The Northern Ireland Economic Council (NIEC) is an independent advisory body. It was set up by the Secretary of State for Northern Ireland in 1977, but following devolution in 1999 it reported to the Office of the First and Deputy First Minister. The Council has a wide remit to provide independent advice on the development of economic policy for Northern Ireland. It carries out this role through four series of publications. Reports generally make specific policy recommendations endorsed by the Council. Occasional papers are intended to promote discussion on topical issues while commissioned research monographs are published under the author's name. Finally, Council responses to consultation documents are included in an advice and comment series. The Council also publishes an Annual Report and the text of the annual Sir Charles Carter Lecture, which the Council sponsors in honour of its first chairman. It also holds seminars and conferences designed to promote debate, and their proceedings may from time to time be published. A list of the more recent publications is presented at the end of this volume.

The Council is composed of 15 members, all of whom are appointed by the Office of the First and Deputy First Minister. There are five independent members, one of whom is the Chairman. Five members represent trade union interests and are nominated by the Northern Ireland Committee of the Irish Congress of Trade Unions. Five members represent industrial and commercial interests and are nominated jointly by the Confederation of British Industry for Northern Ireland and the Northern Ireland Chamber of Commerce and Industry. Members serve four year terms, which may be renewed. A list of Members is included in this report.

The Council has a small staff, including the Director, economists and administration support staff. Council publications are normally prepared by the economists but outside consultants are also engaged for particular projects. All publications go before the Council for comment prior to publication. It is the Council which bears final responsibility for their publication but not necessarily for the content or recommendations of commissioned research monographs.
NORTHERN IRELAND ECONOMIC COUNCIL MEMBERS

Chairman: Janet Trewsdale

Members: Independents
Professor B Ashcroft
P D Montgomery MA

Nominated by the Northern Ireland Committee of the Irish Congress of Trade Unions
F Bunting
John Corey*
T Gillen*
P Holloway
M Morrisey

Nominated by the Confederation of British Industry for Northern Ireland and the Northern Ireland Chamber of Commerce and Industry
A Jackson FCA
R Johnston BA MBA
G P McGrath
N P E Smyth MSc C Eng MIM
Bill Tosh

Director: P K Gorecki

* These Members were appointed in February 2000, after this report had been approved by the Council.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREWORD</td>
<td>i</td>
</tr>
<tr>
<td>1 INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2 BACKGROUND ISSUES</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Priority Setting</td>
<td>4</td>
</tr>
<tr>
<td>Defining 'Need': The Health of the Population</td>
<td>6</td>
</tr>
<tr>
<td>Some Decision Rules to Establish Priorities</td>
<td>7</td>
</tr>
<tr>
<td>Measuring Effectiveness: Evidence Based Medicine</td>
<td>9</td>
</tr>
<tr>
<td>Measuring Benefits: Quality Adjusted Life Years</td>
<td>11</td>
</tr>
<tr>
<td>The Ethical Issue</td>
<td>13</td>
</tr>
<tr>
<td>Conclusion</td>
<td>16</td>
</tr>
<tr>
<td>3 THE INTERNATIONAL EXPERIENCE</td>
<td>17</td>
</tr>
<tr>
<td>Introduction</td>
<td>17</td>
</tr>
<tr>
<td>Selected Comparator International Health Care Systems</td>
<td>17</td>
</tr>
<tr>
<td>Oregon</td>
<td>19</td>
</tr>
<tr>
<td>Aim</td>
<td>19</td>
</tr>
<tr>
<td>The Process</td>
<td>19</td>
</tr>
<tr>
<td>New Zealand</td>
<td>22</td>
</tr>
<tr>
<td>Aim</td>
<td>22</td>
</tr>
<tr>
<td>The Process</td>
<td>22</td>
</tr>
<tr>
<td>Sweden</td>
<td>24</td>
</tr>
<tr>
<td>Aim</td>
<td>24</td>
</tr>
<tr>
<td>The Process</td>
<td>25</td>
</tr>
<tr>
<td>Netherlands</td>
<td>28</td>
</tr>
<tr>
<td>Aim</td>
<td>28</td>
</tr>
<tr>
<td>The Process</td>
<td>28</td>
</tr>
<tr>
<td>Lessons</td>
<td>30</td>
</tr>
</tbody>
</table>
4 GOVERNMENT POLICY IN ENGLAND: THEORY AND PRACTICE 34
   Introduction 34
   Policy Approach 34
   Implementation 41
   Recent Policy Developments 44
   Conclusion 45

5 GOVERNMENT POLICY IN NORTHERN IRELAND: THE REGIONAL FRAMEWORK 47
   Introduction 47
   HPSS Guidance 49
      Commissioning Framework for Northern Ireland 49
      Well into 2000 and the Regional Strategy: Accountability and Monitoring 51
   Regional Strategy 52
   The Management Plan 56
   Sensible Framework for Priority Setting? 61

6 GOVERNMENT POLICY IN NORTHERN IRELAND: THE PURCHASING DECISION - BOARDS 63
   Introduction 63
   GP Fundholders 65
   Health and Social Services Councils 66
   Health and Social Services Boards: Purchasing Prospectuses 74
   Health and Social Services Boards: Purchasing Plans 76
   Health and Social Services Boards: Allocation of Funds 84
   Conclusion 90
## Contents

### 7 RECENT POLICY DEVELOPMENTS IN NORTHERN IRELAND

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>95</td>
</tr>
<tr>
<td>Ensuring Quality</td>
<td>95</td>
</tr>
<tr>
<td>Public Involvement</td>
<td>96</td>
</tr>
<tr>
<td>New Structures</td>
<td>98</td>
</tr>
</tbody>
</table>

### 8 CONCLUSIONS AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>101</td>
</tr>
<tr>
<td>Recommendations</td>
<td>102</td>
</tr>
<tr>
<td>Better Guidance</td>
<td>102</td>
</tr>
<tr>
<td>Greater Public Involvement</td>
<td>103</td>
</tr>
<tr>
<td>Setting Out the Mechanics</td>
<td>103</td>
</tr>
<tr>
<td>Improved Public Accessibility</td>
<td>104</td>
</tr>
<tr>
<td>Transparency: Monitoring Decisions</td>
<td>104</td>
</tr>
<tr>
<td>Ensuring Higher Quality</td>
<td>104</td>
</tr>
</tbody>
</table>

### REFERENCES

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>106</td>
</tr>
</tbody>
</table>
## LIST OF TABLES, FIGURES AND BOXES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Cost-per-QALY of Selected Activities Under the NHS, 1991</td>
<td>12</td>
</tr>
<tr>
<td>3.1</td>
<td>Selected Characteristics of Selected Health Care Systems, 1993</td>
<td>18</td>
</tr>
<tr>
<td>3.2</td>
<td>Clinical and Political/Administrative Priorities in Sweden</td>
<td>27</td>
</tr>
<tr>
<td>4.1</td>
<td>NHS Priorities and Planning Guidance 1993-94: Health of the Nation Main Targets</td>
<td>37-38</td>
</tr>
<tr>
<td>5.1</td>
<td>An Overview of the Regional Strategy for the Northern Ireland Health and Personal Social Services, 1992 to 1997</td>
<td>53</td>
</tr>
<tr>
<td>5.2</td>
<td>NHS Hospital Waiting Lists in Northern Ireland and the UK, 31 March 1997</td>
<td>58</td>
</tr>
<tr>
<td>5.3</td>
<td>NHS Hospital Activity in Northern Ireland and the UK, 1996-97</td>
<td>59</td>
</tr>
<tr>
<td>6.1</td>
<td>Allocation of Funding by Board, September 1997</td>
<td>63</td>
</tr>
<tr>
<td>6.2</td>
<td>Population Breakdown by HSSB for Northern Ireland, 1995</td>
<td>64</td>
</tr>
<tr>
<td>6.3</td>
<td>Share of the WHSSB, NHSSB and SHSSB Expenditure by Programme of Care, 1993-94 to 1995-96</td>
<td>88-89</td>
</tr>
<tr>
<td>6.4</td>
<td>Total Number of GP Fundholders in Northern Ireland and the Population Covered, 1994 and 1996</td>
<td>91</td>
</tr>
</tbody>
</table>
### List of Tables, Figures and Boxes

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A</td>
<td>Levels of Priority Setting in the NHS</td>
<td>5</td>
</tr>
<tr>
<td>2B</td>
<td>Stages in the Process of Evidence Based Medicine</td>
<td>10</td>
</tr>
<tr>
<td>5A</td>
<td>Structure of Setting Priorities in Health and Social Care in Northern Ireland, 1990s</td>
<td>50</td>
</tr>
<tr>
<td>7A</td>
<td>Proposed HPSS Structure</td>
<td>99</td>
</tr>
</tbody>
</table>

**Box**

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Citizens' Jury</td>
<td>14-15</td>
</tr>
<tr>
<td>2</td>
<td>Main Criteria for Priority Setting</td>
<td>32-33</td>
</tr>
<tr>
<td>3</td>
<td>WHSSC Response to Northern Ireland Economic Council</td>
<td>69</td>
</tr>
<tr>
<td>4</td>
<td>Main Criteria for an Effective Purchasing Plan</td>
<td>77</td>
</tr>
<tr>
<td>5</td>
<td>The Eastern Health and Social Services Board and the Eastern Health and Social Services Council Citizens' Jury</td>
<td>83</td>
</tr>
<tr>
<td>6</td>
<td>Criteria for Priority Setting in Northern Ireland</td>
<td>93</td>
</tr>
</tbody>
</table>
# Abbreviations Used

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBA</td>
<td>Cost-benefit Analysis</td>
</tr>
<tr>
<td>CEA</td>
<td>Cost-effectiveness Analysis</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CUA</td>
<td>Cost-utility Analysis</td>
</tr>
<tr>
<td>DHSS</td>
<td>Department of Health and Social Services</td>
</tr>
<tr>
<td>DHSSPS</td>
<td>Department of Health, Social Services and Public Safety</td>
</tr>
<tr>
<td>DSI</td>
<td>Dissimilarity Index</td>
</tr>
<tr>
<td>EBM</td>
<td>Evidence Based Medicine</td>
</tr>
<tr>
<td>EHSSB</td>
<td>Eastern Health and Social Services Board</td>
</tr>
<tr>
<td>EHSSC</td>
<td>Eastern Health and Social Services Council</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HPSS</td>
<td>Health and Personal Social Services</td>
</tr>
<tr>
<td>HSCP</td>
<td>Health and Social Care Partnerships</td>
</tr>
<tr>
<td>HSS</td>
<td>Health and Social Services</td>
</tr>
<tr>
<td>HSSB</td>
<td>Health and Social Services Board</td>
</tr>
<tr>
<td>HSSC</td>
<td>Health and Social Services Council</td>
</tr>
<tr>
<td>HSSE</td>
<td>Health and Social Services Executive</td>
</tr>
<tr>
<td>IVF</td>
<td>In Vitro Fertilisation</td>
</tr>
</tbody>
</table>
### Abbreviations Used

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAHAT</td>
<td>National Association of Health Authorities and Trusts</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHSSB</td>
<td>Northern Health and Social Services Board</td>
</tr>
<tr>
<td>NHSSC</td>
<td>Northern Health and Social Services Council</td>
</tr>
<tr>
<td>NI</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
</tr>
<tr>
<td>NIEC</td>
<td>Northern Ireland Economic Council</td>
</tr>
<tr>
<td>OHE</td>
<td>Office of Health Economics</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>PCC</td>
<td>Primary Care Co-operatives</td>
</tr>
<tr>
<td>QALY</td>
<td>Quality Adjusted Life Years</td>
</tr>
<tr>
<td>QUB</td>
<td>The Queen's University of Belfast</td>
</tr>
<tr>
<td>RCTs</td>
<td>Randomised Control Trials</td>
</tr>
<tr>
<td>SFF</td>
<td>Service and Financial Framework</td>
</tr>
<tr>
<td>SHSSB</td>
<td>Southern Health and Social Services Board</td>
</tr>
<tr>
<td>SHSSC</td>
<td>Southern Health and Social Services Council</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>WHSSB</td>
<td>Western Health and Social Services Board</td>
</tr>
<tr>
<td>WHSSC</td>
<td>Western Health and Social Services Council</td>
</tr>
</tbody>
</table>
FOREWORD

Priority setting is something which has occupied the Council’s attention as successive United Kingdom (UK) governments have sought to restrain, if not reduce, public expenditure as a share of Gross Domestic Product (GDP). However, the demand for many government services increases at a rate faster than GDP. Thus, priorities will have to set. Hard choices will have to be made.

The growth of health and social care in relation to the size of the economy is no different from many other government services. UK total health expenditure, as a proportion of GDP, has risen, for example, from 3.9 per cent in 1960 to 6.9 per cent in 1995. There are no signs that the health and social care share of GDP will decline.

In Northern Ireland the demand for health and social care is set to expand faster than the UK as a whole. This reflects the more rapid ageing of the local population. For example, the numbers of those aged 75 and over are predicted to rise by around 19 per cent between 1996 to 2010 in Northern Ireland but only by 9 per cent for the UK as a whole. The 1996-97 Northern Ireland public expenditure on health and social care per person for those aged 75 and over was £4,319, compared with £2,110 per person for the under 75s.

Northern Ireland, however, already spends more per capita on health care than England. In 1996-97, for example, per capita expenditure in Northern Ireland was £113 or 14 per cent higher than England. We estimate expenditure on health and social care for Northern Ireland will increase by at least 12 per cent by 2010, based on an ageing population alone. Given the tendency of health care costs to rise independently of the ageing of the population, the growth in demand is likely to be much greater.

At the same time, however, public expenditure is likely to come under greater pressure in Northern Ireland compared with the UK. Although Northern Ireland will receive, under the Barnett formula, the same
absolute per capita increase in overall public expenditure as England (across comparable programmes) the percentage increase will be smaller because Northern Ireland's public expenditure per capita, both in general and for health and social care, is higher. Thus, Northern Ireland policy makers will have to make some tough choices.

In this report the Council examines how priorities are set within health and social care in Northern Ireland. The Council recognises that setting priorities is extremely complex and subject to many outside influences such as funding constraints and the large number of national and regional objectives and targets. This does not lessen the need, however, for tough choices to be made. Explicit priorities need to be set. They should be made within a transparent framework, an issue which we address in this report.

The advent of devolution provides an excellent environment for the priority setting exercise. Local decisions can be made within a framework that can result in policies that reflect local preferences and views.

The Council would like to express its appreciation for the documents and comments provided by the Health and Social Services Boards (HSSBs), the Health and Social Services Councils (HSSCs), the Health and Social Services Executive (HSSE) and Dr Jamison of The Queen's University of Belfast. We hope that this report will encourage a wider debate and act as a catalyst to facilitate discussion on health and social care priorities and how they are set.

Janet M Trewsdale
Chairman
1 INTRODUCTION

1.1 When the National Health Service (NHS) was founded in 1948 Beveridge believed that as the population became healthier the demand and cost of health care would decline. In other words, the stock of unmet need would be rapidly satisfied. Fifty years on, this has not occurred. In fact NHS (and Health and Personal Social Services (HPSS)) expenditure has risen inexorably, while demand seems to be almost infinite. More funding, although of undoubted importance, is not the complete answer. In countries which spend far more on their health care system than the UK the pressure to allocate more resources to health care has not abated.

1.2 The result of the gap between demand for health care and the supply of health care has made newspaper headlines on:

- the length of waiting lists:
- the lack of hospital beds:
- the unavailability or restricted availability of selected treatments such as In Vitro Fertilisation (IVF) and new drugs such as Viagra, an impotence treatment, Relenza, an anti-flu drug, and Xenical, an anti-obesity drug; and,
- the introduction of charges for certain services and goods such as prescriptions and eyeglasses.

These headlines reflect decisions made, in considerable part, about how to allocate health care resources. In other words, what services to fund, for whom, when and where. However, these decisions about health care priorities are implicit; they are not usually made openly with the involvement and consent of patients or the wider public. Up until now - with the noticeable exception of Viagra - the government has eschewed becoming involved in explicitly setting health care priorities.

1.3 In the government's proposals for the future of the HPSS in
Introduction

Northern Ireland, *Fit for the Future* (DHSS, 1998a), it is argued that those with responsibility for delivering health care in Northern Ireland "should involve the public and users in decision-making at all levels" (p.42). More specifically views are sought on how:

- the public can be empowered to engage effectively with commissioners and providers in the planning, delivery and evaluation of services; and,

- the perspective of patients and clients can be harnessed to influence policy and service development positively in the future (p.42).

The purpose of this Council report is to advance the discussion as to how the public can be better involved in priority setting (which we take to be synonymous with planning), despite the fact that *Fit for the Future* never refers to or mentions the issue of priority setting1.

1.4 Priority setting is something which has occupied the Council’s interest in the recent past as successive governments have sought to restrain if not reduce government expenditure as a share of GDP. In the area of health the Council pointed out the lack of priority setting in the draft regional health strategy covering 1997 to 2002 (NIEC, 1995), while Professor Chris Ham in the 1997 Sir Charles Carter Lecture argues persuasively in favour of explicit priorities and proposes certain mechanisms to do so (Ham, 1998a).

1.5 This paper is structured as follows. Section 2 discusses some definitional issues and sets out the sorts of tools and information necessary to set priorities. Section 3 discusses what Northern Ireland can

---

1

In a subsequent paper by DHSS (1999a) this issue is not taken any further.
learn from a selection of international experience - Oregon, New Zealand, Sweden and the Netherlands. This should provide an insight into different models used by governments in setting priorities and establishing criteria to be included in priority setting decisions for Northern Ireland. Having examined approaches to priority setting abroad, Sections 4 and 5 review government policy in England and Northern Ireland. Section 6 examines the role of the Health and Social Services Councils and the Health and Social Services Boards in the priority setting process. This will involve an examination of empirical evidence of the Boards’ approaches. Section 7 considers recent policy developments in Northern Ireland in view of *Fit for the Future. A New Approach* (DHSS, 1999a), and Section 8 presents the Council's conclusions and recommendations. It is hoped that these will contribute to greater openness and transparency in the way priorities are set so that equity, quality and effectiveness are all enhanced.
2 BACKGROUND ISSUES

Introduction

2.1 The purpose of this section is to discuss definitions and theoretical concepts used in priority setting. A brief overview of the main tools necessary for effective priority setting is presented, including an examination of their advantages and limitations. This will inform the discussion on England and the way forward for Northern Ireland.

Priority Setting

2.2 The working definition of priority setting used in this report is 'the method or process of allocation of scarce resources between competing claims'. This definition will be treated as interchangeable with rationing, resource allocation and choices. Although it is recognised that it has been argued that there are differences in these terms (Academy of Medical Royal Colleges et al, 1997; New, 1997), they are beyond the scope of this report. Thus, the term 'priority setting' refers to the concept and process involved in the allocation of scarce resources between competing interventions.

2.3 Priorities can be set at various levels. Three levels have been identified: the macro, meso and micro levels (Academy of Medical Royal Colleges et al, 1997). Figure 2A, below, shows these levels forming a hierarchical structure similar in shape to a pyramid. At the top/macro level, government makes decisions on funding distribution between departments. At the regional/meso level, purchasers make decisions on which services and treatments to provide, while at the

By a Working Party which consisted of representatives from the National Association of Health Authorities and Trusts, British Medical Association, NHS Executive and the Academy of Medical Royal Colleges. For further information see Academy of Medical Royal Colleges et al (1997).
local/micro level health and social care professionals also make decisions as to how much and for how long services should be provided.
2.4 Despite the various levels of priorities identified, purchasers and the government should work together to set explicit priorities for health and social care. This will not only make the process more transparent but should ensure that Ministers work with purchasers, clinicians, other user groups and the public in establishing guidelines for setting priorities which are followed by those who make the purchasing decisions.
Defining 'Need': The Health of the Population

2.5 Defining the term 'need' is fraught with difficulties because the definition is subject to various interpretations. 'Need' is one of the NHS founding principles - access to health care should be based on need, not ability to pay. Perhaps one of the simplest ways to consider 'need' is defined by the demand for health care. Individuals may demand health care services because they require medical treatment. However, that need can only be met by effective treatment or intervention. Thus, capacity to benefit is an important aspect of defining need. Furthermore, since healthy individuals can benefit from (say) prevention, ill health is neither a necessary nor sufficient condition for being in need of health care.  

2.6 Before purchasers can decide how and where best to make effective resource allocation decisions to meet local unmet need a Health Needs Assessment is undertaken. Essentially this technique identifies the needs of purchasers' resident populations by gathering epidemiological information to assess the level of local illness and disability. In order to meet this need, 'tools,' outlined below, are then used to decide how best to prioritise competing procedures so as to make informed resource allocation decisions.

2.7 There are a number of resource, informational, conceptual and political problems in undertaking a Health Needs Assessment. These include:

- a lack of agreement over the concept of 'need' or how it should be measured. For example, members of the public may interpret 'need' very differently from the medical profession or hospital managers, because their criteria are different (NIEC, 1994, pp.48-

---

See Culyer (1995, pp.56-58) and Mooney (1992) for further discussion.
Background Issues

- the definition of 'need' changes over time as new beneficial interventions are introduced;

- mortality and morbidity measures, frequently used by purchasers, are somewhat crude and thus fail to measure 'need' or indicate which services are necessary;

- reliable and timely measures of outcome of various interventions are frequently not available;

- difficulty in assessing unmet 'need'; and,

- lack of incentives for government to engage in discussions on what a state-funded system of care should/should not provide.

However, even if all of these problems could be overcome and good data obtained on the health of the population and their capacity to benefit via medical intervention, this does not resolve the issue of which interventions should be funded by the health care system.

Some Decision Rules to Establish Priorities

2.8 In order for resources to be allocated efficiently between competing treatments, purchasers need to make informed allocative decisions to maximise benefit or health gain. They, therefore, require data on cost per intervention which should be matched with associated benefits. There are three main techniques in undertaking such analysis.

1. Cost-benefit analysis (CBA) - The costs and benefits, valued in money terms, are compared. Outcomes could be valued in terms

4

For further discussion see NIEC (1994).
Background Issues

of the lost output to an economy of time lost through sickness or by observing the behaviour of individuals when faced with situations which may affect their health. Treatments are ranked by the ratio of benefit to cost; the higher the ratio the higher the priority;

2. *Cost-effectiveness analysis* (CEA) - The benefit or outcome is taken as given and the cost of alternative methods of achieving the outcome is evaluated. The most cost-effective is the lowest cost treatment. Thus, treatments are ranked by the cost per unit; the lower the cost the higher the priority; and,

3. *Cost-utility analysis* (CUA) - The costs and benefits of different treatments are considered but patients are asked to place a value on outcomes usually measured in, for example, Quality Adjusted Life Years (QALYs). The QALY technique is only one way of measuring outcomes by quantifying health status change by calculating "the cost of delivering a year of life at some defined level of quality" (Powell, 1997, p.95). Treatments are ranked in a similar way to CBA.

CBA and CUA can be used to answer allocative efficiency questions, while CEA and CUA can be used to answer questions of technical

---

5 This follows NIEC (1994, p.41) where further discussion may be found.

6 See paras 2.12 to 2.14 below for a more detailed discussion.

7 Allocated efficiency refers to decisions across the health care system.
2.9 Cost-benefit analysis is a tool which enables purchasers to compare costs and benefits between alternative interventions. To successfully undertake this type of analysis comprehensive information is needed on the costs and benefits of treatments. The preferences of individuals are required in order to weigh outcomes if CUA is to be used. Finally, ethical issues have to be resolved. These include the value of a life and whether treatment should be denied to an old person because the economic benefits are small, compared with an equally costly intervention for a young person with many years of productive life remaining. It is to these issues that attention now turns.

Measuring Effectiveness: Evidence Based Medicine

2.10 Evidence Based Medicine (EBM) is one approach which enables purchasers to combine clinical and cost-benefit results to enable more effective decisions to be made between interventions. This will ensure that new and expensive interventions are not judged on their costs alone. EBM involves "...the evaluation of the effectiveness of medical interventions, the dissemination of the results of evaluation and finally the application of those findings to practice" (NAHAT, 1995b, p.5). In other words, EBM can be thought of in some sense as defining the knowledge that we have as to the degree to which the medical intervention can address health and the need and likelihood that the intervention will be successful. Clearly ineffective interventions yield zero benefit and the resources used could be reallocated to interventions that yield positive benefits and thus increase the overall health status of the population.

Technical efficiency refers to decisions designed to ensure that a given volume of resources output is maximised.
2.11 Figure 2B shows the three stages involved in undertaking an EBM approach. Stage 1 involves a literature review of published material using techniques, such as meta-analysis, a clinical evaluation using randomised control trials (RCTs) and an economic assessment of the intervention to determine cost-effectiveness. This is followed by the dissemination of the research findings to decision makers and purchasers. The final stage sees the utilisation of the findings (Stage 1) in clinical practice. Thus EBM can influence decision making at the macro/meso levels in deciding overall priorities and at the micro level where the dissemination of the medical effectiveness of treatment will influence individual physicians. Suitable mechanisms might have to be put in place to ensure that the findings of EBM do in fact influence decision making by those who actually spend the money - clinicians and other professionals.

9 Meta analysis is defined as "... the process of combining study results that can be used to draw conclusions about therapeutic effectiveness or to plan new studies" (L'Abbé et al., 1987, p.224).

10 RCTs, as the name suggests, is a trial which randomly allocates the individuals selected into either a trial group (ie receives the treatment) or a control group (ie does not receive the treatment but a placebo instead). If the findings are the same for both groups then the treatment is considered as having no medical impact.
Despite EBM offering significant improvements in the way decisions are made, a number of problems remain, including:
Background Issues

- RCTs are carried out under 'laboratory conditions' with only carefully selected patients chosen to take part. This raises questions about the reliability of the findings when applied to the population;
- RCTs can be very expensive and time consuming; and,
- EBM raises new issues that can make purchasing decisions more difficult for purchasers. It may lead to findings which suggest that an intervention could be denied to some patients because of their capacity to benefit. For example, heart bypass surgery is more widely carried out amongst young patients as opposed to elderly patients.

Despite these drawbacks, EBM offers the possibility of using the best available evidence for clinical decision making by practitioners. However, it would be wrong to use EBM as the only technique to allocate resources. Instead of using EBM principles, priority setting decisions should be based on costs and benefits between interventions - ie evidence based purchasing. In that way it will be possible to identify treatments which are effective and cost-effective and enable policy makers to fund interventions which have the greatest benefits per unit of cost.

Measuring Benefits: Quality Adjusted Life Years\(^{11}\)

2.13 A measure which not only tells decision makers whether someone has moved from one health state to another but also by how much is the Quality Adjusted Life Year or QALY (Williams, 1985). The QALY is a measure of health status which takes account of changes in both the quantity and quality of life. A treatment can be evaluated by

\(^{11}\) This follows closely NIEC (1994, pp.42-3).
comparing the quantity of life and life expectancy of a patient before and after treatment in terms of QALYs. Furthermore, the cost of different procedures to achieve the same result can be introduced to produce 'cost-per-QALY' league tables, or the marginal cost per QALY of different treatments may be ranked. If the aim of a health service is to maximise the quality of life as measured by QALYs then resources should be allocated in such a way that cost-per-QALYs are equal at the margin.

2.14 Table 2.1 shows the cost-per-QALY of a range of activities undertaken by the NHS. It shows that, if the objective of the NHS is to maximise output in terms of QALYs, then it is thirty times more productive to encourage GPs to prevent their patients from smoking than it is to carry out a heart transplant. Alternatively, given scarcity of resources, it might be decided that treatments costing more than £4,000 per QALY are too expensive which in this case would mean that kidney and heart transplants and breast screening would be discontinued.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Cost (£)</th>
<th>Activity</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Advice to Stop Smoking</td>
<td>270</td>
<td>Kidney Transplant</td>
<td>4,710</td>
</tr>
<tr>
<td>Pacemaker Implantation</td>
<td>1,100</td>
<td>Breast Cancer Screening</td>
<td>5,780</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>1,180</td>
<td>Heart Transplant</td>
<td>7,840</td>
</tr>
</tbody>
</table>

*The high cost-per-QALY of breast cancer screening reflects the high costs of establishing and running such campaigns relative to the number of cancers detected.*
Background Issues

Source: NIEC (1994, p.42)
2.15 When using QALYs, purchasers must also be aware of the associated limitations, including:

- no account is taken of equity, ethical and moral issues; and,
- the compilation of league tables relies on the results of CUA studies which are not necessarily always comparable (Gerard, 1991).

The QALY is one approach which allows benefits (i.e., quality of life) and costs (i.e., monetary) comparisons to be made between alternative interventions. This has found an increasingly receptive audience. However, due to the limitations outlined above purchasing decisions must be made in conjunction with the other tools discussed.

The Ethical Issue

2.16 Purchasing decisions based solely on economic evaluations fail to reflect moral judgements and the importance society places on different interventions. Ethical questions are very difficult and complex to resolve because they often involve individuals making a moral judgement (from a clinical, religious, moral and/or legal standpoint). Not surprisingly, this type of judgement often produces a variety of responses and media attention, as in the Child B\(^{12}\) case, without bringing purchasers closer to a solution. One approach is to combine CBA with ethical questions by placing a unit of measure on the ethical outcome, for example, quality of life of a coma patient before and after an intervention. Opponents of this method argue that purchasers may make

---

\(^{12}\) Jaymee Brown, known as Child B to protect her identity at the time, had leukaemia and was refused a second transplant operation by the Cambridge and Huntingdon Health Authority. The Authority’s decision was challenged by her father in the High Court but was upheld in the Appeal Court.
resource allocation decisions purely on value judgements or on a financial basis between groups of patients, for example smokers and non-smokers. If the latter approach is adopted by purchasers this could lead to accusations of inequalities in health care. Another method which is increasingly being used to elicit public opinion on ethical issues is referred to as the 'Citizens' Jury' (Box 1). When Cambridge and Huntingdon Health Commission used the Citizens' Jury to assess local opinion on priority setting issues the results indicated that, when applied to the Child B case, jurors would have reached the same decision as that taken (Mattinson, 1997).

**BOX 1**

**Citizens' Jury**

"A Citizens’ Jury is essentially a group of randomly selected or representatively sampled citizens who meet for a number of days to deliberate on a particular issue through considering evidence from expert witnesses" (Letter from Democratic Dialogue, 12 September 1997).

**Process**

The Jury members recruited are independent individuals who are not attached to any interest group. This is to ensure that jury decisions are not biased. Then for a few days they consider the issues. They are provided with all the necessary information including evidence given by witnesses. On the final day of the jury a Citizen's Report is prepared. This report will contain the recommendations of the jury and will be submitted to the relevant body.

The Citizens' Jury is still very much a new concept in the NHS. Assuming that there exist no time constraints, information costs and so on, some of the benefits to purchasers in the health service include:
once presented with all the information individuals tend to learn very quickly;
Citizens' Jury

- jury members can become more familiar with the issues and make informed decisions;
- jury members are more likely to consider the issues in terms of the public good, instead of individual benefit;
- it is a less expensive and quicker approach to resolving problems in comparison with national surveys or holding public meetings;
- creditability is given to the decision making process;
- the decision making process is made more transparent;
- it improves communications between the public and interest groups; and,
- the decisions made are more acceptable.

As with all the other approaches considered, Citizens' Juries can be useful to purchasers in the NHS but they too should come with a health warning. Limitations include:

- difficult to choose members of the public who are truly representative;
- difficult for individuals to be objective on emotive issues, such as the treatment of young children; and,
- conflict in the priorities of the public, the medical profession and health service managers towards setting priorities in the NHS (NIEC, 1994, pp.43-45).

Source: NIEC
Conclusion

2.17 Purchasers face many problems in setting priorities. Using an evidence based approach, information is needed on the effectiveness of a treatment, its costs and its benefits, whether monetary or related to the additional length and quality of life occasioned by the intervention. Even if all of this is available difficult decisions still need to be made as to what exact decision rule is to be used to rank interventions. However, because priority setting is neither easy nor straightforward this is no reason not to undertake such an exercise. The very process will change the mind-set and the way people look at the system as they carefully weigh costs, benefits and investigate the effectiveness of interventions. Explicit priority setting will also result in decisions made by purchasers becoming more transparent and ensure that Ministers work together with GPs and other health and social services purchasers in establishing guidelines for setting priorities.
3 THE INTERNATIONAL EXPERIENCE

Introduction

3.1 The purpose of this section is to present a synopsis of different but explicit priority setting procedures used by Oregon, New Zealand, Sweden and the Netherlands. These four cases have been chosen because they offer four different approaches. Each has taken the lead in developing its own models for setting priorities and they are regarded as examples of best practice. Based on this review, which draws on the work of the Academy of Medical Royal Colleges et al (1997), Kitzhaber (1993), Scheerder (1993) and New (1997), it will be possible to outline the strengths and weaknesses of each approach and to design criteria for priority setting decisions in Northern Ireland.

Selected Comparator International Health Care Systems

3.2 As stated in Section 1, the mismatch between the supply of and demand for health care service is an international phenomenon. Open recognition of the need to set priorities in the NHS should not be viewed as a sign of poor performance - measured using such indicators as infant mortality and life expectancy - but rather of the growing acknowledgement of the need to push the debate forward. Indeed, Oregon, New Zealand, Sweden and the Netherlands all spend more in relation to GDP than either the UK in general or Northern Ireland in particular (Table 3.1). Oregon, for example, spends 14.3 per cent of GDP on health compared with 6.9 per cent in the UK. However, despite the fact that all the comparators devote more of their resources to health care, they nevertheless have undertaken systematic exercises in priority setting. In other words, if government in the UK or Northern Ireland were to spend more on health this would not obviate the rationale for priority setting.
## TABLE 3.1

Selected Characteristics of Selected Health Care Systems, 1993

<table>
<thead>
<tr>
<th></th>
<th>Oregon(^1)</th>
<th>New Zealand</th>
<th>Sweden</th>
<th>Netherlands</th>
<th>UK</th>
<th>NI(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions)</td>
<td>2.8(^3)</td>
<td>3.49</td>
<td>8.69</td>
<td>15.29</td>
<td>57.92</td>
<td>1.6</td>
</tr>
<tr>
<td>Infant mortality rates(^4)</td>
<td>8.5</td>
<td>7.5</td>
<td>6.1</td>
<td>6.3</td>
<td>6.3</td>
<td>7.1</td>
</tr>
<tr>
<td>Male life expectancy at birth (years) 1985-90</td>
<td>71.6</td>
<td>71.5</td>
<td>74.3</td>
<td>73.6</td>
<td>72.3</td>
<td>71.1(^5)</td>
</tr>
<tr>
<td>GDP per capita (£)</td>
<td>15,650</td>
<td>8,376</td>
<td>14,284</td>
<td>13,641</td>
<td>10,798</td>
<td>7,620</td>
</tr>
<tr>
<td>Total(^6) health care expenditure as % of GDP at market prices</td>
<td>14.3</td>
<td>7.3</td>
<td>7.6</td>
<td>9.0</td>
<td>6.9</td>
<td>8.2(^7)</td>
</tr>
<tr>
<td>Public health care expenditure as a % of total health care expenditure</td>
<td>43.4</td>
<td>75.9</td>
<td>83.5</td>
<td>78.2</td>
<td>84.8</td>
<td>84.8(^8)</td>
</tr>
<tr>
<td>Private health care expenditure as a % of total health care expenditure</td>
<td>56.6</td>
<td>24.1</td>
<td>16.5</td>
<td>21.8</td>
<td>15.2</td>
<td>15.2</td>
</tr>
</tbody>
</table>

---

1. Apart from population data, US data are used as a proxy for Oregon.
2. Combined Health and Social Care System.
3. From the 1990 Census.
4. Deaths under 1 year per 1,000 live births.
5. Based on average male life expectancy for 1985 and 1990.
6. Includes public and private spending.
7. Estimated GDP at market prices and health care expenditure.
8. Assumes Northern Ireland is the same split as UK (84.8/15.2).
Sources: OHE (1997); ONS (1996a; 1996b; 1997a; 1997b)
Oregon\textsuperscript{13}

Aim

3.3 The overall aim of the Oregon model is to extend the range of services provided under the Medicaid programme\textsuperscript{14} to the poor by providing a minimum level of health coverage. Previously only the very poor had been included under a comprehensive range of cover. Thus the object was to extend coverage to all those below the official poverty line, not just the very poor.

The Process

3.4 With Oregon facing tight financial constraints and the poor affected by tight eligibility criteria, setting priorities was seen as a solution to this dilemma. It was decided that the best way to provide some form of health coverage for the poor was to extend coverage of the Medicaid programme to those not already included. This meant devising a minimum package of health care, to be funded by the State through the Medicaid programme and provided universally by restricting entitlement for certain services to those already eligible within the Medicaid programme.

3.5 In 1989 a Health Services Commission was established specifically to produce a list of ranked services to be included in the

\textsuperscript{13} For further details see Dixon and Welch (1991) and Ham (1998b).

\textsuperscript{14} The Medicaid programme provides health insurance for the poor who are unable to afford to pay for cover themselves.
Medicaid programme\textsuperscript{15}. By defining an initial basic package of health care it was intended this could then be used as a benchmark against which services could be increased or decreased according to funding levels. In 1994 the Oregon model became a reality and 565 treatments were funded under the Medicaid programme.

3.6 In subsequent developments the Health Services Commission started to develop guidelines for some of the services provided. According to Ham (1998b, p.1,967) in "certain cases, these guidelines are meant to ensure that the cost of providing services is kept within the available budget". In others the motivation was different, to ensure services are delivered "in accordance with the recommendations of national expert groups".

3.7 In order for the Health Services Commission to develop a basic package of health care a number of priority setting tools were employed, including: cost-effectiveness techniques, measurement of well-being, clinical effectiveness data and consultations with health professionals and the public. In order to determine clinical effectiveness, the Health Services Commission established a list of close to 700 condition and treatment pairs from which a sample of doctors were chosen to give clinical details about each condition and treatment pair, for example, appendicitis/appendectomy. This process involved extensive data collection together with eliciting public attitudes and values through consultation.

3.8 Public involvement (attitudes and values) was sought in three ways. First, the values used in the weighting exercise were based on a telephone survey of 1,000 individuals who were asked to attach values

\textsuperscript{15} The Health Services Commission consisted of representatives from the medical profession, a social worker and members of the public.
The International Experience

(ranging from 1 to 100) to 26 different disabling conditions. Second, public meetings were held to collect information on the public's attitudes to particular services and, third, public hearings were organised to place values on nine service categories.

3.9 The Oregon experience is viewed by some as controversial and, by others, as forward thinking. Whatever else, the Oregon approach highlights the difficulties in setting priorities and in choosing and formulating a standardised list of criteria. In the case of Oregon a significant amount of data was gathered through cost-effectiveness analysis and from the public health professionals. However, even when the technique used was altered to take into account public values, fundamental problems remained.

3.10 Although the Health Services Commission recognised the importance of public inclusion in the prioritising process, the approach failed to consider ethical issues. For example, the public were asked to place values on different treatments. In effect this meant the public were asked to choose between interventions for State funding without explicit consideration given to the ethical implications of denying different treatments. In addition, the process of placing community values on treatments to determine if they are funded or not fails to recognise that benefits from treatments are not homogeneous but vary between patients.

3.11 The Oregon approach also involved a trade off: a reduced range of treatments available under the Medicaid programme for increased population coverage. This meant that, when the programme was finally implemented in 1994, only 565 services were funded out of 696 previously funded. However, the system is not static. As more evidence of effective treatments become available revisions are made to the list of eligible treatments. For example, the integration of mental and chemical dependency services into the basic health care package has increased the number of services from 696 to 743.
3.12 Although the purpose of the Oregon model was to contain health care costs, in reality it has led to increased demand and costs for the State. One reason may have been that those eligible under Medicaid may have become much more aware of their entitlements with the result that demand increased. Despite the shortcomings, this approach is unique because it is the first model which produced a core package of services based on excluding services and established a list of priority treatments through incorporating the views of the public and the medical profession using economic techniques.

New Zealand

Aim

3.13 New Zealand, with a population similar in size to Oregon, predominantly public sector funding and a purchaser/provider split introduced in 1993, has attempted to explicitly set which services are to be funded by the government. The purpose of the New Zealand priority setting exercise was to clarify to the population what services could be expected to be funded at a national level while reducing the financial burden of health care on the state.

The Process

3.14 Like Oregon, New Zealand, when faced with rising health care costs, turned to the use of priorities in an attempt to contain costs. In 1992 a National Advisory Committee on Core Health and Disability Services (the Committee) was established by the government to provide a list of services which would be funded at a national level. As a starting point the Committee examined the Oregon model but rejected the

For further discussion see Hadorn and Holmes (1997).
approach - ie providing an explicit well defined list of services to be publicly funded - arguing that treatments which are ineffective for one patient may offer benefits to others. Instead, the Committee started its work with the view that current levels of service provision should form the core package of care. Any restrictions imposed should be adopted over time, based on the effectiveness of treatments, social aspects of an illness (eg duration off work), consultations with the medical profession, experts and the public.

3.15 The Committee proceeded to define entitlement to interventions based on clinical evidence, guidelines or explicit criteria assessment so as to give an indication of medical conditions which patients could expect to be funded by the Government. For example, a patient could receive a particular intervention, funded at a national level, if it could be shown that their condition required a particular treatment and there was evidence to suggest a strong likelihood that they would gain substantial benefit from the treatment. The Committee then assessed a range of services and using consensus conferences - focusing on areas of treatments - developed guidelines on service provision. This work was extended to waiting lists where the criteria developed were used to prioritise on the basis of expected benefit from surgery.

3.16 Five elective surgical procedures have been developed for: cataract extraction; coronary artery bypass graft surgery; hip and knee replacement; cholecystectomy; and, tympanostomy tubes for otitis media with effusion. These criteria included social (age, work status, caring for and loss of independence, time spent on waiting lists, any dependants) and clinical factors.

3.17 On 8 May 1996 £57m was allocated to help reduce waiting lists and patient waiting times. Determination of patient's priority for treatment was based on priority criteria previously established. A criteria is applied to all those patients waiting for surgery and a score is obtained - those patients with the highest score are regarded as having the greatest
need and are treated first. Based on resources available, a cut-off point is then set and patients with a total score above the threshold would be considered for surgery. It is intended that setting priorities through the use of explicit criteria is one method of reducing waiting lists and ensuring that a national criterion exists on surgical procedures to indicate which patients are likely to get treatment and which are not.

3.18 The use of guidelines is based on a top-down approach - national guidelines are set by the Committee through consultation with medical personnel and the community - and disseminated and enforced by purchasers in the provision of treatments for their populations. Arguably, by using guidelines in this way regional variations in service provision could be reduced, even eliminated. Furthermore, by using an evidence based approach together with the dissemination of clinical effectiveness data in setting criteria, this process could potentially lead to greater efficiency in the employment of resources. Although it is still too early to say if the use of priority setting has improved the effectiveness of the New Zealand health care system, it is clear that the way in which waiting lists were dealt with has, as in Oregon, led to increased funding (Ham, 1998a).

3.19 The Committee recognised the necessity to set guidelines which combined evidence based outcomes with patients' needs through public and professional consultation. Not surprisingly the guidelines produced have been well received. The public are more aware of who will be treated first. However, Ham (1998a) argues that this approach needs further work if transparent guidelines are to exist in setting priorities between programmes of care.

Sweden

For further discussion see McKee and Figueras (1997).
Aim

3.20 The reliance on public sector funding for health care in Sweden is similar to the UK. As in New Zealand, the Swedish response to setting priorities involved the establishment of a body, the Priorities Commission, in 1992 by the government to recommend guidelines on prioritisation in health care services.
The Process

3.21 The Priorities Commission identified two types of prioritisation within health care - clinical and political/administrative. The former category focused on decision making between treatments based on medical judgement as opposed to financial controls. The latter referred to limited health care resources which made prioritisation inevitable. Three ranked principles were also put forward to assist in the decision making process:

- **human dignity** - equal rights and dignity;
- **need and solidarity** - particular consideration is given to those individuals with greatest need and little standing in the community;
- **efficiency** - comparing the cost and effect of alternative treatments for the same condition. The Commission rejected prioritising on the basis of comparing different treatments, measured in terms of QALYs or using age, benefit or income as additional criteria in setting priorities.

3.22 The first stage, June 1992 to November 1993, involved gathering information using attitude surveys, discussions with experts and health professionals together with an examination of approaches adopted in other countries. Four different attitude surveys were used to elicit the views of, first, the public, second, health professionals, third, politicians and doctors on ethical issues and finally, doctors and nurses on changes in health service management. This process lead to the development of ten categories or groups of health care:

1. care of life threatening diseases;
2. care of severe chronic diseases;
3. palliative terminal care;
These ten categories were then prioritised under two broad headings: clinical and political/administrative priorities (Table 3.2). The Priorities Commission recommended groups I, II and III as the basic level of care, IA the most important, which the state should provide for everyone, but group V to be funded by the individual.

3.23 Like the approach adopted in Oregon, the Priorities Commission set priorities by exclusion. The approach used was based on individual cases and, since it was accepted that clinical and political/administrative priorities were not always the same, advisory committees were established to reflect the different views of interest groups. The Priorities Commission's emphasis on, for example, the inclusion of different political groups, ethical principles - needs and solidarity, human dignity and cost efficiency - and learning from the experiences of other countries in setting priorities has resulted in the development of a transparent framework to assist decision makers.

3.24 It is still too early to comment on how successful this approach has been. A number of legislative changes were expected following on from the Commission's work, although like the other models it has been successful in widening the priority setting debate.
<table>
<thead>
<tr>
<th>Political/Administrative</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Care of life-threatening acute diseases</td>
<td>IA Care of life-threatening acute diseases</td>
</tr>
<tr>
<td>Care of severe chronic disease</td>
<td>IB Care of severe chronic disease</td>
</tr>
<tr>
<td>Palliative terminal care</td>
<td>Palliative terminal care</td>
</tr>
<tr>
<td>Care of persons with reduced autonomy</td>
<td>Care of persons with reduced autonomy</td>
</tr>
<tr>
<td>II Prevention</td>
<td>II Prevention</td>
</tr>
<tr>
<td>Habilitation /rehabilitation</td>
<td>Habilitation /rehabilitation</td>
</tr>
<tr>
<td>III Care of minor acute and chronic diseases</td>
<td>III Care of minor acute and chronic diseases</td>
</tr>
<tr>
<td>IV Borderline cases</td>
<td>IV Borderline cases</td>
</tr>
<tr>
<td>V Care for reasons other than disease or injury</td>
<td>V Care for reasons other than disease or injury</td>
</tr>
</tbody>
</table>

*Source: Academy of Medical Royal Colleges et al (1997, p.31)*
Netherlands\textsuperscript{18}

\textbf{Aim}

3.25 In 1990 the Dutch government commissioned Professor A. J. Dunning to establish a Committee on 'Choices in Health Care' (the Dunning Committee). The aim was to develop criteria which would assist in defining a package of health care services for the population. At that time the government wanted to shift a greater proportion of the burden of financing the health care system onto the individual. It was argued that, since funding for the Dutch health care system primarily came from health insurance, amalgamating the various schemes into one compulsory scheme would ensure a basic package of coverage. Like Oregon, individuals could opt for additional private insurance to extend their health care coverage.

\textbf{The Process}

3.26 In contrast to the Oregon approach which initially at least defined a package, the Netherlands chose to set priorities using a twin approach - \textit{exclusion} of services and commonly agreed \textit{guidelines}. The government stipulated that the package should incorporate a wide spectrum of health care specialities. The first task was to establish four criteria which would determine which interventions were included in the package and set priorities. The conditions are:

\begin{enumerate}
\item \textit{Necessary Care} - a treatment or service is necessary from a community perspective;
\item \textit{Effectiveness} - the effectiveness of a treatment or service is
\end{enumerate}

\textsuperscript{18} For further discussion see Ven (1995).
recognised;
(3) **Efficiency** - a treatment or service must be efficient using cost-utility and cost-effectiveness analysis; and,

(4) **Individual responsibility** - those treatments or services not satisfying criteria (1) to (3) were to be excluded from the package of care provided by government.

3.27 In applying the four conditions the Dunning Committee concluded that cases such as in vitro fertilisation, homeopathic medicines and dental care for adults should be excluded from the basic health care package and that all new medical technologies should be tested before being included. Moreover, it was accepted that patient access to waiting lists should be determined by explicit guidelines. The Dunning Committee went on to develop a set of guidelines to aid purchasers in defining what health care services and treatments should be included in the insurance package.

3.28 The Dutch model, as noted above, is unique in that the Dunning Committee adopted a twin approach: the exclusion of services and the use of guidelines in prioritising treatments and services. It is regarded by many commentators as one of the more complicated models used for setting priorities. Like the Oregon approach, a government committee was established to assist in developing a basic package of health care services to be available to the population, supplemented by private health insurance. The Dunning Committee stopped short of developing a basic package of health care and, instead, opted for the use of guidelines in the decision making process.

3.29 Although this approach offers the benefit of exclusion it still fails to offer an internationally agreed approach to setting priorities. The government Committee on Choices in Health Care (1992) regarded efficiency, acquiring value for money and benefits derived from treatment as important criteria in setting priorities. However, applying the four broad criteria is subjective. The question of who should make
priorities is not addressed and Ven (1995) argues that if some treatments are included in the package and others are not this could raise questions about a two-tier system.

**Lessons**

3.30 The four approaches discussed above each have attempted to address this problem of setting priorities specific to their own health care system. In the case of Oregon the exercise was confined largely to health care for poor persons, while in others although the proportion of the population covered was much greater, nevertheless the priority exercise was conducted in such a way that private insurance is expected to supplement public provision. Although this means that no one of these approaches can easily be applied to the NHS, Ham (1995) argues that it does offer the opportunity to examine four different approaches to priority setting.

3.31 It is apparent from the international experience that there is no one correct set of tools or a process to be employed in setting priorities. Nevertheless, examining the experience of other health care systems in setting priorities highlights a number of themes or lessons. These are:

- despite considerably different levels of spending on health care in relation to GDP, in the four cases discussed above how to allocate health care resources was still a pressing issue. In other words, priority setting is unlikely to be a panacea for reducing pressure on health care budgets, while increasing the funds allocated to health care is unlikely to result in removing the pressure for more spending. This is simply because demand is seemingly infinite but resources are not and, therefore, tough choices are necessary;

- priority setting is a difficult and time consuming exercise which is likely to take several years rather than months. Thus, it would
The International Experience

seem to be best used as part of a larger exercise in considering
the way forward in health care;

- none of the four case studies was able to adequately address and
  reconcile completely the different areas of efficiency, ethical
  issues and outcome measures;

- there is no simple 'off the shelf' model or approach to setting
  health care priorities. Each of the four case studies used different
  approaches, in part reflecting different institutional settings and
  objectives. Therefore Northern Ireland needs to consider its own
  approach. Certainly a number of factors need to be considered,
  such as the health needs of the local population, institutional
  arrangements and the purpose of setting priorities;

- priorities can be set at a regional level as in Oregon which has a
  smaller proportion of the population covered by public funding
  than in Northern Ireland. Arguably, by using guidelines in this
  way regional variations in service provision could be reduced,
  even eliminated; and,

- it would appear the public have quite different preferences to the
  medical profession. Thus, if any system of priority setting is to
  gain widespread acceptance, there are good grounds for involving
  the public.

In sum, the conclusion of Section 2 (that priority setting is likely to be a
time consuming exercise requiring considerable effort and research and
calling for a wide range of persons to become involved) is consistent with
the experience of the four examples selected.

3.32 Once the purpose of setting priorities is established - for
example, cost containment, defining a core package of health care
services or the development of guidelines - and the process chosen,
criteria need to be set. Drawing on the lessons from the case studies, in
the Council's view this can best be realised by considering some or all of the criteria contained in Box 2. The list should be seen as a menu with different options for decision makers to choose between. The number of criteria chosen will depend on the process chosen but, by identifying a list of criteria to be considered in setting priorities, the Council hopes it will encourage a wider debate and acceptance of the need to set transparent priorities at a national and regional level. It should be noted that these recommendations are consistent with those made by the Academy of Medical Royal Colleges et al (1997). In both cases the thrust is that the government must accept the need to set priorities explicitly.

BOX 2

Main Criteria for Priority Setting

*Flexibility* - The freedom to make purchasing decisions within a national policy framework which recognises that a treatment which is ineffective for one patient may offer benefits to others. This is important because otherwise individual patient needs are ignored. However, a burden is placed on physicians to explain their decisions.

*Wider Involvement in the Priority Setting Process* - Any decisions made on setting priorities must be taken alongside consultation with government, the purchasers, health professionals and the public. Without open debate the views of at least one group are likely to be marginalised and the possibility of making effective decisions is reduced.

*National Framework* - In the NHS applying national guidelines could assist in the decision making process by providing a framework through which decisions made are more systematic and transparent. Moreover, the framework could also ensure that priorities established would reflect national and regional policy (as opposed to the current 'top down' approach discussed earlier).
BOX 2 continued

Main Criteria for Priority Setting

**Transparency** - Information provided on setting priorities must be clear and explicit so that it allows those not involved in the process to understand how priorities are set.

**Accountability** - From greater transparency flows better accountability. It is argued that implicit priority setting decisions have led to controversy. Arguably, if purchasers faced greater accountability over their decisions through legislation and other mechanisms less controversy would surround the whole process.

**Ethical Framework** - In order for broad agreement to be reached in setting priorities ethical issues need to be examined and some way of assessing the importance placed by the public on different issues developed, for example, by Citizens' Juries.

**Cost-effectiveness Techniques** - In order for resources to be allocated efficiently purchasers need to make informed allocative decisions to maximise benefit. By using cost-effectiveness techniques priorities will be set between interventions which offer the best value for money.

**Clinical Effectiveness** - Dissemination of information on interventions of proven clinical effectiveness. Such information could be used to indicate if a patient's condition requires a particular treatment and whether there is a strong likelihood they would gain substantial benefit from the treatment.

*Source: NIEC*
4 GOVERNMENT POLICY IN ENGLAND: THEORY AND PRACTICE

Introduction

4.1 In this section the discussion will focus on health care priority setting in England. This has clear relevance to Northern Ireland despite structural differences in health care in England and Northern Ireland (health and social care combined) and the fact that health care reforms, which made priority setting more explicit, were introduced in England two years prior to their implementation in Northern Ireland. This section, therefore, will begin with a review of government policy for setting priorities in England, followed by an examination of the findings of some studies which assessed how Health Authorities responded to their new role in making resource allocation decisions.

Policy Approach

4.2 From the early years of the NHS up to the 1990s, governments have paid scant attention to the concept of allocating scarce resources through setting priorities. Klein et al (1996, p.40) attributes this to a general acceptance that 'inadequacies' in the NHS were most likely seen as "... part of the natural order of things". Resource allocation decisions between competing interventions were often made implicitly by GPs and consultants through, for example, waiting lists. Although hard choices have always been a part of the NHS it was not until 1976 that the first national document on priority setting was published\(^\text{19}\). This document was important because it recognised that public expenditure could no longer continue on an upward spiral and hard choices in health care had to be made as demand outstripped supply of public funding. However, this document offered little guidance to decision makers in setting

\(^{19}\) Secretary of State for Social Services (1976).
priorities and the lack of national guidance continued until the reforms of the 1990s. These reforms resulted in responsibility for making purchasing decisions being that of Health Authorities and GP Fundholders, while GPs and hospitals provided services. This meant that purchasers were placed at the heart of the priority setting debate and ensured that the issue formed a key element in the changes.

4.3 In the 1990s government explicitly accepted that priority setting was unavoidable but believed adequate government guidance existed to assist local purchasers whom they saw as best placed to make priority decisions on service provision for their populations. However, in 1991 the government began to provide annual guidance for purchasers in England through NHS Management Executive Letters, entitled *NHS Priorities and Planning Guidance*. The purpose of such circulars was twofold. First, to put forward government initiatives, such as the Patient's Charter, which contain their own set of targets and, second, to provide a framework to assist local purchasers in setting priorities. These circulars are also supplemented with *ad hoc* guidelines on individual issues - health promotion targets and waiting times. Based on these national guidelines, local purchasers are then expected to develop priority setting techniques which reflect their own population needs while taking into account national and regional priorities and initiatives.

4.4 The government, while accepting that the aim of the NHS is to promote equity, efficiency, and responsiveness, was not prepared to lay down national guidelines to set priorities. Instead, the government (Department of Health, 1995) insisted that:

- responsibility for deciding priorities lay with Health Authorities;

---

20

*NHS Management Executive was renamed the NHS Executive in 1995.*
any criteria or guidelines used should come from discussions between Health Authorities, clinicians, ministers and GP Fundholders; and,

- no clinically effective treatment should be ruled out of the NHS provision.

This response made no reference to public inclusion and, since May 1997 when a new government was elected, the government's view on priority setting appears to have remained largely unchanged - local purchasers are best placed to make resource allocation decisions.

4.5 National guidance on setting priorities in England is based on flexibility - placing responsibility for setting priorities at a local level. Advocates of such an approach argue that giving purchasers the freedom to develop their own priority models means that the needs of their populations are included in the decision making process. However, as a result of this 'hands-off' approach at a national level two trends have emerged. First, purchasers tended to focus on reducing waiting lists and attaining health promotion targets irrespective of the benefits to their resident population. This is in contrast to the New Zealand approach in which clinical criteria were developed specifically to establish which patients received priority for elective surgical procedures based on clinical need and the possible benefit derived. Second, purchasers developed their own approaches to setting priorities which led to variations in health care service provision between neighbouring practices.

4.6 Although the House of Commons Health Committee (1995), which reviewed priority setting in the NHS, recognised the difficult role governments face in setting priorities and the attempts made to simplify the presentation of national priorities, it urged that:

… [A] balance must be struck between setting meaningful priorities and creating 'wish lists' (p.xvii).
In *Priorities and Planning Guidance 1993/94* (NHS Management Executive, 1992), for example, there are as many as fifteen main priorities for *Health of the Nation Targets* in addition to the many more priorities contained in the remainder of the document. Table 4.1 presents an example of some Government guidance for 1993-94. The fifteen 'priorities' are only an example of the many which exist. Although national guidance has become more specific there is still a lack of clarity. For example, Table 4.1 fails to inform purchasers what the priorities are for the period and how to meet those targets. Moreover, many of the guidelines contained in the annual NHS Executive Letters are only broad objectives, not priorities.

### TABLE 4.1

**NHS Priorities and Planning Guidance 1993-94: Health of the Nation Main Targets**

**Coronary Heart Disease (CHD) and Stroke**
- To reduce death rates for both CHD and stroke in people under 65 by at least 40% by the year 2000 (Baseline 1990).
- To reduce the death rate for CHD in people aged 65-74 by at least 30% by the year 2000 (Baseline 1990).
- To reduce the death rate for stroke in people aged 65-74 by at least 40% by the year 2000 (Baseline 1990).

**Cancers**
- To reduce the death rate for breast cancer in the population invited for screening by at least 25% by the year 2000 (Baseline 1990).
- To reduce the incidence of invasive cervical cancer by at least 20% by the year 2000 (Baseline 1990).
- To reduce the death rate for lung cancer in people under the age of 75 by at
least 30% in men and by at least 15% in women by 2010 (Baseline 1990).
• To halt the year-on-year increase in the incidence of skin cancer by 2005.
### TABLE 4.1 continued

NHS Priorities and Planning Guidance 1993-94: Health of the Nation

Main Targets

#### Mental Illness
- To improve significantly the health and social functioning of mentally ill people.
- To reduce the overall suicide rate by at least 15% by the year 2000 (Baseline 1990).
- To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (Baseline 1990).

#### HIV/AIDS and Sexual Health
- To reduce the incidence of gonorrhoea by at least 20% by 1995 (Baseline 1990), as an indicator of HIV/AIDS trends.
- To reduce by at least 50% the rate of conceptions amongst the under-16s by the year 2000 (Baseline 1990).

#### Accidents
- To reduce the death rate for accidents among children aged under 15 by at least 33% by 2005 (Baseline 1990).
- To reduce the death rate for accidents among young people aged 15-24 by at least 25% by 2005 (Baseline 1990).
- To reduce the death rate for accidents among people aged 65 and over by at least 33% by 2005 (Baseline 1990).

---

*Note that the 1990 Baseline for all mortality targets represents an average of the three years centred around 1990. Technical notes on target setting and monitoring are in the Health of the Nation.*

*Source: NHS Management Executive (1992, p.3)*
4.7 The House of Commons Health Committee (1995) called for:

- a set of explicit principles to be provided at a national level to aid purchasers; and,

- policy makers to provide genuine national priorities as opposed to a variety of initiatives - national policies (waiting lists and smoking).

The government (Department of Health, 1995), whilst accepting that setting priorities was unavoidable, argued that rationing was not an issue as there was room for further improvements in the health service.

4.8 However, with increasing importance being placed by government on the numbers of patients on waiting lists, it could be argued that waiting lists are used as one of the main ways of setting priorities in the health service\(^\text{21}\). Although patients are not directly charged for using services, priorities are set through clinical priority. In other words, clinical priority will determine how long a patient will have to wait for access to treatment - rationing by queuing. The difficulties with using this approach to determine priorities include:

- the government has not openly acknowledged that waiting lists are used as a way of setting priorities, unlike other countries, such as New Zealand;

- there exists no national guidance for Health Authorities except targets for the length of waiting time contained in the *Patients Charter Standards*;

\(^\text{21}\) *In August 1999 the total number of patients waiting for treatment in England was 1,088,869 or equivalent to 1.8 per cent of the total population as at 1997.*
there is a danger that more priority will be given to less urgent, easily treated patients in order to reduce the length of the waiting list. Less attention may be paid to the clinical need of the patient (BMA, 1998); and,

decisions made are often based on implicit criteria. For example, the patient's age, if they are a heavy smoker/drinker, drug abuse or excess weight have all been used by GPs when deciding to refer a patient for additional treatment. It is perhaps noteworthy that in the case of Oregon "for reasons of equity, it has been decided that age and lifestyle factors such as smoking could not be used to deny treatment" (House of Commons, Health Committee, 1995, p.vii).

In addition to rationing by queuing, some Health Authorities exclude certain services such as

… tattoo removal, reversal of sterilisation and certain fertility treatments - in particular, in vitro fertilisation and gamete intra-fallopian transfer (House of Commons Health Committee, 1995, p.xxxi).

4.9 The Academy of Medical Royal Colleges et al (1997) supported the Health Committee's calls for national policy guidance in setting priorities and argued that the values of the NHS put forward by the Secretary of State, namely equity, efficiency and responsiveness:

… are not widely known and understood throughout the NHS … What is clear to the Working Party is that such statements of values even if broadly shared, do not in themselves provide a detailed framework against which to assess priorities (p.12).
and urged that the debate should include health professionals and the public:
… within a framework of nationally agreed values (p.12).

The working party also questioned the importance some purchasers placed on setting priorities.

4.10 The government's 'laissez-faire' approach to priority setting has also led to calls for the government to provide greater guidance on the use of health economic tools, such as cost-effectiveness analysis, greater public debate, consideration of ethical issues and public involvement in the decision making process. Although the discussion in Section 3 on international approaches indicates that there does not exist a correct or single solution to setting priorities, efforts should be made to use at least some of the criteria in Box 2 at a UK level. This would go some way to delivering an agreed national framework to guide purchasers in the decision making process.

4.11 Given the debate that surrounds priority setting in the NHS and the calls for national guidance, it is important to review some of the research which has examined how local authorities in England have attempted to reconcile their local community needs with professionals' interests and policies through setting priorities. Such an overview will offer a valuable insight into variations in approaches to the decision making process between purchasers.

**Implementation**

4.12 The 1991 NHS reforms have meant that Health Authorities in their new purchasing role are responsible for their own budgets and the purchase of services for their population. Arguably, this enhanced responsibility could, in principal, give purchasers the ability to improve service provision and make the decision making process more explicit with greater public involvement. However, with this power has come two main pressures on purchasers, first, to meet increasing government
objectives, against a background of scarce resources, and second, to make their purchasing intentions more explicit through their strategy documents, one of which is the annual Purchasing Plan.

4.13 The main purpose of the Purchasing Plan is to outline the finalised service agreements with providers for the coming twelve months. Although the exact content of the Plan varies between Health Authorities, it is possible to examine how the Health Authorities have gone about setting priorities, the tools used, who was consulted in the decision making process, what treatments and services were funded and whether this had changed over time.

4.14 One of the earliest studies to examine how purchasers responded to their new role was undertaken by Klein and Redmayne (1992). This research involved analysing the 1992-93 purchasing plans of 114 purchasers and found:

- the information contained and audience catered for varied between Purchasing Plans;
- a reluctance on the part of Health Authorities to make decisions between competing services and treatments;
- few cases where services were explicitly excluded from funding by the purchasers;
- any changes in the provision of services tended to occur at the margins;
- purchasers adopting a policy of ‘spreading the money around’ - the average number of priorities funded by the 114 Health Authorities was 15 (p.19);
- an absence of techniques, such as cost-effectiveness and QALYs,
used in determining priorities; and,
the criteria used to choose priorities varied between purchasers.

4.15 Klein et al (1996) examined Health Authorities' Purchasing Plans for 1993-94 and 1994-95. Despite the increasing debate surrounding priority setting in the 1990s there appeared to be little evidence of priorities being set by purchasers. Indeed, much of the funds continued to be spread over a number of services and few cases existed where services were explicitly excluded from funding. Those services which were excluded generally accounted for a small proportion of the individual purchaser's overall budget.


- the information contained and the audience catered for in the 1996-97 purchasing plans had improved since the 1992-93 plans;

- more information was contained in the plans, although the decision making process is not apparent;

- still no 'foolproof priority setting formula' exists, only approaches which assist in the priority setting process;

- national, regional and local priorities continue to exert pressure on Health Authorities, making the priority setting process difficult;

- increasingly more Health Authorities are stating which services they will not provide, except under certain conditions;

- increasing use of cost-effectiveness techniques;
criteria used to choose priorities varied;

- a shift in services from secondary to primary care, in line with NHS reforms; and,

- continued variations in criteria used to set priorities and services provided.

Some examples of approaches to priority setting include North Essex Health Authority (House of Commons Health Committee, 1995, p.xxi) and Exeter and North Devon Health and Sandwell Health Authorities (NAHAT, 1996c, p.17).

4.17 Although more information has been provided in the plans over time, there is still a lack of detail on the tools used in the process, the ethical issues considered and whether the public was involved in the decision making process. It is, therefore, difficult to say the degree to which any of the tools discussed in Section 2 have been used by the Health Authorities other than that the term cost-effectiveness analysis has increasingly been cited in the plans over time.

**Recent Policy Developments**

4.18 Proposals presented in the December 1997 new government's White Paper, *The New NHS Modern and Dependable*, have important implications for priority setting in England. This reflects the emphasis on evidence based medicine and clinical and cost-effectiveness - all important building blocks that are necessary for effective priority setting. 'Quality' will be achieved in the following ways:

- by ensuring through the **Research and Development Programme** the provision and dissemination of high quality scientific evidence on the cost-effectiveness and quality of care;
by developing a programme of new evidence-based National Service Frameworks setting out the patterns and levels of service which should be provided for patients with certain conditions;

- by establishing a new National Institute of Clinical Excellence (NICE) which will promote clinical and cost-effectiveness by producing clinical guidelines and audits, for dissemination throughout the NHS;

- by establishing a new Commission for Health Improvement to support and oversee the quality of clinical governance and of clinical services; and,

- by working with the professions to strengthen the existing systems of professional self-regulation (Department of Health, 1997, p.56, emphasis in original)

Despite these welcome developments, it nevertheless remains the case that the White Paper contains no discussion of priority setting or how models such as those outlined in Section 3 might be applicable to England.

Conclusion

4.19 The 1990s have seen considerable movement in the debate over priority setting in England. The creation of the purchaser/provider framework in the early 1990s, and affirmed by government in the 1997 White Paper, resulted in much clearer responsibility for priority setting. Various bodies such as the House of Commons Committee on Health and the NAHAT and experts such as Professor Chris Ham have argued in favour of explicit priority setting procedures. The House of Commons Health Committee even travelled to view the Oregon experience first hand. Finally, in 1997 institutions were presaged which would result in
the collection of much of the information necessary for effective priority setting.

4.20 Nevertheless, despite such positive developments, on the ground there is little evidence of movement on priority setting. A review of the findings of the purchasing plans discussed above suggests that the lack of clear and explicit guidance at a national level has meant that changes to service provision at the meso level has generally taken place only at the margins, has led to variations in service provision, a lack of transparency in the way priorities are set and a lack of accountability. Although this means that there is no readily available model for Northern Ireland, it also implies that there is scope for local purchasers to be innovative. Whether this is realised or not will depend on a number of factors, not least on the approach taken by individual purchasers.
5 GOVERNMENT POLICY IN NORTHERN IRELAND: THE REGIONAL FRAMEWORK

Introduction

5.1 In April 1992 the reform of health and social care in Northern Ireland resulted in the introduction of the purchaser/provider split in HPSS. The four HSSBs became responsible for the purchase of health and social services for their resident populations. Under this new role the Boards have increasingly been faced with the task of making difficult choices among competing treatments to meet their population's needs while taking into account increasing government priorities against a background of scarce resources. Thus, this section will examine the guidance provided by the HPSS at the regional level and Section 6 will consider how priority setting has been implemented in Northern Ireland, with particular emphasis on the 1990s. This will involve investigating how the four Boards have gone about setting priorities since the introduction of the purchaser/provider split, what those priorities were, what criteria were used and the extent to which the Boards' priorities reflected regional and national priorities.

5.2 However, before a discussion can take place on the priority setting process in HPSS it is necessary to recognise the impact health and social care has on other sectors of the economy and the need for appropriate co-operation with bodies outside HPSS. Advances in health care technology can, for example, improve disease prevention, the length of time patients need treatment, quality of life, length of life and period of working life. Improvements in the assistance given to the disabled in terms of mobility and employment rights will increase their opportunities to gain employment. Curbing health and social care inequalities can also impact on poverty, education and long-term unemployment. However, these improvements can only be realised through interaction between the HPSS and agencies, such as research bodies, employers, the government, housing associations, education bodies and community groups.

5.3 It is also important to highlight the context of funding constraints
faced by HPSS and how they impact on the HSSBs in setting and implementing priorities. At the macro level the UK government sets the overall magnitude of public expenditure for Northern Ireland. The pattern of regional public expenditure and priorities was set by the Secretary of State for Northern Ireland under Direct Rule, but after December 1999 became the responsibility of the devolved administration22. It is at this latter stage that choices first have to be made which determine the level of public expenditure by government departments. In Northern Ireland health and social care provision falls within HPSS through the strategic direction of the Department of Health and Social Services (DHSS)23. Guidance from the DHSS, in addition to national priorities, comes in the form of priorities and targets. As a result, DHSS priorities may lead to funding being directed towards specific areas within health and social care, such as GP prescribing. In the Eastern Health and Social Services Board’s (EHSSB) experience financial priority given to primary care prescribing “… was at the expense of both acute and community care …” (Letter from EHSSB, 8 July 1999).

5.4 The Boards work within a national and regional framework of policy guidance and priority setting. The principle national and regional documents which set the objectives and targets of the Boards are discussed later in this section but, because of their sheer numbers, the Boards face a difficult task between translating the national and regional priorities for their population and setting their own targets. Whatever

22 However, under Direct Rule (but also under devolution) priorities set at Westminster have a clear influence on Northern Ireland as we shall see below.

23 On devolution in December 1999 the department’s name changed to the Department of Health, Social Services and Public Safety.
funding flexibility the Boards have, the Chief Executive of the EHSSB argues “… there has been a high proportion of unavoidable expenditure to meet inflationary pressures in excess of Government provision and the cost of HSS Executive decisions …” (Letter from EHSSB, 8 July 1999).

5.5 The priority setting process is set out in Figure 5A. The overall strategic direction is set by the DHSS’s five yearly Regional Strategy, complemented by the annual Management Plan, which is the responsibility of the HSS Executive, part of DHSS. Translating the strategy and plans into decisions on the ground is the task of the four Boards, with some advice from the four Health and Social Services Councils (which represent the wider public viewpoint) and GPs through the GP Forum or GP commissioning groups formed by the Boards to give them advice.

**HPSS Guidance**

5.6 HPSS, like the NHS in England, is based on a hierarchical structure. At the top is the DHSS which is responsible for the publication of a Regional Strategy document every five years. The present strategy covers the period 1997-2002 and sets out explicit targets and objectives. The Regional Strategy document is also supplemented with ad hoc guidelines on individual issues. For example, *Well into 2000: A Positive Agenda for Health and Wellbeing* (DHSS, 1997) outlines the government’s broad strategic approaches and policies for improving the health and wellbeing of the local population. Since 1990, further guidance for the Boards has come in the form of a rolling annual Management Plan published by the HSS Executive. This sets out the corporate agenda for the management and delivery of health and personal social services for the population over a three year period.

**Commissioning Framework for Northern Ireland**

5.7 In addition, the HSS Executive (1997) also provides guidance,
Commissioning Framework for Northern Ireland, which sets out the procedures involved in commissioning, including priority setting, and outlines how the 'partners' and 'stakeholders' of health and social services are expected to be involved in the process. The document recognises the

**FIGURE 5A**

Structure of Setting Priorities in Health and Social Care in Northern Ireland, 1990s

*HPSS: Health and Personal Social Services; HSSE: Health and Social Services Executive; HSSB: Health and Social Services Boards; HSSC: Health and Social Services Councils*

*Source: NIEC*
importance of needs assessment exercises in the commissioning process and the opportunities offered, via primary care data, for locality or population-level assessments in the long-term. It also refers to a number of the outcome measures discusses in Section 2 above. However, it highlights the reluctance of primary care professionals, in particular GPs, either to be involved in or to share responsibility for setting priorities. It is suggested that the process could be made better if the issues involved in making hard choices were considered at the start of the commissioning process as opposed "to late-in-the-day confrontations …" (HSS Executive, 1997, p.5).

Well into 2000 and the Regional Strategy: Accountability and Monitoring

5.8 Accountability and monitoring arrangements for the major regional health strategy documents are contained in Well into 2000 and the Regional Strategy. Accountability and Monitoring (DHSS, 1998c). The purpose of this document is to:

- increase awareness of the accountability and monitoring arrangements;
- draw the objectives and targets to the attention of those with a contribution to make towards their achievement; and,
- facilitate communication by identifying the Departmental Units which have lead responsibility for individual objectives and targets.

(DHSS, 1998c, p.4)

The HSSBs are responsible for the implementation of the strategy through GP involvement in the planning and commissioning process.
The Department's Health and Social Services Committee\textsuperscript{24} is then accountable to the Minister with responsibility for health and social services in Northern Ireland, in terms of progress made on the strategy objectives and targets. Essentially, this document provides a clear and concise summary of the goals of \textit{Well into 2000} and the objectives and targets of the current Regional Strategy report and identifies the bodies responsible for achieving the government's priorities. Nevertheless, it is unclear how the bodies, namely the HSSBs, are to meet their responsibilities, given their finite budgets and the extent to which HSSCs and other local community groups are to be involved.

\textbf{Regional Strategy}

5.9 Further guidance comes in the form of a Regional Strategy document. Two regional strategy documents have been introduced since the reforms of the 1990s: \textit{A Regional Strategy for the Northern Ireland Health and Personal Social Services 1992-97} (DHSS, 1991); and \textit{A Regional Strategy for Health and Well Being: Into the Next Millennium 1997-2002} (DHSS, 1996). The former followed on from the two previous Strategies and was intended to be "the primary regional planning document for the health and personal social services over the period 1992-97" (p.6). Two policies, \textit{Working for Patients}\textsuperscript{25} (Department of Health, 1989) and \textit{People First} (DHSS, 1990), formed the background for the 1992-97 Regional Strategy and the overall aim of the latter document was "to promote the physical and mental health and social

\begin{itemize}
  \item\textsuperscript{24} Chaired by the Permanent Secretary, includes the Chief Executive of the HSS Executive, the Department's two Deputy Secretaries and the five Chief Professional Officers.
  \item\textsuperscript{25} \textit{Working for Patients} was jointly published by the Secretaries of State for England, Wales, Scotland and Northern Ireland.
\end{itemize}
wellbeing of the population” (DHSS, 1991, p.6). The four strategic themes are outlined in Table 5.1. Finally, the Strategies were developed based on consultation with the Boards, the Health Promotion Agency, the health care professionals, public representatives, trade unions, voluntary groups and others including the Economic Council (NIEC, 1995).

<table>
<thead>
<tr>
<th>TABLE 5.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>An Overview of the Regional Strategy for the Northern Ireland Health and Personal Social Services, 1992 to 1997</strong></td>
</tr>
</tbody>
</table>

1 **STRATEGIC THEMES**

**Overall Aim**

To promote the physical and mental health and social well-being of the population

**Themes**

- promoting health and social welfare
- targeting health and social need
- improving care in the community
- improving acute care

2 **KEY AREAS**

- maternal and child health
- childcare
- accident and trauma
- physical and sensory disability
- mental health
- circulatory diseases
- cancers
- respiratory diseases
Government Policy in Northern Ireland: The Regional Framework

Sources: DHSS (1991, various pages)
5.10 The 1992-97 Strategy. In analysing the two Regional Strategy documents it was apparent that three of the 1992-97 themes follow on from the 1987-1992 strategy document, with the fourth - targeting health and social need - introduced in an attempt to further focus resources where they are needed most. A chapter was devoted to each of the eight key areas, the purpose of which was to identify areas:

… where there is real scope for improvement, and in each of them objectives and targets are set, while leaving room for the Health and Social Services Boards to add their own local priorities (DHSS, 1991, p.3).

The term ‘priority’ is only used in the document in reference to the importance placed on nine key areas of concern (Table 5.1). Guidance that followed tended to come in the form of ‘targets’, with little indication of how they could be reached, if resources should be moved from one area of care to another or what the resource implications of these ‘targets’ might be. The ‘targets’ and ‘objectives’ - over 60 in the 1992-97 Strategy document - are too long to be listed in this report:

… most of which require action by Boards. Around 25 of these, most of them outcome targets, have been assessed as offering greatest scope for health and social gain and should be given priority … (DHSS, 1991, p.13).

This list of ‘targets’ and ‘objectives’, even when scaled down to include only priority areas, highlights a lack of willingness on the part of the DHSS to set concrete priorities in the health service.

5.11 The Boards were expected to adopt the themes from the 1992-97 Regional Strategy while at the same time adding their own priorities to the list of key targets. In addition they had to develop an Area Strategy for 1997 outlining how they intended to meet the targets and objectives set in the Regional Strategy - for example, “search for greater efficiency”
in acute hospital services with the assurance that resources freed "are immediately available to provide a greater volume and/or quality of care" (DHSS, 1991, p.8).

5.12 *The 1997-2002 Strategy.* The Council has commented on the draft regional strategy document for 1997-2002 (NIEC, 1995). The overall aim of the latter final strategy document remained unchanged from the previous regional strategy which is regarded as building:

… on the foundations laid in the earlier strategies in seeking to add years to life and life to years (DHSS, 1996, p.42).

Four strategic themes follow on from the 1992-1997 Regional Strategy. The number of key areas were reduced to seven. These are:

- family and child health and welfare;
- physical and sensory disability;
- learning disability;
- mental health;
- circulatory diseases;
- cancers; and,
- other non-communicable diseases.

These key areas were chosen because "they offer the scope for practical action to improve the length and quality of life for people in Northern Ireland" (DHSS, 1996, p.12) and, as in the previous Regional Strategy document, a chapter is devoted to each of these areas.

5.13 The format of the fourth Regional Strategy document (1997-2002) remains largely unchanged from the previous strategy. The overall aim of the strategy and the themes follow on with a few changes to the key areas. The document, however, is different in that it goes a stage further by introducing underlying principles which are intended to give a
sense of direction to the Boards in health and social services provision over the period. The DHSS also recognises that the use of outcome measures and effectiveness material is important in selecting interventions. Although the guidance in this later Strategy document is welcomed it stops short of suggesting how the Boards should go about setting priorities and the tools to be used. Instead the DHSS suggests:

…Priority must be given to developing the range of indicators for successful interventions and to the dissemination of information about the effective approaches (DHSS, 1996, p.20).

In addition, there is still no indication as to whether the Boards should redirect resources to other areas of care in light of the Strategy, nor is any attempt made at prioritising the targets set.

The Management Plan

5.14 Further guidance for the Boards comes in the form of an annual Management Plan published by the HPSS Management Executive. The purpose of the Plan is to outline a corporate agenda for the HPSS in Northern Ireland which sets out the priority areas for the Boards to follow over a three year period. Each consecutive plan takes account of the main themes of the corresponding Regional Strategy as well as national policies, such as reducing waiting lists. HSS Boards are expected to take account of priorities set in the Management Plan when drawing up their individual Action Plans for the year ahead.

5.15 The inception of the Management Plan dates back to 1990. However, for the purposes of this discussion, attention will only focus on Plans covering the periods from 1991-92 to 2000-01 inclusive. An examination of the plans over this period reveals at least three notable points. First, the layout of the Management Plan has remained largely unchanged over the period - with an introduction, key objectives and
priorities and revised financial arrangements over the period.

5.16 Second, although the layout of the Management Plan has remained largely unchanged, attempts have been made to alter the content to give clearer direction to the Boards and others involved in the HPSS. For example, in the 1994 Management Plan changes to the plan were aimed at:

- reducing the number of targets and concentrating on service delivery;
- specifying priorities more clearly. For example, priorities were not outlined clearly in the 1994 Management Plan; and,
- publishing the Plan well in advance of the focal years that it may be taken into account more readily in the preparation of Boards’ Purchasing Prospectuses.

5.17 Third, from 1995 onwards the Plans focused on areas where it was possible for the HPSS Executive to expect:

   … Boards to secure quantifiable, year-on-year improvements during the period covered by the Plan (HPSS, 1995, p.1).

Areas where it was not possible to set quantifiable targets were not included in the plan but continued to form part of the Regional Strategy which the Boards must fulfil.

5.18 The Management Plans have placed a high level of expectation on the Boards. For example, in the 1999-00 - 2001-02 Management Plan the Boards are expected to reduce the total number of acute bed days taken up by children (under 16 years) by 25 per cent per annum in 2002. This government target has been accompanied by an additional cash
injection of £13 million in 1998 (DHSS, 1998b) - £11 million in April and £2 million in October. Although inpatient waiting list figures (all admissions)\textsuperscript{26} for Northern Ireland in July 1999 stood at 44,836, a decrease of over 2,400 from twelve months earlier (DHSS, 1999b), it is still too early to suggest that this downward trend will continue.

5.19 Table 5.2 shows that waiting lists are equivalent to a higher proportion of the local population (2.8 per cent) than nationally (2.3 per cent).

\begin{table}
\centering
\caption{NHS Hospital Waiting Lists in Northern Ireland and the UK, 31 March 1997}
\begin{tabular}{lcc}
\hline
\textbf{Region} & \textbf{Waiting List} & \textbf{Population} \\
\hline
England & 5,120,000 & 49,000,000 \\
Scotland & 2,400,000 & 5,200,000 \\
Northern Ireland & 44,836 & - \\
\hline
\end{tabular}
\end{table}

\textsuperscript{26}Figures do not include private patients or residents outside Northern Ireland and are based on the number of inpatient waiting list (all admissions) by Board of Residence at month end.
Waiting lists figures at 31 March 1997 of people who were waiting for admission as either an inpatient or a day case and the length of time they had waited to date.

1 Aged under 1 year.
2 Include all patients waiting for treatment at Northern Ireland Trusts including private patients and patients from outside Northern Ireland.

Source: ONS (1998b, 1998c)
cent). Hospital statistics for the period 1 April 1998 - 31 March 1999 (HSS Executive, 1999a) show that only 56 per cent of patients admitted to hospital waited less than six months and 23 per cent were a year or more on a waiting list. The Performance Tables for health and social services (HSS Executive, 1999b) also reveal variations in waiting times from hospital to hospital. For example, only 30 per cent of patients for oral surgery were admitted to hospital within three months of the decision to admit for the Craigavon Area Hospital Group but 99 per cent for Sperrin Lakeland (Table 5, p.13). If we confine our attention to the very young and old - where the demand for health care is highest (NIEC, 1994, Figure 2H, p.15) - then the Northern Ireland waiting lists appear to be much higher than for the UK as a whole\textsuperscript{27}. If Table 5.2 were updated using 1999 data then this finding would continue to hold.

\textbf{TABLE 5.3}

\textbf{NHS Hospital Activity in Northern Ireland and the UK, 1996-97}

\begin{center}
\begin{tabular}{|c|c|c|c|c|c|}
\hline
 & Northern Ireland & UK & \hline

\hline
\end{center}

\footnotesize{\textsuperscript{27} Although Northern Ireland has a higher proportion of available beds (Table 5.3), almost a fifth fewer patients are treated per bed than in the UK as a whole.}
Excluding cots for healthy new-born babies except Northern Ireland.

Relates to finished consultant episodes in England. Data for Northern Ireland relate to discharge and deaths. Northern Ireland also includes transfers to another hospital.

Source: ONS (1998c)
5.20 Twelve months since the regional waiting list target of 39,000 was set in March 1998, overall waiting lists were reduced by 3,600. The decrease is less than the 7,000 target but was the largest fall since December 1997. The Boards put forward a number of reasons for the shortfall. These include

… the original target was unrealistic; non-recurring status of additional monies imposed severe limitations, in particular with regard to the recruitment of the extra specialist staff for a relatively short period to do the work; the resulting inability of the HPSS system to cope with the disproportionate increase in referrals/workload generated by the additional investment of £13m; the effect of winter pressures; and, the reluctance of patients to be treated outside their home area (Letter from HSS Executive, 4 November 1999).

Thus, since the regional waiting list target was not met by April 1999 an alternative approach might involve priorities set as in New Zealand using a points system as discussed in Section 3 above.

5.21 The Boards also have a difficult role to play in meeting the health and social needs of their respective populations, having to take into account national and regional policy objectives and targets. Although the key strategic objectives of the Plans come from the Regional Strategy, often new 'targets' are outlined in the Plans in addition to the those contained in the Strategy documents which are not always service specific but more general. For example, under the heading Targeting Health and Social Need (DHSS, 1997, p.18) the Boards are expected to establish, “… a systematic approach to identifying local needs and preferences”. It could be argued that the Boards should have been doing this in any event as part of any sensible priority setting exercise and should not need to be instructed to undertake such an exercise by the Management Executive.
5.22 Finally, the targets contained in the Regional Strategy and the Management Plan are not costed so no examination is made as to whether the Boards can financially meet the increasing list of targets before they are set on an annual cycle.

Sensible Framework for Priority Setting?

5.23 In Section 3 the eight criteria identified as a framework against which priorities could be set by the Boards in Northern Ireland were applied to national guidance on setting priorities in England. If this approach is now applied to HPSS guidance - the Regional Strategy and Management Plans - only one of the criteria is fulfilled (flexibility) achieved through the placing of responsibility for setting priorities at a local level. There is little public involvement, use of cost effectiveness techniques, the development of ethical framework and so on. This is not surprising since government policies for England are very similar to policies in Northern Ireland. It is apparent, therefore, that there is a lack of clear and transparent guidance for the four Boards at the macro and meso levels. The gaps in national guidance have not been 'filled in' at the regional level and, while there is an overlap between national and regional guidance, it is not clear if there is a need for the large number of additional targets and objectives contained in the HPSS guidance.

5.24 The HPSS, in view of its size and expertise in its central role of providing strategic leadership, has a vital role to play in setting the framework and context within priority setting. In commenting on the way the priority setting process operates and the role of HPSS the Council is struck by the lack of published research and evaluation - despite the information and data having been sought directly from the major actors in the priority setting process. It appears to the Council, therefore, that more could be done in this respect. Thus

the Council recommends that Health and Personal Social
Services furnish guidance at a regional level which will provide a firm sense of direction for priority setting in health care, how this might take place, what tasks should be included and who should be involved.

As we will outline below this should be done in conjunction with other important groups in health care in Northern Ireland.
6 GOVERNMENT POLICY IN NORTHERN IRELAND: THE PURCHASING DECISION - BOARDS

Introduction

6.1 As at September 1997, the HSSBs were allocated a total of £1,106 million funding (Table 6.1) or £671 per person in Northern Ireland. As noted above, the UK government sets the overall magnitude of public expenditure for Northern Ireland, which is then allocated between Departments. Until December 1999 this was the responsibility of the Secretary of State, subsequently of the devolved administration. Spending on health and social services is substantial. As the Standing Committee C of the Northern Ireland Forum for Political Dialogue argues:

Spending on Health and Social Services is truly enormous and is second only to spending on Social Security. For this reason it is vital that such a resource is well directed and that waste is minimised (Northern Ireland Forum for Political Dialogue, 1997, p.14).

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>463</td>
<td>41</td>
</tr>
<tr>
<td>Northern</td>
<td>260</td>
<td>24</td>
</tr>
<tr>
<td>Southern</td>
<td>199</td>
<td>18</td>
</tr>
<tr>
<td>Western</td>
<td>184</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>1,106</td>
<td>100</td>
</tr>
</tbody>
</table>
Government Policy in Northern Ireland: The Purchasing Decision - Boards

Source: Adapted from the Northern Ireland Forum for Political Dialogue (1997, p.14)
Thus, sensible allocation of these funds is crucial for the welfare of the citizens of Northern Ireland. It is to this topic that this section of the report is devoted, with attention being paid not only to the Boards but also the Health and Social Services Councils.

6.2 The proportion of funding each of the four HSSBs receive is dependent on a needs assessment formula-based approach, introduced in 1998, which allocates more funding to those Boards which have, for example, an older population, higher than normal mortality, social deprivation and sparsity relative to other Boards. The Boards then decide how best to spend their funding allocations. Thus, the allocation across Boards takes into account more than relative population size (Table 6.2).

<table>
<thead>
<tr>
<th>TABLE 6.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Breakdown by HSSB for Northern Ireland, 1995</td>
</tr>
</tbody>
</table>
6.3 Since the formula was introduced it has been surrounded by criticisms, constant revisions, implementation difficulties and variations in relative need between areas and localities. When the Capitation Review Group in 1997 proposed the current formula it recommended the addition of one modification\(^{28}\) and recognised that further work is needed … to identify, where possible, needs indicators to replace the interim weightings used in the formula for some programmes of care (HPSS, 1998, p.6).

**GP Fundholders**

6.4 GP Fundholders, introduced in 1993, which are to become part of Primary Care Co-operatives (PCC) after 2001 (see Section 7 below) have been largely responsible for reviewing priority setting at the community level and, to a lesser extent, at the Departmental level. Through savings made from the use of more cost-effective prescribing techniques and hospital outpatient reviews GP Fundholders have played an active role in improving the primary care infrastructure in Northern Ireland. For example, physiotherapists and chiropodists are now often employed in

\(^{28}\) *Boards should benefit from individuals in their area who receive personal social services.*
fundholders’ surgeries so as to tackle the problem of long waiting times associated with secondary care. Many have also opted to invest in improving their practice premises and in providing additional clinical equipment for their surgeries. Such changes mark a shifting of resources at the primary care level and emphasis on the priorities at the community level. Although GPs in Purchasing Pilots (total purchasing - fundholders come together to form groups “… to purchase all hospital and community care for their patients” (NHS Executive, 1995, p.1)) do not have responsibility for actual budgets, they (together with GP Fundholders) have been involved with the HSSBs in the planning and commissioning process to determine service provision and priorities for their local populations.
Health and Social Services Councils

6.5 The four Health and Social Services Councils were established by the Health and Social Services Councils Regulations (Northern Ireland) in 1991 as independent statutory bodies. Their purpose is "... to represent the views and opinions of the general public in all areas of health and social services" (HSSCs, nd, p.10).

6.6 The main activities of the Health and Social Services Councils include monitoring the quality of service, providing information, guidance and advice to the public and representing the public's interests in health and social services in their Board area in order to ensure that their views are included when decisions are being made. It is not, therefore, surprising that, since their inception, the Health and Social Services Councils have increasingly engaged the community and voluntary sectors and the public in discussions on the provision of health and social services in their localities.

6.7 Paragraphs 6 and 7 of the HSS Management Executive Circular (OCE 1/94) outline the way in which the four Health and Social Services Boards are expected to involve the Health and Social Services Councils in their purchasing processes. The two following paragraphs are relevant:

6. **Boards, as purchasers**, should invite Health and Social Services Councils to be involved in the purchasing process, focusing in particular on:

- needs assessment and priority setting with purchasing prospectuses;
- the thinking underlying decisions on the placing of contracts;
- the development of quality standards with contracts;
- monitoring services in co-ordination with
Boards;

- matching the services planned to the cultural, religious and other aspects of health and personal social services.

7. Boards should discuss this involvement with the Health and Social Services Councils and agree the processes (for example, membership of working groups, etc.) and subjects involved. In some cases a contractual agreement, for example, in relation to quality monitoring or patient surveys may be appropriate, in addition to these processes. (HSS Management Executive, 1994, p.2, emphasis in original).

If the Boards fulfil the above guidelines then it is reasonable to expect that the HSSCs will be in close collaboration with the Boards during the purchasing process and aware of how needs are appraised, contracts determined and priorities set by their local Board.

6.8 The views of the HSSCs were, therefore, sought by the Economic Council, particularly their advice and guidance with respect to priority setting in Northern Ireland. In order to do this, each of the four Councils was formally requested to provide annual reports and any additional information which they felt would be of assistance. As a guide to the type of information requested four questions are outlined below:

1. To what extent do you feel your Health and Social Services Council plays an active role in health care policy and social services provision in Northern Ireland?

2. Are you involved in any stage of the Boards' purchasing process? What views do you have on the determination of need in your area?
3. Do you feel the views of the general public are adequately taken into account when the Board makes purchasing decisions? If not, how could this be changed?

4. Are you aware of the priority setting criteria used by the Board to make purchasing decisions? If yes, what is your opinion of the criteria used and how can the process be improved? If no, what recommendations would you make?

All the HSSCs provided annual reports but responded to a varying degree to the four questions above. The Western Health and Social Services Council (WHSSC), for example, answered in a brief and pointed way (Box 3).

6.9 A draft of this (NIEC) report was sent to the HSSCs to give them the opportunity to comment on any factual or other inaccuracies. All the HSSCs took the opportunity to comment on the final draft report and had forwarded documentation to the Economic Council prior to the sending out of the draft report.

6.10 From the documentation and comments received it is apparent that the techniques used by the HSSCs to include the public have been varied, although the overall purpose has been the same - to attempt to include the public in health and social care provision. For example, the Eastern Health and Social Services Council (EHSSC) together with the EHSSB were the first to stage a Citizens’ Jury in Northern Ireland (July 1998) which focused on the consultation document *Fit for the Future* (DHSS, 1998a). As a result the Board is now focusing on getting the public involved in its meetings. While the EHSSC and the EHSSB Citizens’ Jury exercise (EHSSB/EHSSC, 1998) cost £25,000 because experts had to be brought from England, the EHSSC now believes that Northern Ireland has in-house expertise which should lower the cost of future juries. Despite the technique being an expensive approach, the EHSSC argues that it “… was utilised because of the serious nature and
complexity of the topic” (Letter from EHSSC, 5 July 1999). Other methods used by the EHSSC include face-to-face interviews, focus groups and consumer panels, postal questionnaires and/or survey work.

BOX 3

WHSSC Response to Northern Ireland Economic Council

R1. The Western Health and Social Services Council plays a very limited role in health and social care provision in Northern Ireland (as opposed to the Western Area).

R2. The Council is involved in the very early stages of the Board's purchasing process and can identify service developments which were initiated by Council members. Through the members’ geographical representation it has been possible to assist the Board with the identification of priorities in different localities.

R3. I am confident the views of the general public are taken into account when the Board makes purchasing decisions. An essential component of the Council monthly meetings is an Agenda opportunity for Board officers to present intentions. The Council has a policy to set up working parties where a particular issue is complex or needs a detailed response.

R4. The Council is not aware of the exact detail of the priority setting criteria used by the Board to make purchasing decisions other than to be aware of the Agenda set by the Health and Social Services Executive's five year strategy.

Note: R1 to R4 are the responses to Q1 to Q4 which are presented in para 6.8 above.

Source: Letter from WHSSC, 27 August 1999
6.11 The Southern Health and Social Services Council (SHSSC) with the Southern Health and Social Services Board (SHSSB) conducted a review of citizens' views as part of a review of inpatient hospital services. The Council and Board felt this method of investigation "... was considerably less expensive and more informative of the value systems citizens have. For example, the majority of respondents agreed they would rather travel further for inpatient care if that ensured access to good quality diagnosis and treatment" (Letter from SHSSB, 10 November 1998). The Northern Health and Social Services Council (NHSSC), in its response to the Northern Health and Social Services Board's (NHSSB) review of acute services, based its comments "... on the views of 1,000 members of the public" (Letter from NHSSC, 2 July 1999). In the WHSSC the "... Chief Officer participated in an extended telephone survey on Information Advice and Advocacy Services for Disabled People" (Minutes of Eightieth Meeting of the WHSSC, 3 June 1999, p.9).

6.12 It is also apparent that all of the Councils are playing an increased role in collaborative projects with the Boards. For example, when the EHSSB undertook a Dementia Audit they approached the EHSSC for its assistance "... in gaining the views of carers". The EHSSC responded by holding eight focus groups throughout the Board's locality, the outcome of which was a Council report which was subsequently included in the Board's audit and recommendations (Letter from the EHSSC, 4 November 1998). This approach was found to be so successful that the Board and Council have agreed to continue with this type of joint work in the future. The EHSSB is to provide a quarterly review of strategic issues for the Council. The NHSSC has been included in a number of NHSSB's Programme of Care strategies and various joint projects with the Board, for example, a review of acute services and current involvement in the Board's Community Health and Social Wellbeing Project (Letter from NHSSC, 2 July 1999).

6.13 Dialogue between the Boards and Councils appears to have improved over time with all of the HSSCs involved with their respective
Boards in various projects. For example, the SHSSC was included at an early stage of the SHSSB's consultation process (SHSSC, 1997a, p.32). The Board also requested the Council's involvement in "... the advisory group on the commissioning of cancer services and on the specific cancer sub-groups" (SHSSC, 1997a, p.2). Finally, a study was funded jointly with the SHSSB which led to a publication entitled, *Patients' Perceptions and Experiences of Services Provided by Family Doctors* (SHSSC and SHSSB, 1995).

6.14 The WHSSC was involved in the Western Board's Acute Services Review with members providing "... an input to the Steering Group and had a place on each of sixteen Clinical Sub-Groups" (Letter from WHSSC, 27 August 1999). The EHSSC has been included in "... the consultative process of commissioning cancer services [which] was facilitated by membership on the Commissioning groups, sub-group and now the implementation group" (Letter from EHSSC, 5 July 1999). Finally, in taking account of the needs of communities in planning services, the NHSSC, in collaboration with the NHSSB and community networks, is involved in a Social Well-being Project.

6.15 In terms of priority setting the HSSCs' responses to the Boards' documents have been varied but critical. The SHSSC in its responses to the SHSSB's Draft Purchasing Prospectuses highlighted, for example, the absence of Southern Board's targets in the *Draft Prospectus 1997/98 - 1999/2000* and the lack of information provided which the SHSSC felt made it impossible to say whether resources had shifted from the acute to the primary and community sectors. In addition, it has been critical of the presentational style of the Boards' Draft Purchasing Prospectuses and, in the case of the Draft Purchasing Prospectus for the period 1998-99 - 2000-01, the Council questioned the lack of funding by any of the Boards on IVF treatment.

6.16 The EHSSC writes to the EHSSB when they see "... gaps in services ... such as, IVF treatment ..." and respond in general to the
Board's documents (Letter from EHSSC, 5 July 1999). The WHSSC in addition to responding to the Western Health and Social Services Board (WHSSB) documents holds annual meetings with the WHSSB to discuss "... current issues and proposed developments" (Letter from WHSSC, 27 August 1999). Members of the NHSSC also have meetings with the NHSSB officers where they use the opportunity to raise their concerns and issues to be discussed. The NHSSC has also commented on the Board's review of particular services, such as acute services. Based on the views of 1,000 members of the public the NHSSC's recommendations included the NHSSB reviewing Option 3 again in terms of the provision of minor injury units and services for the aged; the inclusion of local GPs in the decision-making process and hospitals under the Antrim and Causeway options so as to ensure "... discharge planning is efficient and effective" (NHSSC, 1998, p.16).

6.17 It is also evident that at least some of the HSSC criticisms have been taken on board. For example, the SHSSC praised the presentational improvements in the SHSSB's Draft Purchasing Prospectus 1998/99 - 2000/01 such as the use of large fonts, and welcomed the targets contained in the Regional Strategy document Well into 2000: A Positive Agenda for Health and Social Wellbeing (DHSS, 1997). The WHSSC has been able to affect the level of service provision citing the respective Boards' Acute Services review as an illustration of this.

6.18 Given that the Health and Social Services Councils were established to ensure the public had a role to play in the decision making process, the Economic Council welcomes the increased interaction between the Councils and the Boards. However, it would appear that the Councils are still unclear as to exactly how the Boards set priorities - despite being involved in the Boards' discussion processes prior to priorities being set. Nevertheless, they do feel increasingly involved and play an effective role in their respective Board's purchasing process.

6.19 Thus, while the HSSCs may not understand or be familiar with
how the Boards set priorities they at least ask questions which is a substantial step in the right direction. In other words, the Councils have asked questions which tie in with the discussion in this report and which would be expected from bodies monitoring how priorities are set. For example, the SHSSC mentions outcome measures in its documents and calls for more information to be made available so that it may be possible to see if health and social service objectives are being fulfilled. The SHSSC would urge the Southern Board to “… conduct research into the potential demand for such a service and if a need is identified to purchase the service for those who would benefit” (SHSSB, 1996, p.18). In the case of the NHSSC response to the NHSSB strategy for Acute Care Services Into the Next Century (NHSSC, 1998) it called for the public to be kept informed and clarification made to parts of the document. The EHSSC and the WHSSC also continually question their respective Board’s strategies, targets, changes to service provision and public involvement.

6.20 In addition, the purpose of Section 6 of the HSS Management Executive circular (OCE1/94) was to explain the HSSC’s participation in the purchasing process. However, from the circular it is not clear how this is actually to be conducted. For example, in the EHSSC’s comments on the Economic Council’s final draft report it stated, “[T]his Council has tried a number of ways of fulfilling this by having Council members sit on planning teams and then by having members of staff sit on Strategic Planning Groups. Neither of these methods have been successful … The EHSSC has struggled with the Board’s Commissioning documents for a number of years” (Letter from EHSSC, 4 November 1998). The WHSSC feels that while all of the Councils “… are able to offer comments in response to consultation documents there appears to be little attention paid to well reasoned criticism and invariably the directives are delivered as originally set” (Letter from WHSSC, 27 August 1999). The NHSSC expressed similar views in their correspondence to the Economic Council but went further, “I am aware that the Northern Board uses a template in priority setting which looks at effectiveness, value, efficiency, strategic
alignment, etc but would not be familiar with the detail” (Letter from NHSSC, 20 November 1998).

6.21 As a way of increasing greater co-operation between the HSSCs a Three Year Strategy document (HSSCs, 1999) has been published. It is recognised by the Councils that the "… planning process should be more strategic, more focused on issues and more consistent across the four Councils” and it is also recognised by them that there is a need for them to influence "… services at a strategic level [and ensure] a consistent approach" (HSSCs, 1999). Thus,

the Council recommends that greater guidance and co-operation are needed from the Health and Personal Social Services in association with the Health and Social Service Boards if the Health and Social Service Councils are to become more actively involved in setting priorities.

The various examples in Section 3 (above) of the international experience provide a rich vein on which to draw. Such a recommendation should also assist the HSSCs to fulfil their 1999-2002 strategy.

**Health and Social Services Boards: Purchasing Prospectuses**

6.22 For the purposes of this report an examination is, first, made of the content of the four Boards' Purchasing Prospectuses, and the Purchasing Plans as these are the documents which contain information on the way the Boards assess need, make the relative prioritisations, on the contracts made with providers and indicate where resources will be allocated. An examination is then made as to how the Boards allocate their funds to specific priority areas.
6.23 The purpose of the Purchasing Prospectus\textsuperscript{29} is to outline the draft purchasing intentions by the Boards for the forthcoming financial years in a summarised format. It is one of a number of documents, including the Purchasing Plan, which are used by the Boards to encourage discussion with the public and their representatives regarding health and social care provision. The Regional Strategy, the Management Plan, together with the reports of the Director of Public Health and the Director of Social Services, provide the background for the Boards' Purchasing Prospectus.

6.24 The preparation of the Boards' Purchasing Prospectuses encompasses a number of interest groups, including GPs, voluntary groups, local providers, the Health and Social Services Councils and user groups. Once the document is drafted it is then circulated for comment and there follows a period of consultation before the Boards' finalised documents are produced. An examination of the four Boards' Purchasing Prospectuses, therefore, must involve a review of the content of the Purchasing Prospectuses and the processes used by each Board in producing the document. It is intended that this form of investigation will provide an insight into the ways in which the Boards assess need and make decisions on which services should be funded.

6.25 Generally, the four Boards acknowledge the complexity of the issues covered in their Prospectuses, the need to include different user groups in the consultation process and for health and social care services to be constantly reviewed to ensure standards are met and, where possible, raised. However, the Purchasing Prospectuses for 1997/98-1999/2000 by the WHSSB and the EHSSB do not contain an explicit statement of which groups were involved in preparing their documents, although the EHSSB does make a passing reference to the Board's

\textsuperscript{29} The Service and Financial Framework (SFF) since 1997-98.
General Practitioner Forum and the EHSSC in their commissioning process. Nevertheless, all the Boards also explicitly acknowledge in their Prospectuses (1997/98-1999/2000) increasing awareness of the need to base purchasing decisions on clinical effectiveness and outcome measurements.

6.26 The Economic Council also recognises the complexity of the issues covered by the Boards in this document and the need for it to encompass a wide readership which may not necessarily be well versed in the issues or the language used. The SHSSB, for example, has tried to ensure that its Prospectuses are accessible to a wide audience, with the inclusion of a Glossary of Terms. In the case of the WHSSB and the NHSSB, particular attention is paid to the language used. However, the EHSSB Prospectus over the same period also contains a Glossary of Terms but their document explicitly states that it "... is aimed at a semi-specialist audience ..." (EHSSB, 1996c, p.1). The EHSSB informed the Council that it "... will continue to try to make the Purchasing Prospectus more accessible to the population and, … will incorporate additional paragraphs to more clearly set out the various processes which the Board has gone through to arrive at the final pattern of resource allocation" (Letter from EHSSB, 8 July 1999).

6.27 Although more effort is being made by the Boards to include the views of the public in purchasing decisions, it is not clear what those views are, the extent to which this happens or when the views of the Health and Social Services Councils and the GP forum/GP commissioning groups are taken into account. It is also not clear the role GP Fundholders have had in assisting the Boards to set priorities, how needs are assessed, how and what priorities are set by the Boards in their Prospectuses (although the purchasing intentions are clearly outlined), what, if any, services are no longer provided by each Board and how such decisions were reached and which clinical effectiveness measures were used to set purchasing priorities. Finally, while the Boards may continually undertake extensive needs assessment analysis there is no
reference to individual working papers held by each of the Boards.

**Health and Social Services Boards: Purchasing Plans**

6.28 The Boards are required to draw up annual Purchasing Plans. The contents of the Plans vary greatly between the four Boards not only in specifying who has been consulted in the priority setting process but the tools and processes used and the targets to be achieved. In order to assess how the Boards have gone about setting priorities since the introduction of the purchaser/provider split a template (Box 4) is used to judge the content of each of the Board's Plans received. It is the Council's view that transparent plans which contain meaningful and explicit priorities will best be realised if some or all of the criteria in Box 4 are fulfilled.

**BOX 4**

**Main Criteria for an Effective Purchasing Plan**

**Needs Assessment** - The approach used in undertaking a needs assessment exercise of the Board's population and the findings.

**Transparency** - Information on the process(es) used in setting priorities and revealed preferences must be clear and explicit in the Board's Purchasing Plans.

**Involvement** - Detailed breakdown of groups consulted and the form this consultation took, for example, internal meetings must be outlined in the Plans.

**Ethical Issues** - The Board's Plans should explicitly state if ethical issues are considered in the decision making process, what they are and how they were examined, for example by Citizens' Jury.

**Cost-Effectiveness Techniques** - Statement as to whether cost-effectiveness techniques were used in setting priorities. If used, a detailed breakdown of
the analysis undertaken, any assumptions made and the results.

**Services Denied** - Explicit statement of any services withdrawn or restricted.

---

**Source:** NIEC

6.29 **Needs Assessment.** The Boards' needs assessment exercises - to assess the health of their population using epidemiological data, such as life expectancy - are the basis of the commissioning process and will ultimately influence the provision of health and social care services. Although needs assessment exercises are unlikely to be ever completely exhaustive they do provide the Boards with the necessary information to make informed purchasing decisions based on, for example, historical service trends, R&D work and perceived population need.

6.30 When analysing the Purchasing Prospectuses, the Purchasing Plans and the individual working papers supplied by the Boards to the Economic Council, it is clear that the Boards recognise that undertaking needs assessments is an essential part of discharging their responsibility for the provision of health and social care for their resident population. The main needs assessment documents, therefore, are the annual Boards' Director of Public Health reports and Boards' Director of Social Services reports together with specific Boards' needs assessment, such as mental health services (SHSSB, 1998). From the Director of Public Health reports received from three Boards and two Board Director of Social Services reports, it is evident that needs assessment exercises undertaken cover a range of health and social care services and, together with individual Board's working papers, present the approaches taken in a needs assessment exercise.

6.31 Although the four Boards did recognise the need to undertake a needs assessment exercise none of the Boards provided epidemiological data, an explicit statement on the techniques used to assess their populations in the plans or the tools and processes used in the decision
making process. Instead, specific Board's needs assessment reviews were presented in working papers to which the Plans made no reference. Clearly the plans fall short of a number of essential details if they are to fully inform the public.

6.32 Given the importance of this information and the purpose of the Purchasing Plan which is, in effect, to act as a summary document of the consultation and processes involved in setting priorities:

the Council recommends that the Purchasing Plans of each of the Health and Social Services Boards should contain a summary of how they conducted their needs assessment including reference to working papers of individual Board reviews, what the results of that assessment are, and how this assists in allocating resources.

For example, only the NHSSB devoted a section in its 1996-97 Purchasing Plan to outlining its population's profile and characteristics. However, it provided no epidemiological data or an explicit statement on the techniques used to assess its populations.

6.33 How Are Priorities Set? In setting priorities, the Boards, as well as taking into account new legislation, the Regional Strategy, the Management Plan, the annual Director of Public Health and the Director of Social Services Reports and public surveys, will also consider Locality Profiles for their area and needs assessment projects on, for example, coronary care (Letter to the Economic Council from the NHSSB, 30 November, 1998) and mental health services (SHSSB, 1998).

6.34 It is apparent that there is not an agreed level of detail which should be contained in the Purchasing Prospectuses and Purchasing Plans. For example, no information is provided concerning the tools used (Section 2 above) and the process employed by the Boards in developing
priorities. Although increasingly more information is being provided in the documents, there still tends to be no information on the criteria used to set priorities, who are consulted in the decision making process, if any cost-effectiveness techniques are used, what ethical issues are considered and which services, if any, are explicitly excluded from the Board's funding. However, the Boards are increasingly recognising the need to consult the public in setting priorities and the use of various techniques which lead to the purchase of services which are cost and clinically effective. For example, the EHSSB held discussions in September 1997 with Professor Dienel which led to the EHSSB, in collaboration with the EHSSC, establishing a Citizens' Jury in August 1998 to advise the Board on public participation in decision making and priority setting. The NHSSB "… commissioned pioneering focus work in the Province which enabled people to address choices between access and quality in the availability and configuration of acute care services" (Letter from NHSSB, 30 November 1998).

6.35 It is, however, important to highlight the difficulties the Boards encounter in achieving consensus over priorities set at the regional level. As discussed in para 6.2 above, the needs-based capitation formula results vary between areas and localities and GP Fundholders have their own priorities which may not necessarily be the same as the Boards. Moreover, "… priority setting within the health and personal social services is an extremely complex matter and subject to the influence of many external factors" (Letter from the NHSSB, 14 July 1999). The setting of priorities for the Boards often involves "… a tightly negotiated and consulted upon-process between Regional policy and guidance, practicalities of service provision as identified by Providers …" (Letter from EHSSB, 8 July 1999) as well as targets and objectives they identify.

6.36 Priorities: Real or Administrative. The priorities, when outlined in the Purchasing Plans, tend to be administrative, organisational and/or targets. This is not surprising when one considers that national and regional guidance on priorities is often expressed in general terms, not
service-specific. There is some consistency in the emphasis on the priorities set across the Boards, for example, health promotion, community care and acute hospital services. Again this would be expected given that the four Boards have to set priorities which take into account national priorities (NHS Management Executive together with ad hoc guidelines) in addition to regional priorities (Regional Strategy documents, HPSS Management Plans and additional ad hoc guidelines). There appears to be little explicit detail on how priorities are set. Therefore,

the Council recommends that public involvement in priority setting by the Health and Social Services Boards should be through the Health and Social Services Councils in agreement with other institutions, including the GP Forum/GP commissioning groups.

6.37 Presentation. The stated purpose of the Purchasing Plans is the same across the four HSSBs - to inform the public (namely, the residents of each Board) of the contracts made with providers in the provision of services and how the resources are to be allocated between competing interventions. Consensus over the purpose of the plans reflects the fact that there is central direction on the purpose of the purchasing plans but this guidance does not extend to the presentation and content of the Plans. For example, the EHSSB places importance on their Purchasing Plans being accessible to a wide audience: "... including public representatives, staff organisations, service providers and members of the general public" (EHSSB, 1996a, p.3).

6.38 The EHSSB Plans were generally aimed at a wider audience through, for example, the extensive use of pie charts. Only the SHSSB (1996) used similar diagrams in its 1996-97 Purchasing Plan but they were situated in the Appendix. The WHSSB (1994) in the introduction outlined its strategic tasks which included assessing the health and social needs of its resident population together with planning and management
of the purchase of services. In contrast, the EHSSB highlighted its willingness to become more: "... involved in decision-making with those who use, provide or affect policy on health and social services so that local priorities can be considered within the broad strategic context" (EHSSB 1996a, p.4).

6.39 It is also apparent there is no agreed standardised level of detail (volume of activity or contract value by speciality) to be included in the purchasing plans, or the format (by Programme of Care or speciality) they should take.

6.40 Klein and Redmayne (NAHAT, 1992a) suggest such differences in presentation of the Plans provide an insight into how the authors view their role. If we apply this idea to the four Boards available Plans we can infer that, for example, the EHSSB regards this type of document as important and that it places importance on its Plans being easily understood and available to the public and other interest groups. The information is also produced with clear section and sub-section headings, with detailed tables of volume of activity and planned expenditure information left to the Appendix.

6.41 The lack of national and regional guidance for the Boards in the content of the Purchasing Plans makes it very difficult for the public to make comparisons across the Boards or over time and limits any analysis which attempts to do so. Arguably the Purchasing Plan is a document that should make explicit purchasing decisions and the level of service provision.

6.42 Although it is not expected that the Boards’ plans are to be identical, it is expected, however, that such a document provides a certain level of information which allows comparison to be made between Boards and over time, and more specifically

the Council recommends that the Health and Social
Services Boards' Purchasing Plans outline the tools and process used in setting priorities within the overall Regional framework, what those priorities are and services provided by volume of activity and contract value by speciality, and
the Council recommends that the Health and Social Services Boards' Purchasing Plans should be accessible and understandable by the lay person.

6.43 Criteria Satisfied? How were the criteria in Box 4 fulfilled by the four Boards? When analysing the Boards' Purchasing Plans only two of the criteria were met to a degree - ethical issues and needs assessment. For example, the EHSSB together with the EHSSC were the first to hold a Citizens' Jury exercise in July 1998. Although public consultation was sought on a number of issues (Box 5), the EHSSC has stressed that the Citizens' Jury approach would not become a permanent characteristic of the work between these two bodies. Instead the process will only be

---

**BOX 5**

The Eastern Health and Social Services Board and the Eastern Health and Social Services Council Citizens' Jury

Questions considered:

- What do we want from our health and personal social services?
- What can be done to make them better?
- What are the advantages and disadvantages of a move to primary care groups, how can our concerns be met?
- Should the public be involved in making decisions about health and personal social services, to what extent, and if so, how?

*Source: EHSSB/EHSSC (1998)*
advocated for very important issues such as whether or not to provide IVF treatment under health and social care.

6.44 If this discussion is taken a stage further and the Boards' Purchasing Prospectuses are assessed against Box 4, again only two of the criteria are met to a degree - involvement and needs assessment. As previously discussed, only the NHSSB and the SHSSB Prospectuses contained an explicit statement as to who was consulted, although it is unclear what form this consultation took. In regard to the needs assessment criteria, the Purchasing Prospectuses do contain more needs assessment information than the Plans but no reference is made to Boards' individual needs assessment work.

Health and Social Services Boards: Allocation of Funds

6.45 In order to assess how the Boards have approached their new purchasing role, in particular, setting priorities, an evaluation is made of the Boards’ expenditure data to examine shifts in the distribution of resources between priority areas over time and to assess whether the movement of resources has been consistent with the broad sense of where resources should be moving. If one or more of the Boards show significant resource movements between areas of care this will indicate a change in priorities and, hence, of health care policy either at the Board level or Regional level. In sum, spending decisions reflect the revealed preference of the HSSBs.

6.46 In June 1997 the Economic Council wrote to each of the four Boards requesting financial information on the Boards' allocation of expenditure to health care services by Programme of Care headings and

30

Specific health or social care category for patients or clients, eg mental health, family and childcare (EHSSB Purchasing Prospectus 1997/1988 to 1999/2000, Glossary).
by speciality for 1992-1997 together with individual Board's Locality
Profiles\textsuperscript{31} and Purchasing Plans\textsuperscript{32} for the period and its latest Annual Reports. Each of the four Boards contacted replied to the Council’s letter although the responses and material supplied varied. In terms of financial information received, the EHSSB was the only one which did provide financial information broken down by speciality such as General Surgery, Urology and Dermatology. However, classification changes meant it was not possible to analyse this information over time. Taking all the information received it was only possible to undertake expenditure comparison across the Boards by Programme of Care and not by services or speciality headings.

6.47 Data Availability. It should be noted that, although the data provided by the Boards under Programme of Care headings are useful, they do not allow for a detailed comparison of expenditure patterns to be made from 1992 to the present, given definition changes. Nor is an assessment of the extent to which priority setting by the Boards reflects national policy, regional policy and national lead initiatives over the period in question possible. Given this apparent lack of comparable detailed information since 1992, the Council wrote to the DHSS requesting this expenditure information and also to each of the Boards inquiring whether detailed Board expenditure information below Programme of Care headings exists. No definite answer was forwarded by any of the four Boards to this question and only expenditure by

\textsuperscript{31} A Locality Profile “…. is a description of part of the area for which the Board is responsible in terms of the main Health and Social Care issues and the services which are in place at present or being developed to meet identified needs (EHSSB, 1996b, p.1).

\textsuperscript{32} The purpose of the Purchasing Plan issued by the Boards is to inform the public of the details of the finalised contracts made with providers and services to be provided for the next twelve months.
Programme of Care was supplied by the DHSS.

6.48 This lack of consistent data is an area which needs to be addressed by the Boards and the DHSS if effective resource allocation decisions are to be made, implemented and monitored. Thus,

the Council recommends that the Department of Health and Social Services and the Health and Social Services Boards should collect and publish financial data on a consistent disaggregated basis across Boards and over time with respect to health care services by, for example, Programme of Care headings and by speciality.

The DHSS and the HSSBs should also make it explicit whether or not they monitor shifts in the distribution of financial resources between departments and specialities. If they do not, they should explicitly state why and put forward any changes they feel are necessary to do so.

6.49 Analysis. The following analysis is based on documents provided by the Boards. These are: Purchasing Plans, Annual Reports, Purchasing Prospectuses\textsuperscript{33}, contracts with individual Trusts, Locality Profiles, together with financial information under Programme of Care headings. As already discussed, the amount of financial information and documents provided vary by Board and over time. This has two main implications for the analysis below:

• inability to compare funded priorities over time by purchasing

\textsuperscript{33}

The Purchasing Prospectus is issued as a draft document which outlines the Board’s proposed contracts and services over a three year period. This draft statement is used by the Boards as an opportunity for consultation with Trusts and other interest groups in order to review service provision before producing their Purchasing Plans.
programme, only by programme of care; and,

- inability to conduct an analysis by service areas, such as mental illness and acute care, over time.
In short, the Council was unable to obtain financial data on a consistent basis over time or across Boards from either the Boards themselves or the Department of Health and Social Services. Therefore, the Council recommends that the Health and Social Services Boards' Purchasing Plans should contain a summary of how data on need relate to service provision.

6.50 In our assessment of the Boards' priority intentions we undertook a two-stage analysis - first, the calculation of a dissimilarity index (DSI) to indicate the magnitude of the shift in priorities between programmes of care for three Boards and, second, an examination as to whether or not the movement of resources has been consistent with the broad sense of where resources should be moving to. For example, the change of emphasis in health care policy at a national level away from secondary care to primary and community care would be expected to be reflected in the way the Boards allocate their funds between programmes of care. In short, the change of national direction not only implies the shifting of services from acute to primary care but also resources.

6.51 The DSI is defined as half of the sum of the absolute percentage point difference for each programme's share of total public expenditure between two points in time. By dividing by two it averages gainers and losers. If there is no change in the distribution of resources across programmes the value of the index is 0. The index has a maximum value of 1, when, for example, all resources are shifted to a relatively unimportant programme between the two points.

6.52 Because of definition changes by the EHSSB, expenditure data from the WHSSB, the NHSSB and the SHSSB only were considered. Comparable years used for the analysis were from 1993-94 to 1995-96. Table 6.3 shows that the DSI over the period was 4.27 percentage points for the WHSSB, 2.92 percentage points for the NHSSB and 3.67
### TABLE 6.3

Share of the WHSSB, NHSSB and SHSSB Expenditure by Programme of Care, 1993-94 to 1995-96

<table>
<thead>
<tr>
<th>Programme of Care</th>
<th>% Share</th>
<th>Absolute Value of (A-B)/2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A 1993-94</td>
<td>B 1995-96</td>
</tr>
<tr>
<td><strong>WHSSB</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Services</td>
<td>35.67</td>
<td>35.24</td>
</tr>
<tr>
<td>Maternity &amp; Child Health</td>
<td>7.93</td>
<td>6.35</td>
</tr>
<tr>
<td>Family &amp; Child Care</td>
<td>5.65</td>
<td>5.97</td>
</tr>
<tr>
<td>Elderly Care</td>
<td>24.48</td>
<td>27.89</td>
</tr>
<tr>
<td>Mental Health</td>
<td>12.12</td>
<td>10.57</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>6.42</td>
<td>5.83</td>
</tr>
<tr>
<td>Physical &amp; Sensory Disability</td>
<td>2.20</td>
<td>2.65</td>
</tr>
<tr>
<td>Health Promotion &amp; Disease Prevention</td>
<td>2.11</td>
<td>2.18</td>
</tr>
<tr>
<td>Primary Health &amp; Adult Community</td>
<td>3.43</td>
<td>3.34</td>
</tr>
<tr>
<td><strong>Dissimilarity Index</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NHSSB</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>45.53</td>
<td>44.62</td>
</tr>
<tr>
<td>Maternity</td>
<td>7.03</td>
<td>5.79</td>
</tr>
<tr>
<td>Family &amp; Child Care</td>
<td>3.89</td>
<td>3.99</td>
</tr>
<tr>
<td>Elderly</td>
<td>20.83</td>
<td>22.75</td>
</tr>
<tr>
<td>Mental Health</td>
<td>8.09</td>
<td>8.33</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>6.10</td>
<td>6.04</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>2.13</td>
<td>2.31</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>1.72</td>
<td>2.20</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>4.67</td>
<td>3.97</td>
</tr>
<tr>
<td><strong>Dissimilarity Index</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 6.3 continued

**Share of the WHSSB, NHSSB and SHSSB Expenditure by Programme of Care, 1993-94 to 1995-96**

<table>
<thead>
<tr>
<th>Programme of Care</th>
<th>% Share</th>
<th>Absolute Value of (A-B)/2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>1993-94</td>
<td>1995-96</td>
</tr>
<tr>
<td><strong>SHSSB</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Services</td>
<td>42.21</td>
<td>40.14</td>
</tr>
<tr>
<td>Maternity and Child Health</td>
<td>8.54</td>
<td>7.27</td>
</tr>
<tr>
<td>Family &amp; Child Care</td>
<td>3.82</td>
<td>4.04</td>
</tr>
<tr>
<td>Elderly Care</td>
<td>24.15</td>
<td>25.15</td>
</tr>
<tr>
<td>Mental Health</td>
<td>7.61</td>
<td>8.47</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>8.72</td>
<td>8.41</td>
</tr>
<tr>
<td>Physical and Sensory Disability</td>
<td>2.19</td>
<td>3.08</td>
</tr>
<tr>
<td>Health Promotion and Disease Prevention</td>
<td>1.92</td>
<td>1.98</td>
</tr>
<tr>
<td>Primary Health and Adult Community</td>
<td>0.84</td>
<td>1.46</td>
</tr>
<tr>
<td><strong>Dissimilarity Index</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Based on data supplied by WHSSB, NHSSB and SHSSB*

percentage points for the SHSSB. Such low DSI numbers for the Boards suggest that there has been little change in priorities with the greatest, though relatively small shift of resources, to the Elderly of 1.71 percentage points, 0.96 percentage points and 0.5 percentage points, respectively across the three Boards.

6.53 Table 6.3 shows that the WHSSB and NHSSB have shifted
resources from acute to community care, health promotion and the elderly although there was a slight decrease in the proportion allocated to primary care. This could have been because of definition changes which resulted in the exclusion of services previously under this heading, or greater resource emphasis on certain services, such as, health promotion which is mainly undertaken in the primary care sector. In contrast, Table 6.3 indicates that the SHSSB has focused more of its resources on acute as opposed to community care. It is difficult to explain why this is so. The SHSSB figures may have been distorted over the period because of definition changes and by in-year 'ring fenced' allocations of money from the DHSS to address national/regional priorities which the Board cannot alter to reflect local priorities. Nevertheless, the WHSSB and NHSSB changes are in line with the general themes of the Regional Strategy document for Northern Ireland.

6.54 Finally, it should be noted that the financial information provided by the Boards excludes GP Fundholders as they purchase services directly from providers, the impact of earmarked funds and Programme of Care definition changes. Exclusion of fundholding data is important as the number of fundholding GPs and the proportion of the population cover in Northern Ireland has increased over time (Table 6.4). This, therefore, suggests that, in implementing the recommendations set out above, due regard needs to be taken of the institutional arrangement with respect to service provision by the Boards and any other purchasers.

Conclusion

6.55 The Economic Council recognises that setting priorities for the Boards within the HPSS is extremely complex and subject to many outside influences such as funding constraints, national priorities, regional priorities and targets. For example, 1999-2000 was regarded by the EHSSB as the first year in which it benefited from some degree of financial flexibility. Nevertheless, any monies available were "… earmarked to HSS Executive priorities" (Letter from EHSSB, 8 July
**TABLE 6.4**

Total Number of GP Fundholders in Northern Ireland and the Population Covered, 1994 and 1996
1999). Indeed, the very plethora of national and regional priorities not only complicates priority setting at the Board level but also clouds lines of responsibility and accountability\textsuperscript{34}.

6.56 Nevertheless, the Boards are increasingly recognising that resources are scarce and that they cannot meet all the needs of their population. They are, therefore, placing increasing importance on developing their information systems, on the need to purchase services that are cost-effective and on increasing co-operation with other bodies. Although such priorities do not necessarily involve an injection of funds, they do suggest that the Boards are becoming more aware of the need to use other approaches to improving services for their populations rather than basing decisions on historical trends.

\textsuperscript{34} It is not clear that the proposed new structures, outlined in Section 7 below, will do anything to change this situation.
6.57 From the Boards’ Purchasing Plans and other documents forwarded to the Council it is clear that more information has increasingly been provided in the documents. There is, however, still no explicit information on the criteria used by each of the Boards in setting priorities, who is consulted in the decision making process and which services, if any, are explicitly excluded from the Board’s annual funding allocations. This suggests that there is still a lack of willingness by the Boards to consult the public in their priority setting process, on the ‘tools’ used (Section 2 above) in the decision making process and on how priorities are set. Clearly there is a need for greater information on the process of setting priorities, greater involvement of the public, standardisation of the information presented across the Boards and over time and more accessible presentation of the processes employed. Furthermore, from the discussion above, it is unclear how priorities are set and if or what model of priority setting is used. Whatever model is used should be referenced. All the case studies discussed in Section 3 above had a clearly defined and explicit approach as to how they allocated resources in health care. This transparency is lacking in the model of the DHSS.

6.58 The discussion and quantitative evidence suggests that there are a number of areas where greater attention should be paid at a national, regional and local level to setting priorities. The Council, therefore, puts forward in Section 3 what it considers are necessary criteria for successful priority setting in general. They are reproduced in Box 6 but in a Northern Ireland setting.

6.59 At present it is not possible to say which of the criteria in Box 6 are actually used by the four Boards in their priority setting process. It is difficult to say whether the funding intentions of the Boards (ie. services outlined in their purchasing plans and other documents) match actual funded priorities as the financial information is recorded under Programme of Care headings. Finally, the experience of the four HSSBs in Northern Ireland is similar to Health Authorities in England. The
BOX 6
Criteria for Priority Setting in Northern Ireland

Flexibility - The freedom to make purchasing decisions within a Regional framework, for example, the Regional Strategy document which recognises that a treatment which is ineffective for one patient may offer benefits to others;

Involvement - Consultation with government, the boards, health professionals and the public must be undertaken. This can take a number of forms, including internal meetings, attitude and telephone surveys, Citizens’ Juries and public meetings;

National Agreed Framework - The need for the DHSS to set out a regional framework through which decisions made are more transparent and systematic, reflecting national and regional policy;

Transparency - The process of setting priorities by the Boards is explicit and transparent in their Purchasing Plans;

Accountability - The Health and Social Services Councils to review Boards’ decisions on service provision, or legislation in place which would make the Boards more accountable for their decisions;

Ethical Framework - Ethical issues need to be considered and assessed, for example, through the Citizens’ Jury and outlined in the Board’s Purchasing Plans;

Cost-Effectiveness Techniques - Using cost-effectiveness techniques priorities will be set between interventions which offer the best value for money;

Clinical Effectiveness - The collection and dissemination of information in a systematic way on interventions of proven clinical effectiveness and held at one or more central locations, such as the DHSS Headquarters.
Government Policy in Northern Ireland: The Purchasing Decision - Boards

Source: NIEC
intentions of the Boards contained in their annual Purchasing Plans, endorsed by the Minister responsible for health and social care in the Accountability Reviews, suggest a lack of political will to make explicit decisions about setting priorities both at a regional and national level.
Introduction

7.1 In April 1998 the DHSS (1998a) released a consultation document, *Fit for the Future*, on the government's proposals for the future of health care in Northern Ireland. These were subsequently affirmed and elaborated (DHSS, 1999a). However, a final decision will wait until the new Minister for the Department of Health, Social Services and Public Safety (DHSSPS) is appointed and the Assembly has reviewed these proposals. Even if the proposals are accepted it is envisaged that implementation will take three to four years.

7.2 Like the White Paper for England, released in December 1997, *Fit for the Future* has important implications for priority setting. These implications occur on at least three levels: the collection and dissemination of information and data on clinical and cost-effectiveness; the involvement of the public in decision-making; and, the proposed reorganisation of the institutional structure of health care delivery. We consider each in turn. It should be noted that both the White Paper for England and the Northern Ireland consultation document have little or nothing to say about priorities. However, in the follow-up paper DHSS (1999a) did comment that the new HPSS "must move forward with a clear common purpose and shared priorities" (p.9) which, it appears, will be developed in conjunction with new Ministers and the Assembly. The Council trusts this report will assist them in this endeavour.

Ensuring Quality

7.3 One of the seven key principles on which the new HPSS will be built is that of Quality - "Quality of care must be the driving force for decision-making". (DHSS, 1998a, p.6). The consultation document outlines the steps that are being taken in England to ensure quality care is delivered. These steps include the National Institute for Clinical Excellence, and the Commission for Health Improvement, which are
described, albeit briefly, in para 4.18 above. In view of the importance of ensuring quality, the Council is disappointed that on such a vital issue *Fit for the Future* merely comments, 

"[T]he DHSS will consider how these or similar measures can best be applied to the HPSS" (DHSS, 1998a, p.18). The discussion is not taken any further in the subsequent paper on the way forward (DHSS, 1999a).

7.4 The proposed new structures of the health and social care system for Northern Ireland follow closely where possible those of the rest of the UK. Furthermore the motivation for change is the same, reflecting the new government’s desire for a system based on co-operation and partnership, not competition. Thus it would seem sensible that Northern Ireland tap into the new institutions being created in England for health care. Much of these new developments relate to gathering of information. There seems little point in Northern Ireland duplicating such efforts. Thus,

the Council recommends that every attempt should be made by the Health and Personal Social Services to focus on delivering quality care and to be specific regarding the promotion of ‘quality’ in their documents.

Since the NHS has issued further guidance on the topic of quality in June 1998, there seems little reason for further delay (Department of Health, 1998). One step in the right direction in Northern Ireland is the establishment of the R&D office for research into health and well being which will help to assist, for example, the use of evidence based medicine in partnership with other health partners (HPSS, 1999).

**Public Involvement**

7.5 One of the themes to emerge from the international experience on priority setting (Section 3 above) is the importance of involving the public in the process. Two out of the seven principles of the new HPSS
are relevant to the issue of public involvement. These are:

- **A local focus** - The new HPSS must be shaped by family doctors, nurses, therapists, social workers and other primary care professionals who know what patients and clients need.

- **Openness and accountability** - The new HPSS must be open and accountable to patients and clients, and must be shaped by their views.

These two principles see the HPSS shaped not only by medical and related professionals but also patients and the public more generally. The Council strongly endorses the involvement of patients and the public in the design and planning of the HPSS. Rising educational standards and increasing interest in health care matters have meant that the patient is increasingly becoming an informed consumer capable of asking searching questions and expressing views on the future of the health care system. The latter may not always accord with the views of physicians. The evidence suggests that the public, for example, has different preferences and priorities from doctors, an issue discussed in the Council’s examination of the economic issues in health care reform (NIEC, 1994, pp.43-45).

7.6 In order to ensure that patients and the wider public play their full part in the design and planning of the HPSS, the Council takes the view that the principle, ‘A local focus’, should explicitly refer to patients/the wider public. Thus, the Council recommends that the new Health and Personal Social Services principle, ‘A local focus’, should be rephrased as follows: The new Health and Personal Social Services must be shaped by family doctors, nurses, therapists, social workers, other primary care professionals, patients and the wider public.
If such a change is not made then there is a danger that health and social care will be driven not by what patients perceive their needs to be but rather by the health care professionals. Furthermore, this change is needed to ensure that ‘A local focus’ is consistent with ‘Openness and accountability’, in which emphasis is placed on the role of patients in shaping the new HPSS.

7.7 One way in which the public could become involved in shaping the health care system - an issue raised in *Fit for the Future* (DHSS, 1998a, p.42) - would be through setting priorities. In other words, how should the scarce resources that the health and social care system commands be allocated across treatments and facilities? Would the public agree, for example, with the 36 per cent of doctors who, in an interview survey, declined to give a patient a drug treatment because it was too expensive (Bouquet, 1998, p.43).

**New Structures**

7.8 The proposed new structures for the health system in Northern Ireland (Figure 7A) would see the creation of five Health and Social Care Partnerships (HSCP) under the control of primary care professionals “to assess health and social care needs and to plan and secure the delivery of services to meet these needs” (DHSS, 1999a, p.16). Membership of a HSCP would be from representatives of the 17 to 33 Primary Care Co-operatives which would have responsibility for commissioning most of the health and social services for the population (p.17). This proposed structure of the health care system with respect to purchasing raises the possibility of different priorities being set, albeit implicitly, by the medical profession across the various Primary Care Co-operatives. Differences in provision would rapidly become the subject of debate and discussion, perhaps even controversy. As a result it becomes imperative that an agreed procedure for setting priorities is reached. Thus,
Recent Policy Developments in Northern Ireland

FIGURE 7A

Proposed HPSS Structure

DHSSPS: Department of Health, Social Services and Public Safety
PCC: Primary Care Co-operatives

Source: DHSS (1999a, Appendix 3)
the Council recommends that procedures for priority setting are agreed between the Health and Personal Social Services, the proposed single Health and Social Services Council, the proposed Health and Social Care Partnerships and the proposed Primary Care Co-operatives and that a uniform structure is put in place for the collection and dissemination of information.

This should ensure that decisions taken with respect to priorities are clear, consistent, transparent and agreed by both the patient and the health care professionals. Thus, the decisions will have democratic legitimacy, particularly since the HPSS is, taken together with new Ministers and the Assembly, to "produce a new, more sharply focused strategy" (DHSS, 1999a, p.9) that would set out "the main priorities and objectives for HPSS".
8 CONCLUSIONS AND RECOMMENDATIONS

Introduction

8.1 Health care systems around the world are faced with rising health care costs against a background of seemingly infinite demand. It is unlikely that this situation will change. The NHS/HPSS, like other health care systems, have just managed to cope but the increased pressure on resources is unmistakable. If Northern Ireland is to learn from international experience then at least two fundamental questions need to be addressed before setting out on the process, ie:

- what is the main purpose of setting priorities - eg to develop a core list of services and/or guidelines;
- who should be included in the decision making process?

The international approach to setting priorities has been varied (Section 3 above) but the experience of Oregon, New Zealand, Sweden and the Netherlands demonstrates that setting priorities at a regional level, via the DHSS, is a realistic approach to take in Northern Ireland. Developing a local model, however, should be seen as an ongoing process which is part of a larger exercise in considering the way forward in health care.

8.2 Although the Council has put forward a number of recommendations it is clear that a lot more work is needed to turn priority setting into reality. The need to set priorities and the benefits from doing so have been the theme of this report. This is consistent with recommendations made by the House of Commons Health Committee (1995) and the Academy of Medical Royal Colleges et al (1997). The Council believes that there is considerable benefit to be had from a region-wide exercise in priority setting.

8.3 The structure of the delivery of health care in Northern Ireland is about to undergo substantial change. The four Boards are to be replaced by five Health and Social Care Partnerships, the four Health and Social
Conclusions and Recommendations

Services Councils by a single Council, while GP Fundholding will be abolished and all physicians will become part of Primary Care Cooperatives. This whole structure will be overseen by a Minister and the Assembly. This change, plus decisions by the Assembly concerning resources, provides an excellent opportunity for a fresh look at priorities in the local health care system.

8.4 Although many of the Council’s recommendations apply to the existing structure they can easily be modified in view of the proposed changes.

Recommendations

8.5 In the course of this report the Council has made the following recommendations:

Better Guidance

• that Health and Personal Social Services furnish guidance at a regional level which will provide a firm sense of direction for priority setting in health care, how this might take place, what tasks should be included and who should be involved (para 5.24);

• that greater guidance and co-operation are needed from the Health and Personal Social Services in association with the Health and Social Services Boards if the Health and Social Services Councils are to become more actively involved in setting priorities (para 6.21);

• that procedures for priority setting are agreed between the Health and Personal Social Services, the proposed single Health and Social Services Council, the proposed Health and Social Care Partnerships and the proposed Primary Care Co-operatives and that a uniform structure is put in place for the collection and
Conclusions and Recommendations

Dissemination of information (para 7.8);

Greater Public Involvement

- that public involvement in priority setting by the Health and Social Services Boards should be through the Health and Social Services Councils in agreement with other institutions including the GP Forum/GP commissioning groups (para 6.36);

- that the new Health and Personal Social Services principle, 'A local focus', should be rephrased as follows:

  The new Health and Personal Social Services must be shaped by family doctors, nurses, therapists, social workers, other primary care professionals, patients and the wider public (para 7.6);

Setting Out the Mechanics

- that the Purchasing Plans of each of the Health and Social Services Boards should contain a summary of how they conducted their needs assessment including reference to working papers of individual Board reviews, what the results of that assessment are, and how this assists in allocating resources (para 6.32);

- that the Health and Social Services Boards' Purchasing Plans outline the tools and process used in setting priorities within the overall Regional framework, what those priorities are and services provided by volume of activity and contract value by speciality (para 6.42);

- that the Health and Social Services Boards' Purchasing Plans
Conclusions and Recommendations

should contain a summary of how data on need relate to service provision (para 6.49);

**Improved Public Accessibility**

- that the Health and Social Services Boards' Purchasing Plans should be accessible and understandable by the lay person (para 6.42);

**Transparency: Monitoring Decisions**

- that the Department of Health and Social Services and the Health and Social Services Boards should collect and publish financial data on a consistent disaggregated basis across Boards and over time with respect to health care services by, for example, Programme of Care headings and by speciality (para 6.48);

**Ensuring Higher Quality**

- that every attempt should be made by the Health and Personal Social Services to focus on delivering quality care and to be specific regarding the promotion of 'quality' in their documents (para 7.4);

8.6 Due to the lack of published research and evaluation the conclusions and recommendations made in this report are largely based on commissioning documentation produced at the regional and Board level. While the NHSSB argues that the Economic Council's approach "…provides a narrow focus for assessing the priority setting debate and does not give due weight to the continuous ongoing work that is undertaken at Board level" (Letter from NHSSB, 14 July 1998), it is the Council's expectation that this report will act as a catalyst to facilitating and broadening the discussion on how priorities are set within health and social care.
8.7 The recommendations made in this report are not intended to lessen the valuable work which the DHSS and the HSSBs undertake in meeting the needs of the population of Northern Ireland. Instead the recommendations should be regarded as a positive step forward in the debate surrounding priority setting so that transparent priorities will be set to ensure equity and efficiency in the local health care system. The purpose of the Council’s report, therefore, is to advance the discussion as to how the public can be better involved in the priority setting process.

8.8 With the event of a devolved legislature in Northern Ireland, the establishment of a new Assembly and an Executive Committee, local politicians will have to face difficult challenges. Not least will be prioritising areas of the economy for funding out of the allocated regional funds for Northern Ireland. Within those areas hard choices in funding will have to be made. Health could be the first such area to be tackled. *Fit for the Future*, while not addressing the issue of priorities, says one of its aims is to identify key health care issues to be resolved. A priority setting exercise is one way of identifying and resolving some of these issues.
REFERENCES


References


References


References


Milne, R. and Hicks, N. (1996) "Evidence Based Purchasing". Evidence Based Medicine, Vol 1, pp.101-104.


References


References


References


ACKNOWLEDGEMENTS

The Council would like to thank a number of people and organisations who provided information and comment in the preparation of this report, as noted in the Chairman’s Foreword. However, the views expressed are those of the Council.
<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>115</td>
<td>Annual Sir Charles Carter Lecture &quot;Competitive Dynamics and Industrial Modernisation Programmes: Lessons from Japan and America&quot; by Michael H Best, Centre for Industrial Competitiveness, University of Massachusetts, Lowell (September 1995)</td>
</tr>
<tr>
<td>118</td>
<td>The 1995 UK Budget: Background and Implications for Northern Ireland (February 1996)</td>
</tr>
<tr>
<td>120</td>
<td>Annual Sir Charles Carter Lecture &quot;Reforming Education in the United Kingdom: The Vital Priorities&quot; by Sir Claus Moser KCB CBE FBA, The British Museum Development Trust (January 1997)</td>
</tr>
<tr>
<td>121</td>
<td>Rising to the Challenge: The Future of Tourism in Northern Ireland (February 1997)</td>
</tr>
<tr>
<td>122</td>
<td>The 1996 UK Budget: Implications for Northern Ireland (March 1997)</td>
</tr>
<tr>
<td>123</td>
<td>Industrial Policy Assessment and Performance Measurement - The Case of the IDB (April 1997)</td>
</tr>
<tr>
<td>124</td>
<td>Annual Report 1996-97 (October 1997)</td>
</tr>
<tr>
<td>125</td>
<td>The 1997 UK Budget: Implications for Northern Ireland (November 1997)</td>
</tr>
<tr>
<td>126</td>
<td>Annual Sir Charles Carter Lecture &quot;Setting Priorities for Health Care: Why Government Should Take the Lead&quot; by Chris Ham, Professor of Health Policy and Management and Director, Health Services Management Centre, University of Birmingham (January 1998)</td>
</tr>
</tbody>
</table>
129 Annual Sir Charles Carter Lecture "Social Exclusion, Income Dynamics and Public Policy" by Professor John Hills, Director, Centre for Analysis of Social Exclusion, London School of Economics and Political Science (April 1999)

130 Let's Get Together. Linkages and Inward Investment in Northern Ireland (June 1999)


133 Publicly Funded R&D and Economic Development in Northern Ireland (December 1999)

Occasional Paper Series

1 Reforming the Educational System in Northern Ireland. A Comment on 'Learning for Life' and Recent Developments in the Education System (January 1995)

2 Demographic Trends in Northern Ireland: Key Findings and Policy Implications (March 1995)

3 "Through Peace to Prosperity". Proceedings of the Peace Seminar hosted by the Economic Council (April 1995)

4 The Economic Implications of Peace and Political Stability for Northern Ireland (June 1995)


"Decentralised Government and Economic Performance in Northern Ireland". Proceedings of the Seminar sponsored by the Northern Ireland Economic Council in association with the University of Ulster on 19 June 1996 at the University of Ulster at Jordanstown (December 1996)

Towards Resolving Long-Term Unemployment in Northern Ireland. A Response to the Long-Term Unemployment Consultation Document (June 1997)

The Impact of a National Minimum Wage on the Northern Ireland Economy. A Response to the Low Pay Commission (February 1998)


Growth with Development. A Response to New TSN (December 1998)

A Step-Change in Economic Performance? A Response to Strategy 2010 (September 1999)

Research Monograph Series

1 Demographic Review Northern Ireland 1995 by Paul Compton (March 1995)

2 The Arts and the Northern Ireland Economy by John Myerscough with A Statement by the Economic Council (January 1996)

3 Successful European Regions: Northern Ireland Learning From Others by Michael Dunford and Ray Hudson with A Statement by the Economic Council (November 1996)

4 Educational Achievement in Northern Ireland: Patterns and Prospects by Tony Gallagher, Ian Shuttleworth and Colette Gray with a Statement by the Economic Council (December 1997)

5 Competitiveness and Industrial Policy in Northern Ireland by John H Dunning, Edward Bannerman and Sarianna M Lundan with A Statement by the Economic Council (March 1998)
6 Regional Economic and Policy Impacts of EMU: The Case of Northern Ireland, edited by John Bradley with A Statement by the Economic Council (April 1998)

7 Improving Schools in Northern Ireland by Tony Gallagher, Ian Shuttleworth and Colette Gray with A Statement by the Economic Council (August 1998)

Advice and Comment Series

98/1 A Response by the Northern Ireland Economic Council to: Northern Ireland Science Park (Department of Economic Development) September 1998 (3 pages)

98/2 A Response by the Northern Ireland Economic Council to: Fit for the Future (Department of Health and Social Services) September 1998 (13 pages)

98/3 A Response by the Northern Ireland Economic Council to: Structural Funds Plan 2000-2006 (Department of Finance and Personnel) October 1998 (2 pages)

98/4 A Response by the Northern Ireland Economic Council to: Housing Selection Scheme Review: Proposals for Consultation (Northern Ireland Housing Executive) October 1998 (12 pages)

99/1 A Response by the Northern Ireland Economic Council to: Water and Sewerage Services in Northern Ireland: A Consultation Paper (Department of the Environment for Northern Ireland) February 1999 (11 pages)

99/2 A Response by the Northern Ireland Economic Council to: Shaping Our Future. Towards a Strategy for the Development of the Region (Department of the Environment for Northern Ireland) April 1999 (16 pages)

99/3 A Response by the Northern Ireland Economic Council to: Vision 2010 - Energy Action Plan (Department of Economic Development) November 1999 (15 pages)
A Response by the Northern Ireland Economic Council to:
A Consultation Paper on Research Funding Allocation Method to be Applied to the Northern Ireland Universities (Northern Ireland Higher Education Council) January 2000 (30 pages)

A Response by the Northern Ireland Economic Council to:
WHY SET PRIORITIES IN HEALTH AND SOCIAL CARE IN NORTHERN IRELAND?

"... in many respects the NHS continues to provide good value for money but the combination of increasing demands and constrained resources is making it difficult to sustain the commitment to offer comprehensive health care to the whole population. The withdrawal of the NHS from aspects of long term care and dentistry, coupled with lengthening waiting lists and waiting times, are tangible examples of the pressures under which the NHS is operating today. Add to this the challenges posed by advances in health care technology, and the need for government to take a lead in the priority setting debate becomes more overwhelming." (Chris Ham, Setting Priorities for Health Care: Why Government Should Take the Lead, January 1998, p.30)

"Muddling through is the British way. While some countries may tackle a problem like the rationing of health care head on - admitting the problem at the highest level, analysing it, declaring their values, and beginning work on a just, transparent solution - the British deny the problem and nibble at its edges. Surely we can do better." (Richard Smith, "Stumbling into Rationing", British Medical Journal, 9 October 1999, p.936)

"A balance must be struck between setting meaningful priorities and creating 'wish lists'. We urge greater clarity in deciding which items are of crucial importance - these are priorities. All others, whether they are urgent or simply desirable, are not 'priorities' but simply initiatives. A reduction in the total number of priorities and initiatives is, in our view, still needed." (House of Commons Health Committee, Priority Setting in the NHS: Purchasing, Session 1994-95, First Report, p.xvii)

"The Working Party is committed to the idea that priority setting may only be seen as a valid and ethical activity if all parties, purchasers, providers, the public and the government accept the gap between the availability of resources and the requirements of health services. The need to make choices in health care should now be made explicit. Recognition should be given to the fact that it is neither possible, or reasonable, for all the possible demands on health care to be met." (Academy of Medical Royal Colleges et al, Priority Setting in the NHS: A Discussion Document, 1997, p.23)