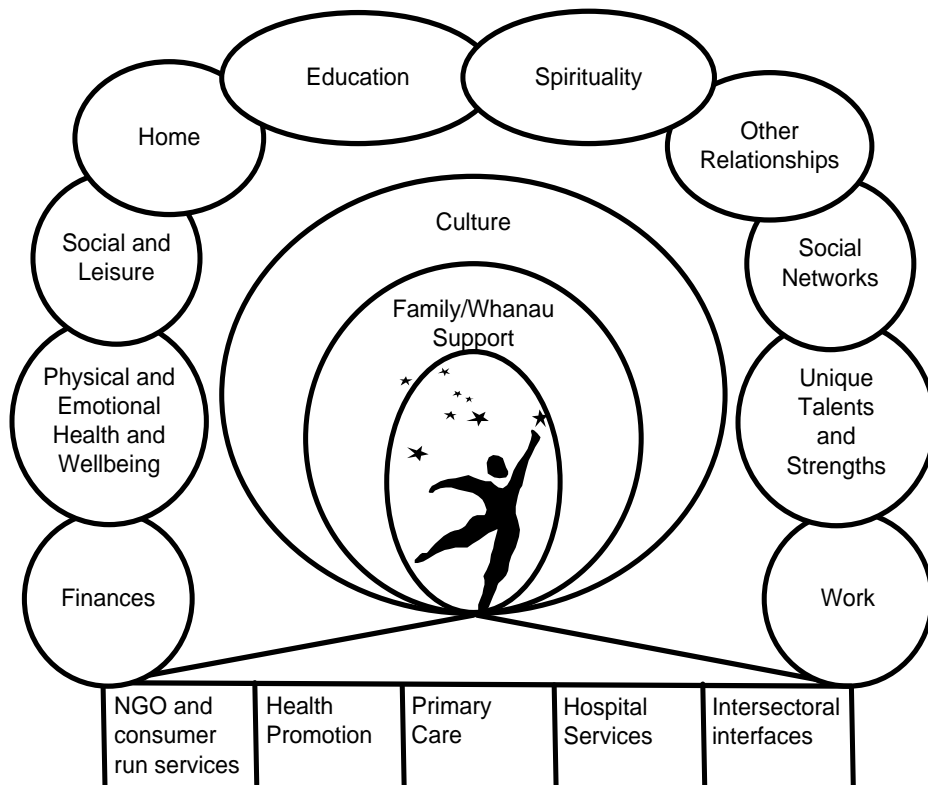


# Primary Health Care Plan for Auckland City 2008-2020 August 2008



ProCARE  
NETWORK  
AUCKLAND



THE TONGAN HEALTH SOCIETY  
(Inc)  
*Ko e Sosaieti Tonga ʻāi Ae Mo'ni Lelēi*



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## ACKNOWLEDGEMENT

The diagram on the front cover is adapted from 'Our Lives' in 2014, the Blueprint and the Strengths Care Plan.

It shows a person surrounded by all the social supports and health services they need for good mental health. This is what we want for people resident in the Auckland District Health Board district.

# Mihimihi

E nga mana, e nga reo, e nga karangarangatanga tangata  
Ko te Toka Tu Mai o Tamaki Makaurau tenei  
E mihi atu nei kia koutou,  
Tena koutou, tena koutou, tena koutou katoa.

Ki a tatou tini mate, kua tangihia, kua mihi kua ea  
Ratou, kia ratou, haere, haere, haere.  
Ko tatou enei nga kanohi ora kia tatou  
Ko tenei te kaupapa, Hauora Maori, o Te Toka Tu Mai  
Hei huarahi puta, hei hapai tahi mo tatou  
Hei oranga mo te katoa.

No reira tena koutou, tena koutou, tena koutou katoa.

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## Treaty of Waitangi Statement

Auckland DHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and iwi. It provides the framework for Maori development, health and wellbeing.

The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes and measures to enable Maori to participate in, and contribute towards, strategies for Maori Health improvement. The measures are a response to the Crown's desire to have greater Maori participation in the health and disability support sector with a view to improving Maori health outcomes, and reducing health disparities between Maori and other population groups. The measures also reflect the Crown's overall partnership with Maori under the Treaty of Waitangi and its commitment to protecting Maori health. The measures include:

- minimum Maori membership on Boards of DHBs
- provision for Maori membership of DHB committees
- training for Board members to ensure they are familiar with Treaty issues, Maori health issues, and Maori groups or organisations in the DHB
- a requirement for DHBs to establish and maintain processes to enable Maori to participate in and contribute to strategies for Maori health improvement
- a requirement that DHBs continue to foster the development of Maori health capacity for participating in the health and disability sector and for providing for their own needs
- an expectation that DHBs provide relevant information to Maori to enable effective participation

This legislation recognises and respects the principles of the Treaty of Waitangi in order to improve health outcomes for Maori. References to the Treaty of Waitangi in this document derive from, and should therefore be understood, in this context.

As a Crown Agency, Auckland DHB will demonstrate how Treaty responsibilities are managed within the health sector by our commitment to the principles of partnership, participation and protection. These principles are outlined by the Ministry of Health to provide direction to the health sector and form the basis of the Auckland DHB bicultural policy.

### **Our Commitment to the Treaty of Waitangi**

Our Treaty relationship is with Te Runanga O Ngati Whatua through a formalised Memorandum of Understanding. This Treaty partnership is operationalised within Auckland DHB through the Maori health purchasing organisation (MaPO), Tihi Ora.

Further relationships and arrangements with other iwi groups and Maori communities residing in the Auckland DHB will be developed and strengthened. If firm relationships with iwi and Maori communities are in place, then this provides a sound platform to lift the health status of all Maori in the Auckland DHB area.

### **Treaty Principles in Action**

<p><b>Partnership</b> Te Runanga o Ngati Whatua as manawhenua, are partners with Auckland DHB at the governance level</p>	<p>Memorandum of Understanding with Te Runanga o Ngati Whatua and its health operational arm Tihi Ora MaPO</p> <p>Ngati Whatua, as manawhenua partners with Auckland DHB at the governance level. This actively protects Maori interests in health planning and funding</p> <p>Auckland DHB has a Maori Health Advisory Committee</p> <p>There is consultation with Iwi Maori in planning health and disability services and regarding service and other changes</p>
<p><b>Participation</b> Maori engagement in planning, development and delivery of health and disability services</p>	<p>Responsible and responsive to Maori communities in our district and those who use our services</p> <p>Active involvement of manawhenua and mataawaka communities in identifying health needs, in providing health services and in our plans to improve health and disability services</p> <p>There is engagement with Maori regarding the impact service and other changes may have on Maori communities and organisations</p> <p>Assistance to further develop Maori providers in our district</p>
<p><b>Protection</b> Equity of participation, access and outcomes for all Maori</p> <p>Maori enjoy the same level of health as non-Maori</p> <p>Safeguard Maori cultural concepts, values and practices</p>	<p>Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rites/rights of Maori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive to Maori needs and interests</p> <p>Services will meet the rights/ rites, needs, interests and aspirations of Maori</p> <p>There is commitment to the Maori Health Strategy, He Korowai Oranga and other national policy</p> <p>We use the national Inequalities Framework and the health inequalities impact assessment tool</p> <p>Also the national Prioritisation Framework which brings whanau ora into a decision making tool</p>

## Section One: Setting the Scene

### *Introduction*

Auckland District Health Board (ADHB) has signalled an intention to broaden its approach to incorporate both the wider healthcare system and consideration of the determinants of health into its remit. There has been a move to develop stronger relationships with other agencies and organisations whose work also impacts on health. This plan is one of a number that support this broader approach and focuses on primary health care.

ADHB would like to provide a supportive environment for primary health care to flourish. ADHB and the Primary Health Organisations (PHOs) in the ADHB district have been making progress on the implementation of the NZ Primary Health Care Strategy 2001. PHOs are well established, most people are enrolled with a PHO and changes have been effected in funding mechanisms to better support the implementation of the Strategy. It is now time to take stock and determine how far the six key directions of the Strategy have been achieved, for example, in reducing health inequalities, engaging communities, and improving the management and prevention of long term conditions. We now see the opportunity to progress these more quickly. ADHB and ADHB PHOs are committed to developing a 'world class' primary health care system for residents of Auckland city.

This plan will focus on keeping people well - a stance consistent with the DHB imperative to 'Lift the Health of People in Auckland City'. We want all parts of the health care sector to contribute to keeping people well. Primary health care services aim to help people to live as independently as possible, and with a good quality of life. A large number of primary health services exist at present and we acknowledge the great work done by all who work in these services. This plan focuses mainly on providers – PHOs, General Practitioners, their Primary Care team members, other primary health care services and hospital services. This work is the core business of the DHB and therefore where we can most effect change for the benefit for the people of Auckland City. Further, we need to foster much greater involvement of Non Governmental Organisations (NGOs) and public health services with primary care services.

The Plan so far:

- Has been developed drawing on the views of the community, key partners (Please refer to the list of participants, pg 31) and current literature about primary health care
- Has been refined using your feedback and ideas, and then presented to the ADHB Community and Public Health Advisory Committee (CPHAC), Maori Health Advisory Committee and PHO Boards, seeking approval to formally consult.
- Is now being presented for formal public consultation.
- Once consultation is complete, it will be presented to Ngati Whatua, PHO Boards, and CPHAC for formal signoff prior to implementation.

## **Links With Other Plans**

This plan fits well with other pieces of work many of which highlight the strategic change signalled above including the New Zealand Primary Health Care Strategy, He Korowai Oranga, and all ADHB Strategic and Operational Plans including The Auckland DHB Maori Health Action Plan Te Aratakina “A pathway forward” and Pacific People’s Healthy Village Action Zones Framework.

### *What Is Our Aim?*

To offer the people of Auckland City a quality primary health care service that achieves well being for everyone and forms part of an integrated, total health care system. We want primary health care services better integrated at local/ neighbourhood level as a means to work better with local communities.

### **Proposed Governance Oversight**

ADHB and our PHO partners intend to establish a governance structure to oversee the implementation of this Plan, once formally consulted on and signed off by the Community and Public Health Advisory Committee of the DHB, Te Runanga o Ngati Whatua and each PHO Board.

### *What Is Primary Health Care In This Context?*

The World Health Organisation’s Alma Ata defines primary health care as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. The Alma Ata approach states that primary health care is an integral part both of the country’s health system of which it is the nucleus and of the overall social and economic development of the community. It is provided in the spirit of self reliance and self determination. This is the spirit in which we have written this plan.

The key characteristics of primary health care from this definition is the practical, affordable, equitable, scientifically sound, universally available first point of call access to health care within communities. Primary health care encompasses a continuing care process over the life-course of individuals and their families. Primary health care services range from birth to palliative care and death, health promotion, disease prevention, screening, health education, diagnosis and treatment and triage to specialist services.

We understand that the scope of this definition includes the involvement of communities in developing their own strategies to improve health. We also appreciate that health gain is achieved through intersectoral action that addresses the social and economic determinants of health, and action within health and disability services themselves. One of our key commitments is to building ‘neighbourhood’ approaches. This approach is what we consider intersectoral action to be at a local level. The DHB’s capacity to act is most closely linked to existing contracted primary care and other providers. Within the scope of our mandate, the DHB intends to work through all available avenues, strengthening community participation as a foundation principle.

### *Key Principles*

A robust primary health care sector is crucial to keeping the population well, through access to primary care practices as well as health promotion activity within the community. Over the next 5 years we seek to develop and support a primary health care services that focus on the health of the community, and will strive to improve the health status of that community within the constraints of the resources available by using the following principles:

- Honouring Te Tiriti O Waitangi
- Addressing health inequalities
- Client owned / family / whanau focused
- Population health focus / approach
- Accessible
- Appropriate
- Affordable
- Timely
- Interdisciplinary
- Not losing sight of what works
- Enhances community participation
- Continually improves quality
- Encourages resilience
- Sustainable
- Aligned to district and national priorities

## Section Two: Building Our Understanding

### *Information about People Who Live In Auckland City*

#### **Characteristics of the ADHB population**

Aucklanders as a group, tend to have a relatively good health status compared to New Zealand as a whole however there is room for considerable improvement, particularly in inequality reduction between groups within our population.

In terms of protective/risk factors to our health, Aucklanders tend to eat healthier food and have slightly lower obesity and overweight prevalence and slightly lower high blood pressure prevalence at the community level than New Zealand overall. Aucklanders also smoke less tobacco and are less likely to smoke marijuana and have slightly lower hazardous drinking habits. However, we exercise less and have slightly higher cholesterol levels.

Males tend to have poorer health statistics than females across most of the risks observed. They smoke more tobacco and marijuana, have higher cholesterol levels, are more likely to be overweight and to have poor diet. They are much more likely to drink alcohol in a hazardous manner. However, they do tend to get regular exercise more often than females.

There are also large differences across social groups in many of the risk indicators. Maori in Auckland are more likely to smoke tobacco and marijuana, to have higher blood pressure, to be overweight, and to drink alcohol in hazardous manner. Pacific people are far more likely to be obese, smoke tobacco, and have a relatively poor diet. Male Maori and male Pacific form a very high risk group. At the other end of the spectrum Asian people have lower risks for all the indicators except regular exercise. However, this grouping hides other communities such as the Indian community who are likely to have the highest rate of cardiovascular disease of all.

In terms of self-assessed health status there is a direct relationship between age, gender, ethnicity and income but for all ethnic groups, except Pacific, self reported health status was higher than the national rates. Those who are poor, Pacific and in age groups 14–24 and 65+ years groups have the lowest self rating scores for their health. Females in general self assess their health as better than males, except in the disability and mental scores where females perceive their health as poorer than males.

Disability is experienced by approximately 22% of the population. The rate of disability increases significantly with age, particularly in the population 65 years and older. The most common types of disability are mobility, agility and hearing.

In 2005, people living in Auckland city had the third lowest mortality rate among all the DHBs. But again inequalities are to be seen. Males die younger than females by at least nine years though for both genders the rates are improving. For all ethnic groups mortality rates in Auckland DHB are lower

than the whole of New Zealand, and are improving faster. However the non-Maori non-Pacific groups had 70% of their deaths after age 75 years compared to only 25% for Maori and 34% for Pacific people.

### Demographic Information

Auckland City's population is expected to grow at a rate of 1.7% per year until 2011 (medium projection).

#### Auckland city population, census 2006 and projection

Year	Population	Population increase	Growth from 2006
2006	428,310		
2011	464,296	35,986	8.4%
2016	499,121	34,825	16.5%
2021	533,850	34,729	24.6%
2026	567,844	33,994	32.6%

The population of Auckland city is young with more than half the population are in the 15–44 year age group but many of our children (41% of all 0–4 year olds) live in the most deprived areas of the city.

#### Auckland DHB ward, census 2006 ethnicity and deprivation

Ward	Population	% Ward	% Maori	% Pacific	% Asian	% Indian	% Others	% Most dep
Avondale Roskill	96,913	23%	20%	29%	33%	46%	17%	38%
Hobson	84,240	20%	9%	3%	32%	9%	23%	23%
Western Bays	41,286	10%	9%	8%	3%	3%	12%	10%
Eastern Bays	48,682	11%	8%	3%	9%	3%	15%	8%
Tamaki-Maungakiekie	86,688	20%	39%	46%	20%	26%	13%	56%
Eden-Albert	61,374	14%	12%	10%	2%	13%	18%	27%
Hauraki Gulf Islands	9,148	2%	4%	1%	0%	0%	3%	52%
Total Auckland City	428,331	100%	100%	100%	100%	100%	100%	31%

The most populated areas in Auckland city are the Tamaki-Maungakiekie and Avondale-Roskill wards – 23% and 22% of Auckland populations respectively. Most Maori and Pacific people live in the Tamaki-Maungakiekie ward – 39% and 46% of their populations respectively. Most Indians and Asians live in the Avondale-Roskill ward – 46% and 33% of their populations respectively. The 'other' populations are fairly evenly distributed across all Auckland wards.

### Review of the epidemiology

Asthma, arthritis and ischemic heart disease are the most major contributors to 'long term conditions' seen in the Auckland city population.

#### Prevalence of major chronic diseases in Auckland

Chronic conditions	Rate %	Number
Asthma	18.5	62,306
Arthritis	12.9	52,196
Ischaemic heart disease	8.4	27,684
Dementia	7.7	3,113
Chronic obstructive pulmonary disease	6.1	19,907
Depression	5.7	18,726
Diabetes	4.2	13,532
Stroke and mild stroke (TIAs)	1.5	5,111
Epilepsy	1.4	5,665
Total cancer since 1994 excluding deaths		7,550
Total		215,790

Three-quarters of all deaths in Auckland city are due to diseases related to the circulatory system (39%), cancer (27%) and the respiratory system (8%). All of these conditions are important contributors to 'long term conditions'. In addition there are a range of risk factors that contribute to the development of long term conditions, including obesity, smoking, hypertension and others.

### **Demographic information**

Maori make up 8.1% of the total Auckland DHB population (approximately 28,000). More than fifty percent of these are under the age of 25 years. More than fifty percent of the Maori population lives in the more deprived areas of the Auckland DHB region (deciles 8-10), compared to less than thirty percent of non-Maori.

### **Health Needs Analysis for Maori**

What keeps Maori well often lies outside the direct influence of the health and disability sector e.g. age, sex and hereditary factors, income and employment, housing conditions, urban design, water quality and education. However, even after controlling for lower socio-economic status, significant health inequalities in health outcome still exist for Maori compared to Non-Maori. These are consistently seen with measures of health by prevalence of risk factors, access and use of services, or by health outcomes.

Several key Maori health issues were identified in this assessment of Maori health needs within the Auckland DHB region. We have been careful in our analysis of need, to balance the negative health statistics for Maori with the considerable strengths and resilience factors which are inherent in Maori culture. We know that resilience factors such as having a strong identity and sense of self, retaining Te Reo, and being part of a dense social support network are all buffers against disadvantage. We support whanau, hapu, iwi and Maori communities who have voiced their desire and right to be part of the solutions that ensure the wellness of all Maori and the unborn Maori child.

The ADHB health needs data tells us that:

- Maori are over-represented in mortality and morbidity statistics
- The most common causes of death among Maori in the Auckland DHB region are cancer, heart disease; circulatory system disorders, and chronic obstructive respiratory disease (CORD)
- Maori become ill and die from conditions that are largely preventable through primary care
- The major causes of death among Maori vary according to age group
- Many of the leading causes of death among Maori are modifiable
- Maori patients do not appear to access certain tertiary services at the same rates as other ethnic groups
- Maori have significantly higher perinatal and infant mortality rates
- A high percentage of Maori hospitalisation rates are for avoidable conditions that can be easily prevented through effective primary health care
- The collection of Maori health information and access to health service providers is an issue for Maori in the primary health care sector.

## Addressing Health Inequalities

### Determinants of Health

The conditions in which people grow, live, work and age have a powerful influence on their health. Inequalities in these conditions lead to inequalities in health. There is a growing body of evidence which demonstrates the importance of less direct determinants of health, factors such as income and employment, housing conditions, urban design, water quality and education as outlined in Figure 1. We want to work with communities, agencies and those organisations whose work also impacts on health to address health inequalities.

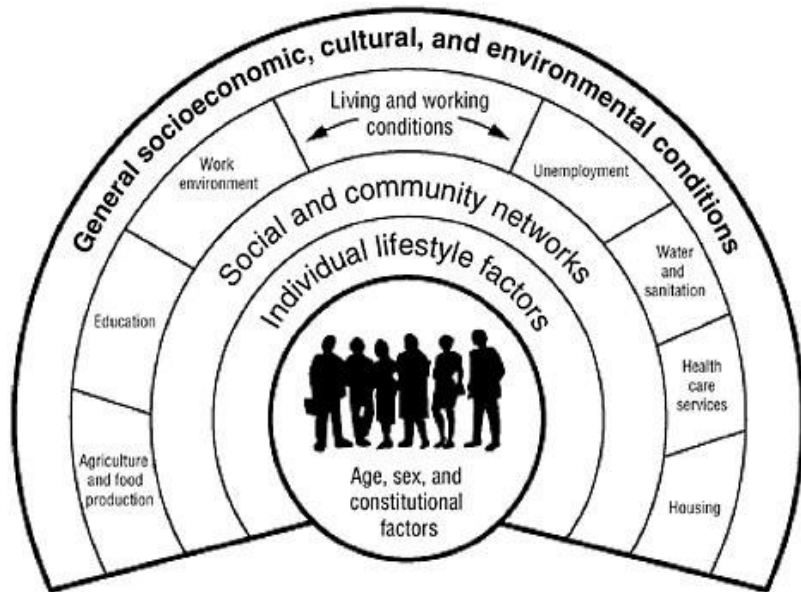


Figure 1: The Dahlgren-Whitehead model.  
SOURCE: Dahlgren and Whitehead (1991).

We will address the inequalities that arise from the differential treatment of some groups by the mainstream health system. We know that discrimination does exist in the health system and has become institutionalised over time exacerbating health outcomes.

### Populations with high health needs

There are population groups in Auckland that have significant health inequalities in health outcomes, as discussed above. Maori, Pacific Peoples, South Asia and Refugee groups have distinct health needs. Inequalities can also be seen when we look at gender and age related health needs.

Auckland DHB recognises the importance of working with these various groups so that services are responsive to their needs in order to contribute to improvements to their health status and to reduce health inequalities.

We know from Census 2006 data that Pacific peoples represent 11.21% of the total Auckland DHB population (approximately 50,000) and that the population is demographically young – approximately 50% are under age 25.

Auckland DHBs Pacific population is comprised of several ethnic groupings which include Tongan, Samoan, Cook Islands, Fijian, Tokelauan and Niuean. Samoan followed by Tongan are the two largest cultural groups identified among Pacific people:

Pacific men and women have the lowest life expectancy in Auckland (compared to Maori and Other) and for Pacific men this is particularly true if they are in the lower socioeconomic group. In terms of deprivation, Pacific peoples are the most deprived with 73% of the population living in the most deprived areas, versus 57% for Maori and 33% for Other. The highest population density areas for Pacific are in the high deprivation and low socio-economic wards of Avondale-Roskill and Tamaki-Maungakekie.

Our South Asian groups have more recently been recognised as having high needs in general with high rates of diabetes and cardiovascular disease in particular.

In Auckland we also recognise refugees and the homeless as having distinct needs and requiring targeted services.

### *What Services We Currently Have*

Auckland District Health Board is the fourth largest DHB in the country and works alongside five Primary Health Organisations (PHOs). In the 2006 census, it had 428,310 people, approximately 10% of the total population of New Zealand. There are 336,064 Auckland residents enrolled with Auckland PHOs - that is 78.5% of all those people living in Auckland. As most New Zealanders are enrolled with a PHO, those who live in Auckland and are not enrolled with an ADHB PHO are likely to be enrolled in another metro-Auckland DHB. In addition Auckland PHOs have a further 95,551 people enrolled who are not residents of Auckland City. Most of these people are likely to live in neighbouring Counties Manukau or Waitemata.

General Practitioners (GPs) and their practice teams provide the greatest quantum of primary care services. Auckland DHB has a high rate of GP FTEs (83 per 100,000) compared to the national rate (70 per 100,000). Data received direct from the PHOs shows that Auckland DHB has almost 400 GPs working full time in the City caring for an enrolled population of 431,615.

Primary care practices align to one of five Primary Health Organisations, these being ProCare Network Auckland, Tamaki Healthcare PHO, AuckPAC PHO, the Tongan Health Society and Auckland PHO. Each has its own philosophy and populations. For example, ProCare Network Auckland is by far the largest with approximately 70% of Auckland City GPs and an enrolled population of 303,000. Tamaki Healthcare PHO, Auckland PHO and AuckPAC PHO are of approximately similar size enrolled populations (Tamaki and Auckland around 43,000, AuckPAC around 37,000). Tamaki PHO is a Maori-Led PHO. The Tongan Health Society is the smallest PHO at 5,000 enrollees, with a predominantly Tongan enrolled population. Of the 30,000 Maori most Maori are enrolled with ProCare Network Auckland and with Tamaki Healthcare Trust

(54% and 26% respectively) and of the 50,000 Pacific people most are enrolled with ProCare Network Auckland, AuckPAC and Tamaki Healthcare (46%, 21% and 18% respectively).

To provide primary care services for their enrolled populations out of hours, some ADHB PHOs use their SIA funding to support reduced co-payments with Accident and Medical Centres, while a telephone triage service and the use of extended opening hours at practice-level is used by others.

The nursing workforce within primary care is vital. As an example, in the last twelve months approximately one in six adults had seen a nurse without seeing a GP. In a wider sense, the most commonly accessed types of nursing services were: Plunket nurses, District Nurses, Occupational Health Nurses, Dental Nurse or therapists, Public Health Nurses and Diabetes Nurses (refer ADHB Health Needs Assessment). However, nurses will need to be far better supported if we are to meet the anticipated growth in chronic conditions and primary care needs of our population over time. Many of these nursing services are currently not fully associated with General Practice teams.

As well as this, Auckland City has a total of 119 pharmacies. The wards with the largest populations, Avondale-Roskill (23%), Hobson (20%) and Tamaki-Maungakiekie (20%) are served by the greatest number of pharmacies. Significantly, almost 50% of all scripts are presented to pharmacies within Avondale-Roskill and Tamaki-Maungakiekie wards; those wards with the most deprivation.

### *What People Are Telling Us They Want*

We have received feedback from an extensive engagement process undertaken within the last six months and amalgamated this feedback with what we know from previous consultations. The following table provides a summary of the key themes that emerged during this process and have helped refine this plan.

#### **People are telling us they want:**

- **Care that is coordinated** – between all health care providers.
- **Access to affordable primary health services.** Cost continues to be a significant issue.
- **Access to culturally appropriate care with good interpreter services available.**
- **Seamless care for people with long term conditions.**
- **Improved information systems** to support booking arrangements that suit people, classification and usage in primary care.
- **Community-based services for people where they live.**
- **Better information available services and options** so that people can make better informed choices.

### *What Evidence Is Telling Us*

Literature has helped shape this plan. The following information highlights the key points identified in the literature.

- A strong primary care system is the linchpin of health care delivery and that it can help resolve the lack of continuity and responsiveness in health care in general (Saltman and Figueras 1997i, WHO 1992).
- Studies have suggested that strong primary care systems are cheaper to operate and their health outcomes are better (Starfield 1994ii, Doescher et al 1999iii, Shi et al 2002iv, Macinko et al 2003v). Improved access to primary care physicians and their gate-keeping function have added benefits such as less hospitalisation, less utilisation of specialist and emergency centres and less chance of being subjected to inappropriate health interventions. Furthermore evidence from a systematic review suggests that broadening access to primary care can reduce demand for expensive, specialist led hospital care (Roberts and Mays, 1998vi)
- There is no one model that works but Community Oriented Primary Care (COPC) is seen as useful in the way that it combines population health approaches with primary care. (Smith and Ovenden, 2007vii, Anderson et al 1998viii, Coster and Gribben, 1999)ix.
- Multi-disciplinary team-working is identified as vital to service development focused on addressing the management of people with long term conditions. Multi-disciplinary teams and clinical networks were seen as two examples of how organisations can be reformed and there is international evidence of such approaches enabling more effective management of long term conditions.(Wagner EH)<sup>x</sup>
- Supported self-care provided alongside interdisciplinary planned care and population health approaches can improve outcomes for people with long term conditions.(Vale et al. 2002)<sup>xi</sup>

## Section Three: The Way Forward

### *Our Commitments*

This plan focuses on the provision of primary health care services and activities for ADHB residents. The NZ Primary Health Care Strategy 2001 states that PHOs are the vehicles through which the NZ government sees improvements being made within the primary health care sector, and so ADHB is committed to working with our PHO partners to achieve the outcomes of the Strategy.

We will work with our PHO partners to prioritise the pieces of work outlined below, assess the readiness of potential providers to successfully engage in this work, and submit projects to the ADHB Prioritisation Process for funding and/or seek other means of funding. Any future service development work in primary health care will need to be consistent with this plan, once fully developed and consulted on. Where these areas of work are new and involve innovation we will need to build evaluation into new services/ approaches from their start-up.

The following section outlines the eight high-level commitments and the subsequent aims and actions that will assist us in offering the people of Auckland City a quality primary health care service that achieves well being for everyone and forms part of an integrated, total health care system.

**The Auckland District Health Board Commitments are to:**

- Commitment 1: Promote resilience among individuals, their families and communities.
- Commitment 2: Work with Maori to build on health gain already achieved and reduce health inequalities.
- Commitment 3: Address health inequalities for high needs groups.
- Commitment 4: Establish a 'neighbourhood' approach.
- Commitment 5: Develop inter-disciplinary primary health care capability and capacity.
- Commitment 6: Reorient the healthcare system to achieve locally accessible services with appropriate specialist support at all times.
- Commitment 7: Implement an integrated approach to the prevention and management of people/whanau with long term conditions and/or primary mental health issues
- Commitment 8: Work with Primary Health Organisations and primary care practices to ensure there is a robust process for quality improvement.

## **Commitment 1. Promote resilience among individuals, their families and communities**

### **Objective:**

1.1. To foster a population health approach that explicitly takes account of all the influences on health (the determinants of health) and promotes intersectorial action.

### **Actions:**

- 1.1.1. Develop a joint health promotion plan between the DHB and PHOs.
- 1.1.2. Brief interventions based on evidence in primary care will be supported – to include smoking cessation, alcohol, drugs and family violence, immunisations and developmental screening.
- 1.1.3. Appropriate health risk profiling occurs at each opportunity, for example, use of cardiovascular risk assessment tools in the relevant age group to determine cardio-vascular risk, followed by appropriate management and advice.
- 1.1.4. Adequate provision of support services for people who are attempting to improve their lifestyles e.g. Quit cards and NRT at every opportunity, supplemented by more intensive smoking cessation services for those who need them for those attempting to quit smoking.
- 1.1.5. Encouraging parents to enrol children in oral health services and Well Child services.
- 1.1.6. Explore options to support primary care to improve immunisation uptake.
- 1.1.7. Promoting and monitoring uptake of cervical screening and breast screening, ensuring that all children are up-to-date with their immunisations, and promoting breast feeding.
- 1.1.8. Provision of a range of ways in which information about local services are provided e.g. via Healthpoint.
- 1.1.9. Enable clients to access their own information wherever feasible, cost-effective and secure e.g. via web-based access.
- 1.1.10. Contribute to the development of the Health Navigator website that will provide information on resources for clients and providers.
- 1.1.11. Advocate for the introduction of evidence-based universal parenting programmes.
- 1.1.12. Work alongside other sectors e.g. housing, particular at the neighbourhood level to maximise health improvement.
- 1.1.13. Work with primary care to increase youth-friendly and youth specific primary care services.
- 1.1.14. Improve participation of people living in Auckland City in the direction of health care services through the establishment of an appropriate forum to discuss healthcare related issues
- 1.1.15. Encourage the development of strength-based health development approaches.

**Commitment 2. Work with Maori to build on health gain already achieved and reduce health inequalities**

**Objective:**

- 2.1. To ensure Maori aspirations and solutions for wellbeing are core components of ADHBs primary health care, thereby building on health gain already achieved and reducing health inequities experienced by the Maori population.

**Actions:**

- 2.1.1. Explore ways to strengthen the Manawhenua partnership arrangement between ADHB and Te Runanga o Ngati Whatua within the primary care sector.
- 2.1.2. Ensure Maori Health Action Plans within PHOs are meaningful to their enrolled Maori population – we would see these developed and implemented with full participation of Maori at all levels.
- 2.1.3. Ensure Service to Improve Access For High Needs Groups and Health Promotion funding within PHOs is effectively targeted for locally oriented and robust services with Maori
- 2.1.4. Explore and implement ways to increase the uptake of funding arrangements for free visits for Under sixes, and Very Low Cost Access funding for Maori
- 2.1.5. Continue to build the capacity and capability of Maori-Led health providers to deliver appropriate services for all.
- 2.1.6. Continue to promote the linking of mainstream services with local Maori networks both formal and informal to assist with health gain, particularly building local/community programmes, for example, Healthy Eating Health Action programmes sited on marae.
- 2.1.7. Develop and implement programmes and services that are based on Maori Models of Care and that are deemed acceptable and appropriate by Maori.
- 2.1.8. Support and resource programmes and initiatives that build Maori community capacity and capabilities and align with the overall aim of Whanau Ora.

### **Commitment 3. Address health inequalities for high needs groups**

#### **Objective:**

- 3.1. To prioritise activities designed to improve health gain amongst people and populations with high health needs.

#### **Actions:**

- 3.1.1. Prioritise those neighbourhoods that have populations with high needs – namely Avondale Roskill and Tamaki-Maungakiekie.
- 3.1.2. Increase our community health worker resource for Pacific, Maori and other high needs populations.
- 3.1.3. Pilot new approaches to case management among our high need populations who have multiple morbidities.
- 3.1.4. Continue to build the capacity and capability of Pacific-Led health providers to deliver appropriate services for all.
- 3.1.5. Encourage uptake of very low cost access practices in high need areas.
- 3.1.6. Ensure a level of cultural competence among primary health care providers through the development and implementation of culturally responsive programmes and resources.
- 3.1.7. Increase the capacity and capability of the Pacific Workforce
- 3.1.8. Explore ways to increase the percentage of children who are enrolled.
- 3.1.9. Explore ways to increase the percentage of practices providing free under-six services through a reduction in the barriers to uptake.
- 3.1.10. Ensure systems are in place and used so that all those requiring interpreters are provided with this service in one form or another that is appropriate for the setting.
- 3.1.11. Reduce the prescription charge for outpatients from \$15 to \$3, consistent with the Budget announcement.
- 3.1.12. Explore ways to communicate effectively with Maori, Pacific and other high need groups attending outpatients.
- 3.1.13. Develop and implement strategies to focus on mobile and transitory populations, especially children.
- 3.1.14. Balance potential new GPs establishing within areas of satisfactory/high GP coverage compared with areas of less coverage.

## **Commitment 4. Establish a 'neighbourhood' approach**

### **Objective:**

- 4.1. To reorient community health services and better align these services with primary health care practices in neighbourhoods.

### **Actions:**

- 4.1.1. Support community action and participation through a neighbourhood approach to service provision, whilst recognising that not all communities focus on specific neighbourhoods.
- 4.1.2. Work with local communities and other agencies to ensure services are linked closely through to primary care practices in a particular neighbourhood.
- 4.1.3. Continue to support and implement services for Pacific people through the Health Village Action Zones
- 4.1.4. Align public health services to the same neighbourhood where practical.
- 4.1.5. Provide a forum where people from community and primary health care sectors can meet to solve system issues and where appropriate discuss clients in common, or linking to existing groups.
- 4.1.6. Work in collaboration with key stakeholders to review the role of district nursing and increase district nursing involvement in the management of people with long term conditions and palliative care in particular
- 4.1.7. Work in collaboration with key stakeholders to maximise the use of skills within DHB community outreach services and integrate these services with primary care.
- 4.1.8. In collaboration with key stakeholders ensure that community services for children are aligned to work in neighbourhoods and with primary care teams.
- 4.1.9. Similarly, examine the interfaces between primary health care services and school nurses to encourage closer ways of working.
- 4.1.10. Examine, with the Ministry of Health, funding impediments to this way of working, including clawback and enrolment issues.

### **Objective:**

- 4.2. Develop a neighbourhood focus for Primary care practices.

### **Action:**

- 4.2.1. Work towards ways for Primary care practices to meet together and align at the neighbourhood level (probably by ward or subset of ward). An increased focus on teamwork would underpin these networks.

These networks would be:

- Another way for primary care practices to work more closely with other primary care practices in the neighbourhood.
- A way for primary care practice team members to increase their specialised skills and use them across a neighbourhood, including the support of nurse-led clinics.
- A way to develop clinical leadership

- A forum to shape the way services are developed in the neighbourhood.
- A means to work collaboratively between PHOs to harness their strengths in a particular neighbourhood.
- A way of PHOs harnessing their health promotion capability to further assist specific communities.
- A way of practices working with the local health providers e.g. NGOs, ADHB community services (children and adults), School Nurses, Health Village Action Zone Nurses (HVAZ), public health service providers.
- A way of supporting or enabling the movement of some services from secondary to primary care.

These networks would need:

- To be based on geographical localities e.g. the Auckland City Wards.
- To be incentivised to meet together and with community and public health providers to discuss issues for their population and how best to support shared clients.
- The involvement of a lead PHO that could coordinate the network but with participation from all PHOs within that neighbourhood.
- To have a place for meeting, both informally and formally, that is independent of practices. It may be a place suitable for setting up clinical rooms, where satellite clinics or group sessions could be held. e-Learning technology can also support knowledge sharing, and provide a mechanism for on-line meetings/collaboration and training.

**Objective:**

- 4.3. Collaborate closely with non-government organisations at the neighbourhood level to maximise resources:

**Action:**

- 4.3.1. Work with local communities and non-governmental organisations to plan and deliver local services.

## **Commitment 5. Develop inter-disciplinary primary health care capability and capacity**

### **Objective:**

5.1. To build capacity within Primary Health Organisations.

### **Actions:**

- 5.1.1. Maximize the resources of smaller PHOs by encouraging them to share back office functions and explore the option of making this a formal arrangement.
- 5.1.2. Work to ensure that programmes do not add to the bureaucratic burden of practices.
- 5.1.3. Develop guidelines around the formation of new PHOs/practices to ensure alignment with the NZ Primary Health Care Strategy and this Plan
- 5.1.4. Improve primary care capacity to deliver for people living with long term conditions.
- 5.1.5. Ensure that current and any future PHOs operate in a manner consistent with this Plan and the NZ Primary Health Care Strategy.
- 5.1.6. By agreement with PHOs and local communities, decide which activities across Services to Improve Access for High Needs Groups (SIA Funded Programmes) and Health Promotion would benefit from a neighbourhood focus.
- 5.1.7. By agreement with PHOs, decide the strategic priorities to be worked on in order to generate synergy across the system.
- 5.1.8. Support PHOs to review and strengthen their governance and management arrangements in relation to the vision of the NZ Primary Health Care Strategy, including clinical governance.
- 5.1.9. Assist PHOs to use the latest population health information to support evidence-based planning.
- 5.1.10. Support primary care practices to play a role in maternity care and ensure greater communication between lead maternity carers and primary care practices.
- 5.1.11. With PHOs, further develop the cultural competencies of primary care staff.

### **Objective:**

5.2. Increase nursing resource in primary care and maximise interdisciplinary working in primary care practices and neighbourhoods.

### **Actions:**

- 5.2.1. Develop a primary care clinical leadership position within the DHB
- 5.2.2. Work with PHOs to ensure that all nurses are part of a Nursing Council NZ accredited professional development and recognition programme including nurse practitioners.
- 5.2.3. Developing the full continuum of nursing roles in primary care including the continued development of nurse practitioners roles. This could entail the development of a scheme similar to the GP registrar scheme.
- 5.2.4. Ensure incentives encourage the development of nursing roles e.g. nurse-led approaches.
- 5.2.5. Work towards increasing links between primary care practices and pharmacies at a neighbourhood level.

- 5.2.6. Work towards increasing links between primary care practices and allied health professionals at a neighbourhood level or where appropriate.
- 5.2.7. Maximise the use of skills and interests amongst primary care professionals at a neighbourhood level through accreditation and devolution of services.
- 5.2.8. Encourage new graduate nurses into the primary care environment.
- 5.2.9. Support post-graduate training in long term conditions for the nursing workforce.
- 5.2.10. Enhance PHO capacity to support primary care teams.
- 5.2.11. Collaborate to support the development of practice management capability.

**Commitment 6. Reorient the healthcare system to achieve locally accessible services with appropriate specialist support at all times.**

**Objective:**

6.1. Provide a wider range of services in primary care

**Actions:**

- 6.1.1. Improve access to diagnostics from primary health care and develop guidelines to enable direct access to a range of tests such as spirometry, CT and MRI.
- 6.1.2. Provide a wider range of services in Primary care that are closer to people's homes for example - devolving minor surgery to accredited primary care practices.
- 6.1.3. Explore the option of providing pre-operative assessment in primary care.
- 6.1.4. Work with local communities, Primary and Secondary Care to explore ways to reduce the rates of Ambulatory Sensitive Hospitalisation (ASH) and the need for hospitalisation.
- 6.1.5. Examine funding mechanisms to support these changes.

**Objective:**

6.2. Improve the responsiveness of hospital-based services to primary health care.

**Actions:**

- 6.2.1. Reduce the numbers of people not attending appointments through a range of mechanisms e.g. text reminders, links with community health workers and coordination of appointments for individuals.
- 6.2.2. Support the availability of specialists to review or discuss management of patients with primary care practices and the use of virtual consultations.
- 6.2.3. Explore ways to improve communication with clients attending outpatients and make the letters more informative around waiting times.
- 6.2.4. Work to improve waiting times for outpatient services and consider the use of vouchers for people to access services privately if waiting times exceed a certain amount.

**Objective:**

6.3. Ensure that Information systems support knowledge transfer for clients and providers and improve communication and coordination across the interface.

**Actions:**

- 6.3.1. Improve the collection and use of information so that where the patient has consented information about them is shared between their health care providers. This would include sharing of aggregated non-identifiable information for planning purposes to improve service provision, (for example, information gained in working with a community could inform how health promotion could be better provided, or how we could address non-financial barriers to service).
- 6.3.2. Improve communication between primary and secondary care so that all health care providers in the region have access to health event summaries

about the patients they are caring for. This means that appropriate information (for example, lab tests results, discharge summaries and dispensed medications) should be readily available to authorised personnel in both primary and secondary care.

- 6.3.3. Ensure that information transfer from secondary to primary care (for example, clinic letters) occurs electronically.
- 6.3.4. Create a regional repository for dispensed medications.
- 6.3.5. Work to ensure that referral criteria are incorporated into the workflow of primary care practitioners.
- 6.3.6. Implement a regional electronic referrals system, so that referrals can be made via standardised referral forms, referrals are acknowledged upon receipt and triaged in a timely manner, and referrers have current information on the status of their referrals.
- 6.3.7. Improve the quality and timeliness of electronic discharge summaries.
- 6.3.8. Work collaboratively between practices, PHOs and the DHB to ensure that reporting requirements for programmes are simplified.
- 6.3.9. Examine the implementation of Web-based prescribing, accessed by GPs, pharmacies and hospitals to reduce or eliminate prescription errors.
- 6.3.10. Work to ensure that referral criteria are incorporated into the workflow of primary care practitioners by advancing Electronic Decision support processes.
- 6.3.11. Work collaboratively between practices, PHOs and the DHB to ensure that reporting requirements for programmes are simplified.
- 6.3.12. Use a range of methods to contact clients attending clinics including email and text.
- 6.3.13. Work on minimal guidelines for practice management systems and support primary care practices to meet these guidelines e.g. around coding and call/recall systems.
- 6.3.14. Consider options for a Regional Electronic Patient Record.

**Objective:**

- 6.4. To ensure that primary health care services are available to people around the clock and in the weekends.

**Actions:**

- 6.4.1. Work with key stakeholders to ensure that out of hours arrangements are equitable and sustainable, and we are working through these issues with all parts of the local health sector.
- 6.4.2. Maximise resources within the healthcare system to improve access.
- 6.4.3. Investigate ways to address 'after hours' provision and home visits for high needs groups

**Commitment 7. Implement an integrated approach to the prevention and management of people/whanau with long term conditions and/or primary mental health issues.**

**Objective:**

- 7.1. Reorient services to improve the prevention, detection and management of long term conditions including primary mental health within a life-course approach.

**Actions:**

- 7.1.1. Implement the recommendations of the Primary Care Mental Health and Addictions Plan (see Appendix 1).
- 7.1.2. Implement a Long Term Conditions Framework (see draft in Appendix 2) that supports self-management, reorients the health care system and harnesses community resources to better prevent and manage long term conditions.
- 7.1.3. Ensure information systems are supportive of an integrated approach to long term conditions, for example, Kidslink Plus.
- 7.1.4. Promote and advocate for models of care that ensure that we provide the opportunities to involve families/whānau in health care.
- 7.1.5. Ensure that people who have palliative care needs have access to the appropriate generalist support in the community.

**Commitment 8. Work with PHOs and primary care practices to ensure there is a robust process for quality improvement**

**Objective:**

8.1. Ensure primary health care services are delivering high quality care to their populations.

**Actions:**

- 8.1.1. Support the development of the Primary Care Clinical Advisory Group to provide leadership for quality in primary care, also linked to wider DHB activities.
- 8.1.2. Undertake a stock-take of current quality improvement programmes.
- 8.1.3. Review the use of Primary Options to highlight areas for quality improvement at the primary secondary interface.
- 8.1.4. Provide feedback to PHOs and practices about their performance on issues that are priorities.
- 8.1.5. Explore the option of a sentinel event reporting system in primary care.
- 8.1.6. Increase the use of guidelines at the primary secondary interface.
- 8.1.7. Consider a more systematic approach to generic prescribing.
- 8.1.8. Encourage the analysis of data to review outcomes on equity of access, alongside the emphasis on clinical safety and effectiveness.
- 8.1.9. Develop strong and effective relationships between the DHB and research institutions.
- 8.1.10. Support primary care with resources in the DHB where appropriate, for example, infection control.

## Section Four: Evaluating Our Progress

### *What Does Success Look Like?*

To assist us in evaluating our progress, we have summarised key points outlined below so that we know when the system is working as we intended. We believe that success includes:

- A strong primary care system will be the linchpin of health care delivery and will act as the driver to coordinate people's health care across the whole system.
- People accessing primary care to determine what they need to do to keep themselves and their families/ whanau well, as well as when they need to access more specialised health care services. This will result in less hospital visits for our population overall, and fewer inappropriate interventions.
- People having easy access to information about services, fees and provider performance.
- A range of primary care services available so people can have chooses according to their culture, language and other needs.
- Strong Multi-disciplinary team-working, as well as, all disciplines used effectively.
- Our primary care services showing a much greater coordination and integration towards meeting physical and mental health needs, as well as shifting the focus towards population health and health promotion as appropriate.
- Our primary and secondary services functioning as if they were one system.
- The scope of PHO services to be broadened and there will be greater community participation in primary health care services.
- A population health approach that sees the primary care workforce as part of an approach that addresses wider health determinant such as community capacity-building, partnering with education, justice, housing, local government. This broadens the concept of working in a team to include health promoters, collaboration with planners in local areas, NGO community workers and other community-based health providers.
- In time, our communities having an improvement in health status, particularly those in our communities with high health needs whereby their health status will indicate the reduction/ removal of current health inequities.
- People being able to access primary health care services out of hours in a primary health care setting. The Emergency Departments will not be considered to be a primary health care service by default.

We want tangible results so we will develop an outcomes framework that builds on our capacity to measure progress in primary care service provision.

These measures are likely to include:

- Measures of screening – cervical, breast, and others: More people will have issues detected within primary health care at an early stage.
- Measures targeting best practice and outcomes: Better management of health issues/events within primary health care and better prevention of issues where we can most influence prevalence rates.
- Evidence of good collaboration between Primary Health Organisations, Secondary Care Services, Non Government Organisations, Allied Health and other health and support services.
- Evidence that we are reaching our high needs groups, particularly reducing inequalities in service areas.
- Measures of collective well-being are important but currently difficult to measure. Whanau Ora is particularly important, and we will work to develop measures with our communities that reflect this.
- As workforce is a critical area we would look to measure gains over time.
- Evidence that we are reaching our high needs groups, particularly reducing inequalities, over time.

The outcomes we want over the medium/long term are:

- Effective coordination and communication across the health care system, including information provided for people and their whanau so that they can better access services.
- Hospital waiting times that are consistent or better than national averages
- Improved access to diagnostic services.
- Further reductions in barriers to accessing primary health care services, for example, cost and transport.
- A system that promotes resilience among individuals, communities and families.
- Alignment of financial incentives to providers to support good quality service provision.
- Improved interdisciplinary approaches to support team work.
- Robust and effective workforce measures for recruitment and retention.
- Information systems that support primary health care, especially primary / secondary integration.

The critical outcome measures we want to achieve over the longer term are:

- Healthier communities and environments
- Equity between groups of people
- An integrated, whole system approach, and
- Health benefits for individuals and their families/whanau

## Section Five: The Next Steps in Consultation

### *The Consultation Process*

This draft has been prepared with the assistance of our PHO partners and members of the wider primary health care sector. PHO Boards have been invited to comment, however timing issues require that further PHO feedback will need to be incorporated prior to formal consultation. Then, all interested stakeholders and members of the public will be invited to comment on the proposed primary health care plan for ADHB and PHOs.

#### **Consultation Process and Timetable**

Consultation with the public and stakeholder groups will take place during the consultation period 15<sup>th</sup> August to 1<sup>st</sup> October 2008.

We will:

- Put this document, the full draft plan and feedback forms on the ADHB website.
- E-mail this document with accompanying information and feedback forms to interested individuals/groups to distribute to their stakeholders and people who have requested consultation material.
- Mail-out of this document with accompanying information and response sheets to people who request the documents by mail.
- Issue press releases to encourage participation.

The last date of receipt of responses from the public and stakeholders is 1<sup>st</sup> October 2008.

#### **After the consultation:**

- The feedback will be analysed and considered
- A final document will be drafted from this feedback and represented for sign off
- A consultation report will be written discussing the results
- Participants will be notified of results by mail

#### **Feedback addressed to:**

**Celia Palmer/ Deirdre Maxwell**

Clinical Leader/ Manager PHOs and Primary Care  
Funding and Planning,  
Auckland District Health Board  
PO Box 92 189, Auckland

[Celiap@adhb.govt.nz](mailto:Celiap@adhb.govt.nz)

[DMaxwell@adhb.govt.nz](mailto:DMaxwell@adhb.govt.nz)

**For more information please following link:**

<http://www.healthpoint.co.nz/default,85568.sm>

## Section Five: Who has been involved so far?

### *The Working Group*

Alison Leversha, Community Paediatrician, ADHB  
Barbara Stevens, Chief Executive Officer, Auckland PHO  
Caroline Ogilvie, Project Manager, ADHB  
Celia Palmer, Clinical Leader and Working Group Chairperson, ADHB  
Deirdre Maxwell, Manager PHOs and Primary Care, ADHB  
Diana Good, RNZCGP Facilitator, Mt Eden GP, GP Liaison ADHB  
John Paerau, Tihi Ora MaPO  
Leani O'Connor, Pacific Health Planning and Funding Manager, ADHB  
Linda Fletcher, Health Information Manager, ADHB  
Linda Kensington, Executive Officer, ProCare Network Auckland  
Nadine Maloney, Primary Health Care Nurse Educator, ADHB  
Neil Hefford, GP, Grey Lynn Medical Centre and Director ProCare Network Auckland  
Nikki Turner, GP, Director of the Immunisation Advisory Centre, University of Auckland  
Tania Waitokia, Programme Manager, Maori Health, ADHB

### *The Steering Group*

The Steering Group were combined sessions of the Primary Health Organisation (PHO) Forum and Primary Care Clinical Advisory Group (PCCAG).

#### **PCCAG Membership**

Celia Palmer, Clinical Leader and PCCAG Chairperson, ADHB  
Deirdre Maxwell, Manager PHOs and Primary Care, ADHB  
Barbara Stevens, Chief Executive Officer, Auckland PHO  
Barnett Bond, GP Liaison, ADHB  
Glenn Mafi, GP, Tongan Health Society  
Jim Kriechbaum, GP Liaison, ADHB  
Karen Hoare, Nurse and Lecturer, School of Population Health, Auckland University  
Lorraine Stevens, Clinical Manager, Tamaki Healthcare PHO  
Maree-Ann Jensen, Community Pharmacist  
Mukul Diesh, GP, AuckPac  
Neil Hefford, GP, ProCare Network Auckland  
Ngair Kerse, Associate Professor, School of Population Health, Auckland University  
Nicki Brentnall, General Practice Liaison Nurse, Auckland PHO  
Russell Smart, GP Liaison, ADHB

#### **PHO Forum Membership**

Barbara Stevens, CEO, Auckland PHO  
Linda Kensington, Executive Officer, ProCare Network Auckland  
Tereki Stewart, CEO, Tamaki Healthcare PHO  
Paul Lavulo, CEO, Langimalie, Tongan Health Society  
Winston Timaloa, CEO, AuckPAC PHO

*Engagement  
with Partners*

Auckland Regional Public Health Service  
Primary Health Care Nurse Leaders Reference Group Meeting  
Practice Nurses (including Kai Tiaki magazine)  
Public Health Nurses  
Allied Health Forum  
Margaret Horsborough (Academic Nurse)  
Academic GP group (School of Population Health)  
GP focus groups  
Individual GPs (including Doctor magazine, direct email and via PHOs)  
Selected ADHB Primary care practices  
ADHB GP Liaison group  
ProCare Health Limited  
Community Pharmacy  
School of Population Health  
Auckland Regional Public Health  
Accident and Medical Clinics  
Pacific Health  
Maori Health  
Ministry of Health Primary Care Team  
Secondary Nursing  
Community Child Health and Disability Services  
ADHB IT Team  
Independent Physiotherapists  
Tamaki Healthcare Allied Health Providers  
Community Health Workers  
Auckland faculty of RNZCGP

*Community  
Engagement  
to Date*

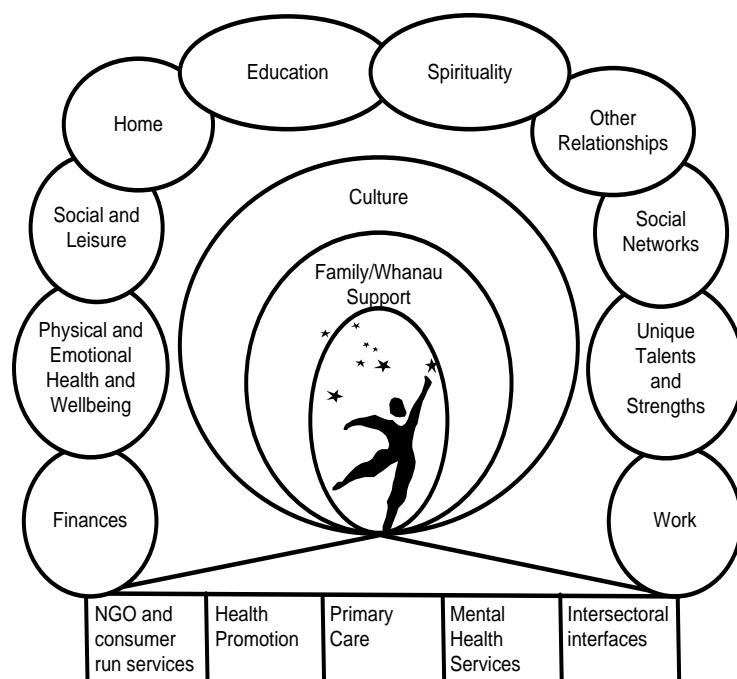
Between October and December 2007, 7 community focus groups (total of 84 people) were held around Auckland City (Glen Innes, Glendowie, Onehunga, Mt Albert, Avondale, Waiheke and Ponsonby). In addition, 9 people with long term conditions were also interviewed individually.

## Appendices

### Appendix 1: *Doing more in primary care to help people with mental health and addiction issues*



#### Auckland District Health Boards Flyer for consultation



**A continuum for good mental health**

The diagram is adapted from Our Lives in 2014, the Blueprint and the Strengths Care Plan.

It shows a person surrounded by all the social supports and health services they need for good mental health.

This is what we want for people resident in the Auckland District Health Board district.

Auckland District Health Board (Auckland DHB) wants to provide services across the full continuum of mental health and addiction issues. While funding in the past has been restricted to people experiencing serious mental health and addiction issues we also need services for people whose issues could be described as more mild to moderate. One of the best ways to reach people at the very early stage of issues is within primary care services.

This plan focuses on wellness, on prevention and early intervention. 'A stance consistent with the DHB imperative to 'Lift the Health of People in Auckland City'. We want all parts of the health care sector to prevent issues and to help people regain wellness when they are unwell.

This plan will:

- Provide the direction we need to identify and help people experiencing mild to moderate mental health and addiction issues in the primary care setting
- Help primary care providers (doctors, practice nurses, school counsellors, etc) to identify and respond to mild to moderate mental health and addiction issues

- Help to build better links between primary care and secondary care for people experiencing serious mental health and addiction issues

A large number of mental health and addiction services are in place already. Some are within primary care practices although the largest number are specialist mental health and addiction services for people experiencing serious mental health and addiction issues, with specific services for Maori, for Pacific Peoples, Asian, children, youth and older people. These help people to live as independently as possible, and with a good quality of life.

The priority groups for new funding are those that carry or are likely to carry the greatest burden including:

- Maori
- Pacific people
- Children
- Young people

When funding is available we will:

- Invite Primary Health Organisations to put up proposals for projects aligned to the aims of this plan
- Encourage Non Government Organisations, Allied Health and other health and support services to work with Primary Health Organisations to extend the primary mental health and addiction services available for the groups above

This means that the DHB is not prescribing what the services should look like. We think the best ideas and innovation will come from our local community based services. An RFP (request for proposal) will be issued when we have funding confirmed. All new work in this area will need to be undertaken with an evaluation component built in from the start.

Any future service development work will need to be consistent with this plan for primary mental health and addictions.

The outcomes we want over the medium term are:

- Resilient and healthy communities
- Strong and resilient families and whanau
- Prevention and early intervention services focused on mild to moderate mental health and addiction issues
- Primary mental health and addiction issues prioritized
- Improved collaboration and links across the health sector and other sectors on primary mental health and addiction issues

New services could include:

- First point of contact for issues (widely accessible, and not necessarily sited within the traditional primary care context)
- Assessment/triage (by people with appropriate skills, or with input from people with appropriate skills)
- Range of services appropriate to assessed needs
- Support for recovery
- Health promotion

This plan does not directly address issues like sexual or other abuse, bullying, discrimination, trauma that all compromise mental health. We will however work with other sectors and communities on these issues.

All interested stakeholders and members of the public are invited to comment on the proposed primary mental health and addictions plan for Auckland DHB.

### **Questions for Consultation**

Do you think the proposed direction will increase early identification of mental health and addiction issues?

Are these the right groups of people to focus on?

Are these the right outcomes to aim for?

Is this the right process for deciding on new services?

How will we know if we are making improvements especially for Maori, Pacific, children and young people?

Do you have any further comments to add?

## **Appendix 2: An integrated approach to the prevention and management of long term conditions.**



### Auckland District Health Boards Flyer for consultation

Long-term conditions have been described as the “healthcare challenge of this century”. The World Health Organisation estimates that globally 60 percent of all deaths are due to long term conditions. Over the next ten years the number of deaths attributable to these conditions is projected to rise by 17 percent (WHO 2005). Long-term conditions are the leading cause of death in New Zealand, and account for more than 80 per cent of the deaths.

The most common conditions by diagnosis in New Zealand are:- Chronic neck or back problems (one in four adults), Mental Illness (one in five adults), Asthma (one in five adults 15-44 years), Arthritis (one in six adults) and Heart Disease (one in ten adults). Others such as Stroke, Diabetes, COPD and chronic pain are significant in terms of the burden of disease. Obesity can also be considered as a chronic condition. Nearly all these conditions have disproportionately high rates among Maori and Pacific populations. Poor people, too have higher rates of chronic conditions and fewer resources to manage them.

They are the leading cause of preventable morbidity, mortality and unequal health outcomes (Ministry of Health 1999). Many people with long-term disease have more than one, in the UK it has been estimated that 45 percent of people have more than one long-term condition. Older people comprise a significant proportion of people with a long-term condition. There are increasing levels of co-morbidity and complexity of long-term conditions associated with ageing. Maori and Pacific people as well as people from Southwest Asia have a disproportionately higher incidence of these conditions as well as earlier morbidity and mortality (Ajwani et al 2003).

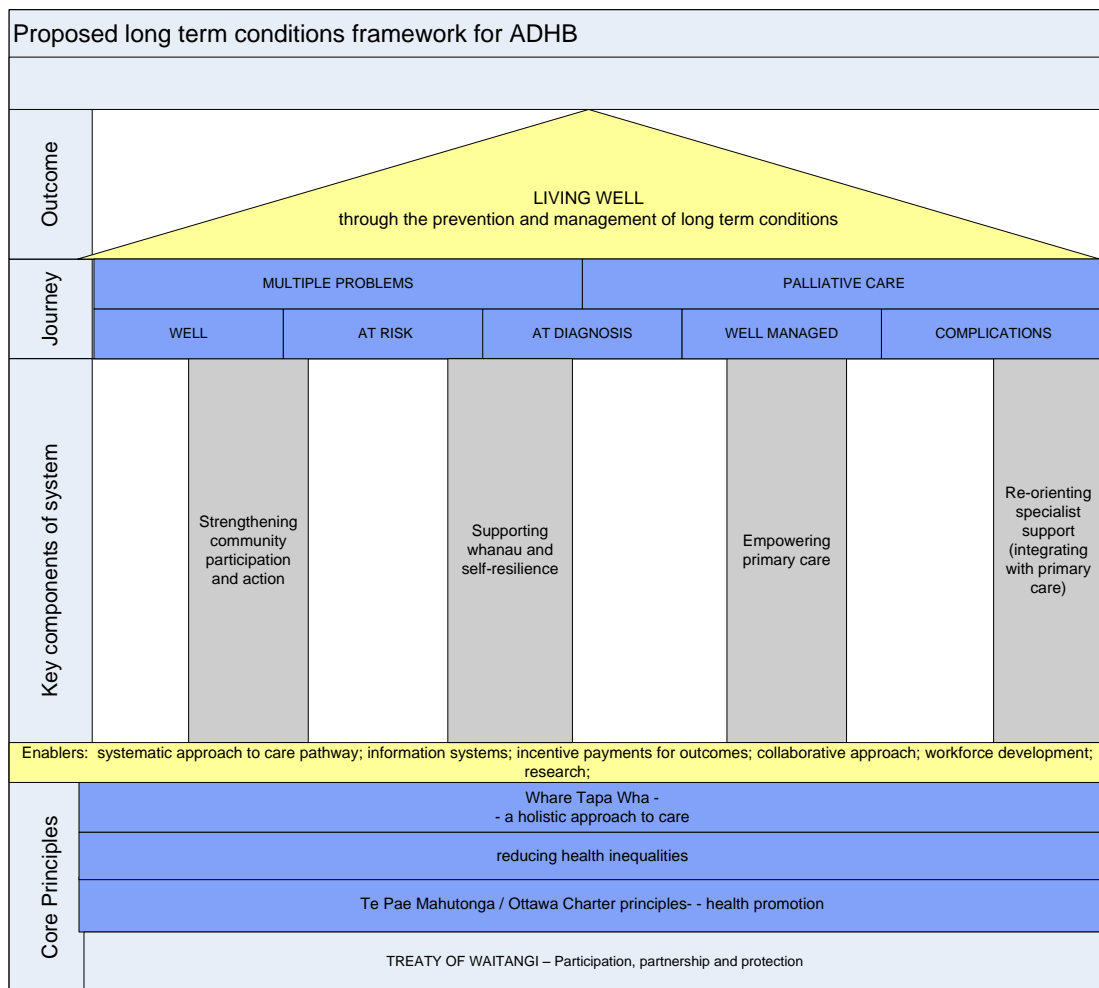
The common themes in the management of long term conditions are the following:

- there are often opportunities for either primary and/or secondary prevention;
- management includes the motivation of people to self manage;
- the healthcare professional needs to be proactive about seeing or contacting the client;
- it is necessary to enlist the help of a multidisciplinary team;
- the gap between the evidence and practice;
- the risk factors are the same and therefore clients often have more than one;
- communication and continuity of care both are key to good management;

To date there has been no strong commitment to these common themes in the development of chronic disease management (CDM) as it has generally been called. Traditionally disease specific programmes are developed and implemented, possibly as these fit most closely with secondary care paradigms where the professional expertise is considered to reside. This work breaks new ground in starting from a different paradigm where the similarities listed above are paramount and the disease or condition is of secondary importance. The approach has more in common with primary care approaches to health which tend to focus holistically on the complete needs of a client. It also ensures both physical and mental aspects of the person’s health are considered, an approach that fits more closely to Maori models of health.

This framework outlined is based on the premise that primary care doctors and teams are attempting to provide best care for people with long term conditions but that the system is not supporting their attempts to do so. This again is a paradigm shift in thinking from the current state which starts from the premise that primary care doctors and teams do not have the knowledge to provide good care. Instead it is suggested that the best care is not being implemented for a variety of reasons of which knowledge is only one factor. Other issues that may be of more significance are lack of client motivation, barriers that prevent clients from engaging with planned care, lack of multidisciplinary team approach, lack of doctor time, lack of communication between health care providers etc. It is hypothesised that previous attempts to improve the management of long term conditions have under delivered due to a lack of consideration of whole system (cross disease, cross professional etc.) approaches as described above.

We will be proposing work in the four work-streams identified in the framework namely self/whanau resilience, strengthening community participation and action, empowering primary care and reorienting specialist support (including integrating with primary care). Where appropriate we will use collaborative quality improvement techniques to implement change. The first step will be a system wide workshop bringing key stakeholders together.



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