The working group on primary care gratefully acknowledges the assistance of the many individuals and groups who helped in the preparation of this strategy. We appreciate and recognise the time and energy invested by many people in this whole process.
Those who made written submissions based on the draft strategy are acknowledged individually in Appendix III. However, we also wish to thank those who contributed to the consultation process in many other ways.
Finally, we wish to thank again all those who contributed to the production of the draft strategy for primary care through written submissions or by other means.

Contents 1

Strategic planning is sometimes seen as a distraction from the important "day to day" tasks. This is probably even more true in relation to the planning of our health services where the "day to day" work is very important indeed. However, there is a need to stand back periodically and take stock of what it is that we are trying to do and how we are doing it.

This strategy looks at the very complex area of primary health care. It was produced as a result of the most comprehensive consultation process ever undertaken within this board in the preparation of a regional strategy. Through this process, a great number of people from across the region, in many varied capacities, were facilitated in taking stock of what it is exactly that we are doing and how we are doing it. These contributions are evident in the strategy and add to its strength.

The very important roles played by all those involved in the provision of primary care services in the board's area are recognised in this document. So too is the need for excellent linkages and communication between the hospital sector and those providing services in the community setting. Most importantly however, is the clear recognition in this strategy of the need for partnership

between all providers of care if we are to achieve a truly integrated health service in this region. This is the challenge presented to us in this document.

Dr. Sheelah Ryan,
Chief Executive Officer.

A&E Accident and Emergency Department
CME Continuing Medical Education
CPD Continuing Professional Development
CPN Community Psychiatric Nurse
CSO Central Statistics Office
CT (scan) Computerised Tomography
DOHC Department of Health and Children
EEG Electroencephalogram
EHO Environmental Health Officer
GMC General Medical Council
GP General Practitioner
HC Health Centre
ICGP Irish College of General Practitioners
ICT Information Communication Technology
IT Information Technology
MPRH Merlin Park Regional Hospital
NHS National Health Service
NUI,Galway National University of Ireland, Galway
PCT Primary Care Team
PHC Primary Health Care
PHN Public Health Nurse
QA Quality Assurance
QC Quality Control
R&D Research and Development
SAHRU Small Area Health Research Unit
UCHG University College Hospital Galway
WHB Western Health Board
WHO World Health Organisation

Region
The use of the term ÔregionÕ and the adjective ÔregionalÕ throughout this document in all cases refers to the administrative region defined in terms of counties Galway, Mayo and Roscommon.

Telemedicine/ Telehealth
Telemedicine is the application of modern telecommunications technology to medicine. Examples include videoconsulting and teleradiology. (The combining form tele- meaning at or over a distance).

Introduction
This strategy is the culmination of the efforts of the working group on primary care for more than eighteen months. It was arrived at through the most extensive consultation process undertaken by the board to date in the preparation of a regional strategy. It represents an important first step in a continuous process that will assist and direct the primary care services in this region over the next 5-10 years.

Primary Care - A Definition.
Primary health care was defined by the World Health Organisation (WHO) at its 30th annual meeting in 1977 as:
Ò...the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.Ó (WHO 1979)
Primary Care can also be defined in terms of who provides it. Based on the definition outlined above, it is clear that Primary Care is provided by a broad range of individuals and groups which includes employees of the Western Health Board, self-employed practitioners and the Voluntary sector.
The development of this strategy reflects the growing recognition of the importance of the primary health care sector and those working within that sector in achieving the mission of the health services. It also reflects the desire to create an integrated service which is responsive to the health needs of the people it serves. It is based on 4 underlying principles: Focus on good health, Partnership, Quality & Equity.

Structure of Services
Debate continues over the most appropriate organisational structure to employ in the delivery of primary care services. These services are currently provided by a range of personnel (both WHB and non-WHB) in some cases working closely together out of the same premises. However, this is not always the case. The physical and organisational structures through which the primary care services are provided should facilitate close working relationships between providers and effective integration with the other elements of the health services. The physical structures from which services are delivered should be suitably dispersed and appropriately equipped to meet the primary care needs of the region.

Recommendations

R3.1 A primary care department should be established with responsibility for the planning, co-ordination and delivery of all primary care services.
R3.2 The General Practice Unit should remain a separate entity and retain its identity and funding within the primary care department. Other professional disciplines will also be represented in the primary care department.
R3.3 The Western Health BoardÕs area should be divided into 10 to 15 primary care population catchment areas, to be known as primary care areas.
R3.4 The overriding criterion in determining primary care area boundaries should be health need.
R3.5 Resource allocation decisions and service planning should be based on the health needs of the primary care area.
R3.6 A complete inventory of health centres should be prepared in conjunction with the Technical Services Office of the Western Health Board.
R3.7 The development of privately owned premises, which are used in the delivery of primary health care, should continue to receive encouragement and support from the Western Health Board.
R3.8 Principal primary care centres should be designated and developed throughout the region.
R3.9 General practitioners should be supported in operating their practices from these centres.
R3.10 Primary care teams should be introduced initially on a pilot basis.
R3.11 The pilot projects should be evaluated after 12 months using input from team members and service users.
R3.12 Service planning in the GP Unit should involve broad consultation with statutory and voluntary service providers and users.

Communication and Linkages

Using the simplest of models the strategy identifies 3 key communication relationships, namely;

Patient ~ Primary Care Provider

Primary Care Provider ~ Primary Care Provider

Primary Care Provider ~ Other Health Services

Each relationship faces a number of challenges including geographical isolation, the existence of two primary languages, the complexity of the structures through which services are provided and the number of personnel involved. However, it is also acknowledged that advances in training and technology have put us in a better position to deal with these challenges than ever before.
The issue of quality is also addressed in this context. While communication systems, which would appear to be effective and adequate exist, the reality is that the quality or the way in which these systems are applied is often a cause of some concern. It is therefore not sufficient to just recommend new systems without also putting in place a mechanism by which the quality of communication can be monitored and measured.

Recommendations

R4.1 Members of the public should have access to sufficient information so that they can make rational decisions about their health.
R4.2 Primary care service users and providers should be supplied with information regarding the range and availability of primary health care services.
R4.3 The communication needs of people whose first language is Irish should be recognised.
R4.4 Primary care providers should be encouraged and supported in their efforts to meet the individual communication needs of service users.
R4.5 A customer services department should be established for the Western Health Board.
R4.6 Linkages should be developed between the disciplines in the primary care team .
R4.7 In so far as possible all geographically based primary care services should be co-terminous.
R4.8 Agreed systems and protocols should be established to allow for the transfer of relevant patient information among primary care providers while protecting the right to privacy of the patient.
R.4.9 A complete review of formal communication systems and linkages between primary, secondary and tertiary care should be undertaken.
R4.10 Appropriate discharge planning should be promoted at each hospital in the BoardÕs area.
R4.11 Shared, quality care protocols for specific chronic illnesses (e.g. asthma, diabetes) should be developed.
R4.12 Hospital based radiology investigations should be available to all patients on direct referral by general practitioners subject to agreed protocols.
R4.13 Selected invasive investigations should be available to all patients on direct referral by general practitioners subject to agreed protocols.
R4.14 Outreach specialist clinics to principal primary care centres should be promoted.

R4.15 The specific skills of general practitioners should be available to the secondary care sector.
R4.16 Each hospital department should have a direct telephone and fax line and these numbers should be notified to each primary care practitioner.
R4.17 Telemedicine facilities should be expanded.
R4.18 A regional Information Communication Technology (ICT) steering committee should be established.
R4.19 All principal primary care centres and GP training practices should be computerised.
R4.20 The computerisation of patient files should be encouraged and supported.
R4.21 The potential of ÒSmart CardsÓ as a means of information transfer should be investigated.

Range of Services

The range of services provided in the primary care sector include prevention and treatment of specific medical conditions as well as a range of activities and supports which increase health and social gain.
The Western Health Board aims to provide a range of primary care services which is both appropriate and adequate relative to the needs of the population it serves. In considering the needs of service users it is important also to bear in mind the needs of primary care providers.

Recommendations

R.5.1 Provision of primary health care services should be examined and developed in a planned way to meet the needs of the population.
R.5.2 The availability of a range of out-of-hours primary care services should be reviewed.
R.5.3 The specific primary care needs of the rural population should be addressed.
R.5.4 Proactive measures should be taken and incentives provided to improve rural recruitment and retention of primary health care personnel.
R.5.5 Each person in the BoardÕs area should have access to an appropriately equipped and staffed ambulance service, which can safely treat and transport seriously ill patients to the closest specialist centre within internationally agreed guidelines.
R.5.6 Systems should be put in place, which encourage treatment of the patient in the most appropriate setting through inter-referral between practitioners.
R.5.7 There should be a review of the services especially procedures and clinics currently being provided by the hospital sector, that would be more appropriately provided in a primary care setting.
R.5.8 The Western Health Board should continue to promote the development of group practice, extended rotas, GP Co-operatives and other joint working arrangements.

Education Research and Development

Education

While the importance of education has been recognised in the past, specific resources allocated to it were often inadequate. This strategy examines training and education needs of primary care providers at all levels. Education regarding the reality and potential of primary care is especially important for those who have never, or will never, work within the primary care environment.

Research and development

The pursuit of research and development is not a goal in itself. The pay back from research and development includes improved quality of patient care. It is important that these benefits are realised.
Irish R&D has not been strongly supported in general and Primary Care in particular has been under resourced.

Recommendations

R6.1 Specific criteria for the prioritisation of educational requests should be developed.
R6.2 A proportion of the nursing undergraduate curriculum should be taught within the primary care setting.
R6.3 A formal needs based postgraduate nursing education programme appropriate to primary care should be established.
R6.4 There should be a greater proportion of the medical undergraduate curriculum taught within primary care.
R6.5 The establishment of combined medical undergraduate and postgraduate teaching practices with appropriate resources should be developed within the community.
R6.6 The present three-year scheme of general practitioner training should be extended to five years.
R6.7 Postgraduate courses in primary care should be established and driven by primary care needs.
R6.8 A co-ordinated approach to R&D in primary care should be adopted by statutory health and educational bodies at a regional and national level.
R6.9 A primary care research network should be established in the region.
R6.10 A proportion of the BoardÕs budget should be ring-fenced for education and research & development.

While much can be achieved at local and regional levels in terms of developing primary care services, it is important to recognise that some issues have wider implications. This means that they must be dealt with at a national level.

The information contained in this strategy will be relevant to a large audience of both health service users and providers. In preparing it we have attempted to present this information to you in a way that is readily accessible. It is intended that this page will give you a little background information, which will help set the scene for the strategy and also give you an idea of how the document is laid out.

Figure I. Primary Care Structure

¥ Figure I contains a useful diagram to bear in mind while reading this strategy. It is an attempt to visually translate the myriad components of the existing primary care services and as such is imperfect. The strategy contains recommendations, which will fundamentally change the way in which services are delivered. In order to be able to see and understand these changes, it is essential to first have an understanding of the current model of service provision. You may wish to refer back to this model during your reading of the strategy.

¥ The strategy itself is divided into 8 sections. In sections 3-6 inclusive, groups of issues are discussed and the recommendations relating to these issues listed at the end of the section. While the recommendations are important, so too is the rationale that supports them.

¥ You may need further information on this strategy. If so please contact the Project Co-ordinator for the development of primary care at (091) 775200.

Working Group on Primary Care Formed by the CEO to draw up a strategic plan or the development of the primary care services.
For membership and terms of reference see appendices.

Pre Draft Consultation
¥ Newspaper adverts in 10 regional newspapers (10 responses)
¥ Written requests for submissions (n=1199) recieved 144 individual and group submissions
¥ Meetings with interested parties
¥ 5 oral submissions

Draft strategy for primary care
Post- Draft Consultation
For details see next page

Revision of Draft
Commenced: April 2000

Post Draft Consultation - February to March, 2000

The consultation process had two key objectives:
¥ To allow anyone in the region who had an interest in the development of this strategy an opportunity to comment on it.
¥ To obtain some in-depth feed-back from both service providers and service users on the draft.

These objectives were achieved in the following ways:
¥ Copies of the draft were printed and distributed (2100 English, 60 as Gaeilge).
¥ Copies of the draft were put on display in each public library in the region.
¥ Copies of the draft were put on display in each health centre in the region.
¥ Copies of the draft were made available through the Mayo Community Care Web site from
Mid-February.
¥ Each GP was asked to display a public notice re. the draft in his/her surgery waiting room.
¥ 6 public meetings were held at:

Galway City (attendance=9)	Ballinasloe (attendance=21)
Ros aÕMhíl (attendance=12)	Roscommon town (attendance=12)
Castlebar (attendance=13)	Ballina (attendance=8)

¥ Advertisements were placed in Newspapers throughout the region including:

Connaught Telegraph	Connacht Tribune
Connacht Sentinel	Roscommon Herald
Mayo News	Tuam Herald
Roscommon Champion	Galway Advertiser

¥ Advertisements were also placed with a number of local radio stations including:
Galway Bay FM

Midwest Radio
Radio na Gaeltachta

¥ In addition to the advertisements, media coverage in the form of local/ community news items, interviews and articles also occurred:

Connacht Tribune
Roscommon Champion
Galway Bay FM
Irish Medical Times
Tuam Herald
Medicine Weekly
Radio na Gaeltachta

¥ In addition to the public meetings, meetings with specific groups were also organised. These included:
Public Health Nurses, GPs, Home Helps, Area Medical Officers, Home Management Advisors, Representatives of WHB Management Services Dept., Professional bodies and Voluntary groups.

¥ Primary Care Workshop - 16th March, 2000.
Attended by 110 people representing 19 health board disciplines, general practitioners, pharmacists, voluntary groups and representatives of service users.

¥ Informal queries.

While we had considerable success in involving service providers in the consultation process we were less successful in involving service users. This is reflected in the numbers of responses received to public notices and advertisements. It is not possible to draw any definitive conclusions why this was the case. However, it should be said that the contribution made by those members of the public who were involved was indeed very valuable.

The task of drawing up a strategy to outline the direction that the primary care services in the Western Health BoardÕs area will take over the next 5 to 10 years is a challenging one. It challenges us because of the number and range of people involved in the provision of primary health care and because potentially, each and every person within the Western Health BoardÕs area will avail of these services in one form or another at some stage in their lives.
Of course, it is for these same reasons that it is of vital importance that we strategically plan what will happen in this area of health care to the very best of our abilities.

This strategy is the culmination of the efforts of the working group on primary care for more than eighteen months. It was arrived at through the most extensive consultation process undertaken by the board to date in the preparation of a regional strategy. It represents an important first step in a continuous process that will assist and direct the primary care services in this region over the next 5-10 years.

The national strategy document ÒShaping a Healthier FutureÓ was based on three under-lying principles namely equity, quality and accountability. While issues of equity and quality are dealt with explicitly in this strategy, the principle of accountability is less explicit in its presentation. The reasons for this are related to the type of document this is and the objectives of the working group in its preparation. As a strategic plan this document aims to set down the broad principles which will help guide the primary care services in the Western Health BoardÕs area over the next 5-10 years. For this reason it does not deal with specific recommendations about specific care groups. It is envisaged that arising out of this document will be a number of operational plans which will deal explicitly with the questions of how the various recommendations of this strategy will be implemented and by whom.

Primary Care - A Definition

Primary health care was defined by the World Health Organisation (WHO) at its 30th annual meeting in 1977 as:

Ò...the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.Ó (WHO 1979)

While there is disagreement regarding the applicability of this definition in industrialised societies, it contains a number of key elements appropriate to this strategy. As a definition it encompasses the notion of first contact care and longitudinality. One of the strengths of effective primary care is the personal relationship that exists between the service user and service provider over time. This relationship exists regardless of the type of health problem or even the existence of a problem.

Who Provides Primary Care?

The definition of primary care can be further expanded by reference to the various professions involved. Foremost among these are general practitioners, public health nurses, practice nurses, community pharmacists and home helps. Other providers include community psychiatric nurses, area medical officers, social workers, community welfare officers, physiotherapists, occupational therapists, speech and language therapists, community nutritionists, community addiction workers, community ophthalmic services, dental services, chiropody, psychology services, addiction counsellors and meals on wheels services. A number of voluntary groups also provide services, often of a specialised nature to people who have special needs e.g. those with terminal illnesses, epilepsy, motor neurone disease or multiple sclerosis.

Why a Primary Care Strategy now?
The decision to draw up a strategy for the primary health care services at this stage reflects:

¥ the importance of the primary health care sector in the promotion of the highest attainable level of health for all people in the Western Health BoardÕs area;

¥ the need to periodically review the direction in which our health services are developing and to redefine our priorities;

¥ the need to ensure the maximum return, in terms of health and social gain, for investment and expenditure in all areas of the health services;

¥ the continuing need to reorient the health services so that their focus is on good health and maximising the potential of each individual;

and

¥ the need to create an integrated health service which is responsive to the needs of the people it serves.

Terms of Reference
The terms of reference originally assigned to the working group on primary care are outlined in Appendix II. It was felt that these terms could best be met through an overarching strategic plan which would guide all the primary care services over the next five years.

Four key principles underpin this strategy. These are:

Good Health Focus
The continued reorientation of the health services away from a focus on illness towards a focus on good health is important if the role and potential of the primary care services in achieving the boardÕs aim are to be fully exploited.

Partnership
The approach to the provision of primary care services should be based on partnership. This means working with all relevant groups and individuals towards a common aim. Linked to the principle of partnership is the necessity for excellent communication between all relevant parties and at every level.

Quality
Quality is defined in the Oxford English dictionary as the degree of excellence. (Fowler, 1990). In terms of health care this means that the right people receive the right services, from the right people, in the right place at the right time. The principle of quality extends into that of equity as a quality service will be a fair service. In the context of our earlier definition of primary care, the provision of health services in the right place means providing services to people as close as possible to where they live and work.

Equity
The principle of equity has many dimensions one of which is access. Access to health care should be on the basis of need rather than ability to pay or geographical location. Equity is about examining the variations in the health status of different groups in society and looking at how these variations might best be addressed.

In 1996, the population of the Western Health BoardÕs area was 351,874 spread over 5,330 square miles including 7 offshore islands. The demography of this region is characterised by:

* Low population density outside of Galway city and a few large towns;
* Rapid population growth in Galway City ~12% between 1991 and 1996);
* Lower than average population growth for the rest of the region.

Population growth for the country as a whole was 3% between 1991 and 1996. Figure 2.1 shows the percentage population growth for each county.

Figure 2.1. Percentage Population Change Within the Western Health Board 1991-1996

Source: Department of Public Health, (1997).

The age structure of the population of the Western Health BoardÕs area is broadly similar to that of the country as a whole. The main differences are that this board has a higher proportion of individuals aged over 65 years (14% compared to 11%) and a lower proportion of persons aged between 20 and 55 years (44% compared to 48%).
As the population aged 65 years and older is proportionally greater in the west of Ireland than the national average, and as up to 25% of people in this age bracket live alone, it is to be expected that additional demands are placed on health and social services in this region.

Projections for the future anticipate an increase in the over 65 age group in the order of 20-30% between 1991 and 2011. While the country as a whole will experience an increase in the over 65 age group the Western Health BoardÕs area will maintain a higher proportion of its population in this age range than the rest of the country.
A sharp fall in the numbers of children and a slight growth in those aged 15-65 years are also predicted. While the projections provide a useful insight into future population trends, they are based on a number of assumptions, which may or may not hold true at county level.
Figure 2.2 shows the numbers of personnel working in 5 key areas of primary care in the Western Health BoardÕs area during 1999.

Figure 2.2

Description of Present Structure - Eligibility
The health system in Ireland is a mixture of public and private schemes with eligibility for individual services determined by income. Those below a set income level are entitled to all health care services (community and hospital), prescribed medicines and dental and ophthalmic care, free at the point of contact. This scheme, the General Medical Services (GMS) Scheme, covers about one third of the total population and approximately 41% of the population of the Western Health BoardÕs area. Patients deemed eligible under this scheme have the right to choose their general practitioner and are then registered with that practitioner. They are free to change that choice at will. The remainder of the population, (Òprivate patientsÓ), have access to hospital care subject to a maintenance charge and free consultant services in that setting. They also pay for dental and general practitioner services and in general, the costs of drugs. Private patients are free to choose their general practitioner, but there is no national registration system to record that choice. General practitioners participating in the GMS scheme were initially paid on a fee-per-item basis. A capitation system replaced this in 1989 (Murphy, 1998).

Debate continues internationally over the most appropriate way to structure the delivery of primary care services. Among European countries there are

arrangements based on single-handed practices or group practices and on multidisciplinary health centres. In Ireland, primary care services are delivered from a number of settings. For example in the Western Health BoardÕs area, health centres are generally used by the public health nurse as a base out of which to work. Some of these centres, while owned by the Board, also accommodate a general practitioner and other practice staff. However, many general practitioners operate out of their own private premises, which may accommodate practice staff but not other primary care providers such as the public health nurse or the community welfare officer (CWO).

Options for the Future

To meet the challenges that lie ahead, we need to build on the strengths of the existing primary care structures and to develop the role of primary care as a provider of integrated services to and with the patient and the community.

It is proposed that the region be divided into 10 to 15 population catchment areas, each containing 20,000 to 30,000 people, to be known as primary care areas. In general the boundary of each primary care area should be drawn along district electoral division lines. While many primary care providers already use district electoral divisions to delineate areas of responsibility, general practitioners in particular do not. It may be necessary to adopt a flexible approach to the setting of boundaries in areas of high population density within the region, an example being Galway City. The over-riding criterion determining boundaries should be health need. The best available data in the areas of population structure and density, geographical constraints, levels of deprivation and the health status of the population will be employed to help determine health need.

The availability of existing community supports should also be taken into account when determining primary care area boundaries. Consideration should also be given to cultural factors such as language in drawing primary care area boundaries.

A network of health centres will serve each primary care area. An inventory of the existing stock of health centres, including an assessment of their physical state, will be required. Principal primary care centres will then be designated and priorities for capital investment established. Principal primary care centres would be equipped and staffed to a standard that would permit the delivery of a comprehensive primary care service. Other primary care centres would continue to provide an appropriate level of service.

The delivery of primary care has always been the responsibility of many professionals and groups. In recent years, service delivery and the provision of care in the community has become increasingly complex with many stakeholders involved. While many primary care providers are employed by the Western Health Board, some are not. In order to ensure excellent communication and co-operation between all those involved in the provision of primary care and a greater integration of activities at community level, it is necessary to develop structures in which the key providers work closely together. It is also necessary that these structures be given adequate support.

The introduction of primary care teams in a limited number of areas on a pilot basis is proposed. The primary care team will be assigned to a particular primary care area and will comprise a broad range of disciplines and professions. Within the primary care team there will be a number of patient care teams. The patient care teams will comprise a general practitioner and a practice nurse as well as a public health nurse. The patient care team will be

supplemented by a variety of disciplines drawn from the larger primary care team depending on individual patient requirements.
Services will be co-ordinated at the primary care area level by a group made up of representatives drawn from the whole primary care team. It is envisaged that this co-ordinating group would be roughly comparable to the District Care Teams, which operated within the Western Health Board area previously with some success particularly in rural areas.
The primary care team pilots should be evaluated after 12 months. This evaluation should form the basis of the decision to expand or otherwise the primary care team network to all primary care areas. The pilots should also help to determine roles, terms of reference and professional relationships.

Figure 3.1. Proposed Primary Care Team
Note: This figure has been simplified for the purposes of clarity. Each primary care team will contain a number of patient care teams as stated above.

It is important to note that the introduction of the primary care team and the division of the region into catchment areas will not interfere with the patientsÕ right to choose their general practitioner.

Patient needs assessment/consultation
Health needs assessment is the process of assessing the communityÕs need for health services. In general, need in the health care sector is defined as Ôthe ability or capacity to benefit from health care in some wayÕ. Ideally, needs assessment involves wide consultation within the wider primary care team, the public, health board and other agencies about strategic issues.

The rationale for carrying out primary care based health needs assessment is:
¥ To develop strategies, training plans and services that are more responsive to local needs;
¥ To improve efficiency of services provided, make them relevant to need and more equitable;
¥ To increase the influence of all primary care professionals in the development of health strategies and service planning;
¥ To increase knowledge about community incidence and prevalence of conditions that do not impact on hospital services to ensure that certain conditions and patient groups are not ignored when services are being planned.

Considerable planning is required to undertake a needs assessment, be it practice or community based. Some form of rapid participatory appraisal is needed to identify broad areas of need. It may also be necessary to use other methods to further clarify specific questions e.g. special surveys, focus groups, in-depth interviews. It is then necessary to review the findings, set priorities and develop a plan to drive change. Implementing change may require training for teams and individuals, and collaboration and partnership with others to help address the identified priorities.

There are many barriers to undertaking such assessments in the Irish primary care setting. Considerable effort is required to develop relationships and build trust between primary care team members. Practice data and community care data are frequently not in a form that can be used readily for needs assessment. Many primary care professionals lack the time and skills to collate, interpret and use data from patient records for planning purposes. Much data available nationally is coded only to county level, which is of limited use in community based needs assessment. There is little experience nationally in rapid appraisal techniques, though there has been an expansion in experience with qualitative research techniques in general.

Protected time and considerable investment in information technology, training, teambuilding and participative techniques is necessary for systematic needs assessment to take place. In summary it can be said that needs assessment is indeed a difficult area and additional research is required to determine the best approach.

Recommendations

R.3.1 A primary care department should be established with responsibility for the planning, co-ordination and delivery of all primary care services.
R.3.2 The General Practice Unit should remain a separate entity and retain its identity and funding within the primary care department. Other professional disciplines will also be represented in the primary care department.
R.3.3 The Western Health BoardÕs area should be divided into 10 to 15 primary care population catchment areas, to be known as primary care areas.
R.3.4 The overriding criterion in determining primary care area boundaries should be health need.
R.3.5 Resource allocation decisions and service planning should be based on the health needs of the primary care area.
R.3.6 A complete inventory of health centres should be prepared in conjunction with the Technical Services Office of the Western Health Board.
R.3.7 The development of privately owned premises, which are used in the delivery of primary health care, should continue to receive encouragement and support from the Western Health Board.
R.3.8 Principal primary care centres should be designated and developed throughout the region.
R.3.9 General practitioners should be supported in operating their practices from these centres.
R.3.10 Primary care teams should be introduced initially on a pilot basis.
R.3.11 The pilot projects should be evaluated after 12 months using input from team members and service users.
R.3.12 Service planning in the GP Unit should involve broad consultation with statutory and voluntary service providers and users.

The Western Health Board aims to promote the highest attainable level of health for all those living in Counties Galway, Mayo and Roscommon. This aim can only

be realised through the development of effective communication of the highest quality and most appropriate nature, between all those involved in the delivery of primary health care.

Considerable barriers and challenges to effective communication exist in terms of the volume of people providing and availing of primary care services and the complex nature of the structures through which these services are provided. While recognising these challenges, it is important also to recognise that advances in training and technology have put us in a better position to deal with these difficulties than ever before.

Formal and informal communications and linkages exist at every level of the primary health care services but vary widely in terms of quality, from excellent to poor.
The model below outlines the various interactions, which occur in the primary health care services.

Figure 4.1. Simple Communication Model For Primary Care

Service User or Patient

Primary Care Provider e.g.
GP, PHN etc.

Other Health Services e.g. Hospital A&E,
inpatient, OPD

Note: For the purposes of simplification all providers of primary care have been included in this category regardless of the extent or importance of the role they play.

Primary health care is mainly concerned with three key communication relationships:

Patient ~ Primary Care Provider
Primary Care Provider ~ Primary Care Provider
Primary Care Provider ~ Other Health Services

The communication that takes place directly between the patient and the other health services is also of importance.

Patient ~ Other Health Services

However, this communication relationship is relevant to this strategy to the extent that some services availed of directly by patients at the secondary level (e.g. through the acute hospital services) would probably be more appropriately and effectively availed of in primary care.

Patient ~ Primary care provider
Low population density, geographical isolation and the existence of two primary languages are some of the factors which hinder effective communication between primary care providers and service users. Some areas within the region are isolated simply by virtue of a poor road network, poor public transport service and their distance from a town or city.

It is essential that patients and service users are aware of the range of services available to them and how and when they can be accessed. The primary care provider is by definition the first point of contact between a patient and the health services. Therefore, it is essential that effective two-way communication takes place at this interface. Primary care providers need to recognise the sometimes-individual communication needs of service users and be supported in their efforts to meet these needs.

Primary care provider ~ Primary care provider
The structures through which primary care is currently provided present challenges to effective communication between primary care service providers. The volume of personnel involved and the manner in which they are widely dispersed throughout the region, often working single-handedly, can result in communication difficulties between community-based Western Health Board employees and other primary care workers.
Improved working relationships between primary care providers should be fostered through joint training initiatives. Multi-disciplinary training and continuing education offer great opportunities to promote an integrated approach to care planning and service delivery. Key shared values can be encouraged through these processes and the importance of teamwork based on mutual respect and dependence can be emphasised and demonstrated.

Primary Care Provider ~ Other Health Services
The primary care provider and, in particular, the GP, has played a key role as ÒgatekeeperÓ to the health services. It is essential that when a patient leaves the community to avail of hospital based services that effective communication take place between relevant health care personnel. It is equally important that effective communication takes place between all relevant service providers when patients are returning to the community. Unfortunately, this has not always been the case. Discharge planning which takes into account all those who need to be contacted when they need to be contacted is essential if the ideal of a Ôseamless serviceÕ is to be achieved.
Seamless care is especially important in meeting the needs of service users whose care is shared between hospital-based personnel and those located in the community. This is often the case with service users with chronic illnesses such as diabetes and asthma.
The availability of radiological investigations, (which are currently hospital based), to all patients on direct referral by their GP may be useful in achieving a greater continuity of care. This may also be true of selected invasive investigations such as gastroscopy and colonoscopy. General practitioners who wish to provide invasive investigations from their centres of practice should be supported.
The involvement of general practitioners both in clinical and managerial capacities could be useful in developing linkages between the hospitals and the community.

Information Communication Technology
Information communication technology (ICT) is the application of technology to the transfer of information. The potential of modern information systems and telemedicine technology in facilitating communication at each of the three levels outlined above should not be underestimated. However, it should also be recognised that it is only when the fundamentals of person to person communication are working effectively that modern technology or computerisation should be considered.
It is also essential that whatever information systems are adopted should conform to national standards for the transfer of data from other health board systems.

Quality of Communication

The essential difference between the communications and linkages that currently exist within the health services and the position we would hope to achieve is the quality of the communication in question. Quality can be measured in a number of ways including speed, relevance and timeliness. It is essential therefore that appropriate systems and personnel be put in place to ensure the quality of communication at each interface. It may be necessary to pilot test models of quality assurance to determine their applicability in this region.

Recommendations

R.4.1 Members of the public should have access to sufficient information so that they can make rational decisions about their health

R.4.2 Primary care service users and providers should be supplied with information regarding the range and availability of primary health care services.

R.4.3 The communication needs of people whose first language is Irish should be recognised.

R.4.4 Primary care providers should be encouraged and supported in their efforts to meet the individual communication needs of service users.

R.4.5 A customer services department should be established for the Western Health Board.

R.4.6 Linkages should be developed between the disciplines in the primary care team~see Section III).

R.4.7 In so far as possible all geographically based primary care services should be co-terminus.

R.4.8 Agreed systems and protocols should be established to allow for the transfer of relevant patient information among primary care providers while protecting the right to privacy of the patient.

R.4.9 A complete review of formal communication systems and linkages between primary, secondary and tertiary care should be undertaken.

R4.10 Appropriate discharge planning should be promoted at each hospital in the BoardÕs area.

R.4.11 Shared, quality care protocols for specific chronic illnesses (e.g. asthma, diabetes) should be developed.

R.4.12 Each per Hospital based radiology investigations should be available to all patients on direct referral by general practitioners subject to agreed protocols.

R.4.13 Selected invasive investigations should be available to all patients on direct referral by general practitioners subject to agreed protocols.

R.4.14 Outreach specialist clinics to principal primary care centres should be promoted~see Section III).

R4.15 The for The specific skills of general practitioners should be available to the secondary care sector.

R.4.16 Each hospital department should have a direct telephone and fax line and these numbers should be notified to each primary care practitioner.

R.4.17 Telemedicine facilities should be expanded.

R.4.18 A regional ICT steering committee should be established.

R.4.19 All principal primary care centres and GP training practices should be computerised.

R.4.20 The computerisation of patient files should be encouraged and supported.

R.4.21 The potential of ÒSmart CardsÓ as a means of information transfer should be investigated.

The primary care services provided directly by Western Health Board staff can be broadly sub-divided into community protection, community welfare, and community health services.
Community protection includes services for the prevention of infectious diseases, child health examinations, health promotion, environmental health, and other preventive services. Community welfare includes income maintenance and the payment of a range of allowances, home help, home management, psychology, social work and childcare services including youth projects and grants to voluntary organisations. Community health services include dental, chiropody, ophthalmic, aural, occupational therapy, speech and language therapy and physiotherapy as well as home nursing. All of the people who provide these services have an important part to play in the delivery of primary care. Home helps and public health nurses are particularly important in the context of primary care due to the volume of personnel involved and the numbers of people to whom they provide a service.

Public Health Nurses
Public health nurses offer a wide range of personal, health and social services within the patientÕs own home, health centres, schools and other community settings. The range of health services provided by public health nurses spans health promotion, education, treatment and care. In general, their responsibilities focus on meeting the needs of specific client groups.

Home Helps
Home helps provide personal, practical and social care, which helps maintain people in their own homes. This service is provided mainly to older people, those with physical and sensory disability, families under stress and to carers. The level and nature of the service depends on the needs of the client and the resources available.

General Practitioners
General practitioners provide a wide range of services for their patients including diagnosis and treatment of acute illness, monitoring and management of chronic diseases, advice support and informal counselling, health education and promotion, referral for specialist opinion, terminal care, combined ante-natal care, family planning, child vaccination, screening and immunisation. Because of the rural nature of the region a large number of GPs are dispensing GPs. In recent years, some general practitioners have become more involved in preventive services, e.g. cervical screening and assessing risk of cardiovascular disease. Many general practitioners have also developed a special interest and provide services in a particular area, e.g. womenÕs health, asthma management and diabetes care.

Community Pharmacists
The main services provided by community pharmacists include compounding and dispensing of medicines, maintenance and monitoring of patient medication history, providing personal advice when medication is dispensed, symptom screening and patient referral to other primary care practitioners. Other services provided by many pharmacies include screening for minor ailments, complementary health remedies, hearing aids, elderly care aids, products for the care of people with diabetes and informal first aid. Many pharmacies provide optometry services. More recently, pharmacies have introduced health screening services. The increasing trend towards deregulation of medications and the legal requirement involved in the dispensing of certain medications requires the pharmacist to discuss symptoms with patients prior to dispensing such medications. Many new pharmacies have included Ôadvice roomsÕ within the pharmacy premises to provide privacy for patients discussing health problems.

The GP Unit

The GP Unit was established in the Western Health Board in 1993, following agreement between the Department of Health and the Irish Medical Organisation and in line with the blueprint document ÒThe Future of General Practice in IrelandÓ and the health strategy ÒShaping a Healthier FutureÓ (Department of Health, 1994). The role of the unit is to support the delivery of a quality health care service to all people in the boardÕs area. It is concerned with and relates to all aspects of general practice including service delivery, practice support, practice staff, premises and equipment, vocational and continuing education and the interfaces between general practice and other health and social services. The GP Unit will remain a distinct entity and retain its identity and funding within the primary care department.

Comprehensiveness and Equity

Comprehensiveness means the availability of all services in the primary care setting which will meet the broad aim of the health services in Ireland i.e. Ôto promote the enjoyment by all of the highest possible levels of healthÕ. A comprehensive health service must also be an equitable health service. Equity has been a recurring theme in national health strategies for the last number of years. ÒShaping a Healthier FutureÓ (Department of Health, 1994) emphasised that access to health care should be on the basis of actual need rather than ability to pay or geographical location. Equity must also extend beyond the question of access to treatment and care. Differences between the health status of various groups in society and how these differences might be addressed must also be examined (Department of Health, 1994).

While eligibility for most of the major health services is clearly specified, there are a number for which no eligibility criteria are set down in legislation. Examples include home help, meals on wheels, community paramedical services, day care centres and transport services.

Primary care services include not only prevention and treatment of specific medical conditions but also a wide range of other activities and supports to increase health and social gain.

The GMS scheme is not oriented towards illness prevention or health promotion. In this region, approximately 41% of the population are medical cardholders and therefore do not have ready access to a range of preventive services through their GP. There is also a concern that those on the margins of medical card eligibility may not be in a position to fund certain services for themselves. Again it is likely that families struggling to meet health care costs will give treatment services priority over prevention.

Public health nurses acknowledge that with an increasing home nursing caseload, it is more difficult for them to devote time to health promotion and routine surveillance. Also, this is primarily a Ô9 to 5Õ service with only planned essential services provided at weekends. This is also the case with the home help services.

Limited weekend cover is provided for childcare emergencies within the social work services. Furthermore, the focus of social work on child protection has meant that services to other client groups e.g. older people and those with disabilities have not developed. This, together with the lack of out-of-hours service, is a serious deficiency.

There are small numbers of physiotherapists, occupational therapists and speech and language therapists working in the community. The community nutrition and community addiction services are also subject to such limitations. As such, it is difficult for these services to meet the demands placed upon them and provide of a comprehensive primary care service to all those who would benefit from it.

Health Promotion

There is a growing recognition that the health status of the population is related to a variety of factors aside from the availability of quality health services. Health promotion addresses all the factors affecting the individualÕs health. It includes health education but incorporates it into a broader context. The Western Health BoardÕs strategy for health promotion, ÒPromoting Health in the WestÓ, outlines three approaches to promoting health. The medical/prevention approach concentrates on reducing medical risk factors, e.g. immunisation. The lifestyle/behaviour approach focuses on behaviours such as diet, smoking and exercise and includes health education by health professionals. The third approach, the socio/environmental approach, is about community and economic development as well as developing environments that support good health, advocacy for health issues, and public policy. Besides being the first tier of the health services with which most people have regular contact, primary healthcare professionals are generally held in high esteem by service users. The combination of these factors means that primary care is a key setting for health promotion. From 2000 on, all Service Plans will have specific Health Promotion components and a percentage of all development monies will be set aside for Health Promotion activities. This will include development funds secured for Primary Care.

Rural Environment

The European Charter for Rural Practice aims to Ôensure that all the rural and isolated population in Europe have access to high quality health care irrespective of location, culture or resourceÕ.

Evidence from across Europe and the rest of the world indicates that problems of rural health care professionals are similar and include issues such as high work load, limited access to training, isolation, poor morale and a decline in recruitment (EURIPA, 1997).

There is a poor public transport service in the Western Health BoardÕs area. Thus patients who do not have their own transport are disadvantaged in accessing health services. Because of this, many patients will have limited or no choice of health care provider.

Difficulties in travel to hospital mean that practitioners in the rural setting have more responsibility in the ongoing management of patients with chronic disease, in dealing with minor injuries and in providing pre-hospital care in major emergencies.

All of these issues have implications for the level of skill of those working in primary care and the level of equipment they need. In addition to general skills, those working in rural areas need an understanding of occupational health issues as they relate to rural communities and environmental issues. In general, rural practitioners carry a higher level of clinical responsibility in relative professional isolation than their urban counterparts.

There is scope to exploit modern information and telecommunication technologies to increase the level of support to primary care workers in a rural setting. The application of these technologies to health (telehealth) has the potential to overcome barriers of distance, cost, poor distribution of services as well as lack of support for health care providers.

The defined population of rural communities provides a unique opportunity for research, which should be encouraged and supported so that answers to rural problems, based on sound evidence, can be developed.

Urban Practice

Within the Western Health Board there are areas of significant urban deprivation. Such conditions pose considerable barriers to the provision of optimal primary care. Support to practitioners working in these areas needs to be defined and methods of implementation agreed.

Group Practice

Related to the issue of rural practice, but not exclusively so, is the issue of group practice. Group practice is often seen as a means by which the balance, which must be struck, between the rights and needs of the patient to receive a primary health care service 24 hours a day, 7 days a week, 365 days a year, and those of the practitioner in terms of holidays, study leave and sick leave can be achieved. However, this is not a simple trade-off as group practice also offers the patient a genuine choice of doctor. Group practice may also ensure easier access to a female physician, which has been shown to be very important with respect to health promotion. Larger practices can also employ more economies of scale thus making investments in personnel and equipment, which result in a better service for the patient, more feasible.

Recommendations

R5.1 Provision of primary health care services should be examined and developed in a planned way to meet the needs of the population.
R5.2 The availability of a range of out-of-hours primary care services should be reviewed.
R5.3 The specific primary care needs of the rural population should be addressed.
R5.4 Proactive measures should be taken and incentives provided to improve rural recruitment and retention of primary health care personnel.
R5.5 Each person in the BoardÕs area should have access to an appropriately equipped and staffed ambulance service, which can safely treat and transport seriously ill patients to the closest specialist centre within internationally agreed guidelines.
R5.6 Systems should be put in place, which encourage treatment of the patient in the most appropriate setting through inter-referral between practitioners.
R5.7 There should be a review of the services especially procedures and clinics currently being provided by the hospital sector, that would be more appropriately provided in a primary care setting.
R5.8 The Western Health Board should continue to promote the development of group practice, extended rotas, GP Co-operatives and other joint working arrangements.

Education

Whilst the importance of education and training for all health care personnel has often been recognised, specific resources allocated to it were often inadequate. Even when resources were provided, more emphasis was often placed on hospital rather than community based personnel. Education regarding the reality and potential of primary care is especially important for those working within the health services but who have never, or will never, work within the primary care environment. It is important to note that while this section makes specific reference to two primary care disciplines namely nursing and medicine, the issues outlined and the various recommendations which follow are relevant to all primary care practitioners.

It is also important to note that the various recommendations already outlined in this document have in themselves training implications for the personnel involved.

The Centre for Nursing Studies NUI, Galway has forwarded to the Board a training needs analysis based on nursesÕ perceptions of their educational and training needs. Whilst this has not yet been published, it is understood to have found that:

¥ A significant number of nurses are not accessing postgraduate education.
¥ ÔBest practiceÕ guidelines need to be established and disseminated for a number of key areas.
¥ Problems with locum availability and resources to pay for locum cover seriously hamper participation.

The Commission on Nursing has also made recommendations in respect of preparation for the nursing profession and three main areas of professional development including in-service training, continuing education and specialist training.
The 1997 Medical Council statement on undergraduate medical education specifically refers to the need for increased exposure to community based care (Medical Council, 1997). This request has been implemented with varying degrees of success in each of the medical schools. The Department of General Practice was established at NUI, Galway in 1997 with significant support from the Western Health Board. Details of the progress of this department are produced in its annual report (Department of General Practice, 1999).

The first ever general practice training programme in Ireland was established in Galway in 1971. The template used then has remained the same: two years of hospital experience with one year in general practice. This scheme has received significant support from the Western Health Board since its inception. The possibility of changing the three year programme to one of five years, which would include a modified internship of two years termed Òpre specialist trainingÓ, is currently under discussion by the manpower committee of The Irish Medical Council. This change has been prompted by the evolution of both primary and secondary care so that many acute and chronic diseases are now wholly managed by general practice and the learning environment offered by the hospital setting is no longer commensurate with the range of illnesses seen by the general practitioner. The extension of the time spent in primary care would also give participants the opportunity of gaining epidemiological and research experience in public health as well as a longer time in general practice. This would result in a more rounded graduate possibly with greater research experience who would be fully equipped to undertake independent practice.
The Irish College of General Practitioners is recognised as an international pioneer of small group community based medical education (Boland, 1991). Such education needs to be further supported for general practitioners and similar models made available to other primary care professionals.

Research & Development
The pursuit of research and development (R&D) is not a goal in itself. It has long been accepted that the Ôpay backÕ includes improved quality of patient care, as well as associated political and administrative benefits and broader economic gains (Buxton & Hanney, 1996) In order to benefit from R&D conducted elsewhere, a well developed internal R&D system is essential.
It is true to say that Irish research and development has not been strongly supported in general and that primary care has been especially under-resourced. This mirrors the situation internationally. Recently the British National Health Service has made significant steps to change based on the recommendations of the Mant Report (NHS, 1998). This states, very clearly, the case for supporting R&D in primary care and shows how high quality R&D in primary care can be obtained and sustained.

At present, there is little training in research and development methodologies for people working in the primary care sector. There is little or no incentive for primary care personnel to carry out R&D work. Enthusiastic minorities generally perform what R&D is done. It also tends to be uni-disciplinary with little genuine multidisciplinary links. It has been estimated that for an R&D culture to operate, 1% of the community need to act as leaders, with a further 10% actively involved. The recommendations detailed below can be pursued on a regional and, in association with other interested bodies, national basis.

Recommendations

R.6.1 Specific criteria for the prioritisation of educational requests should be developed.
R.6.2 A proportion of the nursing undergraduate curriculum should be taught within the primary care setting.
R.6.3 A formal needs based postgraduate nursing education programme appropriate to primary care should be established.
R.6.4 There should be a greater proportion of the medical undergraduate curriculum taught within primary care.
R.6.5 The establishment of combined medical undergraduate and postgraduate teaching practices with appropriate resources should be developed within the community.
R.6.6 The present three-year scheme of general practitioner training should be extended to five years.
R.6.7 Postgraduate courses in primary care should be established and driven by primary care needs.
R.6.8 A co-ordinated approach to R&D in primary care should be adopted by statutory health and educational bodies at a regional and national level
R.6.9 A primary care research network should be established in the region.
R.6.10 A proportion of the BoardÕs budget should be ring-fenced for education and research & development.

While much can be achieved at local and regional levels in terms of developing primary care services, it is important to recognise that some issues have wider implications. This means that they must be dealt with at a national level. While some of the recommendations laid out in this strategy are cost neutral, some are not. Provision for the additional costs associated with the development of primary care services needs to be made at national level.

Other issues which need to be dealt with at a national level are highlighted below.
¥ The issue of encouraging patients to avail of health care in the most appropriate setting and the need to remove any anomalies which prevent this.
¥ The need for information on the health status of the population to be made available on a district electoral division (DED) basis.
¥ The need for the continued expansion of electronic information systems, which improve patient care.
¥ The need to make continuing professional development more inclusive of all primary care disciplines.
¥ The revision of the GMS contract to include items such as health promotion and preventive medicine as well as evidence based medicine.
¥ There is a demand among members of the general public for alternative therapies. To ensure the safety of the public and the provision of effective treatments it is important that such alternative treatments be nationally regulated.

Section VIII - Key Initial Action Steps

The recommendations contained in this strategy will have far reaching consequences for both providers and users of the primary care services.

No attempt has been made in this document to quantify the costs associated with each recommendation. However, if this strategy is to be used successfully as a vehicle through which the allocation of additional resources to the primary care services is justified then detailed consideration of the cost implications of the individual recommendations will be necessary.
Consideration should be given to the establishment of an implementation committee who will work with the existing management structures of the board to devise operational plans from this strategy. This group should have responsibility for the planned implementation of its recommendations and should begin its deliberations at an early date.

References

Boland M. William PickleÕs Lecture: My brotherÕs keeper.
British Journal of General Practice, 1991; 41: 295-300.
Buxton M, Hanney S. How can payback from health services research be assessed?
Journal of Health Services Research Policy 1996; 1: 35-3.
Department of General Practice (1999) Second Annual Report. Galway.
Department of Public Health (1997) Annual Report (unpublished). Galway.
Department of Health (1994) Shaping A Healthier Future.
Department of Public Health (1997) Annual Report. Western Health Board.
European Rural and Isolated Practitioners Association (1997),
The European Charter for Rural Practice. Palma.
Fowler H.W. & Fowler R.E. (1990) The Concise Dictionary of Current English.
Oxford: Clarendon Press.
Irish College of General Practitioners (1997) National Survey of General Practice. Dublin.
Medical Council (1997) Statement on Medical Education. Dublin.
Murphy A. (1998) General practice developments: A primary care led Irish Health system?
in Leahy A.L. and Wiley M.M. eds.,(1998) The Irish Health System in the 21st century.
Dublin: Oak Tree Press.
National Working Group (1998) R&D in primary care (ÔMant ReportÕ) NHS executive, London.
OÕDwyer J (1999) Planning and Delivering Integrated Health Care.
Dublin: Department of Health and Children.
Saltman, R.B. & Figueras, J. (1997) European Health Care Reform - Analysis of Current Strategies.
World Health Organisation.
Small Area Health Research Unit (1997) A National Deprivation Index for Health and Health services Research.
Dublin: Department of community health and general practice, Trinity College.
Starfield, B. (1992) Primary Care, Concept, Evaluation and Policy. New York: Oxford University Press.
WHO (1978) Report of the international conference on primary health care.
Geneva: WHO.

Appendix I - Members of the Working Group

Mr. Tony Canavan, Project Co-ordinator, WHB

Dr. S□an Conroy, Regional Manager for Corporate Affairs and Population Health, WHB
Ms. Ann Cosgrove, A/Administrator GP Unit, WHB
Dr. Martin Daly, General Practitioner, Co. Galway
Dr. Brendan Day, General Practitioner, Co. Galway
Ms. Catherine Duffy, Administrator, GP Unit, WHB
Dr. Patrick Durcan, General Practitioner, Co. Mayo
Dr. Ken Egan, General Practitioner, Co. Mayo
Mr. S□amus Gallagher, Project Leader, WHB
Dr. Joe Gilvarry, General Practitioner, Co. Mayo
Mr. Brendan Hayes, Community Pharmacist, Co. Galway
Dr. Mary Hynes, Director of Public Health, WHB
Dr. Genevieve McGuire, Director of Training Programme in General Practice, UCHG
Mr. William Moran, Regional Manager for Acute Services, WHB
Prof. Andrew Murphy, Chair of General Practice, NUI,Galway
Mr. Brendan Naughton, Senior Executive Officer, Acute Services, WHB
Dr. John OÕDonnell, Consultant Physician, Galway
Dr. Thomas OÕMalley, Consultant Geriatrician, Roscommon
Ms. Dolores OÕNeill, Supt. Public Health Nurse, WHB
Ms. Priya Prendergast, General Manager Galway Community Services, WHB
Dr. Blathnaid Regan, General Practitioner, Co. Roscommon
Mr. Ronan Waldron, Consultant Surgeon, Co. Mayo

Appendix II

Terms of Reference of Working Group for Development of General Practice
(1) To establish Western health Board vision and policy on general practice in the context of integrated primary and secondary health care.
(2) To prepare a strategy, including action plans for the development of general practice for the five year period 1999 to 2003 inclusive.
(3) To develop a consensus on pathways for treatment of specific illnesses (e.g. diabetes, respiratory diseases, back pain).
(4) To promote the development of domiciliary approaches to the care of some persons who may otherwise be admitted to institutional care.
(5) To identify streamlining and co-ordinating measures in the team approach to care to avoid duplication of effort and cost.
(6) To develop formal methods of evaluating initiatives which appear to be successful.
(7) To encourage and monitor health promotion initiatives in the primary care setting.
(8) To explore means of using primary medical care data to assess and monitor the health of communities and the utilisation of services.
(9) To develop methods of assessing public satisfaction with the service provided and consultation regarding continuous quality improvement.

Appendix III - Submissions to the working group based on the draft strategy for primary care

Dr. S. Ryan, CEO,
Western Health Board.
Dr. M. Fitzgerald, A./Sen. Area Medical Officer,
Western Health Board.
Dr. J. McGauran, Area Medical Officer,
Western Health Board.
Ms. A. Skelly, School Public Health Nurse,
Western Health Board.
Ms. M. Fitzpatrick, School Public Health Nurse,

Western Health Board.
Ms. D. Greally, School Public Health Nurse,
Western Health Board.
Ms. M. Holian, School Public Health Nurse,
Western Health Board.
Ms. P. Dwyer, School Public Health Nurse,
Western Health Board.
Ms. E. Ourfali, School Public Health Nurse,
Western Health Board.
Ms. A. P. Mylotte, on behalf of Carna, Rosmuc, Lettermore, Oughterard,
Moycullen, Spiddal & Ballinahown, Public Health Nurses,
Western Health Board.
Ms. B. Lohan, RPHN,
Western Health Board.
Ms. M. Bruton, Sen. Public Health Nurse,
Western Health Board.
Ms. B. Bolger, Sen. Public Health Nurse,
Western Health Board.
Ms. D. Quinn, Sen. Public Health Nurse,
Western Health Board.
Ms. M. McLoughlin, Sen. Public Health Nurse,
Western Health Board.
Ms. B. Fahy, Public Health Nurse,
Western Health Board.
Ms. B. Dockery, Public Health Nurse,
Western Health Board.
Ms. B. Murray, Public Health Nurse,
Western Health Board.
Ms. B. Costello, Public Health Nurse,
Western Health Board.
Ms. T. Bruen, Public Health Nurse,
Western Health Board.
Ms. Marie Todd, A/Diabetic Nurse/ District Nurse,
Western Health Board.
Ms. P. Keigher, Practice Nurse, Co. Mayo.
Ms. M. Haire, Practice Nurse, Co. Galway.
Patient Focus.
Anonymous Service User.
Ms. S. Chong, Service User,
Co. Galway.
Ms. J. Vanneman, Service User,
Co. Galway.
Ms. R. Hanley, Service User,
Co. Galway.
Ms. Carmel Earley, Service User,
Co. Roscommon.
Mr. F. Kinsella, Consultant Surgeon,
Western Health Board.
Prof. M. Cormican, Consultant Microbiologist,
Western Health Board.
Prof. T.J. Fahy, Clinical Director, Dept. of Psychiatry,
Western Health Board.
Dr. H. Grimes, Consultant Biochemist,
WesternHealth Board.
Dr. C. Gavin, Family Doctor, Co. Mayo.
Dr. M.J. Morkan, General Practitioner,
Co. Roscommon.

Dr. D. Murphy, General Practitioner,
Co. Galway.
Dr. J.F. Kent, General Practitioner,
Co. Galway.
The Irish College of General Practitioners.
The Irish Association of Older People.
The Irish Wheelchair Association.
Galway Homeless Forum.
òdar‡s na Gaeltachta.
Coiste Aosach Rosmuc.
Comhdh‡il Oile‡in na hƒireann.
Comharchumann Inis Oirr.
Comharchumann Inis Me‡in.
Cumann na dTithe Deonacha agus Cumann Sl‡inte Pobail Chonamara — Thuaidh.
Tearmann Ain'n (Tith'ocht Sh—isialta).
Cumann Aosach Cheantair na nOile‡n.
Cumas Teoranta (ADM).
"Buaile Cheoin'n", An Cheathrœ Rua.
Cumann na Gaillimhe de Ph‡ist' Lag-intinneach.
Muintearas na nOile‡n.
An Roinn Eala'on, Oidhreachta, Gaeltachta agus Oile‡n.
Galway Simon Community.
Mr. M. Minton, Management Services Dept.,
Western Health Board.
Mr. J. Treacy, Addiction Counsellor,
Western Health Board.
Ms. J. Jones, Sen. Health Promotion Officer,
Western Health Board.
Ms. M. Larkin, A/Pre-school Services Officer,
Western Health Board.
Ms. A. Lydon, Community Nutritionist,
Western Health Board.
Mr. P. J. Kenny, Vice President
Irish Chiropodists/Podiatrists Organisation.
Mr. J. Mansfield, Regional Co-ordinator Child Care Services,
Western Health Board.
Ms. P. Burke, Sen. Occupational Therapist,
Western Health Board.
Ms. L. Moloney, Public Health Nurse,
Western Health Board.
Irish Nurses Organisation.
Ms. K. Walshe, Health Promotion Officer,
Western Health Board.

Apologies

Apologies:
To: Mr. Jerome Quinn, Co. Mayo & Dr. Ambrose McLoughlin, Deputy CEO, North Eastern Health Board for errors in the draft strategy for primary care.

Appendix IV - Measure of Deprivation
The map below shows areas of material deprivation and is based on the District Electoral Division, the smallest demographic area for which population data is routinely collected.
Deprivation is measured using 5 factors;

¥ Unemployment - The proportion of the economically active population i.e. 15-64 year olds, unemployed or seeking a first time job.
¥ Low Social Class - The proportion of the population in social class 5 or 6. Social Class 7 was excluded from this analysis.
¥ No Car - Proportion of permanent private households with no car.
¥ Rented Accommodation - Proportion of permanent private households rented privately or from a local authority, or in the process of being acquired from a local authority.
¥ Overcrowding - The average number of persons per room in permanent private housing units.

These factors are generally accepted to be accurate measures of deprivation. Correlations between material deprivation and health outcomes have been established for many years. More recently, analysis of a household survey in Tallaght, Dublin, confirmed the relationship between this measure of deprivation and demand for a wide range of health service facilities. (Small area health research unit, 1997)

Note:
The Irish social class scale ranges from social class 1 (Higher professional) to social class 6 (Unskilled manual). It is based on the earning potential of groups through their occupation. Those who cannot be assigned to any of the six social classes are assigned a social class code of 7. Social class 5 refers to semi-skilled manual occupations.

1996 Deprivation Index in the Western Health Board