9                     | 80.6   |

Source: Northern Ireland Statistics and Research Agency, 2005

**Table 1.2** Birth rates, infant mortality and standardized death rates, 1994–2003

| Year | Birth rate per 1000 population <sup>a</sup> | Infant mortality | Standardized death rates per 100 000 population (all causes) |         |
|------|---|------------------|--|---------|
|      |   |                  | Males  | Females |
| 1994 | 14.8  | 6.1              | 731.4  | 426.7   |
| 1995 | 14.5  | 7.1              | 718.1  | 422.2   |
| 1996 | 14.8  | 5.8              | 689.6  | 405.7   |
| 1997 | 14.5  | 5.6              | 675.5  | 381.7   |
| 1998 | 14.2  | 5.6              | 655.0  | 371.6   |
| 1999 | 13.8  | 6.4              | 644.6  | 374.0   |
| 2000 | 12.8  | 5.0              | 599.5  | 370.0   |
| 2001 | 13.1  | 6.0              | 575.2  | 346.3   |
| 2002 | 12.7  | 4.6              | 578.4  | 343.6   |
| 2003 | 12.8  | 5.3              | 543.2  | 328.9   |

Source: Northern Ireland Statistics and Research Agency, 2005.

Note: <sup>a</sup> Births to women living outside Northern Ireland are excluded.

### Strategies to address health improvements – Investing for Health

“Working for a healthier people” was one of the Executive’s five overarching priorities. The document *Investing for Health* sets out how the Executive plans to achieve this through the initiation of a dynamic long-term process of health improvement to bring the country’s health standards up to those in the best countries of Europe (DHSSPS 2002a). The success of the process will very much depend on effective partnership working between the departments, voluntary and community sectors, public agencies and statutory bodies.

*Investing for Health* sets out two overarching goals and seven objectives, as listed below:

- To improve the health of the population by increasing the length of their lives and increasing the number of years they have free from disease, illness and disability.
- To reduce inequalities in health between geographic areas, socioeconomic and minority groups.
- To reduce poverty in families with children.
- To enable all people, and young people in particular, to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices.
- To promote mental health and emotional well-being at individual and community level.
- To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home.
- To improve our neighbourhoods and wider environment.
- To reduce accidental injuries and deaths in the home, workplace and from collisions on the road.
- To enable people to make healthier choices.

## 2 Organizational structure

Currently the major difference in the organization of the health care system within Northern Ireland compared to the rest of the United Kingdom is that personal social services are integrated with the health service.

Depending on the status of devolution, services are responsible to the Northern Ireland Assembly or to the United Kingdom Government through the Secretary of State for Northern Ireland. A minister with responsibility for health, social services and public safety is appointed by the Assembly or the United Kingdom Government.

The current structure of the health and social services in Northern Ireland is outlined below. Figure 2.1 illustrates the structural relationships between the organizations established to plan, commission and provide services.

### **Department of Health, Social Services and Public Safety (DHSSPS)**

The Department of Health, Social Services and Public Safety (DHSSPS) administers business relating to health and personal social services, public health and public safety (including the fire service) on behalf of the Northern Ireland Assembly or the Secretary of State for Northern Ireland. Figure 2.2 illustrates the internal arrangements within the Department.

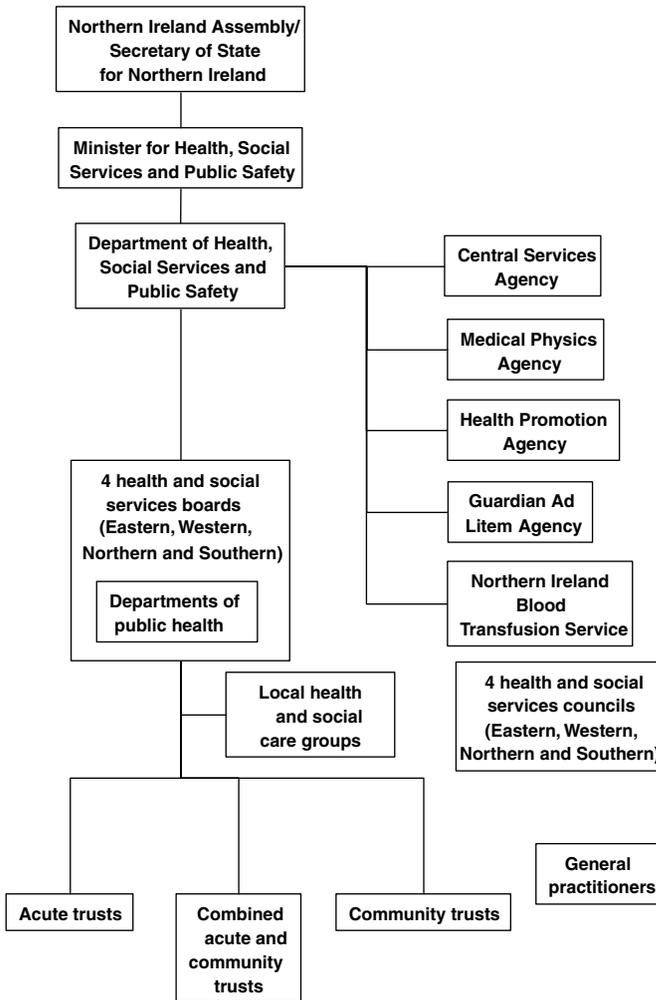
### **Health and social services boards**

The four health and social services boards act as agents of the DHSSPS in the planning, commissioning and monitoring of services for the residents in their areas.

### **Health and social services trusts**

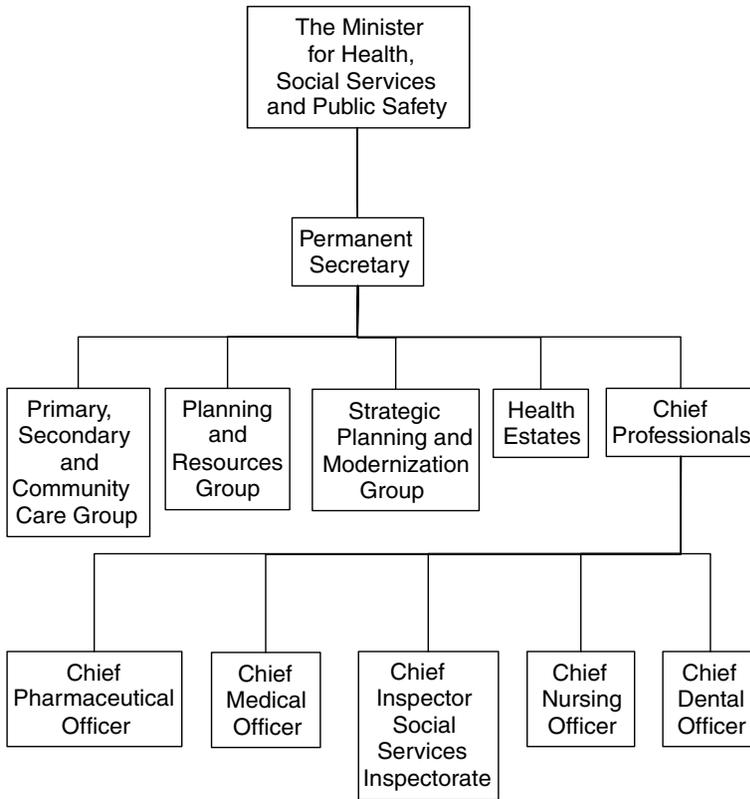
There are currently 18 health and social services trusts providing health and personal social services for the population of Northern Ireland. They directly

Fig. 2.1 Organizational structure of the health service



manage staff and services and control their own budgets. Seven of these are acute hospital trusts, six community trusts and five integrated acute and community trusts. There is also a trust for the Northern Ireland ambulance service.

**Fig. 2.2 The organization of the Department of Health, Social Services and Public Safety**



**Health and social services councils**

The consumer voice in relation to health and personal social services in Northern Ireland is currently provided through four health and social services councils. These councils cover the same geographical areas as the four health and social services boards. They advise the public about services, identify and raise issues concerning the quality of local services, involve the public in responding to consultation about health and social services, and advise the boards on how services might be improved.

Fig. 2.3 The four health and social services boards

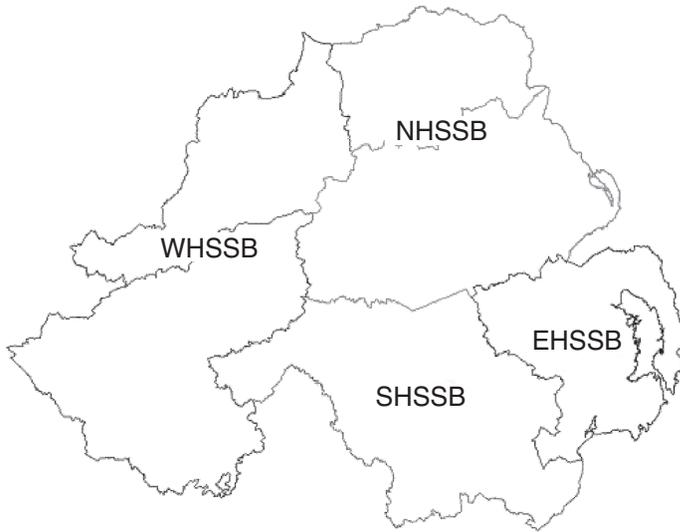


Table 2.1 Population sizes of the four health and social services boards, 2002

| Region                                    | Population size (number of people) |
|---|------------------------------------|
| Eastern Health and Social Services Board  | 666 000                            |
| Western Health and Social Services Board  | 285 000                            |
| Northern Health and Social Services Board | 430 000                            |
| Southern Health and Social Services Board | 316 000                            |

Source: Northern Ireland Annual Abstract of Statistics, 2005.

### General practitioners

General practitioners, as in the rest of the United Kingdom, are independent contractors who have contracts with the health and social services boards to deliver NHS primary care services to the patients registered on their lists. Additional services can be contracted via an item of service fee. The new general medical services (GMS) contract has enhanced the link between the provision of quality evidence-based services and monitored outcomes, and now offers more structured care for some conditions.

**Local health and social care groups**

There are currently 15 local health and social care groups in Northern Ireland. They were formed in 2002 as committees of the four health and social services boards. They bring together providers of local primary and community services under a management board whose membership is drawn from representatives of primary care, community and service users, health and social services boards and trusts. They contribute to their boards' commissioning decisions, where they seek to reflect the local dimension. They originally were envisaged to include general practitioners but this has not yet happened and discussions between GPs and DHSSPS are continuing.

**Regional medical services consortium**

This is a consortium made up of the four health and social services boards with a remit to coordinate the commissioning of specialist regional services for the population of Northern Ireland.

**Chief Medical Officer**

The Chief Medical Officer advises government departments on matters relating to the protection and improvement of the health of the people of Northern Ireland. The remit covers a broad range of areas including monitoring of the health of the public, communicable disease control, environmental hazards and the management of major incidents. The Chief Medical Officer is supported by a team of medical staff many of whom are public health trained, and works closely with the other three United Kingdom Chief Medical Officers and the Chief Medical Officer in the Republic of Ireland.

**Independent agencies**

There are also five independent special agencies of the health and personal social services within Northern Ireland that are accountable to the Minister for Health.

The Central Services Agency supports the health and personal social services by providing a central payment machinery, legal services, advice on coordination of supplies and arrangements for contracts, personal services and holding the register of patients and general practitioners.

The Northern Ireland Blood Transfusion Service is responsible for supplying all hospitals and clinical units in the province with safe and effective blood and blood products.

The Guardian Ad Litem Agency manages a service, which provides guardians *ad litem* – on appointment by the court – for children who are the subjects of

adoption applications and children who are subjects of specified public law applications (e.g. Care Order Application, Secure Order Application).

The Health Promotion Agency provides leadership, strategic direction and support to all those involved in promoting health in Northern Ireland.

The Medical Physics Agency provides a range of scientific, technical and clinical services, primarily in support of trusts. It also undertakes research and teaching.

### **Review of structures**

On 22 November 2005 the Minister for Health announced the reorganization of Northern Ireland's health and social services as part of a review of public administration across the country. The purpose of the reforms is to improve efficiency within the system and refocus on the health and well being of the population. The result of the reforms will be significantly fewer health and social services organizations.

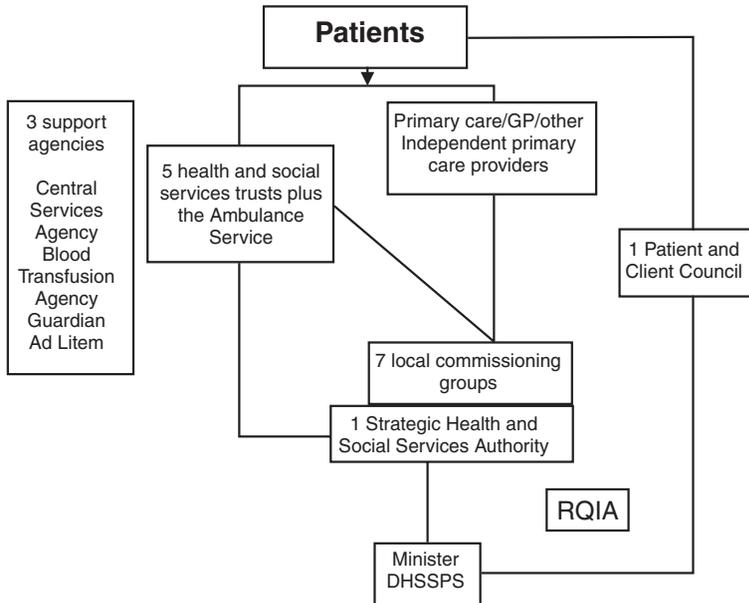
The new organizations will include the following:

- a smaller government Department for Health, Social Services and Public Safety which will develop strategic policy and set long term targets, lead the drive for better performance and efficiency and performance manage the Health and Social Services Authority;
- a Health and Social Services Authority to replace the four health and social services boards and take on some functions currently within the Department. This body will be responsible for commissioning and performance-managing the health and social services;
- five new integrated health and social services trusts, plus one ambulance service trust to replace the current 19 trusts. These trusts will be larger and fully integrated and will strengthen the linkages between hospital and community based services;
- seven local commissioning bodies to take on some roles from the four health and social services boards and some roles from the 15 local health and social care groups. These bodies will act as local offices of the Health and Social Services Authority and will work in conjunction with GPs and other local primary care practitioners to commission services from the trusts;
- one patient and client council to replace the four health and social services councils.

The four health and social services boards, the 15 local health and social care groups and the four health and social services councils will be abolished. The Health Promotion Agency will be incorporated into the new Health and Social Services Authority and the Regional Medical Physics Agency will be

incorporated into one of the new trusts. The Central Services Agency, the Guardian Ad Litem Agency and the Blood Transfusion Service will remain as independent agencies.

Fig. 2.4 Proposed new structures



Note: RQIA is the Regulation and Quality Improvement Authority; it is described in Chapter 3.

The review of public administration also includes significant changes to local government and education services.

The 26 existing district councils are to be remapped into seven larger new district councils. These areas will be coterminous with the seven local commissioning groups. Councils will have a new and enhanced role in a number of areas, including planning, conservation, local economic development, tourism, regeneration, community planning, environmental health, community development and emergency planning. A new power of well-being is also to be introduced which will allow councils greater flexibility and power in implementing community planning and development.

Changes will also occur within the education sector. The Department of Education will focus on strategy, policy development and the translation of policy into improved outcomes, while a new Education and Skills Authority will replace the current education and library boards, the Council for the Curriculum Examinations and Assessment and the Regional Training Unit.

A Reconfiguration Programme Board chaired by the Permanent Secretary was established in January 2006 to carry through these changes. The key milestones in the implementation process are shown in Table 2.2.

**Table 2.2 Key milestones in implementation of new structures**

|                |  |
|----------------|--|
| May 2006       | Five new health and social services (HSS) trusts will have been legally established  |
| June 2006      | Local government boundary commissioner appointed   |
| September 2006 | The local HSS commissioning groups will start operating within the HSS boards and work with stakeholder groups to develop their future role  |
| April 2007     | The existing 28 HSS trusts will be formally dissolved and the five new HSS trusts will become fully operational  |
| December 2007  | Following the Local Government Boundary Commissioner's recommendations, legislation will establish the final boundaries for the seven new councils   |
| April 2008     | Existing HSS boards and councils will cease to exist and the new HSS authority, the local commissioning groups and Patient and Client Council will assume full operational responsibility. New Education and Skills Authority and statutory Education Advisory Forum will become operational |
| 2008           | Elections to new shadow councils will be held  |
| Spring 2009    | New councils will become fully operational   |

## 3 Planning and regulation

### 3.1 Northern Ireland public service planning

The Secretary of State for Northern Ireland assumed responsibility for the direction and control of the devolved public services following the suspension of the Northern Ireland Assembly and Northern Ireland Executive in October 2002 (see Box 3.1).

**Box 3.1 United Kingdom Government's strategic priorities for Northern Ireland**

- Economic growth
- High-quality public services (includes provision of more effective and efficient health and personal social services)
- Public sector reform
- A society based on partnership, equality, inclusion and mutual respect

Source: DHSSPS, 2006.

Public expenditure in Northern Ireland remains 29% higher per person than the United Kingdom average, and yet the contribution to public revenues by the Northern Ireland public is significantly smaller than elsewhere in the United Kingdom.

The Secretary of State, assisted by the Northern Ireland Office ministers, has discretion to allocate available resources across the range of devolved services within 11 departments (see Box 3.2). Funding decisions are outlined in the biannual *Priorities and Budget* investment strategy. Each of the 11 Departments produces a public service agreement (PSA) to support the delivery of key

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priorities and commitments, and to link funding to the achievement of agreed outputs and outcomes.

**Box 3.2 Departments in Northern Ireland Executive**

- Office of the First Minister and Deputy First Minister (OFMDFM)
- Department of Agriculture and Rural Development (DARD)
- Department of Culture, Arts and Leisure (DCAL)
- Department of Education (DE)
- Department for Employment and Learning (DEL)
- Department of Enterprise, Trade and Investment (DETI)
- Department of the Environment (DOE)
- Department of Finance and Personnel (DFP)
- Department of Health, Social Services and Public Safety (DHSSPS)
- Department for Regional Development (DRD)
- Department for Social Development (DSD)

Source: DHSSPS, 2006.

### 3.2 Short-term health and social services planning framework

In line with national-level United Kingdom policy, the public sector has to achieve target cumulative efficiency gains of 2.5% a year over the period 2005/2006–2007/2008, with at least half of these gains releasing resources for reallocation to priority front-line services. This reform, modernization and efficiency agenda continues to underpin the Minister’s priorities for the HPSS, and once again forms the central theme of the *Priorities for Action* (PfA) planning framework.

In addition, the HPSS must continue to take all available opportunities to seek out and demonstrate value for money (VFM), including detailed review of reference costs, benchmarking with appropriate peers, and subsequent action to improve efficiency and effectiveness. Service planning must also address equality legislation specific to Northern Ireland (section 75 and schedule 9 of the Northern Ireland Act 1998), which imposes specific duties on all public authorities with regard to promoting equality of opportunity and good relations among specific groups of people.

The HPSS response to PfA, through geographical defined health and well-being investment plans (HWIPs), primary care investment plans (PCIPs) and

trust delivery plans (TDPs) provides the basis for improved monitoring and accountability arrangements. The introduction in 2005/2006 of a local Health and Care Economy Approach to the planning and delivery of services facilitated greater partnership between HPSS organizations drawing up these plans.

HWIPs currently produced by HSS boards consist of three main elements:

- plans for commissioning services in the local geographical area;
- plans to deliver on the *Investing for Health* strategy and reduce inequalities;
- plans to deliver on the major underpinning Northern Ireland public sector priorities.

At present, health and social care groups (HSCGs) are local primary care based commissioning structures within the HSS boards. HSCGs are required to produce primary care investment plans to reflect how they intend to use their resources, set within the context of the HWIP for the area in which they are located.

HSS trusts are held directly accountable for the effective deployment of all the resources at their disposal. Each HSS trust must produce a TDP outlining how it intends to effectively use the totality of its resources in pursuit of Minister's planning goals.

### **3.3 The Northern Ireland health and social care system in transition**

Published in 2005, a 20-year regional strategy for health and wellbeing (*A Healthier Future*) presents a vision for health and personal social service development in Northern Ireland. The responsive integrated services envisioned in the strategy require a breakdown in barriers between services delivered in communities (primary and community-based care) and services delivered in hospitals (secondary, acute or tertiary care). There is a need for effective community-based services with a special focus on managing chronic conditions and the problems associated with disadvantage. In addition, many services currently delivered in the hospital should be available in the community setting with appropriate linkages to specialist support. Managed clinical and social care networks may provide a flexible structure to offer a seamless service to patients, reduce inequities, improve access to care, promote clinical and social care governance, and standardize care in accordance with evidence-based guidelines.

In the independent review of health and social care services in Northern Ireland completed in 2005, the existing HPSS performance management system was characterised as “centrally-driven within a hierarchically-managed organization” (Appleby 2005: 162). Similar to other health systems, the HPSS was seen to lack “appropriate performance structures, information and clear and effective incentives – rewards and sanctions – at individual, local and national organizational levels to encourage innovation and change” (Appleby 2005: 162). A critical issue identified was the absence of clear accountability arrangements.

The review of public administration (RPA)’s conclusions, published in November 2005, will result in fundamental restructuring across the public sector, in particular in health and personal social services (see Box 3.3).

**Box 3.3 Proposed changes to health and social services structures, 2006–2008**

- A smaller, more tightly focused Department of Health, Social Services and Public Safety (DHSSPS) – serving the Minister; formulating strategic health policy; and driving performance management.
- A Health and Social Services Authority (HSSA) to manage performance.
- Seven local commissioning groups (LCGs) as local offices of the HSSA.
- Five geographically-defined health and social services (HSS) trusts bringing together the provider function for all services and one regional Northern Ireland Ambulance Trust.
- Three support services agencies: Central Services Agency; Blood Transfusion Service; and Guardian Ad Litem.
- A Patient and Client Council to replace four existing HSS councils.

Source: Northern Ireland Executive Review of Public Services, 2005.

The Regulation and Quality Improvement Authority began work on 1 April 2005. It will monitor, inspect and report on the availability and quality of health and social care services in Northern Ireland. It will also promote improvements in the quality of these services and extend its activities to cover a wider range of services in line with the Department’s programme of regulation of health care services.

The HPSS is linked to national bodies such as the National Institute for Health and Clinical Excellence (NICE), the Social Care Institute for Excellence (SCIE), and the National Clinical Assessment Service (NCAS). A formal link with NICE was established in June 2006 through which the Department will validate the Institute’s guidance for its applicability to Northern Ireland and issue-validated guidance for implementation in the HPSS. This will help to ensure the consistent introduction of new technologies (including medicines) across the HPSS.

## 4 Financing

### 4.1 Allocation of resources

The Northern Ireland budget is principally set by the United Kingdom Treasury through a mechanism known as the Barnett Formula. The formula, developed by the Chief Secretary to the Treasury takes account of just three factors:

1. The quantity of charge in planned spending in United Kingdom government departments.
2. The extent to which each United Kingdom department programme is comparable with the devolved services.
3. The relative population size.

The fairness of the formula has been challenged in that it is not updated for changes in relative need, and a major study of needs and effectiveness has been undertaken by Northern Ireland departments.

In July 2005, the findings of a review into the provision of health and social care services in Northern Ireland were presented with terms of reference broadly similar to studies carried out by Sir Derek Wanless into the health and social care sector in Wales and the United Kingdom as a whole. The review concluded that “although the Northern Ireland health and social care sector does not appear to have been significantly under-resourced up until now, looking forward it will come under increasing pressure to replicate the improvements in health outcomes envisaged for the United Kingdom by Sir Derek Wanless – but without a significant increase in funding. Notwithstanding this, however, it is clear that a significant underlying reason for current problems with the Northern Ireland health and social care sector relates to the use of resources rather than the amount of resources available. There is considerable scope for

improvement in the provision of services conditional on appropriate incentive structures being in place that focus on improving health outcomes, while recognizing that more efficient delivery means more resources available for service improvements” (Appleby 2005: 13).

The review’s recommendations are currently being taken forward within the context of the Review of Public Administration.

Resources received in the Northern Ireland block are divided between the government departments following a process of bidding between spending departments and the Department of Finance and Personnel.

Resources are allocated to health and social services boards through a mechanism known as the regional capitation formula. An expert working group has been in place for the past decade developing and refining the formula, which sets target shares for the boards. A significant programme of Northern Ireland-based research continues to be undertaken to enhance the formula.

The basis of the formula is to develop age and needs weightings for each of nine programmes of care (POC) and then to adjust for unavoidable cost differences between board areas.

The nine programmes of care are:

|      |   |
|------|---|
| POC1 | Acute hospital services                 |
| POC2 | Maternity and child health              |
| POC3 | Family and child care                   |
| POC4 | Care of the elderly                     |
| POC5 | Mental health                           |
| POC6 | Learning disability                     |
| POC7 | Physical and sensory disability         |
| POC8 | Health promotion and disease prevention |
| POC9 | Primary health and adult community      |

Adjustments for unavoidable costs include adjustments for sparsity of population (leading to increased travelling time) and economies of scale of facilities. Current research includes consideration of teaching costs and the cost of regional services.

The major influence on resource allocation in recent years has been due to population changes, with a relative lower population in the eastern board as the population of Belfast has fallen, and growth in the other three boards. Changes in population can have profound implications on the funding targets within boards and on local services.

## 4.2 Health expenditure

Table 4.1 illustrates the relative planned expenditure by programme of care for the year 2004/2005.

**Table 4.1 Financing health care by programme area**

| Programme                                      | Spending (£m) <sup>a</sup> |
|--|----------------------------|
| Acute services                                 | 866                        |
| Maternity and child health                     | 95                         |
| Family and child care                          | 126                        |
| Elderly care                                   | 528                        |
| Mental health                                  | 162                        |
| Learning disability                            | 149                        |
| Physical and sensory disability                | 70                         |
| Health promotion and disease prevention        | 37                         |
| Primary health and adult community             | 71                         |
| Expenditure not analysed to programmes of care | 40                         |
| <b>Total</b>                                   | <b>2 144</b>               |

Source: DHSSPS, 2005a.

Note: <sup>a</sup> These figures do not include expenditure on family practitioner services.

The largest single block is for acute services followed by the elderly care programme. Significant increases in expenditure are likely to take place in primary care expenditure with the implementation of the new GP contract.

## 4.3 Capital development

A new programme of capital development is taking place at present with major planned developments for hospitals and in community services. These developments include a new regional cancer centre, a local new hospital in Downpatrick, a new acute hospital for the south-west of the province and major redevelopment programmes at several hospitals. In Belfast, a new model of integrated provision is being put in place where community health, community care, devolved outpatients and other services are being brought together into planned purpose-built centres.



## 5 Physical and human resources

### 5.1 Human resources

The Department of Health, Personal Social Services and Public Safety in Northern Ireland is one of the country's largest employers. In 2003 it employed 67 000 people – accounting for 8% of all employment in the country. The majority of the workforce (80%) is female.

**Table 5.1 The health and personal social services workforce, 1995–2004**

|                                    | 1995          | 1996          | 1997          | 1998          | 1999          | 2000          | 2001          | 2002          | 2003          | 2004          |
|------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Admin and clerical                 | 9 314         | 9 454         | 9 536         | 9 733         | 9 870         | 10 345        | 10 668        | 11 338        | 11 979        | 12 704        |
| Works and maintenance              | 755           | 722           | 654           | 611           | 595           | 569           | 566           | 560           | 554           | 547           |
| Ancillary and general <sup>a</sup> | 7 913         | 7 225         | 6 954         | 6 825         | 7 003         | 6 712         | 7 089         | 7 235         | 7 478         | 7 644         |
| Qualified nursing and midwifery    | 13 680        | 13 514        | 12 994        | 13 031        | 13 134        | 13 396        | 13 428        | 14 137        | 14 905        | 15 407        |
| Unqualified nursing                | 3 874         | 3 931         | 3 799         | 3 865         | 3 967         | 4 044         | 4 214         | 4 506         | 4 530         | 4 617         |
| Social services                    | 3 514         | 3 619         | 3 674         | 3 708         | 3 733         | 3 885         | 4 038         | 4 270         | 4 566         | 4 923         |
| Professional and technical         | 4 203         | 4 352         | 4 378         | 4 501         | 4 731         | 4 925         | 5 131         | 5 474         | 5 779         | 6 259         |
| Medical and dental                 | 2 458         | 2 561         | 2 670         | 2 747         | 2 698         | 2 804         | 2 878         | 3 037         | 3 227         | 3 376         |
| Ambulance <sup>a</sup>             | 591           | 650           | 651           | 649           | 717           | 738           | 742           | 756           | 806           | 867           |
| <b>Total</b>                       | <b>46 302</b> | <b>46 028</b> | <b>45 310</b> | <b>45 670</b> | <b>46 448</b> | <b>47 418</b> | <b>48 754</b> | <b>51 313</b> | <b>53 824</b> | <b>56 344</b> |

Source: DHSSPS, 2005b.

Notes: <sup>a</sup> This group includes some personal social services care staff; <sup>a</sup> Figures for ambulance are taken from the quarterly cost analysis for 1995–2000.

Graduates now make up between 12% and 15% of the workforce.

An additional 10 000 people are either domiciliary (home) carers or similar care providers within the HPSS and provide a range of duties such as personal care, domestic services, health care as well as social, emotional and educational support.

A further 23 000 people provide health and social care services in the independent, community and voluntary sectors.

To date, the structure of the workforce has very much reflected traditional models of care based on a highly professional system. This is increasingly changing as formerly passive patients and carers see themselves as proactive service users. There is also a growing emphasis on prevention and a movement towards less intensive forms of treatment and care.

Considerable pressure has been placed on the service with more people being served often with more complex and acute needs. Resources have not matched the changes in demand. This pressure has been exacerbated in recent years with global and economic market trends. During the 1990s there have been significant difficulties in recruiting and retaining staff due to competition with other sectors offering similar or better conditions of employment. As a result, Northern Ireland has been importing significant numbers of staff from abroad, leading to a workforce that is much more ethnically diverse.

In order to address the pressures that the HPSS faces in maintaining and supporting its workforce, new models are currently being explored. The human resource strategy *Employer of choice* was launched in 2002 and sets out actions across a range of strategic areas. The importance of integrated workforce planning is highlighted along with policies to retain, recruit, return and reward staff through flexible working conditions, improving work–life balance and revised pay and award structures. Education and training strategies will continue to be crucial as the workforce develops and changes to address changing health service patterns.

Health and social care has seen dramatic changes in the past decade. As the pressures continue, in order to ensure the continued delivery of a quality service, professional roles will likely evolve. One of the main drivers for change in this area is the increased workload on doctors coupled with European legislation on junior doctors hours. Increasingly, roles are being transferred from doctors to other professions, an example of which is nurse prescribing.

It is likely that over the next 20 years a range of new roles will develop, such as physician assistants, medical emergency assistants, team support nurses, pharmacists and paramedic practitioners and care managers.

## 5.2 New contracts and pay structures

The period 2004/2006 saw the introduction of new pay structures and contracts for most of the HPSS staff. A new GP contract has also been agreed.

### **Agenda for Change**

In 2003 a new pay system was implemented in England, which applies to all directly-employed staff, except doctors and dentists and the most senior managers. Northern Ireland was included in the system roll-out in October 2004. All staff are expected to be on the new pay system by the end of 2006. The rationale behind *Agenda for Change* is to provide greater scope to create new types of jobs, fairer pay, better links between career and pay progression, and a more transparent system of rewards for staff.

### **New consultant contract**

Northern Ireland consultants have recently agreed to transfer to contracts with new terms and conditions. The main features of the new contracts include more explicit working hours and job plans along with pay increases and better terms for part-time workers. Separate contracts have been agreed nationally for England, Scotland and Wales.

### **GP contract**

A new contract for general practitioners has also been agreed. This sees a move from individual to practice-based contracts, along with a reward system based on a quality and outcomes framework. The aim of the contract is to allow more flexibility and better workload management.

### **European Working Time Directive**

The European Working Time Directive currently applies to all health and social services staff with the exception of junior doctors in training. An extension of the Directive to junior doctors from August 2004 to 2009 will reduce doctors' hours from 58 to 48. This will present a major challenge to the service. Historically, doctors in training have worked long hours and provided much of the out-of-hours medical cover. In order to meet the challenge the service will be required to develop innovative approaches to staffing services – particularly those that require 24-hour emergency medical cover. A range of solutions are being considered such as the development of new health care practitioner roles, emergency night teams and new working patterns for existing staff.

### 5.3 Physical resources – health estates

The Department of Health, Social Services and Public Safety is currently in the process of implementing an extensive capital development programme. There are a number of issues that have driven the need for additional investment in health care estates.

The Department is also considering ways of overcoming difficulties that can arise with the business case process, such as the effects of the long lead in times for major developments.

#### **The need for modernization**

A significant proportion of the health estates in Northern Ireland could benefit from modernization. Much of the mental health estate dates from the early 20<sup>th</sup> century, with many of the acute hospitals being built in the 1960s and early 1970s. The service infrastructure is virtually exhausted on many of the sites, with upgrades being required in medical gases, heating and ventilation, power and drainage. Many of the buildings are in general disrepair and are not energy efficient. In general much of the current facilities would need upgrading to equip them for modern needs.

#### **Regional policy**

Regional policy also sets out government plans to improve, modernize and explore new ways of delivering services. The document *Developing Better Services* sets out a model for future hospital services in Northern Ireland and what capital investment would be required to address the proposals of having nine acute hospitals and up to nine local hospitals.

Modernization of health estates is also a feature of regional policy in terms of supporting the development of protected elective centres, ambulatory care centres, diagnostic and treatment centres, community treatment and care centres, local hospitals and new delivery models.

#### **Addressing demands for increased capacity**

Estates provision and planning must also respond to capacity issues. Pressure on existing hospital capacity is evident through current problems with trolley waits, increases in accident and emergency activity, and pressure on elective surgery and medical beds – particularly since the move of acute beds from local hospitals.

There is an also increased demand for intensive care services, isolation beds and provision for renal dialysis. Recent years has also seen considerable growth in the need for sterile supplies, and hence storage.

**Quality standards**

Required standards of estate provision propose a range of initiatives to improve privacy such as an increase in the bed space, more en suite facilities and more single room availability. Additional space is also required for resuscitation equipment and hoists, etc. Access and other facilities for disabled users also require additional space.

As technology advances, diagnostics and intervention radiology, bed head services and isolation requirements all compete for space.





## 6. Provision of services

### 6.1 Public health

The Chief Medical Officer advises government departments on public health matters including monitoring of the health of the public, communicable disease control, environmental hazards and the management of major incidents.

Directors of public health within the four health and social services boards lead the public health function within their geographical areas.

Specific responsibilities of the directors of public health include:

- assessment of health needs;
- advice on commissioning;
- development and implementation of local health strategies;
- development and implementation of local health promotion strategies;
- leading the work on clinical effectiveness;
- the surveillance, monitoring and control of communicable disease and noncommunicable environmental incidents.

The public health strategy, *Investing for Health*, launched in March 2002, contains a broad framework for action to improve health and wellbeing and reduce health inequalities (see Box 6.1). *Investing for Health* is based on a partnership approach, and builds on existing networks such as Healthy Cities projects, Health Action Zones, Healthy Living Centres, and Local Strategy Partnerships. The cross-cutting domains, objectives and targets, shown in Box 6.1, take cognisance of known determinants of health and health inequalities, historical trends and other health improvement programmes and strategies.

The strategy is being implemented locally by four *Investing for Health* partnerships comprising the key statutory, community and voluntary organizations in the area. These partnerships are responsible for developing health improvement plans to address the identified health needs of people in their area in line with the priorities identified in the strategy.

Existing or forthcoming HPSS strategies which support the *Investing for Health* agenda include: Drug and Alcohol Strategy; Nutrition Strategy; Physical Activity Strategy; Teenage Pregnancy and Parenthood Strategy; Sexual Health Promotion Strategy; Home Accident Prevention Strategy; Tobacco Action Plan; and the Mental Health Promotion Strategy.

Other relevant strategies include: Regional Transportation Strategy (DRD); Reshape, Rebuild, Achieve – Victims’ Strategy (OFMDFM); Road Safety Strategy 2002–2012 (DOE); Essential Skills for Living – Strategy and Action Plan for Adult Literacy in Northern Ireland (DEL); Report of the taskforce on Employability and Long-term Unemployment (DEL); Regional Development Strategy (DRD); Working Together for a Stronger Economy (DETI); Working for Health – Workplace Health Strategy for Northern Ireland (March 2003) (DETI-HSENI); Homelessness Strategy (DSD-NIHE); and Community Safety Strategy for NI (NIO).

**Box 6.1 Investing for Health domains, objectives and targets**

**Physical and functional health and wellbeing**

Goal I: To improve the health of the population by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability.

- **Target I:** To improve the levels of life expectancy here towards the levels of the best EU countries, by increasing life expectancy by at least 3 years for men and 2 years for women between 2000 and 2010.

Goal II: To reduce inequalities in health between geographic areas, socioeconomic and minority groups.

- **Target I:** To halve the gap in life expectancy between those living in the fifth most deprived electoral wards and the average life expectancy here for both men and women between 2000 and 2010.
- **Target II:** To reduce the gap in the proportion of people with a long-standing illness between those in the lowest and highest socioeconomic groups by a fifth between 2000 and 2010.

**Tackling poverty and social exclusion**

Objective 1: To reduce poverty in families with children.

**Box 6.1 continued****Education**

Objective 2: To enable all people and young people in particular to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices.

- **Target I:** In the 25% of primary schools with the highest percentage free school meal entitlement (FSME), to reduce the proportion of pupils not achieving the expected level (level 4) at Key Stage 2 to 25% in both English and Mathematics by 2005/2006.
- **Target II:** In the 25% of secondary schools with the highest percentage FSME, to reduce the proportion of year 12 pupils achieving no GCSEs to 5% by 2005/2006.

**Mental health and emotional wellbeing**

Objective 3: To promote mental health and emotional well-being at individual and community level.

- **Target I:** To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) by a tenth by 2010.

**The living and working environment**

Objective 4: To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home.

- **Target I:** To lift at least 20 000 households out of fuel poverty by December 2004.
- **Target II:** Over the 2-year period April 2002 to March 2004, to support housing providers to build around 2400 lower cost, affordable homes for people on lower incomes.

**The wider environment**

Objective 5: To improve our neighbourhoods and wider environment.

- **Target I:** To reduce levels of respiratory and heart disease by meeting the health-based objectives for the seven main air pollutants by 2005.

**Accidental deaths and injuries**

Objective 6: To reduce accidental injuries and deaths in the home, workplace and from collisions on the road.

- **Target I:** To reduce the death rate from accidents in people of all ages by at least one-fifth between 2000 and 2010.
- **Target II:** To reduce the rate of serious injuries from accidents in people of all ages by at least one tenth between 2000 and 2010.

**Making healthier choices**

Objective 7: To enable people to make healthier choices.

- **Target I:** To stop the increase in the levels of obesity in men and women so that by 2010, the proportion of men who are obese is less than 17%, and of women to less than 20%.
- **Target II:** By 2010 to increase the levels of 5-year-old children with no dental decay experience to 55% and to reduce the gap between the best and worst decayed/missing/filled scores by 20%.

## **Fit Futures**

In August 2004 the Minister for Health, Social Services and Public Safety announced the launch of a taskforce initiative called *Fit Futures: Focus on Food Activity and Young People*. The role of the taskforce is to consider and evaluate options for tackling overweight and obesity in children and young people. The focus of *Fit Futures* is on developing ideas to help prevent overweight and obesity in children and young people by encouraging and supporting healthy eating and active lifestyles.

## **Smoking ban**

In October 2005, the Health Minister announced that a smoking ban is to be implemented in all Northern Ireland's workplaces and enclosed public spaces in April 2007.

## **The review of the public health function in Northern Ireland**

The Department of Health, Social Services and Public Safety commissioned a review of the public health function in Northern Ireland, the findings of which were published in December 2004 (DHSSPS 2004). The rationale for commissioning the review was to strengthen the country's ability to meet the challenges of implementing *Investing for Health* and addressing the priority "working for healthier people" in the Executive's programme for government. The Review considered the Public Health domains as delineated by the Faculty of Public Health, namely health improvement, health protection and service development. It also considered people, capacity and accountability and managing public health knowledge.

## **Health improvement**

In Northern Ireland the public health domain of health improvement is characterized by activity focussing on addressing the determinants of health and root causes of ill health (such as poverty, education and housing), as well as activity aimed at promoting positive health and well-being (e.g. smoking prevention, tackling obesity) and disease prevention (screening programmes). Organizations involved in health improvement include the Health Promotion Agency, HSS boards and trusts, Institute of Public Health in Ireland and community-based initiatives, such as Investing for Health Partnerships, Health Action Zones and the Healthy Cities Initiative.

## Health protection

The Department of Health, Social Services and Public Safety has a contractual arrangement with the Health Protection Agency in England to provide a regional communicable disease epidemiology unit. The Communicable Disease Surveillance Centre (Northern Ireland) was established in 1999 and undertakes regional surveillance of communicable disease and contributes to national and international surveillance programmes, such as meningococcal disease, tuberculosis, influenza and legionella. It provides advice and operational support to the Chief Medical Officer and directors of public health. The unit also has training responsibilities and is a training location for the European Programme for Intervention Epidemiology Training (EPIET).

## Service development

Public health professionals particularly those working in HSS boards contribute to the development of local and regional health and social services through a range of activities including the following:

- quality;
- clinical effectiveness;
- efficiency;
- service planning;
- audit and evaluation;
- clinical governance.

## Managing public health knowledge

Management of public health knowledge has been identified as a major theme by the review of the public health function. It is felt to be an essential component in supporting the overall objectives of improving the population's health and decreasing inequalities. An all-Ireland population health observatory has been set up in the Institute of Public Health in Ireland.

## 6.2 Primary and community care

Primary care teams, which bring together general practitioners and community health and social care professionals, including pharmacists and general dental practitioners, are most often the first point of contact that patients have with

health and social services. They play an increasingly important role in sustaining chronically-ill people in the community, and act as gatekeepers referring on to appropriate levels of acute care.

*Caring for People beyond Tomorrow*, the strategic framework for the development of primary health and social care, sets out a clear direction for the development of primary care services. Through the new GMS contract, directed enhanced services are being planned for people suffering from certain chronic respiratory conditions and diabetes. These services will help to ensure a proactive approach to identify and provide managed care for people with chronic conditions.

In recent years there have been substantial increases in the number of people receiving support from social services. Between 1997 and 2001 the total number of community care packages increased by 29%, that is 3900 packages were made available, providing individuals with the support and care they need to continue living as independently as possible in the community (DHSSPS 2002b). A care package is the main form of care that has been recommended for a client through the care management process. Care packages are provided in the form of places in nursing and residential homes as well as domiciliary care in an individual's own home. Separate services are also provided in terms of home help and meals on wheels, as well as places in day care centres. The current main emphasis is on increasing the proportion of support delivered in people's own homes.

### **6.3 Specialized ambulatory care and inpatient care**

In 2004/2005, 490 058 inpatients were treated in Northern Ireland hospitals. Of these 337 426 (69%) were ordinary inpatients and the remaining 152 632 (31%) were treated as day cases. Overall there were 8323 beds available (see Table 6.1) with an 84% occupancy rate. The average length of stay in 2004/2005 was 7.6 days. There were 1 484 877 outpatient attendances in 2004/05.

Comparing 2004/2005 with 1999/00 the total number of discharges and deaths (all ordinary admissions leaving hospital) increased by 5352 (1.6%). Over this period there has been an increase of 33 691 (28.3%) in the number of patients treated as day cases. Comparing 2004/2005 with 1999/2000 the average length of stay decreased from 7.8 days to 7.6 days (2.4%). Over the last five years the average number of available beds has decreased too. The number of outpatient attendances increased by 49 559 (3.5%).

Comparing 31 March 2000 with 31 March 2005, the number waiting for a first outpatient appointment in Northern Ireland had increased by 64 581 (63.0%).

**Table 6.1 Average available beds**

|                            | Average available beds |           | Percentage change<br>1999/2000–2004/2005 |
|----------------------------|------------------------|-----------|--|
|                            | 2004/2005              | 1999/2000 |  |
| All programmes of care     | 8 322.8                | 8 346.6   | -3.7%                                    |
| Acute services             | 4 473.3                | 4 396.3   | 5.4%                                     |
| Maternity and child health | 662.9                  | 670.4     | -16.6%                                   |
| Elderly care               | 1 500.9                | 1 532.3   | -5.9%                                    |
| Mental health              | 1 127.2                | 1 162.1   | -16.1%                                   |
| Learning disability        | 558.6                  | 585.5     | -15.2%                                   |

Source: DHSSPS, 2005c.

### Outpatient reform

A major £35 million investment is being made to reform waiting lists in Northern Ireland. The funding is being invested in the development of a new integrated clinical assessment and treatment service and will provide for substantial investment in diagnostic capacity, particularly in areas such as magnetic resonance imaging (MRI) and computed tomography (CT) scanning.

*Developing Better Services* (DHSSPS 2002c) sets out the plan for modernizing hospitals in Northern Ireland. The pressures for change include an ageing population with increasing medical needs, new technologies, new ways of working and improving standards. The expectation is that acute services will be patient-focused and organized around populations with decentralization of services and closer integration of primary, secondary and community care. The new model for hospitals proposes a total of nine acute hospitals, including a new hospital in the south-west, local hospitals and protected elective facilities.

Two specialist centres for planned elective surgery have been developed, protected from short-term emergency, in order to maximize elective capacity.

### Ambulatory care

Ambulatory care can be described as the development of primary care and community-based alternatives to acute assessment and treatment in a way that allows people to receive their service without being admitted to an institutional bed. Work is in progress to consider how ambulatory models of care could be developed to ensure that care is provided in the most important setting for a range of specialties and chronic conditions such as diabetes and chronic heart

disease. This work is linked with the development of community care and treatment centres which will provide a whole range of services determined by the needs of their local populations.

### **Networks**

Managed clinical networks support health professionals working across different facilities and geographical/organizational boundaries to provide the right care for patients delivered from the most suitable location. An example is the clinical network for cancer services. Staff at the cancer units and the regional cancer centre work together as a network to ensure that all patients receive high quality accessible care, and to promote sharing of good practice and good communication.

### **Cross-border cooperation**

Cooperation and Working Together is a cross border body, formed in 1992 when the north eastern and north western health boards in the Republic of Ireland (known as the Health Service Executive as of 1 January 2005) and the southern and western health and social services boards in Northern Ireland agreed to cooperate in improving the health and social well-being of their resident populations. To underpin this cooperation, the four health boards entered into a formal accord known as the “Ballyconnell Agreement”.

## **6.4 Mental health**

A regional strategy has been developed on promoting mental health (DHSSPS 2003). This includes the development of a number of initiatives involving partnership working with community and voluntary organizations to promote mental health and develop suicide awareness programmes within the community. A regional medium-secure unit, which will provide treatment and rehabilitation for patient with severe mental illness, opened in 2005. A suicide taskforce has also been established by the Health Minister to address prevention of suicide and a Northern Ireland suicide prevention and action plan is being launched.



## 7 Assessment and conclusions

Northern Ireland's health and social services are embarking on a significant period of change reflecting changes in the rest of the United Kingdom and locally generated activity, some of which commenced during the period when a devolved administration was in place.

Central to the process is a suite of major policy statements on acute hospital services (*Developing Better Services*), quality of care (*Best Practice, Best Care*), public health (*Investing for Health*) and new contracts for general practitioners, consultants and many other staff through Agenda for Change. A regional strategy with a 20-year horizon has been developed.

The independent health review by Professor Appleby (2005) made recommendations on the more efficient use of resources and the need to improve performance management within the HPSS. The recommendations of this report and those of the review of the public health function in Northern Ireland will be taken forward by the review of public administration. Over the next few years there will be major capital work to bring the HPSS infrastructure up to date and fundamental restructuring across the whole of the public sector.



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### Key

All HiTs are available in English.  
When noted, they are also available  
in other languages:

- <sup>a</sup> Albanian
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- <sup>d</sup> Georgian
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- <sup>f</sup> Romanian
- <sup>g</sup> Russian
- <sup>h</sup> Spanish
- <sup>i</sup> Turkish
- <sup>j</sup> Estonian