



Primary Health Care Strategy

20 April 2004



MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tairāroa

Members of the Primary Health Care Reference Group
who developed this Strategy:

Dr David Ayling	General Practitioner; Chairman, Manawatu Independent Practice Association
Dr Donald Campbell	Medical Officer of Health/Director of Public Health Services, MidCentral Health
Professor Jenny Carryer	Professor of Nursing, Massey University and MidCentral Health
Mr Dean Chapman	Community representative, Feilding (with a special interest in mental health)
Ms Debbie Davies	Registered Nurse, Feilding; Deputy Chair, Manawatu Independent Practice Association
Mr Mike Grant (Chair)	General Manager, Funding Division, MidCentral District Health Board
Ms Muriel Hanratty	Group Manager, Rehab & Therapy, ElderHealth and Rural Services, Dental & Public Health Services, MidCentral Health
Ms Chiquita Hansen	Director of Primary Health Care Nursing, MidCentral District Health Board
Mr Craig Johnston	Portfolio Manager, Primary Care, MidCentral District Health Board
Professor Nan Kinross	Community representative, Palmerston North
Mr Stephen Paewai	Manawhenua Hauora representative; CEO, Rangitane O Tamaki Nui A Rua
Mrs Margaret Robins	Community representative, Horowhenua.

Table of contents

Overview.....	1
Priorities and plans	1
MidCentral’s primary health care strategy	2
Vision for primary health care	5
Introduction	7
What is primary health care?	7
Reviewing our past	8
Where are we now?	9
Looking to the future	10
Context for planning	11
Shared values for primary health care	13
What will primary health care services look like in the future?.....	15
What is a primary health organisation?	16
Potential configuration of primary health organisations for our district.....	16
Primary health care teams.....	18
Goals of the primary health care strategy	19
Access	19
Community participation.....	20
Coordination of services	20
Infrastructure development	21
Integration between primary and secondary care	22
Quality.....	23
The way forward.....	24
Sector development.....	24
Health care priorities.....	28
Service initiatives.....	28
Appendix 1 – Profile of MidCentral District.....	34
Appendix 2 – Needs Analysis	37
Appendix 3 – Treaty of Waitangi	38
Appendix 4 – Primary Health Organisation Establishment Path.....	40
Appendix 5 – Primary Health Care Teams	44
Appendix 6 – Primary Health Care Nursing Innovation Funding.....	49

Overview

MidCentral District Health Board is responsible for planning and purchasing (funding) most health services for the 155 000 people living in the following territorial local authority districts:

- Manawatu district
- Palmerston North city
- Tararua district
- Horowhenua district
- Otaki ward of Kapiti Coast district.

MidCentral District Health Board was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000. It has three key functions (output classes):

- Governing and managing the District Health Board
- Planning and funding health and disability services
- Delivering health and disability care services through Crown owned hospital and associated services.

Priorities and plans

The District Health Board's activities are guided by four key health and disability strategies established by the Government. These are the New Zealand Health Strategy (December 2000), The New Zealand Disability Strategy (April 2001), The Primary Health Care Strategy (February 2001) and He Korowai Oranga - Maori Health Strategy (November 2002).

The Government also has 10 priority areas for District Health Boards:

- Reducing the incidence and impact of diabetes
- Implementing He Korowai Oranga (Maori Health Strategy) and Whakataataka (implementation document)
- Reducing inequalities
- Implementing the Mental Health Blueprint
- Progressing the implementation of the NZ Disability Strategy
- Developing Primary Health Organisations
- Addressing waiting times for specialist elective services
- Keeping infrastructure costs as low as possible and within the forecast spending track

- Developing and maintaining good industrial relations
- Producing/developing/implementing innovative approaches so that health services manage within the funding available.

This document (the Primary Health Care Strategy) is part of a suite of strategic and operational plans MidCentral District Health Board is developing to give effect to the Government's strategies and to address the health needs and community concerns of its district. The paramount document is the District Strategic Plan, completed in 2001. This provides a 5 to 10 year outlook for the entire District Health Board. The District Strategic Plan defines the District Health Board's vision, which is that *"the people of our district enjoy the best possible health and independence."*

Beneath the District Strategic Plan are four strategies covering specific areas:

- The Primary Health Care Strategy (this document) which provides overall direction for the development of primary health care services in the district
- The Secondary Services Strategy (under development), which covers secondary (ie hospital and specialist services) and tertiary services (very specialised services usually provided at national centres)
- The Health of Older People Strategy – Ageing in MidCentral (under development)
- Oranga Pumau - Maori Health Strategy (under development).

MidCentral's primary health care strategy

MidCentral District Health Board's Primary Health Care Strategy provides direction in:

- Strengthening and investing in primary health care services through the development of primary health care teams
- Establishing Primary Health Organisations throughout the District
- Addressing the population health objectives outlined in the New Zealand Health Strategy.

This Strategy has been developed with the assistance of the Board's Primary Health Care Reference Group. A draft strategy, "Consultation Document 30 September 2003," was released for public consultation. Feedback from the community was received through public meetings and written submissions, and by a Hearing Committee taking verbal presentations.

The Primary Health Care Strategy sets out six goals to achieve improved health outcomes through primary health care:

Access	People throughout the District will have ease of access to primary health care services
Community participation	The community will actively contribute to shaping primary health care services that meet the priorities and needs of their community
Co-ordination of services	There will be seamless follow-through of services for all people
Infrastructure development	Primary health care services are supported by planned infrastructure development
Integration between primary and secondary care	People receive care that is not interrupted as it moves between primary and secondary care (ie hospital and specialist services) settings
Quality	People can expect the best possible quality when receiving primary health care services.

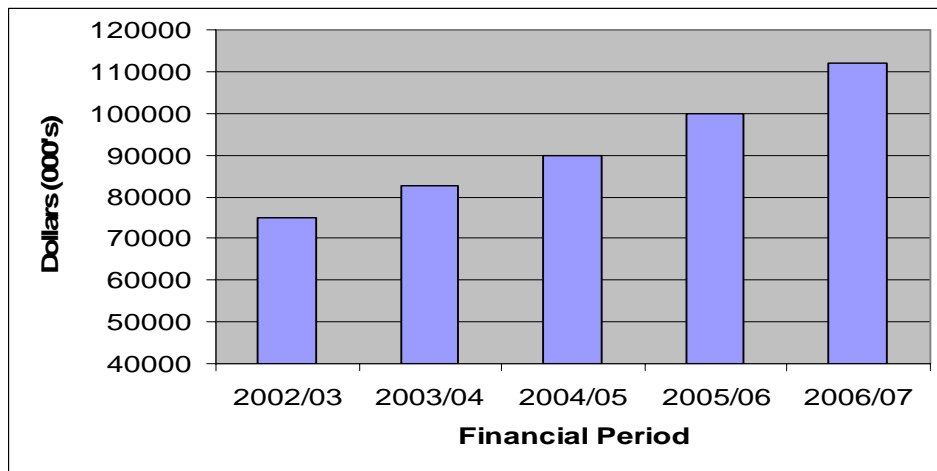
These goals are supported by 48 key actions to be put into practice over the next three to five years. In the future the District Health Board will develop the following detailed plans to give effect to the local Primary Health Care Strategy:

- A Primary Health Care Strategy Implementation Plan
- A Referred Services Management Strategy to assist the District Health Board to manage the use of community referred pharmaceuticals, laboratory tests and radiology procedures
- A series of service development plans for key health priority areas such as diabetes, child health and cancer services.

Over the next five years the District Health Board anticipates considerable additional investment in primary health care. This investment will be guided by this Primary Health Care Strategy. The following graph shows the anticipated

level of new investment. It is based on 2003 Ministry of Health projections.

Fig. 1 Graph of planned investment



Vision for primary health care

Ki mai ki ahau, he aha te mea nui o tenei ao
Maaku e ki atu
He tangata, he tangata, he tangata

If you ask me what is the most important thing in the world,
My reply is this,
It is people, it is people, it is people

Our vision for primary health care in 2014 is that together the District Health Board, health service providers, Maori and the community will have created an outstanding system of health care. This system will be characterised by a total commitment to the health of our community – helping us stay healthy, helping us return to full health and supporting us in ongoing illness.

In 2014 we will look back and laugh a little at ourselves – that we used to try harder and harder doing the same things, when we were doing the wrong things. We will be happy that we chose to change the way things were done. As system managers we will monitor and energise a well-functioning system full of vitality and change. As providers we will be proud that the hard work needed for change was done and produced such great results. And, as the whole community we will have a new trust in, and enjoy the benefits of, our primary health care system.

In 2014 our primary health care system will be defined by:

A commitment to quality

Quality is the main driver of change and the measurement by which we judge our success. We measure our performance against ourselves not against others. Quality is rewarded. We have embraced all the elements of quality – access, equity, effectiveness, efficiency, safety – and wisely balanced these within our financial resources. The savings we have made from reducing wastage of resources have enabled us to provide an ever-wider range of services and to fund even more quality initiatives. We recognise that much of health care has a tenuous evidence base and we are actively involved in research to document our initiatives for the use of other Districts, as we use theirs. We are glad we made an investment in quality 10 years ago as it has provided significant benefits to providers and community alike

A commitment to our providers Our health care providers have become a treasured asset in our community. Their energy, passion, long-cherished values and dedication to providing excellent service have been and continue to be a large part of our success. Their isolation as individual providers or professional groups has gone, and there is collective strength from mutual support not only from other providers but also from the community. We now have a diverse variety of business structures formed out of local need and opportunity. Diversity of opinion, perspective and approach are valued as strengthening the total system rather than detracting from it. Providers have a stable and realistic financial base that allows their values to flower and prosper as tangible results

A commitment to our community Our community is involved more than ever in our health system. As early community input became visibly more effective in directing change, so more input was forthcoming. The community voice has been effective in realigning the health care system to a community perspective. At the same time community values, provider values and management values were found to be similar rather than different, and shared values drove the development of our health care system. We are now seeing the early signs of our health-care model being extended to other areas in society.

***“If you don’t live in the future today,
you will live in the past tomorrow”***

Introduction

What is primary health care?

Primary health care covers a diverse range of health activities that primarily occur in community settings. Primary health care services are the first level of contact people have with the publicly funded health system. Services may be accessed by self-referral or on the referral of a health professional.

Primary health care has a strong focus on health promotion and prevention alongside services that assess, treat and rehabilitate people with specific health problems. Primary health care also includes services that address the health needs of groups and the community as a whole – services designed to help individuals, whanau and communities to be healthy. Community participation is integral to primary health care.

Ease of access is a key attribute of quality primary health care. The publicly funded health system endeavours to bring health care as close as possible to where people live and work, and be responsive to cultural and other needs.

The following figures give examples of the many different types of publicly funded primary health care providers operating in our District.

Fig. 2 Provider care focused on individuals

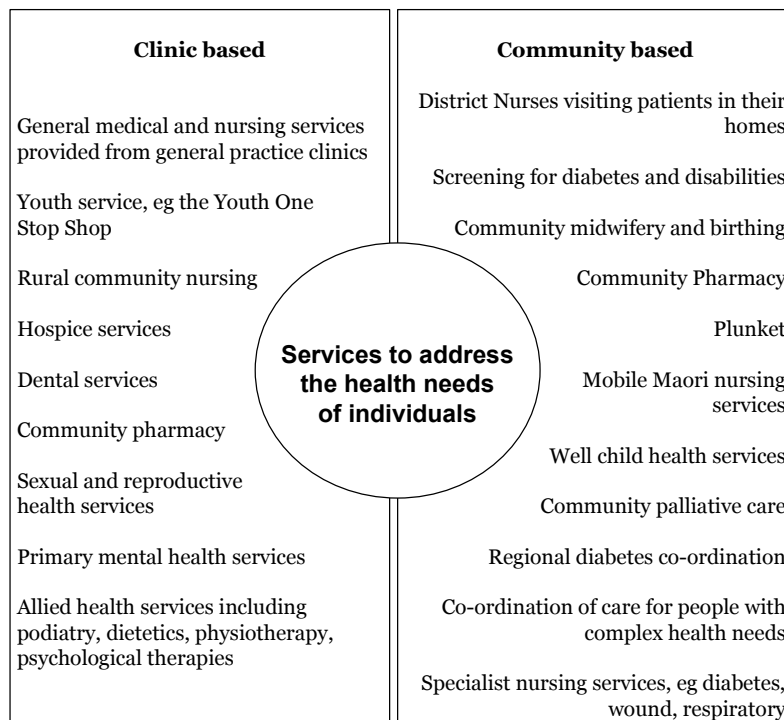
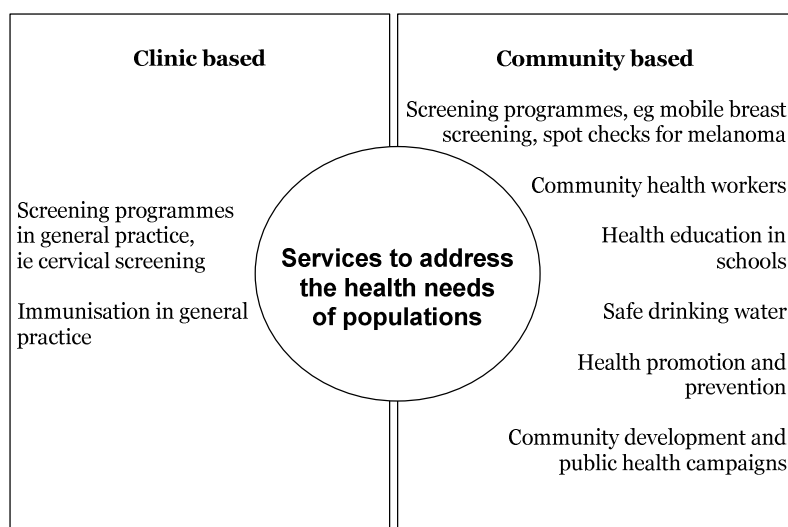


Fig. 3 Provider care focused on populations



In addition to publicly funded primary health care services there is a wide range of non-funded services that the user pays for. This includes, for example, some services provided by mainstream providers (such as most adult dental services and non-funded physiotherapy and pharmacy services), complementary health services (such as homeopathy) and an array of community groups, networks and non-government organisations providing support in the primary health care environment.

Reviewing our past

Changing structures

“With four different health care structures since 1989, New Zealand has the most restructured health system in the world. Those involved in managing and delivering health care are attempting to achieve a continuity of service delivery in a system that has been, from their perspective, in chaos”¹

Changing management

Over the past decade, primary health care has been characterised by changing management and funding structures, ongoing workforce issues and changing political environments

¹ *Continuity Amid Chaos*, Gauld, R, University of Otago Press, 2003

Changing funding

Despite good intentions and a commitment to improving health outcomes, the way primary health care services have been funded and structured in the past has not supported the best provision of services. Many community-based health professionals are frustrated at the barriers to providing an effective and well-coordinated service

Challenging environments

Despite these challenging environments, primary health care providers within the MidCentral District have developed initiatives to maintain quality primary health care service provision. Primary health care has needed investment to build on this foundation and develop our services further to improve the health of our community.

Where are we now?

Local perspective

Given the health status of the population, the community's viewpoints, and national health strategies, the following key challenges face the primary health care sector, now and into the future:

- Wherever people live they need to be able to access health care
- Maori have specific health needs that must be addressed in a culturally appropriate manner
- People benefit from having their services well coordinated; it is good to know all providers are working together for the same goals
- We need to grow and retain a vibrant workforce of health professionals
- There are more people in the community experiencing avoidable disease and disability
- Not all people have the same access to health care
- Our community needs readily available information about health services and service changes

- Intersectoral relationships are important to address determinants of health that occur outside the health system

Working together

MidCentral District Health Board is working with the primary health care sector to address these challenges. This is possible through changes to the structure and funding of primary health care services aimed at enabling local health services to be shaped according to local health priorities and needs.

Looking to the future

In looking to the future we can recognise the gains we have made in the past and build on what we have learned.

Building on health gains

Past initiatives and commitment from primary health care providers have established a base for gains in primary health care service uptake and outcomes. Major gains in primary health care provider and workforce development require strengthening of the infrastructure and leadership within the sector.

Accessible services

We know communities want primary health care services that are affordable, easy to access and culturally appropriate for individuals, their families and whanau.

Proactive self-care

The way people think about primary health care services and the way primary health care services are provided are changing. People are becoming more informed and more active in maintaining their own health care.

Wellness focus

We are focusing on wellness, on maintaining the health of individuals and their families/whanau, and on ways we can improve the health of our population and reduce health inequalities.

Quality services

Looking to the future of primary health care services in MidCentral District is exciting. Primary health care providers are working together to improve and maintain the quality of services, increase consumer access to primary health care services and empower communities to maintain their health.

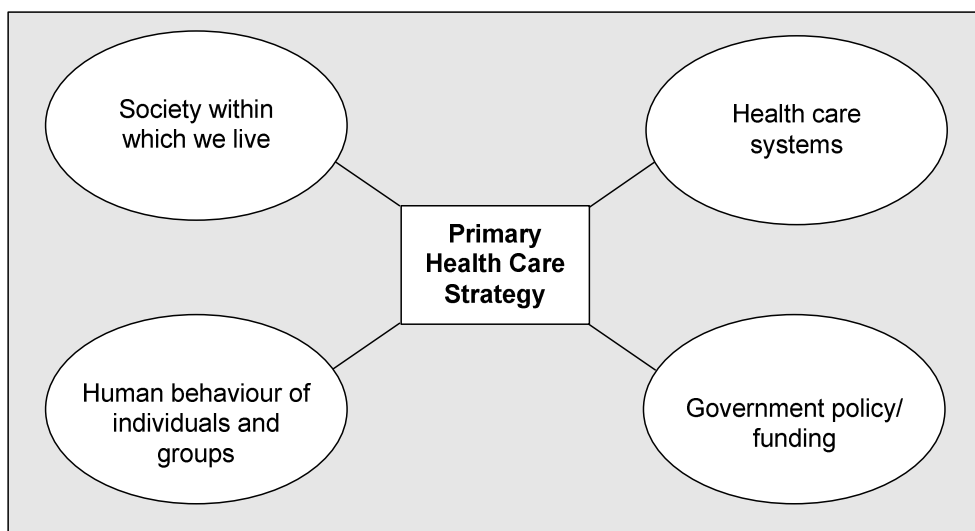
Commitment to our community's health

MidCentral District Health Board is committed to working with primary health care providers and the community to ensure our primary health care services are aligned with local health priorities and recognise national priorities and their relevance to our community. MidCentral District Health Board has been working with primary health care providers and key stakeholders to agree on a shared vision. Fundamental to future progress will be ongoing willingness to work together to achieving this vision.

Context for planning

In planning the development of primary health care services it is important to acknowledge the complexity of the environment. A successful strategy needs to take account of broader societal factors, Government policy and funding, and individual and group behaviour.

Fig. 4 The context of primary health care



We are guided by the Government's core health and disability strategies. These are The New Zealand Health Strategy (December 2000), The New Zealand Disability Strategy (April 2001), The Primary Health Care Strategy (February 2001) and He Korowai Oranga Maori Health Strategy (November 2002). At the local level MidCentral District Health Board has developed a District Strategic Plan to give effect to these strategies and in response to the health needs of its district and the priorities of its communities. The first goal of the District Strategic Plan is to strengthen primary health care in order to achieve MidCentral's vision that *"the people of our district enjoy the best possible health and independence."*

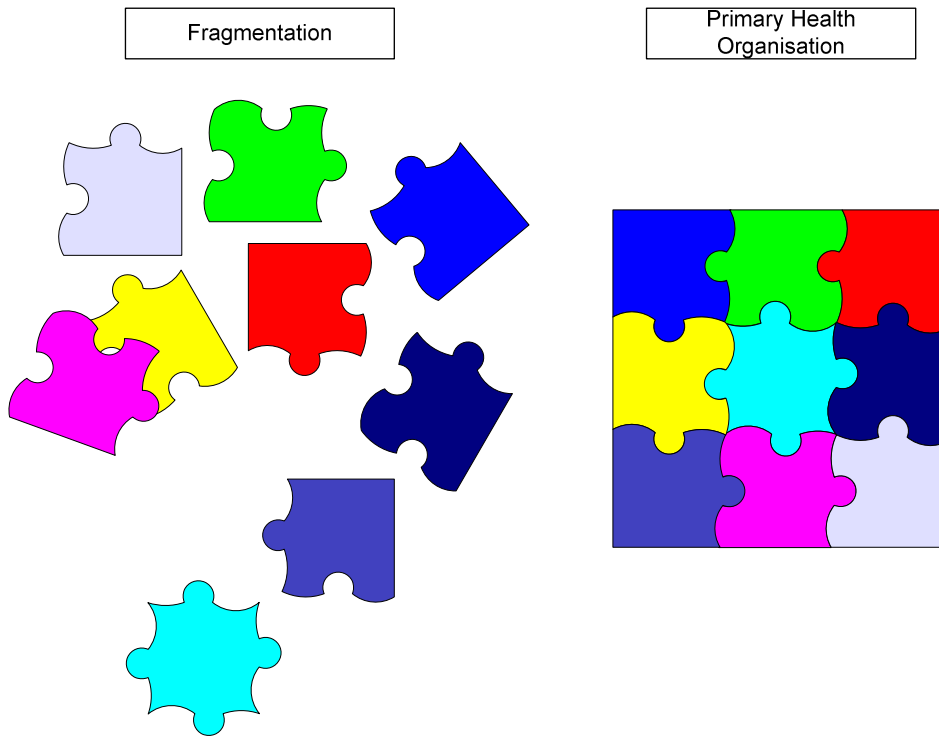
The New Zealand Primary Health Care Strategy is central in terms of the planning the development of primary health care. It proposes a new vision for primary health care over the next 5 to 10 years through the establishment of Primary Health Organisations. The key features of the new organisations are:

- Individuals will enrol with a Primary Health Organisation that will provide access to a full range of primary health care services
- Primary Health Organisations will be funded on the basis of their enrolled population, encouraging a focus on wellness and population health strategies
- Providers will be contracted to Primary Health Organisations
- Primary Health Organisations will be not for profit organisations focused on addressing the health needs of their enrolled populations. They will be locally run with community participation in governance.

The Primary Health Care Reference Group identified the benefits that Primary Health Organisations have as a way of overcoming existing fragmentation and working towards a more coherent, comprehensive community focused service.

Primary Health Organisations are thus the main vehicle for implementing MidCentral District Health Board's Primary Health Care Strategy. Within Primary Health Organisations people will be part of local primary health care services that will improve their health, keep them well, and care for them in illness. Such services will be easy to access, and co-ordinate ongoing care. Services will be more affordable and accessible, and they will focus on better health for our population and actively work to reduce health inequalities between different groups. The governance of Primary Health Organisations will be the responsibility of representatives from the community, health service providers and Maori.

Fig. 5 The primary health care puzzle



Shared values for primary health care

The following values will underpin all activities in primary health care:

Care and respect	Treating people with respect and dignity; valuing individual and cultural differences and diversity
Community involvement	People in the community participating by identifying their priorities, the health care services they need and the way they want services to be delivered
Customer focus	Commitment to meeting the health needs of consumers and the community
Innovation	Constantly seeking and striving for new ideas and solutions, for better ways of doing things and for improved health outcomes
Leadership	Motivating and leading within the primary health care sector

Partnership	The District Health Board, providers and health professionals working alongside each other, focusing on our common vision
Professionalism	Acting with integrity and embracing high ethical standards
Responsibility	Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions
Sustainability	Providing sustainable services which contribute to sustainable health gains for our community
Teamwork	Achieving success by working together and valuing the contributions and skills of all team members.

What will primary health care services look like in the future?

Over the next 10 years primary health care in MidCentral's District will be developed so that:

- Members of the community will enrol with a service provider who is part of a Primary Health Organisation². By enrolling with the provider the individual, their family/whanau will gain access to a comprehensive range of services, including the following:
 - Services promoting wellness and independence through helping people, family/whanau and communities to assume responsibility for their own health and to adopt healthy lifestyles
 - Services to improve health, including screening, prevention and education
 - Services to maintain health, preventing the progression of disease and disability
 - Services to restore health, involving diagnosis, treatment and rehabilitation as well as broader dimensions of health
- First point of contact services for people with specific health and illness needs will be provided by health professionals working as part of a primary health care team. Primary health care teams will be multi-disciplinary with greater emphasis on community nursing and other health care disciplines such as health promotion (nutrition, exercise and smoking cessation), Maori health workers, dietetics and pharmacy
- The health care a person or their family/whanau receive will be coordinated by the primary health care team, ie between:
 - primary providers
 - primary and secondary (ie hospital and specialist service) care providers
 - primary providers and public health services
 - primary and disability support services
 - primary and mental health, and drug and alcohol services
- Quality and continuous service improvement will be key elements of primary health care services. Services will be of the highest standards provided by well qualified competent staff

² People may choose not to enrol in a Primary Health Organisation. They will still be able to access most services but it may be on different terms – for example, higher part charges.

- Local communities and services will be supported to:
 - Participate in the development and governance of the local Primary Health Organisation
 - Engage in the planning of health services
 - Build their capacity to improve their health.

The major visible change in primary health care services over the next 10 years will be the formation of a number of Primary Health Organisations to cover the population of the District. The development of Primary Health Organisations will improve access to primary health care services and involve the community in determining services that are accessible, responsive and appropriate to their needs.

What is a primary health organisation?

Primary Health Organisations are a new way of structuring health services and are a key feature of the New Zealand Primary Health Care Strategy. Within a Primary Health Organisation a range of community health professionals will work together to provide services for the community. Each person in the community will have the opportunity to enrol in a Primary Health Organisation.

The Primary Health Organisation is funded on the basis of the number of people on its register. It provides access to a range of frontline health professionals for the services or care needed - such as general practitioner, primary health care nurse, pharmacist and midwife.

Primary Health Organisations are not for profit organisations. They are responsive to the needs of their communities and involve community members, providers and Maori in their governing processes.

Potential configuration of primary health organisations for our district

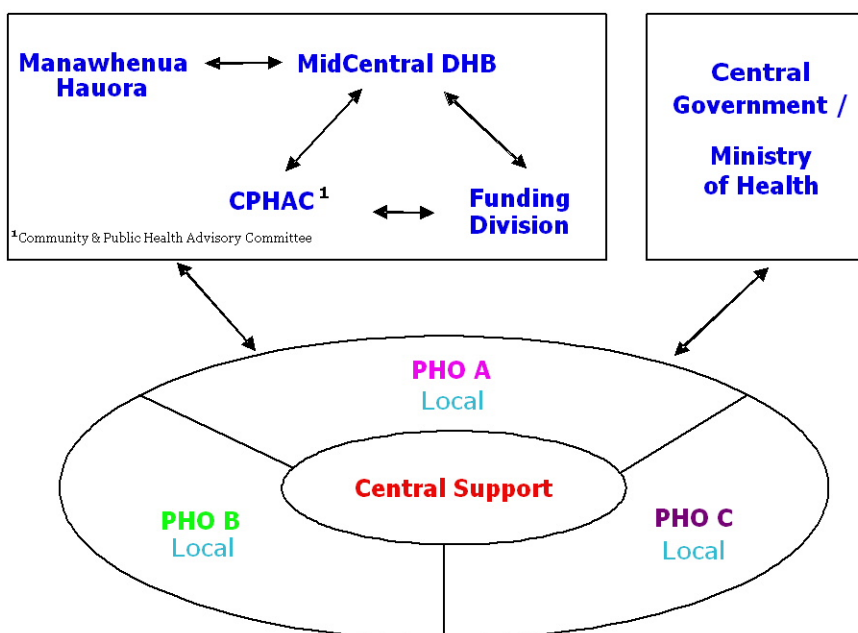
MidCentral District Health Board will work with communities to ensure strong, viable, enduring Primary Health Organisations capable of each providing its enrolled population with the best possible health care are developed.

Primary Health Organisations will be based on geographical districts to ensure total population coverage. The pathway to the formation of Primary Health Organisations is set out at Appendix 4.

The following diagram represents a possible configuration for Primary Health Organisations in MidCentral District. It shows national and local relationships, the support mechanisms for the organisations, and the roles both of primary

health organisations within a local setting and of the central support.

Fig. 6 Primary health configuration



The Primary Health Organisation/Local Support role comprises:

- Governance – Iwi, communities, providers
- Relationship management
- Service provision
- Community input
- Service delivery – Primary Health Practice for communities
- Health information
- Evaluation and review.

Because of the emphasis on creating a strong and enduring health system, the District Health Board will encourage a shared support services agency to undertake administration for local Primary Health Organisations. This shared agency will enable economies of scale and the sharing of expertise. The specific functions the agency could fulfil will be determined by the participating Primary Health Organisations, but could include:

- Management of registers and enrolment
- Processing of information, including monitoring and reporting
- Professional support structures for health practitioners
- Supply systems

- Marketing/communications
- Common approach to referred services management
- Auditing
- Development of best practice guidelines, policies, quality systems, health & safety.

Primary health care teams

Throughout the MidCentral District, Primary Health Organisations will be supported by primary health care teams. These teams are a key component in the delivery of health care services to enrolled Primary Health Organisation populations.

The shape and size of primary health care teams will need to reflect:

- the size, locality, characteristics and needs of the team's enrolled population
- cultural competencies relating to the enrolled population
- relationships with other primary health care teams
- the team's relationship with the Primary Health Organisation
- the team's relationship with other sectors, eg social services.

Good data links and information flow across providers will be an integral part to the success of the team.

Core members of the primary health care team could include:

- Allied health professionals (eg dietitians, podiatrists)
- Dentists and dental therapists
- General practitioners
- Midwives and lead maternity carers
- Maori health professionals
- Mental health workers
- Nurse practitioners
- Pharmacists
- Primary health care nurses
- Health promotion workers
- Community health workers.

For further explanation about the roles of the core members, refer to Appendix 5.

Goals of the primary health care strategy

In identifying the six goals we also determined specific outcomes.

Access

People will have ease of access to health care services throughout the district

Existing primary health care services, such as mobile clinics and community based outreach clinics will be strengthened and improved to ensure services are accessible to both rural and urban communities. The development of new primary health care initiatives will need to link with existing services and focus on improving service delivery to communities.

Reducing the cost of primary health care services to consumers is an important part of the changes taking place in primary health care and the development of Primary Health Organisations. Through Primary Health Organisations, primary health care providers will work together to deliver services that will, over time, become more affordable. The needs of the community will be considered in light of the demographic composition and levels of deprivation within the MidCentral District. Communities with high health needs in the MidCentral District include people with low socioeconomic status, Maori and those people living in rural areas. Primary Health Organisations will work to reduce inequalities in health outcomes.

Culturally appropriate services will be provided for people who live in the MidCentral District. These services may be delivered by Maori, Pacific or Asian peoples, mainstream or community providers; however, the focus is to ensure individuals and their families/whanau are able to access the health care they feel comfortable with, which acknowledges and respects their cultural values. Small but growing populations of Pacific and Asian peoples are important to consider in developing culturally acceptable primary health care services.

We recognise the ability of communities to access primary health care services is significantly affected by their awareness of the types of services available

and the location of these services.

Community participation

The community will actively contribute to shaping primary health care services

The voice of the community and active engagement with our people is a critical link to ensuring primary health care services are delivered in timely and appropriate ways. Individuals and their families/whanau can participate and have input into primary health care services in a number of ways, for example, by providing feedback to their health practitioner. It is important the community takes the opportunity to communicate their concerns, contribute their ideas, provide feedback and play an active role in ensuring primary health care services meet their needs.

Primary Health Organisations will provide mechanisms for the community to participate in primary health care. This will include formal participation in governance through representation on Primary Health Organisation boards. Through participation in primary health care, communities can become empowered to take greater responsibility for their health. Health promotion within communities can improve the availability of health information and improve the ability of communities to maintain their wellness.

Co-ordination of services

There will be seamless follow-through of services for all people

There has been a tendency in the past to think of and organise primary health care services as a series of discrete, independent providers. Better health outcomes can be achieved by improving the coordination of services. This requires a collaborative approach to service delivery. Providers need to recognise the health priorities of the community and to be vigorous in the management of the interfaces between services and providers.

Primary health care is broader than publicly funded health services. Coordination and cooperation is required across the whole sector between the funded, the partially funded and the unfunded. Achieving the vision that *“the people of our district enjoy the best possible health and independence”*

also necessitates intersectoral linkages with other agencies – for example local government, sport and recreation, and the education sector.

Infrastructure development

Primary health care services are supported by planned infrastructure development

The sustainability of primary health care services in the MidCentral District relies on a number of linked components. The primary health care workforce is the heart of primary health care service provision. There are a number of ongoing workforce issues, which include the development, recruitment, and retention of health professionals, as well as the maintenance of links between them. However, the importance and value of these health professionals must be recognised beyond dollar values. The challenge for the future is to develop sustainable systems and initiatives that are flexible and can be used in changing workforce environments. In addition, primary health care professionals need access to high levels of job satisfaction through being engaged in the provision of a high quality service.

Information technology and information systems are a key part of the infrastructure of primary health care services. The collection, maintenance (including storage and security) and provision of accurate patient data, health statistics and general health information will be critical to the infrastructure of primary health care services. Developing and strengthening these systems will be ongoing and will involve collaborative work between providers and consumers to ensure their population's health information is coordinated and shared appropriately.

Information requirements extend beyond patient management to service monitoring and evaluation. Information is a key component of the “plan-do-review” cycle which drives continuous service improvement in both clinical and service management contexts. Accountability to funders and the community is also an important component of the service infrastructure. Further development is required here as new structures evolve.

Integration between primary and secondary care

People receive care that is not interrupted between primary and secondary care events

Improvement to the interface between primary and secondary care (ie hospital and specialist services) is important in developing efficient service delivery, improving the level and quality of care provided, and in supporting health care services to make the best use of limited resources enabling the best outcomes for patients to be achieved.

Generally, primary health care services are the first point of contact for individuals, their families/whanau - the effectiveness of these services has a direct impact on the demand for secondary care services. Secondary care services are predominantly hospital-based services, and include hospital admissions and emergency department consultations. International and New Zealand studies have shown that many hospital admissions and emergency department consultations are avoidable.

The challenges of integrating primary and secondary care are the need for greater sharing of information, and the identification of how primary health care can minimise the avoidable use of secondary care and specialist services.

Effective coordination across primary and secondary care is increasingly important as the emphasis on short hospital stays and avoidance of hospital admissions shifts the burden of providing disease-state care to the community. A collaborative approach between primary health care providers will be needed to strengthen the ability of the primary sector to deliver appropriate and timely care. Primary health care nurses, including Nurse Practitioners, are expected to make a significant contribution in this area.

Primary health care and secondary care have different approaches. There is also considerable variation in the philosophical and service approaches of the various primary and secondary providers. It is important, therefore, that all parties are flexible in their approach to the primary/secondary interface. A collaborative approach is the foundation for this flexibility.

Quality

People can expect the best possible quality when receiving primary health care services

Quality primary health care services give the community confidence in the advice and care they receive and assurance that health practitioners are suitably qualified to provide services. Quality primary health care services can be identified and recognised in different ways – for example, being able to access effective and efficient services, which are provided in a safe environment. Quality also includes accreditation and auditing processes. For primary health care providers, delivering high quality services includes: Continued Medical Education (CME), ongoing postgraduate education in nursing and other disciplines, and multi-disciplinary education on best practice and evidence-based approaches and developments.

Assigning specific clinical responsibilities to health professionals on the basis of their training qualifications, experience and current practice is part of a quality process designed primarily to protect the public. Consumer representatives will have input to this process.

The way forward

To achieve the six goals and our vision of improved health outcomes to the population of the MidCentral District, the following objectives have been identified:

- Sector Development to improve the primary health care sector's ability to deliver care for the needs of the community
- Health Care Priorities to improve health care in key disease states
- Service Initiatives to improve health services in priority areas

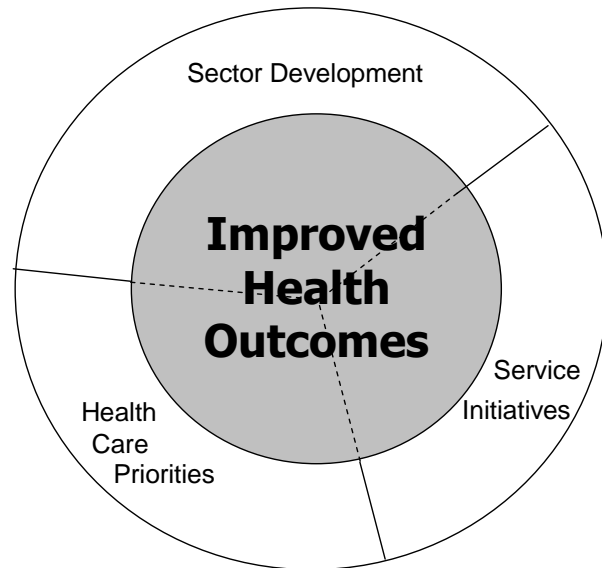


Fig. 7 Improved health outcomes target

Each objective is supported by a series of actions. Listed below are 48 proposed actions. Further work will be undertaken to develop a more detailed implementation plan, which will include timelines, defined responsibilities and resources. The implementation plan will also provide a framework for monitoring progress towards achieving the goals of the strategy. The implementation plan will be scoped over a 3-5 year period with two further 3-year reviews.

Sector development

Achievement of the vision and goals requires improvement in the structure, capacity, attitude and community focus of the primary health care system.

Structure

Reshaping the structure of the primary health care sector to enable providers to deliver the care the community needs

- 1 Enable all people in MidCentral's District to enrol with a Primary Health Organisation. This includes ensuring the community is aware of

and understands Primary Health Organisations.

- 2 Where possible, define Primary Health Organisations by their geographic boundaries. Primary Health Organisations will determine their priorities and objectives to fit best with the demography of their districts, and the health needs and concerns of their populations.
- 3 Ensure 80% of the primary health care providers in MidCentral's District will be part of a Primary Health Organisation.
- 4 Ensure 50% of primary health care providers are part of an identified primary health care team. There will be diversity in the shape and approach of primary health care teams in response to the needs of the local community.
- 5 Quality of service will guide the organisation and delivery of health care. The principles of continuous service improvement will be reflected throughout the primary health care sector. Research and evaluation will be important components of care.
- 6 Support the key principles of collaboration between agencies and providers and multidisciplinary approaches in both planning and service delivery by appropriate structures and processes at every level.

Capacity

Increasing the primary health care sector's capacity to meet the goals of the Primary Health Care Strategy

- 7 Support general practitioners, nursing and other health professionals to deliver the best possible services to local communities, for example through incentives to achieve best practice standards.
- 8 Increase the ability of general practitioners, nurses and other health professionals to participate in primary health teams through leadership, promotion, incentives and training.
- 9 Increase investment in workforce development to enable primary care practitioners to learn the

required skills, attitudes and cultural competencies to work as members of primary health care teams. Invest in ongoing training (including release time), support and teamwork. Include the provision of relief opportunities for health practitioners working alone or within difficult professional environments.

- 10 Increase Primary Health Organisations' access to core skills through resourcing and workforce development to ensure they have the skill sets required to manage the primary health care needs of their population. Particular areas for development include:
 - public health, particularly health promotion and community development
 - nurse practitioners
 - mental health
 - specialist nursing
 - clinical pharmacy.
- 11 Increase Primary Health Organisations' responsibility for the management of discharge from secondary care. Increase their participation in the management of access to specialist elective services (ie Elective Services Waiting Lists) and in the demand for acute services. Primary Health Organisations will increase capacity in various areas for specialist and visiting nursing services and other primary services currently provided by MidCentral Health.
- 12 Increase the involvement of primary health care providers in the management of support services such as laboratory, pharmacy and radiology.
- 13 Expand health professional resources across the District, particularly in rural and socio-economically disadvantaged areas, to ensure the communities are receiving a reliable level of care.
- 14 Support non-government organisation provider workforce development.
- 15 Implement the Nursing Innovation proposal (refer Appendix 6) across the District.

- 16 Implement MidCentral's Technology Plan, to enable the sector to look for opportunities to improve health care by sharing information and improving communication between core providers. For example, analyse pharmacy dispensing data in conjunction with prescribing to identify health gains for consumers, funders and clinicians.
- 17 Work with all providers to ensure the accurate and complete collection of national health information, and define further the minimum clinical data requirements across the continuum of care.

Attitude

The right people will be available with the right attitude in the right place at the right time

- 18 Reduce health inequalities and improve the health of our population through the collaboration of primary health care providers and communities.
- 19 Facilitate the smooth functioning of the sector through open communication between providers and the District Health Board.

Community

The health needs of the community will be the key factor in determining the health services delivered

- 20 Work with communities to enable them to understand and engage in the processes of Primary Health Organisation development and implementation.
- 21 Respond to community aspirations for health service delivery and planning at all levels.
- 22 Work with Primary Health Organisations to ensure they routinely provide opportunities for their communities to participate in the monitoring and evaluation of local health services. Use this information to guide service delivery and policy setting.
- 23 Enhance inter-sectoral collaboration with a range of agencies including territorial local authorities and Government departments

through service planning and strategic planning processes, particularly in child and youth health, and public and rural health.

Health care priorities

To improve the health status of the community a number of high priority disease states need to be addressed. When taken together these diseases account for a significant proportion of the ill health in the community. There is often avoidable morbidity and mortality associated with inadequate prevention and poor management of these conditions. To be effective, there needs to be coordinated, focused attention paid to each of these disease states through promotion/prevention, diagnosis, treatment, rehabilitation and management of chronic conditions.

- 24 Develop and implement a coordinated, district wide plan for the prevention and management of diabetes.
- 25 Develop and implement a coordinated, district wide plan for the management of heart disease.
- 26 Develop and implement a coordinated, district wide plan for the management of respiratory illness.
- 27 Develop and implement a coordinated, district wide plan for the management of cancer.
- 28 Develop and implement a coordinated, district wide plan for the management of oral health.
- 29 Develop and implement a coordinated, district wide plan for the management of depression.

Disease state plans will be developed collaboratively with primary, secondary, and, where appropriate, tertiary care providers, community and stakeholders. The timetable for implementation will be developed after the consultation period, but will occur in the initial 3-year wave.

Service initiatives

In addition to specific disease states, there are a number of specific service areas that need strengthening if we are to ensure we achieve our vision and goals. Again the emphasis is on collaboration between providers and multidisciplinary approaches. Health promotion is an important dimension under each of these service initiatives.

Maori health

Maori health statistics are consistently poorer than non-Maori when taking account of age and socioeconomic measures. MidCentral District Health Board recognises and supports the Government priority on reducing health inequalities in health outcomes.

He Korowai Oranga (the Maori Health Strategy) recognises that Maori whanau and communities want improved health status, reduced health inequalities and increased control over the direction and shape of their own institutions, communities and development as a people. He Korowai Oranga therefore emphasises whanau health and wellbeing as its overall aim. Whanau health will be achieved by building on the strengths of whanau to achieve whanau ora (health and wellbeing) and by reducing inequalities in Maori health status in key disease priority areas.

Maori health priorities for the MidCentral District are:

- reducing smoking
- improving nutrition and reducing obesity
- increasing physical activity
- reducing the rate of suicides
- minimising alcohol and drug use
- reducing the incidence and impact of cancer
- reducing the incidence and impact of cardio vascular disease
- reducing the incidence and impact of diabetes.

Participation is integral to ensuring the Maori Health priority areas can be addressed. MidCentral District Health Board has a formal relationship with Manawhenua Hauora who represent tangata whenua within MidCentral District. Maori also need the opportunity to participate in governance and service delivery right across the primary health care sector. Maori providers have a key role to play in improving the health of their communities.

The objectives for Maori health are:

- 30 Increase the scope of primary health care services provided for Maori by Maori over time. As total District Health Board funding increases through population-based funding, ensure the proportion spent on for Maori by Maori services will be at least maintained.
- 31 Ensure active Maori participation in Primary Health Organisations at governance and provider levels and through community

involvement. Also ensure active Maori participation in sector planning and policy.

- 32 Ensure all Providers are able to provide appropriate and effective primary health care services to Maori.

Public health

Public health services are delivered to whole populations, or sub-groupings of the whole population, at national, regional and local levels. These services include health protection and health promotion. Specific elements of public health services are usually called 'programmes', as they often combine several mechanisms or approaches for action to tackle a health issue.

- 33 Increase the overall investment in public health activities in the primary health care setting.
- 34 Ensure each Primary Health Organisation has public health strategies including health promotion plans that reflect the health needs of the population.
- 35 Boost immunisation rates across the District by implementing the immunisation register.

Child health

The health of our children, given the risk factors for many adult diseases and the opportunities for preventing these diseases arise in childhood, is vital for later adult health. (The definition of a child has been defined as aged from before birth to 14 years.)

- 36 Develop a child health service plan for the District. Include identification of service gaps, the need for any district-wide policies or structures, and the establishment of a Standing Child Health Committee.
- 37 Establish a community paediatric service with joint primary and secondary ownership.

Youth health

Young people between the ages of 14 and 24 years old have a high chance of being caught up in risk-taking behaviour, where negative consequences of their actions can be life long. Compared with other age groups, young people have:

- High rates of mental illness
- High rates of alcohol and drug use and abuse, particularly among young men
- A higher rate of suicide and suicide attempts
- High rates of sexually transmitted infections.

Young people are sensitive about the services they require and often have limited financial means. To provide them with accessible services requires careful planning. In the MidCentral District we recognise the need to reach out proactively and be more responsive to young people.

The priorities for youth health within a primary health care setting are to:

- Actively involve young people in designing primary health care services for young people
- Explore ways of reaching out to young people who do not use existing services
- Ensure health services meet the needs of refugees and migrant young people
- Review consistency of eligibility of young people to access health and other related services.

These priorities are in line with national policy, and MidCentral will work with other District Health Boards to use initiatives developed throughout the country to help our young people.

- 38 Make primary health care more youth-friendly, by taking account of young people's desire for privacy, for example.
- 39 Increase school-based health care services in high deprivation communities.
- 40 Help health workers recognise early signs of mental illness and alcohol and drug abuse, tobacco, and sexually transmitted infections by promulgating youth-focused guidelines.
- 41 Make sexual health services targeted to youth available throughout the District.

Mental health

The National Mental Health Strategy focuses on the 3% of the population with severe mental health disorders. Of relevance to primary health care is the 17% of the population with mild to moderately severe mental health problems. A World Health Organisation study indicated 24% of people presenting to primary health care services have a major psychiatric disorder, while a further 9% have a

sub-threshold disorder. Moreover, preliminary data from a local study suggest as many as 35% of people accessing general practitioner practices in New Zealand meet the criteria for mental disorder.

Although many people with a mental disorder present themselves to primary health care services, responsiveness to their needs depends on the interest and expertise of individual practitioners. In the current primary health care environment, barriers to the provision of effective primary health care services include the cost to general practice of providing care, the cost to the service user of accessing care and the primary health care provider's team's confidence and competence.

Increasing the ability of primary health care to provide for the mental health needs of the community will have a significant effect in reducing the stigma and discrimination surrounding mental illness, arguably the most debilitating effect for those suffering from a mental illness.

In the MidCentral District we envisage a seamless mental health service that is both integrated and multi-disciplinary.

- 42 Increase the mental health care provided in the primary health care environment through appropriate resourcing and the development of capacity (such as expertise).
- 43 Further develop the integrated model of service provision to address the gap between specialist and primary health care services. All providers and agencies will work together to provide people with a continuum of care.
- 44 Reach 17% of the population with effective and targeted early-intervention programmes that have been developed using data on minor to moderate mental illness.
- 45 Align mental health services within the primary health sector to reinforce the ideals of the Mental Health Strategy in the move from a model of institutionalisation to a community-based approach.

Health of older people

As a population group older people vary considerably in health status, mobility, social activity, health needs, and the contribution they can make to society. The vast majority of people over 65 are fit and healthy. A minority are frail and vulnerable and require considerable care and support especially in the last few years of their lives. Nationally, 60% of the over 65s are identified in the lower socio-economic group.

Significant numbers of older people are found in MidCentral's rural provincial areas. This has implications for access to services and will need to be factored in to Primary Health Organisation planning.

The primary health care sector recognises the importance of including older persons in their own health care and of providing health services that are oriented to the total needs of the individual. We are working to develop services to support 'ageing in place' and wellness through the ageing process.

Priorities for older persons' care in the primary health care setting are to:

- Provide timely, coordinated, multidisciplinary care, including integration and communication between primary and secondary care
- Promulgate best practice protocols for acute episodes of ill health, specifically:
 - Rehabilitation to promote recovery
 - Ongoing support for those who are disabled, including mental health
 - Reduction of the period of morbidity
 - Maintenance of quality of life for the individual, family/whanau at the end stage of life
- Engage older persons in health promotion and wellness activities
- Form effective links with community and advocacy groups – education and support groups such as the Stroke Foundation, Parkinsonism Society, Cancer Society, Age Concern and Grey Power
- Investigate access issues, identifying options and possibilities with the community and implementing where feasible
- Develop mechanisms for feedback from elders, their whanau/family and carers, with time-framed action plans

46 Finalise development of a district-wide strategic plan to implement the Ministry's Health of Older Person's Strategy.

47 Improve the coordination of care targeted to the needs of older people.

48 Promulgate clinical guidelines for the management of common age-related health problems in the primary health care setting.

Appendix 1 – Profile of MidCentral District

MidCentral District Health Board serves a wide geographical district stretching across the North Island from the west to the east coast, and is bisected by the Tararua and Ruahine ranges. MidCentral District comprises the following territorial local authority districts:

- Horowhenua District
- Manawatu District
- Palmerston North City
- Tararua District
- The Otaki ward of Kapiti Coast district (includes Otaki, Otaki Forks and Te Horo census area units).

The territorial districts within MidCentral’s boundaries are expected to change in different ways. The populations of Manawatu, Palmerston North, and Kapiti Coast (Otaki) districts are expected to increase. The population of Tararua district is expected to continue to decline, while the population of Horowhenua is predicted to remain relatively constant.

Four Iwi have Manawhenua status within the district: Muaupoko, Ngati Kahungunu, Ngati Raukawa, and Rangitane.

Ngati Raukawa and Muaupoko iwi are located on the western side of the ranges and Ngati Kahungunu iwi is the eastern side. Rangitane iwi cover both sides of the ranges from the Manawatu district across to Pahiatua and Dannevirke areas.

Population profile

The 2001 Census data indicated that the resident population of MidCentral District was 154 983 people. Over the next 10 years the population is expected to grow. However, not all age and/or ethnic groups within MidCentral District will grow at the same rate.

MidCentral District’s population has a number of special features to consider when thinking about health services:

- We have a significant rural population – 28% of the population live outside a major urban or secondary urban area
- At 15%, we have a slightly larger than average percent age of Maori, and this is expected to increase to 20%
- We have a slightly larger than average percentage of older people (aged 65+), which is expected to increase
- The proportion of older Maori (those aged over 55 years) is expected to

increase by nearly 65%

- We have a small but growing population of Pacific peoples, with 3 039 Pacific peoples (1.96% of MidCentral District's total population)
- We have a small but significant migrant (including Asian) population
- We have one university (including a College of Education) and two wananga, a polytechnic, and a large number of private training establishments (including the International Pacific College) within our District. These post-secondary education institutions are most often attended by those aged 15–24 years
- There are two separate bases for the armed forces within the District – Linton Army Camp and Ohakea Air Force Base.

Health profile

A global health needs assessment completed during 2001 indicated disease (morbidity) and death (mortality) rates for people living within MidCentral District's boundaries confirm that diabetes, cancer, cardiovascular and mental health issues need to be addressed adequately in primary health care.

The relationship between socio-economic status and health resembles a gradient – increasing income, education, and occupational status is associated with improving health outcomes. The needs analysis identified two main groups likely to have high health needs those with relatively low socio-economic status, and Maori.

NZDep2001 measures socio-economic status across New Zealand: an area with an NZDep2001 score of 1 is the least deprived (ie has high income, high employment, well educated, privately owned home, car, phone); an NZDep2001 score of 10 indicates the most deprived. Socio-economic deprivation is consistently associated with decreasing life expectancy, increasing mortality rates, increasing hospitalisation rates and higher smoking rates – making high deprivation areas an important indicator of health needs. MidCentral District has some significant pockets of deprivation, noticeably in the communities located along the west coast and in central Palmerston North.

Maori living in MidCentral District have consistently poorer health status than their non-Maori counterparts even when differences in socio-economic status (eg income, employment, housing, education) are taken into consideration.

Diabetes is a major cause of morbidity and early mortality, and causes problems for those affected and their families. Diabetes is rapidly increasing in New Zealand and the incidence is expected to double in the next 20 years.

Unchecked or poorly managed diabetes will have a significant impact on the demand for secondary services – particularly on renal dialysis services, which are costly and unlikely to be able to meet the projected demand. However, a number of interventions can be implemented in the public health and primary health care areas to reduce the impact of diabetes on individuals and health resources.

Cardiovascular disease, while declining, is still the leading cause of death in New Zealand, mainly due to ischaemic heart disease and stroke. Nationally males have over twice the rate of hospitalisation of females. Modifiable risk factors for cardiovascular diseases include smoking, obesity, lack of physical exercise, diabetes, stress, diet, and high blood pressure. Maori are known nationally to have higher rates of heart disease and consequently higher mortality from heart disease.

Cancer is a leading cause of death for middle to older age groups. Maori loss of life from cancer is high in relation to non-Maori.

Despite respiratory illness being a significant cause of morbidity and mortality in New Zealand, it is not one of the 13 priority health objectives set by the Government. Maori are known nationally to have higher rates of asthma and respiratory illness.

While mental health is traditionally a weak area in terms of data for health status profiles, changes in the way mental health data are recorded and reported are slowly changing this. An increasing need for mental health services has been projected, and the World Health Organisation has stated depression in all ages of people throughout the world will increase, and that this will become the major disability of the future. Depression has very high levels of associated disability due to the global nature of the effect on the sufferer.

Appendix 2 - Needs Analysis

To determine how to *improve the health and independence of our community*, MidCentral District Health Board worked with a wide range of groups and individuals, and commissioned a needs assessment for MidCentral District. This process identified the following key issues for our communities:

- The need to know and understand the changes occurring and what these will mean on an individual level
- Access to primary health care across the district, given the high proportion of population who live rurally and the transportation issues they face
- Workforce shortages
- Maori living in the district have a poorer health status than non-Maori
- Inequalities in health exist, particularly for people with a lower socio-economic status
- The deinstitutionalisation of Kimberley Centre – a large, institutional facility for people with an intellectual disability
- The introduction of population-based funding
- Demand for health and disability services is growing, and MidCentral District's population is ageing
- The burden of disease is increasing
- Fragmentation of service arrangements exists
- The introduction of Primary Health Organisations, how they will change the way primary health care is organised, and the need to increase the focus on health promotion, disease prevention and early intervention
- Sound information and information systems are required to ensure planning and purchasing decisions are made that will improve the health status of the District
- MidCentral has a fixed funding pathway and must live within this funding. It is currently in a deficit situation, and facing increasing demand and costs
- Demand for services and the cost of providing such services, exceed the ability to deliver within the available funding and resources. Balancing these factors, together with clinical considerations, means choices will have to be made.

Appendix 3 - Treaty of Waitangi

MidCentral District Health Board recognises the Treaty of Waitangi establishes a unique and special relationship between iwi Maori and the Crown and forms a basis of good health for Maori people. As a Crown agency, MidCentral considers the Treaty of Waitangi principles of partnership, proactive protection of Maori health interests, co-operation and good faith underpin the manner in which MidCentral's governance and management respond to Maori health issues.

MidCentral District Health Board will fulfil its commitment and obligations to the principles of the Treaty of Waitangi through the provision and delivery of services that are accessible, appropriate, and acceptable to whanau, hapu and iwi. MidCentral defines partnerships as relationships established to inform strategic developments for Maori health gain to improve Maori health status.

Partnership	Collaborate with local iwi, hapu, whanau and Maori communities to develop and implement strategic and operational initiatives for Maori health gain and appropriate Maori health and disabilities services.
Participation	Encourage and involve local iwi, hapu, whanau and Maori communities at all levels of design, development and delivery of Maori health and disability services.
Protection	Collaborate with local iwi, hapu, whanau and Maori communities in ensuring Maori enjoy and access a comparable level of health status as non-Maori while preserving Maori cultural concept, values and practices.

Government policy requires development of partnership arrangements between Maori and the Crown at all levels of the health and disability sector. The Treaty of Waitangi gives rise to and recognises the unique relationship between Maori and the Crown.

MidCentral is committed to establishing robust relationships with Maori at all levels of the organisation to ensure we continue to respond effectively to Maori health needs. For MidCentral, this means recognising such a partnership at governance level through support for Maori health development, Maori participation and strengthening of mainstream delivery to Maori.

Relationship with iwi maori

A formal relationship between the Board of MidCentral District Health Board and Manawhenua Hauora has been established to further the advancement of iwi Maori health and to work together to achieve the best possible health outcomes for iwi Maori people residing in Manawatu, Horowhenua, Otaki and Tararua districts.

MidCentral District Health Board and Manawhenua Hauora share these fundamental principles:

- A commitment to advancing iwi Maori health
- Building on the gains and understanding already made in improving iwi Maori health
- Recognising and respecting the principles of the Treaty of Waitangi within the framework of the New Zealand Public Health and Disability Act 2000, to work to achieve the best outcomes for iwi Maori health and to reduce iwi Maori health inequalities
- Partnership and mutual regard.

Appendix 4 - Primary Health Organisation Establishment Path

The Primary Health Organisation establishment pathway is likely to begin with a series of meetings involving interested parties and community groups, and include discussion with DHB representatives. The group will then present a brief proposal to the DHB outlining their intent to establish a Primary Health Organisation, including a list of the organisations involved, the potential enrolled population, the geographic coverage of planned services, the objectives of the Primary Health Organisation, and the key milestones in Primary Health Organisation development.

Should the group require financial support during the establishment period, it will then submit an application for this to the DHB and, following approval of the application by the Ministry of Health, sign an establishment funding agreement with the DHB. Concurrent with this, the DHB will help the group develop a project plan to guide it through the establishment phase and into operation.

Among the milestones that a Primary Health Organisation must achieve during its establishment phase are:

- Establishment of the Primary Health Organisation as a not-for-profit legal entity
- Community engagement, including in relation to enrolment
- Development of a 3-year business plan
- Establishment of robust governance and management structures, with appropriate community and practitioner/provider involvement
- Submission of an enrolment register that complies with Ministry of Health business rules
- Development and implementation of Primary Health Organisation enrolment policy and guidelines with appropriate documentation and staff training
- Implementation of appropriate contracts between the Primary Health Organisation and providers
- Establishment of systems to collect, monitor and report against agreed performance and quality indicators
- Agreement with the DHB plans for delivery of health promotion and services to high need groups (where appropriate)
- Signing a Primary Health Organisation service agreement with the DHB.

MidCentral's requirement for Primary Health Organisations to develop a business plan during its establishment phase (and get DHB endorsement for

this) is intended to ensure:

- A defined strategic direction for the Primary Health Organisation that is compatible with national and local frameworks
- The Primary Health Organisation has a pathway to clinical and financial viability
- The Primary Health Organisation has identified the required capabilities for successful operation, and has a plan for acquiring them.

Primary Health Organisations established in MidCentral District will have a centralised management function to assist with their day-to-day running. Such a function will increase efficiency and use information systems to provide accurate health information that will avoid duplication of services and common systems they need. Significant gains are possible for all MidCentral's Primary Health Organisations through the standardisation of some functions, for example, administration, which will allow them to maximise their use of limited resources.

Governance and ownership

MidCentral District Health Board will contract with Primary Health Organisations to provide primary health care services to their enrolled populations. Primary Health Organisation governance will include clinical (nursing and medical) representation, and community representatives nominated from the Primary Health Organisation enrolled population.

Central support role

The District Health Board is endorsing the establishment of a central support agency, as this will provide the opportunity for economies of scale. The central support agency will be owned and funded by Primary Health Organisations/ Primary Care Organisations.

Functions are likely to include:

- information systems development
- professional support structures – clinical governance, best practice, policy, quality, health and safety practices, training/continuing education
- supply systems
- marketing
- management of referred service budget risks
- liaison and joint planning with the District Health Board
- workforce development including recruitment, planning, co-ordinating leave cover
- quality improvement activities – audit, benchmarking against key

- performance indicators, credentialing,
- liaison with inter-district/sub-regional providers
- development of resources and guidelines for health promotion and prevention by Primary Health Organisations
- population health assessment and population profiling.

Maori

The development of Primary Health Organisations within MidCentral District is an opportunity to improve Maori health status. Maori health status priority areas in relation to Primary Health Organisation development include the following as developed by Manawhenua Hauora in their document Kaupapa Tuatahi:

- Enrolment of Maori - Primary Health Organisations must be able to gain the support of Maori throughout the enrolment process
- Focus on Health Promotion for Maori - Primary Health Organisations need to outline an intended health promotion programme for Maori including the profile of the health promotion workforce
- Health outcomes for Maori - Primary Health Organisations must demonstrate how they will move towards an outcome-based system of reporting that includes the Maori perspective
- Primary Health Organisations to remain cognisant of all health policies - Primary Health Organisations need to be informed of all health policies including youth and mental health
- Maori population and disability objectives - The 22 objectives in relation to Maori Health and Disability are gradually implemented during the life of a Primary Health Organisation
- Maori Health Workforce - The requirements for the development of a Maori Workforce Plan are incorporated in the Primary Health Organisation accountability document
- Primary Health Organisation Governance and Maori representation - Primary Health Organisations must be able to enter into a governance partnership with Iwi or a collective Maori organisation.

Rural communities

As a priority, MidCentral District Health Board will work with Primary Health Organisations to support rural communities because there tend to be lower numbers and concentrations of health practitioners in rural areas, limiting the types and availability of services.

Matters to address are:

- managing expectations of rural communities
- effectively and efficiently delivering services which utilise multi-disciplinary teams
- transport issues
- high health needs
- relative under-service
- low numbers of GPs, nurses, dentists, pharmacists, Maori health professionals per capita
- travel times to secondary care services (eg hospitals)
- need for strong mobile services/clinics.

Appendix 5 - Primary Health Care Teams

Throughout the MidCentral District, Primary Health Organisations will be staffed by primary health care teams. Primary health care teams are a key component in the delivery of health care services to enrolled Primary Health Organisation populations.

The shape and size of primary health care teams will need to reflect:

- the size, locality and characteristics and needs of the team's enrolled population
- cultural competencies relating to the enrolled population
- relationships with other primary health care teams
- the team's relationship with the Primary Health Organisation.

Good data links and information flow across providers will be an integral part to the success of the team.

Core members of the primary health care team could include:

- Allied health professionals
- Dentists and dental therapists
- General practitioners
- Lead maternity carers and midwives
- Maori health professionals
- Mental health workers
- Nurse practitioners
- Pharmacists
- Primary health care nurses
- Public health workers.

Allied health professionals

Allied health professionals work in a range of settings that incorporate primary, secondary and tertiary settings – general practice, hospital, private practice, private homes, residential facilities, schools, in community groups and Government agencies. The Allied Health Professionals group includes, but is not limited to, pharmacists, physiotherapists, occupational therapists, audiologists, dental therapists, speech/ language therapists, podiatrists, dieticians and social workers. Due to the wide and varied professions covered in the umbrella term, their input into primary health care initiatives will need to be sought from various sources. This group faces similar workforce issues as other

health professional groups but has more difficulty addressing these issues due to the diversity of the professionals groups involved and the relatively smaller numbers compared with doctors and nurses.

This group will need to take a proactive approach to participation in primary health care and in particular to Primary Health Organisation development, as they are crucial to ensuring a collaborative approach to integration and co ordination is achieved.

Allied health professionals have a wide range of skills and health perspectives that will readily complement those of their nurse and medical colleagues to meet the community's needs in a holistic way. This range includes skills in mental, family/whanau and community health, as well as physical health.

Initiatives similar to those undertaken in nursing will be needed for Allied health professionals to ensure there are support, research and development to help them work effectively in the new Primary Health Organisation environment.

Dentists and dental therapists

Dentists, dental hygienists and dental therapists are a crucial component of primary health care. Through featuring oral health it is hoped to provide a greater emphasis on the importance of access to dental care. It is envisaged that dental professionals will form part of primary health care teams within the Primary Health Organisation environment. This would facilitate increased resources for oral health and provide an enhanced holistic approach to patient care.

General practitioners

General Practitioners represent the cornerstone of primary health care in most communities. They will continue to be of vital importance to the implementation of the Primary Health Care Strategy. With the advent of Primary Health Organisations, General Practitioners will be encouraged to work within a team-based culture that may be broader than is currently the case. This will provide opportunities for General Practitioners to co-ordinate care across many settings within both primary and secondary care environments.

Lead maternity carers and midwives

Lead maternity carers and midwives in the primary health care setting have brought about significant improvements in choice and voice for women. Some midwives are expressing a desire to be part of primary health care teams and importantly Primary Health Organisations. It is envisaged that primary health care teams will provide multi-disciplinary support for midwives providing high quality ante-natal care, a safe birthing experience and access to high quality post-natal support for all women and their newborns throughout the District.

Maori health professionals

There are a number of established Maori health professionals within MidCentral District who face similar issues to other health professionals. Integrating services and collaboration in achieving national policy goals will be fundamental to further developing Maori health professionals' capability and capacity.

Mental health workers

Mental Health Workers, who may include psychiatric nurses, community support workers and counsellors working in a primary care setting, have the potential to provide significant outcomes for mental health consumers. Mental Health Workers situated in a primary care environment offer greater capacity for managing consumers with mild to moderate mental illness and opportunities for early detection/diagnosis of people in the early stages of psychosis. Early assessment of people in the first stages of a mental disorder will provide quicker access and referrals to specialist services.

Nurse practitioners

The Nurse Practitioner is the most senior level of clinical practitioner. This status is achieved by nurses who have completed at least 3 years of postgraduate practice, who hold a Masters degree in nursing relevant to their specific scope of practice, and who have been certified by the Nursing Council of New Zealand. In primary health care settings, Nurse Practitioners will provide comprehensive health and wellness care and first contact services to a range of families, individuals and children.

Pharmacists

Clinical pharmacists will become a central part of the primary health care team. With the integration of pharmacy, the potential exists for significant benefits to patients and health care professionals to accrue. Linked consultations between consumer, doctor, pharmacist and other team members will bring a new force in primary health care. Clinical pharmacists based in practices will become responsible for the pharmaceutical care of the practice population. They will also liaise with hospital pharmacists and undertake domiciliary visits where necessary.

Primary health care nurses

Primary health care nurses are crucial to the implementation of the Primary Health Care Strategy, and can contribute to reducing health inequalities, achieving population health gains, and promoting and preventing disease. The role of primary health care nurses is explained in Investing in Health, (MoH, 2003), which provides guidance for local implementation of the Primary Health Care Strategy.

Nurses working in primary health care have a number of roles including public health nurses, practice nurses, district nurses, Plunket nurses, community nurses, disease state nurses and child health nurses. Primary health care nurses

work in many environments including being mobile within the community, in general practice clinics, within the DHB's provider arm (MidCentral Health), and in other primary health care organisations such as Maori providers.

The majority of community-based nurses in the MidCentral District work in general practice, with large numbers also working in district nursing roles and providing community based and focused health care, for example diabetes, respiratory and palliative care.

The registered nursing workforce in MidCentral District totals 1 955 (nurses working in both primary and secondary health care) of which 157 (8%) are Maori, well below the District's proportion of Maori (17%). The ratio of nurses per 10 000 population is 122, compared with the national ratio of 106.

Public health workers

Public health is the process of enabling people to increase control over and improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to realise aspirations, to satisfy needs and to change or cope with the environment. Public health workers see their role as helping communities achieve increased control over their health. Health prevention and promotion components will become increasingly important in the development of Primary Health Organisations. Health education is fundamental to both primary and secondary care service providers.

Other links

Complementary health care services

Data relating to the use of complementary health care practitioners are limited. However, the increasing number of alternative health services and practitioners nationwide and the increasing numbers of people seeking health care within these fields, indicate these services are likely to play an increasingly important role in providing primary health care.

Voluntary sector

It is recognised that the mainstream primary health care sector is supported by a network of voluntary providers working in a variety of roles, such as advice, advocacy, community support and assistance.

Changes to the Health & Safety in Employment Act will guide the development of this sector in the future. These changes ensure management structures consider the performance and development not only of staff but also of volunteers. Mainstream primary health care providers need to work with voluntary providers to ensure the important services they offer continue.

Unpaid carers

Carers, usually family members, provide what is often 24-hour care in an unpaid capacity.

As for those in the Voluntary Sector, mainstream primary health care providers need to work with the carers to ensure the important services they offer continue.

Appendix 6 - Primary Health Care Nursing Innovation Funding

Seventeen nurses from across MidCentral's District developed a successful Ministry of Health proposal to build capacity and to share and build on service innovation. Funding was secured to establish a Primary Health Care Nursing Development Team in MidCentral's District to enable primary health care nurses to deliver on the objectives of the Primary Health Care Strategy.

The Team will consist of a Director Primary Health Care Nursing, a Director of Primary Health Care Nursing Maori, and a Quality/Research Co-ordinator. The team will support the Primary Health Care Nursing network of nurses in the District by facilitating their contribution to service innovation and the transition to Primary Health Organisations, as well as drive quality nursing practice so consumers experience continuity and co-ordination in the health continuum. This approach is premised on the health and wellness principles that underpin the concept of healthy communities. Specifically, the Team will act as a capacity building resource, an advisory centre, and a change agent in nursing practice; and will provide information and leadership for nurses who are making the transition to, or developing new models of primary health care nursing delivery in the District. The approach will also lead and support nurses to develop clinical governance over their practice as Primary Health Care Nurses.

The Innovation has two key goals and seven objectives:

- | | |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Goal one | Strengthen the Primary Health Care Nursing Network to enable nurses to improve community health and wellness |
| | <ol style="list-style-type: none">1 Enable clinical nursing leadership in the Primary Health Care Nursing Network.2 Influence the MidCentral District Health Board strategic direction and primary health care nursing workforce development.3 Build capacity of primary health care nursing.4 Foster an evidence based approach to practice.5 Use information technology to enable nurses in practice. |

Goal two

Influence Primary Health Organisation development and service innovation to achieve primary nursing partnerships with people through autonomous collaborative practice

- 6 Influence Primary Health Organisation sustainability by facilitating nursing collaboration.
- 7 Enable the nursing contribution to service redesign to strengthen partnership, protection and participation in practice.

The Primary Health Care Nursing Development Team Service Plan intends to assist nurses, employers, Primary Health Organisations and MidCentral District Health Board in service innovation to improve the health and independence of consumers, while weaving nursing into the fabric of Primary Health Care.