

IMPROVING MĀORI HEALTH AND REDUCING INEQUALITIES BETWEEN MĀORI AND NON- MĀORI: HAS THE PRIMARY HEALTH CARE STRATEGY WORKED FOR MĀORI?

AN EVALUATION OF THE PERIOD 2003-2010

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RANGAHAU HAUORA O AOTEAROA, AND THE MINISTRY OF
HEALTH/MANATŪ HAUORA**

SEPTEMBER 2013

HE MIHI – ACKNOWLEDGEMENTS

Nāku te rourou, nāu te rourou, ka ora ai te iwi

With your basket and my basket the people will live

Tēnei he mihi nui ki ngā tāngata i roto i tēnei arotakenga. Ka mau te wehi mo tō koutou pukumahi mo te kaupapa o te pūrongo nei. E mihi atu ana ki a koutou katoa.

A team of many has contributed to the Primary Health Care Evaluation. They include: Dr. Jackie Cumming, Dr. Antony Raymont, Dr. Judith Smith, Pauline Barnett, Dr. Lynne Russell (Pere), Kirsten Smiler, Prof. Nick Mays, Dr. Barry Gribben, Carol Boustead, Dr. Mary Finlayson, Dr. Ausaga Faasalele Tanuvasa, Marianna Churchward, Mili Burnette, Dr. Margaret Pack, Joanna Minster and Hilary Stace.

This team warmly acknowledges the support of all participants in the evaluation, for giving generously of their time, knowledge and understanding of the issues and questions we raised with them. The frank and open discussion that was generated has been invaluable.

The writing of this Report – *Improving Māori Health and Reducing Inequalities between Māori and non-Māori: Has the Primary Health Care Strategy Worked for Māori?* – is especially attributable to the work of Dr. Lynne Russell (Pere) (Kāi Tahu, Ngāti Kahungunu, Kāti Māmoe, Rangitāne, Ngāti Porou) and Kirsten Smiler (Te Aitanga a Mahaki, Rongowhakaata, Te Whakatōhea). At the outset we acknowledge the delay it has taken in producing, and unreservedly apologise for this – circumstances would not permit otherwise. Engari, he aha te huarahi? I runga i te tika, te pono me te aroha.

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Whāia te iti kahurangi, ki te tuohu koe me maunga teitei

Pursue that which is precious, and do not be deterred by anything less than a lofty mountain

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GLOSSARY

Whaowhia te kete mātauranga

Fill the basket of knowledge

Hapū	sub-tribe/s
Hui	gathering/s, meeting/s
Iwi	tribal group/s
Kaimahi	worker/s, personnel
Kaiāwhina	Community Health Worker/s
Kaumātua	respected elder/s
Kōhanga reo	language nest/s, Māori language pre-school/s
Kōrero	talk, discussion/s
Kuia	elderly woman/women
Marae	traditional meeting place/s of whānau, hapū or Iwi
Pānui	newsletter/s, announcement/s
Pōhara	poor
Pūtea	budget, finance
Rangatahi	youth (singular or plural)
Raru/raruraru	problem, trouble
Tangata whenua	Indigenous persons/people of Aotearoa New Zealand, or the persons/people hosting a welcome
Tangi	funeral/s
Taurahere	Indigenous persons/people of Aotearoa New Zealand who do not hail from that area; those from another Iwi
Te Ao Māori	The Māori World
Tipuna/tupuna	ancestor/s
Tikanga	custom or meaning
Tūrangawaewae	place/s where a person belongs or has kinship links to
Wairuatanga	spirituality
Whakapapa	ancestry or genealogy
Whānau	family/families

ABBREVIATIONS

CSC	Community services card
DHB	District Health Board
NGO	Non-governmental organisation
NZDep	New Zealand Deprivation Index 2001 quintile
NZHS	New Zealand Health Strategy
PHCS	Primary Health Care Strategy
PHO	Primary health organisation
RICF	Reducing Inequalities Contingency Funds
SIA	Services to improve access

SUMMARY OF KEY FINDINGS

Ānei ngā mea i whakataukītea ai e ngā tūpuna; ko te kaha, ko te uaua, ko te pakari

Here are the things valued by the ancestors; it is the strength, the vigour, and the sturdiness

STRUCTURES

Key informants made links between their Primary Health Organisations' (PHOs) underlying philosophies of health and wellbeing for Māori, and these PHOs' structures. For most, these philosophies underpinned the development and evolution of the PHO governance structure and service delivery. Thus, the structure of Māori PHOs varies considerably across PHOs.

KEEPING, OR BRINGING, THE LEVEL OF CO-PAYMENTS DOWN

All Māori PHOs were wholly committed to maintaining low fees, despite struggling to do so. Some PHOs had a strong historical ethos of reducing health inequalities prior to the inception of the *Primary Health Care Strategy* (PHCS). Fees were too low for some PHOs who found their PHO running at a loss, and others found low fees reached a static point. Improving access to health services was cited by most PHOs as the initial motivation for low fees. Most PHOs reported increased utilisation of services since the advent of the PHCS, yet concluded that fees decreases were not the sole reason behind this. One view was that low fees made no difference to economically disadvantaged whānau members¹ who did not pay anyway. Recovering debt from whānau members was commonly discussed. Most PHOs worked with whānau members, encouraging them to pay small, regular amounts. No PHOs refused whānau members based on increasing debt. Poverty was cited as a primary reason for whānau debt.

EQUALISING ACCESS

Identified barriers to access were social, cultural, economic and geographical. To equalise access for Māori, PHOs attempted to tailor their responses to the specific barriers faced by their enrolled populations. Barriers such as economic and geographic barriers were obvious and solutions were readily identified. Identifying social barriers, however, was problematic for some PHOs and was fuelled by a disjuncture between Māori models of health and wellbeing and the 'medical model' (i.e. disease-oriented model) of health and wellbeing. Most PHOs were able to deliver an improved utilisation of services by their Māori populations, yet felt conflicted that increased utilisation of services did not necessarily equate with improved health outcomes for Māori.

¹ The terms 'whānau members' or 'whānau' are used throughout this Report in place of the terms 'patient/s' or 'client/s', irrespective of ethnicity.

Most PHOs provided two types of services: medical – delivered through general practices; and social/cultural – delivered through another social arm (often mandated by Iwi, hapū or marae communities). In many cases, PHOs suggested a collaborative approach between medical and social arms was required to ensure equalised access to health outcomes. PHOs reported funding models (including Services to Improve Access (SIA), Reducing Inequalities Contingency Funds (RICF), and health promotion funding models) privileged medical and western views on health and wellbeing. Consequently, equalised or improved access was not always as a result of well-resourced services, but rather the creative initiatives employed by PHOs.

INCREASING FOCUS ON CHRONIC CONDITIONS

An increased focus on chronic conditions was mostly managed and monitored through the medical arms of PHOs. CarePlus was a key model used to address chronic conditions by most PHOs. While CarePlus was identified as well-resourced and outcomes were easily measured, the model was very involved and logistically difficult to implement. CarePlus generated increasing amounts of paperwork for nursing staff in most PHOs and in some cases, nurses were initially unsure how to implement new structures and procedures. Most PHOs responded by utilising electronic databases to streamline reporting, and some delineated nursing roles more specifically so their efforts were more focused. Chronic conditions were also managed through the implementation of programmes initiated by PHOs. Engaging with Māori was viewed as key to addressing chronic conditions, especially conditions exacerbated by lifestyle choices, such as obesity and diabetes. While the forum of a consultation with a nurse under the CarePlus model was utilised by many PHOs (who were using the opportunity to engage with individual whānau members and their wider whānau), some did not believe this was sufficient. Most PHOs reported developing niche approaches to chronic care and were frustrated that these approaches were poorly resourced or supported.

FUNDING

Angst over funding formulas was expressed by many key informants who believed formulas privileged a clinical perspective on health and wellbeing over Māori models of wellbeing. In order to ensure health outcomes, most PHOs employed medical services alongside social services delivered mainly by Māori providers. Concern was expressed about adequate funding to service a majority high-needs enrolled population faced by some PHOs; high-needs Māori were considered a more expensive population to service because of their multiple and immediate needs. Being expected to deliver excellence on limited resources was also highlighted. Two PHOs in the sample tackled the under-funding of their services through working collaboratively; one of the PHOs which had an established infrastructure often supported the other PHO by offering their infrastructure for free. The belief of the PHO providing the support was that the other PHO in the region should not seek funding for infrastructure that tax payers' money had already established. These two PHOs had a collegial relationship.

ACHIEVING AND USING COMMUNITY INPUT

All PHOs were organised so that key community representatives held positions at governance level. Some were elected on governance Boards, while some governance Boards were structured so that representatives from providers within the PHO also sat on them. Providers in the latter group had a strong history of advocating for improved health status for their communities and this method ensured ongoing advocacy at PHO level. PHOs who had strong Iwi or hapū relationships sought formal mandates and ongoing support from their communities. In these cases, these communities saw the PHO as their representative health agency. Although a strong community presence at representative level was reported, few discussed whether these representatives had a strong connection with communities themselves. Some described their efforts to regularly communicate with communities through a range of media including surveys, road-shows, pānui and hui, which worked well in rural contexts. How PHOs utilised community input was unclear.

MAINTAINING AN EFFICIENT WORKFORCE

The dynamic development of PHOs under the PHCS has prompted PHOs to approach workforce development in a responsive and strategic manner. Many issues regarding workforce need and capacity were unveiled as structures were established, as problem areas arose, and as new policies or funding contracts were introduced. The majority of PHOs delivered two types of services – clinical and social (for example, smoking cessation and healthy lifestyle programmes). The majority combined the two. Many PHOs struggled to maintain a stable clinical workforce; most employed locum General Practitioners (GPs) and a small number had established clinics within the PHO clinical structure. Traditional models which emphasised the role of the GP were challenged in some PHOs, especially with the advent of the CarePlus model. The increasing responsibilities of nurses under this model required a more specialised nursing skill set.

Engaging with Māori communities was a priority for all PHOs, and a Māori workforce was seen as key to engagement. While a strong Māori presence was reported within social services, it was scarce within clinical services. Five PHOs were strategic in their approach to addressing this gap, introducing scholarships for Māori trainee doctors and career pathway programmes for Māori trainee nurses. In most cases, this support was provided on the premise that trainees would make a contribution to the PHO once training was completed.

THE FUTURE

During the third phase of the evaluation, it was found that the majority of key informants had ambivalent feelings about the future of their PHO. The majority had made major investments (emotional, financial, and in terms of time) interpreting the PHCS, understanding its complexity, and gaining traction in achieving improved health outcomes. Some established key informants who had worked in primary health over a significant period of time noted that restructuring of the sector was inevitable, especially with changes in political influence. It was noted also that Māori have historically been forced to work with whatever system exists. Based on this experience then, a level of creativeness and sophistication is required by Māori to ensure they can continue to deliver services.

1. INTRODUCTION

Ki te kahore he whakakitenga ka ngaro te iwi

Without foresight or vision the people will be lost

The *Primary Health Care Strategy* (PHCS), introduced by the government in 2001, aimed to improve health and reduce inequalities. The first Primary Health Organisations (PHOs) to be established under the PHCS, in July 2002, were TaPasefika Health Trust and Te Kupenga o Hoturoa Charitable Trust, both in the Counties Manukau District Health Board (DHB). By late 2006, there were 81 PHOs in operation with 3.9 million whānau members² enrolled, and the government had allocated over \$2 billion in extra funding to primary health care to reduce the charges (amongst other things) these whānau members paid when using services. In the consequent years, primary health care altered to include a period of amalgamation, so that as at January 2011, there were 46 PHOs with 4.2 million whānau members enrolled (<http://www.moh.govt.nz/moh.nsf/indexmh/phcs-pho>).

An evaluation of the implementation of the PHCS was undertaken by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland. This evaluation involved three phases and three time periods (2004, 2006 and 2008/09). Data were collated from: qualitative interviews with a range of key informants and national stakeholders, a sample of PHO Board members and staff, and a sample of staff in general practices; a postal survey of all PHO Board members and staff, practice Managers, General Practitioners (GPs), and nurses working in general practices; and quantitative analysis looking at utilisation of services and fees. Each subsequent phase of the evaluation 'took the pulse' of the sector five, seven and eight years after the PHCS was published; gaining an understanding of the changes and developments in primary health care and PHOs since the first phase of the evaluation in 2004 (Cumming & Gribben, 2007; Croxson, Smith & Cumming, 2009; Raymont & Cumming, 2009).

This Report outlines the findings of the evaluation that are specific to Māori from all three phases. It begins with a literature review; background information documenting Māori health status, trends, indicators and inequalities contextualise the evaluation. Māori access to primary health services and the implication of the PHCS for Māori including its focus on reducing inequalities are also outlined.

The focus of the Report is on: the goals of the PHCS that are specific to Māori; general perceptions from Māori of the PHCS and its implementation; what activities PHOs are engaged in to improve Māori health and reduce inequalities between Māori and non-Māori; and challenges and issues for Māori identified in the evaluation. Essentially, it considers how the PHCS has worked or not worked for Māori.

² The terms 'whānau members' or 'whānau' are used throughout this Report in place of the terms 'patient/s' or 'client/s', irrespective of ethnicity.

2. LITERATURE

Titiro ki muri, kia whakatika ā mua

Look to the past to proceed to the future

DOCUMENTING MĀORI HEALTH: STATUS, TRENDS, INDICATORS AND INEQUALITIES

The status of Māori health is well canvassed in research in Aotearoa/New Zealand; emphasis has been given to outlining Māori health trends, disparities in Māori health, and comparing Māori health status with other population groups. Understanding the complexities underpinning disparities, and ways in which inequalities can be addressed, has been a key concern for many Māori health researchers.

MĀORI HEALTH STATUS IN AOTEAROA/NEW ZEALAND

Studies, statistics and measures documenting the status of Māori health in Aotearoa/New Zealand confirm that Māori experience systematic disparities in health outcomes, determinants of health, health system responsiveness, and representation in the health sector workforce (Pōmare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson & Wātene-Haydon, 1995; Ministry of Health/Manatū Hauora, 2004; 2006; Ministry of Health/Manatū Hauora & University of Otago, 2006; Robson & Harris, 2007).

The 2004 *Portrait of Health* report covered key results from the 2002/03 New Zealand Health Survey (Ministry of Health/Manatū Hauora, 2004b) of 12,929 New Zealanders, including 4,369 Māori, and explored the self-reported health status of New Zealanders based on the Short Form 36 (SF-36) survey (Ware & Sherbourne, 1992) and the World Health Organisation (WHO) Long Form Questionnaire on health status (WHO, 2001). Areas covered in the survey included: general health; vision; hearing; digestion; breathing; pain; mental health; sleep; energy and vitality; understanding communication; physical functioning; self-care; usual activities; and social functioning (Ministry of Health/Manatū Hauora, 2004b). The survey results showed non-Māori (female and male cohorts) generally rated their health status higher than Māori. The results, however, failed to reflect the health disparities illustrated in other studies which typically measure health status by mortality, morbidity, disease and burden of risk.

Objective 11 of the 2001 *New Zealand Disability Strategy* seeks to promote the participation of disabled Māori (Ministry of Health/Manatū Hauora, 2001). A study of Objective 11 by a researcher from Johns Hopkins University (Wiley, 2009), found a need for more active collaboration across sectors to address the needs of disabled Māori.

COMPARING APPLES WITH PEARS: MĀORI WITH NON-MĀORI

The analysis of Māori health status in studies such as the *Hauora: Māori Standards of Health, Decades of Disparities I, II, III and IV*, and *Tracking Disparity* series, and the *Tatau Kahukura: Māori Health Chart Book* (Pōmare et al., 1995; Ajwani, Blakely, Robinson, Tobias & Bonne, 2003; Blakely, Fawcett, Atkinson, Tobias & Cheung, 2004; Ministry of Health/Manatū Hauora & University of Otago, 2006; Blakely, Tobias, Atkinson, Yeh & Huang, 2007; Ministry of Health/Manatū Hauora, 2006) report Māori as: having significantly higher mortality rates than non-Māori; leading in almost every major disease category; having a higher prevalence of chronic diseases than non-Māori; and experiencing higher mortality rates as a result of a chronic disease. *Tatau Kahukura* (Ministry of Health/Manatū Hauora, 2006), a chart of Māori health statistics, reports Māori are more likely to be hospitalised for asthma, intentional self-harm, assault, attempted homicide and unintentional injury, and are also likely to have a higher prevalence in meningococcal disease and rheumatic fever notifications, obesity, diabetes, asthma, low birth weight and hearing loss.

This common method of charting Māori health status in comparison to non-Māori is a useful tool for illustrating inequalities in health between population groups, and for documenting and monitoring health trends. Ratima, Edwards, Crengle, Smylie and Anderson (2006), however, question the collection of Māori health data using these methods, suggesting that this information is not consistently used for evidence-based decision-making, and is often used for mere accountability purposes. Pōmare et al. (1995) also critique the comparison of Māori health status to non-Māori, suggesting that by identifying universal health outcomes, there is a risk of supporting assimilative goals due to the assumption that the health of Māori and non-Māori are underpinned by the same value system. Ratima et al. (2006) argue that while universal health indicators are important, they are limited in their capacity to capture the status of Māori health according to Māori concepts of health, and note that methods used to develop such indicators or measures of Māori health, rarely involve Māori input.

THE RE-FRAMING OF MĀORI HEALTH STATUS

In contrast, 'Te Ngahuru' (Durie, Fitzgerald, Kingi, McKinley & Stevenson, 2002), a framework developed by Māori researchers for Māori-specific indicators of health and wellbeing, utilises an holistic approach to health, wellbeing and development. This framework places value on producing outcomes and indicators which are consistent with Māori perspectives, processes and priorities:

... unless Māori development is closely aligned with Māori views and aspirations, then it might be analysed within frameworks that ultimately disadvantage Māori people... Māori development could be similarly undermined if a narrow developmental model, at odds with Māori worldviews, were allowed to signpost the direction ahead. (Durie et al., 2002:12)

This call to 're-frame' the way the status of Māori health is documented and designed has also led to a reflection on those numerous factors (social, economic, cultural and health services influences) which contribute to health.

CONTRIBUTORS TO HEALTH INEQUALITIES

Jones (2000, cited in Reid & Robson, 2006:26) suggests there are three main pathways that contribute to ethnic inequalities in health:

1. Differential access to the determinants of the health exposures leading to differences in disease incidence;
2. Differential access to health care; and
3. Differences in the quality of care received.

Reid and Robson (2006) argue Māori and non-Māori have very different health profiles with respect to determinants of health – education, employment, housing, income, income support, literacy, engagement with the criminal justice system, and deprivation (see also Howden-Chapman & Tobias, 2000). They suggest that these profiles pattern exposure to risks such as tobacco, alcohol and other drug use and addiction, poor nutrition, problem gambling, overcrowding and substandard housing, and unsafe employment conditions (more blue-collar, low-paying employment).

The issue of differential access to health care and differences in the quality of care is well documented in health system literature. Reid and Robson (2006) note Māori experience longer and slower pathways through the health care system. Low hospitalisation rates for diseases, despite high death rates and the configuration of services, also make it difficult for people without access to transport or resources to access treatment and prevention services.

An exploration into the statistics describing cancer demographics exemplifies the inequalities in health outcomes and health system responsiveness for Māori. Coverage rates for breast cancer screening during 2002/03 showed 44.3 percent of Māori women compared to 62.3 percent of all women in Aotearoa/New Zealand were screened, and coverage rates for cervical screening during 1999/2001 showed 50.9 percent of Māori women compared to 72.7 percent of all women in Aotearoa/New Zealand were screened (Ministry of Health/Manatū Hauora, 2004b). For Māori men, inequalities are also evident. Although Māori male cancer registration rates are much lower than non-Māori, their mortality rates are disproportionately higher (Ministry of Health/Manatū Hauora, 2006). Robson, Purdie and Cormack (2006) conclude inequalities for Māori with cancer have been longstanding and that not only are incidence and mortality rates higher for Māori than non-Māori, but Māori also experience lower survival rates (Gill & Martin, 2002; Cormack, Robson, Purdie, Ratima & Brown, 2005; Jeffreys, Stevanovich, Tobias, Lewis, Ellison-Losch, Mann, Pearce & Blakely, 2005), differences in the distribution of risk and protective factors (Ministry of Health/Manatū Hauora, 2004), and disparities in access to cancer services (Cormack et al., 2005).

The *Decades of Disparities I, II and III* and *Tracking Disparity* series (Ajwani et al., 2003; Blakely et al., 2004; Ministry of Health/Manatū Hauora & University of Otago, 2006; Blakely et al., 2007), which explore the relationship between socioeconomic position, ethnicity and mortality in Aotearoa/New Zealand, illustrate that Māori experience poor health consequences and mortality rates associated with belonging to the socioeconomic strata in all age cohorts – outlining a causal relationship between mortality, poor health, poverty and ethnicity. Other studies (Salmond & Crampton, 1999; Tobias & Cheung, 2003) echo these findings.

In her review of the *Economic Determinants of Māori Health and Disparities*, Robson (2004) analysed how resources impacting health become distributed unevenly between Māori and non-Māori populations. Her framework for analysis employed Williams' (1997) model of 'basic' and 'surface causes', Reid, Robson and Jones' (2002) model of 'distribution gaps' and 'outcome gaps', and theories on the impact of colonialism. Williams (1997) posits that the determinants of health inequality (not to be confused with determinants of health) can be framed in terms of basic causes (such as culture, racism, economic structures, and political and legal factors) or surface causes (such as health practices' stress, psychosocial resources, and medical care). Reid et al. (2002) conclude two types of disparities exist between Māori and non-Māori – distribution gaps (unequal distribution of economic and/or socioeconomic resources) and outcome gaps (differential outcomes, such as health status and health service utilisation, for Māori and non-Māori within each socioeconomic category). Both need to be removed to achieve equity in health. Robson (2004:13) suggests that *"the interlocking nature of axes of inequality must be acknowledged at this point, as well as the context-specific nature of the basic social forces that under-ride collective health outcomes"*.

ADDRESSING HEALTH INEQUALITIES

In an attempt to address obvious health inequalities, the Ministry of Health/Manatū Hauora's (2002a) *Reducing Inequalities in Health* document developed an intervention framework which employs four target levels of intervention:

1. Level one – *structural*;
2. Level two – *intermediary pathways*;
3. Level three – *health and disability services*; and
4. Level four – *impact*.

This layered approach recognises the systemic relationship between the structural and intermediary pathways; for example, targeting the structural level (changes at policy levels – health, welfare, labour market and taxation) has direct implications on intermediary pathways (education, housing, employment, physical and social contexts), all of which have some bearing on health status, outcomes and the need for health care. Level three acknowledges the need to address the complex health profile of Māori, whilst level four aims to minimise the negative impact of disability and illness on socioeconomic position, for example, on employment opportunities. Robson (2004) hypothesises that improved health services may have a greater impact on improving health gains for Māori than for non-Māori, and may have some bearing on the impact level of intervention outlined by the Ministry of Health/Manatū Hauora (2002a). She writes:

Māori are more likely to experience ill health and, therefore, more likely to require support to prevent the spiraling downward mobility, or indeed to increase upward mobility. The greater exposure of Māori to economic discrimination also implies a potentially greater risk of downward mobility for Māori who become ill or injured than for Pākehā (i.e. it is harder for healthy Māori to get re-employed than for non-Māori, let alone unhealthy Māori). In addition, unequal distributions of wealth, income, and insurance, make such support more critical for the Māori population. (Robson, 2004:14)

Statistics and studies documenting and describing Māori health reveal that Māori experience systematic disparities in health. While this common method for documenting health status is useful for monitoring health trends, Māori health researchers note that such approaches fixate on Māori experiences of ill-health, as opposed to the holistic experience of Māori health. In response, Māori health researchers and community leaders have utilised this information to describe types of inequities experienced by Māori and to explain why these inequities exist. As part of this process they have also questioned comparative statistics (in which Māori health is described comparative to non-Māori) and have supported the development of Māori-specific health indicators, which they suggest enable Māori health to be measured against more holistic frameworks.

MĀORI ACCESS TO PRIMARY HEALTH SERVICES

A strong primary health care system is seen as a central contributor to maintaining and improving health and wellbeing, and tackling inequalities in health. A number of studies focusing on differences between Māori and non-Māori utilisation of health services, however, illuminate inequalities in terms of Māori access to primary health care in Aotearoa/New Zealand (Davis, 1986a; 1986b; 1987a; 1987b; Pōmare et al., 1995; Westbrooke, Baxter & Hogan, 2001; Ministry of Health/Manatū Hauora, 2004b; 2006). Early investigations into Māori access to primary health services suggested that Māori utilisation rates of health services varied according to gender and age; female utilisation rates were much lower, males utilisation rates were slightly lower, and children's utilisation rates were average (Davis, 1987a; 1987b). The overall Māori use of GP services though, was higher than non-Māori, although not high enough given their poorer health status (Gribben, 1992; Pōmare et al., 1995). However, later survey data – the 1996/97 and 2002/03 *New Zealand Health Surveys* which control for a wide range of socioeconomic characteristics and for health status (Ministry of Health/Manatū Hauora, 1999; 2004b) – have found Māori were less likely to visit their GP. The National Primary Health Care Survey (Crengle, Lay-Yee & Davis, 2004), which collected data in 2001/02 from 1,999 private general practices, 24 physicians in community governed practices, and 21 doctors who worked with Māori providers, reveals key disparities surrounding the use of primary health care utilisation amongst Māori. More Māori visits to GPs were graded as urgent, yet GPs reported less time spent in consultations with Māori whānau members than non-Māori whānau members (13.7 minutes compared to 15.1 minutes), ordered fewer tests and investigations for Māori than non-Māori (for example, blood-lipid and glucose tests were ordered at a lower rate for Māori despite high diabetes rates), recommended a lower level of follow-up visits (within three months) for Māori than non-Māori (54.6 percent compared to 57.5 percent), and made less referrals for Māori than non-Māori.

The overall results suggest that in many cases Māori have less access to primary health care relative to the whole population, particularly when proxies for need, such as mortality and hospital discharges, are taken into account. Poor access to primary health care for Māori is considered a key factor in higher rates of illness and hospitalisations amongst Māori, in generating poorer health outcomes for Māori, and in the inequalities in health in Aotearoa/New Zealand (Pōmare et al., 1995; Ministry of Health/Manatū Hauora, 2006).

This trend of poor access to primary health care services appears to contradict trends for secondary access (emergency access) where Māori have higher or equal rates of utilisation. Jansen and Smith (2006) note this anomaly based on referral rates in hospital discharges:

By contrast there is little disparity in access to emergency care. For example, Māori and non-Māori have equal rates of access to emergency transport and also to specialist accident-related treatment once a referral is made. In these situations care is dictated by protocol... Once the emergency situation has passed, utilisation of services by Māori appears to revert back to that seen outside an emergency situation, that is, barriers are reinstated, and less than optimal care is provided. (Jansen & Smith, 2006:298)

A variety of explanations have been put forward to explain differences in access, including cost, location, transport, the attitudes and behaviours of doctors and health service staff, the cultural responsiveness of health services, acceptability of the service, and knowledge of the importance of care (Pōmare et al., 1995; Crengle, 1999). The largest and most recent evaluation of projects focused on reducing inequalities in Aotearoa/New Zealand, evaluated 35 different projects aimed at improving access in practices which have predominantly Māori, Pacific or socioeconomically-deprived populations (CBG Health Research Ltd, 2011). Conducted between 2003 and 2006, this evaluation involved: site visits to all participating health providers including isolated rural providers; three rounds of in-depth interviews with providers and a final follow-up telephone survey; interviews with funding DHBs; and quantitative analyses of provider level databases and national data (hospital admissions, Emergency Department use, outpatient clinics, and cervical screening rates). The evaluation concluded that although financial barriers to access are still significant, non-financial barriers are just as important. Crengle, Lay-Yee, Davis and Pearson (2005), Crengle et al. (2004), McCreanor and Nairn (2002), and Jansen and Smith (2006) also suggest that the solution to reducing the lower level of Māori access to primary health care services will involve addressing typical barriers such as costs and policy, as well as improving communication skills and attitudes of health care providers. Jansen and Smith (2006) write:

Primary care providers, like other health professionals, may unwittingly provide less care to those with the greatest health needs because of lack of cultural or social concordance. The lack of background or understanding inhibits the therapeutic relationship, and this in turn impacts the care received. (Jansen & Smith, 2006:299)

FOCUS ON INEQUALITIES AND PREVENTATIVE PRIMARY HEALTH CARE

PRIMARY HEALTH CARE STRATEGY

In the New Zealand Public Health and Disability Act 2000 the New Zealand government introduced a number of overarching strategies to guide the health and disability sector, including the establishment of 21 DHBs as regional organisations responsible for population health. Under this schema, a series of further initiatives geared toward managing and improving population health also came to fruition: the *New Zealand Health Strategy* (NZHS) (Ministry of Health/Manatū Hauora, 2000), which sets the overall direction for the health and disability sector; *He Korowai Ōranga – Māori Health Strategy* (Ministry of Health/Manatū Hauora, 2002a), which sets the direction for Māori health development; and the PHCS (King, 2001), which provides a clear direction for the development of primary health under the NZHS and *The New Zealand Disability Strategy: Making a World of Difference: Whakanui Oranga* (Ministry of Health/Manatū Hauora, 2001).

Through the introduction of the PHCS, the New Zealand government has established a primary health care structure, which aims to improve health inequalities through emphasising a population approach to health. A series of PHOs were established as local non-governmental organisations which serve the needs of an enrolled population. Under this system, the PHCS proposed that: people will be a part of local primary health care services that improve their health, keep them well, are easy to get to, and co-ordinate their ongoing care; and primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups (King, 2001).

Implementation of the PHCS has involved three main changes in policy:

1. Reducing financial barriers to access, by increasing primary care subsidies;
2. Developing PHOs to work with enrolled populations; and
3. Moving to capitation funding.

The implementation of the PHCS has involved a collaborative process between providers, communities, DHBs and the Ministry of Health/Manatū Hauora. Initially in 2001, it was proposed that PHOs would be introduced to the whole Aotearoa/New Zealand population over an eight to ten year period. However, the development of PHOs occurred more rapidly than expected, and in 2004, 91 percent of the Aotearoa/New Zealand population was enrolled in 77 PHOs (including three quarters of the Māori population and almost all of the Pacific Island population) (King, 2004). Since July 2002, 81 PHOs have been established (although following a period of amalgamation, in 2011 there were 46 PHOs) covering 4.2 million out of 4.4 million New Zealanders.

FUNDING PRIMARY HEALTH CARE

At a very fundamental level, the PHCS policy acknowledged the primary link between poverty and health inequalities, and attempted to address this through moving away from a targeted approach in which the government provided varying subsidised rates to different population groups, to an approach whereby all New Zealanders were eligible for funding for primary health care. To ensure that funding set aside for primary health care went to those in most need, however, the government initially chose to create two forms of funding formulae: Access and Interim³. Access-funded PHOs, which generally serve higher needs populations, were funded at higher capitation rates. All other PHOs were deemed Interim-funded PHOs. Since 2003, however, the government has provided further funding, increasing the rates paid to Interim-funded PHOs to come in line with those of Access-funded PHOs. In addition, both Interim- and Access-funded PHOs became eligible for other new funding – SIA funding, management, and health promotion funding.

In October 2006 further changes were made to the funding levels of PHOs; those PHOs offering very low cost access (that is, low fees) became eligible for even higher subsidies. As Access funding was implemented, the government expected that raised capitation would be reflected in a lower or reduced cost to whānau members. This policy was implemented through discussions between the Ministry of Health/Manatū Hauora, DHB and PHO staff. The government provided \$2.2 billion in primary health care funding over seven years to support the implementation of the PHCS.

There have been some inconsistencies, however, related to the Access and Interim funding formulae. Some PHOs whose enrolled populations originally included individuals from the high-needs population groups criticised the formulae – noting that they lost these enrolments to Access-funded PHO in the Interim-funded period. However, in 2004, the Government intended to expedite the PHCS implementation process, and have all PHOs on Access funding by 2004.

IMPLICATIONS OF THE PRIMARY HEALTH CARE STRATEGY FOR MĀORI

He Korowai Ōranga – Māori Health Strategy, introduced in 2002, set the direction for Māori health development for a ten year period. The overall aim of *He Korowai Ōranga* is 'Whānau Ora' – Māori families being supported to achieve their maximum health and wellbeing. Whānau Ora works toward a vision whereby whānau (including those with disabilities): experience physical, spiritual, mental and emotional health; have control over their own destinies; live longer and enjoy a better quality of life; and participate in Te Ao Māori and wider Aotearoa/New Zealand society (Ministry of Health/Manatū Hauora, 2002a).

Improving Māori health and reducing the inequalities for Māori is a key precursor to *He Korowai Ōranga*. *He Korowai Ōranga* acknowledges that to achieve these Māori health outcomes, Māori approaches to wellness must be applied in conjunction with an intersectoral approach. This involves supporting Māori-led initiatives and the desire for Māori control over the future direction of Māori health. In this sense, *He Korowai Ōranga* and the PHCS share a similar approach to health – they both look toward a community approach to overcome health inequalities and to promote positive health and wellbeing.

³ Both Access- and Interim-funded PHOs obtain funding for their enrolled population. Access-funded PHOs, however, received more funding (based on the fact that over 50 percent of their enrolled population are Māori, Pasifika, or from the most deprived 20 percent of Aotearoa/New Zealand according to the NZDep index).

How successful these strategies have been in meeting these objectives, is now the centre of discussion, evaluation and debate (Robinson & Blaiklock, 2003; Earp & Matheson, 2004).

A report to the Ministry of Health/Manatū Hauora's Māori Health Directorate (New Zealand Institute of Economic Research, 2003:i) summarised the impact of *He Korowai Ōranga* on Māori health, concluding that *He Korowai Ōranga* is "creating an environment with significant opportunities for improving Māori health objectives (access, outcomes and participation in governance and provision)". The New Zealand Institute of Economic Research (NZIER:2003) notes that these opportunities stem from a "new orientation as well as from better incentives on primary care providers, and a regulatory environment which seeks greater involvement of, and sensitivity to Māori consumers, community groupings and Māori health providers".

MĀORI-LED PHOs AND MĀORI PROVIDERS

The impact of the PHCS on providers' and PHOs' cultural receptiveness to Māori can also be seen in the increase of Māori providership, establishment of Māori-led PHOs, Māori provider groups, and improved relationships between Māori communities and non-Māori-led PHOs. Under the PHCS, PHOs must evidence engagement with community groups (including Māori community groups) and include them within their governance structures in order to meet funding criteria (King, 2001). Initially this policy aimed to address issues of power and control between health providers and community groups, and to ensure improved communication and relationships between provider and community. However, as the PHCS has unraveled, this dynamic has evolved; issues relating to non-Māori-led PHOs and providers and Māori-led PHOs and providers reveal some of the complexities surrounding power, control and relationships. In the context of non-Māori-led PHOs, PHCS policy has been interpreted as necessitating an increased connection between Māori health providers and mainstream providers (King, 2001).

Within the context of Māori-led providers and PHOs, case studies (Abel, Gibson, Ehai & Tipene-Leach, 2005) and reviews (Crengle, 1999) suggest that Māori-led providers and PHOs tend to adopt a population approach to health and are naturally inclined to adopt a collective view of health – in which community engagement and inclusion at the level of governance is considered essential and is valued. Crengle (1999) notes the governance style of Māori-led providers and PHOs is often characterised by tikanga and/or Māori frameworks for understanding health and delivering care, as opposed to medical frameworks of care; the 'ownership' of provider is held by a tribal or local Māori community group/s. Abel et al. (2005) suggest a major challenge for Māori providers and Māori-led PHOs is finding the right balance between population and individual medical health. For example, difficulties arise when providers have to prioritise population health strategies with a population who have high individualised medical needs (high morbidity rates within the population) (NZIER, 2003).

The NZIER (2003) examined the impact of PHO development on Māori health, identifying some potential risks to Māori health providership. It suggested reducing co-payments in mainstream PHOs for first line service perhaps discouraged mainstream services from adopting and developing Māori health services. In the first instance, many Māori providers found it difficult to meet enrolment criteria without or with very little front line staff, making the task of enrolment either very difficult or unrealistic. Another major risk to Māori providers – the risk of marginalisation within larger PHOs – has been noted as important. Although some providers have transitioned easily and have maintained a strong position (for example, when sole partner/or major partner), others have not remained so.

Another example illustrating this tension is in the use of performance indicators. The Ministry of Health/Manatū Hauora (2004a) draft operational framework for PHO management initially identified nine clinical and five administrative indicators. These indicators have since been reviewed to include financial, clinical and process performance and now target measures identified between PHO and DHB. Abel et al. (2005) criticise this process of identifying indicators, noting that as the implications of the PHCS unfolds, the complexity of delivering primary health care services to Māori unfolds, and performance indicators need to acknowledge and respond to this complexity. For example, while there are indicators which target access and service utilisation, the proposed framework does not consider other dimensions such as whānau or wairuatanga.

3. METHODOLOGY

Moemoeātia te moemoeā, engari whakatinanahia

Dream the dream, but achieve it also

This report canvasses Māori-specific findings from three phases of interviewing (2004, 2006 and 2008/09). Different approaches were used for the various phases.

The approach used in phase one and two captured a breadth of perspective on the PHCS's effectiveness for Māori. Qualitative data was collated from 110-120 key participants from seven selected DHBs; 20 PHOs; and nine key informants or national stakeholders, including from the Ministry of Health/Manatū Hauora, Independent Practitioners Association Council of New Zealand, The Royal New Zealand College of GPs, Primary Health Organisations New Zealand Inc., and Pharmacy Guild. PHOs included a mix of: large IPA-based PHOs, medium and smaller sized PHOs; Access- and Interim-funded PHOs⁴; and Māori, Pasifika and 'Other' focus PHOs.

A different approach was used for the third phase of data collection. The first and second phases of data collection revealed the diverse nature of PHOs and the evaluators found participants' ability to reflect on the effectiveness of the PHCS for Māori also varied. Some participants' knowledge of Māori health and inequalities was extensive, while other participants' knowledge was either superficial or at an exploratory stage. This provided a rationale for a differing approach for phase three: key informants from six PHOs (who had a high percentage of Māori enrolments or were considered to be Māori-led by the Ministry of Health/Manatū Hauora classification system) were purposefully sampled to add a level of depth to the data.

The purpose of this staging of the evaluation was to gain an understanding of the changes and developments in primary health care and PHOs since the first phase of the evaluation in 2004. It was intended to 'take the pulse' of the sector from this period to 2009 (Croxson et al., 2009; Cumming & Gribben, 2007; Raymont & Cumming, 2009).

SAMPLE

Participants from phases one and two included at least four representatives from governance and management within each PHO, for example, the PHO Board Chair, Māori representative on the Board, Pasifika representative on the Board, doctor on the Board, nurse on the Board, and/or the PHO Manager. In addition, a nurse and GP representative from two separate general practices who were members of the PHO were included as participants.

⁴ Some of the 20 PHOs received a mix of both Access and Interim funding.

Although the actual number of Māori interviewed in these phases is unclear, it is estimated that between 15-20 percent of all of the interviews were with Māori. This is based on the fact that the Māori representative on each of the 20 PHO Boards should have been interviewed, and a number of the PHOs involved were considered to be 'Māori-led', meaning they were either a 'Self-Identified Māori PHO', a 'PHO with a focus on Māori', or a PHO who had a large registered Māori population⁵. The assumption is that these 'Māori-led' PHOs have greater numbers of Māori in governance and management roles, and more Māori clinicians.

Participants in the third phase of interviews from six Māori-led PHOs were purposefully targeted and all were Māori. While they specifically responded to questions by discussing the experience of their PHO (which provided case examples for the evaluators), they also articulated their responses in context to their extensive experience in the area of Māori health.

METHODOLOGY

Interviews for the three phases began in 2004. Participants were approached in writing, by email, and phone to scope their interest in participating in the evaluation. Semi-structured interview guides were made available to participants prior to interviews to ensure that relevant evaluation aims were covered during each interview.

Due to the nature of differing expertise of participants in the various stages, some participants' discussions in the first two phases focused on reflections of the implementation of PHOs more generally; consequently, dialogue relating to Māori health was, in some instances, relatively brief. To ensure depth of data was captured in the final phase, a semi-structured interview schedule acted as a guide, with questions encouraging participants to refer to examples from their specific PHOs. Participants were also asked to reflect on the wider question – whether the PHCS has worked for Māori – at the beginning of the interview and were encouraged to respond to this question more generally.

All interviews were recorded with the permission of participants. For the first two phases of the evaluation, summaries of the interviews were developed and returned to participants for checking (unless otherwise requested). For the third phase of the evaluation, key informants were sent copies of their original transcripts and invited to provide ongoing feedback on draft reports.

⁵ The identification of PHOs as 'Self-Identified Māori PHOs' or 'PHOs with a focus on Māori' is derived from an old Ministry of Health classification system, which saw 23 PHOs given this status. The criteria used in these classifications are unknown but it is apparent that the rate of the PHOs' registered Māori populations is irrelevant. Of the 20 PHOs included in this evaluation, one was considered a 'Self-Identified Māori PHO', and two were considered 'PHOs with a focus on Māori'. The percentage of enrolled Māori population varied within these three PHOs from 17 percent in the 'Self-Identified Māori PHO', to 41 percent and 55 percent in the two 'PHOs with a focus on Māori'. This compares with a 73 percent and a 56 percent enrolled Māori population at two other PHOs included in this evaluation, but ones which are not classified as either 'Self-Identified Māori PHOs' or 'PHOs with a focus on Māori'.

A series of notes, transcripts, and PHO and DHB reports was analysed inductively for this Report. Data from the first two phases were organised according to notes and a thematic analysis based on evaluators' reports of key messages and quotes was used. Data from the third phase of collection included transcripts from interviews and reports provided by PHOs. Data were coded according to the evaluation's objectives as well as themes arising inductively from the data. This Report is based on the findings of all three phases of interviewing.

4. FEES FOR MĀORI-LED PHOs

He aha te mea nui o te ao? He tangata, he tangata, he tangata

What is the most important thing in the world? It is people, it is people, it is people

In terms of keeping, or bringing, the level of co-payments down, participants were asked a number of questions around the role PHOs have in reducing fees, what may be done to maintain a low fees environment, and what the particular issues for Māori providers are with fees and fee setting.

Three main points were made. First, there is a distinct core difference within the values of practices; some are aiming to maximise their profit and, therefore, set fees at the highest rate possible, while others have a particular focus on reducing fees for service-users, and keeping them low:

“... they recognise the benefit to patients in fee reduction to provide better access.” (GP Board member, large, IPA-based, non-Māori-led PHO)

Māori-led PHOs were fairly consistent in their focus on reducing fees for their service-users and keeping them as low as possible, providing, for example, free primary health care for those aged under 18 years, charging \$10 for those aged 18 years and over with Community Services Cards (CSCs), and \$15 for all others without a CSC. One Māori representative on an interim-funded PHO was particularly concerned that primary health care for children aged under six years remain free.

Second, there was some degree of sympathy expressed for the practices that do aim to reduce fees. The pressure of costs on delivering primary health care, felt by these practices, is significant, and as costs have risen, some have unavoidably seen a need to increase fees.

And third, despite one of the key roles of PHOs being to work with practices to keep fees low, PHO management of individual practice fees is recognised as being difficult at times. A Pasifika representative on the Boards of two PHOs – one, a Māori-led PHO and the other, a non-Māori-led PHO – aptly indicated this in his response to being asked whether he thought his PHO had good data on fees being charged around different practices in the PHO:

“Initially there wasn’t. One of the biggest problems as a Board member is to try and manage who’s paying what, and at what level, and also whether they have actually taken into consideration the type of population that they have in terms of the deprivation. So, as a Board member, it was quite difficult to receive that information from community practice. In fact, they are not forthcoming with the information. They keep it private and always treat it as [if] it’s not commercial information. They tend to sort of work private as a GP and not share that information with the actual PHO... So, in terms of fees, we’ve had huge problems for Māori and Pacific... Māori, Pacific, and community [representatives], the three of us, we hound the GPs [to] provid[e] us with a list of their fees, so that we know that the enrolled population are getting charged the right fees. We weren’t getting it.”
(Pasifika Board representative, Māori-led PHO and non-Māori-led PHO)

The need to maintain a low fees environment and improve funding were two key factors identified by Māori-led PHOs as important for primary health care. Māori providers have traditionally had lower fees and many participants liked the fact that there was access to many different funding sources to keep fees down.

MAINTAINING A LOW FEES ENVIRONMENT

In terms of maintaining a low fees environment, a number of points were made. First, many participants supported the initiative of using multiple funding streams. One DHB Manager, however, questioned the fairness of this approach, suggesting that Māori providers’ use of ethnic-based funding, such as disease state nursing funds, created an environment which did not have *“a level playing field”*, with Māori providers instead having *“more funding available to help them keep their fees down”*. Her implication was that because Māori providers were ‘rewarded’ or given extra funding to serve the high-needs population they have enrolled under the PHCS, they were more able to maintain their historical lower fees. CarePlus funding was considered to be a more equitable funding formula – presumably because it was perceived as being non-ethnic-based. CarePlus was generally commented on favourably because it allows for longer consultations for people with chronic conditions, and recognises the need for extra visits for these whānau members and those on lower incomes.

There was a suggestion by some practices that fees had already gone as low as they could and may not be able to be reduced any further, although some did manage to maintain zero fees for members and only charge for casual use. For some, keeping a free service was in response to the mobility of the population and the logistic and paperwork difficulties in tracking down non-payments.

It was a common theme, however, that maintaining low fees was not sustainable and carried risks:

“It’s hard, financially, to keep it financially viable. But we originally set up before PHOs – we set up GP clinics – and the reason for setting them up was our people weren’t going to the doctor because they couldn’t afford it, and then they weren’t picking up their medicines because they couldn’t afford it. So that’s sort of been the driver behind us in operating.” (Māori-led PHO)

“I think there should be an increase from the government... We still get a low cost fee, but other places are getting the same fee that we are getting now and they can still increase their fees, whereas we have stayed the same and we are actually losing out. And my theory to that is that we, as far as staffing and equipment and things like that [goes], that if we are not even going to increase our fees or get more from the government, then yes, people are going to get a low cost service, but at what price? Does it come at in terms of staffing and equipment and stuff like that?” (Nurse Manager, Māori-led PHO)

Some were noticing the effect of the recession on the ability of whānau to pay, who were already stretched:

“The biggest issue is just people just genuinely not having the money at the time of the appointment. Quite a big build-up is starting to occur. I think people are just finding it tough.” (Manager, Māori-led PHO)

One small, rural PHO identified an issue with the PHCS which it would like to see addressed – that of trying to maintain zero co-payments with a population that has a higher than designated decile rating⁶. This PHO reported that it would like to be able to offer more services to the community; other PHOs offer additional services such as minor surgery in order to access new funding streams.

Another issue was raised by a small, Access-funded, Māori-led PHO in regard to fees being charged to Māori whānau who live elsewhere in the country but who sporadically return ‘home’ to the area where the PHO is situated. This PHO had historically always been a free clinic, but was now forced to charge ‘out-of-towners’ a casual fee rate for those who were not members of the PHO. When whānau come home, this causes a problem because they are seen as casual and have to pay the higher fees to receive health care, yet they consider the PHO region as their tūrangawaewae:

“Yes there are [issues with fees/fee setting for Māori providers], and those apply specifically to Māori whose whānau consider [the region] as their home. They live in other areas. Therefore, when they come home they expect the same level of non-fees that their home-base whānau are getting when they go out. They don’t want to pay the casual rate because their whānau are here and this is their home. When they go out they need to register, you know, so we get landed with the non-payment of the fees.” (Small, Access-funded, Māori-led PHO)

A Māori-led PHO which had started charging non-members noted:

“It’s about survival. If you don’t charge people who are not members at all, then there’s no incentive for anybody to join up with PHO. So, you’ve actually got to create a differential between those who are members and those who aren’t.” (Māori-led PHO)

⁶ Decile rating refers to levels of deprivation with 1 being the lowest level of need and 10 the highest.

Other initiatives taken by PHOs in response to maintaining a low fees environment included working together and sharing information about fees:

“About two years ago... there was a fees review. Some of the dynamics... is that we have individual GPs who own bricks and mortar and so they are sort of businesses within themselves. And so, to try to get some level of consensus... that sort of relationship has evolved over time. And probably in the first five to six years it was... ‘looking over the shoulder’ sort of thing to even sort of, engineer the sort of values like trust and reciprocity and all those sort of things. So yeah, I mean we’ve gotten better. Over time we’ve been able to get some traction...” (CEO, Māori-led PHO)

IMPROVING FUNDING

The success of the PHCS has led to problems of insufficient funding and threatened the ongoing viability of PHOs:

“But the basic access funding needs to be revised so that those in the lower socio-economic group... the actual calculation is inadequate because we’ve got a system... that addresses that stuff but the multiple just isn’t enough. And it needs to be increased by 50% for lower socio-economic groups because part of what is happening is the success of the Primary [Health] Care Strategy proves to be their downfall because we’re trying to provide free access is what primary care is about by reducing the barriers. The more we reduce the barriers, [the] more patients we get within insufficient funding... The practitioners are paying for themselves basically by having small income[s and] work[ing] long hours. So I see it as a sort of – not a long term viable.” (Māori PHO)

In terms of improving funding, a number of other points were made. Some suggested that small co-payments are helpful to PHOs because they prevent people from not turning up for appointments, which is costly for providers. The implication was that if services are free, it is not as big a deal for service-users to miss them. A small co-payment may, therefore, deter the ‘no-shows’. On the other hand, however, co-payments may discourage other whānau from accessing primary care services. Beneficiaries and large Māori and Pasifika whānau were referred to as examples of those for whom even a small fee may be a deterrent to primary health care access:

“... [even] paying five dollars... young mothers on their own and they’re on the benefit... that will stop them bringing some... Pacific Island [families] they still have big families, and if they pay... five dollars, the cost will be phenomenal... or Māori families because they have a lot of other kids besides.” (Board member, Access-funded, Māori-led PHO)

Accordingly, it was suggested that there needed to be a “better way of looking at” and managing the total costs for some whānau (Board member, Access-funded, Māori-led PHO).

Some PHOs also made a clear call for more funding for people on low incomes. Because the PHCS has managed to reduce barriers for many in accessing primary health services, the number of service-users, and the number of times service-users are accessing services, has put a huge strain on many practices. This has meant that in essence, the more barriers have been reduced, the more insufficient the funding has become. Some PHOs have started benchmarking to illustrate the issues for the funders, and seek more acknowledgement that high-needs populations require a different way of delivery:

“... probably like most Māori organisations, Pacific Island have a lot more whānau presenting more often, and of course you don’t get the extra funding. It also puts pressure on our doctors because it’s whānau-orientated in terms of Mum might turn up but then have things to do for her grandchildren, Dad, or whatever. So instead of ten minutes, it becomes longer so... Our throughput rates in terms of our doctors, is very low compared to mainstream and [this PHO] has done a benchmarking exercise and it did bring it out – some of those anomalies – in comparison to ourselves, other Māori PHO’s, and mainstream. And that’s not recognised by the Ministry either in terms of our funding.” (Board member, Māori-led PHO)

“... it does take us a lot more resource and I suppose nationally the average ratio [of] doctor to patient is 1:1,500. It was like moving the goal post for our services. As a PHO, we wanted to be funded at 1:800, those types of things. But then also from a middle of delivery perspective, was also getting equally importantly the acknowledgement and respect that a whole way we deliver our services need to be different, that our high-needs population deserve larger consultation times.” (Manager, Māori-led PHO)

This problem is compounded by the level at which capitation fees are set. When this model was adopted, the capitation fee for each enrolled person was based on an assumed average number of visits made. Ironically, now PHOs have the previous ‘too poor’ and ‘no-shows’ actually accessing primary health services, and coming back again, that average number of times a service-user accesses services is likely to be wrong. This puts a drain on resources.

And finally, small PHOs in particular, highlighted a need for increased management fees in the funding regime. Although the same request by small PHOs has been acted on before, the level was still not considered to be adequate:

“We need... more management fees from the Ministry of Health in order to deal with low-users, particularly Māori and low socioeconomic people. The management fees are really too low. They don’t make for a viable PHO and it’s based on economies of scale. Like ours is small, [so] that money doesn’t actually make ends meet at all. We’ve got to find money from outside of the capitation management fees in order to survive. In our situation because of the way things are for us, our practitioners, our providers aren’t viable, so part of that management fee goes out to the practices [and] part of it remains with the PHO. But it’s still not enough to actually pay a full-time Manager.” (Access-funded, Māori-led PHO)

5. MĀORI ACCESS TO PRIMARY HEALTH SERVICES

Mō tātou, ā, mō ngā uri ā muri ake nei

For us and our children after us

Participants during the first and second phases of interviewing were asked a number of questions around what role their PHOs had played in improving access; what had been done to increase access; and what the particular issues for Māori providers were with access to services. Participants in the third phase of interviews were asked to discuss what had been done within their PHOs to address inequalities in access to primary health care services. This slight shift in approach to the question of access was in response to initial findings. Improved access in the initial phases was typically framed in terms of evidence of increased enrolments and utilisation, lowered fees, increased service hours, and attempts to provide quality doctors. A small number of PHOs in this sample also framed improved access in relation to their attempts to provide culturally safe services to Māori and/or cultural awareness training to staff, dealing sensitively with non-payers, and for some, specific methods used to employ 'positive discrimination'.

Changing the focus of the question in the third phase – asking what attempts had been made to address inequalities in access – attempted to explore PHOs' understandings of health inequalities for their enrolled Māori populations, what strategies had been employed to remove barriers, and how they had framed their services to promote access.

To equalise access for Māori, PHOs attempted to tailor their responses to the specific barriers faced by their enrolled populations. Barriers such as economical and geographical barriers were obvious and solutions were readily identified. Identifying social barriers, however, was problematic for some PHOs and was fuelled by a disjuncture between Māori models of health and wellbeing and the 'medical model' of health and wellbeing. Some PHOs were able to deliver an improved utilisation of services by their Māori populations, yet felt conflicted that increased utilisation of services did not necessarily equate with improved health outcomes for Māori. Māori PHOs emphasised an holistic wellbeing which involved a Whānau Ora approach to health and wellbeing. In many cases, PHOs suggested a collaborative approach between various services was required to ensure equalised access to health outcomes. PHOs reported funding models (including SIA, RICF and health promotion funding models) privileged medical and western views on health and wellbeing. Consequently, equalised or improved access was not always as a result of well-resourced services but rather the creative initiatives employed by PHOs.

MĀORI ENROLMENTS AND UTILISATION OF SERVICES

All PHOs identified increased Māori enrolments and utilisation of services, attributing this principally to the initial lowering of fees, practices' extended hours of operation, and the availability of more quality doctors. This trend was noted in Māori and Pasifika service-users, in particular:

“What do we know? Our high-need populations access slightly more frequently. Every quarter [we are] enrolling more Māori and Pacific than ever.” (CEO, large, IPA-based, non-Māori-led PHO)

A Board Chair of an Access-funded, non-Māori-led PHO stated that with the increased subsidy, Māori and Pasifika service-users, in particular, were presenting at primary health care services earlier and returning more often for follow-up. This participant also noted though, that there were still some who do not seek care:

“I certainly think that we are seeing more people come back and earlier than they used to and I'm certain that is related to the fees... Unfortunately, I still think there are a lot of people who don't come regardless... Some services, like immunisation, are free... and of course they still don't come... So, there is still a percentage of the population out there who do not come regardless of fees. And the problem is especially among Polynesians...” (Board Chair, Access-funded, non-Māori-led PHO)

A number of enrolments in one Māori-led PHO were reportedly due to increasing referrals from a local Work and Income New Zealand client base; clients whose health profiles were typically high-needs. Communities identified such PHOs (that is, those with cheaper fees and clinical services which are well supported by services that address wide social issues facing whānau – that is, have a Whānau Ora focus), as responsive. These PHOs struggled, however, with servicing the populations in question, within their resources:

“It's huge the amount of work that's been generated from Work and Income – all the beneficiary-type documentation that cuts into our doctor's time so hugely. Whereas, [in] the mainstream service you might get the odd one a day or something. They don't have many beneficiaries on their books, you know. Ours are huge and yet again we're hit with this high demand of work and yet we're not resourced.” (Māori Manager and Board member, Māori-led PHO)

Some participants suggested increased Māori enrolments and utilisation were evidence of engagement with Māori, and should not be framed as evidence of an improvement in health and wellbeing for Māori. When asked about enrolments and utilisation, mainstream PHOs found the increased enrolments of Māori encouraging, yet also noted increases within the context of the clinical arms of the PHO, with issues such as attracting low-users and managing capacity discussed alongside. In this context, enrolments and utilisation were frequently framed as advertising and management issues with onus placed on how to attract Māori and how to manage services to encourage utilisation of services.

For Māori-led PHOs in the sample, however, addressing inequalities in health and wellbeing for Māori was a key driver. The view that increasing enrolments and utilisation (while a positive indicator of engagement with the community) could not sufficiently resolve issues of inequalities in access to health and wellbeing, was common. Māori-led PHOs aimed to utilise an holistic approach to delivering services. This involved delivering clinical services (usually delivered through general practices) and Whānau Ora-focused services – both were often mandated by Iwi, hapū and/or marae communities. One Māori CEO of a Māori-led PHO noted that it was *He Korowai Ōranga – Māori Health Strategy* which was informing how it delivered services, not the PHCS.

Māori-led PHOs viewed enrolments and utilisation in both clinical and Whānau Ora-focused services as significant, with the combination of services promoting an holistic approach to health and wellbeing. The Whānau Ora arm tended to promote positive lifestyle and healthy behaviours, whilst clinical services' focus was to provide high quality clinical care.

ATTRACTING LOW-USERS

Profiling Māori low-users and the barriers inhibiting their access to primary health care services was a strategy some PHOs (especially Māori-led PHOs) in the sample employed. Some participants suggested their PHOs had an intricate knowledge of barriers facing Māori low-users in their communities, while others were trying to come to terms with understanding low-users and the factors contributing to their limited access. Methods used to profile Māori low-users varied and included: using enrolment and utilisation data alongside other clinical data (for example, collected via the CarePlus scheme); and relying on knowledge and experience gained while working in communities, including from Māori staff, nurses, Kaiāwhina, GPs, and community representatives involved at the governance level.

Cost was identified as a significant barrier by most PHOs and the initial implementation of reduced fees and the CarePlus scheme was noted to have a direct impact on typically low-users (including Māori):

“In our case we’ve grown, nearly doubled our enrolled population. A lot of those were people who did not have a GP before.” (Māori CEO, Māori-led PHO)

One Manager of a Māori-led PHO GP Clinic agreed that while this initial focus on reducing costs was valid, cost was not the sole barrier facing low-users. This service re-evaluated operational aspects of their service, by introducing a triage system to improve access and prioritise whānau:

“We all thought cost was the major issue – not always... It ranks up there in the top five. The second one is the way the doctors run their books – they’re sort of like time-slotted: turn up, book ahead, book, book, book, book. So, we had to change that. We found that in terms of patients wanting appointments, we had to differentiate between urgent, really sick, or, ‘No, this can go for my review appointment say, a week later’. So, that’s why we put in the call centre, to differentiate.” (Manager, Māori-led PHO GP Clinic)

One Māori Board Chair of an Access-funded Māori-led PHO suggested the underlying reasons contributing to low use by whānau, including Māori, were complex and localised, and several methods needed to be used to capture and retain low-users:

“Sometimes how you get them is being able to provide a whole range of services in a different way.” (Māori Board Chair, Access-funded, Māori-led PHO)

The majority of participants from Māori-led PHOs in the sample demonstrated an intricate knowledge of their communities and the underlying causes of low use of services. These PHOs attempted to attract Māori communities by adopting an holistic approach. A combination of clinical and Whānau Ora services supported the development of what one participant described as ‘niche’ approaches:

“I believe that there’s been, we’ve been able to do some niche approaches to health care... We’ve been able to pick up on particular programmes with cardiovascular, ischemic heart disease, oral health, which aren’t primarily run through a GP practice. They involve [the Māori provider]. They involve marae service delivery... [the] sort of things that aren’t sort of, historically involved with GPs... We’ve been able to evolve things, to get more sort of, community-orientated... which has flexibility around the times... around venues – and which we believe [is] more responsive to Māori whānau engaging in health.” (Māori-led PHO)

The same participants also argued that this holistic approach demanded services within the PHO be well connected; they suggested PHOs needed to be *“wrapping it around the individual as opposed to wrapping it around the practice”* (Māori CEO, Māori-led PHO).

A number of Māori-led PHOs struggled with providing services to transient populations within the region, especially young people:

“Māori are transient. You can have an enrolled population that you’re not paid for because they’ve gone and seen another doctor in that quarter, or if they don’t come in for three years. Young Māori transient population [are] harder to develop an ongoing relationship [with].” (Māori-led PHO)

A significant number of Māori-led PHOs operate under Iwi/hapū/marae identities and are dedicated to improving the health status of those whānau connecting to these communities. Some Māori-led PHOs are faced with the unique dilemma of providing services to whānau able to trace whakapapa back to these communities, but who are not enrolled members of the PHO. This is especially the case with those who are transient or just visiting the area. Responses to this dilemma varied; one PHO felt their commitment to improving the health status of their Iwi was the priority and, therefore, they were not able to deny such whānau, treating them instead as enrolled members. Another PHO, troubled by the number of transient whānau using their services, treated such whānau as not enrolled because of the challenges they faced with managing the resources that were taken up with servicing transient whānau:

“... we’ve discovered what we think the problem is, is [the] fact that we’ve got this transient population and it’s quite a high number of them that want to be enrolled with our PHO but go live down South. So, consequently they’re not responding to being recalled and they’re not being seen. They might come back once or twice a year, [and] they’ve maybe not seen the doctor down [there]... so that’s creating problems... We charge them [as] casuals, and we’ve had to become quite hard about that and just keep reinforcing that these services are for our enrolled population. Those that choose not to be enrolled here don’t get free service or they have to pay. They have to pay otherwise it’s taking away from those up here... That’s been a hard one because they’re whānau.” (Māori Board member, Māori-led PHO)

In many cases, Māori-led PHOs suggested a collaborative approach between services were required to attract and improve health outcomes for low-users. PHOs reported funding models (including SIA, RICF and health promotion funding models) contributed to improved access to health outcomes for low-users and at-risk populations, yet noted these initiatives tended to privilege medical and western views on health and wellbeing. Some Māori-led PHOs suggested the influx of typically low-users was not always as a result of well-resourced services but rather the creative initiatives employed by PHOs. These initiatives reflected PHOs knowledge of local dynamics.

One Manager from an Interim-funded PHO reported the CarePlus programme had made some impact on attracting typically low-users; however, they did not see it as their role to attract low-users. In their view, attracting low-users was an issue for practices and services who they felt should be identifying opportunities for SIA funding.

CULTURALLY-APPROPRIATE APPROACHES

The importance of providing culturally-appropriate services was also highlighted by many. Participants referred to: Māori trying not to see the doctor until they are very sick, and then having a tendency to call emergency services instead of a primary health care practice; to Māori men avoiding appointments and Māori women avoiding preventive measures; to difficulties in getting Māori service-users to return for follow-up; and to a fear of doctor’s surgeries that some Māori have:

“For a lot of Māori... they hate coming into that medical practice... There is an element of fear... doctors surgeries are seen as a place of illness not wellness...” (Māori Board representative, small, Interim-funded, non-Māori-led PHO)

One Māori representative on the Board of a non-Māori-led PHO reiterated the importance of providing culturally-appropriate services:

“As tangata whenua of this country, we deserve to be treated in a certain manner according to our culture, tipuna, and all of those things, our value base. And they need to come to terms with that if they want to service us...” (Māori Board representative, non-Māori-led PHO)

PHOs in the sample reported that the various ways in which they were attempting to develop their services ensured what was delivered, was culturally-appropriate. Some PHOs, in particular Māori PHOs, were well-positioned to provide such services – with their intricate knowledge of Māori communities, their drive to address health inequalities, and the fact that many were mandated by kaumātua, kuia, and marae, hapū and Iwi authorities. One participant attributed this greater ability to provide culturally-appropriate services to being more able to build and maintain relationships:

“We are matriarch and patriarch people – it’s all about relationships.”
(Māori Manager, Māori PHO)

Approaches used in the delivery of culturally-appropriate services varied, and typically participants expressed other suggestions, including making home-visits; one Māori Board representative felt Māori providers needed to *“take our service to our people”*. Others advocated for an increased role for Māori providers within Māori-led and mainstream PHOs; these providers were considered more equipped to ensure a ‘safe environment’.

For some, this safe environment is the marae, and participants reported varying degrees of success with primary health care services being delivered on marae:

“No doubt about it, that when we are delivering services to Māori in a marae-based setting and there is a Māori nurse there, we are more successful.” (Manager, small, rural, Interim-funded, non-Māori-led PHO)

This experience was mirrored by an Access-funded, non-Māori-led PHO – but not in a positive way. This PHO reported that the co-payment-free, marae-based clinic their PHO established failed due to an inability to attract Māori staff:

“We tried a marae-based doctor and nurse and it did not take off... It was a Sri Lankan doctor and a white nurse simply because Māori and Pacific nurses are hard to find and doctors are even harder to find... But we provided basically a free service, but they did not want to come.” (GP Chair, Access-funded, non-Māori-led PHO)

Establishing a Māori-friendly environment within PHOs was identified as instrumental to drawing in Māori whānau:

“I know that a lot of Māori find it easy to come here. They see the Māori face at [the] reception area [and] see how it is fitted out.” (Māori Board member, large, non-Māori-led PHO)

One Māori nurse of an Access-funded, Māori-led PHO warned that the *“utilisation of Māori models in health care is only academic but not in practice”*, cautioning those who pay lip-service to delivering culturally-appropriate services. Another Interim-funded PHO acknowledged that the experience of being underserved, resulted in Māori being more concerned with addressing inequalities for the large immigrant and refugee communities in their region which funding formulas did not target.

Cultural safety and cultural awareness training were both identified as mechanisms to improve access to primary health care. Some participants reported that accordingly, their entire Boards and all staff in their practices – GPs and nurses – had attended cultural safety and cultural awareness training days:

“That’s all about them coming to terms with us as Māori and what’s culturally-appropriate for Māori. At the end of the day if I go to a GP and I am not treated in a cultural way, I just won’t go back. I will either go somewhere else or sit at home and die, and some of them may be sitting at home and waiting to die... So, doctors, their value base is all about saving patients, and this is one of the ways they can do this – challenging the way they are interactive with Māori.” (Māori Board representative, non-Māori-led PHO)

DEALING SENSITIVELY WITH NON-PAYERS

The initial lowering of fees was directly linked to an initial increase in service utilisation and enrolments across PHOs in the sample; however, the issue of how to deal with those struggling to pay consultation fees was also raised across the sample.

One Manager of a small, Interim-funded, non-Māori-led PHO noted that within their PHO they had very little staff turnover. This stable staff environment allowed the PHO to know who was having difficulty paying, which in turn tempered debt collection:

“We have very little staff turnover and so the patients are well known... Debt collection is tempered by knowledge of the circumstances of a particular family... So, we might need to ask for a small weekly contribution instead of going to debt collection... The GPs also know their people well and are quite at liberty to give free consultations or free prescriptions and these are funded by the PHO from SIA ...” (Manager, small, Interim-funded, non-Māori-led PHO)

A Māori Manager of another Māori-led PHO which has been delivering services to Māori communities and low-decile communities since before the introduction of the PHCS, reflected on why non-payers exist despite the decrease in fees:

“For our population, that low fee that we charge actually hasn’t improved access because they don’t pay it anyway. So, you know, they come anyway ’cause they don’t pay... it wasn’t a barrier in the first place... A lot of it is they won’t pay... our [enrolled] population has different priorities to us, actually. It’s more important to go next door and buy a packet of smokes than it is to pay their GP bill. Because you know, you can’t get smokes on tick but you can get our service on tick, so of course you would buy the smokes... But it’s reasonable to suggest that actually, if you needed three things – you wouldn’t pay the one that you could tick it off eh? ’Cause they’re always having to juggle their money like that... Somebody said to me the other day, ‘Have you noticed the difference since the recession?’, but actually, most of our population are in recession all of the time.” (Māori Manager, Māori-led PHO)

Responses to non-payers suggested that many PHOs in the sample acknowledged poverty-associated barriers and aimed to buffer this by developing positive relationships with non-payers.

“... and we will accept two dollars a week, and that kind of stuff. We’re more lenient, we write off the debts, you know. We do all that stuff, so... Whereas, other GPs will say, ‘No, I’m not going to see you if you don’t pay that hundred dollars you owe us’. We won’t do that, yeah... We are pretty persistent in trying to collect that ten dollars, but we never have and never will turn somebody away because they can’t pay, or won’t pay.” (Māori CEO, Māori-led PHO)

“We don’t actively chase anybody through any sort of debt retrieval process... We identify our people who are poor at paying and I have discussions with them and use that to drive that forward a little... Some of our worst payers are now our best. We have people on our books who have got like three hundred dollars credit and for some of our people we’re their bank because every six months they say, ‘Can I get paid back some of that credit back?’ ...like [at] Christmas or [if] they have a whānau issue, a tangi, [and] they need to travel out, they ring me up: ‘Look, I really need some money. Can I have some of my money? What is it looking like?’ And if it’s above a hundred dollars then I’ll say, ‘Yeah, yeah, yeah – how much do you want?’ and we just put it back into their account. And it’s much better to do that than to forever be in debt, and it builds their self-esteem, you know, they’re valued.” (Māori Manager and Board member, Māori-led PHO)

“None of our reception staff say to anybody, ‘You know you’ve got such and such owing...’ That just does not occur in our practice. We do have on our appointment cards as people book appointments with us, we have a little line that says, you know, you write in what’s left owing just as a reminder, so it’s given discretely. The instruction in our policy is there’s never any kōrero because it’s about respecting where those people are at, and they’re there because of circumstance not because they just don’t want to pay.” (Māori Manager and Board member, Māori-led PHO)

One PHO introduced what they termed the ‘Pōhara Fund’ as one mechanism to support non-payers:

“We have a Pōhara Fund. So, some of our PHO money is Services to Improve Access [SIA] monies. We set aside, in our budget, a portion of it as Pōhara Fund and we use that for all sorts of things, and that is for our poor people. If they need to go to a specialist appointment, and the only way to get them in is to get them private, then we’ll just book them in, we’ll pay it. We just use whatever...” (Māori Manager and Board member, Māori-led PHO)

TRANSPORT

Transport to services was a barrier that was framed in various ways across the sample. One rural-based PHO had no infrastructure in their region, inhibiting the organisation and day-to-day running of their service: internet access was limited, transport in and out of the community was dictated by a ferry service, and costly courier services were used frequently. Other, more urban-based PHOs, which were surrounded with adequate infrastructure, were more concerned with locating their clinics on major public transport routes.

Māori-led PHOs in the sample emerged from a community concern for the health and wellbeing for local whānau, hapū, Iwi and/or community, and often served enrolled populations that included both rural and urban contexts. More commonly, Māori-led PHOs framed transport issues as a 'two-way' phenomenon. In order to increase access, services needed to be localised, with healthcare being taken into the home (through rural nurses, Kaiāwhina and Community Healthcare workers) as well as into established centres, such as marae and key community centre-points used as venues. For example, one Māori-led PHO delivering to a largely rural population had small regional clinics based in key locations within the region, and worked in combination with rural health nurses who visited whānau members within the community – focusing on those with chronic conditions.

6. MĀORI-LED PHOs AND CHRONIC CONDITIONS

Me anga atu ngā kanohi rā ki ngā maunga kei reira te āwhina

Let the direction of all faces be towards the mountains where all things are cherished

INCREASING FOCUS ON CHRONIC CONDITIONS

In terms of increasing the focus on chronic conditions, participants were asked a number of questions around: the extent to which practices had done so; the usefulness of the CarePlus model; and the particular issues for Māori concerning chronic conditions.

An increased focus on chronic conditions was mostly managed and monitored through the medical arms of PHOs. CarePlus was a key model used to address chronic conditions by most PHOs. While CarePlus was identified as well-resourced and outcomes were easily measured, the model was very involved and logistically difficult to implement. CarePlus generated increasing amounts of paperwork for nursing staff in most PHOs and in some cases, nurses were initially unsure how to implement new structures and procedures. Most PHOs responded by utilising electronic databases to streamline reporting, and some delineated nursing roles more specifically so their efforts were more focused. Chronic conditions were also managed through the implementation of programmes initiated by PHOs. Several key informants explained that engaging with Māori was key to addressing chronic conditions, especially conditions exacerbated by lifestyle choices, such as obesity and diabetes, although others including smoking diseases, heart disease, renal failure, asthma, and child oral health were also identified as particularly pertinent for Māori.

While the forum of a consultation with a nurse under the CarePlus model was utilised by many PHOs (who were using the opportunity to engage with individual whānau members and their wider whānau), some did not believe this was sufficient. Most PHOs reported developing niche approaches to chronic care and were frustrated that these approaches were poorly resourced or supported.

SIA funding was identified as an aid in the reported increased awareness of providers in knowing how to work with people with chronic conditions. The example relayed by one Māori representative on the Board of an Interim-funded PHO, however, suggested that not all providers were doing as well in working with these people:

“Most of our chronic Māori still don’t go to the doctor. Classic example, I was diagnosed with diabetes by a girl three months ago and I went to one appointment with a dietitian. She disengaged me in two minutes – just her whole bloody attitude. You know, a Māori goes in there... you talk about what progress that you have made from the day you were diagnosed and this is the lifestyle changes you are talking about, you know. All she did was break down all those initiatives one at a time and said how it wasn’t good enough and how I needed to this and this. And I said, ‘Don’t call me again’... I went home and I was angry, and my daughter said to me, ‘Never mind Mum. You don’t have to satisfy her.’” (Māori Board member, Interim-funded PHO)

Some programmes and approaches identified by PHOs to have emerged through the focus on chronic conditions, include asthma management of Māori children, and the idea of promoting annual health checks on people’s birthdays. Others sought opportunities to specialise or work co-operatively with local trusts or other PHOs:

“... when it was all new and fresh, we kind of went down that track of trying to contract with other PHOs to provide a service like, for example, we provide a COPD service that’s unfunded, and of course, I don’t know if you know much about COPD, but, it never gets any better – it just always gets worse. So, once you take on someone... you can be sure that actually the services that you’re going to have to provide for them will increase – it will get more and more and more as they get older... And so we decided that we’d try and go down that track with approaching the different PHOs and say, ‘This is the need, and you’re not providing that service, but we can provide that service’, you know. ‘Can we start thinking about maybe contracting for some of that money to provide that service to your clients?’” (Board Chair, Māori-led PHO)

The increased focus on chronic conditions also meant a heavier workload for nurses as the importance of their role developed and was accepted by other staff and whānau. One senior member of a PHO noted that once whānau accepted that nurses had highly trained professional skills, their CarePlus nurse was able to develop her enrolled list from nil to almost 400. The increased nursing workload had led to new developments:

“... you’ve got CarePlus, you’ve got the diabetic annual reviews, you’ve got child immunisations, you’ve got all that, you’ve got the HPV, and at the same time, trying to fit in a postgrad study. That really is one of my visions, is to get all our nurses through even a Postgrad Cert [in] Chronic Conditions.” (Manager, Māori PHO)

“We’ve put in as many software programmes as we can to sort of try and ease the paperwork side of things, the assessment forms, and all that, so that you’re not doing things twice. If you write down here that I’ve prescribed whatever, it’ll populate the client file, that sort of thing, so there’s no double ups.” (Nurse, Māori PHO)

CAREPLUS

CarePlus was commented on favourably because it allows for longer consultations for people with chronic conditions. Recognising the need for extra visits for those with chronic conditions, and those on lower incomes, was considered to be a more equitable funding formula:

“CarePlus is assisting us to look at our population for an individual client. Because of the complexity of chronic illness, they often become co-morbid and they’ve got a lot of barriers preventing them from looking at chronic illness. It’s looking at those clients, doing individual assessments with CarePlus, and trying to manage the complex... to ensure the client starts to look at all other areas: managing their chronic health, transport, social dysfunction, housing... or other things that have nothing to do with whether they’ve got asthma or renal disease.” (Manager, Māori PHO)

Recognition of the expanded role of nurses through PHOs, particularly with CarePlus, was especially noted, although for some there had been initial reluctance:

“I think what was not clear from the outset of PHOs, was what the role was of a Practice Nurse... The CarePlus came in, the diabetes annual reviews came in, all these things started getting thrown in, from a Ministry level to the providers, and so you had resistance from the Practice Nurses because they were there to do, I don’t know what they do, wound care, triage, and then they’ve got to do all this also.” (Board member, Māori-led PHO)

“... our CarePlus nurse is Māori and she is good. She provides a good service, a package. She gives clients a folder with lots of info, she provides goals, and constantly monitors them. They should only be on CarePlus for a year because it’s intensive and involves a lot of visits with the nurse. So, once they’re stable, they can get taken off because we are trying to empower them... We try to empower them, educate them, and get them in control. Once they’re all sorted, we discharge them from CarePlus, but that hasn’t been happening at the moment, ’cause they love the service too much.” (Manager, Māori-led PHO)

While nurses often led the initiative the commitment of the rest of team sometimes lagged:

“But what we’ve found, what we had hoped, is that the Care Plus, all that work, would be more integrated with our existing teams. But we’ve sort of found that it’s ended up, the chronic care nursing team is sort of handling a lot of that work and doing the follow-ups and pushing it, and we’ve still got quite a bit of work to do in trying to get the rest of the team on board with doing it.” (Māori-led PHO)

Some had struggled with the implementation of the model and recognition that it required a dedicated workforce and a different way of working, rather than relying on doctors. Consequently, according to a Pasifika representative on a Māori PHO, some GP services with a strong GP-model focus, as opposed to the social model of health PHOs had, were not actively referring whānau:

“... because it’s not seen as a priority – little funding attached to it... They’re not actively referring their patients to be assessed by CarePlus. That’s basically it, you know they are not ... it’s an admin nightmare for some GPs.” (Pasifika representative, Māori PHO)

There was a lot of extra work and administration with CarePlus and incentives such as professional development had helped. A Board member of a Māori PHO noted that, *“it’s made the providers very aware of their responsibilities to their population in terms of chronic care, and it’s done a lot by way of treating and education”*. Others struggled to meet targets for a variety of reasons, including the large percentage of their population with chronic conditions:

“Whereas, a mainstream service is guaranteed that funding, pretty much because they’re ‘worried well’, they’re going to come for their appointment. Like, it’s just a whole another challenge... It’s just working with our market – we’ve got the population that other GP services don’t want. So they’ve been taken off other PHO enrolments and we’ve got them. We get referrals from Work and Income because it’s only just up the road... so our population base is seriously high-needs.” (Board member, Māori-led PHO)

Some noted that CarePlus also required a commitment by the whānau member, which for Māori entailed a whole new approach. One Board member of a Māori-led PHO intimated that the extra time allocated to CarePlus assessments was very much needed by Māori whānau who may have had very little time dedicated to them by health professionals addressing their complex needs in the past:

“... you’ve got to go to the nurse for at least three quarters of an hour, you’ve got to do all these things, and then you’ve got to go to the doctor, and then you’ve got to say, ‘No, I won’t do that’ or ‘Yes, I will’... We have difficulty with physical accommodation, you know. And because then you make these appointments and then they don’t come. [With] chronic conditions, you’ve got to, it’s a whole process of educating our people about their disease. They make the decision as to whether I’m going to have this, this, this, or that cut. What Māori person, you know, like the people we’re talking about, have been given the choices in the past? So, there’s a whole lot of undoing that we’ve got to do, and I believe our kaupapa nurses are doing that.” (Board member, Māori-led PHO)

The different approach required for working with Māori whānau, including understanding their role in the care of other whānau members, was recognised as an advantage in primary health care by one Māori-led PHO in particular:

“I just spoke to the CarePlus nurse and she’s saying that she gets better results when the families have been involved in that person’s plan. Whereas, a lot of the white people, non-Māori, don’t want them involved because, ‘It’s my issue – I’ll sort it myself’. Whereas, when she brings the Māori patients for recalls, she likes to widen the knowledge. So, they all get these CarePlus folders with all the health issues and the progress that they’re making, and that’s become a really family-orientated document... That document has now become quite a valuable document to the family, and so they say, ‘Gee Grandma, I didn’t know you had all these things wrong with you’, ‘Jeez, you’ve run out of pills’ – simple things like getting prescriptions: ‘Jeez, I better go down and get it for you’. And so that’s helped, that’s what we’ve learned from that.” (Manager, Māori-led PHO)

There was generally approval of CarePlus and a perception that it had made an impact on managing chronic care for Māori. But as one Māori representative on an Interim-funded PHO noted, *“I like CarePlus – but Māori still don’t go to the doctor”*. There is still more to do:

“... there’s probably even more out there in the community that haven’t been identified. Our first step in the programme was to just get out there and get these patients in, see them because they hadn’t been seen for such a long time. We’re still doing that because the numbers are so huge out there.” (Board member, Māori-led PHO)

FUNDING FOR CAREPLUS

Initially, working out the intricacies of administration and funding structures was confusing for some PHOs. Participants also talked of the large amount of paperwork that was required for CarePlus, and what a disincentive this was for engagement with it. They felt that for the amount of work it generated, more funding should be provided; instead, there was insufficient funding for the work required for CarePlus. Some key informants referred to practices and GPs who did not find the financial incentive significant enough even to warrant an application.

Two providers noted that some people with chronic conditions were coming back to the doctor and accessing services a lot, lot more. Whilst this was a positive result of the PHCS, because of the capitation issue, it was ending up costing practices money. A lack of recognition in the funding of the need for longer consultations for some people was also highlighted by participants. They reported that despite the longer consultation times allowed with CarePlus, some people required even longer consultations, and this was not well recognised in the funding:

“We’ve got really highly stressed people who are suffering from a whole lot of social problems and before you can even start to look at what’s wrong with them physically, you’ve got to deal with all the other issues that are coming out. And the average of a Pākehā doctor seeing a patient is about ten minutes. Where you’ve got lots of low-income people, particularly if they’re from a particular culture, you need to spend far more time – [this is] not taken into consideration in the formula. We’re dealing with a formula that’s really for well people, not sick people.” (Māori PHO)

Success increases expectations, and it was made very clear that increased funding is required as whānau have come into the system in increasing numbers:

“We really believe in CarePlus because we have such a high chronic care population. So it’s actually... we would be doing this mahi anyway. So it’s a good vehicle for us to be using. I think for us, if we were to highlight an issue, most importantly, it would be the funding model – that we’re funded as a PHO [as] opposed to a service. The whole PHO has to meet the target – we can do all our work, and if there are other pockets of the PHO that don’t meet their target then we don’t get our funding, you know. So again, for Māori, for high-needs, for... you know. We’re putting all this added work in, yet sometimes we’re not getting resourced for it. So once again we have that same struggle.” (Board member, Māori-led PHO)

Capitation rates (five to six visits annually) do not recognise that some chronically ill whānau members are visiting much more frequently, with some reporting 20-40 times in a year:

“... you can only claim back up to a certain number. I forget what the number is but... they give you a set number and say hundred and fifty and that’s it they’ll fund you for... Then they cut you off. So, although we’re in a PHO that has this really high-needs population, nothing’s certain for us. So, we’ll see them eight times instead of four times but we don’t get any other funding for that.” (Board Chair, Māori-led PHO)

Māori have been shown to have a higher prevalence of chronic diseases than non-Māori, leading on to higher mortality rates. An increased focus on chronic conditions in the PHCS is, therefore, particularly relevant for Māori. But many respondents questioned the appropriateness of the funding model:

“They’re percentages of your total population, so again we’re disadvantaged. A mainstream service who might only have, say 18% of their total enrolled population of high-needs, or complex care, or chronic care, who are eligible for CarePlus, only have to achieve a much lower physical number. They have to achieve the same target, but they might only have to do, you know, ten a month. Whereas, for us who have a large number of high-needs, [we] have to get a higher volume output for the same resource, you know. Again disadvantaged, there’s no equality. Funding models do not work for Māori, do not work for high-needs. We’re so disadvantaged, yet we’re so passionate and so driven about caring for those high-needs people.” (Board member, Māori-led PHO)

On the other hand, one Māori community representative on an Interim-funded PHO was dismissive of the financial incentives: *“The concept of CarePlus is awesome, but why can’t they do it for the sake of it, not because they’re getting more money?”* A senior member of a Māori PHO suggested an alternative funding method based on the Ministry of Health’s disability support model:

“You know with barriers, that was the whole, the sort around SIA, and whilst we’ve got the chronic care programme, I just think that it should be Ministry funded separately, just straight out. And stop using support services to improve access funding because chronic care’s a major issue everywhere and so it should be funded separately... Just like how they fund disability support services.” (Board member, Māori-led PHO)

COLLECTING DATA

Delivering chronic care services such as CarePlus, and accessing funding, has meant increased administration time and investment in Information Technology for collection of data and maintenance of databases. The lack of enthusiasm for collecting this data met some initial reluctance to participate:

“... it relies on GPs volunteering that information to the PHO.... They are struggling to put patients on CarePlus, because... [there’s] very little money in it. So, therefore, it is not a priority. But there are heaps of patients that should be under CarePlus and are entitled to cheaper rates... It would involve probably two hours of nursing time to sit down and do that assessment and then it gets referred back to the doctor to make that approval and then a recommendation comes into the CarePlus programme to make that final decision whether this patient is agreed. So, this is an admin nightmare for some of these GPs”. (Pasifika Board representative, Interim-funded PHO)

In contrast to this view, a Māori PHO in the same region as the Interim-funded PHO this Pasifika Board member referred to was one of the first to qualify for a government incentive payment for enrolling over 1,000 on CarePlus. It had developed a computerised database enabling easy reporting of statistics to the DHB and monitoring of their high-needs population.

Updating, resourcing and maintenance of good database records was a frequent theme. Knowledge of the data collected about chronic conditions, and services aimed at addressing chronic conditions, varied amongst providers. There were inconsistencies in such things as diagnostic criteria and data collection between practices. However, data about services for diabetes and cardiovascular disease in particular, appeared common. One Māori-led PHO referred to diabetes-specific data collected within their PHO, as well as an imminent cardiovascular strategy. Another Māori-led PHO was analysing a disease register so it could contact whānau members and remind them about their checkups. In the third phase of the evaluation, a senior member of a Māori-led PHO summed up the additional work required:

“We’ve tried to really maintain a high level of delivery for CarePlus. I don’t think it’s delivered a high level of additional paperwork as such. We run a totally electronic system so it is about putting data in... which does take time... I would say it’s been a moderate increase [in work].” (Board member, Māori-led PHO)

7. COMMUNITY INVOLVEMENT AND INPUT

Ehara tāku toa i te toa takitahi, engari he toa tahitini

My strength is not that of the individual, but that of the multitude

The PHCS proposed that: people will be a part of local primary health care services that improve their health, keep them well, are easy to get to, and co-ordinate their ongoing care; and primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups (King, 2001). Some PHOs reported elaborate processes to ‘ensure’ or actively pursue community input. These were usually the socially-driven PHOs, or Māori-led PHOs. In contrast, some traditional IPA/GP-model PHOs were criticised for having reluctantly sought community input. They may have come from the perspective that they own the ‘bricks and mortar’ of their business and saw the consultation process as a threat to this model.

All PHOs within the sample were organised so that key community representatives held positions at a governance level. Some were elected on governance Boards while some governance Boards were structured so that representatives from providers within the PHO also sat on Boards. Many Māori-led PHO built up their PHOs with a high level of community participation and had their own structures and tikanga.

APPROACHES TO ENGAGING WITH MĀORI COMMUNITIES

Approaches to engagement with communities varied across the sample; the values – implicit and explicit – held by the PHO and staff working within the PHO, largely underpinned the nature of engagement with Māori communities. Some PHOs in the sample actively sought to connect with communities and were typically driven by a passion for addressing prominent health inequities in Māori and hard-to-reach communities. They saw community engagement as an essential component of this process. Māori-led PHOs in the sample commonly fell under this category and tended to utilise established networks and tikanga to activate and maintain relationships. One Māori Manager of a Māori-led PHO considered itself to be “*probably the closest [to how the community model was envisaged] in the country*”. This was referenced to a completely community-driven election process for representation and consultation. Some non-Māori PHOs in the sample expressed similar motivations.

Several key informants accused some PHOs for functioning under the guise of a population approach, while they were most interested in the ‘bricks and mortar’ of their businesses. The population approach was viewed as a threat to this traditional model:

“... you’re dealing with a group of GPs that have been in [this area] for a while, probably about 20, 25 years. They’ve invested sweat and tears into their bricks and mortar. So they have a strong vested interest. Whether we want to work with that crowd or whether we want to work alongside those who are a bit more innovative... who are working Monday to Sunday, 7[am] to 7[pm], 8[am] to 8[pm], and know that Māori are the significant population you need to take notice of. We’re no longer the guys five doors down – we’re the guys one door ahead of you now. Yeah. I mean, but it’s changing.” (Māori Manager, Māori Provider, Māori-led PHO)

These ‘types’ of PHOs were also criticised for their reluctance to seek community input, and in some cases, were accused of debasing the types of knowledge Māori community representatives brought to Board meetings:

“... GP providers have particular issues with community, particularly Māori and PI input at particular times. An example of this is the lab/pharms prescribing, which is very clinically driven. Often clinicians think, ‘What do Māori know about clinical indicators?’ and ‘What good is their input?’ There is a mindset of pigeon-holing. Clinicians do have some expertise with clinical data, but the Māori sitting next to them is the recipient. All consumers do have an opinion. Input must come from all different perspectives, which can challenge the way we operate.” (PHO Manager, small, Access-funded PHO)

One Māori CEO of a Māori-led PHO who sympathised with those GPs who had made a significant investment of time and money into their own ‘bricks and mortar’, acknowledged the specialised skills of GPs working within this traditional model, and concluded it was far more useful to their Māori population to negotiate through these differences.

Those mainstream PHOs in the sample who had little history of engagement with Māori communities prior to the introduction of the PHCS were concerned with establishing a starting point for engagement. These PHOs were most concerned with strategising on how to engage and develop relationships with Māori. Common responses within these ‘types’ of PHOs included placing a Māori community representative to act as an advisor and as a go-between with Māori communities on their Board. In other instances, Māori providers working within the mainstream PHO were viewed as ‘the’ community contact for Māori and heavily relied on for advice and guidance.

A Māori representative on the governance Board of a small, Interim-funded PHO which had not had significant relationships with Māori prior to the PHCS suggested that having Māori community representatives was not enough of a response to engage with Māori. The PHO chose to conduct cultural workshops to bring clinicians ‘on board’ as well, concluding:

“We have to get our own house in order.” (Māori Board representative, small, Interim-funded PHO)

PHO STRUCTURE AND MĀORI INVOLVEMENT

The structure of each PHO in the sample was unique; giving insight into the relationships PHOs had with Māori communities and the underlying assumptions underpinning their view of the population approach to primary health.

Mainstream PHOs in the sample were structured with at least one Māori community representative at Board level and in many mainstream PHOs, Māori representatives were commonly expected to act as advisors and as a go-between with Māori communities. In other instances, Māori providers working within the mainstream PHO were heavily relied on for advice and guidance for engaging with Māori communities. The process for selecting Māori community representatives chosen as PHO Board members, varied; some worked under a strict voting system whilst others purposefully selected key personalities in their area. The success of this approach varied across the sample. Māori representation at Board level did not necessarily translate to strong connections or relationships with communities themselves. Representatives were sometimes marginalised within Board settings; either by other representatives who considered the Māori representative's skills to be less professional, expert and valid, or, by the actual culture of the Board setting itself. The underlying views of the validity of Māori community members' expertise characterised some Board meeting dynamics.

One Manager of a small, Access-funded PHO was frustrated that higher level relationships established with an Iwi authority did not filter to the community level, and local Iwi representatives' attendance at Board meetings was ad hoc.

Another Manager of a small, Access-funded PHO found the support from their local Māori providers invaluable:

"I cannot speak highly enough of them. For me, I really appreciate what they have done and without them, I would have been struggling."
(Manager, small, Access-funded PHO)

Some non-Māori-led PHOs also inadvertently deferred the responsibility of the Māori population to local Māori-led PHOs; either because there was a belief that they were better equipped and had more knowledge of Māori communities to deliver a Māori population approach to health, and/or because it was seen as their responsibility. Some were grappling with the intricacies of local Māori politics:

"Tangata whenua are ten percent of the local Māori population, and they are not in harmony, so it is challenging." (PHO Manager, Interim-funded PHO)

One large Interim-funded PHO canvassing an urban area with a large migrant population weighted the need for those minority groups over the needs of Māori because of their density within their PHO.

Improving the health status of specific whānau, hapū and Iwi was the impetus for the establishment of many Māori-led PHOs in the sample; the resulting structure of these PHOs reflected social and political dynamics in their communities. One Māori-led PHO organised themselves according to the traditional geographical boundaries and marae: each region was represented at Board level by a representative who was chosen via an annual election. The Board of another Māori-led PHO purposefully selected representatives from the key providers within their PHO for their governance Board. This PHO canvassed an enrolled population across several related hapū and Iwi. Providers tended to target specific localised communities (ranging from rural to urban settings). Key informants reported that while their governance Board was small, it maintained strong relationships and communication across the providers and provided effective leadership. One Māori-led PHO serviced an urban Māori community not generally bound by common whakapapa. The networks and services for this PHO were well-established prior to the introduction of the PHCS resulting in an already-established commitment to a population approach to addressing health and social inequalities within their communities.

The tendency to structure themselves alongside established Iwi, hapū and marae networks had strengths and limitations, however.

Some Māori-led PHOs in the sample found mandates from Iwi, hapū and marae communities useful when engaging at community level; in particular, when targeting at-risk groups. One Māori-led PHO reported the successes of utilising marae settings to deliver services and the multiple benefits of using these venues:

“... we look to utilise them [marae] all in the service end as a part of the service provision. Mainly because we don't have to spend huge lots of money on the bricks and mortar... you know that they're a focal point for our whānau to utilise. Because they're [whānau] also more rural, then urban and [marae] are an integral part of our service. So, I mean the level of reciprocity is, you know, to do with health and safety. We are conscious of those things, you know, reciprocate them.” (Māori Manager, Māori Provider, Māori-led PHO)

Several other Māori-led PHOs described similar successes; however, one reported that their marae-based service initiative did not receive much interest. Although no formal evaluation of this initiative was undertaken, reasons given by a key informant included the non-Māori GP and timing of clinics which proved an unsuitable match for the community – despite being held on site at a marae.

One key informant saw this issue from a different angle. For them, a key indicator of whānau wellbeing included the utilisation of venues such as marae and kōhanga reo. Although not traditionally seen as a component of primary health care in the western tradition, this Māori-led PHO concluded that the flexibility of the PHCS had meant that the use of such venues to deliver intervention, clinics, and to disseminate health information, also had the dual benefit of drawing whānau to traditional infrastructures:

“... we want to see our marae being used, we want to see our kōhanga being visited, and those aren't things that are captured in primary health... And for us it's thinking of visibility, you know. One thing is to engage Māori: do it on the phone or you can do it on the computer, you know – that would get you nowhere. If you do it face-to-face, in a setting that is comfortable and they are comfortable to come [to], you're going to win it.” (Māori Manager, Māori Provider, Māori-led PHO)

“... a different strategy for rangatahi... what we’d do is, it’s winter time now, we do movie nights, you know, stay out there. You know the thing about movie nights was about reciprocity. You know, 20 cents, they’d come [to marae], you know, trying to get the rangatahi back on the marae. Demystify [that] marae are only there for tangi and that sort of stuff. Yeah, that’s the sort of insight to what we sort of do.” (Māori Manager, Māori Provider, Māori-led PHO)

Alignment with Iwi, hapū and marae structures had benefits when PHOs were strategising the direction of the PHO amongst an ever-changing political context. In the same vein, these allegiances meant Māori-led PHOs were intertwined with the complexities of Iwi, hapū and marae politics. Māori-led PHOs in the sample tended to negotiate these as and when issues arose. The pathway, however, was complex:

“Oh no, it hasn’t been okay, no illusions. Look, there’s always raru because when you try and merge two differing philosophy, you know... yeah. And it’s not been an easy process, but we’ve all focused on the end goal, and we all agree that that’s where we need to get to. So, it’s just about ensuring we protect and respect where each other sits to get to that end goal.” (Māori Manager and Chair, Māori-led PHO)

SCOPE OF COMMUNITIES

Identifying the parameters of a community, Māori and non-Māori, was at times complex. Some communities were clearly demarcated by geography or Māori social structures such as marae, hapū and Iwi groups and had natural points of engagement (for example, key kaumātua or kuia). These natural parameters were often used to help identify the scope of the community, their health status, and to network with key players in the community to ensure positive relationships. Many PHOs in the sample, especially Māori-led PHOs, were founded by specific Māori communities and although they welcomed the broader population to join, their focus on a specific community was often made clear. Some Māori-led PHOs noted the complexity of community engagement in their regions, especially Māori-led PHOs providing service in areas with high concentrations of pan-tribal (taurahere) and tangata whenua groups. Māori-led PHOs’ responses were also largely led by tikanga and knowledge of local Māori politics.

The language used to describe an enrolled population varied across the sample. Some PHOs made explicit reference to their ‘community’ in natural discourse with the common understanding of who the community comprised. Others made reference to their ‘enrolled population’, and not all PHOs’ enrolled populations comprised, or could be configured into, the category of a ‘community’, especially those in urban settings. For example, the enrolled Māori population in a large urban-based PHO was not referred to as a Māori community within their PHO. In fact, the PHO was most concerned with addressing the pressing health needs of the migrant communities enrolled in their PHO. It was unclear if the enrolled Māori population in this PHO were not bound by a sense of community, or if the PHO itself did not recognise them as a community.

COMMUNICATION WITH COMMUNITIES

Pathways for communication and information-dissemination varied across PHOs in the sample, yet for most PHOs, the ease of communication with communities hinged on the strength of relationships and whether they had adequate resources to engage with communities. One key informant described the processes as entailing *“a lot of work, a lot of effort, a lot of time”* (Māori Manager of a Māori-led PHO).

Knowledge of what bound communities appeared to be significant. Some communities were bound by Iwi, hapū and marae communities, whilst others were bound by gang identities, geography, or housing location. The factors were multifaceted and multilayered. Insight into community dynamics informed some communication and information-dissemination methods. Some mainstream PHOs reported that they used the Māori representative on their governance Boards as the main communication link to Māori communities. Some of the Māori-led PHOs in the sample established themselves from Iwi, hapū and marae communities wanting a local health agency to service their communities. These PHOs were more intuitive about how to reach hard-to-reach communities, utilising methods such as surveys, road-shows, newsletters/pānui (electronic and paper-based), suggestion boxes and open-invitation hui to communicate. Through these they were able to gain rapport and a greater understanding of their community dynamics, identify pressing health concerns, and to develop relationships with the community. PHOs reported varying successes with these types of approaches.

Key informants generally commented that resources or budgets for communication were generally meagre and PHOs needed to think creatively on how to engage communities. Most took advantage of common networks and infrastructure as a part of the communication and information-dissemination channels to the wider community. Much of this type of work was conducted under the umbrella of health promotion for which there was little funding:

“We’re talking \$22,000 in health promotion spread across six practices on a pro-rata basis – is not a lot of funding – and it’s almost as if from the MOH guidelines, you’ve formed a Board to decide how we’re going to spend ten dollars on a meal. Are we going to buy ten dollars worth of chips or five dollars worth of chips and two pieces of fish?” (Māori Manager, Māori-led PHO)

Some found community responses enthusiastic, whilst others were a little more critical of the meaning of community responses:

“Why would the community be bothered about the PHO unless it directly affects the service they were being provided? Then they want to know who the hell this person is. But if it didn't, why the hell would you want to bother about it? And it doesn't really affect because if something went wrong, they would go to their GP service, they wouldn't got to the PHO. So, that's why I think that's like that.” (Māori CEO, Māori-led PHO)

One Māori Manager of a Māori provider and Board Member of a Māori-led PHO with a direct relationship with specific hapū and Iwi, reflected on the key challenges they faced as a PHO committed and driven to deliver services for their whānau who were not just considered the enrolled population:

“Let’s face it – every Iwi is pretty much global now, you know; we’ve got people living in all areas of the world.” (Māori Manager, Māori provider and Board Member, Māori-led PHO)

This PHO disseminated information locally through their strong local networks at provider level and utilised their intricate database of Māori enrolled in their PHO as well as Iwi and hapū registers, to send information (ranging from specific health issues, to information about staff working within the PHO) more globally.

STRENGTHS AND LIMITATIONS OF COMMUNITY INVOLVEMENT

Key informants gave descriptive accounts of some of the strengths and limitations of community involvement.

One Practice Nurse from a small, Interim-funded PHO suggested that the concept of community involvement and engagement was excellent, but the reality was it did not always work because the ten percent of community people who did all the work were already heavily involved in the community.

Some PHOs canvassing a large geographical spread found health promotion across long distances and dispersed populations difficult, especially for small PHOs. Working with other PHOs in joint applications was one method of addressing this difficulty:

“One of our issues here in this particular PHO is the fact that we’re so spread out and it makes that difficult. And it goes into unique areas as well, and when you’re doing health promotion it really is centred on that area rather than having one health promotion.” (Manager, large, Interim-funded PHO)

Participants highlighted one issue for PHOs in being able to consult and gather feedback from their communities was that Māori in the community did not know enough about PHOs. Community consultation and accountability was, therefore, hindered by this limited knowledge:

“The biggest problem with PHOs is that half the people don’t know what PHO they belong to. All they can relate to is their collective [local practice] and their doctor... That is the major difficulty.” (Māori Board representative, Interim-funded PHO)

Board composition and politics had a direct influence on community input. One Pasifika representative who had been a member of various PHOs suggested that PHOs which had high numbers of Māori and Pasifika representatives generated much more community-orientated discussions. In comparison, PHOs dominated and driven by GPs which tended to just have one Māori representative, one Pasifika representative, and one community representative, focused much more on GP or organisation needs:

“... you get more community-orientated discussions going on in that PHO because you find that half the Board is from the community. Then you have to look at the two PHOs driven by GPs... you may have one Pacific rep, one Māori on the Board - driven by GPs... You find the Board is always dominated and driven by the GPs.” (Pasifika Board representative, Māori-led PHO and Interim-funded PHO)

Although, there were many descriptive accounts of the strengths and limitations of community involvement, what constituted strength or limitation was largely a matter of perception.

Many PHOs in the sample, Māori-led PHOs in particular, had clear views of what a community approach to health meant to them; community input was a natural part of their philosophy or approach to health and wellbeing. One participant from a Māori-led PHO commented that they were naturally aligned with the principles of a population approach to health and wellbeing prior to the introduction of the PHCS:

“It’s how we’ve always been... trust is formed through the community representative. The PHO hasn’t actually changed – we thought of ourselves as a natural PHO. When the idea came up, we thought, ‘This already fits us. We already do that.’” (Māori CEO, Māori-led PHO)

Many participants from Māori-led PHOs noted that the process of setting up their PHO in alignment with Iwi, hapū and marae communities was an empowering process in itself. In these cases, these communities saw the PHO as their representative health agency:

“The old people were continually trying to get something created. There was probably four of us who were in the nursing profession and we were being hounded to come and start the service – and we were all saying, ‘No, no, no, no no’, largely because there was no putea. After probably two years of that, the previous Manager, agreed... to drive it forward, largely at the call of the old people.” (Māori Manager, Māori Provider and Board Member, Māori-led PHO)

Relationships with communities and their ongoing involvement from the point of the establishment of the PHO were complex. Experiences of gaining support, or getting communities actively involved in the PHOs were diverse. However, how this process was framed determined whether this process was viewed as a burden or an operational challenge.

8. WORKFORCE ISSUES

Waiho i te toipoto, kaua i te toiroa

Let us keep close together, not wide apart

WORKFORCE SHORTAGES

Addressing Māori workforce issues is vital for the success of PHOs and for addressing health disparities. These issues include: training; recruitment and retention; remuneration; working in culturally safe and respectful ways including with Kaiāwhina in the community; and having appropriate funding that acknowledges and recognises the holistic nature of Māori health and well-being. Findings from this evaluation add to the pool of evidence that Māori experience systematic disparities in representation in the health sector workforce (NZIER, 2003), or as a Board member of a Māori-led PHO said, “*Māori nurses are as scarce as hens teeth; Māori doctors are scarcer than dinosaurs*”.

Participants identified a number of workforce issues, particularly in regard to recruitment and retention of doctors, nurses and Māori Community Health Workers or Kaiāwhina. Whilst the need to more fully involve Māori in the care of Māori was well recognised, the shortage of doctors and nurses was suggested as one of the biggest issues that had come about as a result of the PHCS, with the limited Māori workforce being one of the most affected.

One PHO Manager from a Māori-led PHO suggested the dearth of Māori health professionals was most apparent outside the Auckland region. Regardless, the need for a greater Māori workforce across the primary health sector was undisputed, including within management:

“There are some Māori staff, but we need some succession planning to see them start to move into management.” (Māori Board representative, small, Interim-funded PHO)

PHOs have employed various measures in response, including encouragement of a locally grown workforce through the provision of scholarships to local people to help them attain health qualifications. The Board Chair of a small, rural, Interim-funded non-Māori-led PHO highlighted the need for the recruitment and retention of a Māori health workforce to be considered more fully at a national level, however, and jointly between health and education. Another response to workforce issues implemented by some PHOs was the adoption of whānau-friendly workplaces – identified as particularly important in retaining Māori staff:

“It’s very whānau-orientated here – whānau comes first. Mums [on staff] can look after their kids [here]. It’s a good, caring, supportive group here. That makes a huge difference [to burnout].” (Māori nurse, Māori-led PHO)

The Board Chair of this Māori-led PHO expanded on this philosophy, one which was shown to be particularly effective in the retention of the Māori workforce in her PHO:

“We kind of try to run the organisation like a bit of a whānau-based organisation... I support the women in the organisation when they have babies, and generally allow them to bring their babies for the first year until they are big enough to go into kōhanga.” (Board Chair, Māori-led PHO)

This Chair also referred to a number of other initiatives aimed at reducing pressure on an already stressed Māori workforce, through the use of team-building exercises, and ensuring staff were well resourced and trained:

“Some of the things that I’m committed to ensuring is that they have the very best that we can afford to give them. We don’t expect them to use their own vehicles for example, because I know how difficult it is to get a car, and then get on, and running clients around [in] them... We take all the staff away on a team building trip. We’ve been down the South Island. We’re going up North in October for seven or eight days for team building. And they get ample amount of training. We will support them like right through if they want to do their Masters actually. What we do is, we will pay it [study fees] up front, if we can’t get any kind of scholarships for them, and then they just pay half of it back over a period of time. As much as they wanna do, we will support them to do that.” (Board Chair, Māori-led PHO)

An inherent risk of professional development and up-skilling of Māori staff is that they become even more sought after by competitors, a fact this Chair recognised. She noted though, that despite the inevitability of this, she gained *“a great deal of pleasure”* from seeing Māori *“go on and do other things”*. She admitted this was difficult when a number of staff left at once, but was resigned to the fact that the bigger picture of Māori health development was more important:

“What would worry me is if they left because we weren’t looking after them. But I don’t think that’s true.” (Board Chair, Māori-led PHO)

A distinguishable approach to the recruitment of a Māori workforce was reported by a Māori representative on the Board of a large, Access-funded PHO. This participant suggested the selection of Māori staff in PHOs was *“based upon everybody know[ing] who’s who”*. This means that, in contrast to the non-Māori health workforce, within Māori health *“everyone knows who all the Māori nurses and doctors are”*. When recruiting Māori staff, therefore, PHOs are able to go directly to possible candidates.

The importance of research was also identified in addressing workforce issues. Some participants reported involvement of their PHOs in current research aimed at putting together actions to attend to workforce issues. The need for more specific research was highlighted, however – one participant suggesting there was not enough known about best practice with the most disadvantaged whānau:

“There’s... not enough information from people. We need it from those who are struggling. Where is the research that’s going into their homes? [Where is the research] into Māori and poor people? ...We need research [about] Māori and low-income users. People [policy makers] still don’t know [their situation].” (Māori nurse, Māori-led PHO)

WORKFORCE ISSUES WITH DOCTORS

The difficulty in attracting doctors into not-for-profit organisations, and doctors wanting to be salaried, was also highlighted. Within Māori-led PHOs, doctors have tended to be on salaries, unlike a large proportion of their counterparts in non-Māori-led PHOs who own their own practices and draw their income from them:

“I think the difference between this PHO and say, maybe some of the other PHOs, is that the doctors here and nurses here are all salaried. Most of the other practices are owned by their own, you know, the doctor-owners – so the philosophy is a little bit different. This PHO has a very strong social sort of mind set, so it’s not driven by profit.” (Manager, Māori-led PHO)

However, most of the doctors seeking salaried positions have tended to also want part-time positions, leading a couple of Māori-led PHO participants to suggest the level of commitment of these doctors was not as high. This in turn has led to even more pressure on the health workforce. There are also shortages of doctors wanting to go into general practice so the current GP workforce is aging.

“... the new wave of General Practitioners is not around. They don’t want to invest their time and resource and money on bricks and mortar. They want to come, they want to give good service... They also want to enjoy life. And so we’ve got to understand our services as well... So, when one decides to leave, we are caught high and dry. And next thing all our money has been put up in locums, you know what I mean?” (CEO, Māori-led PHO)

Two Māori participant representatives on Boards – one, of an Interim-funded PHO, and the other, of a large, Access-funded PHO – referred to the additional challenges faced by Māori doctors. Māori doctors are in high demand from PHOs, particularly given their low numbers. Their minority, however, can isolate them from collegial support from fellow Māori doctors. One Māori-led PHO practice reported that their GPs had established a network to encourage others:

“They have a network, a group of GPs that they encourage training, and eventually one out of three of those will come back and be part of a practice. But what we’re saying is, those people are only coming for a certain term now. They are not buying into the practice.” (Board member, Māori-led PHO)

Because they tend to be known within the Māori world, even greater demand and expectation was also placed on them by Māori:

“It is an isolated world for Māoridom in that world... for doctors becoming GPs and that sort of thing... It is really, really hard and the Māori networks are really hard for them.” (Māori Board representative, Interim-funded PHO)

According to a Māori representative on the Board of a large, Access-funded PHO, this greater expectation on Māori GPs by Māori results in their increased level of work:

“The world is not as small for them as it is for us.” (Māori Board representative, large, Access-funded PHO)

As explained by a Pasifika representative on the Boards of two PHOs – one, a Māori-led PHO and the other, a non-Māori-led PHO – there is a desire amongst Māori and Pasifika for “*our people to provide services [to our own populations] because they understand more*”. Although referring specifically to the nursing workforce, the expectation and reasons for cultural match in primary health service delivery are no different for Māori doctors:

“They go to a home because they are more comfortable in that environment because they are basically in that same environment. If you get someone else [non-Māori or non-Pasifika] to go in there, you find there is that reluctance to go into homes.” (Pasifika Board representative, Māori-led PHO and non-Māori-led PHO)

WORKFORCE ISSUES WITH NURSES

Another workforce issue identified was the increased need for nursing recruitment and retention. There was a clear need for increased nursing engagement and use of nurses across the primary health field.

Although one Māori-led PHO attributed the MenzB programme with facilitating nursing recruitment and in particular, increasing numbers of Māori nurses in their PHOs, many other PHOs stated that recruitment and retention of nurses had been difficult.

Much higher rates of pay in private institutions, and an increase in the pay rate for hospital nursing some years ago, added to the lack of primary health care nurses. Retaining nurses in the primary care environment became difficult once pay parity came about and secondary care nursing became more attractive. However, primary health was beginning to come into line in terms of this pay parity; one PHO noting that as the hospitals increased nurses’ wages, so had they had to, in order to hold on to their existing nursing workforce. For some it had meant employing less experienced staff as two Board members of Māori-led PHOs mentioned:

“...we’ve had to use new grads, and so it lessens the capabilities of our medical centres because we’re not able to attract experienced nursing staff because we can’t afford to pay an extra \$10,000 per annum which is around about that, that disparity between NGOs and particularly Māori providers and DHB rates.” (Board member, Māori-led PHO)

“In collaboration with the DHB, we’ve also got a ‘New Entry to Practice Expansion Programme’ whereby we can take new grads, and there’s a formal clinic on an academic pathway for them on that first year into practice. And that’s just been audited and passed by the Nursing Council, so that’s wonderful.” (Board member, Māori-led PHO)

The shortage of Māori and Pasifika nurses was especially highlighted by a Pasifika representative on the Boards of two PHOs – one, a Māori-led PHO and the other, a non-Māori-led PHO. This representative referred to the struggle in retaining these nurses and the impact on services of losing them to higher paid positions within the DHB:

“The DHB, they poach. They took three of our long-term staff who have been here since we started. They took them and it took us almost a year to recruit those nurses into the service.” (Pasifika Board representative, Māori-led PHO and non-Māori-led PHO)

Recognition of the expanded role of nurses through PHOs, particularly with CarePlus, was especially noted. Although nurses have traditionally played a major role in the care of clients and have always been heavily involved in the care of the community, nurses are now operating as lead practitioners. A Māori representative on the Board of an Interim-funded PHO stated that *“nurses are becoming, and are doing, a lot of what the doctors used to do”*. Some nurses now take their own appointments and reported being fully booked. Participants suggested that this significant alteration to nursing practice was in stark contrast to the under-utilisation of nursing skill prior to the PHCS:

“For a long time nurses weren’t utilised and their skill level was not utilised. They were kind of at the beck and call of the doctor. But actually, there is some things, lots of things, nurses can do, and should be doing. Where there is a wider need for nurses, nurse-led clinics and stuff, it’s just really valuable.” (Board Chair, Māori-led PHO)

A Pasifika representative spoke highly of the outcome of nurses adopting new responsibilities under the PHCS, suggesting that this development in nursing that saw nurses going into people’s homes and discussing health promotion and intervention, had given them *“more integrity”* and made them more accepted by the community:

“There was a perception [prior to the PHCS] that nurses were based in hospitals and were always under the guidance of doctors. It was a very confined sort of role. Whereas now, we have primary health care nurses who are community-based, and apart from prescribing medication, they can advise a family the best way to deal with a health issue. They [families] don’t need to go to a doctor for that. They can get it from the nurse and it is very good advice. And they [nurses] work with the family putting together those programmes on how to actually improve the health of that family.” (Pasifika Board representative, Māori-led PHO and non-Māori-led PHO)

The new role of Nurse Practitioners made use of in the PHO environment, was a natural progression in nursing for several of the informants:

“It’s obvious or normal that they would lead CarePlus and that they would be leaders in other [areas]... They are significant practitioners.” (Māori-led PHO)

“We’ve got three that are almost Nurse Practitioners in the organisation. It takes just a bit longer. I was talking to one yesterday saying, ‘You should have been a doctor’ ‘cause actually it’s less training. It’s more training to be a Nurse Practitioner, more years.” (Board Chair, Māori-led PHO)

A nursing background also helped one nurse Manager with her role:

“I think coming from a clinical background, a nursing background, you bring into your Manager role some added skills, added value, around nursing recruitment, collegial support, professional development, you know, like you can add a little bit of you there... But people are still enticed to the big dollar, we’re still forced by our... you know, we still have to survive and it is becoming increasingly competitive, which, you know, some of those DHB nurses are on really good MECA⁷, and that’s a huge issue for us.” (Nurse Manager, Māori-led PHO)

⁷ Union negotiated agreement for pay and conditions called a Multiple Employer Collective Agreement.

One Māori-led PHO suggested that with the increased workload, nurses were becoming more competent and specialised. Whilst this may be regarded as a positive outcome, it had occurred purely out of a need to divide the workload into manageable chunks. Many PHOs had nurses whose sole role was immunisations, for example. Although the expansion of primary health care nursing was seen as positive and, when coupled with pay increases, encouraging for nurses, there were also examples relayed of nurses being heavily overloaded and becoming “snowed under” as a result of their increased roles in primary health and as their numbers were stretched:

“It’s actually overbearing the nurses... Everyone... said, ‘Get nurses to do it’. But it’s actually the nurses getting snowed under. And we’re saying to the PHO, ‘Hold on! Nurses are already busy. Find someone else.’ They’ve got CarePlus, they’ve got vaccinations, the recall systems, and then chasing up patients.” (Practice doctor, Māori-led PHO)

The specific role of Māori nurses had increased alongside the expansion of nursing generally, as alluded to by a GP on the Board of a small, Interim-funded PHO. This GP referred to the role of the sole Māori nurse in their PHO in driving a programme associated with CarePlus, “seeking out those who do not come in”. A Māori representative on the Board of another Interim-funded PHO also referred to the importance of Māori nurses: “If we can’t get a GP at the marae, we like to have a Māori Practice Nurse in there.”

As a result of lower numbers, the impact of this increased workload was especially felt in an overworked Māori and Pasifika nursing workforce, however:

“It is huge. For us, for a service, for example, we only have three nurses. We have just completed our AGM where we had 900 referrals. Now, if you break that down between three nurses into how many weeks a year, that is just a small part of their work following up those referrals. There is another huge part of running group sessions, and visiting, and making ongoing, normal, routine calls to homes. We also have clients based here, enrolled clients. Not clients with the GPs, but registered with the service. So, we sort of follow them up as well. So, 900 referrals is just on top of their normal work, and this is funded all over the [region] from GPs.” (Pasifika Board representative, Māori-led PHO and non-Māori-led PHO)

One Māori-led PHO reported a change in work hours for their nurses from full-time to part-time in order to cope better with the “heavy burden” of their increased workloads. This appeared to be successful in cutting down the amount of stress the nurses felt under.

WORKFORCE ISSUES WITH MĀORI COMMUNITY HEALTH

WORKERS OR KAIĀWHINA

The importance of Māori Community Health Workers or Kaiāwhina, and their increased role, was also highlighted by a number of participants. One Māori-led PHO described their role as so “absolutely critical”, that despite their PHO’s funding stringency, it was not prepared to “go backwards” and lose this position once funding for the five year programme ended. Whilst not disagreeing with this sentiment, the Board Chair of a Māori-led PHO suggested that the role of Māori Community Health Workers was not clearly or consistently defined by all PHOs. In her experience, their role was similar to that of social workers in that it focused on client’s social issues. She illustrated the benefits of this position, particularly when combined with the health-focused role of nurses:

“When we employ nurses, we get a client and the [Māori] community [health] worker will go with the nurse to deal with that client. Like the [Māori] community [health] worker will deal with the social issues and the nurse will deal with the asthma issues.” (Board Chair, Māori-led PHO)

This role of Māori Community Health Workers in this PHO was differentiated from community health educators who, in this scenario, for example, would “*competently educate someone in the taking of their insulin medication*”. The Chair noted, however, an increased questioning of this role, particularly by those who considered this to be the traditional role of nurses. She did not endorse this view:

“I think we are seeing a real switch from where, especially Māori organisations really, we are committed to the whole role of employing Māori educators, now turning around and saying, ‘Oh, no, no. They can’t do that. That’s the role of nurses’. So yeah, we are seeing more of them who object and we don’t support that at all.” (Board Chair, Māori-led PHO)

Members of largely rural PHOs explained how their practices used the Kaiāwhina role:

“So, in our community house centres, we have a GP, and a Practice Nurse, and a receptionist, sort of based at the clinic most of the time, and then we have a Kaiāwhina Community Health Worker who’s working out in the community, normally alongside our rural health nurse... Our rural health nurses up here are sort of like super nurses really – they do a whole range of things like public health nursing, Whānau Ora, tamariki ora, and they’ve just taken on the outreach nursing contract for 12 months.” (Board member, Māori-led PHO)

“... if it’s something clinical, it’s the rural health nurse that makes that first approach because the Kaiāwhina’s not clinical and the Kaiāwhina will go in there to support. The nurse would normally say, ‘Oh, somebody needs information dropped off’ or ‘Might need a ride to the clinic if there’s something available’. The rural health nurse will make the first contact with the patient before the Kaiāwhina goes in...” (Board member, Māori-led PHO)

The ability of Māori Community Health Workers to more easily find ‘hard to reach’ families and enter into their environments to encourage access to and completion of care because of their expertise and knowledge of the networks was especially highlighted:

“Using the Kaiāwhinas, we have reduced disparities. We have moved the service into the community, but they found the people and it’s acceptable for them to speak up and get people to use the service.” (Manager, Māori-led PHO)

An example of this reduction in disparities due to the use of Kaiāwhina was in children’s hearing tests. A Manager reported more Māori children were supported to access hearing services in their region due to the combined work of Kaiāwhina and community clinics. A Māori representative on the Board of a large, Access-funded PHO noted that ideally Māori Community Health Workers included both rangatahi and kaumātua – both have expertise and knowledge of specific networks and support services available to whānau.

HOLISTIC VIEW OF HEALTH

The severity of the increased workload experienced by Māori was compounded by a much broader view of health and accountability held by both Māori and Pasifika:

“You have a nurse who will go out to see a kid, who ended up seeing four or five and also ended up seeing Grandma or Granddad who might have been unwell that morning. So, she has ended up doing four or five assessments and you were only expected to be there for one. So, everything else is put out of kilter, and there may have [been] issues like housing, and [they] might be on the benefit and not receiving their full entitlement. So, the nurse will ring the Community Health Worker to make an appointment for this family and they have to go with the family to advocate and speak on their behalf... Quite often our nurses will go to a home and come running back and then go to the foodbank, pick up parcels take them back, find that there are kids there, young kids, hardly any food in the house... If you don’t have food on the table, the last thing families want to hear is you preaching about health education when they are hungry, the bills need to be paid, or the power will be cut off... That’s not health... [but] we can’t just turn around and say, ‘We are only here for health’. They couldn’t do it. We are not funded for that [the extra work]. We are not paid to do that, but we can’t turn our backs on that. That’s what we are trying to convince the powers that be. Look, don’t judge us. The value of the money you are paying us and what we deliver in terms of health, we do a lot more than that and it is all a part of health... We see that as our role. Unfortunately, we only get funded to deliver health, but we made a decision – ‘No, we are not going to abandon that. Continue to do it’. So that’s where the overworked, the high expectation of work issues come from.” (Pasifika Board representative, Māori-led PHO and non-Māori-led PHO)

A Māori representative on the Board of a large, Access-funded PHO also confirmed this situation:

“All Māori and Pacific have big families, so... [it’s] very hard to say, ‘We won’t deal with the kids’ [when] the grandmother turns up and all of a sudden there is eight people.” (Māori Board representative, large, Access-funded PHO)

IMPORTANCE OF TEAMWORK

There was recognition amongst participants of the importance of teamwork within practices and also across practices. This was noted as especially necessary given the increased workload from the PHO initiatives:

“You can’t do it on your own... You’ve got to have good working teams in each of the providers in order to implement the vast number of things we’re now supposed to report on... Teamwork is a good thing... If we run out of vaccine, we can ring up and borrow some [from another practice]. We can help each other out.” (Māori-led PHO)

A Ministry of Health/Manatū Hauora representative noted that ‘by Māori for Māori’ providers had always worked as teams, an observation supported by a DHB Manager who suggested that teamwork was highest amongst Māori because of both the historical and current lack of GPs to serve the population. The reasoning for greater teamwork was due to an insufficient capacity to complete service delivery otherwise:

“Māori providers have fewer GPs and thus, they have been more innovative about teamwork.” (DHB Manager)

A practice doctor from a Māori-led PHO described teamwork as an essential part of primary health care reform because of the way clinical teams now worked together. They reported that every single staff member within the practice was part of the team approach to whānau care. A Board Chair in another Māori-led PHO noted that staff buy-in to the PHO philosophy was important, as was having representation in governance:

“Most of the staff, the doctors, and nurses, and community workers, who come to our services are people that kind of buy into our way of thinking, our philosophy, because actually we pay lower than other sectors. So, they’ve got to kind of buy into our way of thinking so it’s kind of like they are owners of the service as well, so they have a say in the direction that the service is going in.” (Board Chair, Māori-led PHO)

“... we do have staff that are on our Board. So, they’re reps on our Board, and then any of the other staff can come anyway. So, the only time that we would go into committee and exclude them is if we were talking about other staff. But generally, in all other instances they can be part of the decision-making.” (Board Chair, Māori-led PHO)

WORKFORCE TURNOVER

One Māori-led PHO raised a number of issues surrounding workforce turnover, particularly in regard to the Māori workforce. They suggested that Māori staff turnover was of particular concern to providers, because given their lower numbers, *“when just a few leave, the effect is much greater”*. The difficulty in staff turnover relative to the size of organisations was also pertinent:

“Because we’re a small hospital, our hospital workforce is vulnerable to a couple of people deciding to do a different career choice. If someone else is having a baby, your workforce is suddenly decimated... It’s a constant focus for us.” (Māori-led PHO)

The difficulty in paying the workforce what they were worth was highlighted. In particular, the PHO referred to the complexity in employing Māori staff on the same money as other PHOs, but requiring them to provide a much broader perspective of health:

“Our people are doing the wider role, but all we can manage to do is to match what they’re paying elsewhere.” (Māori-led PHO)

There was also the recognition that kaupapa Māori training made staff more attractive to the DHB:

“... what happens is, you know, you’ll get a Kaimahi who will come and work for a Kaupapa Māori organization, they send them to the training, they get them all upskilled, and then the DHB will say, ‘Come’. You know, you can’t compete with say, paying somebody \$26 and with the DHB paying somebody \$36, you know. So, it’s just really, really difficult.” (Board member, Māori-led PHO)

RURAL RECRUITMENT

The difficulties associated with workforce recruitment in rural and remote areas were specific. One Māori-led PHO referred to the juxtaposition of trying to attract kaimahi to their service by advertising and promoting the cultural lifestyle change, whilst knowing the scope of rural work provided little chance of resting and refreshing and increased the possibility of burnout:

“... we had a rural health nurse from the most Northern clinic leave about a year and a bit ago and I haven’t managed to replace them fully. I’ve managed to get somebody in there to cover 0.6 but there’s still 0.4 vacant. And it’s just been an ongoing saga, and it is a real issue when we’re trying to get out there.” (Manager, Māori-led PHO)

Difficulties also lay in recruiting clinicians who had spouses and families, when employment prospects for partners were minimal:

“There’s one more barrier... you’ve got a nurse come up, but what’s the husband going to do?” (Māori-led PHO)

“... we’ve been quite lucky because a lot of the nurses that are working for us have got whānau... they’re connected to the communities and they’re here because they want to bring their whānau up here, and so we have been quite lucky. But, it’s just trying to find fresh faces to come back, you know. We’ve had one leave and yeah, and that’s an issue.” (Manager, Māori-led PHO)

The need to cater to, and care well for, this rural and remote workforce, including through financial acknowledgement of the rural and remote situation was, therefore, significant. The same Māori-led PHO suggested that funding was not cognisant of this fact, and the result was that inevitably staff left for a more tenable situation. It was noted that on exit interviews and letters of resignation there was always gratitude expressed for the organisational support shown, as well as a degree of sadness noted at leaving a much loved workplace. The greater needs of their families, however, took precedence.

The responsibility of rural and remote PHOs towards the professional development of those staff who chose to work in these areas was also highlighted. One Māori-led PHO referred to their need to ensure this workforce was able to readily access external training. This allowed them to continually feel refreshed and clinically competent and aimed to combat the possibility of becoming over anxious about the scope of their roles. The reality of accommodating this need, however, was that the collegial support required allowing doctors and nurses, in particular, time away at external training, was lacking rurally. This was one of the inherent risks of working in rural and remote areas.

The scope of rural practice is so big that nursing and medical staff must be able to keep up to date with clinical advancements. The dearth of the rural workforce, though, acted counter to this need, and according to the Māori-led PHO, there was no acknowledgement of this in the funding of rural and remote PHOs:

“There’s always the assumption that you can pay people the same to work in remote and rural [areas] as you pay them in the city. [But] the reality is that to entice people to make a career choice in rural medicine, it might be helpful if we [rural PHOs] could compete a little better and have a premium for working in remote and rural [areas].” (Māori-led PHO)

The Manager of a small, rural, Interim-funded non-Māori-led PHO commented further, noting that despite their PHO Board identifying the specific need for more Māori staff, there was no funding to support this:

“I would love to have the opportunity to have some funding from government to identify and work alongside the NGOs [Māori and Pasifika] to try and support them in having more staff trained up, so in two or three years we can do something solid.” (Manager, small, rural, Interim-funded non-Māori-led PHO)

Others reported local initiatives were underway to encourage new staff:

“... we’re sort of taking on nurses, third year nurses, and sort of giving them a big immersion in rural nursing on the Coast in the hope that they go back and spread the word that it’s really cool to work up here.” (Manager, Māori-led PHO)

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Ma pango, ma whero, ka oti te mahi

By black and red together, the work is done

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