The Primary Health Care Strategy

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FOREWORD

In December 2000 I released the New Zealand Health Strategy for a health system that people can trust, that is there when they need it regardless of their ability to pay, and that really helps reduce the inequalities that exist in health status.

I was very pleased with the way people endorsed that Strategy and I am determined to see it achieved. This Primary Health Care Strategy is a key first step. Indeed most of the principles, goals and objectives in the New Zealand Health Strategy will only be achieved through a strong primary health care system.

District Health Boards will be guided by this Strategy in how to organise and fund the provision of services to meet local needs. The Ministry of Health will now be working with Boards to ensure that implementation of the Strategy goes smoothly.

A strong primary health care system means community involvement so that local people can have their voice heard in the planning and delivery of services.

Doctors, nurses, community health workers and others in primary health care will work together to reduce health inequalities and to address the causes of poor health status. Services will be readily available at a cost people can afford. High quality care will ensure co-ordination over time and across the different providers needed to deal with a wide range of problems.

The Strategy has been developed with considerable input from individuals and groups working in the field. I wish to thank them all for their very important contribution to the Strategy.

Considerable work is needed to ensure that the Strategy can be put in to practice. The process will be one of evolutionary change over the next few years.

My vision is for the primary health care sector and local communities to work together to improve the health of all New Zealanders.

It is a vision worth achieving.

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THE STRATEGY IN SUMMARY

Primary Health Care in the New Health and Disability System

A strong primary health care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health.

This Strategy provides a clear direction for the future development of primary health care so that it can play this central role within the new health system. There is evidence available about the specific contribution primary health care can make to improved health outcomes which has informed the new direction.

This Strategy follows on from the New Zealand Health Strategy and the New Zealand Disability Strategy. The New Zealand Health Strategy sets out principles, goals and objectives for the health system – and these have guided the development of the Primary Health Care Strategy. The New Zealand Disability Strategy, which is still being developed, has also helped shape this Strategy.

The Vision, Key Directions and the Population Approach

Over five to ten years a new vision will be achieved:

> People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.
>
> Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

This vision involves a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals, and the advantages of funding based on population needs rather than fees for service.

Six key directions for primary health care will achieve this vision:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- co-ordinate care across service areas
- develop the primary health care workforce
- continuously improve quality using good information.

New Arrangements for Primary Health Care

The New Zealand Public Health and Disability Act 2000 gives District Health Boards overall responsibility for assessing the health and disability needs of communities in their regions, and managing resources and service delivery to best meet those needs. Twenty-one District Health Boards are supported by the Ministry of Health, which is the national policy advice, regulating, funding and monitoring agency. This Primary Health Care Strategy will guide District Health Boards and the sector to achieve health and independence gains through primary health care.

The vision and the new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary Health Organisations will be the local structures to achieve this. People will be encouraged to join a Primary Health Organisation by enrolling with a provider[1] of primary health care services such as a general practice or local health clinic. District Health Boards will work through Primary Health Organisations to achieve health goals locally.

Key points about Primary Health Organisations are as follows.

- They will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.
- At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell.
- Primary Health Organisations will be expected to involve their communities in their governing processes.
- All providers and practitioners must be involved in the organisation's decision-making, rather than one group being dominant.
- Primary Health Organisations will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
- While primary health care practitioners will be encouraged to join Primary Health Organisations, membership will be voluntary.

Implementing the Primary Health Care Strategy

The Strategy will evolve over the next few years and may not be fully realised for five to ten years. During this transition there will be flexibility about how new initiatives develop, and tolerance of short-term teething problems. Key priorities for early action are:

- reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health, and to improve access to first-contact services
- supporting the development of Primary Health Organisations that work with enrolled populations

[1] In this Strategy, 'provider' is used for any entity that provides health services, and 'practitioner' is used for an individual who provides health services.

- encouraging developments that emphasise multi-disciplinary approaches to services and decision-making
- supporting the development of services by Māori and Pacific providers
- facilitating a smooth transition to widespread enrolment of Primary Health Organisations through a public information and education campaign to explain enrolment and promote its benefits for communities.

The Strategy outlines a new vision for primary health care. It does not contain details of implementation, which will involve evolutionary change to protect the gains already made. Involvement and collaboration with the primary health care sector will be a key feature of the implementation process in the coming months and years. This is crucial to ensure that all issues are considered in developing the new arrangements.

To achieve this involvement, working parties of providers· communities, District Health Boards, and the Ministry of Health will be formed around key areas of work. Consideration may also be given to developing a primary health care advisory group to help guide developments in the sector.

INTRODUCTION

A strong primary health care system is central to improving the health of New Zealanders and, in particular, removing inequalities in health. There is evidence available about the specific contribution primary health care can make to improved health outcomes (for example, Starfield 1992, 1998; Shi 1997; Pincus et al 1998; Malcolm 1999).

The health system is currently undergoing significant change. This Primary Health Care Strategy provides a clear direction for the future development of primary health care within the new health system, while protecting the gains that have been made in recent years.

A strong primary health care system is central to improving the health of New Zealanders.

In March 2000 the Minister of Health began consultation on this Strategy with the release of *The Future Shape of Primary Health Care: A discussion document*. Feedback from 54 meetings and 290 written submissions to the discussion document[2] has been used to develop this final Strategy, with the assistance of a primary health care reference group (see Appendix 1).

Defining Primary Health Care

Quality primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that is:

- universally accessible to people in their communities
- involves community participation
- integral to, and a central function of, New Zealand's health system
- the first level of contact with our health system.

This definition is based closely on the World Health Organization's Alma Ata Declaration (see Appendix 2). Primary health care covers a broad range of services – although not all of them are Government funded:

This Strategy focuses on publicly funded services, particularly population health approaches and first-contact care for a general range of problems.

- participating in communities and working with community groups to improve the health of the people in the communities
- health improvement and preventive services, such as health education and counselling, disease prevention and screening
- generalist first-level services, such as general practice services, mobile nursing services, community health services, and pharmacy services that include advice as well as medications
- first-level services for certain conditions (such as maternity, family planning and sexual health services, and dentistry) or those using particular therapies (such as physiotherapy, chiropractic and osteopathy services, traditional healers and alternative healers).

The Primary Health Care Strategy aims for closer co-ordination across all of these services. However, in the first instance, it has particular relevance for the first three of the above categories.

[2] A summary of the submissions received is available from the Ministry of Health.

THE STRATEGY IN CONTEXT

The Government is changing the health system and its structure to focus better on getting results through understanding the factors that determine health and by influencing them positively. The changes are being guided by overarching strategies for the health and disability sector, specifically the New Zealand Health Strategy and the New Zealand Disability Strategy. The changes are being put into effect through the New Zealand Public Health and Disability Act 2000. Also important are population-based strategies, such as the Māori Health Strategy, the Pacific Health and Disability Action Plan, the Strategy for Health of Older People and other changes such as the Health Professionals Competency Assurance Bill.

New Zealand Health Strategy

Primary health care is a service priority area in the New Zealand Health Strategy.

The New Zealand Health Strategy provides an overall framework for the health sector, with the aim of directing health services at those areas that will ensure the greatest benefits for our population, focusing in particular on tackling inequalities in health.

Primary health care is one of five service priority areas in the New Zealand Health Strategy. The Strategy identifies seven fundamental principles for the health sector and, out of a total of ten goals and 61 objectives, the Strategy highlights 13 population health objectives. The Strategy has also identified three priority objectives to reduce inequalities (see boxes).

New Zealand Health Strategy Principles

- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi.
- Good health and wellbeing for all New Zealanders throughout their lives.
- An improvement in health status of those currently disadvantaged.
- Collaborative health promotion and disease and injury prevention by all sectors.
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
- A high performing system in which people have confidence.
- Active involvement of consumers and communities at all levels.

New Zealand Health Strategy
Population Health Objectiveó

The 13 population health objectives are to:

- reduce smoking
- improve nutrition
- increase the level of physical activity
- reduce the rate of suicides and suicide attempts
- minimise harm caused by alcohol, illicit and other drug use to both individuals and the community
- reduce the incidence and impact of cancer
- reduce the incidence and impact of cardiovascular disease
- reduce the incidence and impact of diabetes
- improve oral health
- reduce violence in interpersonal relationships, families, schools and communities
- improve the health status of people with severe mental illness
- ensure access to appropriate child health care services including well child and family health care, and immunisation.

New Zealand Health Strategy
Priority Objectives to Reduce Inequalities

- Ensure accessible and appropriate services for people from lower socioeconomic groups.
- Ensure accessible and appropriate services for Māori.
- Ensure accessible and appropriate services for Pacific peoples.

New Zealand Disability Strategy

The New Zealand Disability Strategy will sit alongside the New Zealand Health Strategy once it has been developed. Feedback from consultation on the discussion document has shown broad support for the vision of:

'A fully inclusive society, where our capacity to contribute and participate in every aspect of life is continually being extended and enhanced.'

The New Zealand Disability Strategy aims to help open the way into community life for people experiencing disability, by removing the barriers to their participation. To advance New Zealand towards a non-disabling society, the discussion document proposed 13 actions.

New Zealand Disability Strategy
Proposed Actions

- Encourage and educate for a non-disability society.
- Ensure rights for people experiencing disability.
- Provide the best education.
- Provide opportunities for employment and economic development.
- Foster leading voices by people experiencing disability.
- Foster an aware and responsive public service.
- Improve services to people experiencing disability.
- Improve access to quality information.
- Promote the participation of Māori experiencing disability.
- Promote participation of Pacific peoples experiencing disability.
- Enable children and youth experiencing disability to lead full and active lives.
- Improve quality of life for women experiencing disability.
- Value families, whānau and carers.

District Health Boards

The New Zealand Public Health and Disability Act 2000 established 21 District Health Boards and gave them overall responsibility for assessing the health and disability needs of communities in their regions, and managing resources and service delivery to best meet those needs. District Health Boards are supported by the Ministry of Health, which is the national regulating, funding and monitoring agency.

The Role of the Primary Health Care Strategy

To achieve the New Zealand Health Strategy goals and the vision of the New Zealand Disability Strategy, primary health care services need to be organised and delivered in a way that ensures the best health and independence for populations.

The Primary Health Care Strategy provides direction for District Health Boards in bringing about these changes. It sits below the New Zealand Health and Disability Strategies umbrella, creating an overall framework for the organisation and delivery of primary health care. District Health Boards will work through Primary Health Organisations to achieve the health goals locally.

Primary Health Organisations

The vision and the new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary Health Organisations will be the local structures to achieve this. Some of the key points about these organisations are as follows.

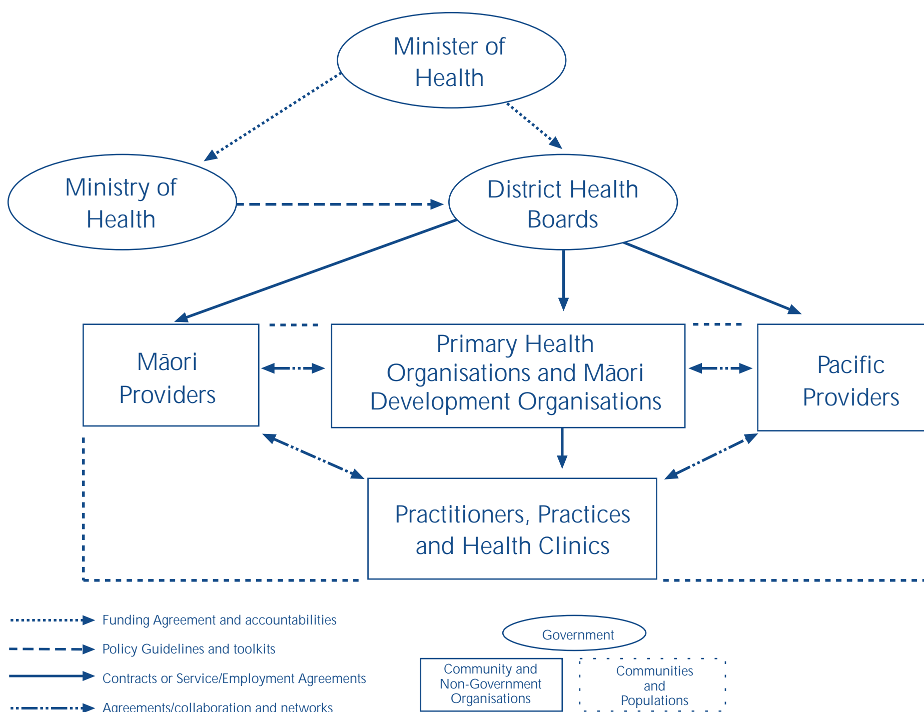
Primary Health Organisations will take various shapes and sizes.

- Primary Health Organisations will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.
- At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell.
- Primary Health Organisations will be expected to involve their communities in their governing processes. They must also be able to show that they are responsive to communities' priorities and needs.
- Primary Health Organisations must be able to demonstrate that all their providers and practitioners can influence the organisation's decision-making, rather than one group being dominant.
- Primary Health Organisations will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
- While primary health care practitioners will be encouraged to join Primary Health Organisations, membership will be voluntary.

The diagram below shows the relationships between Primary Health Organisations, the Ministry of Health, District Health Boards, communities, and other providers.

Existing organisations will need changes to become Primary Health Organisations.

The New Primary Health Care Sector[3]



[3] This diagram reflects the sector as envisaged under this Strategy, however, as noted previously, primary health care practitioners will be free to decide whether or not they join a Primary Health Organisation.

THE PRIMARY HEALTH CARE STRATEGY

Over five to ten years a new vision will be achieved:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

The table below shows, in broad-brush terms, some of the differences between most existing arrangements and the vision.

Old	New
Focuses on individuals	Looks at health of populations as well
Provider focused	Community and people-focused
Emphasis on treatment	Education and prevention important too
Doctors are principal providers	Teamwork – nursing and community outreach crucial
Fee-for-service	Needs-based funding for population care
Service delivery is monocultural	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non-health agencies

The six key directions for achieving the vision and new arrangements are:

- **work with local communities and enrolled populations**
- **identify and remove health inequalities**
- **offer access to comprehensive services to improve, maintain and restore people's health**
- **co-ordinate care across service areas**
- **develop the primary health care workforce**
- **continuously improve quality using good information.**

These are discussed in detail below.

1. Work with Local Communities and Enrolled Populations

Primary health care services can best improve the health of the communities they serve by organising services around defined populations – rather than just responding to those individuals who actively seek care.

Primary health care needs to involve participation by people in the communities covered to achieve this. Services will then be more likely to reflect needs and priorities that are set by the people, not just by providers.

Primary Health Organisations will be required to include some members of the community on their governing bodies. They must also be able to demonstrate that they have processes for identifying need and allowing community members and those who use services to influence the organisation's decisions.

Voluntary Enrolment

The first steps of linking providers to defined groups of people have already begun. Already many general practice organisations, some Māori providers and others keep lists of the people for whom the organisation is taking responsibility. A system of voluntary enrolment will be introduced to expand these moves across the country.

People will be encouraged to join a Primary Health Organisation in order to gain the benefits associated with this population approach and to improve the continuity and co-ordination of the services that they receive. Most people will enrol with a provider of first-contact services (a general practice or a local health clinic) that is part of the organisation.

Most people will enrol with a local practice or health clinic that is part of a Primary Health Organisation. They will gain the benefits of better continuity, co-ordination and more attention to preventive services.

Existing lists of the patients who normally attend a practice or health clinic may form the starting point for enrolment but, over the first couple of years, individuals will be asked to make an active choice to join the Primary Health Organisation.

Some Primary Health Organisations will be new organisations rather than ones built up from existing providers. These groups, such as those aimed at particular Māori or Pacific populations, will seek to directly enrol people in their communities.

The move to comprehensive enrolment will involve a significant change process over several years. The system will work best when the whole population is enrolled; however, enrolment will be voluntary.

Enrolment and Continuity of Care for Patients

Continuity in primary health care means that people have a usual source of care, and can use that source for advice and help over time. People using the service form important relationships with their provider. It may not be necessary to have complete continuity of an individual carer – a small team could be the usual source of care.

Continuity can be shown to result in a number of benefits, particularly where there is a relationship with a particular practitioner. It is associated with:

- better preventive care (Lieu et al 1994)
- patients who feel more able to care for themselves in future (Howie et al 1999)
- better recognition of problems (Gulbrandson et al 1997)
- less recourse to medication as a first-line treatment (Hjortdahl and Borchgrevink 1991)
- better patient compliance with prescribed medication (Becker et al 1974)
- fewer hospitalisations (Weiss and Blustein 1996)
- lower total costs (Flint 1987).

People will be encouraged to nominate a practitioner, practice or provider for continuity of care when they enrol. However, they will still be free to seek care wherever they wish, regardless of which provider they have nominated.

Despite the apparent importance of continuity of care, a number of recent developments in the New Zealand health system have tended to reduce continuity. These include the growth of large-scale out-of-hours arrangements, the increasing number of 'walk-in' clinics offering episodic care, and the involvement of a wider range of practitioners in providing care.

However, many of these developments have also brought benefits in convenience and availability of service, and these factors are often more important at the time than the ability to see a known practitioner. A recent review (Guthrie and Wyke 2000) states that 'it seems likely there will be patients and problems where personal continuity really matters and others where personal continuity is irrelevant or even harmful'.

The future primary health care system will enable people to have continuity of care where it is important, but will not reduce their freedom to choose between different practitioners where this is valuable to them. In the process of enrolling with a Primary Health Organisation, people will also be asked to nominate a practitioner, practice, or provider for continuity of care.[4]

There will be some national minimum requirements or protocols that will be fully explained to people at the time they make their choice. These might, for example, include ensuring that enrolled people have access to 24-hours-a-day, seven-days-a-week urgent services; that systems allow people to ask to see a particular practitioner; and that, unless people specifically request otherwise, their nominated provider will receive information about consultations or tests with other practitioners. These protocols will build on the work and advances already made by the Health Funding Authority in this area.

Enrolment will not reduce people's choice of provider. They will be free to seek care wherever they wish regardless of which provider or Primary Health Organisation they have enrolled with. This is important for people's

[4] Enrolment will usually take place through the provider rather than directly with the Primary Health Organisation, so nominating a provider for continuity will be quite straightforward.

convenience and to allow them to choose a different practitioner at times when they want a second opinion, a confidential consultation, or to see a practitioner with a particular skill.

If a person chooses not to enrol they will still be entitled to seek care – but they may miss out on some preventive services because they are not in the identified population.

Regardless of people's nomination for continuity, the enrolment system will allow them to continue to see any primary health carer. The system will also allow people to change their nominated provider without difficulty and without having to explain or seek permission.

Actions

- Primary Health Organisations will be expected to respond to the needs and priorities of their communities, and involve communities in their governing processes.
- People will be invited to join a Primary Health Organisation, usually by enrolling with a provider of first-contact. Enrolment will be voluntary.
- People enrolling with a Primary Health Organisation will be given full information about their options so they can make an informed choice about their nominated practitioner, practice, or provider team for continuity of care.
- Regardless of their nomination for continuity, people will be able to choose any primary health care provider at any time, and will also be able to change their nominated provider without difficulty or explanation.
- National protocols for enrolment will spell out the information people will be given before joining, protections that must be in place to protect confidentiality, and requirements that organisations must meet.
- Information to clearly explain enrolment will be widely communicated to all New Zealanders.

2. Identify and Remove Health Inequalities

There are significant inequalities in the health of different groups of New Zealanders. Inequalities are related to socioeconomic differences, poor housing, lower educational levels, occupation and so on. Such health gaps are shown in higher mortality rates, in measures of the broad burden of disease and injury, and in higher rates of avoidable hospitalisation (Ministry of Health 2000).

Primary health care will play a crucial part in reducing health inequalities. Primary Health Organisations will be required to identify and address those groups in their populations that have poor health or are missing out on services. In addition, primary health care organisations that take a community development approach act as advocates for and involve the communities in finding ways to improve health for the most disadvantaged.

Māori and Pacific peoples' health lags behind that of others in the population and the differences are more than can be explained by socioeconomic differences alone. Improvements for these groups will be achieved through Māori and Pacific provider development as well as by improving the delivery of mainstream services for those groups. This Strategy acknowledges, as does the New Zealand Health Strategy, the special relationship between Māori and the Crown under the Treaty of Waitangi.

All Primary Health Organisations

All Primary Health Organisations and providers will be required to understand the nature of their populations and identify disadvantaged groups in order to address their needs. Meeting the needs of these populations will often require different strategies since they frequently represent hard-to-reach groups.

Primary providers and Primary Health Organisations must be able to identify disadvantaged groups within their populations. Meeting needs may mean a variety of approaches for hard-to-reach groups.

Primary Health Organisations will be required to work with their communities and will be encouraged to take a community-development approach to find appropriate solutions for disadvantaged groups.

Mainstream providers and organisations must be able to identify different ethnic communities within their populations, and to provide for their different needs and priorities – and especially those of groups who are not being reached by the existing service configurations.

In at least the medium-term future, many Māori and Pacific peoples will continue to be cared for outside of Māori or Pacific providers. Mainstream providers will be expected to organise and deliver services in ways that are culturally competent and effective.

Organisations that have significant numbers of Māori or Pacific peoples among their enrolled population should, where possible, establish specific services for these people (such as services on marae or particular clinics aimed at specific groups).

Māori Services

In recent years, Māori have begun to develop:

- specific culturally competent health services for their own people which are usually delivered by Māori health practitioners in the home, in marae, at kohanga reo and schools, as well as through health centres
- Māori co-purchasing and Māori Development Organisations, which work to improve the funding and delivery of services to Māori, with responsibilities for achieving specified Māori health gain priorities, co-ordinating service delivery, and working with both Māori and mainstream providers to build their capacity to deliver comprehensive and responsive services to Māori.

It is essential that recent gains in Māori health care provision are not lost.

It is essential that these gains are not lost. District Health Boards will continue to contract with Māori providers, and support their further development, so that Māori communities have control over their health and wellbeing.

The Māori Health Strategy will lead the way in this process.

Pacific Services

Services for Pacific peoples provided by Pacific peoples can address many of the health problems of Pacific peoples. New initiatives are emerging, particularly in the Auckland region, which involve a wide range of practitioners and services.

Active involvement of Pacific communities in the delivery of services helps ensure that services are accessible to, and right for, the people in their communities.

Further building Pacific provider capacity is central to improving health outcomes for Pacific peoples. District Health Boards will fund and support further development of Pacific providers and organisations.

Further building Pacific provider capacity is central to improving health outcomes for Pacific peoples.

Pacific providers will form Primary Health Organisations in their own communities or other networks where this is appropriate for the population.

Leadership at a national level will be important to guide improvements in Pacific peoples' health. The Pacific Health and Disability Action Plan will provide a framework for further developments.

Actions

- All providers and Primary Health Organisations will be required to identify disadvantaged groups in their populations in order to reach out to them and address their needs.
- Primary Health Organisations will be required to show that they know the ethnic mix in their populations and address their needs in ways that are culturally competent and effective.

- Mainstream Primary Health Organisations that have significant numbers of Māori or Pacific peoples among their enrolled population should consider establishing specific services for these people.
- Māori providers and Pacific providers may form Primary Health Organisations in their own communities where it is appropriate for the population.
- District Health Boards will be required to continue to support and further develop Māori providers and Pacific providers.

3. Offer Access to Comprehensive Services to Improve, Maintain and Restore People's Health

Primary health care services will include services that improve, maintain and restore people's health.

Improving health involves health promotion, education, counselling and helping people to adopt healthy lifestyles. In these activities primary health care practitioners and Primary Health Organisations need to work closely with providers of public health services. There are also many challenges at the one-to-one level that will require primary health care practitioners to be skilled at the various techniques for identifying and helping people change behaviour that threatens their health.

Primary health care must work closely with public health services.

Maintaining health and independence involves preventing the onset and progression of disease and disability. Primary health care practitioners and Primary Health Organisations will need to focus on appropriate screening, opportunistic education, interventions to help change damaging behaviours, early detection and careful management and support for people with ongoing conditions (including specific disease management approaches).

Restoring health and independence also covers a wide set of services. Primary health care must include ready access to first-level advice and treatment for people when they are unwell or concerned about their health. With the right mix of services, practitioners and supporting investigations and therapies, over 90 percent of new problems can be successfully dealt with at the primary level. Services must include appropriate use of any pharmaceuticals, diagnostic testing and other referred services needed to provide primary level care.

Many health concerns and problems can and should be managed by individuals themselves. This requires ready access to information to support self and family care and to further help when appropriate. Primary health care practitioners need to be open to make good use of new sources of health advice such as telephone helplines and the Internet, increasing nursing involvement, improved technology for patients to be safely managed in the community, and community rehabilitation services.

Many health problems can and should be managed by individuals themselves – with ready access to information and support.

Primary Health Organisations will all be required to provide a defined set of services including population services to improve health, screening and preventive services; support for people with chronic health problems; and information, assessment and treatment for any episodes of ill health. Specification of these services has already been started in discussion with providers. Some organisations may offer an expanded range of services.

Some primary health care services are directed at particular groups of people or those with particular problems. These services include, for example, maternity care, family planning, sexual health, and well-child services. In New Zealand these services have often developed along parallel paths to the more generalist services and are provided by different groups. Many of

these separate arrangements offer people an alternative and preferred source of care for sensitive and confidential problems. This Strategy recognises the importance of continuing to provide such alternative choices for people – in maternity services, the arrangements that have grown up over the last 10 years around lead maternity carers will continue.

Funding Services According to Health Needs

Most Government funding of primary health care services is currently distributed according to the number of services provided by doctors and the associated prescriptions that are written. This has led to an uneven and inequitable distribution of resources, often more related to the number of practitioners than to people's needs. There is some evidence, for example, of lower pharmaceutical expenditure in areas with greater deprivation despite these populations having higher health needs (Malcolm 1999).

Primary Health Organisations will be funded according to the populations they serve.

A population approach to primary health care that focuses on improving, maintaining and restoring people's health requires adequate funding, allocated fairly according to the needs of the population served. When funds are not tied to particular numbers of services or types of practitioners, there are no barriers to using the most appropriate health practitioner in each situation.

For this reason, Primary Health Organisations will be funded according to a formula that reflects the relative need of their enrolled populations, taking account of factors such as age, sex, deprivation level and ethnicity. Suitable formulae are already under development in consultation with providers and communities.

Primary Health Organisations will be not-for-profit in order to ensure that public funds are not diverted from health services to private gain.

Population-based funding will help to reduce inequalities by directing resources to communities with greatest health needs. However, additional services and funding may also be required for some hard-to-reach populations such as Māori and Pacific peoples, refugees and those in remote areas. The costs of reaching such populations are often not sufficiently taken into account in funding formulae.

Population-based funding may also help ensure a more stable forecasting and service planning environment for District Health Boards. However, the full benefits of population-based funding will not be realised while a large percentage of providers' revenue is generated through user part charges – the fee-for-service nature of user part charges encourages the continuation of episodic treatment.

District Health Boards will only fund not-for-profit Primary Health Organisations. This will guard against public funds being diverted from health gain and health services to shareholder dividends.

Best Use of Therapeutic, Support Services and Referrals

Achieving good quality care at the primary level requires the best use of investigations, therapeutics, and referral to other practitioners. Attention must be given to managing the levels of utilisation of diagnostic testing, medication and referral for specialist support. In New Zealand as elsewhere in the world there is evidence of considerable variation between practitioners in their use of such services (Malcolm 1999). Examining the reasons behind such variation and moving towards best practice is a very significant challenge for the future.

Moving towards best practice is a challenge.

As Primary Health Organisations will be funded according to their population rather than their use of investigations and medications, they will be in a good position to co-ordinate the best use of therapeutic and support services.

Removing Barriers to Accessing Appropriate Services

The Government is committed to ensuring that all people can get the primary health care services they need. Because primary health care is the first level of contact with the health system, it is often at this level that an individual's need for other services is identified. Barriers to accessing primary health care therefore reduce access to heath and disability services generally, with consequent effects on health status and inequalities.

Barriers to access to primary health care services include where those services are delivered, how much they cost, whether the service is right for the patient and whether they know about them.

Making Sure Cost Is Not a Barrier

New Zealand is unusual among developed countries in only funding about 40 percent of first-contact services through Vote Health, in what is otherwise a predominantly publicly funded system.

User charges are targeted according to age, income, and family size. However, there is clear evidence (Gribben 1996; Barnett and Coyle 1998; Ministry of Health 1999a; Waldegrave 1999; Barnett 2000) that cost is a barrier to accessing appropriate primary health care services for many people in New Zealand, particularly people from groups with the greatest needs and who experience the worst health status. There is also evidence from various international comparisons and studies (Saltman and Figueras 1998) that user charges for health services impact more on those who are poorer and sicker – that is, those with the greatest health need who experience the worst health status. Since subsidies are at present targeted according to income, redistribution of existing funds would only result in increased costs for people already on low incomes (taking from the poor to give to the very poor). New funds are needed.

Cost is a barrier for many people.

The Government is committed to reducing cost barriers to accessing primary health care services. This will occur over time with first priority going to improving access for the groups with the greatest health needs. As funds become available (either by transfers from other parts of the health budget, or by preferentially using new funds for these purposes) more support will be able to be given to a larger group of people. These matters will be considered by the Government against other funding priorities in the upcoming budget process for 2001/02 and future years.

Additional funding will also be required for implementing the wider range of preventive, outreach, and disease management services outlined in this Strategy, which should also result in additional services for those most in need.

Primary Health Organisations and providers will be encouraged by their communities to also consider the affordability of services. Population-based funding formulae allow greater flexibility about use of appropriate staff and services and can reduce the cost for patients. Supporting people to care for themselves and their families will also reduce their need to visit (and pay for) health services.

Knowing About Services and How to Access Them

Some people cannot get to services and providers will need to actively go out to them.

Some people are unaware of how best to get care when they need it. They may, for example, be used to using the hospital A&E clinic as their source of primary care. Others do not know what to expect, how much they will have to pay, or what is available when costs are too high.

Information about what primary health care services are available and how people can get to them must be provided in ways that people in the communities can understand. This will vary among communities, and may require the use of a wide range of formats and tools.

It may be written, provided orally (such as by telephone or on the radio or television), via the Internet or face-to-face at meetings, hui or fono. It may need to be provided in different languages and formats, including sign languages and Braille.

Some people are physically unable to get to first-contact services. Primary Health Organisations will need to go actively out to people who cannot or do not come to them. They need to be open to providing services in a range of different settings, for example in people's homes, workplaces, in schools, or on marae.

Actions

- Service coverage descriptions will clearly set out all the primary health care services that District Health Boards will be expected to fund – whether through Primary Health Organisations or by alternative arrangements.
- The Ministry of Health will build on existing work to finalise standard service specifications for the essential primary health care services that District Health Boards will fund. This will include population services, first-contact care, and managing pharmaceuticals, diagnostic testing and other referred services.

- Other providers will be funded to provide services that are not covered by Primary Health Organisation arrangements. These will include maternity services as well as the provision of care to people who have not enrolled in a Primary Health Organisation.
- A national funding formula that reflects the relative need of populations for primary health care services will be finalised.
- Primary Health Organisations will be not-for-profit entities but will be able to contract for services from private, for-profit providers.
- The Government is committed to ensuring that people can afford primary health care services and will move to reduce costs as funds become available.
- Primary Health Organisations will be encouraged to develop innovative ways of providing services that people can afford.
- The public will be informed and educated about the primary health care services that are available to them through a range of media.
- District Health Boards will actively monitor the availability and effectiveness of information about primary health care.

4. Co-ordinate Care Across Service Areas

Effective co-ordination will become more important as primary health care becomes more comprehensive.

People have diverse health needs, and use a number of services provided by different providers in various settings. It is important that there is co-ordination of care between these services, so that the best possible total package of care is provided to the patient without unnecessary duplication.

Effective co-ordination of care will become even more important as we extend the focus of primary health beyond treatment and support services towards a more comprehensive disease prevention and management approach. There is good evidence (McCarthy 1998; Pincus et al 1998; Baum 1999) that adopting a broader approach to primary health care can contribute to reducing health inequalities and improving outcomes.

A Broad, Intersectoral Approach

It has been estimated that health services only contribute about a fifth of health improvement. Health improvement mainly occurs through changes in the social, economic and cultural impacts on the community's health problems. A broad approach to primary health care means working with other sectors to effect change in these areas.

Primary Health Organisations will be expected to work through District Health Boards to highlight and help address intersectoral issues affecting the health of the community served. This will involve Primary Health Organisations and District Health Boards working increasingly with local bodies, education, welfare, housing, and public transport services, to facilitate and lead changes that will improve the health of their communities.

A Collaborative, Multi-disciplinary Approach

No single practitioner can meet people's needs completely under this Strategy.

The broad vision of primary health care in this Strategy means that no single practitioner or type of practitioner can meet people's needs completely. A range of practitioners with the skills to communicate and collaborate in the patient's interest are needed.

Providers of first-line services will usually involve nurses and doctors but may need a range of other community workers for some populations. Providers of other primary care services will continue to involve pharmacists, midwives and the range of other practitioners. Primary Health Organisations will need various professional, managerial and support staff to carry out their functions. The ability to recognise the role and importance of others, and to work collaboratively with them, will be essential. Likewise, networking and sharing some administrative services will help to minimise costs for Primary Health Organisations.

The increasing number of practitioners and their changing roles increase the risk of fragmentation of care. However, the increasing complexity of the task means that wider expertise is necessary and that new ways of working are essential. The world of primary health care is changing and old isolated ways of working must be replaced by new collaborative models.

Although Primary Health Organisations will not be responsible for providing all services, they will be a co-ordinator of care for their enrolled patients. As the central point of contact for both community and secondary care providers, Primary Health Organisations will be responsible for keeping key information (for example, about immunisation and smoking status) about their enrolled patients, and for linking those patients with appropriate service providers where appropriate.

Primary Health Organisations will work with other providers and agencies to maximise opportunities for prevention and early intervention of health problems. For example, working in partnership with Māori and Pacific providers is important for reducing health inequalities in these populations.

Co-ordination Between Primary and Secondary Care

Primary health care requires the assistance of secondary services in order to achieve best management of a range of health problems and conditions. For example, the best care of patients with chronic conditions such as diabetes, respiratory and/or cardiac disease may occur in primary health care settings, but with significant input and support from secondary services.

Specific initiatives that will help improve co-ordination between primary and secondary include:

- building on the advances already made, particularly increased primary health care access to secondary services such as diagnostic tests, and the development of electronic referral guidelines and decision support
- implementing evidence-based guidelines and other tools that aid effective clinical decision-making and management of patients in primary health care, with responsive and appropriate support from secondary services
- developing local initiatives that bring together primary health care practitioners and hospital clinicians to develop better access to hospital services and support for primary health care in condition management.

It is important that successful local initiatives for co-ordination are shared nationally.

A number of primary health care providers have implemented successful initiatives to better co-ordinate care. It is important that successful local initiatives are shared nationally with other provider groups where they offer potential solutions to common system-wide problems. This is a role for District Health Boards and the Ministry of Health, as well as Primary Health Organisations.

Co-ordination Between Primary and Public Health Services

Public health is concerned with improving, promoting and protecting the health of the population through the organised efforts of society. Ensuring a cohesive linkage between primary health care and public health services will be key to the success of initiatives to improve people's health.

Primary health care will need input, advice and support from public health services to achieve the key directions outlined in this Strategy. Public health services may need to be strengthened and resourced to provide this expertise.

In building linkages and networks with public health services, Primary Health Organisations may need to consider:

- how primary health care can make the best contribution to intersectoral and population health initiatives which are being led by public health services (and vice versa)
- useful and effective ways of sharing information about its enrolled population with public health services (with appropriate protection of patient confidentiality)
- how best to draw on public health knowledge and expertise when delivering health improvement services at the one-to-one level (such as helping people to change behaviour that threatens their health).

Co-ordination Between Primary and Disability Support Services

People experiencing disability are disadvantaged by social and environmental barriers to their full participation in society. Overcoming these barriers requires action on a wide range of fronts, from education and employment to housing and transport.

Overcoming the social and environmental barriers to full participation faced by people with disabilities requires action on a wide range of fronts. Primary health care has an important contribution to make.

Primary health care has an important contribution to make to such efforts, consistent with the broad definition of primary health care used in this Strategy. Specifically, Primary Health Organisations may need to consider how best to:

- ensure that barriers (physical, psychological, communication) to accessing primary health care services and practitioners are minimised for people experiencing disabilities
- build linkages with disability organisations and input into their initiatives
- maximise, through intersectoral activities, opportunities for people experiencing disabilities to participate in the community and wider society.

Co-ordination Between Primary and Mental Health Services

Recovery from mental illness, including alcohol and drug problems, occurs when people can live well in the presence of, or absence from, their mental illness and the social and economic losses that may come in its wake. As with other aspects of health and wellbeing, recovery depends on people being a part of communities and being able to make their own choices.

To assist in recovery, Primary Health Organisations will need to consider:

- activities to reduce the incidence and impact of mental health problems on their enrolled population, specifically education, prevention and early intervention activities
- the skill mix of primary health care practitioners and their ability to effectively respond to the majority of mental health problems which can be managed in primary care settings
- building effective linkages with other providers of mental health care, so that the care of those with chronic and/or long term mental health problems is effectively co-ordinated.

Co-ordination for Specific Population Groups

Some populations have particular needs for services that involve a number of different providers at different times. Older people, for example, often have changing needs over time due to gradual deterioration in their functioning. Similarly, children and young people often need a range of care and services from different providers simultaneously.

In order to respond effectively to the co-ordination needs of such groups, Primary Health Organisations will need to consider:

- how to maintain continuity of care for patients who have significant periods in the care of other providers (eg, hospitals)
- developing joint 'plan of care' arrangements with other health and disability providers so that optimal care is provided and the patient has clarity about their care regime
- activities to maximise the health and independence of groups, usually by working/advocating intersectorally.

Actions

Primary Health Organisations and District Health Boards will:

- participate in wider intersectoral activities that aim to address the social, cultural, and economic causes of ill health
- take responsibility for the co-ordination of care for their enrolled patients
- be required to co-ordinate and manage resources for the services for which they are responsible in order to ensure best use of workforce and associated diagnostic and therapeutic services
- support initiatives to help improve co-ordination between primary and secondary health care services
- consider how best to co-ordinate and link with providers from other service areas, particularly for members of a Primary Health Organisation's enrolled population who receive significant input and care from other providers.

The Ministry of Health and District Health Boards will facilitate the national sharing of successful local initiatives.

5. Develop the Primary Health Care Workforce

The Strategy will have significant implications for the number, mix, distribution and education of the primary health care workforce.

The Strategy will have significant implications for the number, mix, distribution and education of the primary health care workforce. The current mix and distribution of the primary health care workforce has been largely an unplanned response to demand and to various initiatives and incentives in the system. As a result the ratio of practitioners to patients is not closely matched to population need (some of the lowest number of doctors are in places of highest need). Because of Government subsidies New Zealand has a higher ratio of practice nurses to population than many other countries but the roles, competencies, and training of these nurses vary considerably. In recent years there has been some growth in managerial and support staff in first-contact services, as new organisations have appeared.

The workforce in other primary health care services is generally less plentiful. Community health workers and Māori and Pacific general practitioners and primary health care nurses are limited, public health and well-child nurse numbers have been mostly static, and midwife numbers show signs of falling recently after growth earlier in the last decade. Deficiency of appropriately trained workforce in these and similar areas may be a significant limiting factor in the speed of future achievements. They need to be addressed at the national level by the Health Workforce Advisory Committee as well as by professional bodies and providers.

Availability of Practitioners

New Zealand does not have an overall shortage of doctors or nurses in general practice – but there is uneven distribution and significant shortages in some places.

Most people in New Zealand can easily access first-contact services (mostly nurses and doctors working in general practices) when they seek care. The numbers of general practitioners and practice nurses per head of population in New Zealand are on a par with, or higher than, comparable countries.

However, there are shortages of first-contact practitioners in some places around the country. Some parts of our cities have many fewer doctors and primary health care nurses than other parts, and some rural towns have difficulties in retaining sufficient practitioners to have a viable service. There are similar problems of variable availability in other primary health care services, such as maternity service providers.

In future, explicit minimum standards for availability of first-contact services will be stated as service coverage levels that District Health Boards will be expected to achieve. Availability of first-contact general practice-type services will be stipulated according to the size and isolation of the community. Minimum levels of primary level maternity services will also be stipulated taking account of local birth patterns and the availability of facilities.

These minimum levels will be made public and District Health Boards will be required to demonstrate availability and identify where there are service coverage gaps or risks.

Primary Health Care Nursing

The move towards greater population focus and emphasis on a wider range of services will increase the need for well-trained primary health care nurses. Such nurses will share a common set of generalist knowledge and skills as well as developing advanced skills in particular areas of professional practice. The concept of the primary health care nurse needs further development with clarification of the appropriate capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements. Primary health care nursing will be crucial to the implementation of the Strategy, and will therefore be best addressed at the national level.

Rural Workforce

Maldistribution of workforce is a particular issue for rural areas. Although New Zealand is now 80 percent urbanised, our rural communities are still extremely important to the economy. As well as sharing the health risks of urban people, those in the country also have risks unique to the rural environment and its agricultural industry. People living there need good access to essential primary health care services.

The difficulties of attracting and retaining basic health services in rural communities have not lessened over recent years.

However the difficulties of attracting and retaining basic health services in rural communities have not lessened over recent years. Even some recent initiatives to further encourage rural general practice have so far made little impact on problems.

Rural problems need special consideration – further work is needed.

Rural problems need special consideration. They must encompass the issues of hospital facilities as well as the provision of services. In the country the differentiation between primary and secondary is less clear-cut.

The Ministry of Health will develop a coherent policy and package of assistance for rural communities. This work will involve local communities and iwi, all relevant providers, District Health Boards and the Ministry of Health.

Actions

District Health Boards will be expected to achieve minimum standards for first-contact service coverage levels, according to the size and geographical nature of the district and its communities, and to identify where there are service coverage gaps or risks.

- Primary Health Organisations will deliver services in a range of settings to reach all their enrolled populations.
- The Health Workforce Advisory Committee will be asked to consider the national workforce implications of this Strategy.
- The Ministry of Health will facilitate the development of a national approach to primary health care nursing that will address capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements.
- The Ministry of Health will facilitate the development of a coherent approach to rural health service provision including the difficult issues of attracting and retaining appropriate workforce. This work will involve local communities and Māori, and District Health Boards.

6. Continuously Improve Quality Using Good Information

Quality and safety are critical aspects of any health services. While some recent high-profile cases have shown up the risks inherent in primary health care interactions, it is important to recognise that there have also been some encouraging developments in the area of quality improvement for primary health care.

Examples of quality assurance processes among primary health care professionals include:

- the College of Midwives' annual standards review (which includes consumers)
- the growing range of College of General Practitioners' Quality Assurance resources to back up its reaccreditation requirements and recently introduced practice standards
- Health Care Aotearoa's Te Wana quality programme for community-owned providers
- the range of quality tools used by various Independent Practitioner Associations.

Complying with new accountabilities increases the cost of providing services and should be reflected in contracts.

There is now a much greater acceptance by providers and their representative bodies of the need to be accountable both to the community served and to those Government agencies that pay for services.

New primary health care groupings have also shown that they are prepared to take collective responsibility for the quality of clinical care. This has been highlighted by the requirement in some contracts to manage within a set budget – but there is also evidence of changes where no financial risk is involved. These developments and changes in professional attitude are a worldwide phenomena associated also with the move towards evidence-based practice. They do, however, place a considerable extra burden of compliance costs on practitioners, which need to be recognised in contracts.

District Health Boards will be required to ensure that Primary Health Organisations can demonstrate the quality and safety of the services for which they are responsible. Primary Health Organisations will be required to document their compliance through their annual reports, which should be made available to the community as well as the District Health Board.

Accountability and formal reporting requirements should be the end point of other quality processes. These are most effective when they are an integral and ongoing part of the way the system operates. High-quality organisations and providers of primary health care will be those that have a culture of continuous improvement with individuals looking for learning opportunities and the organisation rewarding and supporting such behaviour.

An Effective Infrastructure for Information Collection and Sharing

Accurate and useful information about enrolled populations and their health needs is critical to quality as well as to the successful adoption of a population health focus in primary health care.

Information and information sharing is needed particularly to support and inform:

- needs assessment and effective service funding, planning, delivery, and monitoring
- co-ordination of provider activities and patient care
- improving the continuity of care between episodes of illness and treatment
- clinical decisions about the care and treatment options available, and their likely efficacy for individuals
- processes for monitoring and improving the quality of care.

The need for accurate information will increase as we move to public funding based on the needs of an enrolled population. In particular, it will be important to ensure that cost-effective methods of capturing data about utilisation of services are developed to inform future needs analysis and funding decisions.

The need for accurate information will increase as we move to public funding based on the needs of an enrolled population.

There are a number of initiatives already occurring in the sector that are designed to improve information collection and sharing:

- The Ministry of Health is currently developing a draft Health Knowledge Strategy that will address issues of privacy and confidentiality, and will identify key principles and goals for health information.
- The Child Health Information Strategy currently being implemented by the Ministry of Health provides an overarching plan for the development, collection, and use of information for improving the health of children.
- There is a range of local initiatives which seek to ensure better collection and sharing of information within primary health care, and between primary and secondary providers. One example is KidZnet,[5] which links providers to basic information (particularly well child services) about the local child population, using the National Health Index (NHI).

KidZnet and other similar information projects could well provide a platform for broader improvements in primary health care information. Building on these initiatives, and supporting the development of further information initiatives, will be a key priority for the Ministry of Health, District Health Boards and Primary Health Organisations. All parties need to work together to ensure that accurate and useful information is collected and shared. In particular, it is important that funding agreements and contracts explicitly consider information requirements, with an emphasis on minimising costs while building a standardised primary health information infrastructure.

[5] A joint venture between Health Waikato, Rotorua Area Primary Health Services, and the Ministry of Health.

Enrolment provides some opportunities to address information needs. In particular, improving the accuracy and effectiveness of the NHI will be a priority as we move to widespread enrolment. It will also be important to ensure patient confidentiality is protected throughout the enrolment process. Primary Health Organisations and providers will need to ensure that patients are informed about information collected and its intended uses. For example, patients will need to give informed consent before personal/clinical information held at a general practice or health clinic level is passed to other practitioners inside or outside the Primary Health Organisation.

Evaluating the Impact of New Arrangements and Guiding Future Policy

While this Strategy is based on the evidence where it is available, there are many aspects of primary health care where significant questions about policy and implementation remain.

More research and evaluation is required.

More research and evaluation is required to resolve issues such as the degree of variation in service provision, the most appropriate ways to target limited resources, the most efficient ways to provide care and what services are best in different circumstances. This Strategy is an evolutionary one and allows considerable variation. It will be supported by ongoing research during its implementation so that the final arrangements are effective and acceptable.

Actions

- Minimum monitoring requirements, toolkits and other guidance will be developed to assist in the area of continuous quality assurance.
- District Health Boards will specify and monitor quality and safety standards and outcomes of care through service arrangements.
- Primary Health Organisations will be openly accountable to the public for the quality standards they plan to achieve.
- The Ministry of Health will consider the needs of primary health care in its development of the Health Knowledge Strategy, including key principles and goals for health information.
- The Ministry of Health, District Health Boards, and the New Zealand Health Information Service will develop cost-effective, administratively simple methods of capturing data about utilisation of services to inform future needs analysis and funding decisions.
- All parties will co-operate to build on promising information initiatives that have the potential to improve patient care.
- All parties will co-operate to improve the effectiveness and accuracy of the National Health Index as widespread enrolment is introduced.
- Providers will ensure that patients are informed about information collection and give consent where their personal/clinical information is shared with other practitioners inside or outside the Primary Heath Organisation.
- The Ministry of Health, District Health Boards, Primary Health Organisations and providers will be encouraged to build evaluation, research and development into new primary health care programmes.

IMPLEMENTING THE STRATEGY

The achievement of the new direction for primary health care will clearly involve a period of change over the next five to ten years. In implementing the Strategy there are a number of important principles for ensuring a stable and constructive transition:

- in the first instance, protect the gains already made and build on successful initiatives
- involve, discuss and collaborate with the primary health care sector, providers and communities in the implementation of the Strategy
- focus on stepwise, evolutionary, change which is progressively consistent with the Primary Health Care Strategy.

The Government is committed to funding additional health promotion, disease prevention, and community development services in primary health care. Primary health care is a high priority for additional funding within Vote Health, as it is central to removing inequalities and improving health. However, any additional funding for primary health care will need to be considered against other health priorities, as well as funding for other areas of Government and District Health Board expenditure. The first priority for any additional funding will be the groups with the greatest health need, both in terms of additional services to improve health, and to reduce financial barriers for access to first-contact services.

Principles:

- Protect the gains
- Work with providers and communities
- Stepwise evolution.

The implementation details will be developed and communicated through a number of mechanisms.

- Funding agreements and other accountability documents for District Health Board performance. These accountability documents will include performance measures specifically related to primary health care and the implementation of this Strategy. There will be close monitoring of District Health Board performance by the Ministry of Health until key objectives are achieved.
- The Ministry of Health will develop toolkits and policy guidelines for District Health Board contracting with providers. This will support the Boards to build relationships and support local providers and communities who are interested in primary health care, develop district plans for primary health care, and manage existing local contracts in order to prepare for future change.
- Training and communication about best practice through, for example, seminars for providers and induction training for District Health Board directors.

In preparing for implementation, providers and their organisations (including existing organisations that have primary health care contracts) should build relationships with their communities, and with their District Health Board. They will also need to consider what changes to make to their organisational arrangements, and will plan how to prepare themselves for the new tasks and services that will be needed.

District Health Boards and primary health care providers should support communities and interested individuals to be involved with primary health care developments, so that the future system can understand and address people's needs and priorities.

APPENDIX ONE

Primary Health Care Reference Group

The Ministry of Health had the task of developing a definitive primary health care strategy for Government approval, building on the Minister of Health's discussion document *The Future Shape of Primary Health Care*. To assist in this task it appointed a reference group of individuals with wide sector experience.

Terms of Reference

The reference group will assist the Ministry of Health in this task by:

- commenting on the summary of submissions
- with reference to the discussion document, the submissions and the sector, commenting on the implications of the strategy as it is developed
- engaging with the sector and sharing ideas, while recognising that some documents which members will see will require confidentiality.

Membership

Win Bennett (Chair), Manager, Ministry of Health

Bridget Allan, CEO, Hokianga Health Enterprise Trust

Patsi Davies, Consumer Perspective/Consumer Rights Researcher, Hamilton

Barbara Docherty, Goodfellow Unit, General Practice and Primary Health Care, Auckland University

Dianne Gibson, CEO, Ngati Porou Hauora

Karen Guilliland, National Director, New Zealand College of Midwives

Liz McElhinney, CEO, Ko Te Poumanawa Oranga

Julie Martin, Primary Health Care Project Manager, Ministry of Health

John Marwick, Principal Technical Specialist, Ministry of Health

Allan Moffitt, General Practitioner, East Health

Debbie Ryan, General Practitioner, Southseas Healthcare Ltd

Branko Sijnja, General Practitioner, Clutha Health First

APPENDIX TWO

Definition of Primary Health Care

Drawn up by the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

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