

**Evaluation of the Implementation and
Immediate Outcomes of the Primary Health
Care Strategy:
The Experiences of Pacific PHOs and Pacific Populations**

FINAL

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	3
EXECUTIVE SUMMARY.....	4
1. INTRODUCTION	7
2. BACKGROUND TO THE STRATEGY AND PRIMARY HEALTH CARE IN NEW ZEALAND	9
3. RESEARCH METHODS	13
4. PACIFIC PEOPLES IN NEW ZEALAND	18
5. PACIFIC PEOPLE AND PRIMARY HEALTH CARE	26
6. PACIFIC PEOPLE AND THE PRIMARY HEALTH CARE STRATEGY	31
7. CHANGES TO PRACTICE FEES AND CONSULTATION RATES 2001-2007	52
8. DISCUSSION AND POLICY IMPLICATIONS.....	57
REFERENCES	64
APPENDIX 1	69

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EXECUTIVE SUMMARY

This report presents key findings about how the Primary Health Care Strategy (PHCS) has worked for Pacific people in New Zealand. It is part of a suite of reports from the Evaluation of Primary Health Care Strategy (see Appendix 1).

The objectives of this report are to:

- Describe the Strategy and evaluate its implementation against the objectives, focusing on the experience of Pacific-led Primary Health Organisations (PHOs) and PHOs with large enrolled Pacific populations.
- Examine the impact of the Strategy on reducing health inequalities for Pacific peoples in New Zealand.

This report is intended to have stand-alone value, but has also been informed by findings from the lead Evaluation and other Strategy evaluations. Key findings from this report have also been fed into the final reports of the lead evaluation in 2010. The report is based on three phases of evaluative activity from 2003 to 2010, involving key informant interviews, surveys and statistical analyses of fees and consultation data.

KEY FINDINGS

- The five to ten year vision of the PHCS was to shift primary health care (PHC) services to focus more on the health of various population groups by: providing services which are easy to access; improving and maintaining their health; and coordinating their ongoing care (King, 2001). Underlying this vision was a greater emphasis on the role of community participation in health improvement. PHC was seen to encompass a wide variety of services, including health promotion and preventive care, which necessitated the involvement of a wide range of health professionals (multidisciplinary teams) in the service delivery model.
- Pacific peoples are disproportionately represented in the most deprived areas of the country and have poorer health status than other New Zealanders. Pacific peoples were a key priority group for the PHCS, given the focus of the PHCS on reducing inequalities in health. The PHCS had a focus on services for Pacific peoples provided by Pacific peoples, active involvement of Pacific communities in service delivery, further building of Pacific provider capacity, the formation of Pacific-led PHOs, and leadership at a national level. All providers and PHOs were to identify, reach out to and address Pacific health needs (King, 2001).
- Reducing the costs of medical consultations was a primary motivation for practices to become involved in the PHO initially.
- There was a positive response to the lowered cost of healthcare from the stakeholders interviewed in the Pacific-led PHOs, mirroring the findings of the earlier evaluation report (Cumming et al, 2005).
- Despite Pacific providers offering lower fees compared to other mainstream providers, services are still being underutilised by Pacific patients (Raymont et al, 2010).

- Although it was found that Pacific patient enrolments increased as the PHCS began to be implemented, consultation rates for Pacific-led practices are still low compared to other practices. This could be due to the way Pacific-led practices record their patient contacts in clinical records compared to their mainstream counterparts, while longer and complex consultations with Pacific patients could also result in a lower number of overall consults at Pacific-led practices. Those interviewed noted the need to ensure the collection of comparable data, including on the length of consultations, across PHOs, as lack of good information was seen to be having an impact on planning and service development.
- There is enthusiasm by Pacific-led and Access PHOs which serve the more disadvantaged populations about the funding available for services to improve access. There are many initiatives that participants considered were working effectively to support people accessing the health care they required. However, high and complex patient needs inevitably increased the length of consultations which impacts on the workload of the PHO treatment providers such as general practitioners and nurses.
- The lack of availability of free transport to treatment was identified as a barrier by some of Pacific-led PHOs.
- Lack of information about the PHO enrolment process and how to access support services and culturally appropriate treatment were raised as commonly encountered barriers when dealing systemically with Pacific patients and their families.
- As overhead costs, such as administrative and managerial costs, increased, the low treatment cost structure within the smaller Pacific PHOs became less easy to sustain. Various financial 'struggles' within some of the smaller PHOs suggested the need to amalgamate with other Pacific PHOs so that administrative costs, information systems and management could be managed more effectively.
- The geographic boundaries of the PHOs were seen as an obstacle to Pacific families referring from other regions to see Pacific healthcare providers.
- The difficulties of patients who enrol in one PHO whilst visiting another for medical treatment with the second practice billing for the service (referred to as 'clawbacks') was identified as a continuing issue impacting on the financial viability of some of the smaller PHO practices.
- At the later interviews, there were a number of community/DHB collaborations that were working in tandem with the community churches and with other Ministry of Health initiatives such as the HEHA programme. For example, the local community, dieticians and other treatment providers in the PHOs, DHBs and HEHA were working together in one community gardening project whose primary aim was to encourage wellness through healthy eating.
- A community model of care facilitated by the PHOs was described as a positive development across the PHO providers interviewed. This model consisted of several elements, including remaining small enough to know the local community which enabled managers and treatment providers to remain aware and responsive to locally defined needs. Participants referred to this flexibility and philosophy of altruism as 'dealing where we find people' and for themselves as practitioners as 'resilience to get on and keep doing it'. In practice this meant working holistically with almost any issue the client presents with.

- The relationships of the Pacific-led PHOs and District Health Boards (DHBs) and the Ministry of Health (MoH) took time to form and there were early problems with ‘personalities’ when they started working together. Once a regular meeting structure was implemented, these relationships with local DHBs improved and came to be seen as constructive and purposeful.
- Cultural competence – the capacity of the health system to improve health and wellbeing by integrating cultural practices and concepts into service delivery – was recognised as an important tool for addressing the cultural barriers to accessing care experienced by Pacific peoples.

1. INTRODUCTION

In February 2001, the New Zealand government released the Primary Health Care Strategy (the Strategy) with the aim of improving the health of New Zealanders and reducing health inequalities.

The five to ten year vision of the Strategy was to shift primary health care (PHC) services to focus more on the health of the population by: providing services which are easy to access; improving and maintaining their health; and coordinating their on-going care (King, 2001). Underlying this vision was a greater emphasis on the role of community participation in health improvement. PHC was seen to encompass a wide variety of services, including health promotion and preventive care, which necessitated the involvement of a wide range of health professionals (multidisciplinary teams) in the service delivery model.

To achieve the vision, the Strategy emphasised six key directions for the future development of PHC in New Zealand:

- 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 PHC workforce
- Continuously improve quality using good information (King, 2001).

Overall, implementation of the Strategy involved three significant changes in PHC:

- The development of Primary Health Organisations (PHOs, local non-governmental organisations which serve the PHC needs of their enrolled patient population).
- Increased government funding and the extension of eligibility for funded services to the entire NZ population; with the intention of reducing the fees that patients pay for PHC service use and expanding services.
- A shift towards capitation funding of PHOs, replacing fee-for-service subsidies of general practice services; with the intention of allocating funding based on needs of the enrolled PHO population (Cumming and Mays, 2009).

A large number of PHOs were established between 2002 and 2005. By mid-2008 there were 80 PHOs in operation, with additional funding to the value of \$2.2 billion having been provided for further PHC service developments since 2001 (Cumming and Mays, 2009).

1.1 THE EVALUATION

An independent *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy* (the lead *Evaluation*) commenced in 2003; funded by the Health Research Council of New Zealand, the Ministry of Health (the Ministry) and the Accident Compensation Corporation (ACC). The Evaluation is led by researchers at the Health Services Research Centre, Victoria University of Wellington; CBG Health Ltd, Auckland; and a team of researchers from New Zealand and the United Kingdom.

1.2 THIS REPORT

This report presents key findings about Pacific people in New Zealand in the context of the Primary Health Care Strategy. It is part of the suite of reports included in the lead Evaluation (see Appendix 1).

The objectives of this report are to:

- Describe the Strategy and evaluate its implementation against the objectives, focusing on the experience of Pacific-led PHOs and PHOs with a large enrolled Pacific population.
- Examine the impact of the Strategy on reducing health inequalities for Pacific peoples in New Zealand.

This report is intended to have stand-alone value, but has also been informed by findings from the lead Evaluation and other Strategy evaluations. Key findings from this report have also been fed into the final reports of the lead evaluation in 2010.

Outline of the Report

This report has eight main sections:

- Introduction
- A background section detailing the Strategy and PHC in New Zealand
- Research Design and Methodology
- A background and context section looks at Pacific populations in New Zealand, and provides an overview of the health status of Pacific peoples
- A section describing the PHCS, the introduction of PHOs and changes to funding and looks in detail at the establishment of Pacific-led PHOs and at enrolled Pacific populations
- Key themes and findings from the interviews with Pacific and Access PHO informants
- Quantitative data analyses relating to practice fees and consultation rates
- Discussion and the implications for policy.

2. BACKGROUND TO THE STRATEGY AND PRIMARY HEALTH CARE IN NEW ZEALAND

In the decades before the Strategy's implementation, PHC was largely funded on a fee-for-service basis – where general practitioners (GPs) claimed a government subsidy for every patient visit. In the early 1990s, the fee-for-service payments were specifically targeted to low-income Community Service Card (CSC) holders, and High User Health Card (HUHC) holders. Under a traditional model of service delivery, GPs tended to own small private businesses, deriving their income from a combination of public funding, and consultation fees ('co-payments') charged to the patient. Alternative models of health care delivery such as the union health centres and iwi and marae-based services were established during the late 1980s and early 1990s within the not-for profit sector by non-government organisations (NGOs). These practices were often funded on a capitation basis and they offered free or low cost health care services for groups who were identified as having particularly high needs (Cumming and Mays, 2009).

During the 1990s, the establishment of a stand-alone purchasing function (in the form of four Regional Health Authorities or RHAs and later a single, national Health Funding Authority or HFA); the pooling of PHC, secondary care, disability support and public health funding; and the introduction of contracting for all services, saw many general practices become affiliated with independent practitioner associations (IPAs) or other networks to enhance their bargaining power for receiving government funding and to develop initiatives that would enhance the scope and quality of PHC (Barnett et al, 2009). During this time there was also an increase in the use of capitation funding – a form of population-based funding whereby the government makes monthly payments to practices, based on the number of patients enrolled at the practice (ie 'per head' funding as opposed to 'per visit' funding) – and in the use of other contracts and payment methods (Crampton and Foley, 2008). Community-based providers flourished: for example, the number of Māori-led providers increased from around 30 to around 200 (Ministry of Health, 1997) and the first Pacific-led providers were also established (Tukuitonga, 1999).

A Labour-led Coalition government elected in 1999 reformed the health system in 2001, establishing 21 District Health Boards (DHBs) to oversee health and disability services planning and hospital services delivery, and contract with a range of community-based providers to deliver mental health, aged care and public health services. The Government then released its Primary Health Care Strategy in 2001.

The five to ten year vision of the PHCS was to shift primary health care (PHC) services to focus more on the health of various population groups by: providing services which are easy to access; improving and maintaining their health; and coordinating their ongoing care (King, 2001). Underlying this vision was a greater emphasis on the role of community participation in health improvement. PHC was seen to encompass a wide variety of services, including health promotion and preventive care, which necessitated the involvement of a wide range of health professionals (multidisciplinary teams) in the service delivery model.

Pacific peoples are disproportionately represented in the most deprived areas of the country and have poorer health status than other New Zealanders. Pacific peoples were a key priority group for the PHCS, given the focus of the PHCS on reducing inequalities in health. The PHCS had a focus on services for Pacific peoples provided by Pacific peoples, active involvement of Pacific communities in service delivery, further building of Pacific provider capacity, the formation of Pacific-led PHOs, and leadership at a national level. All providers and PHOs were to identify, reach out to and address Pacific health needs (King, 2001).

The Strategy introduced three significant changes to funding and service delivery models in PHC (Cumming and Mays, 2009). First, the Strategy saw the formation of Primary Health Organisations (PHOs). PHOs are local governance organisations, comprised of groups of primary care providers (ie general practices and various community health care providers) with the following features:

- They are funded by DHBs to provide essential PHC services to their enrolled patient population;
- The services provided under the PHO include approaches directed towards improving and maintaining the health of the population, as well as providing first-line response services to restore people's health when they are unwell;
- They are expected to involve local communities in their governing processes, and be responsive to communities' health needs;
- All providers and practitioners under the PHO must be involved in the decision-making, rather than one group being dominant;
- They are not-for-profit bodies required to be fully and openly accountable for all public funds that they receive (King, 2001).

PHC practitioners were encouraged to affiliate with, or form PHOs, although membership was voluntary. Similarly, patients could choose which practice to enroll with, which in turn provided them with a PHO 'home', although patients could choose not to enroll with any practice if they wished. There was a strong incentive for both practitioners and patients to participate in the new institutional arrangements, however, as those who remained outside the new PHO organisational structure could not access the new PHC subsidies. A large number of PHOs were established between 2002 and 2005 (Cumming et al, 2005); and by mid-2008 there were 80 PHOs in operation, all of which varied in their enrolled patient population size – ranging from 1,500 to over 350,000 (Smith et al, 2009).

The second significant change introduced by the Strategy was an overall increase in government funding provided to PHC, and the extension of eligibility for funded services to the entire New Zealand population. This extended funding signaled a shift away from the previous targeted approaches, towards a universal approach, which was intended to reduce the co-payments all patients pay for PHC; thereby reducing the cost barriers to accessing primary care.

The third change was a shift towards capitation funding of PHOs, replacing fee-for-service subsidies at the practitioner level, with the intention of allocating funding based on the needs of the enrolled PHO population (Cumming and Mays, 2009). Although the basic general practice business model remained the same, the Strategy emphasised a 'needs-based funding population care' approach.

To ensure the new funds went to those most in need, and in keeping with the now universal approach to funding PHC, two forms of 'First Contact' PHC funding were created – Access and Interim funding. First Contact funding is the main capitation-based method for subsidising PHOs for their enrolled patients' visits to general practices and other services (King, 2001). Access-funded PHOs were defined as those where more than 50 percent of its enrolled patient population was Māori or Pacific; living in a lower socio-economic area (i.e. living in New Zealand Deprivation index deciles 9 or 10; see Crampton, Salmond, & Kirkpatrick, 2004); or holding a CSC or HUHC. All other PHOs were classified as Interim-funded PHOs.

The First Contact funding for Access PHOs was available from 1 July 2002. Initially, First Contact capitation funding of Interim PHOs was restricted to enrolled children under six years old – guided by the rationale that more Access PHO populations have poorer health status on average and, therefore, have the greatest health needs (Ministry of Health, 2007). From 2003, First Contact funding was progressively rolled out to Interim PHOs at the same, or similar, rates paid to Access PHOs. This roll out of First Contact funding for Interim PHOs occurred in the following manner:

- 6-17 years from 1 October 2003
- 65 years and over from 1 July 2004
- 18-24 years from 1 July 2005
- 45-65 years from 1 July 2006
- 25-44 years from 1 July 2007 (Ministry of Health, 2007).

Since the Strategy's release, the Government has provided some \$2.2 billion in funding to support its implementation (Cumming and Mays, 2009). In addition to providing new funding to reduce user charges, other funding pools have been provided in the following areas (Ministry of Health, 2003; Ministry of Health, 2007a; Ministry of Health 2007b; Ministry of Health, 2008; Ministry of Health, 2008a; Ministry of Health, 2009a).

Health Promotion

Health Promotion is a key aspect of the population-based primary health care approach of the Strategy; and is aimed at improving the health status of, and reducing health inequalities within, a PHO's enrolled population. Since the 2002/2003 financial year, PHOs have been funded to develop, deliver, and assess Health Promotion programmes through working with their local communities, existing public health service providers, and NGOs. A guideline for Health Promotion programme development was published in 2003 (Ministry of Health, 2003), with emphasis being placed on addressing the structural determinants of health (eg living and working conditions, culture, socioeconomic status, education) as well as the various individual-level factors which mediate the impact of the structural determinants (eg lifestyle, behavioural, and psychosocial factors). PHOs are required to meet certain criteria to be eligible for Health Promotion capitation-based funding.

Services to Improve Access

Services to Improve Access (SIA) funding is available for all PHOs to assist with reducing inequalities in high needs populations known to have poorer health status (Māori, Pacific and those living in NZDep index 9-10 decile areas). SIA-funded services can either be new services, or extensions of existing services, which are designed (by the PHO) to improve access to primary care in high needs groups. Examples of SIA-funded services include: outreach health services (eg church-based health programmes for Pacific people); mobile nurse-led services; after-hours services; and school-based clinics. SIA initiatives proposed for Pacific (and Māori) populations should: emphasise the need for community partnership in service planning and delivery; include Pacific (and Māori) health workers; and be delivered in locations where Pacific (and Māori) are comfortable and can easily access the service. PHOs apply for SIA funding by submitting a proposal to their DHB who, in turn, submits a summary of the proposed service/s to the Ministry of Health for approval. Like Health Promotion funding, SIA funding is a capitation-based, and is provided in addition to the First Contact funding a PHO receives, with different multipliers being used for various groups of need.

Very Low Cost Access payment

The Very Low Cost Access (VLCA) payment was introduced in October 2006 for PHOs and practices that charge and maintain low fees for their enrolled population. Participation in the VLCA initiative is voluntary. Overall, the VLCA payment is designed to provide extra support for PHO practices who charge low fees (ie practices who have forgone revenue normally obtained from charging high patient co-payments). Most practices receiving the VLCA payment provide services to high needs communities who typically do not have the income to pay high fees. Therefore, the VLCA payment keeps fees low for those who can least afford PHC – effectively enhancing access to PHC services for high needs groups, with the intention of reducing the health inequalities faced by these groups. To be eligible for the VLCA payment, the PHO practices must meet the following patient fee thresholds:

- Zero fees for children 0 - 5 years
- \$11.00 maximum for children aged 6 -17 years
- \$16.50 maximum for adults aged over 18 years (Ministry of Health, 2009).

Care Plus

Care Plus provides additional capitation-based funding to PHOs for those enrollees who have to visit a GP or nurse more frequently because of multiple chronic health conditions, such as diabetes or heart disease, acute medical or mental health needs, and/or a terminal illness. The Care Plus programme was rolled out nationally from 1 July 2004, with funding allowing for up to five percent of the New Zealand population to be eligible. Overall, Care Plus aims to: improve the management of chronic conditions; reduce inequalities; improve teamwork and collaboration in primary health care; and provide reduced service costs for high-needs primary health care users. Although the Care Plus service delivery varies between PHOs (and between practices within PHOs), generally the patient receives an in-depth initial visit with a nurse or doctor to explore their health needs and develop a Care Plan. Patients are then seen in subsequent visits throughout the year to monitor their ongoing care (CBG Health Research, 2006). There are maximum duration consultation times under the Care Plus programme. The length of the initial consultation and subsequent visits are linked to reimbursement for the nurse or doctor who treats the patient once they are found eligible and become registered for Care Plus.

Zero Fees for Under 6s

The Zero Fees for Under 6s is a voluntary scheme, similar to the VLCA initiative, which was introduced in 1997 and then refreshed in the 2007/2008 financial year. The scheme is designed to support practices in providing free PHC services to children under six. Practices are eligible to apply for the Under 6s payment if they commit to providing free standard consultations to children under six. The practice's PHO notifies the DHB of all the practices under their PHO who are eligible for the payment during each payment quarter. From July 2008, the Under 6s payment was calculated as a 16 percent premium on the First Contact capitation Access, non-HUHC user rates (Ministry of Health, 2008a). Practices who receive a VLCA payment are not eligible to apply for the Under 6s payment.

Pharmaceutical co-payment

From April 2004 charges on subsidised pharmaceuticals and medicines were reduced to a maximum co-payment of \$3 for patients of all ages enrolled with Access PHOs; and for children aged 6-17 enrolled with Interim PHOs. Additional reduced charges on prescription items, for those enrolled at Interim PHOs, were rolled out between 2004 for people aged 65 years and over, and 2007 for those aged 25-44 years.

From September 2008, the \$3 co-payment on subsidised medicines was extended to a broader range of prescribers/providers (including public hospitals and midwives). Patients are no longer required to be enrolled with a PHO to be eligible for the reduced co-payments (Ministry of Health, 2009a).

3. RESEARCH METHODS

RESEARCH DESIGN AND METHODOLOGY

This chapter describes the research design, approach and methods used for each phase of the evaluation that relates to the Access and Pacific-led PHOs. This report is based on qualitative and quantitative data collected as part of the lead *Evaluation*. Interviews and questionnaires aimed to provide an in-depth understanding of the experience and activities of PHOs and member practices in response to the Strategy. A summary of data collection methods follows below; and is further detailed in the main lead *Evaluation* reports (Cumming et al., 2005; Cumming and Gribben, 2007; Raymont and Cumming, 2009; Croxson, Smith, and Cumming, 2009; Barnett et al., 2009; Smith and Cumming, 2009, Raymont et al, 2010).

Ethical Approval

The research plans for all the evaluations were submitted for ethical consideration to the Chair of the Wellington Ethics Committee. The Chair noted that the project did not require formal ethical approval. However, the research team adhered to sound ethical research principles. Therefore, the following steps were incorporated in relation to the qualitative data:

- Potential participants were given the right to decline to be interviewed.
- Participants were given the right to withdraw their involvement or their contributions at any time.
- A transcript of each interview was sent to the participant for perusal and amendment, unless the participant waived this requirement.
- Data was to be stored for ten years.
- Every effort was made in the analysis and reporting to protect the identification of the individual participants and their DHBs.
- Māori and Pacific researchers were used as advisors throughout each phase of the research to address culturally sensitive aspects of the research (Cumming et al, 2005).

Data from the lead Evaluation

Qualitative data collection included:

- A first phase of interviews in 2003-5 with a sample of PHOs and practice staff and those working in key stakeholder organisations.
- A second phase of interviews in 2006 and 2008.
- A third phase of interviews was held between 2008 to early 2010.

Quantitative data collection included:

- A postal survey sent to all PHOs and a sample of general practice staff.
- Data collected between June 2001 and December 2007 from random samples of New Zealand general practices working within PHOs. The data covered general trends in the actual fees paid for primary care services; and trends in consultation rates (service utilisation) for general medical services delivered by both doctors and nurses. The available data were available only to the end of 2007, so that only six months of the final roll-out of new funding (to those aged 25-44 from 1 July 2007) are included in our analyses.

Data Collection

Alongside the lead *Evaluation* data collection, additional interviews were conducted in three phases within the Access and Pacific-led PHOs (referred to as the 'Pacific PHO interviews'). PHOs meeting the selection criteria of either being Pacific-led, or providing services for large numbers of enrolled Pacific patients, were contacted by the researchers to invite participation. Most were Access-funded PHOs. Pacific interviews were targeted to a range of staff working within the PHO, including: board members (nurse representatives, GP representatives and chairs); practice staff (GPs and nurses); and community workers (e.g., health promoters, community health workers and youth workers). The first phase of Pacific interviews took place between 2003 and 2005 during the initial establishment of the PHOs. All phase one Pacific interviews were open-ended and conducted in person, using an interview guide based on themes identified by a Steering Committee as part the lead *Evaluation* (see Barnett et al., 2009:19 for details).

A second phase of Pacific interviews took place between 2006 to early 2008. Qualitative data from these interviews captured PHO experiences arising from the additional rollout funding to Interim PHOs for those aged 18-24 years (July 2005); 45-64 years (July 2006); and those aged 25-44 years (July 2007).

Phase two Pacific interviews also captured experiences arising from the introduction of Care Plus, PHO Performance Payments, VLCA and Zero Fees for Under 6s funding. All Phase two Pacific interviews were conducted in person using a semi-structured schedule based on themes identified from interviews and quantitative findings from previous phases of the lead *Evaluation* – including phase one of the Pacific interviews.

Phase three of the interviews during 2008-2010 reported trends in the Pacific and Access PHOs experiences in relation to the implementation and subsequent review and refinement of their initial establishment plans, looking towards the future. Pacific interview participants from all phases received a gift on behalf of their PHO for their participation.

In addition to data from the lead evaluation, this report has also considered other studies and quantitative information relating to Pacific peoples and primary health care (both pre- and post-PHCS).

Aims and Purpose of the Qualitative Evaluation

This qualitative evaluation is based upon an inductive approach to develop and verify ideas through systematic collection and analysis of the data relevant to the thirteen themes initially identified for the project. One of these themes was the PHO partnerships with Pacific peoples (Project Plan, 2004). Specifically a 'snap shot' of day to day experiences of the implementation of the Primary Health Care Strategy within the Pacific PHOs were sought.

A second aim of the qualitative interviews was to inform the design of a nationwide postal survey. The intention was to allow the quantitative findings to be contextualised by reference to the views and experiences of those working within the PHOs (Cumming et al, 2005).

Recruitment of Participants

A fact sheet inviting participation was sent to all PHOs and practices outlining the aims and objectives of the evaluation. The PHO participants were asked to meet the interviewers for approximately an hour to discuss the initial positive response to the Primary Health Care Strategy and the changes needing to address any concerns about its implementation. It was made clear that participation was voluntary, that all information provided by individuals and practices would remain confidential to the researchers and that no individual or organisation would be identifiable within the final report or subsequent publications.

From this letter and fact sheet, Pacific-led PHOs and PHOs with high Pacific resident populations (hereafter, Pacific PHOs) were followed up to negotiate participation in this part of the evaluation.

In phase one of the interviews, two Pacific PHOs agreed to participate and six individuals were interviewed. The relatively small number of PHOs identified at stage one of the project reflects the fact that many PHOs had not been established or were just establishing their services by 2004-5.

In phases two and three, four Pacific PHOs in total agreed to participate and eleven individuals were interviewed in total. One of the Pacific PHOs declined to participate due to time commitments as they were dealing with the grief and loss of residents' family members following the Tsunami in Western Samoa when approached to participate initially. During the third phase this PHO was again approached and declined to participate due to commitments surrounding EOI negotiations.

The Interviews with PHO Providers, Managers and Board Members

The first series of semi-structured interviews were conducted during 2003-05 following ethical approval of the wider project. Follow up interviews were held in 2006-08 and a third phase were conducted during 2008-10. PHOs were selected to represent the range of sizes, structures and geographical locations of PHOs nationwide in the wider study. The Pacific PHOs were defined by their geographic location and the composition of the enrolled patient population as detailed in earlier chapters. The Pacific-led PHOs were defined as being those PHOs comprising high numbers of residents who were self identified as Pacific, with Pacific leadership. Each PHO meeting these criteria was approached to discuss the project and to gauge interest in participation. Following an initial contact by telephone an information sheet and consent form was sent to each individual who agreed to participate.

Interview Guide

The qualitative interviews began with inquiring about the role of each participant and how long they had been involved in the PHO. From these introductory questions, the structure of the PHO including governance and relationships between providers within the PHO and amongst other providers in the PHO network were explored in detail using questions to prompt where necessary. The development of the relationship between the PHO, DHB, community and Ministry of Health since the establishment phase, were other topics explored to ascertain how these relationships had evolved over time. Any difficulties in the relationships with any of these groups were then followed up.

The second part of the topic guide asked about the sorts of fees being charged within practices, how difficult this had been to sustain, and if there had been additional pressure to increase as the costs of delivery increased.

The third section of the interview schedule addressed the topics of improving, maintaining and restoring health, and co-ordinating care across services. The health promotion and educational programmes rolled out within the PHO for the resident population, how this was working in practice and what made the PHO's services culturally appropriate or safe were inquired about.

The fourth section of the interview schedule dealt with how the community representatives were chosen, how they provided feedback from the communities they represented, and how the geographical spread affected representation within the PHO interviewed.

Fifth, the recruitment and retention of healthcare providers, the implications for the expanded role of nurses and the multi-disciplinary team in relation to Care Plus, were addressed.

Last, the role of the Strategy in relation to reducing Pacific health inequalities in illness management and health outcomes were inquired about from the participants' roles and experiences within the PHO structure.

Interview Process

Each interview was conducted in person at the PHO or at the HSRC offices in Wellington and took around an hour to complete depending on the time the participant had available. The topic guide for the interviews was informed by the wider PHO evaluation and guided by the first phase of the interviews with the Pacific PHO stakeholders. The interviews aimed to provide a summary of the views and experiences of those individuals who worked within the PHOs over this time frame (Evaluation of the Implementation and Intermediate Outcomes of the Primary health Care Strategy, First Report, 2005). Individual interviews were held with representatives from the managers of Pacific PHOs (CEOs, programme managers and board members), administrators and co-ordinators and clinical team leaders and health providers (nurses, general practitioners and community workers). Each interview was audio-taped and transcribed verbatim. The transcripts were reviewed by the team of Pacific researchers who were involved in the interviewing of the participants.

Data Analysis

All Pacific interviews were recorded and transcribed in line with the confidentiality agreement. A thematic analysis of the transcripts was conducted by the researchers and subsequently peer-reviewed. Thematic analysis is a method of identifying patterns within data in which there are a number of instances of the same theme within a data set (Braun and Clarke, 2006 p. 82).

The data were analysed for emergent trends using the topic guide as a lens by which rich description in each area of the daily life within a Pacific PHO, was reported. Themes or patterns within the data were identified using inductive reasoning which means the themes were linked to the data themselves but were not prescribed by the pre-existing coding framework or the researchers' interests or frames of reference (Patton, 1990). The process is similar to a grounded theory approach but differs in that the broader implications of the patterns are analysed for significance in the process (Patton, 1990) and in relation to the wider PHO evaluation reports (Cumming et al., 2005; Cumming and Gribben, 2007; Raymont and Cumming, 2009; Croxson, Smith, and Cumming, 2009; Barnett et al., 2009; Smith and Cumming, 2009, Raymont et al, 2010).

A further frame of analysis used to interpret the findings was the key goals and directions identified for the PHCS (Cumming et al, 2005). Particular attention was given to the participant's understanding of the Pacific Health and Disability Action Plan. At the time of writing, this report has been supplanted by 'Ala Mo'ui': Pathways to Pacific Health and Well-being 2010-2014 (Minister of Health and Minister of Pacific Island, 2010). As a consequence, particular attention was paid to models of care for Pacific patients and the role of caring for patients un-used to communicating in English (Cumming et al, 2005).

The Stages of Data Analysis

The phases of thematic analysis involve moving backwards and forwards between the entire data set and coded extracts of the data (Braun and Clarke, 2006). These phases include:

- Transcription of verbal data.
- Familiarisation with the data through reading and re-reading transcripts.
- Generating initial codes and grouping these together to form themes.
- Searching for relationships and patterns amongst themes.
- Reviewing themes/sub-themes.
- Defining and naming the themes.
- Writing up the report (Braun and Clarke, 2006 pp. 86-93).

Following transcription of the audiotapes and checking for accuracy of the data, the interview transcripts were read and re-read for common ideas. An initial list of ideas about initial themes was developed. Out of this list a number of sub-themes were identified and categorised. These themes and sub-themes were peer reviewed for relevance in relation to the original transcripts and looked at alongside the interview schedules. The emerging data from the quantitative results from the evaluation were triangulated with the codes and key words from the qualitative interviews by the original research team and several external research consultants.

Thus key words and codes were developed into themes and sub-themes as the relationship between the themes and the sub-themes were tested for relevance against the data set as a whole and within particular phases of interviewing. Direct quotations from interview participants were used to justify the various themes that had been identified.

The themes that had been identified from the interviews provided a further framework for analysing the quantitative findings that were later reported (Raymont et al, 2010).

The findings of the qualitative themes from the in-depth interviews with participants in the Access and Pacific-led PHOs are reported in chapter six of this report.

4. PACIFIC PEOPLES IN NEW ZEALAND

4.1. PACIFIC POPULATION DEMOGRAPHICS

There are more than 22 different Pacific communities living in New Zealand, each with its own distinctive culture, language, and history, although, there are some underlying commonalities (e.g. strong links within extended families) between Pacific communities (Ministry of Health 2008b). There were 265,974 people who identified as being Pacific in the 2006 Census – representing 6.9 percent of the total New Zealand population. This was an increase of 15 percent (34,173 people) since the 2001 Census (Statistics New Zealand, 2007)¹.

The six largest Pacific groups in New Zealand are Samoan, Cook Island, Tongan, Niuean, Fijian and Tokelauan (as shown in Table 1); with Fijians experiencing the largest growth (40 percent increase) between 2001 and 2006 (Statistics New Zealand, 2007).

Table 1: Pacific ethnic group populations, total counts 1996-2006

Pacific Group	Ethnic	1996	2001	2006	Change 2001-2006
Samoan		101,754	115,017	131,103	16,077
Cook Island		47,016	52,569	58,011	6,522
Tongan		31,392	40,716	50,478	9,765
Niuean		18,474	20,148	22,476	2,322
Fijian		7,698	7,041	9,864	2,820
Tokelauan		4,917	6,204	6,819	624

Note: These figures include all people who stated one or more Pacific ethnic groups in response to the ethnicity question of the 2006 Census (ie Total Response output). Some of these people may also belong to other ethnic groups or more than one Pacific ethnic group.

Source: Callister and Didham (2008).

The Pacific population is highly urbanised, with about 92 percent residing in areas containing populations of over 30,000 people (Ministry of Social Development, 2009). In 2006, the majority of the New Zealand Pacific population lived in the North Island, with approximately two thirds of all Pacific people residing in the Auckland region (Statistics New Zealand, 2007).

The Pacific population is youthful in structure, with a median age of 21.1 years in 2006, compared to the median age of the Total New Zealand population (35.9 years). The number of older Pacific people is increasing, with those aged over 65 years making up 4 percent of Pacific peoples in 2006; although the proportion of those aged over 65 years was still lower than the Total New Zealand population (12%)(Statistics New Zealand, 2007).

¹ The New Zealand resident Pacific population fluctuates around the Census population number because the population is transnational. Pacific people retain important ties to their country of origin and/or ancestral land. They are continually moving between Pacific nations and many Pacific people provide financial support for extended families living in Pacific Islands (see Bedford, 2008; Callister and Didham, 2008).

The New Zealand Pacific population is undergoing significant demographic and socioeconomic change, which will likely impact future health policy-making decisions. The proportion of New Zealand-born (NZ-born) Pacific peoples increased from 38% in 1976 to 60% in 2006 (Callister and Didham, 2008). Niueans, Cook Island Maori and Tokelauans had the highest proportion of NZ-born people (74.1%, 73.4%, and 68.9% respectively); and, in these three Pacific subgroups, there are substantially more people living in New Zealand compared to their respective Pacific nations (see Table 2, and Callister and Didham, 2008). To some extent, the higher proportions of Niuean, Cook Island Maori and Tokelauan New Zealand residents reflects the special status of the citizens of these nations - all hold New Zealand citizenship and unrestricted rights of entry to and settlement in New Zealand.

Table 2: Percentage of each Pacific group who were born in New Zealand, total counts, 2006

Pacific Ethnic Group	Percentage New Zealand Born (%)
Niuean	74.1
Cook Island	73.4
Tokelauan	68.9
Samoan	59.7
Tongan	56.0
Fijian	43.6

Note: These figures include all people who stated one or more Pacific ethnic groups in response to the ethnicity question of the 2006 Census (ie Total Response output). Some of these people may also belong to other ethnic groups or more than one Pacific ethnic group.

Source: Callister and Didham (2008).

Related to the subtle differences in the proportions of each Pacific subgroup’s NZ-born population, a certain degree of heterogeneity within the Pacific population is emerging as a significant issue to consider. There are subtle differences between various Pacific subgroups, in the extent to which aspects of ‘Pacific culture’ seem to have been retained. For example, in the last Census substantially lower proportions of Cook Island Maori (16%) and Niuean (25%) spoke their language compared to Samoan (63%) and Tongan (61%). Similarly, lower proportions of Cook Island Maori and Niuean reported having a religion compared to Samoan and Tongan populations; and ethnic intermarriage was much higher among Niuean and Cook Island Maori (Blakely et al. 2009).

These demographics suggest Pacific subgroups may be acculturating at different rates. Acculturation is the process of acquiring, adapting to, or adopting a second culture, occurring when two distinct cultural groups have continuous first-hand contact (Ministry of Health 2008e). These subtly different demographics imply the underlying health beliefs, and the needs and expectations of a quality health service could differ between Pacific subgroups. Some of the DHB’s more recent Pacific health needs assessments are recognising these differences between Pacific subpopulations (eg Novak 2007).

In addition to the increasing proportion of NZ-born Pacific people, the number of Pacific children with parents from more than one ethnic group has increased, resulting in an increasing number of Pacific people identifying with dual or multiple ethnicities. Over half (54 percent) of Pacific children born between 2000 and 2004 had more than one ethnicity; and almost a quarter (23 percent) had more than one Pacific ethnicity (Callister and Didham 2008).

This increase in the number of Pacific identifying with dual or multiple ethnicities has implications for future policy-makers allocating resources on the basis of mutually exclusive ethnic group membership. Although most population surveys (eg the New Zealand Health Survey) have now adopted Total Response² ethnicity as an output measure, information from some national health data collections continue to be published using a Prioritisation method devised in the mid-1980's; whereby those who identify with more than one ethnic group, are allocated to a single ethnic group – with Maori having first allocation priority, followed by Pacific, Asian, Other, Other European, then NZ European.

Prioritised datasets have greater impact upon young Pacific people who are increasingly identifying with multiple ethnicities. Didham (2005) showed, as early as in 2001, that almost one third of children (29.5%) under 15 years with Pacific and Maori ethnicities would be counted *only* as Maori using the Prioritisation technique; effectively biasing the data and the conclusions that policy-makers can draw.

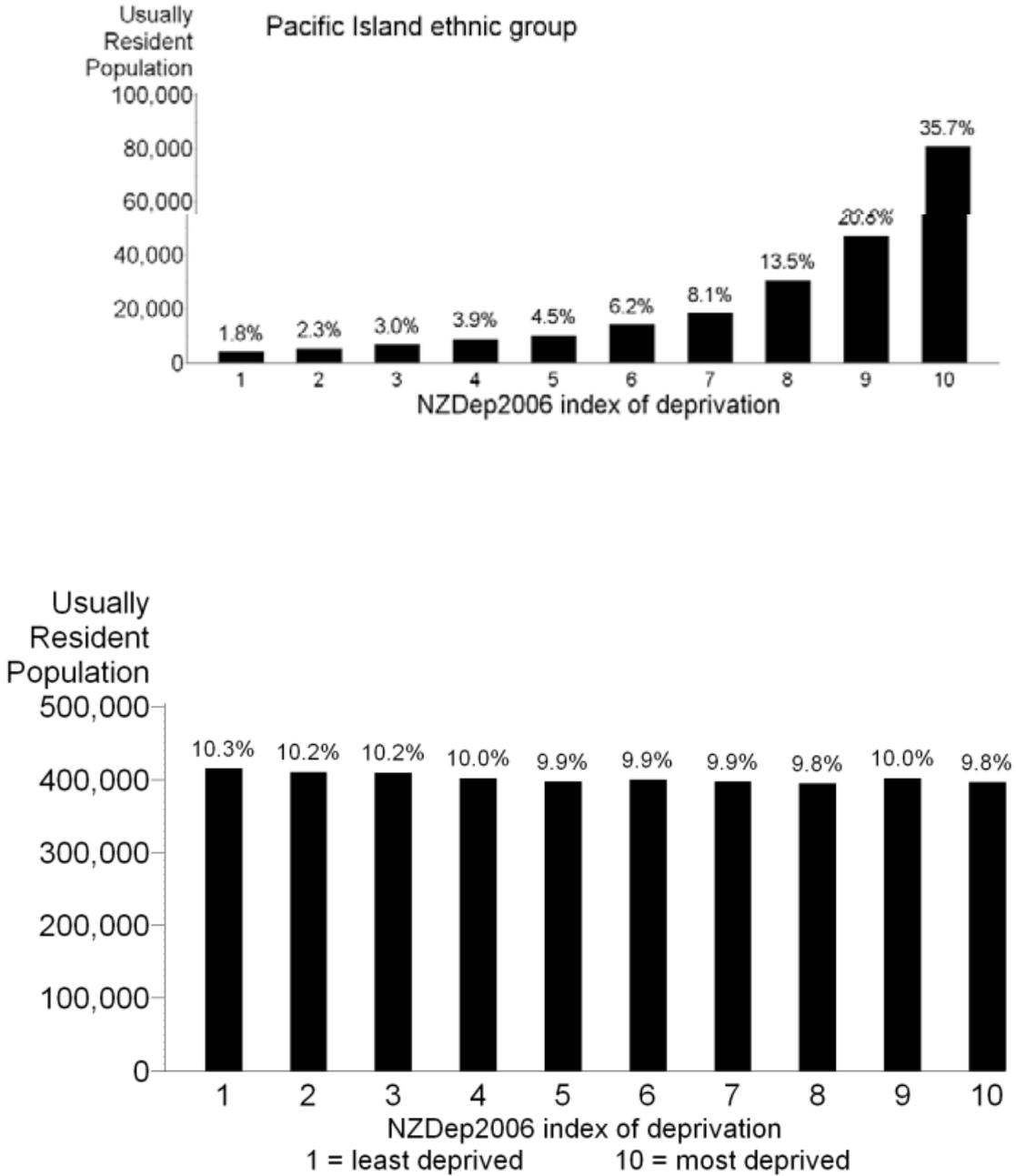
Recent longitudinal evidence suggested younger people who identify as being Pacific, Maori or Asian ethnicity, and those reporting belonging to more than one ethnic group in the first year, were the strongest predictors of respondents changing their self-identified ethnicity by the third year (Carter, Hayward, Blakely, & Shaw, 2009). Carter et al.'s (2009) study is an example of the burgeoning body of evidence which raises the issue of the fluidity of one's ethnic identity (ethnic mobility) – both over time and across contexts - for policy-makers to consider when developing culturally appropriate primary health services (see Callister, Didham, and Kivi, 2009 for a comprehensive review).

4.2. PACIFIC PEOPLE'S SOCIOECONOMIC STATUS

Pacific (and Maori) peoples are disproportionately represented in the most deprived areas of the country. Approximately 36 percent and 21 percent of Pacific peoples resided in deciles 10 and 9 NZDep2006 areas at the time of the previous Census (White et al. 2006). The majority of Pacific students (61%) attend low decile schools (deciles 1 to 3) - the highest of any ethnic group in this decile band (Ministry of Education, 2008).

² Total Response methods count each of the ethnic groups the respondents identify with. People with responses that fall into more than one ethnic group (eg Maori and Pacific), are counted in each of the groups – meaning the sum of all ethnic groups is greater than the total number of respondents.

Figure 1: NZDep2006 profile of Pacific Island Ethnic Group p.23.



Source: Atlas of Socioeconomic deprivation in New Zealand NZDep2006 p.3

Pacific peoples are more likely, than those in the total New Zealand population, to fall within the lower income bands, although some of this is explained by the youthful structure of the Pacific population (Statistics New Zealand 2007). Pacific people’s employment rate has recently fallen (to 62.4%); and has been the lowest of all ethnic groups since 2007. In June 2008, the median hourly earnings for wage and salary earners, was the lowest for Pacific adults (\$15.40) compared to all other ethnic groups in the New Zealand population, although, there has been a 14 percent increase in the Pacific median hourly earnings over the previous 11 years (Ministry of Social Development 2009).

There are differences between Pacific male and female occupations. In 2006, Pacific men were most often employed as labourers, machinery operators/drivers, and technicians and tradesmen; whereas Pacific women were most often employed as clerical/administrative workers, professionals, or community and personal service workers (Statistics New Zealand 2007).

Since 2007, Pacific people have made progress in some educational areas. Pacific children's participation in early childhood education increased by 24 percent between 2002 and 2008, although, Pacific continue to have the lowest participation levels of all ethnic groups. In 2008, 84 percent of all Pacific school leavers had achieved NCEA level 1 literacy and numeracy requirements; 63 percent left with NCEA level 2 or above; and 23 percent achieved university entrance standard (Ministry of Education 2008).

4.3. PACIFIC PEOPLE IN THE HEALTH WORKFORCE

It is recognised that there is a low representation of Pacific peoples across the health sector (Ministry of Health 2004a). Recent information collected on the DHB health workforce indicated Pacific peoples comprised 3 percent, the majority of whom were the care and support workers (eg community health workers, youth workers, residential carers). Pacific doctors made up only 1 percent of the total health workforce (DHBNZ 2008).

Pacific participation in the science subjects required for entrance into tertiary medical qualifications is low, although, recent funding has been allocated to increase Pacific participation in these subjects, to increase the growth of the Pacific health workforce (Ministry of Health 2009b).

The Pacific Health and Disability Workforce Development Plan was developed to help increase the numbers of Pacific health workers, in order to better meet the health needs of Pacific peoples. The Plan, although having not been formally evaluated yet, had four underlying goals designed to ensure the needs of Pacific peoples could be met: increasing the capacity and capability of the Pacific health and disability workforce; promote Pacific models of care and cultural competence; advance opportunities in the Pacific health and disability workforce; and improve information about the Pacific health and disability workforce (Ministry of Health 2004a).

4.4. PACIFIC PEOPLE'S HEALTH STATUS

There is a small, but growing, body of literature and research on the health status of Pacific people in New Zealand. The chronic disease burden is particularly high, with higher prevalences of ischaemic heart disease, stroke, diabetes, and chronic obstructive pulmonary disease (Ministry of Health and Ministry of Pacific Island Affairs 2004; Ministry of Health 2008b).

The prevalence of diabetes among Pacific peoples is high. Age-adjusted prevalences of diagnosed diabetes, reported by Pacific men and women, were 3 times the prevalence of diagnosed diabetes reported by men and women in the total population (Ministry of Health 2008c). Cardiovascular disease mortality rates are significantly high, particularly among Pacific men, whose rates are about twice as high in middle age than those of the total population, and are higher than Pacific female rates for all age groups (Ministry of Health 2007c).

Pacific stroke event rates, in an Auckland regional study, were shown to have increased about 66 percent from 1981 to 2003, and this was associated with corresponding declines in stroke rates among the NZ European population (Carter et al. 2006). It should be noted, however, there were wide errors associated with this estimate (ie the stroke rates increased by between 11% and 225%) due to the methods of data collection (Blakely et al. 2007).

The *Tracking Disparities* report examined ethnic differences in mortality rates from 1981-84 to 2001-04. Age-adjusted all-cause mortality rates had fallen for all ethnic groups (aged under 75 years) throughout the study period, but Pacific people experienced the smallest decrease - 14 percent for Pacific males and 10 percent for Pacific females. Pacific all-cause mortality rates were still intermediate between Maori and European/Other, but the rates are closer to the Maori rates, especially among Pacific males. Over a third of the Pacific:European/Other mortality disparity was due to cardiovascular disease; and 'other' causes of death – a category which includes type 2 diabetes – made about a 40 percent contribution to the disparity (Blakely et al 2007).

Pacific peoples show health risk behaviours, and have a higher presence of risk factors, for the chronic conditions they experience. Pacific children and adults have high prevalence rates of obesity³ – shown in the most recent NZ Health Survey to be 2.5 times higher for Pacific adults and children compared to the Total population's adult and child rates of obesity. The prevalence of obesity nearly doubled between Pacific children aged 2-4 years and Pacific children aged 5-9 years (Ministry of Health 2008c; Ministry of Health 2009c). Pacific peoples also have a higher prevalence of Metabolic Syndrome – a syndrome characterised by the presence of at least three cardiovascular risk factors (large waist circumference, high triglyceride concentration, low HDL concentration, raised blood pressure, and high fasting glucose) (Gentles et al. 2007).

Related to the high prevalence of obesity, healthy nutrition is an issue for Pacific people. Pacific children in the NZ Health Survey were less likely to eat breakfast before going to school, and had higher fizzy drink and fast food consumption patterns over the previous 7 days before the survey (Ministry of Health 2008c). Similarly, Pacific adults are less likely to consume the recommended daily intake of vegetables (3 or more servings) every day compared to the Total NZ population, although, they are equally as likely to consume the recommended daily fruit intake (Ministry of Health 2008c). The Pacific Obesity Prevention In Communities (OPIC) project found that a large proportion of New Zealand Pacific students (aged 12-18 years) use the school canteen as their primary source of lunch (Utter et al. 2008).

Smoking is a major contributor to the increasing incidence and prevalence of lung cancer, heart disease, stroke and respiratory disease among Pacific people. Pacific people (31%) were more likely to be current smokers compared to the total population in 2008 (Ministry of Health 2009d).

Second hand smoking, as well as living conditions (eg poorly insulated, damp, overcrowded housing), is implicated in high rates of respiratory infections among Pacific children and adults. Pacific children also have significantly higher incidence rates of acute rheumatic fever (ARF) – approximately 20 times the rate of NZ European/Other children in New Zealand (Jaime et al. 2008; Ministry of Health 2008d).

³ Obesity was defined as having a Body Mass Index (BMI) of 30kg/m² or above. Internationally recommended cut-off points were used for adults (World Health Organisation BMI cut-off points) and children (International Obesity Taskforce BMI cut-offs) (Ministry of Health 2008c). Elevated obesity rates as for Pacific as a risk factor for cardiovascular disease is supported by the higher waist-circumferences seen among Pacific adults (see the online tables at: www.moh.govt.nz/moh.nsf/indexmh/portrait-of-health).

4.5. DIVERSITY OF PACIFIC PEOPLE'S HEALTH STATUS

Recent evidence suggests diversity in health status exists between Pacific peoples in New Zealand. One Official Statistics Research study used Census data linked to mortality data (from the New Zealand Census Mortality Study) to estimate mortality rates among the four largest Pacific groups (Samoan, Cook Island Maori, Tongan, and Niuean). Results showed clear differences in the cardiovascular disease (CVD) mortality rates between the Pacific groups. The CVD mortality rates for Cook Island Maori was the highest - at 1.66 (1.26 to 2.13) times greater than the Samoan rate. The Niuean rate was also slightly higher (1.11 times greater; 0.72 to 1.58) compared to the Samoan CVD rate, but the Tongan rate was not significantly different from the Samoan rate (Blakely et al 2009).

The finding that Cook Island Maori and Niuean CVD mortality rates are higher than Samoan and Tongan rates is further supported by other streams of research. The New Zealand Mental Health Survey found, for example, that mental illnesses were more prevalent in Cook Island Maori peoples, and slightly less prevalent in Samoan and Tongan groups. Although the findings did not reach significance, due to small numbers, the patterning was similar between the Pacific subgroups for each mental illness in the survey (Oakley Browne et al. 2006).

Similarly in a recent needs assessment in Counties Manukau – the city with the highest Pacific population in New Zealand – it was acknowledged that Pacific Cook Island Maori were more similar to Niuean on many indicators of culture and health; and Samoan were more similar to Tongan. Samoans and Tongans, for example, were less likely to have been born in NZ, more likely to speak their Pacific language, more likely to live in overcrowded housing, less likely to use home heating, and more likely to have larger families compared to Cook Island Maori and Niuean peoples. Childhood respiratory-related hospitalisation rates (e.g. acute bronchiolitis, pneumonia and other respiratory infections) for were higher for Samoan and Tongan compared to Cook Island Maori and Niuean (Novak 2007).

Some emerging evidence suggests that other indicators of health status and health risk behaviours may differ between Pacific people, depending on how long they have been living in New Zealand.

4.6. INDICATORS OF HEALTH CARE QUALITY FOR PACIFIC PEOPLES

Pacific peoples experience a relatively high rate of avoidable mortality. Avoidable mortality refers to causes of death occurring under age 75 years that are potentially preventable, or treatable, given the current understanding of causation and available health care technologies. Avoidable mortality also includes deaths from causes that could have been prevented by addressing determinants external to the health care system (eg socioeconomic status) (Ministry of Health and Ministry of Pacific Island Affairs 2004).

Amenable mortality is a subset of avoidable mortality, reflecting *only* those deaths that should not have occurred given the availability of health care technologies – including health prevention. Amenable mortality, therefore, is an indicator focused on the effectiveness of care for populations (Tobias and Yeh 2009). Table 2 shows amenable mortality rates were high for Pacific (and Maori) people in 2001-04 (Blakely et al 2007).

Table 2: Amenable mortality, rate per 100,000 population aged 1-74 years, by sex and ethnicity 2001-04

	Pacific	Maori	Asian	European/Other
Female	110 (93-127)	141 (129-154)	31.8 (23.9-39.7)	60.5 (58.1-63.0)
Male	131 (111-151)	166 (151-180)	50.9 (39.9-61.9)	70.6 (67.9-73.3)

Source: Blakely et al 2007

Pacific trends in amenable mortality, estimated in the *Tracking Disparities* report, provide cause for concern for health policy makers. Unlike in other ethnic groups, Pacific amenable mortality declined relatively little, if at all, over the 1981-84 to 2001-04 study period; whereas, for Maori, the decline in amenable mortality was more marked from 1996-98 to 2001-04, especially among Maori males. Pacific male amenable mortality rates decreased only slightly, whilst Pacific female amenable mortality rates actually increased by 12 percent over the study period (Blakely et al 2007; Tobias and Yeh 2009).

A recent article used Pacific amenable mortality rates to estimate the *proportion of Pacific all-cause mortality due to health care*. Researchers found that amenable mortality made a substantial contribution to the disparities in all-cause mortality between Pacific and NZ Europeans (26% and 34% of the gap for males and females) (Tobias and Yeh 2009). The reason that Pacific peoples have benefited the least of all ethnic groups in New Zealand from available health care technologies is unclear; and warrants further investigation into quality of care and cultural safety issues (Tobias and Yeh 2009).

Another indicator that partly reflects effectiveness and access to health care is ambulatory sensitive hospitalisation – that is, the hospitalisations of people aged less than 75 years from conditions sensitive to interventions delivered through primary health care. Ambulatory sensitive hospitalizations could, therefore, potentially have been avoided (Ministry of Health and Ministry of Pacific Island Affairs 2004).

Pacific peoples experience high rates of ambulatory sensitive hospitalisations, suggesting primary care is less effective, or not reaching, Pacific people. The ambulatory-sensitive hospital admission rate for Pacific people was 1.9 times and, for Maori 1.67 times, that for European/Others between 2000/01 to 2005/06. During this time period, ambulatory-sensitive hospital admission rates declined for non-Maori non-Pacific (ie, 'Other') people; but rates have remained the same, or increased slightly, for Pacific and Maori (Ministry of Health 2008b). Pacific children have very high rates of ambulatory sensitive hospitalizations, most notably for asthma and respiratory infections (Ministry of Health 2008d).

In the next chapter the implications of these demographic trends for Pacific peoples will be drawn in relation to the primary health care strategy.

5. PACIFIC PEOPLE AND PRIMARY HEALTH CARE

5.1. PRIMARY CARE SERVICE UTILISATION AND ISSUES FACED BY PACIFIC PEOPLE

There is a small body of studies investigating Pacific people's access to, and utilisation of primary care services. Most studies place particular emphasis on barriers, experienced by Pacific peoples, that prevent them getting access to care. Access to care has traditionally been measured in terms of entry into the system, for example, by using enrolments or consultation rates as proxy measures of service utilisation.

Although there is a dearth of in-depth information on Pacific utilisation of primary health care services in New Zealand, much of it suggests Pacific peoples utilise primary health care services at a lower rate compared to other New Zealanders (Crompton et al 2007; Davis et al 2005; Pacific Health Research Centre 2003). The recent New Zealand Health Survey 2006/07 suggests that Pacific peoples have available access to primary health care, but may encounter barriers to utilising that care. For example, after adjusting for age, Pacific adults were equally likely as adults in the Total NZ population to have a primary health care provider they go to when first feeling unwell. However, Pacific men and women were also significantly more likely, than men and women in the total adult population, to report an 'unmet need' for GP services in the past 12 months – that is, they needed to see a GP in the previous 12 months but were unable to for any reason (Ministry of Health 2008d).

Utilisation of other services delivered in the primary care setting was also shown to be low in the NZ Health Survey. Pacific women aged 20-69 years, for example, were less likely than the Total female population to have had a cervical smear in the last 3 years; and Pacific women aged 45-69 years were less likely than the Total female population to have had a mammogram in the previous 2 years (Ministry of Health 2008d).

The barriers to care, faced by Pacific people, play different roles and are interrelated in a complex fashion. Service cost is an important barrier to care, and much emphasis has been placed on reducing fees throughout the implementation of the Strategy (Croxson et al. 2009).

However, there are other barriers to consider as explanatory reasons for Pacific people's low use of services. The evaluation report on the Reducing Inequalities Contingency Fund (RICF) initiatives found, for example, that Pacific people often had problems with appointment times, getting to the service location, and understanding the nature and necessity of the appointment (CBG Health Research Ltd 2006). Some of the more documented barriers to care for Pacific peoples are described below.

Cultural discomfort

For Pacific peoples, it is recognised that access to care should also be considered in terms of whether the care is culturally appropriate and effective (Barwick 2000; Ministry of Health 2008b). Unfamiliarity or cultural discomfort can act as a barrier preventing Pacific peoples accessing some health services (Pacific Health Research Centre 2003; Ministry of Health 2008b). There is evidence, for example, indicating some Pacific people (and Maori) feel unwelcome and uncomfortable in the traditional primary care setting; and this acts as a barrier to their accessing the services (CBG Health Research 2005). Similarly, some Pacific people find it difficult to discuss their personal and health problems with a health provider from a different ethnic group (Tukuitonga 1999; Ministry of Health 2008b).

Related to the theme of cultural discomfort, some Pacific people have reported experiencing discrimination (because of their race) by a health provider. In a recent analysis of the Racism module from the New Zealand Health Survey 2006/07, a small proportion of Pacific peoples (5.8%; CI=3.5-8.1) reported experiencing unfair treatment (e.g. being treated differently, or kept waiting) by a health professional because of their ethnicity (Harris et al 2006).

Cultural competence – the capacity of the health system to improve health and wellbeing by integrating cultural practices and concepts into service delivery – is recognized as an important tool for addressing the cultural barriers to accessing care experienced by some Pacific people (Ministry of Health 2008e). There are some Pacific initiatives in New Zealand that have recognized the importance of integrating aspects of Pacific culture into their service delivery models. These cultural aspects include, for example, the provision of on-site bilingual health workers; recognizing the Pacific family as the core of the health; and delivering services in locations closer to the Pacific community (eg churches) (Ministry of Health 2008e) .

It is important to emphasise that, although some Pacific people feel more comfortable discussing health issues with other Pacific health workers, there are other Pacific people who will feel more comfortable seeking care from a non-Pacific health worker. For example, some younger Pacific people avoid using Pacific providers or Pacific staff in services for fear that, due to the close-knit nature of the Pacific community, their confidentiality might be breached (CBG Health Research Ltd 2005; Ministry of Health 2008b).

As the previous chapter pointed out, Pacific people's cultural identities are increasingly diversifying as various Pacific subgroups undergo acculturation in New Zealand. It is likely that a uniform 'one-size-fits-all' approach to health care will not meet the needs of all Pacific peoples, and multiple approaches (including services tailored to meet youth needs and Pacific subgroup needs) will need to be recruited to ensure the variety of cultural barriers experienced by the Pacific population are addressed effectively (Ministry of Health 2008b; Ministry of Health 2008e).

Language

Language can present communication challenges which act as a barrier to accessing care for some Pacific people. Communication barriers can significantly affect the quality of care the patient receives. Misunderstandings about patient symptoms can, for example, result from communication issues, and this may affect diagnosis, or patient understanding of the use of prescribed medicine.

Language is especially an issue for Pacific-born individuals, many of whom speak English as their second language (Tukuitonga; National Health Committee 2007; Ministry of Health 2008b). Language is also more likely to be a barrier for Samoan and Tongan, and less of an issue for Cook Island Maori and Niuean, because lower proportions of Samoan and Tongan are NZ-born, and higher proportions of Samoan and Tongans living in New Zealand still speak their Pacific language (Statistics New Zealand 2007; Novak 2007).

Transport

Transport has been identified as a significant barrier to accessing primary care for Pacific people. Transport is not only needed for travelling to primary care, but is also needed for any secondary referrals and hospital appointments. Some recent initiatives adopted by providers have included the provision of an outreach nurses and transport services, although, these services are often costly for single providers to cover (Pacific Health Research Centre 2003; CBG Health Research Ltd 2005).

Pacific people's uptake of entitlements

Pacific people can be unaware of the support and services available to them from government agencies and health providers (Ministry of Health 2008b). The National Primary Medical Care (NatMedCa) Survey 2001/02, for example, found that only three quarters of their Pacific sample living in the most deprived areas had some form of health concession card (Davis et al. 2005). Similarly, recent information from the primary care database showed just over a third (35%) of Pacific peoples enrolled with PHOs in the highest deprived areas (NZDep quintile 5) had a Community Services Card (Ministry of Health, personal communication 2009). Some of the low uptake may be partially explained by the youthful structure of the population.

Pacific people's health care experiences: Doctor-Patient interactions

There is some evidence to suggest that aspects of health consultations may be different for Pacific peoples. For example, the NatMedCa Survey 2001/02 described Pacific patterns in primary health care from information provided by their private GP, or local community-based doctor. The information collected captured characteristics of providers and their practices, the patients they see, the problems presented and the management offered. Results showed GPs (most of whom were private GPs) were less likely report having had high rapport with Pacific patients (54.8 percent compared with 68.7 percent for patients drawn from the entire sample), although it is unclear whether the differences in rapport score reflect difficulties associated with consulting through of a third person because a large portion of the Pacific patients were children, and some older people; so the likelihood that a caregiver was present in the consultation was high (Davis et al 2005).

The NatMedCa survey also showed fewer tests and investigations were conducted for the Pacific patients (17.8 percent for Pacific compared with 24.9 percent for the whole sample). The length of the visit for Pacific patients was also shorter (11.9 minutes on average, against an overall sample average of 14.9); and Pacific patients had a lower rate of referral to specialists than the total surveyed (10.2 percent versus 15.8 percent). Again, it is unclear whether this finding is due to the young age of the Pacific sample (half were aged under 25 years), and the correspondingly different health problems presented to the GPs by the Pacific sample. Short-term acute problems, particularly respiratory infections, were predominant among the Pacific sample, and there was a correspondingly higher rate of prescribing (of mostly anti-infectives) for the Pacific sample (Davis et al. 2005).

One notable finding from the NatMedCa Survey was that Pacific patients attending community-based not-for-profit providers received higher levels of service than those at private GPs. At the community-based providers visits lasted longer, more treatments were provided, and referral rates were higher (Davis et al. 2005). This finding may reflect differences in the business models of the providers (the private GPs saw more patients on average which results in more revenue if the patient co-payments are relatively high).

Ideally, there would be more qualitative research conducted on Pacific patients and their interactions with GPs and primary care providers, to more clearly identify the reasons for the patterns seen in the NatMedCa Survey.

5.2. PACIFIC-LED PRIMARY CARE IN NEW ZEALAND

Making available health care workers from the same ethnic group as populations facing barriers to access of health services is often seen as an effective strategy for improving their access, particularly Community Health Workers, who have the trust and respect of their local communities; and can facilitate access to other health professionals and health services (Barwick 2000).

The growth of Pacific-led (pacific-governed) health services is one mechanism by which Pacific health workers have been made available to Pacific communities. As early as 1989, the first Pacific-led (or “by Pacific for Pacific”) primary health care service was established - West Auckland Pacific Island Health Fono - Pasifika Healthcare. This was followed, in the 1990s, with the establishment of additional Pacific clinical practices and health service providers; most of whom were located in the Auckland region. These Auckland regional Pacific-led providers included: Langimalie Health Centre (a Tongan led organisation in Onehunga and later also in Glen Innes), South Seas Health (Otara), and Pasifika Fono (West Auckland). Health providers were also established in other areas in New Zealand, such as K’aute Pasifika in Hamilton and Pacific Trust Canterbury in Christchurch (Ministry of Health 2003a).

The majority of these providers were not-for-profit organisations who had their origins in Pacific community or church groups. Many of the organisations experienced difficulties largely due to a lack of capacity in business management and governance, and clinical workforce shortages. However, the use of a model of strong community involvement in planning and service delivery, extended operating hours, health workers able to speak different Pacific languages, and reduced consultation fees, was positively received by many members of the community (Ministry of Health 2003a).

In 2000/01, the Government established the Pacific Provider Development Fund (PPDF) to support the development of not for profit ‘by Pacific for Pacific’ services as a response to the health needs and inequalities experienced by Pacific peoples. The PPDF aimed to increase the number of appropriately structured, skilled, qualified and experienced providers in the health and social services sector. The PPDF was established to increase provider diversity, and enhance the potential for improvement and innovation, and the capacity to contribute to improvements in the wider health system and services (Ministry of Health 2004a).

By 2000, there were 30 Pacific-owned and governed health providers in New Zealand, and a range of health promotion programmes being developed in Pacific community settings such as churches and schools. Soon after the introduction of the Primary Health Care Strategy, a number of the more developed Pacific providers were involved in the establishment of Pacific-led PHOs. There are now over 40 Pacific led health providers throughout New Zealand.

There are ongoing Ministry-led initiatives aimed at increasing the capacity and capability of the Pacific health workforce. The Pacific Provider Workforce and Development Fund programme of Action 2009/10 – 2011/12, for example, targets Pacific health workforce capacity building right from secondary school level, through to tertiary education, and helps support clinical and professional development of the existing workforce (Ministry of Health 2009b).

5.3. PACIFIC MODELS OF PRIMARY CARE IN NEW ZEALAND

Pacific peoples have holistic worldviews and beliefs about health. For some Pacific peoples, health and illness, and their respective causes, are closely linked with social relations, the family, culture, and spirituality (Capstick et al. 2009; Ministry of Health 2008b).

Pacific peoples, owing to the demographic changes occurring within their population (increasing ratio of NZ-born: Island-born and acculturation), may seek out different types of health services, with very different models of care. For some Pacific people, traditional Pacific healers are the first point of health care contact (Finau and Tukuitonga 2000), while others prefer to see traditional medicine as a complementary tool for addressing health issues in conjunction with Western medicine. There is also a large number of Pacific, particularly those who are younger and NZ-born, who are more familiar with Western models of care and are more distrustful of traditional medicine (Ministry of Health 2008b).

It is difficult to ascertain how much of the Pacific population uses traditional medicine. The previous two NZ Health Surveys suggested utilisation of traditional healers was low (only 1.4% of all adults using complementary or alternative medicines reported using a Pacific healer in the most recent 2006/07 survey), although, there has been some criticism that the figures underestimate traditional healing use among Pacific communities (Ministry of Health 2008b). What makes for an approach to health care that is deemed appropriate by Pacific Peoples in New Zealand is addressed in the next chapter which explores the day to day experience of health providers and managers in Access and Pacific-led PHOs.

6. PACIFIC PEOPLE AND THE PRIMARY HEALTH CARE STRATEGY

INTRODUCTION

This chapter reports findings from the Evaluation in relation to Pacific people and Pacific-led PHOs. It reports findings from qualitative interviews with key stakeholders in the PHO services nationally. The Strategy goals and objectives informed the development of the topic guide for the in-depth interviews with advisors who worked within the PHOs. These PHOs worked predominantly with low income, Māori and Pacific Peoples and included the Pacific-led PHOs. The data were analysed thematically in light of the health and demographic factors identified for the Pacific population in New Zealand, and as summarised in earlier chapters. These issues include efforts to identify and address Pacific health inequalities, public health promotion, assessment, cost of care, health utilisation, quality of care, governance and management.

GOALS AND STRATEGIES FOR THE PHCS

A key goal of the primary health care strategy or PHCS is to reduce inequalities in health and in access to healthcare. At present, Māori, Pacific peoples and under-resourced communities have poorer health and less access to healthcare (PHC Project Plan, 2004). The PHCS is important for the health of Pacific peoples because its aim is to reduce inequalities as part of the New Zealand Health Strategy.

Community engagement and involvement in governance, support for “by Pacific for Pacific” service providers in contributing to reduced inequalities, and an inter-sectoral and multi disciplinary, coordinated approach to delivering services are examples of aspects of the PHCS of particular relevance for Pacific populations and Pacific health providers.

The PHCS recognises that most Pacific people will continue to be cared for by “mainstream” providers and expects mainstream providers to organise and deliver services in ways that are culturally competent and effective. Defining what is culturally appropriate approaches when working with Pacific Peoples was another area to be explored in the PHCS.

Three of the goals of primary health care/PHO strategy were identified in relation to this evaluation as:

- Reducing inequalities
- Service teams and inter-sectoral co-operation
- Factors for success (Project Plan, 2004).

To achieve these goals, the Primary Health Care Strategy emphasised six key directions for the future development of the strategy. These six directions formed the basis for in-depth interviews with key stakeholders working within Pacific-led PHOs. These goals are to:

- 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 PHC workforce
- Continuously improve quality using good information (King, 2001).

The PHO stakeholders who agreed to participate were asked to what extent they considered the PHC strategy was fulfilling these goals within their PHO, speaking from the perspectives of where they worked within the organisation.

These six directions within the PHC strategy will be addressed under the themes from interviews with key advisors. These themes are:

- Providing low cost health care and improving access to a range of services
- Community partnerships; co-ordination, collaboration and team work
- Barriers to successful implementation of the PHO vision
- Workforce development and service boundaries/practice relationships
- Chronic or long term conditions
- Relationships of the PHOs with other PHOs; PHO relationships with the Ministry of Health and district health boards.

Seven main categories were identified during the interviews with Pacific PHO stakeholders. Sub-themes within each of the categories that were identified are outlined below:

1. Reducing inequality by providing low-cost healthcare and improving access to services.

Sub-themes in this category were:

- Low cost health care and improving access to range of services
- The PHO fee paying structure, targeting resources for those in the greatest need
- Improving access to these services for 'at risk' groups.
- Publicising services and enrolment procedures

2. Community Partnerships

Sub-themes within the community partnerships theme were:

- The role of NGO
- The ethos of altruism and not-for-profit provision
- Governance and working with the community appointed boards.

3. Co-ordination, collaboration and teamwork

This theme encompassed sub-themes of:

- Interagency and multi-disciplinary team work
- Health promotion/education.

4. Development of the PHC workforce

This sub-theme included:

- The increasing role for nurses
- The recruitment, training, and retention of the multi-disciplinary workforce with a particular focus on the nursing workforce
- Pay parity for treatment providers working in the PHOs with comparable DHB roles.

5. 'Barriers'

Specific sub themes that were identified in this category included:

- Consultation duration due to dealing with an array of psychosocial and cultural problems which informing health
- 'Clawbacks' when enrolled patients sought treatment from other PHO practices
- Addressing social inequalities through advocacy as part of the 'health' treatment or intervention
- Financial struggles of the smaller PHOs to remain financially viable
- Dealing with the lack of administrative/ IT systems infrastructure.
- Transport to treatment.

6. Chronic or long term conditions

These were discussed primarily in relation to the uptake and day to day experience of the Care Plus programme.

7. The reporting requirements and working relationships with other PHOs, the DHBs and Ministry of Health. This theme had a number of diverse sub-themes including:

- Reporting, developing and sustaining working relationships to secure ongoing funding
- Managing expectations about what services could be delivered realistically given the time-frame for delivery of services and the available resources for the funding of new and continuing projects
- 'Turf' debate over the population-based boundaries of the PHO was another sub-theme for the representatives of the PHOs interviewed which they considered the Ministry of Health should consider further.

FINDINGS

Incentive for joining a PHO: Reducing inequality through lowered cost and improved access to a range of services

There was an enthusiastic response to the lowered cost of healthcare from the stakeholders interviewed.

Reducing the costs of medical consultations was a primary motivation for practices to become involved in the PHO initially. As one manager of a Pacific-led PHO explained during the first round of interviews in 2005:

'...You know the first benefit is to us is no or low cost and they [patients] don't pay.'

The CEO from another Pacific PHO discussed in 2009 that the fee paying structure still offered a means of providing a targeted approach to those patients most in need of low or no-cost consultations:

... 'PHO I think it's a success with 90 plus percent enrolment throughout the country plus Pacific people, people are saying that they [lowered costs] are the advantage of PHOs. Low cost consultation fees I think is the main product ... So a lot of people have enrolled and are making use of the services. We know here that there are a lot of people that come so often because it's free, we are free from 0-17 years and only \$15 if you are a PHO member, from 15-64 years (\$15), 65 is free, that's it, that's our PHO fees ... so it's only the middle that we charge'.

The availability of low cost health care was not, however, widely known in the local community initially, which necessitated promotion of the PHO service. There was also a need to publicise the specific services that were offered. Information dissemination about how patients could enrol themselves and their family members in order to obtain access to low or no cost consultations, lower prescription fees and other services, was part of the implementation strategy of each of the PHO managers interviewed. For example, the use of promotional campaigns on Pacific Radio spoken in a range of Pacific languages was one way of publicising the availability to an audience of Pacific residents that was discussed at interview with one urban Pacific-led PHO. Community meetings with local groups were another way in which this PHO publicised the range of services their PHO offered. Fono that were organised by this PHO provided an opportunity to distribute more general information about health promotion to a range of audiences in face to face mode. It was considered important to follow up any presentations to answer queries and to hold meetings with the professional groups working at the PHO:

'We have a very strong Samoan Residents' Association and we tell them about health stuff and PHOs as well and then we also have a meeting of other nurses of different communities and we tell them about the PHO. We encourage people to ring us if they don't understand'.

Access to a Range of Services

Access to a range of other services such as free transport to treatment and lower prescription costs were important incentives to establishing a PHO. This was seen by participants as a means of improving access to comprehensive health care services for residents. Another PHO organised 'health days' to introduce a range of health services to local residents including their own services:

'...we just have a health day, we go to a hall and stakeholders are invited to come and display their information and tell people about the services that they provide, that's what we do in the health days and we do screening and so forth during those days'.

Another PHO responded to identified needs when hospital-based services were not being used suggesting gaps in the way these services were delivering their services to local residents. Patient missed out-patient appointments at the local hospital suggested the need for alternative modes of service delivery. In response to these missed appointments at hospital, this PHO decided to organise specialist clinics at the PHO that were considered to be more culturally appropriate and more user-friendly to Pacific patients. The manager of this PHO, in the following excerpt, discusses the benefits of how they developed care in these clinics using free parking, interpreters and hospitality upon arrival to engage clients:

'We run diabetes specialist clinics, we run arthritis clinics specialist clinics I'm talking about, we run eczema and asthma, we run hearing technician clinics every month and we also run a podiatry clinic together with [another]PHO. We run the specialist diabetic clinic with the hospital – you know those specialist clinics there – in 2005 was when we piloted for a programme for six months whereby instead of the diabetes specialist seeing patients in hospital we got them to come in here ... and the reason why was because of the high level of DNAs [Do not attends].

'When I looked at the diabetes specialist clinic that was in there, it was hard to find. When you go there to park it says: 'Reserved'. Your vehicle will be towed away. You walk in there and you will find very sloppy nurses and administrators who look so sad and so stressful and so forth. You get[to] the specialist clinic and you're very much just focussed on doing the thing without really putting a little bit of people attribute on ... when they[patients] came out here [to the clinic], they're different people altogether so the level of DNA was very high when it was at the hospital but when we had it at the community here in that room next door when we had it here, the level of attendance is now between 95-100% ... And when people walk in here, we've got the staff in here saying: " Oh would you like a cup of coffee or tea?" and so forth. We got the staff in here to say:"Hello" and spend 2-3 minutes just to sort of talk and so forth. You've got staff who can interpret and sit with them, and they come in and it's a very user friendly environment...'

An Ethic of Care

The attitudes of PHO staff towards their work were reported by participants to differ from the business orientation of many medical practices who worked from a business-centred model. Partly this difference in philosophy was thought to stem from the values underpinning PHO organisations being supported by charitable trusts. A workplace based in a shared enthusiasm for helping under-resourced communities was the major motivation described by one general practitioner working in a PHO where 97% of local enrolled population is described as 'low income, Māori and Pacific Island' :

'The philosophy of this practice is improved access with lower fees... affordability has always been an important part of the organisation really for us and for other members of the PHO... We provide a free taxi service for people who can't get to their appointments as well. We have access to free PHO funded prescriptions. We can pay after hours medical bills and x rays in exceptional circumstances where people haven't been able to afford them...we don't get that much more funding when you look at it than the interim practices and my observation is that they're using that increased money to bring their fees down whereas my observation is that we're putting money back into services which is a very different way of looking at things really'.

Altruism, and the 'not-for profit' motivation to remain working within the PHO was seen by PHO workers as important for putting funds back into community, as the same general practitioner interviewed suggested:

'I'm a salaried GP so I don't get the financial incentives, it's not my business that I'm safeguarding, if you know what I mean, which is how I think it should be....The PHO as an entity across the country is supposed to be a not-for-profit organisation. But if you look one layer down you've got for profit businesses. And that's a different model from the sort of third sector where there's a long history of community ownership and not- for- profit being part of the way that we operate'.

The difference between PHOs who worked explicitly from a 'not for profit' philosophy was discussed at interviews. The PHO representatives who were interviewed were prepared to 'go the extra mile' in dealing with social issues that impact upon health. This ethos was seen as strengthening their relationships with their local community. In turn, this good will and passion for helping the under-resourced influenced the range of collaborations and services the PHO was able to deliver in conjunction with community groups. Examples were given of collaborations of PHOs with a range of social service agencies. Together they advocated for patients who presented with a combination of social and financial problems that impact upon health. For example, one PHO nurse who had an established relationship with local social services organised food parcels from a local food bank for a patient who had not been eating an adequate diet due to lack of money to spend on grocery items. The lack of food had meant that he had become dizzy and fallen from scaffolding at work resulting in a trip to the local hospital's accident and emergency department. Through the PHO nurse liaising with the accident and emergency department at the local hospital, the reason for the accident was clarified with the patient and advocacy arranged with the social services.

Thus Pacific PHOs looked at health more holistically deriving from social inequalities and so they actively advocated on behalf of patients. A PHO nurse who was interviewed described advocating with WINZ on behalf of sickness and invalid beneficiaries who could not see a general practitioner for review of their medical condition immediately to avoid a cessation of WINZ benefit payments. She encouraged those patients with long- term or complex presentations who had debts to pay to continue coming to the practice for treatment despite lacking the means to pay for their health care whilst she advocated with WINZ on their behalf. Care Plus and other social service programmes were a major way in which these situations were managed within this PHO.

Relationship with Community: PHO Partnerships with NGOs Residents and Local Communities

The establishment of PHOs was seen as a positive move by its managers as it provided an opportunity to collaborate to provide culturally appropriate services designed and delivered by Pacific clinicians. As one manager of a Pacific health PHO discussed at interview, it was envisaged that PHO funding would build capability in the workforce for care of Pacific by Pacific:

'See I like this new approach by the government, this new way, the collaborative approach, I like that approach so that we can say to the government, we are doing all this why give the money to all those other people but give it to us, although we don't have the capacity now but by having the money, that money will also bring capacity at the same time and what that means is that there will be Pacific people that will have some of that expertise who will end up working under this organisation for example to deliver to Pacific and support other Pacific under other organisations ...'

Another PHO explained that historically their services have always had a high level of community involvement. This infrastructure now enables them excellent community involvement with the PHO. Board membership includes selected community representatives for different ethnic groups. They advised that these people have status within, and are recognised and have networks throughout, their own community. However, appreciating that it is a difficult task to bring together the views of the total community, the PHO holds public meetings about important health matters. The meetings have been a successful way of bringing together the community, and this has helped the PHO to develop its outreach and community health approaches:

'Representatives are selected to represent the ethnic group. This community is made up of many different ethnicities; they can't represent the views of everyone so we also invest in public meetings.'

Structures exist that can be used to mobilise communities to support and run health initiatives. As a manager of one Pacific PHO explained these connections enabled their PHO to offer an array of different services:

'Our PHO communicates to the community the different services that are offered under the PHO. And I know this PHO is made up of 22 service providers of all kinds. You name it: mental health, social services, Alzheimer's, TB, you name it, I've got it here [PHO].'

Another Pacific-led PHO used the services of a medical specialist to run a clinic to see patients who had been screened by a self-administered patient questionnaire to identify health issues. This consultant was unique in being able to speak a number of Pacific languages which enabled him to engage more easily with the majority of patients at that PHO. The shared language was an important means of building relationship with Pacific clients.

A community model of care facilitated by the PHOs was described as a positive development across the PHO providers interviewed. This model consisted of several elements - remaining small enough to know the local community which enabled treatment providers to remain aware and responsive to locally defined needs. Co-ordination of services and communication across practices meant that duplication of services in a geographic area could be avoided as the following excerpt from an interview with a general practitioner in a Pacific-led PHO illustrates:

'You know it's good to have that sort of relationship because of referral and we're basically seeing people from the same community. It helps avoid duplication of services and knowing what people are doing, having input with different families without knowing that each other is involved in, which I think happened a lot more under pre-PHOs.'

There was a sense of the community owning and governing their own health services which contrasted with a business model of general practitioners owning their own businesses for which they needed to make a profit each year. The not-for profit nature of many PHOs was considered beneficial to fostering greater co-ordination and more effective team work as the need to run at a profit was not seen as being the first priority. The election of community representatives on boards of governance provided the community with a voice as one Pacific PHO board member commented:

'We had a huge community forum last night for this service and we elected two representatives from the community forum...that's one of the reasons we go with our PHO was because it's community focused and it works on a holistic approach...'

This point was emphasised by some participants who explained that the work of the Pacific PHO organisations was undertaken by community health workers and nurses accessing community resources. They drew on a range of established links such as schools, churches, community and cultural groups. Representatives noted that although within the Pacific community there was an increasing emphasis on accessing communities via church networks – and it was agreed that churches are an important gateway into Pacific communities - depending on the issue involved, other networks existed (such as cultural leader groups and women's groups) which provided better access in some instances.

'It depends on the matter. It may be an access matter for the cultural leaders of that community and not the church leader. The Pacific community is structured around other groups too.'

This is in contrast to comments made by non Pacific PHOs in interviews about the difficulty of engaging with Pacific communities when the process was not relational (e.g. – one PHO did a mail out of about 5000 letters to Pacific families and received less than 100 responses). It illustrates the importance of understanding how to engage Pacific and the value that Pacific practices bring in their capability to do this. Establishing processes and protocols for making decisions and acknowledging shared values including the spiritual dimensions of care involved in the helping professions, aided success, as a CEO of a Pacific PHO explains:

'We're bound by a common philosophy and I kind of... I'm a lapsed Catholic, but I say... when I look at us relative to other organisations I say, I think fundamentally in essence we are a Christian organisation bound by a set of Christian values that hold us together in quite hard times and they are around all of those things, you know like..., integrity, respect... we do have hard times and we have our difficulties and battle but we try to work through them and there is a lot of passion. It's still trying to work through that respect and just wanting the best for our community.'

Collaboration, Co-ordination and Team work across Services

Since joining the PHO a common experience amongst participants was improved communication between diverse social and statutory agencies to avoid the silo-effect of services acting independently of one another. These social connections and networks enabled more comprehensive wrap-around services to be offered to Pacific patients.

'The difference between [name of another PHO] and [name of participant's PHO] is the community focused, community driven, focus on, you know, the health needs of the people. Whereas [name of other PHO] is very much doctor driven now....'

Having a manager who shared a vision and philosophy of working with under-resourced communities was seen to be advantageous by colleagues working at the same PHO as a shared vision of the local community was facilitated. A common purpose for continuing to work within the PHO was a 'passion' for work with what were considered to be under-resourced communities. As one participant commented:

'Our manager [name] who is Māori understands where the lower socio-economic people are coming from. She has a passion for this population here. And that's why we are getting that support because we know that she's there because of that passion.'

Another participant who worked as a general practitioner in a not for profit PHO described this as 'a collective approach to providing a service'. This was seen by those interviewed as being part of this shared vision for work in the PHO:

'We are not alone as a Pacific Islander within this PHO. We are here working alongside others and do collectively have a very strong communication strategy, making sure the population focus on their needs.'

At the follow up to the initial interviews in 2006-10, there were community collaborations that were working in tandem with the community churches and with other Ministry of Health initiatives. For example, one community gardening project involving a Pacific PHO and local churches integrated with a nutritional advisory service. HEHA healthy eating programme came to support the initiative which enabled an expansion of the gardening project. Being a small PHO allowed for the process of collaboration to develop out of a network of relationships which had grown since the initial establishment of the PHO.

Governance

The PHO representatives who were interviewed discussed that the PHO has created a cost effective management structure. The teams interviewed felt that the structure affords good administration of services whilst keeping staffing costs to a minimum. They explained that the organisations' contracts are managed by managers who each have a different skill set (for example, in management, accounting, business or administration).

Benefits were highlighted to having a smaller PHO structure and strong community networks. For one, information sharing and lines of communication were easier to maintain and coordination between the various layers of Board, management, clinical staff, and community could be encouraged.

Recruitment of board members was often ethnically specific (for example, a representative from each culture in the locality) was nominated within their communities which ensured diversity of representation and accountability back to their communities within the PHO resident population.

One management team advised that as a smaller organisation they have been able to involve all practice staff in the PHO through the establishment of clinical boards. These boards meet on a monthly basis to discuss different clinical issues and practice business. The clinical board relates to the PHO board through shared representatives and ideas are exchanged between the two forums. GPs have their own separate board meetings. One team explained that this segregation works because each group is most comfortable presenting opinions in the company of their peers.

This was supported by comments from other Pacific PHO representatives who felt that the board was working well to govern the organisation and provide direction to the service. Communications between board members and the management committee for clinical services support PHO influence in service development at the clinical level.

Participants felt that it is each PHO's responsibility to set targets for population health and support practices to achieve them. Staff observed that they relate to and work with each practice in the way that best suits them. In particular, they do not prescribe service structure, but recognise that individual practices and will adapt services to fit into their practice.

'They are independent practices; we work differently with each one. We can't dictate to them how to work...one size never fits all.'

An NGO participant reported that board membership made them feel part of the PHO structure. Funding arrangements however, particularly a silo-ed approach to PHO funding, is limiting workforce development between the NGO and PHO. One PHO had invited 31 NGOs for their AGM to retain working relationships with all NGOs in their geographic area. Whilst complicated this was seen as being an example of operationalising the principle of social inclusion which was important to Pacific cultures, in practice.

'Barriers'

Longer Consultations working Holistically with Social Problems

Initially there was enthusiasm about the funding available for services to improve access. There were many initiatives that participants considered were working effectively in terms of people accessing the health care they required. However, high and complex patient needs inevitably increased the length of consultations which impacted on workload of the PHO treatment providers such as general practitioners and nurses, as the following comment from a general practitioner working in a Pacific PHO illustrates:

'The heavy workload is helping them [patients] with social issues, so, sickness benefit, housing, all immigration issues. There is a lot of expectation that we will help them with that. We do quite a lot of it which prolongs our consultation time with the doctor or nurse. There are social workers in public health that we pass things on to...very nice to have social workers except that their contracts are all around youth. We actually use them when they've got time for the elderly for the housing issues. So their [social workers] contracts ought to cover those other things not just those youth things. I don't know how those contracts came to be like that. But the strategy needs to cater for elderly and social issues a bit better.'

General practitioners working in Pacific-led PHOs found that they needed to take longer to explain medical screening procedures prior to undertaking them with Pacific patients. This work needed to be done in face to face mode as contact by telephone and letter did not work as effectively with Pacific patients. The unavailability of funded transport to treatment was seen as an obstacle by a clinical manager/general practitioner of one Pacific-PHO who was interviewed:

....'We had a lot of DNA's [did no attends] and she[nurse] said to me yesterday that she thinks transport has got something to do with it and that if we could provide transport, that would really help. But, we don't have a transport service as part of this clinic. I mean we do, do a little bit, but we don't have an official transport service. That would help meeting Pacific health needs. Some sort of subsidy that would cover transport would be helpful. It also affects our immunisation rate because transport can be an issue for women getting their babies immunised. The other thing with mammograms and cervical sears... I don't know how you're going to put what I'm telling you into all your questions but, it's just understanding what it is. So, if it's a first-timer then that person needs a lot of explanation and it's basically done best face-to-face not in a pamphlet or letter and not so well over the phone because especially with cervical smears you need a bit of a diagram to explain what it's going to be about.'

Infrastructure and the Costs of Smaller PHOs

As the administrative and managerial running costs increased, the low cost structure within the smaller Pacific PHOs became less easy to sustain to remain financially viable, particularly when specialist clinics such as diabetes clinics had been established. Various financial 'struggles' within some of the smaller PHOs suggested the need to amalgamate with other Pacific PHOs so that administrative costs, IT systems and management across PHO networks could be shared to enable the continuation of specific clinics and services:

'We are struggling because the clinics are not really, its not able to pay its way, it's really the other contracts that we have that carry us forward ... so yeah, the funding that we get for the clinics is not sufficient, we are locked into the low cost structure, which is a very low cost agreement with the government but the new government is taking some of it away, the very low cost payment at the PHO level .. its going to be reduced next year to 50 percent and then 25 and then finished ... its scaling off but they are increasing the frontline, still very low cost for individual practices so that continues and they're increasing that but that's okay with us because the clinics are owned by us so the money comes to us anyway so that's fine ... but we are beginning to the new environment and may collaborate with the other Pacific PHOs..'

The movement to consolidate overhead costs and achieve economies of scale through amalgamation of smaller Access and Pacific-led PHOs with larger Pacific and Access PHOs was marked during the second phase of the interviews. This was seen as a way of maintaining investment in the clinics and other local initiatives that had been developed in the initial few years following the PHOs establishment.

'Clawbacks'

The difficulties of patients who enrol in one PHO whilst visiting another for medical treatment with the second practice billing for service ('clawbacks') was identified in the first round of interviews in 2005 as a funding issue threatening the viability of PHO practices .The financial position of one PHO was described by its general practitioner as 'shaky' in 2005 due to the level of 'clawbacks' at the practice:

'I think services like ours are in danger of getting into trouble financially because of clawbacks...we don't have a very big co-payment so we are reliant almost entirely with money from Health Pak. With lots of clawbacks where people are clearly coming to us and we can't find out where else they're enrolled. One particular person had gone and seen a GP over in [suburb's name] for a skin complaint- just as a one-off because she'd heard that he was good with eczema.... And the woman had been seeing us every two weeks really and he registered her so that he got all the funding for her for three months and we weren't able to find that out until now...'

By 2010 'clawbacks' were considered still to be impacting on the financial viability of PHO practices and so were recognised as a risk factor and dealt with proactively by PHO administrators when they were identified. The lack of administrative assistance was, however, a further impediment to early identification. As one CEO of a Pacific PHO explains in 2010, the constraints of patient privacy and medical practices failing to share information were proving to be significant obstacles to knowing why getting paid for consultations was problematic. Patients who 'doctor shop' or go to after hours services in crisis taking their extended families with them, were still posing difficulties for the financial viability of the practice in which these patients were first enrolled:

'And there is still another factor which is other PHOs are still enrolling whole families and that. One person seems to go after hours and the whole family seems to get enrolled. Which is kind of... we just kind of try re-enrol them back, we don't get too septic about it, I suppose.'

'And between different PHOs... we cannot track consultations between different PHOs, I said the information is not available, however, it should be available as a condition of the clawback. Where else in the world do you lose money without being told why or where it's gone? So I think there is an issue around they can't or there is some debate around the privacy legislation. They [medical practice] said: 'I can't tell you '. But I go: 'Well how can you take the money without telling us?' Do you know what I mean? It should be open...'

Robust information gathering systems and sharing of information to 'track' patients were considered crucial to knowing where enrolled patients were presenting for service across the PHO network of practices. The alternative was as one CEO of a Pacific-led practice suggested that:

'You lose it, it's [the enrolment] has gone somewhere else. No you can't find out where. They [medical practice] will not provide it so you don't know. If you get really stropky and believe that it's been a dodgy thing happening cause it's like too big a clawback the DHB will tell you what PHO but they won't tell you which provider. So, I believe we should know which provider got the funding, made the claim. To me it's a pure commercial transaction, it's nothing about privacy. You take our money, you need to provide a full financial reconsolidation and [tell us] where did it go as well as where as it went because we can't solve the problem. But there is also the issue, which is we don't know what time of day they sought the care which means it's really hard to plan your services and that's an issue around IT, you know, it's not captured'

Lack of IT Infrastructure, administrative and managerial support for Research and Reporting

Due to funding constraints having robust IT systems for gathering information was necessary for two reasons. Firstly these systems were needed for accurate data recording and retrieval for meeting Ministry of Health PHO reporting requirements. Secondly these systems were needed to identify health needs amongst the enrolled population. These requirements were considered as being vitally important by PHO managers and executives. However, there was wide variability as to which systems and computer software were used at each PHO which made the information less readily available in some PHOs due to the constraints of funding to rationalise systems of data collection and retrieval. The differing formats in which the information about the enrolled population was available made comparisons across geographic regions and PHOs difficult. One CEO who was interviewed commented that some rationalisation across the Pacific PHOs would facilitate better planning for specific health care services and to meet the identified needs:

'We standardise on Med Tech, we have a whole suite of advanced forms which allow a point of care daily capture across our structured programmes....we really would love for the government to fund all pacific providers to use those tools so, we could get that traction cause it allows for example like, if you have coded all your hypertensive patients it will tell you and compare you to other practices similar to your own and show you how many of your patients have not been monitored in the last fifteen months if you set the indicator at have they had their blood pressure monitored in the last fifteen months and then it'll tell you the name.'

Staying in touch through the use of IT and shared data management systems and resources across PHOs was another way in which smaller PHOs thought they could remain connected and viable as a one PHO manager commented:

'We tele-conference and we stay in quite close contact via email. It's a very supportive thing so we have that. And there is the data management that happens through consulting. And so that's what we've always had anyway. And we've done some research together and... so again the joining of [name of two PHOs] could in the future include those PHOs as well. We're looking at it specifically, like our trust deed we'll have space for others to come in if they choose.'

As the following excerpt with another Pacific PHOs suggests, amalgamation with other Pacific providers was seen as a way of maintaining viability by sharing of IT and administrative resources:

'Our IT is setup, not with a PHO but with other Pacific providers ... yep, and there are five of us who are all joined together to one server and I'm not IT but I'm sure you would have some understanding of what I am saying ... we don't have a local server....Its safe because its backed up all the time but what that means for us is that we have no control, no ownership of the server, what we used to have is that we also had the same process we had the server in the back room back there and the staff take turns, had a roster, to back it up and take the backing tape home, so that's exactly what they're doing, they back it up, security comes and picks up the tape and takes it to another offsite address ..'

The same PHO saw cost savings through economies of scale by merging their IT and management services with another PHO:

...'.for us I believe there is room for some of the services to be merged here in[name of geographic regions], there is room for that and if that happens then there is definitely costs that are going to be cut from that process cause we'll be streamlining our admin, we'll be streamlining our IT, we'll be streamlining payroll, we'll be streamlining financial package and all of that stuff, we'll be streamlining the staff as well especially the management to go into a merge, you can't have three or four managers managing a merger...'

Workforce Development

The issues around Pacific health workforce shortages are well recognised and a significant amount of activity within the Ministry of Health, and DHBNZ and DHBs has been underway for some time to address and improve this situation.

Some Pacific PHO staff admitted that smaller organisations and services felt threatened by early debates about the ideal size of a PHO and/or practice in terms of workforce efficiency – to the extent that they were reluctant to discuss their struggles with the DHB in fear of adversely affecting future funding. There was a pressure felt to obtain a certain critical mass to enable the sharing of overheads, skills and supports teamwork.

'Does size matter debates...It's not about that, it's about working smarter. There has to be room for smaller niche PHOs who understand their communities.'

One Pacific PHO felt that their workforce had a team based working style that is consistent with Pacific culture:

'It's part of our culture to work as a team, we don't compete with each other, we work as a team. That is the only way that we work.'

Sharing and helping each other is a large part of Pacific life, and people tend not to compete against each other (Ala Mou'i, Ministry of Health/Pacific Affairs 2010). There is a strong alignment between this aspect of Pacific culture and community involvement in health care because community initiatives encourage Pacific people to work as a team.

'As services move into the community, we are organising the Pacific community to work as a team. Pacific people need to work together as a team that is how it works best.'

Many of the comments related to the development of the nursing workforce due to the expanded role of nurses within the PHO network.

Nursing

The daily experience of being a nurse within the PHO did not often fit the theory for new graduate nurses working at the PHO. This gap between nursing theory and practice meant that some nurses left the PHO soon after joining them. Becoming overwhelmed and 'overloaded' with various roles due to the various PHO contracts was seen as part of this dilemma as a CEO of one Pacific-led PHO commented:

'Definitely, there are more and more being added on to our nursing and they are overloaded ... now PREDICT has been added on by ... mental health is now coming in and they want to implement it at the primary level, you know, you only have so much time and if you want to give a good quality care you have to spend the time to measure and Care Plus on its own is enough ... but we are required to do also other things as well to add on. Another contract is Chlamydia with youth as well we check it ... so they keep adding on little things and with the small contracts which really load ...'

Nurses employed by the PHOs were seen as having a key role in the dissemination of information about the range of PHO services offered. Nurses in health promotion and education roles became increasingly important as services were added to the range provided by Access and Pacific PHOs over time. The diversity of these roles meant that nurses often became the first point of contact and referral agent to other social and allied health services. There was a tendency more recently for nurses in these roles to become overloaded with commitments so the PHO managers and CEOs who were interviewed were mindful of the impact of these new services on nurses and the need to attract and retain skilled and experienced nurses. Opportunities for on-going professional development, pay parity with hospital nurses, and job security in the recruitment and retention of nurses in the Pacific-led PHOs, were discussed as being important considerations to workforce development. Offering practicum placement experiences to student nurses within the PHOs leading to career pathways following the completion of training within the Access and Pacific PHOs were discussed:

'Nursing, yes, we've been advertising for the ... nurse, our last one has moved to [agency name]. She was so good here, and they offered her quite a lot so she moved over there ... anyway I found out she's not very happy there, money is not everything ... anyway so we are looking for another nurse, we've been advertising but we've been unable to get one. We have no problem with retaining staff here ... getting them in really is the main thing but I think that's one thing ... we find there was one graduand came and trained with us and after she graduated she stayed on with us, so its probably because lack of appreciation that we are fairly well organised and solid and everyone will be here for the long haul. ... Maybe nurses think that ... they would rather work at the hospital or some big organisation ... that's probably why nobody applied... They prefer the shiny gloves at the hospital.'

The lure of the 'shiny gloves in the hospital' and the lack of funding to attract and retain a skilled nursing workforce to the PHO was apparent in the following comment from a general practitioner in another Pacific-led PHO:

'There is a lot of demand put on nurses to try and do the Care Plus education promotion, all of that. And I think we are understaffed in our nursing area....pay parity issues? Yes. We've got nurses who do a bit of hospital work at the weekends. So they come to us a bit tired and they say: 'Oh well I need the money.' It is a difficulty. Because our capitation is small we haven't been able to take on enough nursing staff to meet all those demands of health promotion and screening.'

Long Term Conditions and 'Care Plus'

Pacific PHOs were supportive of programmes such as *Get Checked* and *Care Plus* and the increased focus on chronic condition management.

One PHO reported that their focus on chronic conditions had increased through SIA, RICF, and diabetes and CVD projects. This PHO supported advancements in the management of conditions through a multi disciplinary team, and a 'one stop shop' approach to the care. One of the Access PHOs interviewed, for example, encompassed free access to regular and structured general practice care, specialist help, nutritional support, exercise activities, outreach and community health work.

Care Plus is generally well supported by health professionals and thought to be an effective programme that will make a difference to many patients with long term conditions. However, recruitment rates were slightly slower than originally expected. Of the 104135 people enrolled in Care Plus at the end of 2007, 11,179 (11 percent) were Pacific. The structured nature of appointments coupled with the complexity of presenting issues in a limited assessment and follow-up timeframes for consultations meant that for one PHO, Care Plus added to the challenges nurses working in the Pacific PHOs faced:

'They[patients] walk in and 15 minutes is not enough because of the multiple diabetes and so forth, you know, and they say that the ratio for their GP should be 1 for every 1,500 but we think that for the Pacific population it should be 1 for 1,200 because of the high needs, you know, and I think the doctors here would say that when our numbers go higher there are further pressures here so we try and use that as a proportion to keep the numbers low, because we had one doctor here one time, we changed the appointment system to not appointment but just to walk-in and our people they prefer just to come rather than make appointments. So one doctor she walked in and the clinic was too full ... they didn't support the change from booking to the walk-in and she just walked out ... when there were so many people waiting at the clinic so she said: "Look I didn't agree with this change, you know, I prefer the booking because you've got your list and you work through that"'

For smaller PHOs, programmes such as Care Plus have been reported as very taxing on provider capacity and resources, and difficult to implement on top of regular clinic work. Uptake of these programmes was described as slow, but efforts were made by PHOs to provide nurses and trainee medical staff to set up and support the initiatives. This view was exemplified by one of the GPs interviewed who commented:

'Our clinics are inundated with their regular work...Care Plus has been slow but now we have given them clinical support.'

Over time it became easier to manage the administrative requirements of Care Plus with planning and relevant IT and administrative support staff. The process of documentation for Care Plus through the 'Notebook' was seen as not fitting the way the providers needed to work with patients who had complex, long term conditions. A careful initial assessment enabled decisions to be made about how the patient's various presenting issues would be dealt with by the multidisciplinary team as the following quotation from a Pacific PHO manager interviewed in early 2010 illustrates:

'Yes, it's [the assessment] is half an hour ... it was tough in the beginning when the patient comes in and do that first assessment but 30 minutes is now good since they've been on the programme and they know what they're doing and so forth ... and the other thing is that Care Plus is very much managed next door but if there are any ongoing issues in relation to the patient, the team here they make referrals through MedTech32 and they refer the patient to here and say: " We've done the acute stuff, we've done the clinic stuff" , and so forth, "Can you please follow up all these other stuff, that's where the team here and then the nurse here will reassess it and will decided if it's a clinical nature or not?" And if not then they will be referred to the community health worker – issues like housing, WINZ.'

The day to day experience of one PHO's clinical manager was that patients eligible for Care Plus arrived often in a crisis and did not become enrolled due to the acute and sporadic nature of their presentations. Some Care Plus patients had underlying mental health issues adding to the complexity of engaging with them with refusal to sign the forms for enrolment in the programme being a common experience.

Another difficulty was the availability of funding for additional services that the patient needed:

'So they are the ones that really need the care. ...well, I think they'll be getting it here but they might not be getting everything they need because we won't deliver it; we can't afford to bring it in for them.but they get well cared for, we see them anyway. It's like the high user card; it takes forever to fill the forms out, you know, they [Ministry of Health] just make everything so hard and yet they want these people seen...'

Relationships of PHOs with DHBs and MOH

The relationships between the PHOs and DHBs and MOH took time to form and there were early problems with 'personalities' when working together. Once a regular meeting structure was implemented, these relationships with local DHBs improved and came to be seen as a working and purposeful. The CEO of a Pacific PHO discussed this process of each attuning to the other:

'DHB when it first started wasn't very good but I think it was due to personalities ... they had new staff and it's very good now, the relationships with DHB, we have a monthly meeting of PHO CEOs with the DHB top team every month. We sit down and talk and the agenda is driven by the current, you know, and through that we talk about the long term conditions cooperation, agreed, bang, implement it'

Representatives discussed that relations with the DHB are largely around contract negotiations. One PHO team had few expectations of the DHB with regards to supporting them and recognising the value of their contribution to health. Some of the PHOs indicated that it was difficult for them to reveal struggles to the DHB because they feared such revelations might affect their chances of receiving future funding. They explained that there was pressure to demonstrate capacity and capability because they believed many smaller PHOs would not survive.

'We talk to the DHB about contracts, we enforce our funding agreements with them...do they understand us, the struggles?...Probably not. They are the funder...that is the relationship.'

PHO managers outlined that they have established systems to enable the collection of the prescribed performance measures. However, they detailed that while the GPs are open to providing the indicators, many of them feel that some of the measures are not effective indices of quality for their type of practice.

'The PHO is ready to do this (referring to performance measures). GPs are open to it, but think that some of the indicators are not applicable, especially for high needs populations.'

The PHO network can encourage increased co-operation and innovative ways of sharing skills, resources and overheads. One PHO had, for example, set up systems for Care Plus by working with the DHB and a larger PHO. When an holistic approach to complex needs guided the PHO's philosophy, there was some caution evident to becoming too involved in work that was unsustainable as partnerships with local DHBs. The example of running a suicide postvention fono in conjunction with the hospital-based services was seen as a challenge to the limited resources of one urban Access PHO:

'It's [the fono] run by Regional Public Health but we're invited ... see those guys (Regional Public Health) get to run all those programmes for Pacific but do you know what? Where is Pacific? They [Regional Public Health]get the money and they try and then make us run around to make them look good but they don't know how to deal with Pacific ... as part of their consultation they're asking us to meet ... as a general comment I'd like to say that we get to do a lot of stuff here, we have a contract that has been given by the DHB or the Ministry to deliver to provide primary care support and all that sort of stuff but we end up doing lots and lots of other stuff unfunded and you find lots of that work relates to mainstream organisations who have some Pacific and then rob you for the money and they give the money to them and when they get the money they come to us to seek advice ...'

The Ministry of Health seemed more remote to the PHOs than the DHBs. The PHO representatives interviewed accepted that the primary point of contact for them and their organisations was the local DHB. Therefore, the working relationships developed were primarily with DHBs and PHOs:

'The DHB is good but Ministry of Health seems to be so far away, they only come when the Minister visits us or if they need some information ... but I think maybe that's the way it was structured that we work basically with DHB and DHB are around rather than the Ministry...'

'Turf Debates' between PHOs and MOH

A number of Pacific-led PHOs could not see the wisdom of the population based 'patch' system demarcating each PHO when they saw their people living in areas not included in the designated geographic boundaries of their PHO. A CEO of a large Pacific PHO described a need to include residents not considered part of their PHO reflecting the extended family values central to Pacific Peoples wellbeing (Ala Mou'i, 2010). The following excerpt from an interview with a CEO of a Pacific led PHO exemplifies this view of going over and above the catchment boundaries to treat Pacific people. This connects with the theme of all Pacific people seeing themselves as extended family and the ethos of altruism earlier described in the access and Pacific-led PHOs:

'This locality-based planning which the DHBs approach very fiercely locality-based, like which is virtually around the borough you know the very... on this side of the street... whereas, Pacific go kind of... it's more fluid. And so we have a kind of fluid, probably family centred approach that is like irrespective of what side of the road people live on, we will deal with where we find people and find a solution for... work with them to find a solution. Which is more around I suppose a set of strength based and needs based and around a geography and where they want to seek care. Because they're parts of communities that are not always GP-centric or something, do you know what I mean? It's just the other thing's a bit too rigid.'

Conclusion

Interviewees emphasised that existing informal community structures and an holistic philosophy of well-being were important in the success of their PHOs. Church, community leaders have been instrumental in gaining community input into the delivery of health initiatives. Community involvement in the development and planning of interventions is critical to engaging harder to reach Pacific families. An ethos of altruism and ethic of care guided the work of Pacific and Access PHOs which enabled them to work collaboratively with other community groups and organisations. There was a feeling expressed by participants that Pacific practices and NGO providers needed to be consulted more to gain a better understanding about how Pacific communities function in New Zealand and how engagement and education about PHOs could be improved. Structures exist that can be used to mobilise communities to support and run health initiatives.

PHO board members outlined their role as providing governance, direction, and consensus decision making for the organisation. The board usually comprises selected providers and community representatives and so represents a partnership. There is often a member or representative of each ethnic group in the community and they are recognised as being an elder or expert in their profession. However, there are issues of shortages of appropriate expertise for governance roles and some issues in the various personalities working together in some boards.

Care Plus has brought extra responsibilities for nurses who are employed in the PHO. The focus on chronic care management in general has brought nurses greater responsibilities in relation to working holistically with patients who have long term medical conditions. These conditions were often associated with a range of social and financial problems. The PHO nurses who were interviewed mentioned dealing with a range of social and mental health related issues connected to their work. This was particularly marked when dealing with patients eligible for the Care Plus programme where multiple physical and social conditions were evident, requiring intervention. These extra responsibilities for nurses have implications for workforce recruitment and retention, particularly for nurses in the Pacific and Access PHOs. Removing administrative tasks from nurses and increasing the level of their autonomy was seen as a possible solution to burgeoning workloads of PHO nurses. Having ready access to a multi-disciplinary team for consultation and referral was another possible solution discussed by those PHO nurses interviewed. Nurses are also having an expanded role in education and health promotion in such areas as chronic care through Care Plus and smoking cessation since the PHOs became established. How to make the holistic care and health promotion work of nurses working in the PHO more visible and more widely recognised and acknowledged is an area for consideration.

Effective teamwork and sharing of resources and expertise was identified as a key feature and strength of Pacific PHOs and providers. This was in contrast to PHO practices that were seen by the Pacific PHOs as retaining a traditional GP focused medical model. Pacific-led PHOs saw these medical practices as elevating the general practitioners at the expense of developing nursing and allied professional skills.

Pacific-led PHOs felt that workforce debates should not be solely focused on increasing size or workforce numbers, but also on sharing skills and resources across practices. This PHO felt that in their experience, it was essential that the PHCS leave room for smaller or niche PHOs who work in a manner most suited to their communities. The lack of IT systems and an infrastructure of support, however, meant that many smaller PHOs had amalgamated or were considering amalgamation with larger PHOs and health care providers to share administrative, managerial and IT systems to remain financially viable.

Pacific PHOs expressed difficulties in recruiting doctors and nurses, when few qualified staff was available or willing to work in high needs areas with additional work requirements and stresses. Another major problem for the PHOs who were interviewed was the difficulty in recruiting and retaining staff that could speak a Pacific language – especially doctors and nurses.

However, the PHOs were looking for solutions and had worked towards reducing the impact of these issues. One PHO has supported overseas trained doctors to become NZ registered. At the time of interviews, two doctors had completed registration, and were working for the practices within the PHO. Another PHO reported that many new staff was attracted to the salary option. This was something that was being considered by other PHOs as a way to attract young GPs and GPs approaching retirement.

The necessity of innovative recruitment strategies and approaches to training and up-skilling of PHO staff created by workforce constraints in Pacific practices and NGO providers was also recognised in the evaluation of the Pacific Provider Development Fund (PPDF). Many Pacific led practices face challenges. The evaluation found that the PPDF played a significant role in supporting workforce development and capability building to enable Pacific led practices to deliver a wide spectrum of services to Pacific people – something that is not possible within existing service contracts. PPDF provides further support from resulting retention issues that arise from an up-skilled workforce – many staff will move to higher positions and better paid roles.

Interviewees advised that their services historically had involved a high degree of community involvement stemming from collaborations already established amongst Pacific providers in the church and NGO sectors. There were many examples such as the 'Healthy Villages' initiative that was further advancing community involvement with the PHO through inter agency collaboration and partnerships.

It was difficult for participants to say how far these innovations were addressing social inequality and improving access on the basis of need due to the mobility of the Pacific population and the significant level of casual use of the PHO services.

The trend of Pacific families to move between health care providers meant for those interviewed that it was more difficult to reach people with high primary health care needs. Participants thought the reasons for 'treatment shopping' were related to other barriers to access such as lack of understanding of PHOs and the enrolment process, and difficulties with transport to treatment. Whilst acknowledging that some of the multiple enrolments at PHO practices resulted from patient's behaviour, interviewees also felt that the current environment encourages providers to enrol Pacific people when they present as a casual user of a service or in an acute situation. When patients are inadvertently enrolled in multiple practices, this causes administrative confusion and a loss of funding for the practice in which they are at first enrolled. Practice representatives who were interviewed detailed many scenarios where patients claimed that they had not intentionally enrolled with another provider. Participants questioned whether the current registration system requires review to prevent a patient from enrolling with a new provider before they were removed from the registers of other PHO practices.

Participants reported that their focus on long term and chronic conditions had increased with the availability of the Care Plus programme. The PHOs interviewed supported advancements in the management of long term conditions through a multi-disciplinary team, 'one-stop shop' approach to care. They explained that service encompasses free access to regular and structured general practice care, specialist help, health education and promotion such as nutritional support, exercise activities and other outreach services.

Interviewees described taking part in regular meetings with the DHBs to discuss new projects and emerging issues. They also discussed receiving DHB support to establish systems to implement new projects. Resourcing for new projects was an issue expressed in the later interviews with Pacific PHOs. This meant that the PHOs initial enthusiasm to become involved in DHB initiatives was tempered with a pragmatic assessment about the sustainability to continue the project if the funding was unavailable.

PHO participants thought the Ministry should increase their consultation with Pacific health providers to increase their understanding about how Pacific communities function in New Zealand. They expected that through such consultation the Ministry would develop policies to educate Pacific people about the PHO through using methods of engagement that fitted Pacific cultures and world views.

7. CHANGES TO PRACTICE FEES AND CONSULTATION RATES 2001-2007

INTRODUCTION

This chapter outlines the changes in the fees charged to PHO patients and the consultation rates at Primary Health Care Practices in New Zealand between 2001 and 2007. These levels of fees and consultation rates were explored in relation to all ethnic groups in New Zealand over the period 2001-2007 and here we report fee levels and changes in fees over time for Pacific peoples. This report should be read in conjunction with the main report on the analysis of general practice data from the Primary Health Care Strategy Evaluation (Raymont et al, 2010).

These data are important for examining issues relating to equity of access and use of services. When average fees are kept lower, it is likely that equity of access is maintained for lower income earners and those living in under resourced areas (lower decile NZDep populations).

FEES - VARIATION IN FEES CHARGED

We begin by looking at the average fees paid by different groups in the population. The following table shows the relative fee-level for those attending Access practices compared with Interim practices. The table compares fees for Māori, Pacific and Asian people with fees for the “Other” ethnic group; and fees for those living in under-resourced communities (NZDep 5 neighbourhoods) with those living in better off (NZDep 1-4) neighbourhoods.

Table 1 Average Invoiced Fees by Funding Formula (Access as % of Interim), by Ethnicity (Māori, Pacific and Asian as % of “other”), and by NZDep Quintiles (NZDep 5 as % of NZDep 1-4)

	6-17	18-24	25-44	45-64	65+	Mean
Fees by funding formula (2007)						
Access fees as % of Interim fees	41	59	57	58	58	54.6
Fees by ethnicity (after introduction of new subsidy)						
Māori as % of “Other”	63	71	70	71	62	67.4
Pacific as % of “Other”	39	60	55	57	46	51.4
Asian as % of “Other”	114	99	90	94	97	98.8
Fees by NZDep quintile (after introduction of new subsidy)						
NZDep 5 as % of NZDep 1-4	50	87	81	73	61	70.4

Fees for Pacific peoples were the lowest as a proportion of the ‘Other’ population throughout the 2001-2007 period. However, fees rose as a proportion of ‘Other’ also throughout the period (Raymont et al, 2010).

CONSULTATIONS

Over the evaluation period (2001-2007), PHO practices have increased the number of enrolled patients. There has been a growing financial incentive to formally enrol patients as practice income has become more dependent on capitation payments.

Consultation rates across the PHOs initially rose, particularly for those in Interim practices and for those in Access practices without community services cards. However, there were significant falls in consultation rates between 2005/06 and 2006/07, particularly in Access practices. Between 2001 and 2007 the, consultation rates for all ethnic groups increased only for those with community services cards at Interim practices. For patients at Access practices and for those without a community services at Interim practices there was a drop in consultation rates, however (Raymont et al, 2010).

Table 4.7. shows the rates of consultation by ethnicity and by year. Consultation rates differed by ethnicity and level of deprivation. Compared with those of "Other" ethnicity (mostly New Zealand Europeans), Pacific peoples' rates were lower (mean 75.4%) prior to the roll out of the Strategy, and although consultation rates rose initially, they then fell for Pacific peoples, and Pacific peoples ended the study period with a lower rate of consultations than prior to the roll out of the Strategy and with a lower ratio of consultations compared with 'Other' ethnicities than prior to the roll out of the Strategy.

Table 2 GMS Consultation Rates 2001/02-2007 (by year and ethnicity; and with Māori, Pacific and Asian as Percentage of "Other", and percentage change over the period)

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007	% change
Other	3.35	3.55	3.76	4.02	4.18	3.61	3.53	5.5
Māori	3.62	3.79	3.96	4.15	5.04	4.68	4.71	29.9
Pacific	2.52	2.69	2.92	3.37	3.22	2.35	2.18	-13.7
Asian	1.57	2.01	2.12	2.57	2.73	2.22	2.11	34.5
Missing	1.09	1.32	1.38	1.54	1.74	1.64	1.57	44.2
As % of "Other"								
Māori	108.3	106.7	105.4	103.4	120.6	129.7	133.3	
Pacific	75.4	75.7	77.8	84.0	77.2	65.2	61.7	
Asian	46.8	56.5	56.3	64.1	65.3	61.5	59.7	
Missing	32.6	37.1	36.7	38.4	41.7	45.3	44.6	

Table 3 GMS Consultation Rates 2001/02-2007 (by ethnicity and funding formula; and with mean for whole period, rates for Māori, Pacific and Asian as a percentage of "other", and percentage change over period)

	<i>Mean pa</i> <i>2002/02-2007</i>		<i>As % of "other"</i>		<i>% change</i> <i>2001/02-2007</i>	
	Interim	Access	Interim	Access	Interim	Access
Other	4.18	3.09	100.0	100.0	9.4	-1.8
Māori	5.27	3.80	126.2	123.1	9.7	52.9
Pacific	4.20	2.40	100.6	77.8	-5.7	-19.3
Asian	2.42	1.83	57.9	59.3	19.3	57.6
Missing	0.98	2.38	23.4	76.9	22.7	25.2

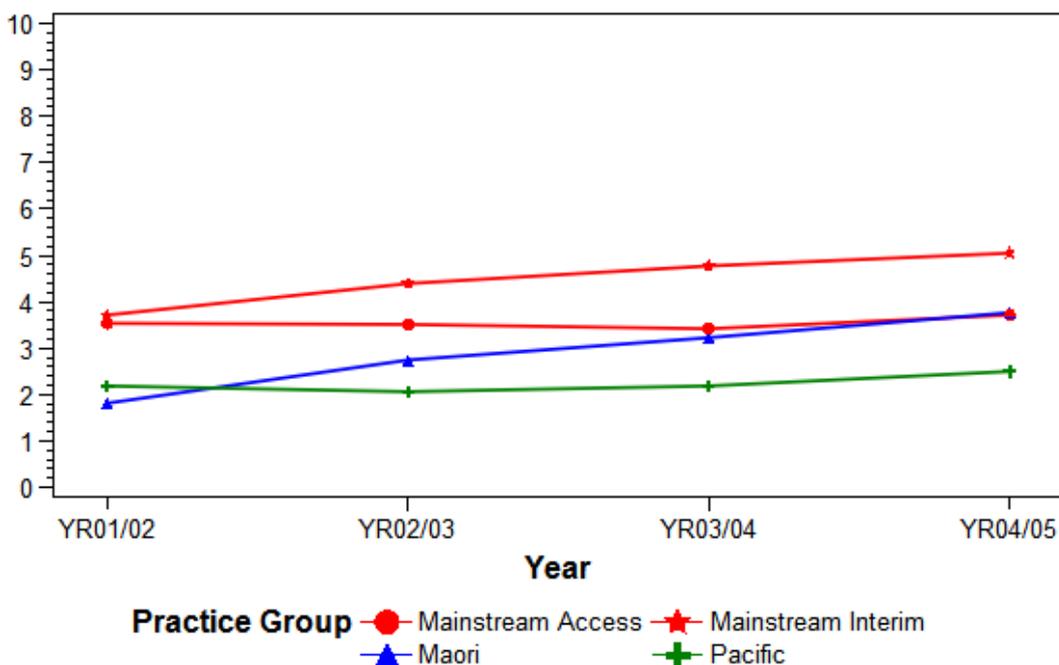
GMS consultation rates for Pacific patients, by practice group

The research group has some data available comparing Pacific population consultation rates within Māori-led, Pacific-led and Mainstream Access and Interim practices.

The data for these analyses come from two sources. First, are the 99 general practices included in our first quantitative analyses (Cumming et al, 2007). At the time the practice samples were drawn there were 58 practices in Maori-led PHOs and 7 practices in Pacific-led PHOs. This national sample was a random sample of all practices in NZ and included 7 Maori-led practices and 1 Pacific-led practice. To compare the experiences of patients enrolled in these practices with those enrolled with the non-Maori non-Pacific practices in the national sample, further random samples were drawn from Māori-led and Pacific-led providers. Pacific-led practices that were not in the National sample were invited to participate and all took part (100% response rate). A random sample of 28 Māori-led practices were invited to participate in this research. This resulted in cohorts of approximately equal numbers of Māori patients attending mainstream practices and Māori-led providers. Four of the 28 practices declined to participate, leaving 24 Maori providers (24/28=86% response rate). In the analyses in this report the Pacific-led and Maori-led practices in the original national practices have been reallocated to the Maori and Pacific groups.

The following graph shows GMS consultation rates for all Pacific patients regardless of age group, comparing Māori-led and Pacific-led practices with “Access” and “Interim” practices in the Mainstream sample. The row labelled “N” gives the number of registered patients at the beginning of each time period.

Visits per annum



<i>All</i>		Year			
		YR01/02	YR02/03	YR03/04	YR04/05
<i>Practice group</i>					
<i>Mainstream Access</i>	<i>N</i>	11619	13640	15330	17843
	<i>GMS consults</i>	3.53	3.51	3.42	3.71
<i>Mainstream Interim</i>	<i>N</i>	5339	5930	6699	7536
	<i>GMS consults</i>	3.71	4.39	4.77	5.05
<i>Māori</i>	<i>N</i>	2401	5628	7224	9169
	<i>GMS consults</i>	1.81	2.74	3.22	3.76
<i>Pacific</i>	<i>N</i>	18163	22600	27036	32247
	<i>GMS consults</i>	2.18	2.06	2.18	2.50

Average Pacific consultation rates began the study period with the lowest consultation rates at Māori-led practices, followed by Pacific-led practices. At the end of 2005, Pacific consultation rates were the lowest at Pacific-led practices, and rates had increased substantially at Mainstream Interim and Māori-led practices.

		Year				% change 01/02 - 04/05
		YR01/02	YR02/03	YR03/04	YR04/05	
<i>Practice group</i>						
<i>Mainstream Access</i>	<i>N</i>	11619	13640	15330	17843	
	<i>Consults</i>	3.53	3.51	3.42	3.71	5%
<i>Mainstream Interim</i>	<i>N</i>	5339	5930	6699	7536	
	<i>Consults</i>	3.71	4.39	4.77	5.05	36%
<i>Māori</i>	<i>N</i>	2401	5628	7224	9169	
	<i>Consults</i>	1.81	2.74	3.22	3.76	108%
<i>Pacific</i>	<i>N</i>	18163	22600	27036	32247	
	<i>Consults</i>	2.18	2.06	2.18	2.5	15%

The low consultation rates of Pacific patients in Pacific-led PHO practices warrant further investigation. It was thought that the difference in consultation rates for Pacific Peoples may relate to difference in practice business processes in Pacific practices compared with other practices, in particular the completeness with which patient contacts are recorded in clinical records. The increase in consultation rates for Pacific patients at Interim-funded practices and Māori-led practices provides some support for this possibility (Gribben, 2007). However, we have since found that overall, and in Pacific-led practices, the percentage of recorded encounters has increased over time (Raymont et al, 2010).

Conclusion

In introducing the Primary Health Care Strategy and providing significant new funding for primary health care, the Labour government aimed to reduce the fees patients pay and increase consultation rates particularly for those groups who have higher health needs such as Māori, Pacific and low income earners. Given higher health needs amongst these groups, and lower incomes, if we are to reduce inequalities in health we may need to ensure that fees remain low for these groups. Currently, New Zealand is funding PHC on a universal basis but there are aspects of the funding models that would enable fees for Pacific patients to remain lower than for other groups – including higher capitation rates for some forms of funding (eg, health promotion, SIA) and Access funding and VLCA funding aimed in part at Pacific populations. Practices may also continue to provide lower cost care for those people they believe cannot afford services easily. At the same time, however, new funding has been provided in particular to reduce the costs for those without CSCs, ie higher income groups. Thus, we see lower fees on average for Pacific populations, but the ratio of fees relative to ‘Other’ groups in the population rising over time.

Again, if we are to see improvements in access to services and reductions in inequalities in health, we should expect to see consultation rates rising for Pacific peoples over time. We do see this occurring initially, but the low rates of Pacific consultations needs further investigation.

The unique nature of the Pacific population in New Zealand also may be related to these trends. In the next chapter the composition of the Pacific population will be explored, showing the significant demographic and socio-economic change and the likely impact on health policy decision making in the future.

8. DISCUSSION AND POLICY IMPLICATIONS

The five to ten year vision of the PHCS was to shift primary health care (PHC) services to focus more on the health of various population groups by: providing services which are easy to access; improving and maintaining their health; and coordinating their ongoing care (King, 2001). Underlying this vision was a greater emphasis on the role of community participation in health improvement. PHC was seen to encompass a wide variety of services, including health promotion and preventive care, which necessitated the involvement of a wide range of health professionals (multidisciplinary teams) in the service delivery model.

Pacific peoples are disproportionately represented in the most deprived areas of the country and have poorer health status than other New Zealanders. Pacific peoples were a key priority group for the PHCS, given the focus of the PHCS on reducing inequalities in health. The PHCS had a focus on services for Pacific peoples provided by Pacific peoples, active involvement of Pacific communities in service delivery, further building of Pacific provider capacity, the formation of Pacific-led PHOs, and leadership at a national level. All providers and PHOs were to identify, reach out to and address Pacific health needs (King, 2001).

A key goal of the Primary Health Care Strategy was to reduce inequalities in health, and data on utilisation are useful for examining issues relating to equity of access and equity in the use of services for particular socio-economic and ethnic groups. The pattern of fees and consultation rates provides a mixed picture when it comes to equity of access and equity in the use of services for Pacific Peoples in comparison with other ethnic and socio-economic groups. Lower fees for particular socio-economic and ethnic groups do promote equity of access, but the ratio of fees for these groups relative to other groups has generally risen, resulting in a potentially slightly less equity promoting environment. Lower rates of consultations at Access practices and for those from more deprived areas may suggest that these groups' primary health care needs are not fully met. All of the practices included in the Pacific-led PHO evaluation were Access PHOs. The lower consultation rates for Pacific and the fact that these fell over the study period (2001-2007) are of concern (Raymont et al, 2010).

In the larger study from which this report is drawn, consultation rates were found to differ by ethnicity and deprivation. Compared with those of "Other" ethnicity (mostly New Zealand Europeans) Pacific peoples' rates of consultation were found to be lower (mean 74%) and decreased (by 14%) over the period studied, 2001-2007. With consultation rates among Māori rising faster than among the "Other" ethnic group, the ratio of Māori to "Other" consultations increased over the period. This is also true for Asian populations. However, worryingly, the ratio of Pacific to "Other" consultations fell (Raymont et al, 2010).

Reduced fees do not seem to have been associated with increased rates of consultation for Pacific Peoples, therefore. Access practices with on-going lower fees have not achieved consistently greater growth in consultation rates than Interim practices; and those without community service cards who have experienced the biggest reduction in fees have shown no consistent growth in utilisation. It is likely that outreach and other activities aimed at attracting those who tend to under-use services have been successful and explain the growth in consultation rates for example for those with community service cards attending Interim practices. Lower than desirable consultation rates for Pacific populations, those in Access practices and those from more deprived areas suggest we have some way to go to ensure equitable consultation rates.

VALUES INFORMING MODELS OF PACIFIC HEALTHCARE

To explore the experiences of the primary health care strategy in relation to the Pacific-led PHOs is to ask the question of the values underpinning Pacific approaches to health care. The quality of relationship between providers and patients, altruism and an ethic of care that transcended prescribed roles and responsibilities were part of what participants discussed as making Pacific and access PHOs unique. Spirituality and an holistic approach are key aspects of Pacific models of healthcare (Ala Mou'i, 2010, pp 4-5; Agnew et al, 2004). Participants in the Pacific-led PHOs have suggested in this study the need to consider co-ordinated approaches to health care which are comprehensive, culturally appropriate and flexible to respond to local needs. These approaches derive from traditional Pacific beliefs which include 'going the extra mile' to meet the consumer where they live in a diversity of local and cultural contexts (Agnew et al, p.ix).

Previous studies provide evidence that community-based models of intervention contribute to positive health outcomes (Barwick, 2000). The service providers interviewed mentioned a number of Pacific models they drew from in their work that were used alongside clinical models of assessment and treatment. Many of these frameworks adopt a focus on wellness in the community, and are underpinned by an ethos of altruism, interpersonal relationship and social inclusion. Building trust and support at the first point of contact requires what has been termed 'a roundabout Pacific rapport building approach' which is learned by healthcare providers in practice rather than in theory (Agnew et al, 2004 p.ix). This approach involves ensuring that patients feel comfortable in their surroundings as an integrated part of the health service delivery. Rapport building to engage patients and their families is considered an important requirement when working with Pacific peoples (Agnew et al, 2004). Pacific models and modes of service delivery are distinct from western models of care and remain implicit in the practices of the health care providers who use them. These styles of service delivery follow the principles underpinning the Government's strategic direction for Pacific health care.

These principles are:

- Respecting Pacific Culture
- Valuing Family
- Quality health care
- Working together (Ministry of Health, 2010 p.5).

These align with the principles and priorities of the Pacific Health and Disability Action Plan (Ministry of Health, 2002 p.2). These principles are:

- Dignity and sacredness of life are integral in the delivery of health and disability services
- Active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- Successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

The interviews with participants suggested strategies and approaches for furthering these strategic directions in terms of the aims of the primary health care strategy. Therefore, the themes identified in earlier chapters are synthesised in this chapter with these guiding policy principles for working strategically with the Pacific population in New Zealand.

AN ETHOS OF ALTRUISM: LOWERING COSTS AND IMPROVING ACCESS TO SERVICES

The organisational models developed within Pacific-led and Access PHOs with large numbers of Pacific patients were predominantly based in a 'not for profit' philosophy. This philosophy is consistent with the NGO Pacific providers who worked alongside the PHOs and in many instances these NGOs had established relationships with the local communities prior to the establishment of the PHOs. An example is the role of Pacific Health Services within the PHO network nationally.

Lower medical consultation fees enabled cost savings to be reinvested into the local community to enhance the range of community resources available. Removing the necessity to run a medical practice for profit meant that there was scope for developing new services and delivering services in new and innovative ways. Cultural assessment, holistic models of care, specialist clinics, hospitality practices and use of Pacific protocol and languages were adopted by the Pacific led services within which the research participants were working.

Participants referred to this philosophy of altruism as 'dealing where we find people' and for themselves as practitioners: 'resilience to get on and keep doing it'. In practice this meant working holistically with any issue the client presents with.

An ethos of care that goes beyond the traditional medical consultation to developing a relationship of mutual respect and trust with the patient, poses many challenges both personally and professionally for the practitioner, in terms of skill set, knowledge, time and the availability of services. In relation to resourcing within the PHO and the Ministry of Health's reporting requirements, capturing the extra effort and time taken with individual patients was not often reflected accurately in standardised consultation times and reporting formats. An example is the funded assessment time for Care Plus which was often found to be inadequate when dealing with patients who had multiple health and social problems. Review of the PHO reporting requirements and consultation times was suggested by the individuals interviewed to better reflect the worker's day to day experience of the complexity of work within Pacific PHOs. Whether mainstream PHO services and methods of delivery are relevant and comparable with the tasks and activities of access and Pacific PHOs, are related issues to be addressed by Ministry of Health and within the professional associations' competencies. To articulate what is uniquely Pacific about these ways of working more explicitly would assist the professional associations to framing their key competencies and designing professional development to align with the actual experience of the work in Pacific PHOs.

RESPECTING PACIFIC CULTURE: VALUING FAMILY

A third of the Pacific population in New Zealand lives in extended families. (Agnew et al, 2004 :1).). There were a variety of ways in which participants involved extended family in the care of an unwell family member. This principle was discussed by one Pacific-led PHO manager as being 'a family focused approach'. In practice, this meant working through the traditional hierarchies, for example, using elder and church networks. These networks were seen as ways of reaching Pacific families in need. With the changing demographic profile of Pacific populations now being born in New Zealand, these traditional hierarchies might themselves be transformed over time.

The overriding principle of any model used when approaching health care with Pacific people is one of ensuring the dignity of the individual and the right to choose amongst a range of services (Ministry of Health, 2010). The benefits of being spoken to in one's own language, having familiar and welcoming surroundings, and access to traditional health practices was considered important to wellness from the participants' perspectives. Fluency of one or more Pacific language was highly recommended. Knowledge of Pacific models of health need to be integrated into existing curricula of professional healthcare programmes. The professional associations of nurses, general practitioners and allied health care workers need to incorporate such knowledge into their core competencies and integrate this with professional development programmes. How to integrate the cultural with the clinical was one of the challenges described by the providers interviewed.

Providing families with information about the PHO enrolment process and how to access support services, appropriate medication and treatment were raised as commonly encountered barriers when dealing systemically with Pacific patients and their families. PHO managers discussed disseminating information on the availability of PHO, allied health and social services through health promotion activities such as 'Health days' involving community organisations, Pacific Radio talk back, as well as community clinics and projects. Follow up meetings to these events were scheduled to answer specific queries from family members. One of the challenges identified by participants was how to design a service philosophy that can develop and incorporate such events into constituting its core business. This study suggests the need to explore the development of such a formula.

The geographic boundaries of the PHOs and their population-based areas were seen as an obstacle to Pacific families referring from other regions to see Pacific healthcare providers. Treatment of Pacific people by Pacific providers was an underlying concern of the participants in this study. Social inclusion and a refusal to turn any person away who presented by referring them to another practice was an overriding theme. Alongside this principle of inclusion is the administrative obstacles caused by patients enrolling inadvertently in multiple PHOs which cause a loss of funding for service from the PHO in which the patient is primarily enrolled (clawbacks). Processes for the early identification and resolution of 'clawbacks' is proposed as a project Pacific respondents wish to see the Ministry of Health to consider urgently. The current level of 'clawbacks' was described as negatively affecting the financial viability of the Pacific and access PHOs interviewed as well as causing administrative confusion among the wider PHOs. Confidentiality surrounding the sharing of information between PHOs and the lack of shared IT systems hampered efforts to resolve the issue of multiple enrolments at an early stage.

COMMUNITY PARTNERSHIPS: QUALITY HEALTH CARE

Encouraging intersectoral collaboration and team work across the enrolled population is an aim of the primary health care strategy. Evidence of partnerships between the PHO and community suggested this aspect of the PHO was working well for Pacific-led PHOs. However, In terms of Ministry of Health reporting requirements, the documentation expected of the PHOs often failed to capture the additional or wrap-around services offered which has been referred to by participants as 'a one stop shop'. The service managers and providers discussed being hampered at times by health promotion and education activities as not being seen as part of their core business activities. Again the tension lies with finding a funding formula that incorporates health education/promotion and the development of new services as part of the core business of PHOs.

Alternatively when partnerships were established with other organisations in conjunction with the Ministry and/or district health boards to offer specific programmes, some of these projects grew to the point that they became unsustainable in the longer term in terms of the availability of time, and staffing resources. Therefore, there was a fear expressed by several of the Pacific PHO managers of over-committing to new initiatives with the regional district health board services in case they were unable to resource and deliver these new services over time.

ACCESS TO A RANGE OF SERVICES: WORKING TOGETHER

Overall participants felt the PHOs were working well as it allowed for the development of a range of services linked to locally defined needs. In particular, the way in which PHOs allowed each practice to adapt services that suited them was viewed positively. Having smaller PHO structure and strong community networks allowed for information sharing and lines of communication which were easier to maintain. However, they had few expectations of DHBs and MOH viewing their role as contractual and not one of support or recognising their contribution to health. This made it difficult for them to reveal struggles in fear of it having a negative impact on their funding.

PACIFIC HEALTH WORKFORCE DEVELOPMENT

The practices of Pacific health care providers remain often as an 'oral tradition' though recommendations have been made to document these practices more formally so that they can inform the teaching of healthcare professionals (PMMHSD Project). How these practices align with the bio-psychosocial models taught in a health science curricula for nurses, general practitioners and other allied professionals has been questioned. Previous studies have discovered that the services are responsible for developing their own cultural assessment frameworks and interventions in the absence of explicitly taught models of Pacific healthcare (PMMHSD Project, 2004 p.17)

The diversity within each of the Pacific cultures is also a factor to be considered as models specific to each Pacific culture need to be framed to take account of the local community resources within each PHO. Clinical placements need to provide a range of learning opportunities for treatment providers including work in Pacific-led PHO services.

The Pacific population is a significantly younger population which requires that youth issues need to be considered in the design and delivery of services in the primary health sector. Service development, therefore, needs to be sensitive to and responsive to the issues of child, family and young peoples' preferences for service provision and delivery.

OBSTACLES: THE UNDERUTILISATION OF HEALTH SERVICES

Despite Pacific providers offering lower fees compared to other mainstream providers, services are still being underutilised by Pacific patients (Raymont et al, 2010). The introduction of the PHCS has had little impact on Pacific-led practices as they were always offering lower fees than their mainstream counterparts.

Although it was found that Pacific patient enrolments increased during the period 2001-2005, consultation rates for Pacific-led practices are still low compared to other practices in the Practice Data Analysis report 2007. Again this could be due to the way Pacific led practices record their patient contacts in clinical records compared to their mainstream counterparts. Longer and complex consultations with Pacific patients could also result in a lower number of overall consults at Pacific led practices. Collecting quality data is an overarching issue which has been raised and is having an impact on various areas. Despite upgrading their IT support, the quality of information is still dependent on whether the information being entered into the system is appropriate. Having a consistent system for entering client information across all practices will make retrieving information in comparable formats.

RECRUITMENT AND RETENTION OF SKILLED STAFF

Workforce issues surrounding Pacific PHOs are related recruiting and retaining staff. Additional funding through PPDF has enabled some practices to up-skill their workforce and offer more promotions. However, some Pacific PHOs and providers felt sharing of resources across practices was an important aspect of workforce development which also requires attention. Team based working style and community involvement are consistent with the Pacific way of life consequently having the community input is also a key aspect to workforce development. This concept is particularly beneficial when it comes to accessing those in the community that are hard to reach.

Limited capacity and resources have made it difficult for Pacific providers to implement additional programmes such as Care Plus. Although it is beneficial for patients with long term conditions, sharing resources, skills and overheads are ways in which PHOs are trying to overcome them.

CONCLUSION

The objective of this report was to consider the PHCS from a Pacific perspective. Since its introduction, there has been an increase in Pacific patient enrolments in both Pacific-led practices and within the national sample. Conversely when it came to monitoring utilisation of the services, consultation rates are still lower at Pacific-led practices. In comparison to other practices, 'lower or no fees' are still being offered for patients classed as 'high needs' suggesting financial issues are not be the only barrier for Pacific patients.

It is still difficult to gain a clear picture of disparities and obtaining quality information should be a priority. Differing methods of data collection and retrieval across the PHO network made comparisons of patient data on the cost and utilisation of health care services, problematic. Providers in the access PHOs and Pacific PHOs who were interviewed did, however, note that being free from the constraints of fee-for service did mean that they were able to spend longer with patients and, therefore, they were able to provide what they considered to be a higher quality service. How to set and monitor quality targets, is likely to remain unclear until information technology and infrastructure for recording data are upgraded to ensure consistency across the PHO network.

In introducing the Strategy and providing significant new funding for primary health care, the government aimed to reduce the fees patients pay and increase consultation rates, and, given a desire to reduce inequalities in health, might have expected consultation rates to increase faster for groups with higher health needs, for example, Pacific and for more socio-economically disadvantaged groups. We have found that key aspects of government policy relating to fees are generally being met in Access practices, but that reductions in fees in Interim practices may not have been as great as might have been expected.

Consultation rates initially rose; however, there were significant falls in consultation rates in 2006/07, particularly in Access practices, and over the full study period, consultation rates increased only for those with community service cards at Interim practices (Raymont et al, 2010). For patients at Access and Pacific-led practices and for those without a community service card at Interim practices there was a drop in consultation rates. This fall in consultation rates merits further investigation – in particular to assess whether this trend continued beyond 2007.

In relation to equity, questions about the adequacy of service need to be addressed, particularly for Pacific populations, those in Access practices and those from more deprived areas. In particular, we need additional evidence on how, and to what extent, would the health of those with lower consultation rates be improved if the rates were raised and what evidence is there that those with higher consultation rates obtain equivalent benefits?

In the meantime, effective teamwork which includes sharing of resources and expertise are all part of the work ethics used by Pacific PHOs. This concept has enabled them to cope with the shortfalls in funding, although at times resources are stretched when it comes to dealing with existing patients and implementing new programmes. Overall the implementation of PHOs has provided the ability for better communication between various parties from the Board down to those working at community level.

For providers in the Pacific-led and Access PHOs the increased range of services offered and the efforts in health promotion and education in programmes such as Care Plus has meant expanded roles and responsibilities. The expectation of work in these PHOs can sometimes test the reality for some of the providers interviewed and is clearly impacting on the recruitment and retention of staff. The use of Pacific language was considered an important component of working well with Pacific patients. Further research is needed to delineate what is uniquely Pacific in the approach of the Pacific-led PHOs.

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APPENDIX 1

Evaluation Publications

Phase / Focus/Data source	Methodology	Date	Reference/Summary
Early implementation / Selected PHOs	Interviews/ survey	Mid 2002	(Perera, McDonald et al. 2003)
I: Implementation / Selected PHOs, Practices, Others	Interviews	Mid 2004	(Cumming, Raymont et al. 2005)
II. Fees and consultation rates / Sample of practices	Electronic download	2001- 2005	(Cumming and Gribben 2007)
II. Primary Health Care Nursing / Practice nurses and informants	Interviews/ Survey	2006- 2007	(Finlayson, Sheridan et al. 2008)
II. Practice and GP experience / Practices and GPs	Interviews/ Survey	2006- 2007	(Raymont and Cumming 2009)
II. PHO experiences /PHO Managers, Board members	Interviews/ Survey	2006- 2007	(Barnett, Smith et al. 2009)
III. PHO experiences / PHO managers	CATI Interviews	2008	(Smith and Cumming 2009)
III. Fees and consultation rates / Random sample of practices	Electronic download	2001- 2007	(Raymont, Cumming et al. 2010a)
III. DHB experiences / DHB primary care managers	Interviews	2008	(Raymont, Cumming, Gribben and Boustead, 2010)
III. Practice experiences/ Sample of Practices	Survey	2009	(Raymont, Cumming, Gribben and Boustead, 2010)
III. PHO, Practice and GP experiences / Selected PHO/practices (Managers/GPs)	Interviews	2009	(Raymont, Cumming, Gribben and Boustead, 2010)