Primary Care

A New Direction

Quality and Fairness - A Health System for You

Health Strategy

DEPARTMENT
OF HEALTH AND
CHILDREN
AN ROINN
SLÁINTE AGUS LEANAÍ

Baile Átha Cliath
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Le ceannach díreach ón
Oifig Dhíolta Foilseachán Rialtais,
Teach Sun Alliance, Sráid Theach Laighean, Baile Átha Cliath 2,
nó tríd an bpost ó
Foilseacháin Rialtais an Rannóg Post-Tráchta,
4 - 5 Bóthar Fhaearchair, Baile Átha Cliath 2,
(Teil: 01-6476834/35/36/37; Fax 01-4752760)
nó trí aon díoltóir leabhar.

© Government of Ireland 2001

Dublin
Published by the Stationery Office.
To be purchased directly from the
Government Publications Sales Office,
Sun Alliance House, Molesworth Street, Dublin 2,
or by mail order from
Government Publications, Postal Trade Section,
4 - 5 Harcourt Road, Dublin 2,
(Tel: 01-6476834/35/36/37; Fax: 01-4752760)
or through any bookseller.
Available from : www.doh.ie

€5 £3.94
Pn. 10539
ISBN 0-7557-1179-3

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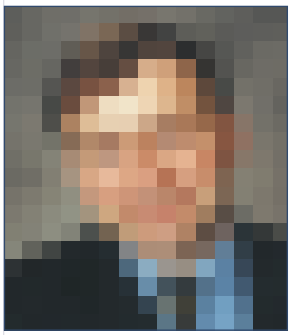
Minister for Health and Children's Foreword



It gives me great pleasure to launch this detailed account of primary care as a key component of the Government's Health Strategy, *Quality and Fairness: A Health System for You*. It demonstrates the commitment of the Government and the Department of Health and Children to primary care as the first and on-going point of contact with the health and personal social services. This means dealing with health problems at the lowest level of complexity.

Many countries have now acknowledged that primary care should be the cornerstone of modern health services and the gatekeeper of specialist services. In so doing, they have prepared strategies that have highlighted the importance of a team-based approach to primary care. This is affirmed in the messages which emerged from the consultation process which identified the need for an enhancement in services delivered in the community. The Government plans to strengthen primary care so it can contribute further to the health of the population.

Primary Care: A New Direction acknowledges the central role of primary care in the future development of our health services and proposes the introduction of an inter-disciplinary team-based approach which will be introduced on a phased basis using existing infrastructure and encouraging the use of public-private partnerships where practical.

These changes will improve access for all to primary care services, especially out of hours, will improve links between primary and secondary care and will emphasise the importance of prevention of disease and health promotion. It will also help to make primary care a more satisfying and rewarding career by providing an environment in which each person and profession can maximise his/her contribution.

Primary Care: A New Direction will enable primary care to develop the capacity to meet the challenges with which it is faced such as ageing of the population, earlier hospital discharge, care in appropriate settings as well as the opportunities afforded through modern information and communications technology.

This is a comprehensive and ambitious Strategy which will provide a blueprint for the planning and development of primary care over the next 10 years. It will help to ensure the development of a primary care infrastructure and service of which we can be justifiably proud.

Micheál Martin

Micheál Martin, T.D.
Minister for Health and Children

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Executive Summary

Introduction

Primary care is the first point of contact that people have with the health and personal social services. The Health Strategy 2001 sets out a new direction for primary care as the central focus of the delivery of health and personal social services in Ireland. It promotes a team-based approach to service provision which will help to build capacity in primary care and contribute to sustainable health and social development.

The aims of the proposed developments are: to provide (a) a strengthened primary care system which will play a more central role as the first and ongoing point of contact for people with the health-care system, (b) an integrated, inter-disciplinary, high-quality, team-based and user-friendly set of services for the public, and (c) enhanced capacity for primary care in the areas of disease prevention, rehabilitation and personal social services to complement the existing diagnosis and treatment focus.

Primary care in context

Primary care is the appropriate setting to meet 90-95 per cent of all health and personal social service needs. The services and resources available within the primary care setting have the potential to prevent the development of conditions which might later require hospitalisation. They can also facilitate earlier hospital discharge.

Primary care needs to become the central focus of the health system. The development of a properly integrated primary care service can lead to better outcomes, better health status and better cost-effectiveness. Primary care should therefore be readily available to all people regardless of who they are, where they live, or what health and social problems they may have. Secondary care is then required for complex and special needs which cannot be met solely within primary care.

The need for change

Primary care services offer great potential to achieve the growth and development in service provision that the Health Strategy is seeking to achieve. Their wide availability, their locally accessible and personal nature facilitates a close on-going relationship between providers and users of the service. Although many aspects of primary care services are satisfactory, nevertheless the current system has a number of deficiencies. Primary care infrastructure is poorly developed and the services are fragmented with little teamwork and limited availability of many professional groups. Liaison between primary and secondary care is often poor and many services provided in hospitals could be provided more appropriately in primary care. Out-of-hours primary care services are underdeveloped at present.

Many countries are now developing primary care services as the cornerstone around which their health services are built. These countries are implementing strategies which highlight the importance of a team-based approach to primary care. There is evidence in the published health literature of the success of team-based primary care which incorporates an appropriate skill mix.

The consultation process for the Health Strategy called for an improvement in services in the community. The need for improved integration of services so as to create a seamless, people-centred service was specifically identified.

The Health Strategy, therefore, proposes to develop the capacity of primary care to meet the full range of existing and future health and personal social service needs which are appropriate to that setting. There will be a significantly enhanced commitment to the funding and infrastructural development of primary care. This will

ensure a more equitable, accessible, appropriate and responsive range of basic health and personal social services for all. It will also enable primary care to lessen the current reliance on specialist services and the hospital system, particularly accident and emergency and out-patient services.

Model of primary care

The Health Strategy proposes the introduction of an inter-disciplinary team-based approach to primary care provision. Members of the primary care team will include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel. A wider primary care network of other primary care professionals such as speech and language therapists, community pharmacists, dieticians, community welfare officers, dentists, chiropodists and psychologists will also provide services for the enrolled population of each primary care team.

The population to be served by a team will be determined by encouraging GPs to join together their existing lists of enrolled individuals and families, within certain geographic considerations. This geographic focus will strengthen the capacity of the primary care team to adopt population health approaches to service provision. Teams will be based in single locations where possible and will be easily accessible. Individuals will be encouraged to enrol with a primary care team and with an individual doctor within the team. Many services will be provided on an extended-hours basis and out-of-hours cover for defined services will be greatly enhanced. There will be an increased emphasis on prevention and rehabilitation as well as the traditional focus on diagnosis and treatment.

Liaison between primary and secondary care[1] services will be improved. The primary care team will have better access to hospital services. Discharge planning will also be improved, with the development of individual care plans and the identification of key workers for individuals when appropriate. Integration between primary care and specialist services in the community will be strengthened.

The introduction of a team-based approach to primary care will have advantages for users and providers.

Requirements for implementation

This model of primary care represents a change in emphasis from secondary care to more appropriate primary care services that provide a single point of entry to all health and personal social services. Such a fundamental change will require major investment in human resources, physical infrastructure and information and communications technology. It will also require commitment and support from the various providers. The model described sets out the principles for progress but does not purport to address all of the detailed issues that will need to be worked through in the implementation phases.

The model will be implemented on a phased basis initially through implementation projects located around the country. The model will be refined and developed by agreement and on-going evaluation in which partnership with all stakeholders will be critical. Locations will build upon existing infrastructure where possible to ensure their success and will allow the development of the wider network of primary care providers for those primary care teams. Various models of teamworking will be applied in the implementation projects and participation will be on a voluntary basis.

The model will require new ways of working for providers who deliver the range of primary care services available in the community. The level of integration and enhancement required will need to be supported through investment in physical infrastructure, to provide a co-ordinated, user-friendly, inter-dependent range of services in a suitable location and physical environment. The model is dependent on adequate information and

1 Secondary care refers to specialist services which may be either community- or hospital-based.

communications technology infrastructure and on the ability and willingness of all parties to utilise available technologies. There are also major human resource implications which will dictate the pace of investment. In the short term, reliance will be on existing human resources to get implementation projects up and running, with expansion of numbers weighing in more heavily in the longer term.

Actions

This document outlines the following actions that need to be taken in order to achieve the implementation of the primary care strategy:

1 A National Primary Care Task Force will be established

2 Individual health boards will prepare needs assessments for primary care teams

3 A Primary Care Human Resource Plan will be produced

4 Primary care teams will be put in place to meet the health and social care needs for a specific population

5 Primary care networks will be developed to support the primary care teams

6 Availability of primary care services out-of-hours will be extended

7 A system of voluntary enrolment will be introduced for primary care users

8 An improved information and communications infrastructure will be provided for primary care teams

9 A system of direct telephone and electronic access to primary care services will be introduced for each health board area

10 There will be greater integration between primary and secondary care

11 Community-based diagnostic centres will be piloted

12 Policy support for the primary care model will be provided by the Department of Health and Children

13 Appropriate administrative arrangements will be put in place to support primary care at local level

14 Investments will be made in extension of GP co-operatives and other specific national initiatives to complement the primary care model

15 Modules of joint training and education of primary care professionals will be developed

16 Continuing professional and personal development programmes will be made available to Primary Care Professionals

17 A framework for quality assurance in primary care will be developed

18 Academic practice and research will be developed

19 Mechanisms for active community involvement in primary care teams will be established

20 Strategy for Nursing and Midwifery in the Community will be developed

Implementation plan

An implementation plan for primary care is outlined in this document. Some of the actions, such as improvements in out-of-hours co-operatives and development of information and communications technology, are independent of but necessary to support the model. Existing infrastructure will be used where possible and the potential of public-private partnerships will be explored.

The primary care model will be implemented on a phased basis in partnership with all the relevant stakeholders. Actions, including timeframes and targets, are set out in this document. The principal actions to be achieved in the short term relate to the development of administrative structures and implementation projects in each health board area and the introduction of services which will have the greatest likelihood of reducing pressure on the hospital system such as home helps and health care assistants. The timetable is contingent on availability of resources, partnership with the service providers and the learning derived from the implementation projects.

While the implementation projects are put in place in the identified locations, primary care in general will be strengthened by increases in the number and range of staffing levels, improved infrastructure, improved organisational arrangements and improved information and communication.

Introduction

Details on the proposals for primary care set out in the Health Strategy 2001 are presented in this document. The model of primary care is founded on the core principles of the Health Strategy (equity, people-centredness, quality, accountability) as well as principles which specifically relate to primary care – continuity of care, a holistic approach and improved population health.[2]

The aims of the proposed developments are to provide:

- a greatly strengthened primary care system which will play a more central role as the first and ongoing point of contact for people with the health-care system
- an integrated, inter-disciplinary, high-quality, team-based and user-friendly set of services for the public
- enhanced capacity for primary care to complement the existing diagnosis and treatment focus in the areas of prevention, early intervention, rehabilitation and personal social services.

The document is divided into three parts. Part 1 examines the case for change in the current system, based on an analysis of the strengths and weaknesses of primary care in Ireland, the evidence base for change, international primary care models and also what the consultation process for the Health Strategy revealed about primary care. Part 2 sets out a description of the model of primary care. Part 3 outlines the requirements for implementation of the model. These proposals are developed into an action plan, a set of targets and a timescale for phased implementation. The new primary care model will be introduced on a phased basis, in partnership with all the relevant stakeholders. Existing infrastructure will be used where possible and the issue of public-private partnership will be explored. While the new model is being introduced, primary care in general will be strengthened and improved on a national basis.

2 Population health is an approach to health that aims to improve the health of the entire populations or sub-groups within the population and to reduce health inequalities among population groups.

PART 1

Background - the need for change

What is primary care?

For the purposes of the Health Strategy, primary care is defined as follows:

> ***Primary care*** *is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.*

This means dealing with health problems at the lowest level of complexity. Primary care is the first point of contact that people have with the health and personal social services and should be available to all people regardless of who they are, where they live, what their income is or what health and social problems they may have. Primary care is the part of the system that ensures that services are co-ordinated and integrated across the boundaries of health and personal social care to the benefit of the consumer in terms of better quality, better outcomes, better cost-effectiveness and better health status. The Declaration of Alma Ata in 1978 was an important milestone in the promotion of world health and outlined the concept of primary health care.

The term 'primary care' is often used synonymously with 'general practice'. While general practice is a key element, it is broader than general practice alone. It encompasses a wide range of health and personal social services delivered by a variety of professions. Primary care providers can make a significant difference not just in treating illness, but also in supporting people to care for themselves and their families, improving wellness, preventing illness and supporting those with long-term problems, from a health and social well-being perspective.

Primary care includes the range of services that are currently provided by general practitioners (GPs), public health nurses, general nurses, social workers, practice nurses, midwives, community mental health nurses, dieticians, dentists, community welfare officers, physiotherapists, occupational therapists, home helps, health care assistants (see Appendix 1), speech and language therapists, chiropodists, community pharmacists, psychologists and others. The current primary care system is delivered by a combination of these disciplines, very often working in isolation, either as private practitioners or as direct employees of the public health system. GPs are independent contractors while most other services are provided by employees of health boards and voluntary organisations. An outline of the national policy context and a more detailed description of current service provision is presented in Appendix 1.

The need for change

Better health for everyone is the first national goal of the Health Strategy 2001. This requires a mobilisation of effort across various sectors with an influencing role on the health status of the Irish population. The reform and development of health and personal social services in Ireland planned over the lifetime of the new Health Strategy aims to deliver improvements in the personal experiences of the many thousands of individuals who are availing of services every day. The ease of access to services, the quality, responsiveness and timeliness of the treatment and care received and the degree to which individuals are supported in leading healthier and more independent lives in their own communities are fundamental indicators for people of how well their needs are being served.

The development of a high-performing health system will require, among many other things, that the overall volume and range of health and personal social services available be greatly expanded over the coming years. In seeking to achieve this, investment and effort needs to be focused on the parts of the service that are best placed to provide maximum return, to grow to serve unmet need and to deliver the kind of person-centred, holistic and locally accessible range of services that are required if the Health Strategy is to make a real difference.

The development of primary care offers great potential to achieve the growth and development in service provision required. The existing strengths of primary care services in Ireland provide a very firm foundation on which to base the level of expansion and development that is needed. These strengths are evident, for example, in the satisfaction that has been expressed with GP services during the consultation process for the Health Strategy. Primary care services are available in their various forms in every part of the country. Their locally accessible and personal nature facilitates close ongoing relationships between provider and patient.

However, the current system of primary care has many inadequacies which must be addressed. It is fragmented from the user perspective and is difficult to access out-of-hours. The current system also places emphasis on diagnosis and treatment while having limited capacity for health promotion, prevention of illness and rehabilitation. The limited impact of current approaches to prevention particularly need to be addressed if the improved health status targets of the Strategy are to be met. There is a scarcity of many key professional groups which results in secondary care[3] having to provide a number of services that are more appropriate to primary care. In the future, additional challenges will arise from increases in the population of elderly and high-dependency groups. This will add to the pressures on the secondary care system. Strong public demand exists for the development of locally responsive services to meet these needs.

Principal inadequacies in current system of primary care

- Poorly developed primary care infrastructure and capacity
- Current system fragmented from user's perspective
- Limited opportunities for user participation in service planning and delivery
- Emphasis on diagnosis and treatment with weak capacity for prevention and rehabilitation
- Potential to reduce pressure on secondary care not fully realised
- Secondary care providing many services which are more appropriate to primary care
- Current system oriented around needs of providers rather than those of users
- Out-of-hours services underdeveloped
- Limited availability of many professional groups
- Professional isolation
- Limited teamworking
- Communication between professionals and sectors inadequate
- Lack of quality assurance framework
- Limited information from primary care for planning, development and evaluation

In considering the options for developing and enhancing the services, a four-part analysis was undertaken. The analysis included an examination of primary care as it currently stands in terms of strengths, weaknesses, opportunities and threats; the identification of the main messages from the consultation process undertaken as part of the preparation of the Health Strategy; a review of the international evidence base for key aspects of primary care; and consideration of systems of primary care in other countries. The details of each of the four components are set out in Appendix 2. Key conclusions that can be drawn from this analysis are as follows:

- Developments in primary care should build upon and add to the very significant strengths of the system that currently exist in Ireland. Same-day access to many primary care professionals and co-operative working for GPs in some areas on an out-of-hours basis, are examples of these strengths

3 Secondary care refers to specialist services with may be either community- or hospital-based.

- The commitment of individual professionals and their professional organisations has compensated for the absence of a well-developed infrastructure for primary care
- The skills and commitment of individual professionals are not employed as effectively as they could be. GPs, for example, can be isolated from many other community services. Communication and work-sharing with other primary care professionals is not always readily facilitated or supported
- Primary care infrastructure is poorly developed and the services are fragmented, with limited teamwork and availability of certain professional groups
- Liaison between primary and secondary care is often poor and many services provided in hospitals could be provided more appropriately in primary care
- Primary care out-of-hour services are underdeveloped
- Key concerns to emerge from the consultation process for the Health Strategy relate to the need for an improvement in local access and availability of care out-of-hours; and the need for improved integration of services, so as to create a seamless, people-centred service in the community
- Many countries are now developing primary care services as the cornerstone around which their health services are built. These countries have prepared national strategies that have highlighted the importance of a team-based approach to primary care
- Common themes that have emerged from international strategies include: the key role of inter-disciplinary teamworking; the importance of preventive services; the need for improved information; and the importance of patient enrolment
- There is evidence in the published health literature of the success of primary care in providing continuity of care and in playing a crucial gatekeeper role to secondary services
- Teamworking has been shown to provide a more responsive service to patients who benefit when health professionals work together with an appropriate skill mix.

The analysis indicates that primary care, planned and organised on a 24-hour basis, has the potential to lessen the current reliance on specialist services and the hospital system, particularly accident and emergency and out-patient services.

Conclusion

All but the most complex and acute health care needs of individuals, families and groups may be effectively met within the primary care setting. The management of that wide range of care in this setting represents the most appropriate, effective and user-friendly approach to the organisation of service delivery. The development of primary care services, so that they become the cornerstone of care and preventive services for communities across the country, is consistent with best international practice. This document proposes a model through which the increasing need for health and personal social services can be significantly addressed through the orderly development of primary care based services.

The weaknesses of the current system, the views expressed during the consultation with the public, and the international evidence point to the need for change in the way primary care is planned, organised and delivered in Ireland. The principal change required is a shift in the balance from secondary specialist care to primary generalist care. This will need major investment in the development of an appropriate infrastructure for primary care.

The proposals outlined aim to develop the capacity and infrastructure of primary care so that it:

- is easy to access and understand
- is available when needed
- helps people to stay healthy
- provides appropriate care in the appropriate setting
- improves the health of the local community and the overall population
- enables people to take control of and responsibility for their health
- co-ordinates on-going care for individuals and families
- contributes to reduction in health inequalities
- responds to the needs of individuals and families when problems or acute needs are experienced.

It is important to note that the new model does not affect in any way the current status of GPs or the professional-patient relationship, with members of the primary care team.

PART 2

Primary care model - a description

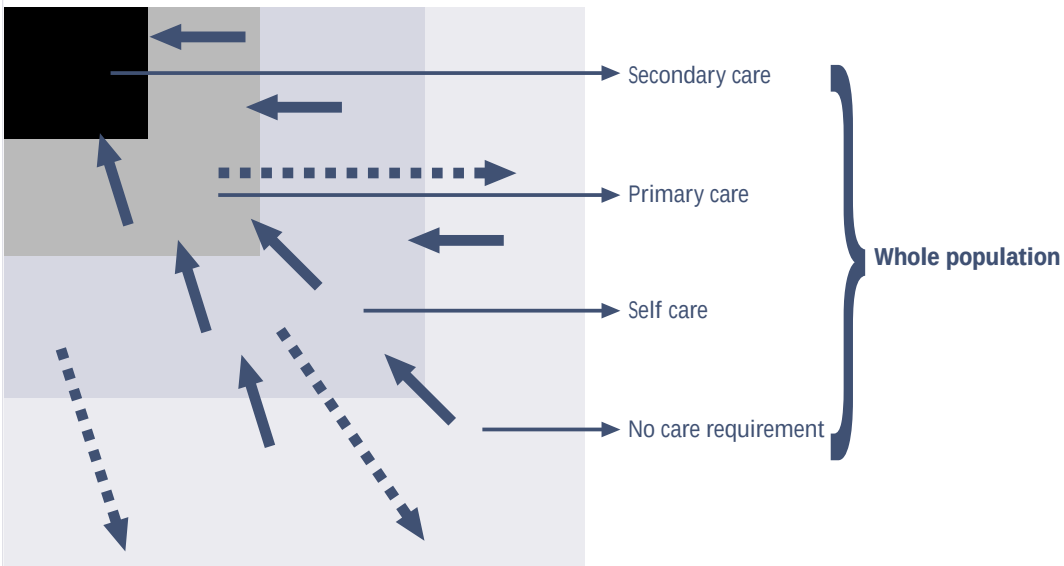
Introduction

The considerations set out in Part 1 of this document point to the need for the development of community-based health and personal social services in Ireland. However, in doing this, equal attention needs to be given to how the various services and individual professionals operate so that patients or clients can easily access the services or range of services they require. Experience elsewhere points to greater effectiveness from an integrated team-based approach. For these reasons, the Government has decided that the development of primary care, based on a team approach, will be central to the planning and delivery of health and personal social services for the future. This section outlines an expansion of primary care so that it becomes the main setting for delivery of health and personal social services and a key component of health education, early intervention and disease prevention.

Primary care should be the first point of contact that people have with the health and personal social services. The role of the primary care services as the provider of the majority of all care requirements and the gatekeeper of specialist services will be strengthened. This will involve a team-based approach to service provision, which will help to build capacity in primary care.

The Irish health system places a considerable reliance on hospital care as illustrated in Figure 1. This diagram shows a series of squares, becoming progressively smaller. The outer square represents the whole population in a given time period, including those who are healthy. The next layer represents those who have some health issues but do not seek professional assistance and very often provide care for themselves. The grey zone represents those who seek assistance from GPs, nurses and other primary care providers, while those who require secondary care are represented by the very small black square. This illustrates that only a very small proportion of those who seek care require secondary hospital or specialist care. The dark arrows represent forces such as recent trends towards increased specialisation or over-reliance of people on professional help rather than self care. The primary care model can provide a force (dotted arrows) which runs counter to this and can therefore move care, where appropriate, from secondary to primary level, from primary level to self care (by empowering people), and from self care to no care requirement (through illness prevention and health promotion). In Ireland, it is estimated that there are 15-16 million consultations in general practice while approximately 1.9 million consultations take place in out-patient departments each year.

Figure 1: Relationship between primary care and other care levels



Source: Adapted from Green et al*. 2001*

Model of primary care

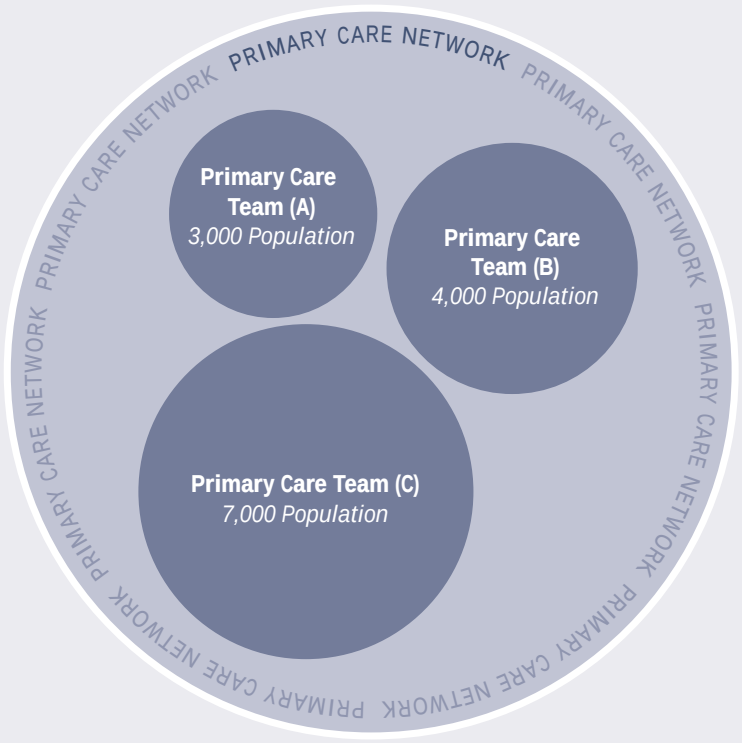
This section describes the proposals for primary care. It outlines the model under a number of relevant headings, and provides an overview of the service as envisaged in the Health Strategy.

Primary care team

Primary care will be centred on the needs of individuals and groups of people and will match their needs with the competencies required to meet them. Some of the essential competencies will include assessment, diagnosis, therapy, nursing, midwifery, prevention, health education, counselling, administration, management, social services, referral and rehabilitation.

A group of primary care providers will come together to form an inter-disciplinary team, known as the primary care team. These teams will serve small population groups of approximately 3,000-7,000 people, depending on whether a region is rural or urban. Among other factors, the number and ratio of team members will depend on needs assessment, location and population size. In the long term, approximately 600-1,000 primary care teams will be required nationally, based on a population of 3.8 million. Teams will include appropriate levels of administrative support. A wider network of additional professionals will be formed to provide the therapy services required by a number of core primary care teams. Figure 2 illustrates the proposed membership and interaction between the core primary care team and the wider network of primary care providers. The diagram is for illustrative purposes only. In practice, there may be more or less than three primary care teams working with the wider primary care network. The ultimate arrangement will be determined by needs assessment and geographical spread of the enrolled population.

Figure 2: Primary care team and primary care network



Primary care team

GP
Nurse/midwife
Health care assistant
Home help
Physiotherapist
Occupational therapist
Social worker
Receptionist
Clerical officer
Administrator

Primary care network

Chiropodist
Community welfare officer
Community pharmacist
Dentist
Dietician
Psychologist
Speech and language therapist

The proposed membership of the primary care team is set out in Table 1. The numbers of various team members presented are for illustrative purposes only and will need to be considered in depth during the implementation process. The nurse/midwife functions would include advanced nurse practitioner, clinical nurse specialist, public health nursing, midwifery, mental health, practice nurse and general nursing competencies. The optimal number and ratio of physiotherapists, occupational therapists and social workers required for the primary care team will depend on needs assessment and the geographic location of the team. Some therapists may work with more than one core primary care team. This will be determined in the implementation phase.

Table 1: Proposed membership of primary care team

Primary care team	*Number envisaged*[4]
General practitioner	4.0
Health care assistant	3.0
Home helps	3.0
Nurse/midwife	5.0
Occupational therapist	0.5 – 1.0*
Physiotherapist	0.5 – 1.0*
Social worker	0.5 – 1.0*
Receptionist/clerical officer	4.0
Administrator	1.0
**to be assessed*	

Primary care network

It is envisaged that a wider network of health and social care professionals will be formed who will work with a number of primary care teams. Each primary care team will have access to a range of health and social care professionals who will provide services for members of their enrolled population group. Members of the network will work with more than one primary care team. Formal communications processes will be established between the core primary care team and the wider network of professionals. Named members of the primary care network will be designated to work with specific primary care teams. The proposed membership of the wider network is set out in Table 2 below.

4 For the purpose of calculations, the average population size served by the primary care team is taken as 5,000. Some eight additional whole-time equivalents (WTEs) will be required to provide extended-hours care by the primary care team and 24-hour GP and nursing/midwifery services.

Table 2: Proposed membership of primary care network

Chiropodist
Community pharmacist
Community welfare officer
Dentist
Dietician
Psychologist
Speech and language therapist

Capacity of primary care team

The inter-disciplinary team approach will help to develop the capacity of services at primary care level. The wide skill mix within the team will allow a more appropriate distribution of workload between members of the team. This will allow each team member to work to his or her maximum professional capacity. It will also allow team members to spend more time on areas such as preventive work and continuing professional development. Additionally, this will allow support to be given to inter-referral between primary care providers such as GPs which can also enhance the capacity of primary care.

This approach to primary care will facilitate communication between team members which will greatly reduce the time currently spent trying to contact other primary care providers. The team structure will provide support to all its members. To reach its full potential, however, significant investment in education and training will be required.

The provision of a wide range of services in this way will allow a higher percentage of patients to be cared for in the community. The increased provision of home helps, for example, should enable patients to stay at home with support and prevent crisis hospital admissions. The provision of health care assistants and occupational therapists in the community should allow patients to be discharged earlier from hospital.

Information and communications technology

Appropriate electronic communications and electronic record systems are central to the operation of both the primary care team and the wider network of professionals. There will be considerable investment in information and communications technology infrastructure. This will include the development of an electronic health record based on a unique client number. Patient information will remain confidential and will only be available to those team members who need it.

Many of the issues relating to information and communications technology will be addressed in the forthcoming National Health Information Strategy and in the on-going General Practice Information Technology project.

Enrolment with primary care team

GPs and other professionals keep records of patients who utilise their services. However, it is recognised that these systems may be inadequate for key functions such as comprehensive call and recall as required for screening and immunisation. In this regard, practice registers are an essential component of high-quality primary care.

The Health Strategy 2001 envisages a system whereby people are invited to actively enrol. All individuals will be encouraged to enrol with one primary care team, and with a particular GP within the team. Where appropriate for an individual's needs, a key worker will be identified.

Enrolment will be voluntary. The benefits of enrolling with a team will include better continuity of care, improved co-ordination of services, and more attention to preventive services. Enrolment will not reduce people's choice of provider and patients will be free to seek care wherever they wish. Individual members of a family will be able to enrol with different teams or with different doctors within the team. The system will also allow people to change their nominated team or doctor.

The primary care model in action…

Delivering integrated family care

Mary is 37 years old and lives with her husband Niall (42 years), a casual labourer, and four children, Paul (10 years), Mairéad (6 years) and Seán and Conor (twins of 15 months). Mary has come to the primary care centre with Seán and Conor for their MMR vaccination. At the visit she appears very stressed and expresses concerns to the nurse that Conor has not started walking yet. Patricia, the nurse, spends some time with Mary, listening to her concerns and reassuring her about Conor's developmental progress.

In the course of the consultation she discovers that Niall has been drinking heavily, leading to worsening financial problems, and that the oldest child Paul has started to wet the bed and has become disruptive in school. Patricia arranges to see Paul a few more times in keeping with the practice protocol on enuresis and provides Mary with information on the local branch of Al-Anon. An appointment is arranged for Mary and her husband with the community welfare officer for the following week to assist with accessing financial benefits.

Access to primary care team

Individuals will be able to self-refer to any given member of the primary care team or network as appropriate. There will also be a system of triage and referral at the point of access available for those who wish to use it. This will ensure that people can be linked with the most appropriate professional for their needs.

Access to primary care services, particularly out-of-hours, will be improved for all, following the introduction of this new model of primary care. Services will be more flexible to accommodate those who work during the day. This system will build on the strengths of the current co-operative model for GPs. The hours during which all of the basic primary care services are provided will be increased, with a number of essential services on a 24-hour basis. An improved range of services will also be provided at weekends.

Eligibility

The broad issue of eligibility is addressed in the Health Strategy (2001) document. The main actions outlined are as follows:

- New legislation to provide clear statutory provisions on entitlement will be introduced
- Eligibility arrangements will be simplified and clarified

- Income guidelines for medical card eligibility will be increased
- The number and nature of free GP visits for an infant under the Maternity and Infant Care Scheme will be extended.

Broad focus for primary care services

The primary care team will work with local populations and other agencies to identify health and social needs. It will also provide appropriate responses including the range of general medical services in addition to the generalist aspects of services for mental health, elderly care, drug misuse, disabilities, family support and child health. This will necessitate inclusion of personal social services staff on the teams.

Population health services will be strengthened and expanded to ensure widespread uptake of initiatives such as screening, immunisation and early intervention. Primary care teams will be facilitated and funded to develop and expand cross-sectoral activities which can promote and protect the health of people and families enrolled with them through, for example, school and community-based health education, counselling and classes, links to local area action plans to provide integrated information and services, as well as links to community development projects.

Broadening the focus of primary care means the re-allocation of responsibility to the primary care team for services which are currently provided in specialist care settings but which may require less extensive specialist input. Examples include care of those with diabetes mellitus, high blood pressure, routine ante-natal and post-natal care, child health surveillance and generalist mental health services.

The primary care model in action…

Delivering a person-centred inter-disciplinary preventive service

John, a 45-year-old businessman, is worried about a dark mole on his arm and he decides to telephone his local primary care centre. He looks up the web site from his office and calls to arrange an appointment.

Ann, the receptionist, sees from John's electronic record that he was invited for a 'high-risk cardiovascular assessment' earlier in the year but did not come in. She suggests that when John is in this evening with the GP he could also meet with the nurse and have his assessment done. John thinks this is a great idea as he was away on business for the last appointment and has been too busy ever since.

Órla, the GP, removes the mole in the surgery and sends it to the local hospital for histological examination. She feels that it is not malignant and reassures him on that basis. This is confirmed when she receives the report electronically from the hospital five days later.

Peter, the nurse, meets with John and in the course of the consultation John discloses that he smokes 20-25 cigarettes a day and that he has tried to give up in the past, with little success. Peter arranges a prescription for nicotine replacement therapy and invites him along to the stop-smoking support group that meets in the primary care centre on Thursday evenings.

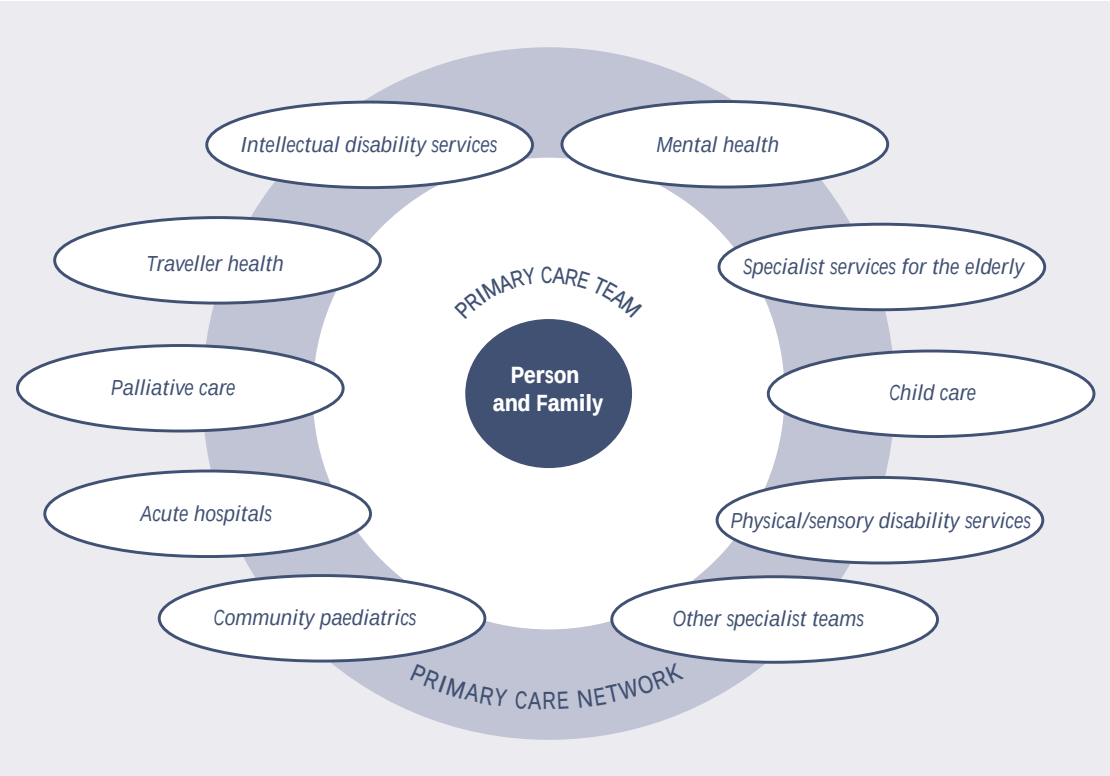
Co-ordination of primary care and specialist services

The primary care team will liaise with specialist teams in the community to improve integration of care. Community-based specialist teams are already in existence in the community for many specific care groups. The primary care team will integrate with these community-based specialist teams in ways similar to how the

primary care team will integrate with the specialist institutional services, e.g. acute hospitals. The benefit of this from the perspective of users is that they are facilitated, through a single point of contact, in accessing whatever specialist services they require. Examples of specialist teams based in the community include:

- Palliative care
- Mental health
- Child care
- Disability (intellectual and physical/sensory)
- Special client groups (e.g. homeless, Traveller health teams)
- Community services for the elderly.

Figure 3: Overview of primary care and specialist services



Primary care teams have the potential to deliver much of the care currently provided by specialist services. However, realising this potential will require better integration between secondary and primary care services. The purpose of such integration is to provide more seamless care for individuals, families and groups and to ensure that the two sectors operate together as a whole rather than two separate entities. Figure 3 is provided to assist in understanding the complexity of services available in the community, particularly the connection between the generalist primary care team and the wider primary care network and specialist services.

Primary care teams will have direct access to appropriate hospital-based diagnostic services based on local protocols, which can support earlier intervention and better on-going care for individuals. In addition, community-based regional diagnostic centres to support primary care and care in the community will be piloted and evaluated. There will also be improved shared care arrangements for patients with conditions such as

diabetes and asthma, to enable them to be managed more effectively and by a broader range of professionals in the community.

Local arrangements will also be put in place covering referral protocols, discharge plans, individual care plans, integrated care pathways and shared care arrangements. Some of these developments will require certain team members to act as key workers for individuals with complex chronic care needs.

The primary care model in action…

Interface between primary and secondary care

Jane is worried about how she will cope now that her mother has just been admitted to hospital. Bridget (79 years) had a mild stroke from which she still has some weakness in her left hand and arthritis in her left hip. Although frail prior to the stroke she had lived independently in her own home.

The day following admission the hospital discharge nurse contacts the local primary care team administrator to plan in advance for Bridget's discharge. Liam, the occupational therapist, calls Jane to arrange a time convenient to do a needs assessment of the home care environment. Following the assessment he convenes a meeting with Jane, together with the nurse, GP, physiotherapist, social worker and hospital discharge nurse to draw up an individual care plan aimed at maintaining her mother in her own home. The hospital discharge nurse attends the meeting. The meeting concludes by agreeing that the home help and health care assistant will visit Bridget daily and the physiotherapist will visit every second day.

Jane leaves the meeting relieved that with a home care plan for her mother in place, the primary care team will be able to provide her with the support that she needs to allow her mother to come home. She also feels that her mother, with access to respite care, might be able to avoid admission to hospital in the future and may be able to be back in her own home sooner.

Location of primary care teams

Though not essential, primary care team members should ideally be located on the same site or in very close proximity. The exact location will reflect local circumstances and the availability of appropriate pre-existing facilities. The role of public-private partnerships and other options will be explored as an alternative when premises are being sought to house the primary care teams.

Facilities for some of the professionals operating in the wider network should be made available in the primary care premises. The nature of work carried out by some team members, such as public health nurses, home helps and health care assistants, dictates that a number of services will be delivered to people in a home setting. The goal should be to establish lines of communication and mechanisms for integration that lead to a more efficient and seamless service for the individual and the community.

This will have particular implications for some members of the wider network, such as dentists, psychologists and community pharmacists who, while continuing to operate as independent private practitioners, will need to develop stronger linkages to the primary care team. For all other team members, the goal will be to ensure that they operate from premises located in a convenient and accessible location for the population which the primary care network serves.

Advantages for consumers and patients

One of the principal advantages for consumers and patients will be improved access to primary care services, particularly out-of-hours. The range of services provided in a primary care setting will also be increased, especially in areas such as prevention, health promotion and rehabilitation. A variety of supports will be provided, e.g. health care assistants to support patients in the home, and thus reduce the need for crisis hospital admissions. Greater availability of GPs will allow for increased consultation time to the benefit of both patient and doctor.

Many primary care services will be provided in a 'one stop shop' setting, which means that a patient or family can access a number of health care providers in the one centre. Patients who enrol with a particular team or doctor and wish to change will be facilitated in doing so. From an individual's point of view the system will become simpler and more supportive. A clarified and simplified system of eligibility will be provided so that people know what services they are entitled to and how they can access these services. Finally, information about health and the health services will be easily accessible via a single telephone and internet access point.

Advantages for professionals

Advantages for professionals involved in a primary care team will include improved access to other team members. Direct access to diagnostic facilities, secondary care services, and infrastructural and information technology supports will also be improved upon.

The introduction of a properly resourced primary care team with its skill mix will ensure that many health professionals will have more time to engage in preventive activities and continuous personal and professional development. With the introduction of extended hours, working hours for many team members will become more flexible. This model of primary care will also mean less stress and improved morale for the health care professionals involved. Career structures will be enhanced for all members of the primary care team. Research and development opportunities will also be improved.

Advantages for the health system

Primary care, planned and organised on this basis, could lessen the current reliance on specialist services and the hospital system (particularly accident and emergency and out-patient services) and, based on available evidence, would have the potential to reduce the requirement for specialist services, reduce hospitalisation rates, reduce lengths of stay for those who are hospitalised, promote more rational prescribing, and improve efficiency.

The primary care model in action…

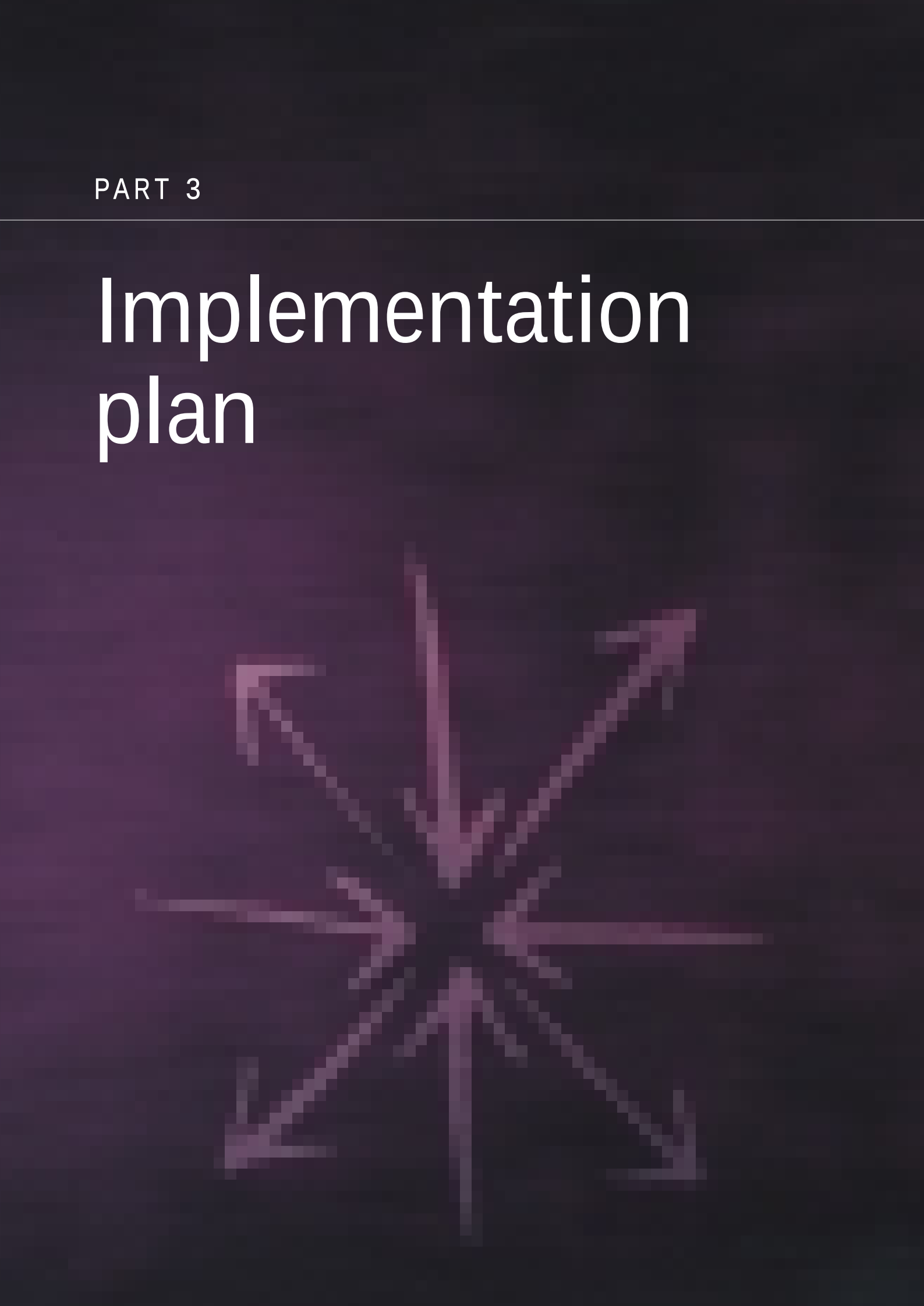
Delivering a high-quality primary care service

In the course of setting up the primary care centre, an audit was carried out which identified a number of people with a history of heart disease who were not taking aspirin. Pauline (67 years) was invited to attend the primary care centre to review her treatment in light of this. She has a history of high blood pressure and had a heart attack two years ago but is doing well since. Dermot, the GP, explains that, in light of her past history, aspirin would be of benefit to her and he adds it to her regular quarterly prescription.

When Pauline collects her prescription, the community pharmacist who has received electronic notification of the new prescription explains the effects that aspirin might have when taken along with her current medication. Pauline meets a friend for coffee and tells her about the thorough service at the primary care centre.

PART 3

Implementation plan



Requirements for implementation

Introduction

The model of primary care described in this document is designed to broaden the focus and extend the availability of services so that the core orientation of service delivery in the health system is fundamentally shifted from an existing emphasis on hospital settings to more appropriate, locally available community-based services that provide a single point of entry for the individual to the full range of health and personal social services. This fundamental change will not be easily achieved. It will require major investment in human resources, physical infrastructure and information and communications technology to develop the new capacity that is required for the primary care services to take on that expanded and enhanced role. Successful implementation of the primary care model will require the commitment and support of the various professional providers and other staff involved in order to ensure that the development and change envisaged is successfully progressed on a partnership basis.

Consultation

The model described sets out the principles for progress; it does not purport to address all of the detailed issues that will need to be worked through in the implementation phases. Consultation with all the relevant stakeholders will be required on the way forward. The Department of Health and Children is committed to working in partnership with the key stakeholders, including service providers, unions, professional bodies, staff representatives and the education sector on the development of a structured programme for the phased implementation of the primary care model over the next ten years. This partnership approach will be achieved through ongoing participation in local and national structures.

Implementation projects

The model described will be implemented on a phased basis to ensure that the necessary capacity building takes place. This will allow the model to be rolled out in a manner that draws on experience gained and enables all relevant professional and user stakeholders to participate in shaping its more detailed aspects. Implementation projects will be initiated around the country on the basis of the principal features of the model set out in this document. It is envisaged that the model will be refined and developed by agreement through the joint learning that these initial implementation projects will allow for. The positive contribution of all stakeholders in a meaningful and open partnership during this implementation phase will be critical to the fundamental reorientation of health service delivery being aimed for.

Suitable locations will be identified for the introduction of implementation projects with a view to having 40 to 60 teams, covering an overall population of approximately 300,000, up and running within 3 to 5 years. The locations will build upon existing infrastructure and local primary care or community development projects as appropriate. The locations of primary care teams for the implementation projects will be selected so that teams can operate in close proximity. This will allow for the development of a wider network of primary care providers that will relate to primary care teams as they develop.

Various models of team working will be applied in the implementation projects. This will include issues such as leadership, team relations, co-ordination and communication. The introduction of primary care teams and networks will not interfere with the professional relationship between individuals and carers. The on-going evaluation of these projects, on a partnership basis, will point the way for the future development of primary care services in Ireland.

Resource requirements

The model described for progression through the implementation projects will require new ways of working for the many professional providers and other staff who deliver the range of primary care services available in the community. The level of integration and enhancement required will need to be supported through investment in physical infrastructure, to provide a co-ordinated, user-friendly, inter-dependent range of services in a suitable location and physical environment. The model is also dependent on an adequate information and communications technology infrastructure and on the ability and willingness of all parties to utilise available technologies. Finally, there are major human resource implications. While cost estimates for full implementation will be informed by the progression of the implementation projects, it is possible to broadly quantify the likely cost implications of the implementation project proposals as they stand and to project outline longer-term costs on that basis.

(i) Physical infrastructure

Modern, well-equipped, accessible premises will be central to the effective functioning of the primary care team. While for practical purposes teams would be likely to operate out of more than one premises in the short term, the development of locally accessible primary care centres that allow many of the services being delivered to be made available on a single site, providing a single point of access for the user and encouraging closer co-ordination between providers, is a key longer-term implementation objective of the new model. The existing network of community health centres would not be adequate to serve this purpose. The operation of public-private partnerships will be explored as one way of providing the necessary accommodation for primary care teams and the wider networks. At current prices, the capital cost of developing the facility required for the range of services planned is of the order of £2 million[5] (€2.5M) per facility. Taking an initial 40 to 60 implementation projects, and allowing for the fact that the selection of locations will be guided by the availability of good infrastructure where it exists, it can be expected that a capital outlay of approximately £100 million (€127M) will be required during the initial five-year implementation phase. In the longer term, on the assumption that between 400 and 600 core primary care teams will be required for two-thirds implementation in 2011, the capital investment would be in the order of £1,000 million (€1,270M) at current prices. The National Development Plan may provide some of this investment.

These figures indicate the order of investment required and emphasise the need to gain full benefit from existing buildings and to fully exploit any opportunities for public-private partnerships in implementing the development programme. These possibilities will be fully explored in the course of the early implementation phase with a view to reducing the burden on public funding.

(ii) Information and communications technology

Effective communication and pooling of information is essential to the delivery of an integrated service at primary care level. The information and communications technology that is required to support that objective needs to be invested in as a prerequisite to the roll-out of the model. The software, hardware and training requirements to support a secure network with remote access for team members and the wider network of providers will entail significant seed investment and ongoing recurring costs. The costs involved per team are estimated at £60,000 (€76,000) start-up and £15,000 (€19,000) per annum on an ongoing basis, exclusive of training costs. Based on this, together with the ICT costs in developing the wider network, the implementation projects will involve an initial investment of some £5 million (€6.3M) with annualised costs running at an additional £1 million (€1.27M). In the longer term, it is estimated that an investment of up to £50 million (€63M) once-off and recurring costs of £10 million (€12.7M) per annum will be entailed at the end of ten years.

(iii) Human resources

The membership of the primary care teams and the network of primary care providers set out in Part 2 will be

5 Excludes cost of site acquisition.

drawn from existing professionals and staff to the extent available. The model described, however, represents a major enhancement of the level and nature of services that are currently available in primary care settings. Taking account of the expansion of services involved and of the extended-hours availability of certain core services, including some on a 24-hour basis, the investment involved will be of major significance. Short-term initiatives in terms of equipment, education and personal development will be required.

An estimation of the additional costs involved, allowing for the availability of existing staff and taking account of the makeup of typical core teams and wider provider networks, averages out at approximately £970,000 (€1.23M) per team in the longer term. On this basis, the total cost of the implementation projects would amount to £48 million (€61M).[6] Taking into account estimates of existing expenditure, some £25-30 million (€32-38M) additional investment on human resources will be required over the next five years.

Assuming two-thirds implementation (400-600 teams) of the model over the next ten years, approximately an additional 500 GPs and 2,000 nurses/midwives will be required, with similar large increases in health and social care professionals, administrative staff, home helps and health care assistants in order to provide in the range of 400-600 teams as set out in Table 1. The increases in therapy professionals are in keeping with requirements set out in projections made for the Department of Health and Children in the Bacon Report entitled *Current and future supply and demand conditions in the labour market for certain professional therapists* (see Appendix 1).

Considerations in relation to the supply of human resources in the disciplines required will dictate the pace of investment in the short to medium term. For this reason, in the short term there will be a heavy reliance on existing available human resources in getting the implementation projects up and running, with the expansion of numbers weighing in more heavily on the further roll-out as supply side measures referred to in Chapter 5 of the Health Strategy document are effected in the disciplines involved. At the end of ten years, the staffing costs of implementation will entail an approximate overall investment of £484 million (€615M) per annum.

(iv) Co-operatives

Further development of current GP co-operative models will take place on a national basis as a key support to the enhanced availability for a defined range of primary care services on a 24-hour basis. This will require a framework for the extension of GP co-operatives on a national basis. Along with medical cover, 24-hour cover will be provided through the availability of nursing services, health care assistants and home helps, leading to the development of primary care co-operatives. In this regard, it is expected that a number of teams would come together to provide out-of-hours coverage for population groups. To provide the infrastructure required for the operation of the enhanced 24-hour service an annual cost in the region of £25 million (€32M) is estimated.

(v) Academic centres

A small number of academic centres of primary care will be created, as an authoritative source of policy and practice advice. The precise location, staffing and costing of these centres will be finalised by the National Primary Care Task Force during the implementation phase in partnership with professional organisations, the education sector, the Health Research Board and the Health Information and Quality Authority recommended in Chapter 5 of the main Health Strategy document.

(vi) Community-based diagnostic centres

Three community-based diagnostic centres will be piloted to support primary care and community-based care. Up to £5 million (€6.3M) will be made available for each project. Evaluation of these projects will determine the future direction of such services. Funding will be disbursed via health boards and joint board co-operation and public-private partnerships will be actively encouraged.

6 This figure does not include existing GP costs but does cover estimated additional GP costs.

Action plan for implementation

Implementation actions

The implementation of some of the actions required to support the development of primary care, such as improvements in out-of-hours co-operatives and the development of information and communications technology, is independent of the model of primary care. In implementing the model through the initial implementation projects and further roll-out, the following actions will be required.

1 A National Primary Care Task Force will be established

A small, full-time task force, called the National Primary Care Task Force, will be established to take responsibility for driving the implementation of the changes and developments set out in the model. The Task Force will be inter-disciplinary and will report to a wider representative Steering Group which will be chaired by the Department of Health and Children and include representation from health boards, primary care professional groups, unions, and other relevant stakeholders. The Task Force will focus on

- driving the implementation of the primary care model as outlined in this strategy
- identifying representative locations for the implementation projects
- planning human resources, information and communications technology and capital requirements for primary care on a national basis
- putting in place a framework for the extension of GP co-operatives on a national basis with specific reference to payment methods and operational processes.

The Steering Group will give leadership in

- defining a broad set of primary care services which should be provided by primary care teams
- co-ordinating the development of quality initiatives in primary care
- identifying locations for the establishment of academic centres of primary care as a source of policy and practice advice
- developing a national framework for achieving closer integration with the secondary care system
- providing policy advice to the Department of Health and Children, health boards and other bodies as appropriate
- evaluating progress, including an annual report on implementation, on the basis of an agreed set of performance indicators.

2 Individual health boards will prepare needs assessments for primary care teams

Health needs assessment is central to effective primary care and will be a continuous process. The coverage, composition and number of primary care teams in each health board area will be established on the basis of

needs assessments consistent with a population health approach, to be initiated by the health boards. These assessments will conform with any guidelines or frameworks developed by the National Primary Care Task Force. They will take into account demographic factors, epidemiological factors, geographical considerations and existing health and social service provision. Needs assessments should specifically identify special needs or areas of disadvantage to ensure that primary care teams can be targeted to meet those needs.

3 A Primary Care Human Resource Plan will be produced

A Primary Care Human Resource Plan will be produced by the National Primary Care Task Force and the health boards to develop the capacity of primary care. Immediate improvements in human resource planning as proposed in Chapter 5 of the main Health Strategy document will be accelerated to enable projected longer-term requirements for staff numbers and skills mix to be identified, particularly in the health and social care professionals. This will allow a greater focus on issues such as health promotion, disease prevention, and rehabilitation as well as diagnosis and treatment. It will also allow for a shift in the location of the delivery of many services from secondary care to primary care, where appropriate.

The Human Resources Plan will require the commitment and support of various professional providers and other staff involved in order to ensure that its successful development and implementation is progressed on a partnership basis. It will be based on the needs assessments to be carried out by the individual health boards.

Developing capacity to provide a broader and more comprehensive range of services in the community means recruiting more general practitioners, nurses/midwives, health and social care professionals, home helps, health care assistants and others, and supporting all staff in ongoing personal professional development.

This capacity will be developed in a number of ways. Initially, priority will be given to short-term solutions such as introducing more professionals whose input can limit the burden on hospital and institutional services and increase the likelihood of people being maintained in their homes. These include in particular nurses, home helps and health care assistants. Short-term mechanisms for attracting more of these professionals into the primary care services will be pursued.

Human resource requirements will need to be reflected in increased intake to relevant undergraduate and postgraduate faculties or in the provision of new undergraduate courses, as appropriate. This will be pursued as a matter of priority with the relevant professional training bodies and the third level education sector.

4 Primary care teams will be put in place to meet the health and social care needs for a specific population

The population to be served by a team will be determined by encouraging GPs to join together their existing lists of enrolled individuals and families, with certain geographic considerations. This geographic focus will strengthen the capacity of the primary care team to adopt a population health approach to service delivery. In the implementation projects, the other professionals and staff that will make up core teams will be aligned around the resultant general practice lists to provide care to these expanded population groups. Currently general practice populations do not automatically align with community care catchment populations. However, with some flexibility, it should prove possible to agree a basis on which common catchment populations for a combination of both can emerge. Various models of teamwork will be introduced during the implementation projects.

5 Primary care networks will be developed to support the primary care teams

There will be investment in developing infrastructure and human resources in the wider primary care network (see Table 2). This will ensure that there will be continued development in primary care, in addition to the developments taking place in the primary care teams .

6 Availability of primary care services out-of-hours will be extended

In the interests of a patient-centred approach to service delivery, access to primary care services will be improved by extending the hours of availability of primary care professionals and providers and ensuring an appropriate core of services on weekends and public holidays. This will require development of flexible working arrangements and 'twilight' services. New arrangements in this regard will be worked out in full consultation with the professionals and other staff involved.

Resources will be dedicated to further develop GP co-operative cover arrangements on a national basis. In addition to medical cover, 24-hour cover will be provided through the availability of nursing services, health care assistants and home helps. In this regard, it is expected that a number of teams would come together to provide out-of-hours coverage for population groups.

7 A system of voluntary enrolment will be introduced for primary care users

The entire population will be encouraged to enrol with a team of their choice and with a doctor within that team. The benefits of enrolment will be explained to individuals so that they can make an informed decision on whether to take the opportunity. Enrolment will also serve as an important planning tool for health boards and other public policy-makers in undertaking needs assessments. The system of enrolment will be flexible. Individuals will be free to change teams easily should they so wish. The system will be based on the introduction of a unique person identifier for all health services. This will be developed in the context of the National Health Information Strategy. A key purpose of enrolment will be to facilitate a long-term relationship between the client, the team and the wider network of providers. This continuity of care will allow complex health and social problems to be dealt with through a detailed knowledge of clients and their families. The geographic focus of the primary care team will promote social inclusion, by using proactive measures to ensure that vulnerable individuals, families and groups are registered with a primary care team and GP.

8 An improved information and communications infrastructure will be provided for primary care teams

The transformation of the information and communications technology infrastructure to be used will be driven through the National Health Information Strategy and the General Practice Information Technology Project. Key to this will be the development of a single electronic health care record to be used for primary care and other purposes, which will be based upon the system of voluntary enrolment and will include the implementation of a unique client identifier. This is described in Chapter 5 of the main Health Strategy document.

Such an infrastructure has the potential to greatly improve communication, integration and efficiency in primary care and with other elements of the health system. It will include linkages to secondary care electronic records for referrals and results. It will also ensure availability of appropriate hardware, software, education, training and technical support. New services, such as medical card applications and GMS claims on-line, will be prioritised.

9 A system of direct telephone and electronic access to primary care services will be introduced for each health board area

The public will have direct telephone and internet access to information, advice and triage services. These will complement and operate in parallel to primary care services and will be available on a 24-hour basis for those who wish to use them. They will consist of nurse-led telephone advice and triage with appropriate decision support systems and, for those not already enrolled, a link to a team of their choice. In addition to providing a clear and convenient point of access during core hours, these will act as the point of access to out-of-hours primary care services, as in existing general practice co-operatives. Operational arrangements will be worked through in the implementation projects.

10 There will be greater integration between primary and secondary care

The interface between primary and secondary care will be advanced through a number of initiatives, designed to improve integration. Services will be organised to provide the most appropriate response to initial needs and thereafter may reduce pressure on hospital services. Integration initiatives, aimed at enhancing communication and exchange between primary and secondary care, should be locally agreed but within a national framework to be developed by the National Primary Care Task Force. They will include:

- referral guidelines and protocols for consultant care and diagnostic services
- discharge plans agreed between the hospital and a key primary care worker
- integrated care pathways facilitated by key workers
- individual care plans for certain people, appropriate to their needs
- shared care arrangements for specific health conditions.

11 Community-based diagnostic centres will be piloted

Three community-based diagnostic centres will be piloted to support primary care and community-based care. These will be evaluated on the basis of their ability to provide more accessible services and their cost-effectiveness in terms of reducing the pressure on hospital-based diagnostic facilities. In this regard, the potential of public-private partnerships will be actively encouraged.

12 Policy support for the primary care model will be provided by the Department of Health and Children

Consideration will be given to how best to support primary care and its implementation in the context of the restructuring of the Department of Health and Children, which is recommended in Chapter 5 of the main Health Strategy document.

13 Appropriate administrative arrangements will be put in place to support primary care at local level

The administrative capacity required to support the development of primary care and the implementation of the primary care teams at health board level will be strengthened to ensure that there is a major emphasis at senior level on the planning, development, evaluation and implementation of agreed policy. Responsibility will be identified for management to ensure comprehensive integration is reached. How best to achieve this, and the most appropriate mechanisms for the allocation of funding, will be addressed in the audit of structures outlined in Chapter 5 of the main Health Strategy document.

14 Investments will be made in extension of GP co-operatives and other specific national initiatives to complement the primary care model

In addition to the implementation projects, the full extension of the new model of primary care will require a sustained programme of investment in staffing, buildings and equipment over the next ten years. This increased level of investment will address specific areas needed to complement the new model of primary care including:

- GP co-operatives
- General increases in personnel needed for primary care teams and wider networks leading to improved out-of-hours services
- Information and communications technology.

15 Modules of joint training and education of primary care professionals will be developed

Modules of inter-disciplinary training between different disciplines at postgraduate level will be developed nationally so as to enhance teamwork, leadership and other competencies. The Department of Health and Children will pursue this in the context of the liaison arrangements recommended in Chapter 5 of the main Health Strategy document. These modules could be incorporated into existing professional training programmes for public health nurses, practice nurses, vocational training programmes for GPs and other professional training programmes.

16 Continuing professional and personal development programmes will be made available to primary care professionals

Human resources within the team and wider network of providers will be developed through a number of mechanisms such as continuous professional and personal development programmes, leadership development programmes and protected time for study, research and courses within core working time. The time and resources to underpin this will need to be provided for in resourcing the teams.

17 A framework for quality assurance in primary care will be developed

A framework for quality throughout the health system is set out in the main Health Strategy document. This will provide for appropriate monitoring and evaluation of effectiveness and outcomes. The National Primary Care Task Force and the Health Information and Quality Authority recommended in Chapter 5 of the main Health Strategy document will have a key role in developing the specific framework for primary care.

18 Academic practice and research will be developed

A key component of a high-quality system is a high-performing research and academic community. As an integral part of the development of primary care there will be a strong emphasis on research and academic practice. A small number of academic centres of primary care will be created, as an authoritative source of policy and practice advice. These academic centres will be inter-disciplinary and will reflect the broad definition of primary care set out in this strategy. The National Primary Care Task Force will identify locations for these centres. The Health Information and Quality Authority will have a key role, drawing on the input of these academic centres, in fostering a culture of excellence, grounded on evidence-based practice throughout the primary care services.

19 Mechanisms for active community involvement in primary care teams will be established

Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services. Consumer panels will be convened at regular intervals in each health board. At local level, primary care teams will be encouraged to ensure user participation in service planning and delivery. Consumers will also have an input to needs assessments initiated by individual health boards. A greater input from the community and voluntary sector will enhance the advocacy role of primary care teams in ensuring that local and national social and environmental health issues, which influence health, are identified and addressed.

20 Strategy for Nursing and Midwifery in the Community will be developed

The Strategy for Nursing and Midwifery in the Community, which is being developed at present, will be guided by this primary care model and will address the deficits in the current system by providing a plan for the integration of nursing and midwifery services within primary care. This strategy will build on the existing diversity of nursing and midwifery competencies, currently provided by public health nurses, practice nurses, general nurses, midwives, community mental health nurses and others. The strategy will seek to maximise the use of nursing/midwifery competencies in the provision of a needs-led, high-quality and sustainable primary care service.

It will also consider the potential for the role of the clinical nurse specialist/clinical midwife specialist and advanced nurse practitioners/advanced midwife practitioners as members of the primary care team, in line with the guidelines developed by the National Council for the Professional Development of Nursing and Midwifery.

Timeframe and targets

In the first year there will be an emphasis on developing the structures to support the introduction of this model of primary care at a national level. Work will then commence on the development of the implementation projects in each health board area, building on existing infrastructure as far as possible. Each health board will initiate needs assessment for primary care teams. Workforce requirements will also be prioritised, including the commencement of a human resource plan for primary care. One immediate priority will be the introduction of services which will have the greatest likelihood of reducing pressure on the hospital system, e.g. home helps and health care assistants.

By the end of the second year, early implementation projects will be up and running. Local administrative structures will be in place in each health board area to support the development of the new primary care model and agreement on a framework for evaluating the implementation projects will be in place. Outcomes from the consultation on progression of the model will inform refinements in the implementation process. Out-of-hours services and co-operatives will also be expanded on a national basis.

By the end of the fourth year, 40 to 60 implementation projects will have been established nationally, serving an aggregate population of 300,000 people. The system of patient enrolment will be in place in each health board area and will be promoted locally. There will also be measures in place to achieve improved alignment of primary care service providers in areas where implementation projects have not yet been established. Community participation in issues relating to primary care and feedback regarding developments to the service will be encouraged on an on-going basis.

In ten years time, between 400 and 600 core primary care teams with wider providers networks will be in place. This is approximately two-thirds of the full implementation of the model. The population health focus will promote a much closer collaboration between the public and the primary care team, resulting in a growth in innovative and community-led initiatives. Those enrolled with a particular team will be encouraged to attend for screening and health promotion advice. Issues such as joint training will also have been addressed by this stage and initiatives undertaken in the context of the wider quality agenda set out in the main Health Strategy document will have facilitated the widespread development, dissemination and adherence to treatment and care protocols and the use of evidence-based models of best practice throughout primary care services. An action plan including target dates for implementation of the primary care model is set out at Table 3. The timetable is indicative and is contingent on availability of resources, partnership with the service providers and stakeholders and the learning derived from the implementation projects.

Table 3: Action Plan

Action	*Deliverable*	*Target date*	*Responsibility*
1 A National Primary Care Task Force will be established	Task Force established	Jan 2002	Department of Health and Children
2 Individual health boards will prepare needs assessments for primary care teams	10 needs assessments completed	End 2002	Health boards
3 A Primary Care Human Resource Plan will be produced	Human Resource Plan for Primary Care	End 2003	Primary Care Task Force,* Health Service Employers Agency and health boards
	Increase intake to third level training places for primary care providers	2003	Primary Care Task Force,* Health Service Employers Agency, Inter-Departmental Committee and education sector
	Consultation with stakeholders	On-going	Primary Care Task Force* and health boards
4 Primary care teams will be put in place to meet the health and social care needs for a specific population	20-30 primary care teams for implementation projects	End 2003	Primary Care Task Force* and health boards
	40-60 primary care teams for implementation projects	End 2005	Primary Care Task Force* and health boards
	400-600 primary care teams in place	End 2011	Primary Care Task Force* and health boards
5 Primary care networks will be developed to support the primary care teams	Network arrangements for 20-30 implementation projects in place	End 2003	Primary Care Task Force* and health boards
	Network arrangements for 40-60 implementation projects in place	End 2005	Primary Care Task Force* and health boards
	Network arrangements for 400-600 teams in place	End 2011	Primary Care Task Force* and health boards
6 Availability of primary care services out-of-hours will be extended	Extended hours and GP co-operatives available nationally	End 2003	Primary Care Task Force and health boards*
	Primary care co-operatives in place for implementation projects	End 2004	Primary Care Task Force and health boards*
7 A system of voluntary enrolment will be introduced for primary care users	System in place in each health board	End 2005	Primary Care Task Force,* Department of Health and Children/Inter-Departmental Committee and Health Information and Quality Authority

	Action	Deliverable	Target date	Responsibility
8	An improved information and communications infrastructure will be provided for primary care teams	Electronic patient records and supporting ICT infrastructure in place for 40-60 implementation projects	End 2004	Primary Care Task Force; health boards* and Health Information and Quality Authority
		Electronic patient records and supporting ICT infrastructure in place nationally	End 2008	Primary Care Task Force; health boards* and Health Information and Quality Authority
9	A system of direct telephone and electronic access to primary care services will be introduced for each health board area	1850 number, support software, website and trained personnel in place in each health board	End 2003	Primary Care Task Force and health boards*
10	There will be greater integration between primary and secondary care	Frameworks for referral, care pathways, shared care, access to diagnostic services, and discharge arrangements between primary and secondary care in place	End 2003	Primary Care Task Force,* health boards and Health Information and Quality Authority
		Local arrangements for referral, care pathways, shared care, access to diagnostic services, and discharge between primary and secondary care in place	End 2004	Primary Care Task Force and health boards*
11	Community-based diagnostic centres will be piloted	Three community-based diagnostic centre pilot projects in place	End 2005	Department of Health and Children, Primary Care Task Force and health boards*
		Diagnostic centre pilot projects evaluated	End 2007	Health Information and Quality Authority, Primary Care Task Force and health boards*
12	Policy support for the primary care model will be provided by the Department of Health and Children	Responsibility for primary care identified in the restructuring of the Department	On-going	Department of Health and Children
13	Appropriate administrative arrangements will be put in place to support primary care at local level	Agreement on local management structures to support the model following audit of functions and structures in the health system	End 2003	Department of Health and Children, Primary Care Task Force and health boards*

	Action	Deliverable	Target date	Responsibility
14	Investments will be made in extension of GP co-operatives and other specific national initiatives to complement the primary care model	GP co-operatives available nationally	End 2003	Primary Care Task Force and health boards*
		Increases in personnel needed in both teams and networks on a national basis	On-going	Primary Care Task Force,* Health Service Employers Agency and health boards
		New physical infrastructure and equipment	On-going	Primary Care Task Force,* health boards
		Availability of information and communications technology nationally	On-going	Primary Care Task Force,* health boards and Health Information and Quality Authority
15	Modules of joint training and education of primary care professionals will be developed	Inter-disciplinary training modules (postgraduate) in place	End 2005	Primary Care Task Force,* Inter-Departmental Committee and education Sector
16	Continuing professional and personal development programmes will be made available to primary care professionals	Programmes in place in each health board	End 2003	Primary Care Task Force, health boards* and Office for Health Management
17	A framework for quality assurance in primary care will be developed	Framework developed and agreed	End 2004	Primary Care Task Force, health boards and Irish Centre for Health Excellence*
18	Academic practice and research will be developed	Five academic centres in place	End 2006	Primary Care Task Force, education sector,* Health Research Board, Inter-Departmental Committee and Health Information and Quality Authority
19	Mechanisms for active community involvement in primary care teams will be established	Consultation with consumer panels in each health board about specific primary care development	On-going	Health boards
20	Strategy for Nursing and Midwifery in the Community will be developed	Publication of Strategy for Nursing and Midwifery in the Community	End 2002	Department of Health and Children

**Identifies lead responsibility*

Bibliography

Adams C. and Thomas E. (2001). The benefit of integrated nursing teams in primary care. *British Journal of Community Nursing,* 6 (6) pp 271-274.

Bacon P. and Associates (2001). Current and future supply and demand conditions in the labour market for certain professional therapists. Dublin: Department of Health and Children.

Bodenheimer T., Lo B. and Casalino L. (1999). Primary care physicians should be coordinators, not gatekeepers. *Journal of the American Medical Association,* 281 (21) pp 2045-9.

Brearley M. (2000). Teams: lessons from the world of sport. *British Medical Journal,* 32 (7269) pp 1141-3.

Brennan J., Sennessy E. and Moran D. (2000). *Financing of primary health care.* Dublin: The Society of Actuaries in Ireland.

Caulfield E. (2001). *The organisation of the healthcare services in Ireland – A general practitioner's perspective.* Dublin: ICGP.

Choice and Opportunity: Primary care, the future (1996). Presented to Parliament by the Secretary of State, United Kingdom.

Commission on Medicare (2001). *Caring for medicare: sustaining a quality system.* Saskatchewan, Canada: The Commission on Medicare.

Commission on Nursing (1998). *Report of the Commission on Nursing: a blueprint for the future.* Dublin: Stationery Office.

Cragg D., McKinley R., Roland M., Campbell S., Van F., Hastings A., French D, Manku-Scott T. and Roberts C. (1997). Comparison of out of hours care provided by patients' own general practitioners and commercial deputising services: a randomised controlled trial. I: the process of care. *British Medical Journal.* 314 (7075) pp 187-9.

Dale J., Crouch R. and Lloyd D. (1998). Primary care: nurse-led telephone triage and advice out-of-hours. *Nursing Standard,* 12 (47) pp 41-5.

Department of Finance (1999). *The National Development Plan 2000-2006.* Dublin: Stationery Office.

Department of Health (1991). The future of general practice in Ireland. Unpublished.

Department of Health (2001). *Primary care, general practice and the NHS Plan.* London: Government Publications.

Department of Health and Children (1997). Public health nursing: A review. Unpublished.

Department of Health and Children (*2001).Evaluation of pilot initiatives undertaken in the North Eastern and South Eastern Health Boards on the provision of General Practitioner out-of-hours services in those areas.* Dublin: Stationery Office.

Department of the Taoiseach (2000). *The Programme for Prosperity and Fairness.* Dublin: Stationery Office.

Dixon J., Holland P. and Mays N. (1998). Primary care: core values developing primary care: gatekeeping, commissioning, and managed care. *British Medical Journal,* 317 (7151) pp 125-8.

Eastern Health Board (1999). A Framework for a Primary Care Strategy. Dublin: Eastern Health Board.

Etter J. and Perneger T. (1998). Health care Expenditures after introduction of a gatekeeper and a global budget in a Swiss health insurance plan. *Journal of Epidemiology and Community Health,* 52 (6) pp 370-6.

Falloon I., Ng B., Bansemann C. and Kydd R. (1996). The role of general practitioners in mental health care: a survey of needs and problems. *New Zealand Medical Journal,* 109 (1015) pp 34-6.

Green L., Fryer G., Yawn B., Lanier D. and Dovey S. (2001). The ecology of medical care revisited. *New England Journal of Medicine,* 344 (26) pp 2021-5.

Grumback K., Selby J., Damberg C., Bindman A., Queensberry C., Truman A. and Uratsu C. (1997). Resolving the gatekeeper conundrum: what patients value in primary care and referrals to specialists. *Journal of the American Medical Association,* 282 (3) pp 261-6.

Gulbrandsen P., Hjortdahl P. and Fugelli P. (1997). General practitioners' knowledge of their patients' psychosocial problems: multipractice questionnaire study. *British Medical Journal,* 314 (7086) pp 1014-8.

Health Act, 1970. Dublin: Stationery Office.

Hjortdahl P. and Borchgrevink C. (1991). Continuity of care: influence of general practitioners' knowledge about their patients on use of resources in consultations. *British Medical Journal,* 303 (6811) pp 1181-4.

Holmwood C. (1998). Challenges facing primary care mental health in Australia. *Australian Family Physician*, 27 (8) pp 716-9.

Iliffe S. (2000). Nursing and the future of primary care. *British Medical Journal,* 320 (7241) pp 1020-1.

Irish College of General Practitioners and Irish Medical Organisation (2001). *A vision of general practice, 2001-2006.* Dublin: ICGP & IMO.

Jarvis S. (2001). *Skill mix in primary care: Implications for the future.* London: Medical Practices' Committee.

Kinnersley P., Anderon E., Parry K., Clement J., Archard L., Turton P., Stanthorpe A., Fraser A., Butler C. and Rogers C. (2000). Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting 'same day' consultations in primary care. *British Medical Journal,* 320 (7241) pp 1043-8.

Kvamme O., Olesen F. and Samuelsson M. (2001). Improving the interface between primary and secondary care: a statement from the European Working Party on Quality in Family Practice (EQuiP). *Quality Health Care,* 10 (1) pp 33-9.

Maynard A. and Bloor K. (1995). Primary care and health care reform: the need to reflect before reforming. *Health Policy,* 31 (3) pp 171-81.

McKinley R., Cragg D., Hastings A., French D., Manku-Scott T., Campbell S., Van F., Roland M. and Roberts C. (1997). Comparison of out of hours care provided by patients' own general practitioners and commercial deputising services: a randomised controlled trial. II: the outcome of care. *British Medical Journal,* 314 (7075) pp 190-3.

Mundinger M. and Kane R. (2000). Health outcomes among patients' treated by nurse practitioners or physicians. *Journal of the American Medical Association,* 283 (19) pp 2521-4.

Nauright L., Moneyham L. and Williamson J. (1999). Telephone triage and consultation: an emerging role for nurses. *Nursing Outlook,* 47 (5) pp 219-26.

North Western Health Board (1999). *Primary Care in the North West.* Manorhamilton: North Western Health Board.

Ontario Medical Association (1996). *Primary Care Reform: A Strategy for Stability [discussion paper].* Toronto: Ontario Medical Association.

Ontario Medical Association (1998). *Primary Care Reform: A Strategy for Stability.* Toronto: Primary Care Reform Physician Advisory Group.

Pearson P. and Jones K. (1994). The primary health care non-team. *British Medical Journal,* 309 (6966) pp 1387-8.

Powell D. and Peile E. (2000). Joint working. It's a stitch-up. *Health Services Journal*, 110 (5702) pp 24-5.

Practising Together (1998) Cardiff: Royal College of General Practitioners Welsh Council, The Welsh General Medical Services Committee and The Welsh Practice Nurses Association.

Prescott P. (1994). Cost-effective primary care providers. An important component of health care reform. *International Journal of Technology Assessment in Health Care,* 10 (2) pp 249-57.

Primary Care Strategy (2000). Galway: Western Health Board.

Primary Care Strategy – Primary Care Partnerships: Going Forward (2001) Victoria: Victorian Government Department of Human Services.

Primary Health Care Nursing Policy (1999) Draft Statement The newsletter of the College of Nurses Aotearoa New Zealand (online), Available:http://www.nurse.org.nz/1299/primary.html (2001, Sept).

Primary Health Care Project for Travellers – Project report for October 1994 to October 1995 (1995). Pavee Point, Eastern Health Board.

Primary Health Care Towards the year 2000; A report of the Consultative Committee on Primary Health Care Development (1990). Geneva: World Health Organisation.

Primary Health Care: Report of the International Conference on Primary Health Care, Alma Alta, USSR (1978). Geneva: WHO/UNICEF.

Rigby M., Roberts R., Williams J., Clark J., Savill A., Lervy B. and Mooney G. (1998). Integrated record keeping as an essential aspect of a primary care led health service. *British Medical Journal,* 317 (7158) pp 579-582.

Ritsatakis A., Barnes R., Dekker E., Harrington P., Kokko S. and Makara P. (2000). *Exploring health policy development in Europe.* Copenhagen: World Health Organisation.

Roberts E. and Mays N. (1998). Can primary care and community-based models of emergency care substitute for the hospital accident and emergency (A & E) department? *Health Policy,* 44 (3) pp 191-214.

Rudd A., Wolfe C., Tilling K. and Beech R. (1997). Randomised controlled trial to evaluate early discharge scheme for patients with stroke. *British Medical Journal,* 315 (7115) pp 1039-44.

Sabin M. (1998). Telephone triage improves demand management effectiveness. *Healthcare Financial Management,* 52 (8) 49-51.

Salmon G. (1994). Working in a multidisciplinary team; need it be so difficult? *British Medical Journal,* 309: p 1520.

Shum C. et al (1996). Nurse management of patients with minor illnesses in general practice: multicentre, randomised controlled trial. *British Medical Journal,* 320 (7241) pp 1038-43.

Smith S., Robinson J., Hollyer J., Bhatt R., Ash S. and Shaurak S. (1996). Combining specialist and primary health care teams for HIV positive patients: retrospective and prospective studies. *British Medical Journal,* 312 (7028) pp 416-2.

Starfield B. (1992). *Primary care, concept, evaluation and policy.* New York: Oxford University Press.

Sweeney B. (1994). The referral system. *British Medical Journal,* 309 (7028) pp 1180-1.

The Primary Health Care Strategy (2001). Wellington, New Zealand: Ministry of Health.

The Primary Health Care Team (1998). RCGP Information Sheet no 21. London: Royal College of General Practitioners.

The Victorian Ambulatory Care Sensitive Conditions Study. Preliminary analysis (2001). Melbourne: Victoria Government, Department of Human Services.

Team working in primary care. Realising shared aims in patient care (2000). London: Royal Pharmaceutical Society of Great Britain and British Medical Association.

Tyrer P., Evans K., Gandhi N., Lamont A., Harrison-Read P. and Johnson T. (1998). Randomised controlled trial of two models of care for discharged psychiatric patients. *British Medical Journal,* 316 (7125) pp 106-9.

Venning P., Durie A., Roland M., Roberts C. and Leese B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal,* 320 (7241) pp 1048-53.

Warner R., Gater R., Jackson M. and Goldberg D. (1993). Effects of a community mental health service on the practice and attitudes of general practitioners. *British Journal of General Practitioners,* 43 (377) pp 507-11.

WHO/European Commission (1997). *Highlights on health in Ireland.* Copenhagen: World Health Organisation Regional Office for Europe and the European Commission.

Wilson C.K. (1998). Team behaviours: working effectively in teams. *Seminars Nurse Management,* 6 (4) pp 188-94.

Appendices

Appendix 1

- **National policy context**
- **Current service provision**

National policy context

Health Acts

The Health Act, 1970 established regional health boards for the delivery of health services. The operation of the health boards is centred around three core programmes: general hospitals; special hospitals; and community care programmes. The Health Amendment (No 3) Act, 1996 requires health boards to adopt service plans and to operate within these plans throughout the year. It also established the Eastern Regional Health Authority.

General Medical Services (GMS) Scheme

Persons who are unable without undue hardship to arrange general practitioner services for themselves and their dependants receive a free general medical service. When the GMS scheme was introduced in 1972 it was a fee per item based scheme. However, following a review of the operation of the scheme in 1989, the basic payment structure changed to a capitation system.

Blueprint document: The Future of General Practice in Ireland

This document was produced by the Department of Health in 1991. It made proposals for the future organisation and management of general practitioner services.

Establishment of National and Regional General Practice Units

These units were introduced in 1993 to facilitate, support and develop general practice as a whole. GP unit general practitioners were appointed in each health board area to support local general practice.

Indicative Drug Budgeting Scheme

At the same time as the setting up of the GP units an indicative drug budget was calculated for each GMS GP based on age-related prescribing averages. Any savings made on these indicative drug budgets were initially divided 50 per cent to GP unit and 50 per cent to doctors concerned. All savings made are invested in the development of general practice.

Review of public health nursing

A review of public health nursing was undertaken by a working party established by the Department of Health. The report *Public Health Nursing, A Review*, presented in 1997, set out recommendations for developments, which were used by the Commission on Nursing when considering issues relating to nursing in the community.

Departments of Public Health

Departments of Public Health were established in each health board area led by a Director of Public Health during the 1990s. The Departments of Public Health have a major role in health service planning, the introduction of best practice protocols and monitoring of services already in place. They are a significant resource in the areas of health promotion and health gain.

Commission on Nursing

The *Report of the Commission on Nursing* (1998) identified the need for integration of community care services and co-ordination of community nursing care. It recommended developments in the management structure for public health nursing, the development of specialist career pathways, developments in the midwifery services and removal of the mandatory requirement for midwifery as a requirement for entry to the higher diploma in public health nursing or registration as a public health nurse.

CEOs' review of general practice

This review was commissioned by the health board CEOs with input from the Department of Health and Children. The purpose of this review, which was completed in September 2000, was to identify measures necessary to meet the challenges posed in the strategic development of general practice.

Working Group for Nursing and Midwifery in the Community

This group was established by the Department of Health and Children in March 2001 to prepare a revised strategy for nursing and midwifery in the community. It is envisaged that among other issues this group will address the need for integration of the diverse range of nursing services provided in the community. The recommendations made in the Health Strategy 2001 will play a key role in directing the Strategy for Nursing and Midwifery in the Community.

A Vision of General Practice, 2001-2006

This IMO/ICGP document outlines a vision of the future of general practice. It makes a number of recommendations regarding practice development, funding, human resources, education/training and quality assurance in general practice.

Nursing and Midwifery Resource

The Nursing Policy Division of the Department of Health and Children is undertaking a detailed study of the Nursing and Midwifery Resource. The primary objective of the study is to forecast, as far as is possible, future nursing and midwifery workforce needs. The steering group for the study published an interim report in September 2000, which set out a series of recommendations pending the final report. Included among these was a recommendation to substantially increase the number of places on the public health nursing higher diploma programmes and the introduction of measures in relation to fees and salary to encourage uptake of places.

Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists ('Bacon Report')

The Bacon Report (2001) identified significant deficiencies in the supply of chartered physiotherapists, occupational therapists and speech and language therapists. The principal gaps result from the number of unfilled vacancies, the number of posts that would be created if service in Ireland reached objectively set targets, the number of additional places that will arise due to demographic and survival trends and the number of new posts that will arise due to demands for an enhanced quality of health care service. The report indicates that there will be a need for increases of between 102 per cent and 328 per cent above existing supply of therapy professions to meet the requirements of the service up to 2015. The report set out a series of recommendations relating to finance, course places, clinical training, management and regulation, to ensure that the required increases are achieved.

Programme for Prosperity and Fairness

The Programme for Prosperity and Fairness (PPF) sets out the agreement between the Government and social partners, published in 2000. Health care is identified specifically under Frameworks I and III, which set out actions for living standards and the workplace environment and also for social inclusion and equality. The programme makes a specific commitment to the 'development of new models to explore ways of moving further towards 24-hour seven-day primary care and a programme of refurbishment and upgrading of community health centres'.

National Development Plan 2000-2006

The National Development Plan allocates £2 billion (€2.54 billion) over the plan period to address the capital needs of the health services. Part of this is intended to be invested in a network of health centres, resulting in a wide geographical spread of multipurpose health centres for the provision of a range of community health and personal social services.

Effective Utilisation of the Professional Skills of Nurses and Midwives

The Working Group on the *Effective Utilisation of the Professional Skills of Nurses and Midwives* (2001) recommended that the grade of health care assistant/maternity care assistant be introduced as a member of the health care team to assist and support the nursing and midwifery function. The group recommended that the title health care assistant (HCA) be adopted and employed uniformly across all health care settings.

A national 6-month training programme for health care assistants is commencing in November 2001. Pilot programmes are being delivered by the health services in conjunction with the Further Education Training Awards Council (FETAC). Community care is one of the areas included in the pilot programmes. Following evaluation the programme will be available nationally.

Current service provision

Access to primary care is based on a means-tested system of eligibility comprising two categories. People whose income falls below a certain threshold fall into Category I and are entitled to a wide range of free services. This group constitutes approximately 30 per cent of the population. The remainder of the population has limited eligibility and is classified as category II (70 per cent of the population). There is also a well-developed private sector, which can be accessed through insurance cover and/or direct payments (46 per cent of the population has private health insurance). There is some overlap between medical cards and those who are insured. Similarly, not all those in Category II have private health insurance.

General practice

General practitioner services in the Irish health system have been described as 'largely made up of a series of disparate personnel, with individual spheres of activity, relating to separate functional units and employed under a variety of different contracts' (Caulfield, 2001). The public-private mix of entitlements complicates access to services. GPs are self-employed professionals who engage in service commitments, under a range of individual contracts with health boards, for delivery of services to either exclusively public patients or to a public-private mix under the Maternity and Infant Care Scheme or the National Primary Childhood Immunisation Scheme. They also provide services directly to private patients.

People in Category I can register with a doctor of their choice from a list of physicians participating in the scheme. GP services, prescribed drugs, medicines and appliances are then supplied free of charge to them and their dependants. Those in Category II (70 per cent of the population), who pay in full, are free to choose any GP or specialist. GPs are paid on a capitation basis according to the patient's age, sex and place of residence.

Community nursing services

A nursing service, spanning the life cycle, is provided by the health boards, on a geographic basis and incorporates prevention, treatment and rehabilitation. This holistic service operates in the community and is delivered through public health nurses, general nurses, mental health nurses, practice nurses, midwives, specialist nurses, health care assistants, home helps and others.

The current public health nurse (PHN) service is based on a Department of Health circular on the 'District Nursing Service' (circular 27/66). The concept outlined in the circular was of a public health nursing role encompassing a broad range of preventive and caring functions. However, the role of the PHN has evolved in the thirty years since the circular of 1966. PHNs carry out a diverse range of nursing services responding to the needs of individuals, families and the community. The range of community nursing services provided by PHNs includes:

- support and advice to a parent or parents following the birth of a child. Such a service may be provided from shortly after the birth of the child and, if required, continues until the child is of school-going age
- the delivery of school health services
- the provision of personalised nursing care to patients who have been discharged from hospital
- the provision of a range of nursing services to the elderly and support for carers in the home
- the provision of nursing services and support in the home for persons with a disability (*Commission on Nursing,* 1998, p 150).

The Commission on Nursing (1998) identified the increasing trend where 'a number of other nursing groups have started to work in the community: these include general nurses, palliative care, psychiatric (other than community psychiatric nurses), mental handicap, practice nurses and other specialist nurses'.

Practice nurses are employed in general practices and deliver a broad range of nursing services such as immunisations, women's health issues, ante-natal care, wound care, counselling and asthma care. Practice nurses do not visit people in their homes.

Community mental health nurses manage a case load and provide a wide range of nursing services including rehabilitation, social skills training, individual counselling, group work, psycho-education, family support, liaison work and mental health education.

Community midwifery service provision is currently being evaluated through three pilot programmes which have been established in Dublin, Cork and Galway to evaluate different models of care. They include a home birth service by independent midwives in Cork and outreach home birth and DOMINO (DOMiciliary IN and Out) births provided by community midwives employed in the National Maternity Hospital and University College Hospital Galway.

The Commission on Nursing recommended that the Department of Health and Children issue a revised strategy statement on the role of public health nursing. A strategy on nursing and midwifery in the community is currently in preparation. It will address the deficits in the current system by providing a plan for the integration of nursing and midwifery services within primary care.

Maternity and Infant Care Scheme

This scheme provides for free ante-natal care for expectant mothers and medical care for infants up the age of six weeks, irrespective of eligibility category. It is operated by GPs who have agreements with health boards to provide the services in return for specified fees.

Child health services

Child health services are provided by a range of disciplines in a variety of settings (home, health centre, GP surgery) and are focused on preschool children and children at national schools. The preschool service encompasses both primary (immunisation, parenting advice and support) and secondary prevention (developmental and metabolic screening). The national school service is delivered on school premises and includes examination of school entrants and programmed hearing and vision screening at regular intervals until children reach 12 years of age.

Primary dental care

Dental services are provided by dentists employed by health boards and by private dental practitioners under contract to health boards. Children attending national schools (up to 14 years of age) are provided with dental services through school-based dental programmes.

Community pharmacy

Prescribed medicines are supplied by retail pharmacists free of charge to medical card holders (Category I). Under the Drugs Payment Scheme, persons who are ordinarily resident in the State and who do not have a current medical card can benefit. No individuals or families have to pay more then £42 (€53)in a calendar month for approved drugs, medicines and appliances for themselves or their families. In order to benefit under this scheme, people must register themselves and their dependants with their local health board; each registered person is provided with a Drug Payment Scheme Card which carries a family identification number. New arrangements were introduced in November 1996 for the supply and dispensing of high-tech medicines through community pharmacies.

Under the Methadone Treatment Scheme, Methadone is prescribed and dispensed by doctors and pharmacists for approved clients. The GMS Payments Board pays capitation fees under this scheme to participating doctors and community pharmacists.

Long-Term Illness Scheme

On approval by health boards, persons who suffer from one or more of a schedule of illnesses are entitled to obtain, without charge, irrespective of income, necessary drugs, medicines and appliances under the Long-Term Illness (LTI) Scheme. The GMS payments board makes payments on behalf of the health boards for LTI claims submitted by pharmacies.

Health Board Community Ophthalmic Services Scheme

The Health Board Community Ophthalmic Services Scheme was launched in July 1999 to provide optometrist/ ophthalmic services to adult medical card holders and their dependants not entitled to benefit under the Department of Social, Community and Family Affairs Benefit Treatment Scheme.

Appendix 2

- **Strengths and weaknesses of the current system**
- **The consultation process**
- **Overview of published literature**
- **Primary care systems in other countries**

Strengths and weaknesses of the current system

Developments in primary care should build upon and add to the very significant strengths of the current system. GPs, public health nurses and other professionals have historically provided primary care in Ireland. They have provided a critical front-line service which has acted as a gatekeeper for many secondary elements of the broad range of health and personal social services. In many cases, and for long periods, it has been the commitment of such professionals in the absence of an appropriate infrastructure for primary care which has ensured that the public has been able to avail of a personal, local, accessible and timely service with which they have been satisfied.

Professional bodies such as the Irish College of General Practitioners, the Institute of Community Nursing, the Irish Practice Nurses Association, the Commission on Nursing and many others have developed initiatives to improve the quality of primary care services delivered to the public. There has also been a strong tradition of community and voluntary involvement in primary care service provision in such programmes as meals on wheels. Primary care infrastructure however remains poorly developed. Some of the principal inadequacies of the current system are shown below.

Principal inadequacies in current system of primary care

- Poorly developed primary care infrastructure and capacity
- Current system fragmented from user's perspective
- Limited opportunities for user participation in service planning and delivery
- Emphasis on diagnosis and treatment with weak capacity for prevention and rehabilitation
- Potential to reduce pressure on secondary care not fully realised
- Secondary care providing many services which are more appropriate to primary care
- Current system oriented around needs of providers rather than users
- Out-of-hours services underdeveloped
- Limited availability of many professional groups
- Professional isolation
- Limited teamworking
- Communication between professionals and sectors inadequate
- Lack of quality assurance framework
- Limited information from primary care for planning, development and evaluation

Medical treatment services predominate and availability of other elements, e.g. social services, occupational therapy, physiotherapy, counselling, home help, etc. has been limited. Non-medical services are also provided during limited hours, except on a planned essential needs basis. General practitioners and other primary care staff often work in isolation and communication between the different primary care service providers is not optimal. This leads to public services that are poorly integrated and do not comprehensively meet the needs of individuals and communities in an appropriate primary care setting. Eligibility arrangements are also not clear with the exception of the choice of general practitioner. Information and communications technology is very underdeveloped. The potential of ICT to inform the public and to significantly impact on service delivery, especially the sharing of information between practitioners and continuity of care plans for patients across programmes of care, needs to be realised.

A comprehensive international evidence base is now available to assist in policy, planning and improvement of clinical care through the development of quality standards and accreditation in primary care. It also demonstrates that the public can be better informed about health and health services and that professionals can benefit in the areas of education and skills development.

The current capacity of primary care is insufficient to meet the evolving needs of the population. Changes in demography, reorientation towards prevention and health promotion and shifting the focus from secondary care towards primary care will increase the burden already facing community services. Commitment to change at many levels will be required to meet the challenges and build the appropriate capacity into the future.

The consultation process

During the consultation process undertaken to inform the development of the Health Strategy, submissions were sought from the general public, organisations and health service personnel. A National Consultative Forum comprising approximately 180 members representative of key stakeholders in the health service was also established. A separate document, entitled *Your Views about Health*, has been published with the Health Strategy which gives full details of the consultation process. One of the issues identified in proposals from individuals, organisations and professionals was the need for improvement in services delivered in the community, and a much more flexible approach to delivery. The major messages emerging for each level of the consultation process are set out below.

Consultation with organisations

The need for enhanced community-based health services was raised in 31 per cent of submissions from organisations. The key themes running through the organisation submissions were the need for enhanced levels of a wide range of community services, local availability and local access as important dimensions of a quality service. The need for stronger linkages and connections within and between services, so as to create a holistic, seamless, people-centred service was also highlighted. Flexible out-of-hours support services for families was identified as a major concern. In the absence of comprehensive and flexible supports, the impact of caring on the health, well-being and family income of the carer was highlighted.

The case was made by many organisations for increases in the numbers and kinds of community health personnel working at local level: public health nurses, practice nurses, physiotherapists, occupational therapists, speech and language therapists, community health workers, women's health development officers, health psychologists and people offering medical specialties at community level.

Consultation with general public

Improvements in community health and personal social services were the subject of almost 2,000 proposals and accounted for 18 per cent of all proposals made in individual submissions. The main changes and improvements sought were: additional community-based services and community health professionals (GPs, nurses and therapists), improved health centres, local testing and screening, help lines, community-based counselling, local transport, improved access to complementary medicine and better linkages between services. The main requests in relation to GP services were for more flexible out-of-hours services, more group practices, greater access by GPs to diagnostic services and lower GP charges.

Consultation with health service personnel

Each of the ten health boards and the Department of Health and Children held focus group meetings and discussions with staff. One of the key recommendations, common across the submissions, related to primary care and community social services including improved access to GP services, a team-based approach to provision, priority for groups with special needs and improved linkages within the between services.

National Consultative Forum

At the second plenary meeting of the National Consultative Forum held in July 2001 the stakeholders were given feedback from the consultation process and a progress report on the development of the Strategy document. A presentation was given on the proposals for the introduction of a new model of primary care. Eight workgroups were established to consider some of the proposals in greater detail. One of the workgroups was specifically asked to consider the main obstacles and actions required to introduce the model of primary care. The workgroup recommended that the model be put into action, have implementation projects, resource the system, manage the relationships between primary and secondary care and evaluate the progress. The group recommended building on some of the local initiatives already introduced in parts of the country. During the feedback session at the end of the workgroup activity, the Forum endorsed the introduction of the proposed inter-disciplinary primary care team.

Overview of published literature

The proposals outlined in this document are evidence-based. A literature review was undertaken to examine the evidence for the various components of this model such as teamworking, skill-mix, continuity of care, generalist versus specialist care, and telephone triage. A short summary of the review is presented below. The full literature review is available on request.

A team-based approach

The importance of a team-based approach to primary care has been acknowledged by the Royal College of General Practitioners (RCGP) in the UK and the Irish College of General Practitioners (ICGP) along with the Irish Medical Organisation (IMO) in their vision document. The European Working Group on Quality in Family Practice also identified team building as one of the major targets for development in primary care. A report recently drawn up by health professionals and patients in the UK presented evidence to show that teamworking provides a more responsive service to patients who benefit more when health care professionals work together. The importance of preserving the central role of the doctor-patient relationship in any developments in primary care has also been stressed.

Various studies have shown that the introduction of inter-disciplinary primary care teams are associated with the ability to keep patients at home in times of crisis, reduced emergency admissions, shorter lengths of stay for patients admitted and increased patient and carer satisfaction. Key areas to be addressed to ensure that teams are effective are: access to information, clearly defined team roles, and appropriate team size.

Team members

The RCGP in the UK identified the core primary care team membership as consisting of GPs, practice nurses, community nurses, health visitors, practice managers and administrative staff. They suggested that other members might include counsellors, midwives and psychiatric nurses. Clinical psychologists, physiotherapists, occupational therapists and dieticians should also be available to provide a range of services for patients. The important role of community pharmacy in the team has been acknowledged in many countries. The team composition might vary according to the needs of the population served and the individual patient. As the GP is the common link in all primary care teams he or she may assume a leadership role within the group. However, any member of the team can lead in circumstances where his or her skills are more relevant. As primary care team members often have an incomplete understanding of the skills of other team members, possibilities regarding shared education should be explored at undergraduate, postgraduate and practice team levels.

Skill mix

Skill mix is the use of a variety of professionals to carry out roles traditionally performed by one health care professional. It ensures that all team members are always working to their maximum professional capacity. Many studies have concentrated on one aspect of skill mix such as the introduction of the nurse practitioner. Patients have been shown to be satisfied with nurse practitioner consultations and the number of prescriptions issued and referrals to secondary care have been found to be similar to those that result from GP consultations. However, patients may prefer to continue to seek medical rather than nursing care.

Continuity of care

Continuity of care allows health professionals to get to know patients. This has been found to be associated with time saving, reduced referrals, reduced prescriptions and improved compliance. The literature also shows that continuity of care is associated with improved recognition and management of patients' psycho-social problems.

Most research suggests that a patient's satisfaction with a consultation is strongly associated with visiting the same doctor. Studies which have looked at out-of-hours care provided by GPs from the patient's own practice versus those from deputising services have found that deputising doctors were less likely to give telephone advice, took longer to visit at home and were more likely to prescribe medication. Patients were more satisfied with services provided by their own doctors.

Generalist versus specialist care

The literature shows that generalist and specialist teams can work synergistically. Various studies have highlighted the potential of primary care teams working with specialist mental health services in the community. Studies have also shown that primary care providers are keen to become more involved in the care of those suffering from mental disorders and see the value of having a community psychiatric nurse working as part of the team. For stroke patients, studies have shown that early discharge with community support is as clinically effective as conventional care and is as acceptable to patients and, for patients with HIV, improved collaboration between primary care and specialist teams leads to a reduction in hospital lengths of stay.

The concept of shared care means that the members of the primary care team can work with other specialist groups in the care of individual patients. Shared care has been successfully employed in areas such as diabetes care, asthma care and palliative care. Important components of successful shared care include agreed objectives and locally developed written guidelines.

Gatekeeper role

GPs provide a crucial gatekeeper role to secondary care services. Studies have shown that patients value this gatekeeper role and it has also proved to be cost-effective. Open access to specialist clinics can lead to over-investigation and fragmentation of patient care. The ICGP/IMO vision document acknowledged this important gatekeeper role of the GP.

Telephone triage

Telephone triage is becoming a key point-of-entry tool for patients accessing the health system. It has been shown to be a cost-effective way of providing care which facilitates continuous access to primary care. Nurses are currently the key professionals providing this type of service. The introduction of decision support software can further improve the consistency of decisions taken by the nurses.

Primary care systems in other countries

In developing a strategy for the development of primary care for Ireland, strategies for primary care in a number of other countries were examined so that components of successful models could be incorporated into the model. Some common themes emerged from all of the major strategies that were reviewed. These included

- the key role of inter-disciplinary teamworking
- the importance of preventive services
- the need for improved information
- the importance of patient enrolment.

The methods of funding and payment for services were disparate. Many of the changes proposed in the various strategy documents were facilitated by single-tier systems. A synopsis of the key features of the primary care services provided or proposed in a number of different countries is outlined below. The list of countries included is not meant to be comprehensive. A more detailed review of these and other international models has also been prepared and is available on request.

New Zealand

In February 2001, a new primary care strategy was launched in New Zealand. All people are encouraged to enrol with a primary care provider. Enrolment is voluntary. If persons choose not to enrol they will still be entitled to seek care but they may miss out on some preventive services.

The broad vision of primary care in the New Zealand Strategy means that no single practitioner or type of practitioner can meet people's needs completely. Providers of primary care services will involve doctors, nurses, pharmacists, midwives and a range of other practitioners with adequate numbers of managerial and support staff. The ability to recognise the role and importance of others, and to work collaboratively with them, will be essential.

The New Zealand strategy document also advocates improved co-ordination between primary and secondary care including increased primary health care access to secondary services such as diagnostic tests, implementing evidence-based guidelines with appropriate support from secondary services and developing local initiatives that bring together primary health care practitioners and hospital clinicians to develop better access to hospital services.

Canada

In Saskatchewan, Canada, a Commission on Medicare which produced its report in April 2001 recommended the development of an integrated system for the delivery of primary care services by

- establishing primary health service teams bringing together a range of health care providers including general practitioners
- integrating individual teams into a primary health network
- ensuring that comprehensive services, including a telephone advice service, are available 24-hours a day, seven days a week.

The commission stated that team-based delivery of primary health services is recognised around the world as the most effective way to deliver everyday health services. All provinces in Canada have launched primary health care demonstration projects, with doctors, nurses, therapists and social workers operating as inter-disciplinary teams, each contributing unique skills which, taken together, ensure a comprehensive range of services.

The Canadian strategy document acknowledged the fact that although most organisations of health care professionals support the idea of primary health teams there are different ideas about how these teams should work. The group outlined the practical steps necessary to make primary health service teams and networks work. These include the following:

- Primary health teams should include providers such as physicians, primary care nurses, home care nurses, dieticians and mental health nurses
- All members of the primary health team are responsible for ensuring that a comprehensive range of services is available to meet client needs. This consists of a standard set of services including 24-hour access
- Primary health practitioners are co-located whenever practicable, so as to promote a positive environment for integrated practice
- Primary health teams serve a defined population, with citizens free to choose or change providers.

The advantages for team members would be improved quality of working life, reduced on-call responsibilities, freeing up of physicians to make the best use of their training and expertise, opportunities for all members to employ their training and skills and closer integration with other health care professionals. A strategy document entitled *Primary care reform: a strategy for stability* was recently produced by the Ontario Medical Association. Some of the key features of this strategy document were:

- patient registration with a solo provider, group or agency
- implementation of an electronic patient record (EPR); EPR-information follows patient to all interactions within the health care system
- provision of 24-hour services, such as after-hours clinics or 24-hour telephone information
- economic incentives for integration of primary care. Inter-disciplinary teams encouraged through budget restructuring resulting in integrated organisation.

United Kingdom

The composition of primary care teams in the UK varies from area to area. Some teams consist of GPs, nurses and practice administration staff, whereas others also have physiotherapists, phlebotomists, etc.

A document entitled *Primary care, general practice and the NHS plan* was produced in January 2001. This document acknowledges that the future of the NHS rests on the strength of its primary care. Some of the key points recommended in this report are:

- further development of flexible inter-disciplinary teamworking to deliver better services to patients
- the development of 500 one-stop primary care centres by 2004
- nurses undertaking more roles
- extending the role of pharmacists
- better use of receptionists and practice nurses to deal with coughs, colds and minor ailments.

The report states that nurses and health visitors will undertake a wider range of roles determined by patient and community need. They will be trained to take on more of the routine and minor ailment workload, enabling GPs to spend more time with patients and concentrate on those who need their expertise.

Australia

The Australian Medical Association (AMA) produced a position paper on primary care in January 2001. This document, while recommending an integrated team approach to the provision of primary care, stresses the central role of the general practitioner. The following are the key points:

- General practice should be formally recognised as the central discipline of medicine around which medical and allied health disciplines are arranged to form a co-operative primary health care team for the benefit of the individual, the family and the community
- The dominant clinical role of the GP must not be undermined in favour of that of a mere gatekeeper, administrator and coordinator
- Integrated care is the key to successful primary health care
- There is greater scope for a primary care role for nurses working within general practices as members of the primary care team
- GPs, as part of their primary health care role, should be involved in activities aimed at improving the health of the population, including programmes to prevent illness, public health screening and health promotion initiatives.

Sweden

Treatment in Sweden is primarily hospital-based, with no clear distinction between primary and hospital-based care. There is no recognised system of family doctors and members of the public are free to refer themselves directly to hospitals in their region. Primary health care, however, has been greatly developed during the last decades. Active health promotion and systematic disease prevention programmes are considered to be as important as curative activities. Primary health care is organised around district health centres staffed by GPs, nurses, midwives and sometimes specialists.

Norway

GPs are considered to be the foundation of health care in Norway. Patients need referral from a GP to receive treatment at hospitals: thus, the GPs are used as gatekeepers for hospital service. GPs are organised in units providing not only curative treatment but also public health services, after-hours home visits and other services.

The Netherlands

Health care in The Netherlands is provided by thousands of institutions, tens of thousands of contracted or self-employed health professionals and hundreds of thousands of other health workers. Most health care facilities are owned and managed by not-for-profit, non-governmental entities of religious and charitable origins. As a rule, they have self-appointed boards responsible for overall policies and budget approval, but the management bears responsibility for ongoing daily business. Most GPs work in small group practices, and there are a small number of health centres where they work with other health professionals. Almost all dentists have a solo practice. Physiotherapists outside institutions usually work in small group practices. Most other health professionals are employed by hospitals or other health care facilities and organisations.

The Ministry of Health provides financial support for the introduction of information and communication technologies, for example by providing subsidies to GPs for computer practice systems. Until 1989, GPs needed the permission of local authorities to set up a new practice, but this requirement no longer applies.

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