Primary Focus

The future of primary health care

Conference Handbook

Information Centre
Ministry of Health
Wellington

30 and 31 May 2002

Wellington Convention Centre
Wellington
New Zealand
Contents

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Foreword

Welcome to Primary Focus. The outstanding response from presenters and participants shows how important primary health care is to all of us. This is now the biggest conference ever hosted by the Ministry of Health.

The programme is full, varied, and exciting. It reflects a wide range of views, opinions and experiences and you will be sure to find plenty of interest.

There will be ample time to question, share experiences and meet people. Indeed the lasting success of the conference depends upon how much you are prepared to take part for these two days – and to carry home for further action with your own colleagues and communities.

I hope you enjoy these two days – and that you are inspired to join with others to make the Primary Health Care Strategy a reality for New Zealanders.

Hon Annette King
Minister of Health
Information for Registrants and Presenters

Registration and Information Desk
The registration and information desk is located in the Fletcher Challenge foyer of the Michael Fowler Centre (ground floor) and will be open each day at 7.45 am.

Coats and Luggage
There will be a coat rack and luggage storage area available for registrants, located in the Fletcher Challenge foyer.

Name Badges
Please wear your name badges at all times so that catering staff know to serve you.

Teas and Lunches
Morning teas and lunches will be served in the Town Hall Auditorium. Afternoon tea will be served at a location near your session. The caterer has been advised of any special dietary requirements. If you requested a special diet in advance this will be available for you. Please make yourself known to the catering staff to obtain your special requirements.

Presenters
If you are using any visual aid equipment (in particular, data projection, slides or video) please report to the Speakers Preparation Room (Dressing Room 1 - located on the first floor of the Michael Fowler Centre - turn left up the stairs). There will be a technical director there who will either take your CD with your PowerPoint presentation loaded from you or check that he already has it. You can check any finer details with him at this time. All presentations will be loaded onto the laptop in each room prior to the presentation.

Posters
Posters will be displayed in the Town Hall Auditorium.

Messages and Phones
Messages received for registrants will be placed on the notice board at the registration and information desk. There are pay phones in the foyer of the Town Hall and the Michael Fowler Centre. Please keep your mobile phones and pagers turned off during conference sessions.

Parking
Car parking is available in the Michael Fowler Centre car park, the James Smith car park adjacent to the Duxton Hotel, Lombard Street car park, Queens Wharf Event Centre car park and Taranaki Street Wharf.
Room Locations

If you have any difficulty finding the room you wish to go to, please do not hesitate to ask any of the convention centre staff or the conference registration staff. The following alphabetical list of rooms may help in interpreting the room locations listed alongside the abstracts:

<table>
<thead>
<tr>
<th>Room</th>
<th>Building</th>
<th>Floor</th>
<th>Directions (as you arrive at the given floor)</th>
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<tbody>
<tr>
<td>Air NZ Suite 1</td>
<td>Town Hall</td>
<td>2nd</td>
<td>Michael Fowler Centre side.</td>
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<tr>
<td>Air NZ Suite 2</td>
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<td>City council side.</td>
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<td>Fletcher Challenge Foyer</td>
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<tr>
<td>Frank Taplin Room</td>
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<td>Green Room</td>
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<tr>
<td>Lion Harbourview Lounge 1</td>
<td>Michael Fowler Centre</td>
<td>2nd</td>
<td>Turn left and walk all the way around in the direction of the Town Hall.</td>
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<tr>
<td>Lion Harbourview Lounge 2</td>
<td>Michael Fowler Centre</td>
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<td>Turn right and walk all the way around in the direction of the car park.</td>
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<td>Michael Fowler Centre Auditorium</td>
<td>Michael Fowler Centre</td>
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<td>Renouf 1, Michael Fowler Centre</td>
<td>Michael Fowler Centre</td>
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<td>Straight ahead (Town Hall side).</td>
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<td>Renouf 2</td>
<td>Michael Fowler Centre</td>
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<td>Speakers Preparation Room</td>
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<td>Square Affair Suite 1</td>
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<td>Square Affair Suite 2</td>
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<tr>
<td>Town Hall Auditorium</td>
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## Programme

**Thursday 30 May 2002**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>7.45 am</td>
<td>Registrations open</td>
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<td></td>
<td><em>Michael Fowler Centre Auditorium</em></td>
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<tr>
<td>9.00 am</td>
<td>Welcome</td>
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<td></td>
<td>- Hon Annette King, Minister of Health</td>
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<tr>
<td>9.30 am</td>
<td><strong>Primary care: 21st century challenges to quality</strong> (Keynote presentation)</td>
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<td></td>
<td>- Barbara Starfield, Johns Hopkins University</td>
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<td><em>Michael Fowler Centre Auditorium</em></td>
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<td>10.30 am</td>
<td>Morning Tea</td>
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<td><em>Town Hall Auditorium</em></td>
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<tr>
<td>11.00 am</td>
<td>Morning Concurrent Session – New Possibilities (10 options)</td>
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### Option 1: Future PHO Models (Free standing presentations) Renouf 1

- An innovative approach to community-based primary care
  - Jill Calveley, Green Lane Hospital
- Focusing on populations and new possibilities for quality primary care
  - Sharon Kletchko, Janet McLean, Graham Dyer and Ron Dunham, Bay of Plenty DHB
- Best practice: best value
  - Dennis Pezaro, Rural General Practice
- The future of primary care
  - Ray Anton and Dr Branko Sijinja, Clutha Health First

### Option 2: Porirua and Kapiti (Symposium) Square Affair Suite 2

- Porirua – leading primary health care collaboration
  - Maureen Gillon et al, Porirua Healthlinks
- The Kapiti experience – integrated care across primary and secondary provision
  - Catherine Gibson, Kapiti Community Health Group Trust

### Option 3: Current Primary Care Organisations (Free standing presentations) Renouf 2

- Working for the whānau and community – Ngati Porou Hauora Inc
  - Caroline Thompson, Ariane Roberts, Kura Forrester, and Jo Hale, Ngati Porou Hauora
- Māori primary health care model
  - Bill Halkyard, Te Hauora O Te Hiku O Te Ika
- Rural primary health care: directions and dilemmas from a Hokianga perspective
  - Joe Topia, Tony Birch, Bridget Allan, Kathrine Clarke, John Wigglesworth, Wellington School of Medicine

### Option 4: Call Centre Telephone Triage (Symposium) Green Room

- Healthline, Plunket Line, the Mental Health Line, the Greater Murray Access Line
  - call centre telephone triage and management in primary care
  - Ian St George, Healthline

Primary Focus – the future of primary health care
Option 5: Continuous Quality Improvement in General Practice
*Free standing presentations*
*Lion Harbourview Lounge 2*

- Clinical audit
  - Dean Millar-Coote, South Link Health
- Ways to further develop the evidence base for the New Zealand primary care sector
  - Bruce Scoggins, Health Research Council
- Significant event management in general practice
  - Helen Rodenburg and Lynn Saul, RNZCGP
- Purchasing primary health care better
  - Angela Hands, Office of the Auditor-General

Option 6: Changing scopes of practice
*Free standing presentations*
*Air New Zealand Suite 1*

- The new Primary Health Care Strategy – opportunities for pharmacists to enhance patient care
  - Joan Baas and Linda McLauchlan, Pharmaceutical Society of New Zealand
- Delivery of eye care in rural areas: the Otago model
  - Laurence O’Connell, New Zealand Association of Optometrists
- The future of community nursing
  - Marsha Marshall and Helen Frances, Waitemata DHB
- Palliative care – the art of dying at home
  - Peter Woolford and Kees Loder, Integrated Primary Care Services and West Auckland Hospice Home Care

Option 7: Budget Management
*Symposium*
*Lion Harbourview Lounge 1*

- Funding of primary care
  - Clare Copland, Pegasus Health
- PHO risk management
  - Daphne Rawstorne, Jackie Cumming, Gordon Cameron, WIPA

Option 8: Diversity and Innovation
*Forum*
*Air New Zealand Suite 2*

- Working together
  - Representatives of a number of health professions explore new opportunities in primary health

Option 9: Brief Interventions
*Workshop*
*Square Affair Suite 1*

- High on health: changing harmful behaviour
  - Barbara Docherty, TADS National Project Director and Richard Fox, PHC Facilitator

Option 10: IT in Primary Health Care
*Workshop*
*Frank Taplin Room*

- Vision to reality: IT in primary health care
  - Mike Rillstone and panel

1.00 pm Lunch
*Town Hall Auditorium*
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
<th>Presenters/Details</th>
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<tbody>
<tr>
<td>2.00 pm</td>
<td>Population approaches in primary health care (Keynote presentation)</td>
<td>Michael Fowler Centre Auditorium</td>
<td>Don Matheson, Ministry of Health</td>
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<td></td>
<td>Afternoon Concurrent Session – Focusing on Populations (10 options)</td>
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</table>
| 3.00 pm      | Option 1: Targeting (Free standing presentations)                     | Lion Harbourview Lounge 1       | • Addressing primary care needs in diverse communities: can we keep all the people happy all of the time?                                          - Tom Love, WIPA  
• Routine referred services data shows that people seek primary care near where they work, not where they live  - James Harris, Wellington IPA  
• Making ethnicity count in general practice  - Donna Cormack, Wellington School of Medicine and Bridget Robson, Te Ropu Rangahau Hauora a Eru Pomare |
|              | Option 2: Child Health (Free standing presentations)                  | Square Affair Suite 2           | • The Mana Health Clinic  - Jill Clendon and Josie Clausen, Massey University  
• Increasing access to well child services: the clinical implications  - Trish Jackson-Potter and Anne Lensen, Plunket Society  
• Manukau City Child Advocacy Service, primary health care involvement  - Coral Elliot and Claire Arthur, Manukau City Child Advocacy Service  
• Care for our children, they are the treasures of the world  - Rose Mohi, Te Kete Manaaki Health Services |
|              | Option 3: Youth Health (Free standing presentations)                  | Frank Taplin Room               | • Meeting the needs of secondary students with type 1 diabetes in a college clinic setting  - Kirsty Newton, WIPA/CCH  
• Chlamydia infection is a major public health problem  - Karl Cole  
• Successful strategies for dealing with sensitive youth health problems in the general primary care visit  - Paula Renouf, RN, MS (UCSF, California), PNP |
|              | Option 4: Older People (Free standing presentations)                  | Air New Zealand Suite 2         | • Challenge or a chore – a consumer perspective  - Audrey Fenton, Waitakere City  
• Person-centred dementia care  - Lisa Rogers, Tauranga Hospital  
• Role of primary health care in an ageing population  - Judy Glackin and Paulette Finlay, Ministry of Health |

Primary Focus - the future of primary health care
Option 5: Developing Performance  *(Free standing presentations)*
*Renouf 2*
- Getting the infrastructure right for expanding roles and seamless client focused services
  - Sheryl Jury, Barbara Stevens, Mary-Anne Boyd, Waitemata DHB
- A practical approach to quality improvement – the experience of the RNZCGP practice standards validation field trial
  - Maureen Gillon RNZCGP, Dr Stephen Buetow, University of Auckland, Keith Carey-Smith, GP
- Performance indicators for primary care: tools for health gain, quality and accountability
  - Peter Crampton, Wellington School of Medicine and Health Sciences
- Implementing the concepts of clinical governance in primary care
  - Steven Lillis, Pinnacle

Option 6: Immunisation and COPD  *(Free standing presentations)*
*Green Room*
- Tamariki Ora – cc-ordination for our future
  - Nicholette Pomana and Tania Pompallier, University of Auckland
- Immunisation delivery – we must not fail!
  - Nikki Turner and Tania Pompallier, University of Auckland
- CHF – an integrated care management programme
  - Stephen Kara, Procare, and Sue McAuley, COPD project
- A randomised controlled trial of integrated care for COPD
  - Peter Didsbury, ProCare

Option 7: Building PHOs  *(Workshop)*
*Renouf 1*
- Establishing PHOs, enrolment, service specification and funding
  - Ministry of Health presentation

Option 8: Health Improvement Public/Primary Interface  *(Workshop)*
*Lion Harbourview Lounge 2*
- Health improvement in primary health care
  - Ruth Richards, Ministry of Health
- Improving the primary health/public health interface
  - Dr Cindy Kiro, National Health Committee

Option 9: Māori Providers  *(Workshop)*
*Air New Zealand Suite 1*
- Māori providers to share experience in primary health care
  - Māori Health Directorate, Ministry of Health

Option 10: Pasifika Health Care  *(Workshop)*
*Square Affair Suite 1*
- Successful primary health care in action
  - Moera Douthett, Pasifika Healthcare

5.00 pm Close
Friday 31 May 2002

8.30 am  Primary health care and communities *(Keynote presentation)*
- Anne McMurray, Griffin University and Kathrine Clarke, Healthcare Aotearoa
Michael Fowler Centre Auditorium

10.00 am  Morning Tea
Town Hall Auditorium

10.30 am  Morning Concurrent Session - Involving the Community (10 options)

**Option 1: Community Consultation *(Free standing presentations)* Renouf 1**
- Community orientated general practice
  - Jocelyn Tracey, First Health
- Community consultation - what is that?
  - Steven Lillis, Pinnacle IPA, Hilary Graham-Smith, Waikato Institute of Technology
- Gaining community acceptance and involvement in the development of a primary health organisation on the West Coast
  - Graeme Savage, West Coast DHB, Greville Wood, GP, David Hamer
- Working together
  - Chris Millar, New Zealand Nurses Organisation

**Option 2: Community Involvement *(Symposium)* Lion Harbourview Lounge 1**
- Involving the community in primary health care
  - Peter Crampton, Senior Lecturer in Public Health, Kathrine Clark, Health Care Aotearoa, Bridget Allan, Director Public Health Consultancy, Deborah McLeod, Department of General Practice, Tom Love, Lecturer in General Practice

**Option 3: Referred Services *(Free standing presentations)* Green Room**
- Pharma co-management in the new way – a systems approach
  - Avril Lee, Waitemata DHB
- Evaluating a community radiology pilot which increased access to radiology
  - Cathy O'Malley, WIPA, and Marjan Kljakovic, Department of General Practice
- Is better quality associated with lower general practice costs?
  - Laurence Malcolm, Aotearoa Health

**Option 4: Mental Health In Primary Care *(Free standing presentations)* Lion Harbourview Lounge 2**
- Primary mental healthcare – an issues paper developed by the Mental Health Advocacy
  - David Codyre and others, Mental Health Advocacy Coalition
- Dealing with mental health in primary care: a preliminary look at the potential of findings from the MaGPIe study
  - Professor Tony Dowell, Wellington School of Medicine
- Promoting mental health through primary care
  - Alison Taylor and Kayleen Katene, Mental Health Foundation
- A review of the opportunities – primary care and mental health
  - Kristan Johnston, Ministry of Health

Primary Focus – the future of primary health care
Option 5: Nurse Practitioners in Primary Health Care  
*Free standing presentations*  
**Air New Zealand Suite 1**

- Watch this space: nursing practitioners are coming to primary health care!  
  - Paula Renouf, RN, MS (UCSF, California), PNP
- Introducing nurse practitioners in primary health care  
  - Jenny Carryer, Massey University and College of Nurses, Marion Clark, Nursing Council, Jenny Phillips, future nurse practitioner, Helen Snell, future nurse practitioner

Option 6: Diabetes  
*Free standing presentations*  
**Frank Taplin Room**

- Structuring services and treatments for better outcomes  
  - Suzanne Snively, PricewaterhouseCoopers
- Diabetes 2000 – how far have we come?  
  - Sandy Dawson, Ministry of Health
- Improving the outcome for diabetic patients  
  - Professor Murray Tilyard, South Link Health

Option 7: Acute Management  
*Free standing presentations*  
**Air New Zealand Suite 2**

- A strategy for acute services management  
  - Jane Lawless, College of Emergency Nurses (NZNO)
- Accessibility of after-hours general practice care in Auckland  
  - Nicholas Jones, Auckland Public Health Service, Jinfeng Zhao, University of Auckland, Professor Pip Forer, University of Auckland, Kerry Boyle, Auckland Public Health Service
- Community care – a model of patient/provider empowerment  
  - Carolyn Gullery, Pegasus
- Primary options for acute care – general practitioners using their skills to manage ‘avoidable admission’ patients in the community  
  - Harley Aish, GP and clinical director, POAC, Peter Didsbury, GP, Paul Cressey, East Health, Janice Grigor, service coordinator, POAC

Option 8: Building Primary Health Organisations  
*Workshop*  
**Renouf 2**

- Establishing PHOs, enrolment, service specification and funding  
  - Ministry of Health presentation

Option 9: Involving the Community  
*Workshop*  
**Square Affair Suite 1**

- Cartwright, Gisborne, Greenlane: three good reasons for evaluating your views about community participation  
  - Patsi Davies, community consultant, Alan Moffitt, GP and clinical advisor in primary health care

12  

Primary Focus – the future of primary health care
12.30 pm  Lunch  
  *Town Hall Auditorium*

1.30 pm  Working together in primary health care  (*Keynote presentation*)  
  - Shirley Smoyak, Rutgers University  
  *Michael Fowler Centre Auditorium*

2.30 pm  Afternoon Concurrent Session - Working Together in Primary Health Care  
(*10 options*)

**Option 1: Managing A Capitated Network  (*Free standing presentations*)**  
*Renouf 1*

- Knowing the population through enrolment: the opportunities and the practicalities  
  - Harry Pert
- Improving health outcomes through performance related remuneration: the opportunities and the practicalities  
  - Harry Pert
- Geocoding: the opportunities and practicalities. What does it mean to health planning in a primary care environment?  
  - Harry Pert

**Option 2: Working Closely With Populations  (*Free standing presentations*)**  
*Lion Harbourview Lounge 1*

- Embracing change in well child health  
  - Belinda Macfie and Linda Polaschek, Plunket
- The whānau as the source of health  
  - Sylvia Kupenga, Kupenga Medical Services
- An integrative neighbourhood-based service innovation through the introduction of a family nurse  
  - Merian Litchfield
- A decade of primary heath care in the Petén, Guatemala  
  - Rubidia Guerra RN, rural health practitioner, Guatemala

**Option 3: Prescribing  (*Free standing presentations*)**  
*Frank Taplin Room*

- Green prescriptions - using today’s model for tomorrow’s primary health care  
  - Diana O’Neill, Sport and Recreation New Zealand
- The development of a new, innovative, primary health care-focused, pharmacy model  
  - John Dunlop, Comprehensive Pharmaceutical Services
- The future role of pharmaceuticals in primary care  
  - Edward Watson, Pharmacia New Zealand

**Option 4: Working with Mental Health Organisations  (*Free standing presentations*)**  
*Air New Zealand Suite 2*

- Wellington’s primary and secondary mental health liaison programme  
  - Helen Rodenburg, WIPA, Peter McGeorge, Capital & Coast DHB, Valerie Bos, WIPA
- Mental Health NGOs working with primary health - a vision for future development  
  - Hugh Norriss and Gary Platz, Wellink Trust
- The St Luke’s shared care project: preliminary results  
  - Tom Woods, Shared Care Liaison Nurse, St Luke’s CMHC
- Working with the third sector  
  - Marion Blake, Platform

Primary Focus – the future of primary health care
Option 5: Viewpoint  
(Presentations from leaders of national health organisations)  
Renouf 2

- Back to the future  
  - John Adams, New Zealand Medical Association  
- Tell me the old, old story  
  - Peter Glensor, Health Care Aotearoa  
- This is not about us  
  - Professor Jenny Carryer, President, College of Nurses  
- Life, the universe, and everything: the GP’s guide to the galaxy  
  - Helen Rodenburg, President, RNZCGP

Option 6: Information Technology  (Free standing presentations)  
Air New Zealand Suite 1

- Routinely collected primary care data: pitfalls and potential  
  - Deborah McLeod and Donna Cormack, Wellington School of Medicine and Health Sciences, Tom Love, WIPA  
- ARC View  
  - Matthew Davey, South Link Health  
- WestKids Kidslink – the integration of health providers to develop a database for sharing Well Child and immunisation information across regions  
  - Trish Lawther, WestKids  
- The role of national shared service groups in supporting the work of DHBs and providers in meeting the needs of their populations  
  - Ann Bodkin, Ministry of Health

Option 7: Nursing (Workshop)  
Lion Harbourview Lounge 2

- Doing it differently to make a difference  
  - Rose Lightfoot, First Health, and members of the MOH Primary Health Care Nursing Advisory Group

Option 8: Diabetes (Workshop)  
Green Room

- Diabetes in primary care: how could we improve on what we already have?  
  - Sandy Dawson, Ministry of Health

Option 9: Integration (Workshop)  
Square Affair Suite 2

- Integrated services – objectives and pitfalls  
  - Lannes Johnson, chair, IPCS, board member of Waitemata DHB, and Mary-Anne Boyd, Waitemata DHB

Option 10: Māori Providers (Workshop)  
Square Affair Suite 1

- Where to now for Māori providers?  
  - Joe Puketapu, Te Matarau

4.30 pm  
Summary and Conclusion  
Looking forward  
- Karen Poutasi, Director-General of Health, Ministry of Health  
  Michael Fowler Centre Auditorium

5.00 pm  
Close
Abstracts

Thursday 30 May 2002
Morning concurrent session – New Possibilities

<table>
<thead>
<tr>
<th>Primary care: 21st century challenges to quality</th>
<th>Keynote Address</th>
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<tbody>
<tr>
<td>Thursday 30 May: 0930 - 1030, Michael Fowler Centre Auditorium</td>
<td>Professor Barbara Starfield is from the John Hopkins University Medical Institution, Baltimore, USA.</td>
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Many of the challenges to primary health care practice have been solved. Primary health care is now a well-defined entity whose components can be measured, thus allowing for the assessment of the quality of its delivery.

Old challenges to quality are now being replaced by new ones. The challenges that remain concern the integration of primary care with other levels of the health services system and the institutionalisation of the focal role of primary health care within health services systems.

Four areas of concern now deserve attention.
- Person-focused assessments rather than disease-focused assessments.
- Dangers of medical interventions.
- Assurance of the quality of health services delivery.
- Considering equity in health as a goal of health services.

Person-focused assessments of need are imperative because of the newly recognised role of comorbidity as a predominant feature of health needs. Morbidity clusters in the population, consistent with theory as to the web of influences that determine health and illness. The integration of primary care and specialty care is now mandatory.

Medical interventions carry a certain degree of risk. Increasing rates of use of powerful medications and more invasive technology therefore promise to increase overall rates of iatrogenic illness. Currently, ill effects of interventions may account for a substantial proportion of deaths in the population, and as many as 15 percent of patients suffer documented adverse effects in outpatient care alone.

The powerful effect of mechanisms of health services delivery in general and primary health care in particular has been documented by both international comparisons as well as within-country studies. Even considering other possible impacts on health, such as income inequality and smoking, areas that have better primary care systems achieve better health, especially for those aspects of health that are particularly amenable to intervention specifically by primary health care.

Achievement of equity in health is now a worldwide priority. Although a new area of focus, recent studies are showing that the theoretically beneficial effect of primary health care on equity in health is confirmed by empirical evidence.

The meeting of these new challenges is facilitated by the availability of tools to measure these characteristics and to ascertain changes that occur over time in response to implementation of policies in the health services system.
Option 1: Future PHO Models
(Free standing presentations)

An innovative approach to community-based primary care

Thursday 30 May: 1100 – 1125, Renouf 1, Michael Fowler Centre
Dr Jill Calveley is with the Funding and Service Planning Unit, Green Lane Hospital, Auckland.

This proposal describes an innovative model of primary care suitable for development in New Zealand; a model that meets all Government priorities for primary care described in the New Zealand Health Strategy and the discussion document, ‘The Future Shape of Primary Health Care’, 2000.

This model has been designed as a resource for a community of enrolled members, to provide a comprehensive range of culturally responsive primary, community and public health services that reflect and respond to the constantly changing health needs of its members. Full involvement of the community in every stage of service development, governance and monitoring is a fundamental principle. Providers and the community would work together as one organisation to deliver health care to a population of approximately 10,000 people.

A range of health, community and public health staff would work as teams and reflect the ethnic mix of the community. Staff would be guaranteed excellent work conditions. They would receive ongoing education as well as regular feedback from members regarding health outcomes and overall performance. Both staff and members would have timely access to the latest evidence-based research.

A membership of around 10,000 would be large enough to provide a range of skilled staff, yet small enough to facilitate a supportive working environment and maintain close links with members and the community. Efficiencies normally associated with larger organisations could be created by developing a network of linked support systems across centres allowing easy transfer of information, education, multi-centre research and inter-centre support.

Focusing on populations and new possibilities for quality primary care

Thursday 30 May: 1130 – 1155, Renouf 1, Michael Fowler Centre
Dr Sharon Kletcho, Janet McLean, Graham Dyer and Ron Dunham are with the Bay of Plenty DHB.

The Bay of Plenty District Health Board will discuss a different but compellingly logical framework for a Primary Health Organisation (PHO) that meets the minimum requirements as specified by the Minister of Health. The focus of the PHO will be to develop a network of care providers who will be linked together to enable access to a range of services by enrolled populations.

Primary health care providers in the Bay of Plenty will be encouraged to join a PHO but membership will not be compulsory. Members of the population will not be required to access services through the PHO.

In the proposed BOPDHB structure, it is envisioned that the PHO would be existing provider(s) receiving core funding, who will then co-ordinate the care of targeted groups of patients, including services that are not available through the providers within the PHO. The PHO will operate as a coordinating agent to ensure that concatenated networks of providers pull together to ensure access to defined ‘programmes of care’ (PoC) that will optimise health and independence for a population.
PoC can be thought of as sets of grouped services across the continuum of care, that meet the particular needs of a population. These evidence-based 'service packages' will include, for example, a range of episodic primary health services (GPs, community workers, pharmacists), residential services (DSS support care), education services, community liaison (local authority agreements), secondary care consultation services (expert advice, for example, on diabetes), palliative care services and home care services.

Specific PoC may be disease-focused or wellness-focused, based on the particular needs of a population. Specifically, 'programmes of care' will be defined for particular groups and will be the principal mechanism for providing services co-ordinated by PHOs.

We will discuss the theory, principles, values, operational considerations and proposed structure of the PHO and the issues around formulating evidence-based programmes of care.

**Best practice: best value**

**Thursday 30 May: 1200 - 1225,**
Renouf 1, Michael Fowler Centre

Dennis Pezaro is a rural GP in Wanaka, Otago.

Rural health care is different.

- There may be only one or a few doctors.
- There may be only one or a few practice nurses.
- Ambulance services are voluntary and may be at some distance.
- The roads are of a lower standard.
- Costs are comparatively greater... but the people are special.

Rural people are resilient and, of necessity, self-reliant. Patients put up with ills and injuries until they request help at a reasonable time, being unaccustomed to the convenience of an after-hours clinic. Health care workers cope with a wide range of emergencies with less support than is available in the cities.

The rural doctor/nurse team has given good service over the years, often with the use of less health resources. There is now a potential to develop rural health care to provide a wider range of patient services, closer to the rural community, of a high standard and at a much lesser cost than if people are referred to the base hospital.

This presentation shall focus on the following rural health initiatives:

- PRIME treatment of accidents and emergencies
- Fracture management in a rural setting
- Thrombolysis in a rural setting
- General Practice Hospitals with strong links to base hospital
- Extension of Outreach Clinics.

It shall be illustrated with photographs of work done in a well-resourced rural clinic. A case will be presented to increase community involvement in rural general practice.

Primary Focus – the future of primary health care
The future of primary care

Thursday 30 May: 1230 – 1255,
Renouf 1, Michael Fowler Centre

Ray Anton and Dr Branko Sijina Renouf 1, Michael Fowler Centre are with Clutha Health First.

An open forum representing health service providers from the southern and western Otago regions met to discuss the impact of the Primary Health Care Strategy on rural regions. As a result, a working party was formed to recommend a direction for the development of primary health organisation(s) for our rural area. We would like to share with participants of this conference two topics considered by the working party.

What services does a PHO provide?
The Ministry of Health has indicated that in the initial phase of implementation a PHO will be funded for GP, practice nurse services only. Eventually, in order for a PHO to carry out its objective of improving and maintaining health for a set population, the range of services expected from the public and available/coordinated through the PHO need to be more comprehensive. The working party has drafted a list of primary services and tried to identify services that should be funded through a PHO for our area, and services where the PHO needs to establish a relationship with regional and national providers.

What are the barriers and aids for the successful implementation of a PHO?
This exercise was used to identify the hurdles that need to be overcome. Predicting these hurdles and planning activities to overcome them will improve the likelihood for a successful implementation of a PHO. Also this analysis provides a list of aids or factors that should support the implementation process.
Porirua - leading primary health care collaboration

Thursday 30 May: 1100 - 1300, Square Affair Suite 2, Town Hall
Maureen Gillon is from Porirua Healthlinks.

Key players committed to improving the health of people in Porirua are working together to develop services that meet the varied needs of the communities of Porirua. The participants, local government, local communities, local providers, DHB and the Ministry of Health have built relationships and processes based on multilevel communication, joint action and a commitment to the shared goal.

Porirua has brought to life the phrase ‘involving the community’ by valuing the varied knowledge, strengths, relationships and resources that participants bring, and acting together from these bases. Healthlinks is the focus for this action through processes built on local and external networks communicating information.

As with any community initiative, ‘things take time to evolve’. This is an ongoing process with lessons for all involved. Research, evaluation and continual feedback for learning are vital to success, as are reaching goals, professional development, support and mentoring.

The Kapiti experience – integrated care across primary and secondary provision

Thursday 30 May: 1100 - 1300, Square Affair Suite 2, Town Hall
Catherine Gibson is with the Kapiti Community Health Group Trust.

This session focuses on the particular topographical and population features of the Kapiti Coast – Paekakariki, Raumati, Paraparaumu, Waikanae and Otaki – and how related health access issues have been identified and responded to in an integrated manner.

The Kapiti Coast with a population of just under 50,000 people is one of the fastest growing areas of New Zealand and faces a number of infrastructural challenges as a result of this and through its beginnings as a series of seaside townships along a narrow coastal strip. Timely access to appropriate health care has been one of these challenges – one that was thrust to the forefront of people’s attention with Government’s decision in 1999, to site the tertiary hospital for the Wellington region, at Newtown, Wellington.

Recognising the implications of this decision for Porirua and the Kapiti Coast, the Government established a community-based project to determine just what the particular health needs of the people in these areas are, and how those needs might best be addressed. The project was given the name ‘Healthlinks’. It operated over a period of approximately 10 months and in late 2000, two health and disability reports – one focusing on Porirua and one on Kapiti – were presented to Government.

The conference presentation will focus on how the Healthlinks process unfolded for the Kapiti Coast, what has happened since 2000 and what still has to be accomplished. It will illustrate how community, iwi, local government, central government, private and public providers have worked and are working together to achieve an integrated approach to primary and secondary health care provision.
Option 3: Current Primary Care Organisations
(Free standing presentations)

Working for the whānau and community – Ngati Porou Hauora Inc

Thursday 30 May: 1100 – 1125, Renouf 2, Michael Fowler Centre

Ariana Roberts is a rural health nurse.
Kura Forrester is a kaiawhina and community health worker.
Jo Hale and Caroline Thompson are from the Kaitiaki and community health teams.

We believe in ‘growing our own’ health workers from kaiawhina to nurses and doctors. Last year we were able to offer one nursing and one doctor scholarship to two Ngati Porou people. We recruit where we can from within our own communities and focus heavily on staff development.

Most of us are related to the people that we look after and also live in the community that we work in. This means that sometimes we need to be a taxi driver to transport a nanny to a clinic or we have to be a courier to drop medicines off to young mothers who have no vehicle, or it could be the weekend when you are off duty and Aunty so and so has got a bad flu and is banging on your door. We are directly accountable to the people that we look after.

Our whānaungatanga (teamwork) both within our primary health care teams and with the real people in our communities is what works for us. We recognise and respect that each of our seven communities are different and that means that what works in one community may not work in another. Our kaumatua, kuia and whānau are our bosses who are extremely vocal about their expectations of their health service and health professionals. We are driven by a fiery passion which comes from having such close links to the people that we work with and from sharing a whakapapa.

Māori primary health care model

Thursday 30 May: 1130 – 1155, Renouf 2, Michael Fowler Centre

Bill Halkyard is part of Te Hauora O Te Hiku O Te Ika.

Te Hauora O Te Hiku O Te Ika is a Māori health provider delivering primary care services to Māori in the far north (Te Hiku O Te Ika). Its trustees are representatives of the five iwi which provide the trust with collective strength and political stability. It provides 15 services that are largely mobile and free to overcome the major health access barriers of travel and cost facing Māori, including:

- Maranga Mai central clinic – GP-type service
- mobile nursing
- dental health education
- disease state management
- mental health
- home support
- child car seats
- health promotion focusing on auahi kore, physical activity and nutrition.
- Outreach clinics – GP-type service
- well child
- maternity support
- hepatitis B programme
- smoking cessation
- IFAS treatment
- breast screening

The staff is 90 percent Māori and all have whakapapa links to the local iwi. A multidisciplinary approach to health care is used incorporating a team of community health workers, registered nurses and a GP. It is also a nursing-led model with the GP acting as medical consultant to nurses, thereby extending the nurses’ scope of practice.

Outreach clinics are provided in three locations to provide greater access for those hard-to-reach Māori, delivered by a team of nurses and a GP. Our trust is the only Māori provider accredited with Quality Health New Zealand. The trust employs 25 full-time staff including nine registered nurses and a GP. We are actively trying to recruit a second GP. We also employ 110 part-time home support workers.
Hokianga has always been different - from the days of GM Smith onwards. This paper describes the integrated primary health service and the role of general practitioners in the service. Challenges for the future, in particular in a PHO environment, are discussed.

The challenges of delivering effective primary health care in rural settings are increasing rapidly. The Hokianga primary health care service is unique in its history, but its evolution offers several insights into addressing unmet needs and inequalities, and providing sustainable services, in rural New Zealand.

The presentation will outline the key features of the Hokianga model, the results that have been achieved over the past decade and the likely future challenges. From this foundation, the presenters will offer some comments on what is needed to ensure sustainable rural primary health care in New Zealand in the 21st century. The discussion period will allow participants to assess the wider applicability of the Hokianga model and the lessons from its development.
Call centre technology has advanced to the extent that it is being used in a range of enterprises, and we examine its recent applications in Australasian primary health care. All these call centres are staffed by health professionals.

The Healthline pilot after two years:
- Ian St George, Medical Director, Healthline, New Zealand.
Healthline is a nurse-led 24/7 primary care triage service which has been piloted in the last two years in four regions in New Zealand.

Independent evaluations of Healthline:
- Chris Cunningham, Director of Health Studies, Māori Studies Dept, Massey University and Helen Moriarty, Senior Lecturer, Wellington School of Medicine.

It has proved a popular and clinically safe decision support and educative service for the populations it covers, and local health professionals are now seeing the service as complementary to their own.

Plunket Line:
- Jenny Allan, Plunket Line Manager, and Brett Austin, Operations Manager, Plunket Society, Wellington.
Plunket Line is a national toll free telephone service that is staffed 24 hours a day, 7 days a week by specially trained Plunket nurses. It provides a specialised well child, parenting, education, and health promotion advice service. Callers are referred to other services if self care is not an option.

The Mental Health Line pilot in Wellington, Hutt and Waikato:
- Michelle Branney, Site Director, McKesson, New Zealand.
The Mental Health Line is a primary mental health triage service, staffed by mental health clinicians, being piloted from April 2002 for the Wellington, Hutt and Waikato District Health Boards.

The Greater Murray Access Line:
- Darya McCann, McKesson, New South Wales.
The Greater Murray Access Line provides triage, counselling and management services to mental health callers in the remote Greater Murray area of New South Wales.
Clinical Audit

Thursday 30 May: 1100 - 1125,
Lion Harbourview Lounge 2, MFC

Dr Dean Millar-Coote is an executive board member at South Link Health.

South Link Health has identified clinical audit as a key priority to improve patient care at a practice and practitioner level. Audit is a process of critically and systematically assessing your own activities with a commitment to improving personal performance and ultimately the quality and/or cost effectiveness of patient care.

The audit process is often perceived as being a 'heavy tool'. Our aim is to minimise the hassle and maximise the benefit.

A Clinical Audit programme has been developed for use throughout South Link Health’s full membership. The programme contains material on how to undertake an audit including how to carry out an audit cycle through to setting a strategy for choice for change. This programme has been designed for use by practices and general practitioners.

Discussion will occur in regard to the value of audit and the processes that South Link Health has put in place.

Ways to further develop the evidence base for the New Zealand primary care sector

Thursday 30 May: 1130 - 1155,
Lion Harbourview Lounge 2, MFC

Dr Bruce Scoggins is chief executive at the Health Research Council of New Zealand.

Provision of accessible and appropriate primary health care for all New Zealanders is pivotal to addressing the health inequalities that currently exist within our country. To enable the Ministry and District Health Boards to make evidence-based policy and purchasing decisions in primary care, the HRC proposes the development of a Primary Care Research Action Plan. Such a plan would underpin and complement the New Zealand Primary Health Care Strategy, and enable provision of New Zealand-specific evidence which is a key component in quality health services.

The HRC is focused on working in partnership with the Ministry to develop the evidence base for the health sector in New Zealand. To date, the HRC and Ministry have developed joint research initiatives in a range of national priority areas, from diabetes to Māori health. These initiatives are highly targeted strategies managed by Steering Committees with broad stakeholder representation. Research priorities are identified and research is commissioned through a contestable Request for Proposals process. All applications are peer-reviewed to ensure that the best quality research is purchased, although the process is quite separate from the annual funding round. These Ministry of Health-HRC joint initiatives have been very well received by all stakeholders.

The HRC will discuss potential frameworks for a joint initiative in Primary Care Research.
Significant event management in general practice
Thursday 30 May: 1200 – 1225,
Lion Harbourview Lounge 2, MFC
Dr Helen Rodenburg is a GP in Wellington and president of RNZCGP. Lynn Saul is a research and development officer at the National Office of RNZCGP.

The RNZCGP promotes a ‘culture of safety’ for general practice by promoting continuous quality improvement processes. Significant event management is a process based on work by the English general practitioner Professor Mike Pringle. The process builds on, and is consistent with, the reportable events and sentinel events processes developed by the Ministry of Health.

For general practice ‘significant events’ covers any event from which valuable learning can occur. It includes events that went well, minor incidents, accidents and sentinel events. The process promotes general practices setting up systems and regular meeting times for the practice team to get together to discuss all types of events but with a focus on the more frequent minor events, for example double-booking of patients or follow-up problems. It is believed that analysing these events can lead to improvements in care for many and may avert more major events.

A process which comes into play when a serious adverse event occurs misses the opportunity for prevention and is more likely to be perceived as inquisitional or looking for blame. However establishing a regular process for analysing the more frequent minor events allows the practice team to become familiar with and feel safe with the process, learning what can be applied if a more serious adverse event takes place.

Purchasing primary health care better
Thursday 30 May: 1230 – 1255,
Lion Harbourview Lounge 2, MFC
Angela Hands is with the Office of the Auditor-General.

This paper looks at the results of our recent study in purchasing primary health care provided in general practice. Although our study was focused on general practice, the lessons learned and improvements identified could be applied across the purchase of health care.

We will discuss improvements that need to be made in:
• developing and maintaining purchaser capability
• the collection and use of information from providers
• developing consistent funding arrangements
• the contract itself – to focus on health objectives, outputs and outcomes and the responsibilities of each party
• ensuring that monitoring responsibilities are clearly defined
• evaluating models of service delivery
• reporting – so that the results of the quantity and quality of health care being purchased by DHBs is measured and reported on.
Option 6: Changing Scopes of Practice
(Free standing presentations)

The new Primary Health Care Strategy – opportunities for pharmacists to enhance patient care

Thursday 30 May: 1100 - 1125, Dr Joan Baas is chief executive and registrar of the Pharmaceutical Society of New Zealand. Linda McLauchlan is a pharmacist – practice and legislation, the Pharmaceutical Society of New Zealand.

A significant body of international literature exists that details the serious and costly results of medicines-related morbidity and mortality. Appropriately trained pharmacists are the health professionals best positioned to address these issues. The pharmacist’s goal is to minimise the number of different pharmacological preparations a patient may be taking while maximising the benefits of necessary medication.

Wherever there are patients, and whatever the practice setting, there should be pharmacists working collaboratively in a clinical, caring, role to ensure optimal benefits from medicines. A number of initiatives are under way in New Zealand following this model and working to demonstrate the benefits of pharmacists’ involvement. It is the role of the Pharmaceutical Society of New Zealand, and the New Zealand College of Pharmacists, to ensure pharmacists are prepared for their primary health care role, and to promote this role.

The society is the statutory registration body for all pharmacists. It is responsible for ensuring that pharmacists and pharmacies are registered, and for promoting quality and competence within the profession of pharmacy. Through local relationships and networks the society identifies and explores opportunities for the profession. It has a competency project under way. The college provides quality accredited training programmes to assist pharmacists advance their skills better to provide effective primary health care.

The possibilities for quality primary health care involving pharmacists will be explored, as well as a new contribution in the delivery of cost-effective pharmaceutical public health.

Delivery of eye care in rural areas: the Otago model

Thursday 30 May: 1130 - 1155, Laurence O’Connell is with the New Zealand Association of Optometrists, Wellington.

Otago eye care services are delivered in a co-ordinated and co-operative manner using both private and public agencies from the ophthalmologic, optometric, general medical and nursing professions, under the loose but integrated control structures established by Professor Tony Molteno of the Dunedin Ophthalmology Department.

The levels of registered blindness in Otago are approximately 30 percent less than Southland, a similar demographic spread, and 13 percent less than Canterbury, which is a younger population. More efficient and earlier intervention in diagnosis and treatment of sight-threatening disease is the reason for these statistics.

Delivery of tertiary care is Dunedin based, but primary diagnosis and follow up is performed throughout the region.

The focal point of service delivery in Central Otago is the practice of the optometrist. This paper discusses the relationships between professionals and patients, the evolution of the service delivery modality, the difficulties faced by the contributing parties, and the future of the services offered.
The future of community nursing

Thursday 30 May: 1200 - 1225,
Air New Zealand Suite 1, Town Hall

Marsha Marshall is manager of District Nursing for Home Support Services and Home Care for Kids, Waitemata DHB.
Helen Frances is service manager of the Home and Older Adults Service, Waitemata DHB.

The Primary Health Care Strategy offered by the Ministry of Health outlines the national objective of enacting primary health care, internationally recognised as the most effective means of improving the health status of populations. Given that this requires fundamental change, it has implications for all health care professionals in New Zealand, not the least of which is community nursing.

No longer is it acceptable to work independently or competitively. The requirement now is to partner with other providers and look at new ways of integrating services to achieve local, continuous, effective, and quality multidisciplinary care for New Zealanders. Additionally, it requires that all health care providers re-examine how they currently deliver care to make it more accessible, affordable and relevant to consumers. Most importantly however, the Primary Health Care Strategy requires that the public have a voice - a contribution to the design and delivery of services.

This has implications for the future of community nursing, requiring changes of systems, structures, processes and people. This presentation will explore what the future of community nursing may look like in a primary health care environment. It examines the shape of primary health organisations, and how they might look to ensure community nursing resource and potential is maximised. The issues of partnerships, working relationships and integration are examined with a view to visioning how the transition to the future may be made. Nursing workforce issues and the composition of this workforce are explored, including discussion around specialist and generalist roles for community nursing, and the use of the nurse practitioner. The discussion sets out some scenarios for how the future of community nursing may look in terms of structure, function and process.

Palliative care - the art of dying at home

Thursday 30 May: 1230 - 1255,
Air New Zealand Suite 1, Town Hall

Peter Woolford and Kees Loder are with the Integrated Primary Care Services and West Auckland Hospice Home Care.

Palliative care is a field that has traditionally been neglected. Patients in the 20th century have been cared for in hospital, and their needs, especially but not exclusively, regarding pain control have been poorly met. There has been next to no psychological support for the dying patient or their families. Patients were routinely left in hospital side-rooms in pain, to die.

This glaring need was addressed by the Hospice movement, originating in Oxford, England and spearheaded by Robert Tywcross. The substitution of hospice beds for hospital beds has been an advance, but it is still institutionalised care with all the associated pitfalls and drawbacks. Now the next stage of change is happening. The move is now to provide support to allow patients to die in their own homes. This is the gold standard of care and as such demonstrates that life and death are part of everyday life.

Aims of the project
When setting up this project we felt strongly that there were two core values that needed to be written into the programme. These were:
• that the GP personally provided 24-hour care for those patients who were dying
• that there be an automatic referral to a hospice.
The first seven months
This project has been extremely successful already. The feedback from patients and GPs has been very positive. Unrefined figures demonstrate patients dying at home rising from below 50 percent to 55 percent. This compares with the best international figures of about 57 percent, and with the most recent report from a New Zealand metropolitan hospice of 37 percent.

The benefits are:
• for the patient – better, more personalised care
• for the families – improved psychological and hence physical health
• for the community – economic returns make this an initiative that is very important.
Funding of primary care

Thursday 30 May: 1100 – 1155, Clare Copland is with Pegasus Health.
Lion Harbourview Lounge 1, MFC

Pegasus Medical Group (later Pegasus Health) was established in 1993. In 1994 it was the first IPA in New Zealand to take on a budget holding contract. The Global Budget contract of 1999 has been a pilot for a new mechanism of funding.

Constantly evolving, Pegasus Health has seen significant positive results from the methods used to fund primary care since the health reforms of the early 1990s. Highly visible, in some contexts it has been a 'tall poppy'.

What is the experience of Pegasus Health in terms of the funding models applied? What can be learnt from the results? What can be learnt about creating the right environment for ongoing development of primary care?

The presentation will consider the impacts of the various primary care funding methods applied along with the Pegasus Health view of the critical elements of success that need to be fostered around the country.

The presenters intend to allow some time for discussion.

PHO risk management

Thursday 30 May: 1200 – 1255, Daphne Rawstorne, Jackie Cumming and Gordon Cameron are with Wellington IPA.
Lion Harbourview Lounge 1, MFC

Primary health organisations will face a number of risk management challenges as the primary health care strategy is implemented. District Health Boards and communities will therefore need assurance that PHOs have the capacity to manage such risks without disrupting services or making inappropriate use of DHB funding.

The financial risks that a PHO will face are likely to include managing budgets for services provided directly under the umbrella of the organisation, and managing budgets for referred services provided by other organisations such as hospitals or laboratories. This presentation will explore some of the issues and precedents for PHOs that hold budgets for services, and will consider the options open to PHOs for managing these risks. It will consider the scale and level of aggregation of population at which PHOs can reasonably manage such risks.
Option 8: Diversity and Innovation
(Forum)

Working together
Thursday 30 May: 1100 - 1300,
Air New Zealand Suite 2, Town Hall

Representatives of a number of health professions explore new opportunities in primary health

Developing innovative primary health care initiatives requires health professions to work together in new ways. New roles for themselves may be envisioned by each discipline but are not necessarily understood by colleagues more familiar with the existing models of practice. This forum will offer a facilitated discussion exploring the possible roles of a range of health professions in primary health care.

Each participant will be asked to make a short (maximum five minutes) presentation identifying their profession’s possible specific contributions to primary health. Following each presentation, there will be an opportunity for clarification and questions from the floor. Finally, participants will be offered an opportunity to comment on the potential for innovative trans-disciplinary or multidisciplinary initiatives in primary health care.
High on health: changing harmful behaviour

Thursday 30 May: 1100 – 1300, Barbara Docherty is TAOS national project director.
Square Affair Suite 1, Town Hall

Dr Richard Fox is with the Faculty of Medical and Health Sciences at the University of Auckland.

This workshop will showcase the TAOS National Training Programme, funded by the Ministry of Health. We believe providers will need to make use of this programme, to be able to show progress towards the 13 population health objectives outlined in the New Zealand Health Strategy.

We will highlight the importance of early and brief interventions in primary health care as essential strategies for assisting people to make healthy lifestyle choices.

At present health professionals tend to describe talking to patients around changing their health behaviour, as both difficult and frustrating. We are trained in how to fix people, not in how to encourage them to change! We demonstrate ways of training health professionals, providing them with the attitudes and skills to intervene with patients in ways that are most likely to be effective.

We will explore possible future partnership opportunities between TAOS and both funders and providers of health care, in order to improve and enhance health outcomes for individuals and populations.

The presentation has been designed to inform and entertain with a mix of demonstrations and participation, including the four strands of the TADS programme: primary health care, Māori, Pacific and youth.
Vision to reality: IT in primary health care

Thursday 30 May: 1100 – 1300, Mike Rillstone and panel (see table below)
Frank Taplin Room, MFC

A team-based approach to health care delivery is viewed as a means to deliver better quality and more appropriate services to the ‘whole person’. In this model, the management of information between the patient and their providers is critical to not only the efficiency of delivery but also the effectiveness of delivery. Common information standards and a technology infrastructure, which provides interoperability between sector participants, are the foundation building blocks.

This workshop includes projects that use innovative information approaches and management tools to deliver successful primary care projects. It also outlines the initiatives the Ministry of Health, in conjunction with DHBs and other sector participants, intends to progress to provide the foundation information infrastructure required to support the Primary Health Care Strategy. The workshop concludes with a discussion with participants providing their perspectives on information management issues with a view to agreeing future actions.

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<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
<th>Organisation</th>
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<tr>
<td>11.00</td>
<td>Introduction</td>
<td>Mike Rillstone</td>
<td>Ministry of Health</td>
<td>Chief Advisor, Health Sector Information &amp; Technology</td>
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<td>11.15</td>
<td>Implementation approaches</td>
<td>Ian Rowe</td>
<td>Counties Manukau DHB</td>
<td>Information Systems Enterprise Architect</td>
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<td>11.30</td>
<td>Implementing an information system for Hepatitis B</td>
<td>Chris Bullen</td>
<td>Project Director</td>
<td>Programme Management Unit, Northern Regional Hepatitis B Consortium</td>
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<td>11.45</td>
<td>The standards puzzle</td>
<td>Martin Entwhistle</td>
<td>Enigma Publications</td>
<td>Managing Director</td>
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<td>12.00</td>
<td>INFOSTRUCTURE – WAVE foundation projects</td>
<td>Ray Delany</td>
<td>Ministry of Health</td>
<td>Group Manager, New Zealand Health Information Service</td>
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<td>12.30</td>
<td>Panel discussion</td>
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Primary Focus – the future of primary health care
This presentation will begin with a discussion of the historical origins of primary health care, and highlight the strong public health agenda that underlies a primary health care approach. Building on the concept that primary health care is the meeting point between primary medical care and public health approaches, the paper will outline the extent that current areas of both public health and primary medical care practice will need to change to meet the aspirations of the Government's Primary Health Care Strategy as expressed through the formation of primary health organisations.
Option 1: Targeting
(Free standing presentations)

Addressing primary care needs in diverse communities: can we keep all the people happy all of the time?

Thursday 30 May: 1500 – 1525, Lion Harbourview Lounge 1, MFC
Tom Love, Wellington IPA.

The Primary Health Care Strategy clearly directs the sector to address populations with high health need as a priority. There are several tools available to help primary health care funders and providers identify geographical areas with populations of high health need. But when planning for real populations served by a primary care provider, there is the challenge of applying such population tools to health services that are ultimately accessed by individuals.

This presentation will look at the use of the New Zealand Deprivation index to identify geographical areas of high health need, and will consider the consequences for socioeconomically targeted services in homogeneous and diverse communities. It will analyse the proportion of the population with high levels of health need who live in geographically distinct areas, and those with high health need who live in a community of generally lower need. Such homogeneous and diverse communities present different issues for primary care configuration and funding. In particular, if funding is narrowly targeted to specific population groups who form a minority within a given community, the mechanisms for targeting become more complex to administer at the level of an individual health service.

Routine referred services data shows that people seek primary care near where they work, not where they live

Thursday 30 May: 1530 – 1555, Lion Harbourview Lounge 1, MFC
James Harris is manager of Information and Strategy at Wellington IPA.

Routine laboratory referral data is used to see where people from a given region access general practice services. Over 70 percent of laboratory referrals identify the patient NHI in addition to the ordering practitioner. Geocoding of the patient and practice addresses enables mapping of access to services.

Population-based health measures such as the ratio of practitioners to population assume that people visit general practices near where they live. The routine laboratory referral data for the greater Wellington area shows that this assumption is extremely misleading. In some urban areas, over half of general practice services are sought 25 km away from the patient’s home address. This has major implications for measuring service coverage and for targeting health resources.

Primary Focus – the future of primary health care
As part of a study looking at the relationship of ethnicity and socioeconomic deprivation with utilisation of primary health care services, the HURA team have been working with a number of general practices in the Wellington region to facilitate the collection of patient ethnicity data.

There is a lack of accurate ethnicity data from the primary health care sector. Many general practices do not routinely collect ethnicity data from their patients. In setting up processes for the consistent, appropriate, and ongoing collection of this data, there are a number of factors that need to be considered, including: the acceptance by practices of the need to collect this information; educating practice staff about appropriate methods for collecting the data; providing resources for practice staff and for patients; balancing the collection of this information with competing information needs within practices; and, the level of knowledge of practice computer systems and the ease of entering and retrieving ethnicity data.

These issues, as well as some of the broader issues around the collection of patient ethnicity data, will be discussed.
Option 2: Child Health
(Free standing presentations)

The Mana Health Clinic

Thursday 30 May: 1500 - 1525,
Square Affair Suite 2, Town Hall

Jill Clendon is a lecturer at the
School of Health Sciences, Auckland.
Josie Clausen is a nurse at
the Mana Health Clinic.

The Mana Health Clinic, set up in a primary school in Auckland, opened its doors for the first time on 1 May 2000. Nurse-led, the clinic has had over 1800 client contacts since that time. While the focus is children aged 5 to 10 years, the nurse at the clinic welcomes parents, siblings and community members of all ages. Health promotion, health education, assessment, referral and the treatment of minor illness and injury are all part of the nurse's role.

This presentation will look at the factors that led to the establishment of the clinic, how the community has been involved, who comes to the clinic and for what reasons. The role of the nurse has been integral to the success of the clinic and I will examine how this is developing at the clinic in the context of legislative changes in New Zealand. The presentation will conclude with a discussion of future possibilities for this type of nurse-led clinic in the community.

Increasing access to well child services: the clinical implications

Thursday 30 May: 1530 - 1555,
Square Affair Suite 2, Town Hall

Trish Jackson-Potter is clinical advisor
(Northern) at the Plunket Society.
Anne Lensen is clinical advisor (Central)
at the Plunket Society.

While maintaining a commitment to a universal well child service for all New Zealand children, Plunket programmes have evolved to focus on the health of priority populations. The needs of tamariki Māori, Pacific children and children from families experiencing social and economic disadvantage must be met, to improve child health status.

It is well recognised that if health disparities amongst populations are to be reduced, access to services must be improved. One method of doing this is by offering home visits, an effective means of early intervention. Contact with families and whānau in their homes, based on a relationship of trust, facilitates a holistic approach to well child and family health care.

Plunket’s mobile clinics are another effective means of reaching families who are not accessing health services. Many of these people have high health needs but a variety of barriers, whether financial, cultural or geographic prevent them from accessing the services that they require. Mobile clinics operate in a range of locations around the country and deliver well child checks, health promotion and referral to other agencies. Some also offer immunisation services.

This paper will describe how the Plunket Society has developed home visiting and mobile services and explore the clinical support required for these programmes to work effectively. Issues such as staff safety, resources, clinical supervision, community networking and the policy development required to underpin clinical effectiveness will be discussed.
Manukau City Child Advocacy Service, primary health care involvement

Thursday 30 May: 1600 – 1625, Coral Elliot is the Manukau City Child Advocacy Service co-ordinator.
Square Affair Suite 2, Town Hall
Claire Arthur is a Healthy City co-ordinator.

Ensuring that United Nations Convention for the Rights of the Child principles, ratified at New Zealand Government level, are realised locally is largely dependent on local body commitment to developing policy that recognises children’s unique vulnerabilities and needs in their community.

Manukau City is the third city council in New Zealand to initiate a child advocacy service and have contracted to the Plunket Society to fulfil goals aimed at developing children’s policy, processes for children’s voices to be heard and to improving the future for Manukau children.

The proportion of children in the population (under 15 years) in Manukau was 27 percent at the 1996 census and is projected to rise to 34 percent by 2008. The population of Manukau is ethnically diverse with over 51 percent, the majority of the population, being from Pacific Island, Māori and Asian cultures. These factors offer the promise of a rich, unique and vibrant community. To achieve that, policy must reflect an inclusive approach to culture and one in which children’s issues are paramount.

The foundations of adult health, patterns of nutrition and growth, knowledge, attitudes and behaviours are established in childhood. Children’s health and wellbeing reflects the real lives that they live daily. Children have no political power and rely on adults to influence health and related policies.

This presentation will outline the vision and goals of the Manukau City Child Advocacy Service, a partnership between local government, community members and a child-focused primary health care organisation.

Care for our children, they are the treasures of the world

Thursday 30 May: 1630 – 1655, Rose Mohi is an RNOG/advanced nurse practitioner/tamariki ora nurse.
Square Affair Suite 2, Town Hall

Awhinatia nga Mokopuna te Taonga mo te Ao.
This presentation is an opportunity for me as an advanced nurse practitioner working as a Tamariki Ora education nurse in rural New Zealand (Northern Maniapoto Rohe), to evaluate our development as a Māori iwi health provider.

Te Kete Manākī Health Services, loosely translated is ‘baskets of kindness’, was born seven years ago with an ‘itty-bitty’ contract, when four Maniapoto Māori women were asked to address glue ear/hearing loss issues in 12 kohanga reo in Northern Maniapoto. The Health Funding Authority again approached Te Kete Manākī with the aim to identify as early as possible those children not likely to access tamariki ora/well child and immunisation services and to provide them with a way of receiving them. Whānau will have the opportunity and the resources available to them to make informed choice. The focus was on Māori and/or rurally isolated communities and so we become a Māori tamariki ora health service employing skilled Māori to reach the vulnerable populations.

Discussion
• Demographics – who are the people?
• Reaching te whānau.
• What are the health issues for this population?
• How we met their needs through promotion, education and prevention.
• What are the health gains?
• Supportive whānau.

Where to in the future?
Recommendations based on findings:
• role of Tamariki Ora Nurse and Kaiawhina from a Māori perspective
• is this a Māori model of practice?
Meeting the needs of secondary students with type 1 diabetes in a college clinic setting

Thursday 30 May: 1500 – 1525,
Frank Taplin Room, MFC
Kirsty Newton is with Wellington IPA and Paraparaumu Hospital.

Type 1 diabetes is a difficult condition to live with and when combined with adolescence can become problematic. Adolescents are not always reliable in keeping logs of insulin doses and blood glucose results, even if they bother injecting or testing at all. They may also be indulging in ‘normal’ risk behaviours of adolescence which become more risky when combined with diabetes, for example, drugs, smoking, and alcohol. Juggling insulin doses (which can increase sharply with puberty), exercise and diet can become hazardous for this group. They also have a higher rate of non-attendance at clinic. For these reasons I trialled a clinic at a local college in 2001 which had three students with diabetes, with an expected population of seven students in 2002.

The college has been extremely co-operative with this initiative and it has worked well with the students who are seen separately (without parents and siblings) to review their results and manage their insulin doses, and together for occasional group education sessions with the dietitian. Plans this year include other relevant speakers for short education sessions. The students still attend Paediatrics/Adolescence Clinic as well on a quarterly basis.

Chlamydia infection is a major public health problem

Thursday 30 May: 1530 – 1555, Dr Karl Cole.
Frank Taplin Room, MFC

Chlamydia infection is a major public health problem. Strategies developed to control chlamydia infection in the general population should include a component aimed at addressing asymptomatic carriage in males. Some studies estimate up to 50 percent of infections in males are asymptomatic.

Our study reported a prevalence of 4 percent in 200 males. This rate is similar to that found in a recently reported study in another (asymptomatic) military population, where a prevalence of 4.1 percent was recorded, and more than that reported in a similar recent study on asymptomatic Dutch males (2.8%). Other studies have identified age (less than 25 years), lower socioeconomic status, and number of partners as risk factors.

The chronic complications of chlamydia infection impact disproportionately on the female population. The consequences of the untreated disease include PID, infertility, and ectopic pregnancy. Advances in molecular diagnosis of chlamydia infection present health workers with a unique window of opportunity to attempt to control and reduce the rate of new infections.

Previous studies of the economic impact of mass screening have indicated that molecular testing is cost effective in populations with prevalence rates above 3 percent.

The ease of specimen collection for nucleic acid amplification detection of chlamydial infection ensures patient acceptance, therefore facilitating early diagnosis as well as exhibiting high specificity and sensitivity. Although there are direct and obvious benefits in screening female patients, the existence of an asymptomatic male reservoir represents an otherwise undetected source of infection and brings up the question of male screening programmes.

Testing first void urine from any at-risk population simplifies screening, and in our opinion meets Jungner and Wilson’s criteria for a workable screening programme. How should this screening be done? Should a formal programme be set up at youth medical centres?
Successful strategies for dealing with sensitive youth health problems in the general primary care visit

Thursday 30 May: 1600 – 1625, Paula Renouf, RN, MS, paediatric/adolescent nurse practitioner, UCSF, California.

Despite enormous progress in the area of youth health and development, significant barriers to care still exist in areas where the family GP and the local chemist may be the only available health care providers and teens perceive a lack of confidentiality and privacy.

How can you effectively screen for and help prevent educational failure, pregnancy, STIs, suicide, drug, tobacco and alcohol misuse, violence and abuse in the context of episodic clinic/office visits? How do you deal with a 15-year-old girl, a new patient, accompanied by her mother, presenting with a first urinary tract infection? How can you encourage parents to bring an 8-18-year-old in more often for primary health care including risk screening, anticipatory guidance and follow-up? Why are young people in New Zealand denied a minimal free health care maintenance schedule from the age of 7 to 18? Should primary health care providers advocate more forcefully for a special health care access card for teens, to enable them to seek care for ‘minor consent’ health problems?

These are some of the thorny problems child and youth health care providers confront. This interactive session lays the groundwork for effective teen risk screening strategies and teen-friendly care that will keep them from ‘falling through the cracks’ in the health care system.
Challenge or a chore – a consumer perspective

Thursday 30 May: 1500 – 1525,
Air New Zealand Suite 2, Town Hall

Audrey Fenton, Waitakere City.

What opportunities can be made in your practice to ensure that your older patients feel safe in your care and outcomes improve? Are there changes that could take place to assure a more positive health care experience for your older patients as well as you and your practice?

Can you visualise how the ethos of your busy practice can be improved by all those working there taking time to be polite, listening, and changing verbal and non-verbal language so that ageism is not part of your practice?

Have you considered how a designated person can be employed as a valuable asset to deal with those overlooked matters be they reviewing pharmaceuticals, appropriate appointments, home care, etc? There is a way not only to save time and money for you and your practice but to also lessen fear and apprehension for your older patients.

Person-centred dementia care

Thursday 30 May: 1530 – 1555,
Air New Zealand Suite 2, Town Hall

Lisa Rogers is a case manager – specialist mental health for older people – Tauranga Hospital, RMN, MSc, DCM trainer.

Person-centred care was coined as a key concept in dementia care by Tom Kitwood. It is a humanistic philosophy that aims to revisit the way that people with dementia are traditionally viewed in society. It looks holistically at the care of the person with dementia and the factors that can influence the way that people act or respond.

The workshop will look at how staff interact with people with dementia through the use of reflection and interactional learning methods. The skills and knowledge are transferable to any kind of care setting and any individual.

Aims
- Provide an arena for self reflection.
- To review care practice and challenge assumptions.
- To be aware of the way environment can impact on the individual.
Role of primary health care in an ageing population: implications of the Health of Older People Strategy

Thursday 30 May: 1600 – 1625, Air New Zealand Suite 2, Town Hall

Judy Glackin is manager, Health of Older People Policy, Ministry of Health. Paulette Finlay is senior analyst, Health of Older People Policy, Ministry of Health.

While New Zealand has a comparatively young population by OECD standards, the proportion of older people is projected to increase significantly, from 11.5 percent of people being aged 65 or over in 1996, to about 22 percent by 2031 and 25 percent by 2051. The increase in older people will be most marked between 2010 and 2030.

The Health of Older People Strategy, planned for implementation by 2010, sets out the health sector’s response to what will be a dramatic shift in demand for health and disability support services.

The primary aim of the strategy is to develop an integrated approach to providing health and disability support services that are responsive to older people’s varied and changing needs. This places a greater emphasis on primary and community health care and supporting older people to ‘age in place’ in the community to avoid unnecessary hospitalisation or inappropriate entry to residential care.

This focus poses significant challenges for primary and community health care providers in terms of needing to develop:

- a much greater emphasis on promoting wellness through providing health education and intersectoral collaboration to promote messages about healthy living options
- active approaches to managing care through a greater focus on early detection of disease and/or disability; proactive approaches to managing complex, multiple conditions and polypharmacy
- co-ordination of services across community and hospital-based care and between health and disability support services.
Option 5: Developing Performance
(Free standing presentations)

Getting the infrastructure right for expanding roles and seamless client focused services

Thursday 30 May: 1500 – 1525,
Renouf 2, Michael Fowler Centre

Dr Sheryl Jury is a liaison general practitioner.
Barbara Stevens is primary care service manager.
Mary-Anne Boyd is programme manager,
Waitemata DHB.

This presentation focuses on integration strategies, long-term relationships and clinical governance. It also addresses other factors required for competence and safety as new possibilities for quality primary health care and seamless services are taken up. Development of integrated acute services is taken as an example. District-wide Primary/DHB Steering Group, Quality Forum and Clinical Governance Forum mechanisms are described. Evaluation focus is shared and our experience of critical success factors is outlined.

A practical approach to quality improvement – the experience of the RNZCGP practice standards validation field trial

Thursday 30 May: 1530 – 1555,
Renouf 2, Michael Fowler Centre

Dr Keith Carey-Smith is chair of the RNZCGP
Quality Group, a member of the RNZCGP
Professional Development Committee and a GP
in Stratford.
Maureen Gillon is an RNZCGP research and
development officer.
Dr Stephen Buetow is a senior research fellow
and deputy director of research, Department of
General Practice and Primary Health Care at the
University of Auckland.

Background and objectives
Following a pilot study of 20 general practices in 1999 to test the ability of indicators and criteria that were developed specifically for general practice in New Zealand, the Royal New Zealand College of General Practitioners (RNZCGP) has undertaken a further field trial to validate the practice assessment tool, assessment process and training of assessors. The development and implementation has been supported by a philosophy of continuous quality improvement and a commitment by general practitioners, practice nurses, practice managers, Māori and consumers to work collaboratively in a partnership.

Methods
Eighty-three practices participated in the field trial during 2000–2001. The RNZCGP trained 60 GPs, practice nurses and practice managers, who were nominated by 19 independent practitioner associations, to undertake the assessments.

The assessors used the RNZCGP tool 'Aiming for Excellence - Standards for general practice' to measure the performance of each practice. With evaluations of the face and content validity of the tool, these practice measurements enabled testing of the internal consistency and construct validity of the assessment tool.

Conclusions
The analysis of the field trial data has provided the RNZCGP with a CQI tool and process that includes for the future: a standard for training assessors and a set of assessor competencies; a standard for the process of practice assessment; and an assessment tool that has been validated.

The RNZCGP has now identified a tool and a process that can provide information and assurance to the MOH, DHBs, IPAs, PCOs and independent practices about the level of quality in general practices.

Primary Focus – the future of primary health care
Performance indicators for primary care: tools for health gain, quality and accountability

Thursday 30 May: 1600 - 1625, Renouf 2, Michael Fowler Centre

Peter Crampton is a Senior Lecturer at the Renouf 2, Michael Fowler Centre Department of Public Health, Wellington School of Medicine and Health Sciences.

The measurement of performance of primary care providers is essential if policies and services are to be developed in an informed manner that focuses on population health gain and quality. Despite this New Zealand lacks a nationally agreed set of performance indicators for primary care. This paper presents the rationale for the development of such a set of performance indicators for primary care in New Zealand, and introduces a study that aims to go some way towards achieving this goal.

There are four key arguments for the development of a set of theory-based and evidence-based performance indicators. First, performance indicators may be an especially helpful means of assisting the public to understand the health care system, and of conveying to communities and iwi the differences in the ways that key elements of care are provided in different localities. Second, development of performance indicators will assist primary health organisations in assessing their own performance in improving the health of their population and reducing inequalities. Third, performance indicators are important in the context of policy and funding. Fourth, performance indicators are useful in research.

A collaborative study is planned that aims to develop performance indicators for primary care in New Zealand. The study will develop a theoretical framework for performance indicators, and a set of measures and criteria to guide their selection. An initial list of candidate indicators will then be piloted and evaluated in a range of primary care organisations. The final set of indicators will be widely disseminated for further use and development.

Implementing the concepts of clinical governance in primary care

Thursday 30 May: 1630 - 1655, Renouf 2, Michael Fowler Centre

Dr Steven Lillis is with Pinnacle.

Clinical governance is a concept used frequently in the secondary care environment. Due to the nature of general practice services, being small independent businesses, clinical governance has been difficult to implement. Pinnacle is an IPA that has been slowly working toward the concept of governing clinical quality. Pinnacle has developed a quality programme and more importantly a quality culture that starts to take on responsibility for the clinical outcomes of our practices. This has been a steady and complex evolution of capability building.

Pinnacle has two significant capabilities that drive our start into clinical governance. The first is our ability to change clinical outcomes (based on trust, education and incentives) and the second is our information systems to analyse and then demonstrate the need for change in practice.

The presentation details our work towards clinical governance in the fragmented environment of primary care.
Option 6: Immunisation and COPD  
(Free standing presentations)

Tamariki Ora – co-ordination for our future

Thursday 30 May: 1500 – 1525,  
Green Room, Town Hall  
Nicholette Pomana and Tania Pompa/lier are at  
the Immunisation Advisory Centre, Department  
of General Practice and Primary Health Care,  
University of Auckland.

The past 10 years has seen the delivery of Māori health service providers expand to a figure of 240, over 70 of these holding Well Child/Tamariki Ora contracts. These contracts can be delivered through either health education and promotion, health protection and clinical assessment, or family/whānau care and support. Not all providers have primary health care contracts with GPs, nurses or clinical teams. Their services are based on ‘by Māori for Māori’ values and more often than not deliver services that are outside the contracted obligations.

Ten years ago the focus for Māori providers would have been to access funding. Their workforce may have been largely voluntary and recognition and respect was something they battled to achieve within the primary health care sector. Today we have a different picture. Incredible gains have been made and it is important that these gains and successes are not lost, or more importantly, not developed further. The Immunisation Advisory Centre (IMAC) offers providers (through a local/regional co-ordination service) education and training, evaluation and mentoring support, promotion and advisory.

Workforce development for Well Child/Tamariki Ora at a national level is a priority. Developing standards for Well Child/Tamariki Ora service delivery, providing clinical supervision for nursing staff and regular education sessions to community and promotional workforce is essential. The impacts of developing Primary Health Organisations (PHO) should not limit the potential and importance of ongoing local and regional Māori networks development. Māori providers no longer intend to work in isolation of other service providers but want to be leading from within. They need the tools and the support at all levels to be able to deliver on a comparable level with mainstream providers. In 10 years, Māori health has challenged and determined for itself what it is and how it works – its future directions will no doubt be as robust.

Immunisation delivery – we must not fail!

Thursday 30 May: 1530 – 1555,  
Green Room, Town Hall  
Dr Nikki Turner and Tania Pompa/lier are at the  
Immunisation Advisory Centre, Department of  
General Practice and Primary Health Care,  
University of Auckland.

Childhood immunisation is one of the strongest evidence-based aspects of modern medical practice. Despite this, New Zealand has a poor track record with recurrent epidemics, particularly of pertussis and measles. Other countries have managed to deliver much more effectively than ourselves – what are the missing ingredients?

From a synthesis of international and local evidence it seems clear to us that we lack proper information systems, decent remuneration to providers, and particularly we all lack the courage of our convictions. Immunisation is strongly evidence-based, it saves lives, it has clear science and yet we have a country terrified and confused.

We can improve. Australia, the United Kingdom and the United States have shown us important ingredients that work: firstly, the need for more money in the system is an inescapable fact; secondly, an ability to find the children missing out; and thirdly, through better communication strategies. Communication strategies require a new approach to intersectoral efforts (no more competitive contracting!), a 21st century approach to communicating messages (ditch those old didactic health messages), and a supported community (remove the fear factor).

Immunisation is a key ingredient to population-based health – we cannot afford not to deliver on this one!
CHF - an integrated care management programme

Thursday 30 May: 1600 - 1625,
Green Room, Town Hall

Stephen Kara is at Procare.
Sue McAuley is project manager of the COPD Project, Auckland.

Aims
To evaluate the perceived effectiveness and acceptability of a disease management programme for patients with congestive heart disease in South Auckland.

Method
Enrolment of 150 patients with a diagnosis of congestive heart failure (CHF) to participate in a chronic disease management programme, record diagnostic accuracy and appropriate management of this illness via an electronic template. Patient and GP satisfaction with a chronic disease management focus evaluated via focus groups and questionnaires.

Results
Diagnostic accuracy of CHF low when clinical diagnosis compared to the gold standard of echocardiography. Management of CHF improved with an increase in beta blocker and Spironolactone usage in the appropriate NYHA Classes. ACE Inhibitor prescribing at >90 percent before the trial. Statistically significant reductions in hospital admissions and bed stays were obtained, unexpected given the initial short duration of the project.

The programme was reported as changing patient lifestyle behaviours and patient understanding of medications and CHF. GP management was also seen as having improved. All aspects of the programme were seen as important: clinical review with GP, educational sessions with PN, patient-held care plan and educational material. Main issues were lack of time for practice staff to be involved and payment for their time.

Conclusions
Disease management programmes such as this are of value and acceptable to both patients and providers.

A randomised controlled trial of integrated care for COPD

Thursday 30 May: 1630 - 1655
Green Room, Town Hall

Peter Didsbury is with ProCare Health Limited.

Primary health care was enhanced to provide chronic disease management by following a care plan based on a clinical guideline with collaboration between patients, GPs, practice nurses, hospital-based physicians and nurse specialists.

Method
The study was a 12-month randomised controlled trial based in primary health care. GP practices were randomised to either a control group (CON) care as usual, or an intervention group (INT) care plan. Of 700 patients screened, 136 were enrolled. Pre and post trial assessment included spirometry, exercise tolerance and quality of life (QOL) measures. The ‘care team’ involved the patient’s general practitioner, practice nurse and respiratory nurse specialist (RNS). The RNS provided a link to resources and specialist care, assessed INT patient admissions and communicated patient needs between sectors.

Results
Total days in hospital INT (N=84) were reduced from pre-trial 508 to trial 208 and CON (N=52), from 331 to 298. QOL measures indicated significant increases in self-confidence and control for the INT patients compared with the CON patients. Spirometry (FEV1) and walking distance also improved for INT patients.

Conclusions
This trial suggests that a collaborative approach led by primary care can reduce hospital bed days and improve health-related quality of life. Key elements were patient participation, development of trust and information sharing.

Supported by South Auckland Health, South-Med Limited, ProCare Health Limited and First Health.
Establishing PHOs, enrolment, service specification and funding

Thursday 30 May: 1500 – 1700, Renouf 1, Michael Fowler Centre

The Minister of Health released the Primary Health Care Strategy in February 2001. Since then there has been considerable interest and activity by communities, providers, District Health Boards, the Ministry of Health and Government to prepare the way for the Strategy’s implementation.

This session will be particularly relevant for those involved with, or considering taking a part in, the establishment of a Primary Health Organisation. It will assume a certain prior knowledge of the Strategy (copies of which will be available at the conference or through the Ministry website).

The session will present information about:
- the minimum requirements for PHOs
- service specifications
- enrolment
- funding arrangements
- the transition over the next few years.

The session will be an interactive one with plenty of opportunity for questions and discussion.
Option 8: Health Improvement Public/Primary Interface
(Workshop)

Health improvement in primary health care

Thursday 30 May: 1500 - 1555,
Lion Harbourview Lounge 2, MFC

Dr Ruth Richards and colleagues are with the
Public Health Policy Group, Ministry of Health.

The Primary Health Care Strategy states that one of the key points about Primary Health Organisations is that they will provide a set of essential primary health care services that at a minimum will include approaches directed towards improving and maintaining health as well as first line services to restore people’s health when they are unwell.

The strategy also details what is expected of co-ordination between public health and primary health services, including how primary health care and public health can contribute to each others’ population health initiatives, share information and how primary health care can draw on public health knowledge and expertise when delivering health improvement services at the one-to-one level.

The primary health care and public health sectors need to develop a common understanding and language around what the intent of the part of the Primary Health Care Strategy that refers to ‘improving and maintaining health’ means in practice.

This workshop will be structured around:
• issues and interfaces between public health and primary health care
• common goals
• health outcomes
• how to get there.

Improving the primary health/public health interface

Thursday 30 May: 1500 - 1555,
Lion Harbourview Lounge 2, MFC

Dr Cindy Kiro is with the National Health Committee.

A population focus is key to the Primary Health Care Strategy and an expectation on emerging PHOs. This workshop discusses key issues for the primary health/public health interface from a primary care, public health and DHB perspective. Participants will work in small groups to identify specific actions that can be taken by individual professionals, professional organisations and District Health Boards to enhance co-operation across the interface.

The findings of the workshop will inform the work of the National Health Committee and will be discussed with the Minister and the Ministry of Health.
Option 9: Māori Providers
(Workshop)

Māori providers to share experience in primary health care

Thursday 30 May: 1500 – 1655,
Air New Zealand Suite 1, Town Hall

Māori Health Directorate of the
Ministry of Health

Primary Focus – the future of primary health care
Option 10: Pasifika Health Care
(Workshop)

Successful primary health care in action

Thursday 30 May: 1500 – 1555, Square Affair Suite 1, Town Hall

Moera Douthett is manager at Pasifika Healthcare.

West Auckland Pacific Island Health Fono Inc operating as Pasifika Healthcare is one of the first Pacific health providers in New Zealand. It was founded by Pacific people and is governed, managed and staffed by Pacific people. Our mission is to develop and provide an affordable, accessible, and culturally appropriate health service that contributes to best health outcomes for Pacific peoples.

Unfortunately the increasing number of people it draws in exceeds the funding allocation of this organisation. Not having a responsive and flexible funding regime will mean that health care provision is at risk of being compromised.

At present Pasifika Healthcare offers a variety of services from a seven-day GP and nursing practice to mental health support, child health, youth health, women’s health including regional cervical screening promotion and pregnancy support, injury prevention, community health services, community projects, education and promotion. Pasifika Healthcare is already providing the range of services that are reflective of the Primary Health Care Strategy.

This interactive workshop will be facilitated from nursing, medical and management perspectives and will address the following issues:
• clinical safety
• cultural complexity
• risk management/quality
• funding.

It will show by practical examples how a ‘by Pacific for Pacific’ provider on a daily basis reduces inequalities and addresses unmet health needs for Pacific people.
This presentation addresses primary health care in the community of the 21st century. Globalisation and rapid technological change, especially in communications technology, has made all of us more aware of other communities and the characteristics of their environments that compromise health and wellbeing.

To build a sense of renewal in community life for this century requires ongoing commitment to primary health care at every level of society. One way forward is to extend the 'best investments in health' approach of the previous decade, to encourage health literacy among those who populate communities. This means providing sufficient and appropriate factual information so that the community can participate fully in health partnerships. It also requires support to sustain that participation, including the critical skills to capitalise on resources and strengthen people's resilience to social and economic adversity.

As health professionals we can foster such a vision by working within the context and circumstances of families and communities to enhance opportunities for accessible antenatal care, school health services, adolescent mentoring and counselling, family support, job training and lifestyle support during ageing. The ultimate goal of our work and that of our community partners, is no less than reduced health risks, recovery from illness, and maintaining continuity of health and health care and sustainability of family and community life.

One of the exciting things that has occurred with all the changes in the health sector of the past decade or so, is the opportunity for communities to participate in defining primary health care services in a way that they can relate to. Health Care Aotearoa member services, along with many other community, Māori and Pacific groups are an example of that, and I am lucky enough to be able to share some of what it is that members of Health Care Aotearoa do, to support communities to participate.

Health Care Aotearoa accepts community participation as integral to the development of and provision of health services to an identifiable community. Our members understand the dynamic that is community, and work in ways that supports these dynamics, which I suggest is different to 'main stream' primary health care.

So what is it that we do?

- One of the fundamental things that our members do is, they take action with the community and not for the community.
- They consider the people who make up the community; what they look like, where they live, what cultural norm or set of values shape who they are.
They consider the voice of the marginalised and less confident sector of the community.

And, they work within the current leadership structures that already exist in the community and in some cases these are long standing structures and often not in the form of organisations, but in the form of culture.

My kōrero will weave these four elements together to demonstrate how communities can participate in determining their direction and how organisations can work with them in that. To do that I will reflect on my own experiences as well as sharing some of what our members do. Remembering this is my view as a Health Care Aotearoa staff member and the approach and style maybe different for other community health providers that are not a part of our network.

**Acting with the community and not for the community, in a way that acknowledges the identity of the community.**

Communities are dynamic. Communities have lots of overlapping bits to them. The way individuals view the community they live in depends on how they interact in the community and where they come from, including their economic status and educational opportunities. And, what cultural background they come from.

To explain this a little more I will talk from a personal point of view. My cultural norm and therefore, the way I interact in the community I live in comes out of being Māori. The things that I am attracted to and want to participate in are things that look like, and feel Māori. Built into my way of being is the cultural practice that I have been brought up with. I recognise Māori structures of leadership and relationships, Marae, whānau and hapu, and integral to that is the practice of tikanga, which guides what I do.

So if I am to engage in the decisions surrounding primary health care, it would require the organisations to interact with me and my whānau in a way that acknowledges my Māoriness first and my understanding of the primary health sector second.

Health Care Aotearoa organisations work hard at acknowledging the dynamic that is community. They work at being flexible in their approach to primary health care, with a willingness to engage with the community in a way that fits the community first and the organisation second.

An example of this, is a relatively new primary health care service and member of Health Care Aotearoa, Hauora o Puketapapa, Mt Roskill Community and Union Health.

The title up front tells me a little about the service, and its relationship to the community of interest.

Like other Health Care Aotearoa members they are a not-for-profit organisation, with community-based governance, and in this case the title suggests governance which is Māori, community and union. The governance is not one that is solely geographically based, but the immediate population surrounding Puketapapa or Mt Roskill is represented on the governance.

The key driver for this organisation is to reduce the barriers to access to primary health care within a geographic area for a specific group of people, these being union members, which in this case equals low income people. Māori, and other ethnic groups of people residing in the area.

Removing barriers to access is more than a low co-payment. It is also about providing a service that fits within the culture that is Mt Roskill. It does this by explicitly employing people (work force capacity issue aside) who look like and feel like the community. The first contact with the service is with someone who understands and knows the community.

Where gaps are identified in the service that may cause concern to the accessibility of the service, the governance and staff seek support from other organisations to help overcome these. An example of this is working with Refugees as Survivors (RAS), for the growing migrant and refugee population seen at this service. Another example, is working with Ngati Whatua Orakei health service, to continue to support Māori participation.

Monthly governance meetings ensure close links to the community via elected and mandated representation. An annual election process does not assume a 'one-size-fits-all', with the various positions on the board being filled in a way that best fits that position or in a way that is appropriate. For example, Māori representation is determined by Māori, the unions determine union representation, and the community representation is determined by them.

Hauora o Puketapapa, Mt Roskill Community and Union Health is an example of acting with and not for the community.
Working within the current leadership structures that already exist in the community.

Now we have all read the community development manuals that talk about identifying the ‘movers and shakers’ in any community and working with them if you want to effect change. This is true, but if we are serious about engaging with the community there has to be a conscious decision on the part of the organisation wanting to engage to recognise the existing leadership structures that are already there and work with them, and not trying to redefine or take over.

Some of the leadership structures that exist in communities are Māori, Pacific, churches, organisations and their CEO or GMs, sport and volunteer groups etc. If we are going to work with these existing structures we have to be flexible in our approach and style.

I talked a little earlier about my acknowledgement of the cultural structures that provide the basis for the way in which I connect to the community that I live in, and for me that is about working with leadership structures that are Māori. Within the Health Care Aotearoa network we have numerous examples of how members have managed to work with existing leadership, an example of this, is an organisation that I have considerable connection to, and that is Hauora Hokianga.

Within the Hokianga there is quite clear Māori leadership, and the structures of Marae, whānau and hapu are well imbedded into the fabric of the community. To work with this community is to fully acknowledge these and to seek advice and support from within them in the development and engagement of the community. The process of defining the ‘movers and shakers’ or in this case, the person or persons leading the development on behalf of the community will come out of this process. The person or persons may not be those who people within organisations may have originally identified, but once decided using this process, they will receive the backing and support from the community and the engagement with the community will be cemented and able to move forward, regardless of the project. To work outside of this process is to undermine the structures that exist and any development will be (I believe) less sustainable and more difficult to get buy-in, and more than likely will have to be repeated many times before ‘getting it right’.

Another example of how this works is Te Taiwhenua o Heretaunga. Te Taiwhenua o Heretaunga providers services to the Heretaunga region, or Hastings and Flaxmere as some of us know it by.

Te Taiwhenua o Heretaunga has 12 Marae in its rohe, region, with each Marae represented on a governance board. Each Marae determines its own process of selection. The provider by accepting this acknowledges that each Marae has its own leaderships structures and way of operating (kawa) and does not interfere with that. Like the Hokianga by allowing the cultural dynamic of leadership its place the person who is put forward as the representative is supported by the Marae, which in turn supports the sustainability of engagement with each of the 12 Marae communities. This then allows Te Taiwhenua o Heretaunga - the provider of services - to be integral to the community not additional to the community.

Summary

In summary then, community participation is much more than having one or two community people participating around the table with us health professionals, managers and service providers alike. It is about recognising our place within the context of the community. Recognising that although we may have some of the planning skills and the professional clinical skills, the way forward is to see the community for who they are, and not what demographic profile we can glean from the outside. It is up to us to interact with the community and not them with us. We can support communities to develop the type of services that fit their needs, after all we make up communities and have real contributions to make, but we certainly do not have all the answers just some of the questions.

My final little gem I would like to leave with people is that communities are dynamic, flexible and very energetic and if we want to participate in them we too have to be dynamic in our thinking, flexible and energetic in our processes and have a willingness to allow time.

No reira, nga mihi ki a tatou katoa
Option 1: Community Consultation  
(Free standing presentations)

Community orientated general practice

Friday 31 May: 1030 - 1055,  
Renouf 1, Michael Fowler Centre  
Dr Jocelyn Tracey is clinical director – Disease  
and Injury Management, First Health, Auckland.

The Primary Health Care Strategy encourages a more community-orientated approach within primary health care.

There has been a growing trend within general practice PCOs to have community input at the board level, but little is being done at the grass roots level to encourage a partnering between individual general practices and the community.

We are promoting a model that while acknowledging the fundamental importance of the one-on-one relationship between the general practitioner or practice nurse and the patient, also promotes the fostering of a relationship between the general practice and the community.

The early stages of a project that aims to establish systems and tools for initiating and implementing community orientated general practice projects in general practice will be presented.

Community consultation – what is that?

Friday 31 May: 1100 - 1125,  
Renouf 1, Michael Fowler Centre  
Dr Steven Lillis is at Pinnacle IPA.  
Hilary Graham-Smith is a nurse clinician,  
manager, WINTEC Health Centre at the  
Waikato Institute of Technology.

The presentation will be based on the work of a group of second-year Bachelor of Nursing students completing a compulsory semester-long community systems paper.

Students work in groups of five or six, with the supervision of a tutor, alongside a community agency/organisation on a community project that is of use to both the organisation and the community it serves. This particular project entitled ‘Community Consultation. What is that?’ is being carried out in collaboration with Dr Steven Lillis from Pinnacle IPA.

In November 2001 the Minister of Health Annette King published the ‘Minimum Requirements for Primary Health Organisations’. Listed among the key points in this document is that ‘Primary Care Organisations will be required to involve their communities in their governing processes’. What is not clear is how such community involvement should occur and what form it should take. The literature reveals a dearth of information about the beliefs and desires of the community regarding such input. Without understanding those beliefs and desires, true community input may not occur.

It is possible that this work will be developed with sequential groups of students but as a beginning point this project will engage the community in a discussion based on the following two questions:

• What say do you want?
• How would you like to have that say?
Gaining community acceptance and involvement in the development of a primary health organisation on the West Coast

In order to meet the requirements of the New Zealand Health Strategy and the Primary Health Care Strategy, the West Coast DHB has established a project to develop a Primary Health Organisation.

Process
The key project objectives are to:
• define the West Coast PHO concept
• design the functionality of a PHO
• develop an implementation plan.

This is being achieved through a wide involvement of community members and health providers on the West Coast.

Issues
A number of critical issues needed to be resolved for the development to proceed. They included:
• designing a methodology for effectively involving the community and providers in the development of the community’s conception and expectations of a PHO
• synthesising this with the ‘minimum requirements’ into workstreams of activity that enable the establishment of the West Coast PHO
• the management approach driving the development
• resolving economies of scale in sparsely populated areas when more small rural communities seek to ‘go it alone’ and develop their own PHO.

Community and provider involvement in initiative governance
Project governance is provided by a steering committee whose membership was nominated through meetings of community members involved in primary care development.

Sector and local communities are represented using an advisory reference group. The group provides special interest advice and guidance as well as knowledge and expertise to the project. The method of co-opting reference group membership resulted in a large and diverse number of sector and community interests being represented.

Working together
This presentation will look at the relationship/collaboration between nurses in the community and other health professionals and organisations and will explore ways in which nurses can work collaboratively with other health professionals in primary health to provide a needed health service.
Involving the community in primary health care

Option 2: Community Involvement
(Symposium)

Friday 31 May: 1030 – 1230,
Lion Harbourview Lounge 1

Peter Crampton is senior lecturer in Public Health,
Kathrine Clarke is a provider development officer,
Health Care Aotearoa.
Bridget Allan is director of Public Health
Consultancy, Department of Public Health,
Wellington School of Medicine.
Deborah McLeod is research manager at the
Department of General Practice.
Tom Love is lecturer in General Practice.

Within the implementation of the New Zealand Primary Care Strategy, the new Primary Health Organisations (PHOs) will be required to involve their communities in their governing processes. They must also show that they are responsive to communities’ priorities and needs. DHBs will be responsible for deciding whether or not community participation in PHO governance is genuine and gives the communities a meaningful voice. This symposium will discuss the origin of and rationale for community involvement in primary health care, and explore the possibilities, drawing on a wide range of experience in New Zealand.

Session one – What do we mean by involvement?
This session will describe the dimensions of community and community participation, and develop a continuum of community involvement. It will discuss the evidence about the effects of community involvement in primary health care.

Session two – Presentations by primary health care organisations
Each presenter will describe:
• Who is our community?
• What do we expect from community involvement?
• How do we involve our community? What ways do we use?
• What has been successful?
• What has been difficult?

Discussion – what can we learn?
Facilitated discussion between panel of presenters and the audience, exploring the possibilities through questions, answers, and comments.
Option 3: Referred Services
(Free standing presentations)

Pharma co-management in the new way – a systems approach

Friday 31 May: 1030 – 1055, Green Room, Town Hall
Avril Lee is an integration pharmacist at the Waitemata District Health Board.

The philosophy behind the formation of Independent Practitioner Associations (IPAs) in 1994 was to encourage best use of resources and opportunities for reflection, evaluation and innovation. It also raised for primary health care, in an explicit way, the need to work within limited resources.

Budget holding/management for laboratories and pharmaceuticals was introduced in New Zealand in 1995. There is a range of ways this can occur. IPAs/Primary Care Organisations (PCO) are able to fund new initiatives by accessing, for example, 50 percent of annual savings in these areas.

Issues with the model
• Complicated budget holding formula.
• Base calculations may not be equitable - may advantage/disadvantage some entities and populations.
• Areas of high need and historically low spend areas are disadvantaged by this model.

Work in Ballarat, Victoria, in 2001 demonstrated the joint benefits of community pharmacists and general practitioners working together in integrated approaches to health care.

Integrated Primary Care Services (IPCS) and Waitemata District Health Board (DHB) made a joint appointment to try a new model. The result is an Integration Pharmacist, supported by the funder and provider DHB and a PCO. Collaborative working relationships are being established with community pharmacies in West Auckland. Joint education sessions with Pharmacists and GPs provide information on pharmaceuticals, joint debate and learning.

The key question that requires debate still remains – are we in the business of improving health outcomes, or a cost-reduction exercise on pharmaceuticals? This presentation describes some pilot work in progress in West Auckland. With District Health Boards having responsibility for the continuum of service, a unique opportunity exists to develop a systems approach to manage the safe and effective use of medicines and to resolve associated problems.

Evaluating a community radiology pilot which increased access to radiology

Friday 31 May: 1100 – 1125, Green Room, Town Hall
Cathy O’Malley is with Wellington IPA.
Marjan Kljakovic is with the Department of General Practice.

This paper reports on the evaluation of a community radiology pilot, which was developed in response to historically limited community radiology access in the Wellington region, the inability of the hospital to deliver on contracted volumes, and the attempt to improve access to specialist assessments by providing GPs access to required diagnostics.

The seven-month pilot provided the Wellington region with additional radiology funding to enable all Wellington patients who were not entitled to alternative sources of radiology funding access to free or heavily subsidised radiology services, where the referral was consistent with National Radiology Referral Guidelines. To ensure sufficient supply of services, both private and public providers provided services under the pilot. However, where CCH could demonstrate meeting timeliness and quality parameters, they would be channelled requested volumes in recognition of their baseline radiology contribution to the pilot. This service was extended and has now been in place for 15 months.
For a number of reasons, the community radiology pilot was a radical one.

- The pilot offered open access to radiology despite demand for community radiology being unknown (close monitoring was required to revise access criteria if necessary).
- The pilot enabled both public and private provision, despite a political setting focused largely on public sector provision.
- Primary and secondary stakeholders agreed that a primary care organisation (Wellington Independent Practitioners Association (WIPA)) manage the project, despite health sector reforms that suggested health services could become more hospital based.
- The pilot used National Radiology Referral Guidelines (NRRGs) that had not yet been implemented, seeking explanation where referrals were inconsistent so the NRRGs could be amended where necessary.

Preliminary findings suggest that this pilot has been successful, with appropriate referrals and an improvement in patient management such that a Community Radiology project was implemented for the 2001–2002 year. This paper reports on the pilot’s final evaluation.

Is better quality associated with lower general practice costs?

Friday 31 May: 1130 – 1155, Green Room, Town Hall

Professor Laurence Malcolm is with Aotearoa Health.

Important progress has been made in New Zealand in promoting clinical quality including in primary care organisations (PCOs). A critical factor in this progress has been committed clinical leadership with a strong focus upon promoting clinical quality in PCO development. Studies undertaken of nine GP-led PCOs in 2001 showed that a wide range of quality initiatives had been implemented. Sets of quality indicators were being used to measure, compare and improve practice performance.

Studies of PCOs have consistently shown wide variation in per capita expenditure between practices in GMS, pharmaceutical and laboratory expenditure, after standardisation for age and CSCs. This paper reports on studies to examine the question ‘Is better quality, as now being measured by PCO quality indicators, associated with higher or lower per capita primary care expenditure?’

Evidence will be presented from PCOs with developed quality measures that wide per capita variation between practices remains after standardisation in the above categories, as well as ACC expenditure. Higher standardised per capita expenditure is associated with lower clinical need. Preliminary evidence also indicates that higher quality scores are associated with lower expenditure and with capitated as compared with non-capitated practices. Tackling variation on the basis of quality would appear to offer a much more effective strategy in reducing wide variation unrelated to clinical need.
Primary mental health care – an issues paper developed by the Mental Health Advocacy Coalition

Friday 31 May: 1030 – 1055, Lion Harbourview Lounge 2, MFC

David Codyre, New Zealand Mental Health Advocacy Coalition.

The common mental health (including drug and alcohol) conditions are:
- very highly prevalent, affecting 25 percent of the New Zealand population at any point in time, 33 percent of GP attenders, and up to 50 percent of people with chronic medical conditions
- a leading cause of disability and disease burden, cause significant mortality, and exact an enormous cost (human, social, and financial)
- most often not detected and/or treated effectively.

Yet, they are very treatable, with recovery rates of 80 percent or more for most conditions if detected early and treated effectively, and are relatively low-cost to treat. This leads to the conclusion that the very high disability, burden, and cost is a direct consequence of lack of detection and access to effective treatment.

Relevant literature regarding the range of issues involved in provision of effective primary mental health care is reviewed, including literature regarding the substantial co-morbidity of chronic medical conditions and mental health conditions and related very poor outcome. A series of recommendations regarding the development of primary mental health care are made.

In particular, it is proposed that development of sustainable systematic approaches to effective primary mental health care delivery should be a central element of the current primary care agenda arising out of the Primary Care Strategy. The case is made that this is the single development that will contribute most to achieving the population health objectives outlined in the New Zealand Health Strategy.

Dealing with mental health in primary care: a preliminary look at the potential of findings from the MaGPIe study

Friday 31 May: 1100 – 1125, Lion Harbourview Lounge 2, MFC

Professor Tony Dowell is at the Wellington School of Medicine.

Mental health problems constitute a significant part of the workload of general practice. A major New Zealand study, the Mental Health and General Practice Investigation (MaGPIe) has just completed field work. It aims to identify the prevalence, nature and outcomes of disorders seen and managed by general practitioners in New Zealand.

Methods
Seventy randomly recruited general practitioners from the lower North Island participated. Fifty consecutive patients from each of these doctors completed a general health questionnaire (GHQ). The doctor described the mental health of each of those patients, and a separate assessment to identify any diagnosable psychological disorder was conducted (CIDI). Patients recruited to the study were followed for one year with both telephone and personal interviews. Major areas of research interest include determining the extent of mental health problems, the degree of associated disability, and the factors associated with recognition, intervention and outcome of disorder.

Results
Over 90 percent of general practitioners approached agreed to take part and GHQs were obtained from 3414 patients. Nine hundred and ten patients completed the CIDI interview (70% of those selected). The GPs thought 13 percent of patients had a predominantly psychological reason for consultation, and 22 percent had experienced psychological problems in the last 12 months.
Conclusions
In a primary health care environment where GPs provide most of the health care delivered to patients with psychological problems, the range of issues that will be able to be explored by this large research project will be discussed.

Promoting mental health through primary care

Friday 31 May: 1130 – 1155,
Lion Harbourview Lounge 2, MFC

Kayleen Katene and Alison Taylor,
Mental Health Foundation

A review of the opportunities – primary care and mental health

Friday 31 May: 1200 – 1225,
Lion Harbourview Lounge 2, MFC

Kristan Johnston is an analyst, Mental Health Policy & Service Development, Mental Health Directorate at the Ministry of Health.

The paper looks at the key issues in relation to primary mental health care that will need to be taken into consideration during planning for the implementation of the Primary Health Care Strategy.

The focus of the National Mental Health Strategy is on people with the most severe mental health problems, with specialist services targeted for this group. The 17 percent of the population with mild to moderately severe mental health problems are of particular relevance to primary health care services and it is well recognised internationally that the majority of people in this group will need to have their mental health needs met within a primary care setting.

This paper identifies the evidence to show that there is currently a high prevalence of people with mental disorders presenting to primary care services. Service provision is currently dependent on the interest and expertise of individual practitioners and therefore models and standards of service delivery are haphazard and inconsistent.

At present in New Zealand there are no national guidelines regarding the interface between specialist mental health and primary care services. Most often they operate as two ‘hard pressed’ services that relate poorly to each other.

This paper looks at the:
• barriers to the provision of effective primary mental health services
• support required for primary health care practitioners taking the lead role in the provision of mental health services for people with mild to moderate mental health problems
• role of primary health care practitioners with respect to providing mental health services for the people with severe mental health problems
• issues to consider in relation to improving the interface between specialist and primary mental health services.
Option 5: Nurse Practitioners in Primary Health Care
(Free standing presentations)

Watch this space: nurse practitioners are coming to primary health care!

Friday 31 May: 1030 – 1055, Paula Renouf, RN, MS, paediatric/adolescent nurse practitioner, UCSF, California.

It is 36 years since a Primary Health Care Nurse and a Paediatrician in Colorado, USA, developed in collaboration the Nurse Practitioner (NP) role in response to the problems of inequalities in health access and outcomes for high risk populations: indigenous, immigrant, refugee, homeless, and rural and urban poor. Although the role has since expanded and developed to include a number of specialty practice areas, the philosophical and practical commitment of NPs in primary health care is to comprehensively provide in a culturally safe manner: immunisations, health and psychosocial risk screening and follow-up, health education and promotion, along with the diagnosis and treatment of all common illnesses, in order to truly expand access to care for at-risk communities.

An historic overview of the development of the role will be presented with a review of the literature on NP effectiveness, NP prescribing and NP practice safety in primary health care in the United States. What are some of the prerequisites for this role to evolve as effectively in New Zealand?

Introducing nurse practitioners in primary health care

Friday 31 May: 1100 – 1230, Professor Jenny Carryer is CEO at the College of Nurses. Marion Clark is CEO of the Nursing Council. Helen Snell is with the Midcentral DHB. Jenny Phillips is with the Midcentral DHB.

The New Zealand framework for introducing nurse practitioners will be briefly outlined. The rationale for developing this role in the primary health care arena will be explored. Two senior clinical nurse specialists will outline their current and potential contribution to primary health care as they move towards acquiring the nurse practitioner role.

Their individual specialist areas are care of people with diabetes and management of chronic wounds and they will demonstrate the gains in patient outcomes that can be shown with this level of nursing practice.

Primary Focus – the future of primary health care
Option 6: Diabetes
(Free standing presentations)

Structuring services and treatments for better outcomes

Friday 31 May: 1030 – 1055
Frank Taplin Room, MFC

Suzanne Snively is with PricewaterhouseCoopers, Wellington.

The situation in asthma and diabetes
New Zealand loses 18,800 disability-adjusted life years per year to asthma.\(^1\) The total medical costs are estimated to be $125 million and the non-medical costs $699 million.\(^2\)

The Diabetes 2000 report estimated that about 106,000 people had Type 2 diabetes in 2001. This number was predicted to rise to 133,000 in 2011 and 167,000 in 2021. The report further estimated that Type 2 diabetes cost the public health system almost $175 million in direct costs.\(^3\) A more recent study by PricewaterhouseCoopers found that the medical costs for Type 2 diabetes for the year 2001/02 is more likely to be $247 million.\(^4\) Since then, the Ministry of Health has published further projections of the prevalence of Type 2 diabetes. The total number of people with diagnosed Type 2 diabetes is now estimated to increase to 145,000 in 2011.\(^5\)

The project
For asthma and diabetes (Type 2), the study examines the outcomes of current service and treatment mix and compares these to the outcomes of changes to the mix of services offered to patients. We have developed templates consisting of three scenarios and three case studies for asthma and four case studies for diabetes. For asthma, the scenarios describe the status quo and different stages of implementation of the Guidelines. For diabetes, the description of the status quo is followed by detailed analysis of two sample District Health Boards.

The motivation
A longer-term approach to resource planning has the potential to improve the services and treatments offered to patients, particularly with the roles played by the District Health Boards and the consequent impact on the delivery of primary health care.

Project design
The project has been designed to be consultative and collaborative. A number of workshops and meetings have been held to identify the key inputs, outputs and outcomes for both diseases and the possible changes that could improve those outcomes. A wide range of people have contributed.

Acknowledgement
The project is funded by the Research Medicines Industry.

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\(^3\) Health Funding Authority, 2000, *Diabetes 2000*.

\(^4\) PricewaterhouseCoopers, April 2001, *Type 2 Diabetes: Managing for Better Health Outcomes*, Diabetes New Zealand Inc.

Diabetes 2000 — how far have we come?

Friday 31 May: 1100 - 1125,
Frank Taplin Room, MFC

Dr Sandy Dawson is chief clinical advisor, Health Services, Clinical Services Directorate at the Ministry of Health.

This presentation reviews the substantial improvements in the quality of primary care in New Zealand that has been associated with the ‘Get Checked’ programme run by primary care organisations. It summarises the New Zealand experience with clinical audit and feedback in diabetes, and the additional clinical value for people with diabetes that results from relatively protected time with a nurse or doctor to review the important aspects of an evidence-based guideline, and plan the year ahead.

The value of this simple intervention is reflected in the quality of care for each individual, but also in the quality initiatives that have developed as a result of collective information available to clinicians in primary care organisations about the risk factors in this population. The primary care organisations that have developed ‘Get Checked’ programmes have a sound and demonstrably world-class foundation for increasing the effectiveness and scope of primary care.

Improving the outcome for diabetic patients

Friday 31 May: 1130 - 1155,
Frank Taplin Room, MFC

Professor Murray Tilyard is executive director of South Link Health.

South Link Health will present the outcome for the first 12 months of its annual Diabetic Review programme. This programme is based upon known diabetics being offered a free annual visit with their general practitioner. It also involves the integration of key educational messages to practitioners and patients. Feedback on how well each practitioner or practice is faring in terms of key outcome indicators for diabetes is also provided.

During the programme 10,983 patients were identified as being diabetic, and within the first twelve months 88 percent underwent an annual review. The results of these reviews will be presented, as well as the key indicators of health status. Comparisons will be made between the South Link Health programme and programmes within the United Kingdom.

Data will also be presented on absolute cardio-vascular risk status for the diabetic population and individuals within the population.
A strategy for acute services management

Friday 31 May: 1030 – 1055, Jane Lawless is chairperson at the College of Air New Zealand Suite 2, Town Hall

Patients presenting with acute illness or injury (acutes) are impacting increasingly on the ability of both the primary and tertiary health sector to match demand and provide appropriate services.

Most major hospitals have reached the point where the resources and facilities struggle to maintain an efficient service in the face of increasing acute admissions. National strategies over the last two to three years have revolved around optimising patient processes and flow by increasing resources and reconfiguration of services. These strategies have had limited success in managing the problem. It is questionable whether continuing with this approach will achieve anything more than very short-term relief for the sector.

The government has signalled a reorientation of health services towards primary health care. Health professionals working in the primary sector experience significant frustration with the lack of access to services particularly diagnostic, primary management with specialty oversight and short-term care options other than admission to the regional tertiary hospital. Inpatient admission for an acute episode is part of the continuum of care. A significant percentage of acute admissions could be managed in the community with appropriate support. The present paradigm where care is divided into specialties and sub-specialties and is focused on inpatient management, does not lend itself to this approach.

Coping with the issues facing the delivery of primary and tertiary health services requires an intersectoral collaborative approach. The government’s health strategy and funding system provides us with the opportunity to embrace such an approach.

The development of an ‘Acute Services Management’ strategy would:
- develop a focus around acute patients
- co-ordinate the interface between primary care and inpatient services
- provide a multidisciplinary collaborative approach to acute patient assessment and management
- enable innovative treatment strategies to be developed
- smooth the access to inpatient services
- provide cost-effective patient management
- improve patient outcomes
- build relationships with communities
- support primary health care workers to manage acute episodes in the community.

This paper explores an alternative model for acute services management based on the primary/tertiary interface. Such a strategy will be required to make any gain in the medium to long term with regard to managing the acute demands on tertiary hospitals, satellite facilities and the primary health sector.
Accessibility of after-hours general practice care in Auckland

Dr Nicholas Jones is director, Disease Surveillance, at Auckland Public Health Protection. Jinfeo Zhao is with the Geography Department, University of Auckland. Professor Pip Forer is with the Geography Department, University of Auckland. Kerry Boyle is with the Auckland Public Health Service.

The availability of after-hours primary care may influence hospital emergency department visits and hospitalisation rates. A project, sponsored by the three Auckland District Health Boards, was undertaken to assess geographical and other aspects of after-hours care access in the Auckland region.

Practice opening hours and after-hours consultation fees were obtained using a fax survey with telephone follow-up. Practice locations were then geocoded and allocated to a road network model. Service distribution areas were created for each practice at sample days and times, and overlaid to identify the closest provider for each residential address in the region. Distance to the nearest provider was then compared with distance to the nearest hospital emergency department.

These models have been used to create maps of after-hours general practice availability for the Auckland region. A relative cost model is being developed, based on travel cost and consultation fees.

Community care – a model of patient/provider empowerment

Carolyn Gullery is with Pegasus.

By providing an enabling framework from which general practice teams can select services, the decisions on care options are now made at the patient/clinician interface and the result is a reduction in Emergency Department referrals as well as a sense of empowerment for the clinicians, the patients and the families.

The Pegasus approach to managing growth in acute demand (known as the Community Care project) has depended on a change in behaviour by clinicians and patients. The project was set up using a fundamental change management approach which centred on providing a framework within which the people on the frontline could work and make the key decisions about what care was required – a bottom-up rather than a top-down approach. The intended effect was to create an environment in which patients, their families or whānau, and the general practice team members could design the care to meet the needs of that individual in that circumstance.

The result has been a sense of empowerment for patients, their carers and their doctors and nurses achieved at a comparatively low cost per case. In addition, the indicators of emergency department attendance and growth in acute medical admissions show that Canterbury is moving against the national trend.
Primary options for acute care – general practitioners using their skills to manage ‘avoidable admission’ patients in the community

Friday 31 May: 1200 – 1225,
Air New Zealand Suite 2, Town Hall

Dr Harley Alsh is a general practitioner and clinical director for POAC.
Peter Didsbury is a general practitioner.
Paul Cressey is manager at POAC and director, East Health.
Janice Grigor is service coordinator at POAC.

Aim
To enrol 600 primary health care ‘avoidable admission’ patients in Primary Options for Acute Care (POAC) from 26 February 2001 to 31 December 2001. Of these 600 patients, 25 percent (150) would eventually be admitted to South Auckland Health.

Method
Using networks already established, primary care teams were invited to manage patients who would usually be admitted in the community. Any resources they required, up to approximately $266, could be obtained. If needed, the POAC service co-ordinator could arrange the investigations, care, or treatment.

Results
From 26 February 2001 to 31 December 2001, 707 patients were enrolled in POAC, by 100 GPs. One hundred and four patients (15%) were eventually admitted. An average of $200.73 per patient per episode was spent (not including administrative costs). A variety of patients and diseases were managed.

Patients were very happy with the care, and delivery. GPs that used the programme were very satisfied with the extra service they could offer.

Conclusion
POAC demonstrated the ability and willingness of Primary Care to successfully manage patients who were traditionally sent to hospital. Primary Care showed responsibility in managing a budget without external controls.
Establishing PHOs, enrolment, service specification and funding

Friday 31 May: 1030 – 1230, Renouf 2, Michael Fowler Centre

Members of the Ministry of Health Primary Health Care Strategy implementation team.

The Minister of Health released the Primary Health Care Strategy in February 2001. Since then there has been considerable interest and activity by communities, providers, District Health Boards, the Ministry of Health and Government to prepare the way for the Strategy’s implementation.

This session will be particularly relevant for those involved with, or considering taking a part in, the establishment of a Primary Health Organisation. It will assume a certain prior knowledge of the Strategy (copies of which will be available at the conference or through the Ministry website).

The session will present information about:
• the minimum requirements for PHOs
• service specifications
• enrolment
• funding arrangements
• the transition over the next few years.

The session will be an interactive one with plenty of opportunity for questions and discussion.
Option 9: Involving the Community
(Workshop)

Cartwright, Gisborne, Greenlane: three good reasons for evaluating your views about community participation

Friday 31 May: 1030 – 1230,
Square Affair Suite 1, Town Hall

Patsi Davies is a community consultant. Alan Moffitt is a GP and clinical advisor in primary health care.

In Aotearoa/New Zealand, recent decades have been characterised by the voices of communities and individuals whose words signal a plea for high quality services and involvement in the public health services.

The New Zealand Health Strategy 2000 appears to provide a listening ear for these voices. Two of the underlying principles require a ‘high performing system in which the people have confidence’ and ‘active involvement by consumers and communities at all levels’. Although these principles are reflected in the Primary Health Care Strategy, there is suspicion about the degree to which community participation will occur.

This workshop is targeted at community groups and individuals, health care practitioners, and people involved with health sector governance and management. It provides an opportunity for workshop participants to evaluate their current views about community participation.

Small group activities will:
• explore what is meant by community participation
• identify institutional, professional, and personal barriers to community participation
• assess the origins and implications of these barriers for all parties
• design frameworks and key messages that will support all parties to move towards achieving genuine community participation in the public health services
• explore practical implementation issues, for example, how to get community participants.
Primary health care: new professional roles and expectations  

**Keynote Address**

**Friday 31 May: 1330 - 1430,**

**Michael Fowler Centre Auditorium**

Professor Shirley Smoyak is with Rutgers University

Change is rarely embraced with open arms, even when there is acknowledgement that something needs fixing. In the United States, in the late 50s and early 60s, physicians, nurses and patients or clients were distressed with the dysfunctional health care system. Several nationally funded studies documented the animosity between professions and the reasons for nurses leaving the field.

In the 70s, the National Joint Practice Commission (NJPC), comprised of eight physicians appointed by the American Medical Association (AMA) and eight nurses, appointed by the American Nurses Association (ANA) worked to repair the discord and attempted to institute collaboration and colleagueship in primary care settings. Problems in educational systems and service delivery settings were addressed. Advanced practice nurses were at the centre of the debates. New strategies were developed and promulgated by conferences and publications. Many lessons were learned in that decade and the following years.

While health care delivery in New Zealand is organised differently from the United States, nurses, physicians and other health care professionals are educated similarly and socialised to expect certain behaviours from their colleagues and consumers. New ways of relating to each other can be realised when basic questions about assumptions and beliefs are placed squarely on the table. "Who owns what?" and "Who has the knowledge and/or skill to do what?" are basic questions to begin the dialogue. The fact that no one can "own" knowledge, in the sense that this is licensed or controlled is critical. The needed negotiations are then more clearly seen as dialogues about time, place, populations and politics. This address will clarify the nature of health care work and workers in new delivery arrangements.
Option 1: Managing a Capitated Network
(Free standing presentations)

Knowing the population through enrolment: the opportunities and the practicalities

Friday 31 May: 1430 - 1500, Renouf 1, Michael Fowler Centre

Dr Harry Pert, RGPG, Rotorua.

RGPG has managed a capitation contract since 1996 and has considerable experience in enrolment and capitation management. Over 95 percent of the Rotorua population is enrolled with a RGPG practice. This presentation will examine the benefits and opportunities of enrolment, the changes in attitudes and accountabilities that will arise and share some of the practical experiences of managing a capitated network.

Improving health outcomes through performance related remuneration: the opportunities and the practicalities

Friday 31 May: 1500 - 1530, Renouf 1, Michael Fowler Centre

Dr Harry Pert, RGPG, Rotorua.

RGPG has a quality improvement team that sets a variety of clinical and management goals. Ten percent of capitation remuneration is withheld and made available when agreed performance indicators are achieved. Some examples include the recording of NHI (now greater than 99%), ethnicity (greater than 85%), cervical screening and immunisation.

This presentation will describe the benefits and pitfalls of this approach which has potential but is still a work in progress.

Geocoding: the opportunities and practicalities. What does it mean to health planning in a primary care environment?

Friday 31 May: 1530 - 1600, Renouf 1, Michael Fowler Centre

Dr Harry Pert, RGPG, Rotorua.

RGPG believe there are exciting opportunities to be achieved by combining demographic and clinical data stored in age/sex register with statistical information collected through census. By using geographical information system technologies we can begin to understand and demonstrate the impact of deprivation and affluence on health status and utilisation.

Because over 90 percent of the population attends general practice within two years, and most practices now can access sophisticated information systems and support through their IPA, we have a unique opportunity to examine this proposition in more detail.

This presentation will illustrate the potential of this tool. We will describe some of the practical problems and solutions involved in the significant task of improving the quality of practice age/sex registers and combining them at an IPA level.
Embracing change in well child health

Friday 31 May: 1430 – 1455, Belinda Macfie is clinical advisor at the Plunket Society. Linda Polaschek is clinical educator at the Plunket Society.
Lion Harbourview Lounge 1, MFC

The recent focus on primary health care has brought a range of new opportunities and challenges for health care providers. Success in this new environment is dependent on providers’ ability to collaborate more effectively, share information more willingly and address increasingly complex client health needs. Remaining flexible within the changing context of health care is imperative.

The Plunket Society is a primary health care provider to young tamariki/children and their whānau/families. It has faced the need to continually evolve and change in order to achieve health gain for New Zealand children.

This presentation will examine Plunket’s focus on sharing information and working collaboratively. It will outline changes in our practice philosophy from professional autocracy to partnership, and discuss how we are developing service provision to better meet the health needs of Māori. The development of the Plunket’s new data collection system and the implementation of policy will serve to illustrate the methods used in the process of change.

The whānau as the source of health

Friday 31 May: 1500 – 1525, Dr Sylvia Kupenga is with Kupenga Medical Services, Stokes Valley, Lower Hutt.
Lion Harbourview Lounge 1, MFC

Integral to a Māori concept of health is the whānau. Whānau is one of the four pillars of health – tinana (the body), hinengaro (the mind), wairua (the spirit) and whānau (the family).

As the world has become smaller, the whānau has become smaller and lost some of its mana. The primary source of care, the whānau, has been weakened and with that Māori health. At the turn of the 19th century when it looked like Māori as a race were dying and would pass into history Māori created their own solution to the problem. They strengthened that which had always sustained them, the whānau.

Girls’ schools like Hukarere and Turakino were developed to help Māori women become firstly good mothers. Te Aute, as well as producing social leaders would produce good husbands and providers. When all else is said and done the number one affliction for Māori is an affliction of the whānau. Good health in regards to good diet, exercise, non-smoking and temperance in all things including alcohol, is learnt firstly in the home. If we as health providers want to reduce the incidence of heart disease, diabetes, cancer, and kidney failure among Māori we must help to strengthen the whānau.

Firstly, we need to promote good parenting and ensure that funding is made available to train people to be good parents. Teaching and learning good habits in life as early as possible will be the best prevention ever. A child who is loved, supported, given a good diet and encouraged to play, exercise and learn will have a better chance of carrying these habits through to adulthood.

If we can start to reverse the trend now, we will prevent future cases of disease and this, and probably only this, will prevent a massive rise in future health spending. What are you waiting for?
An integrative neighbourhood-based service innovation through the introduction of a family nurse

Friday 31 May: 1530 – 1555,
Lion Harbourview Lounge 1, MFC

Dr Merian Litchfield.

The presentation is of a potential model of service delivery that spans public health, primary, secondary and tertiary care. It involves the introduction of a new neighbourhood-based, family-oriented role for a nurse at the hub of a network of nurses employed in the various sectors to link interdisciplinary teams and specialist services. The current contracting within funding silos poses barriers to the full contribution that nurses might make to health and cost containment. This model of health care opens the way to reframing and redefinition of scopes of nursing practice within the new DHB structure. It is in a format ready to be introduced as a demonstration project.

The scheme provides for the identification of the families with the most complex of health circumstances and the recognition of patterns of need to be addressed, with access to, and discerning use of, services as appropriate. It has been constructed through a 10-year programme of research, including the novel practice of a family nursing practitioner. The research to date has shown considerable cost saving immediately, and the potential for ongoing cost containment in the longer term.

A decade of primary health care in the Petén, Guatemala

Friday 31 May: 1600 – 1625,
Lion Harbourview Lounge 1, MFC

Rubidia Guerra is a rural nurse practitioner in Guatemala.

The Petén is a largely inaccessible area in the north of Guatemala, famous for the magnificent Mayan site of Tikal in the heart of the rainforest. During the civil war, thousands of Mayan groups fled to the Petén from the violence and genocide in their villages all over Guatemala and from the near slavery conditions of the southern coffee plantations. Later, thousands of returned refugees from Mexico trickled into the Petén, their own villages destroyed or taken over by the military. Precious mahogany forests were burned and cleared and the people began to eke out a subsistence living. There was minimal infrastructure (almost no roads or schools, one public health post, and very limited sanitation or water).

In 1986, I arrived in Dolores, Petén, to develop the only health service for that town and its 100 villages (50,000 inhabitants). I attended 50 patients per day in my clinic and travelled sometimes 12 hours through mud and rivers on horseback to attend sick patients in their villages. I encountered extreme poverty and malnutrition, diarrhoeal diseases and dysentery, malaria, tuberculosis, parasites, dengue, cholera, leishmaniasis, fatal snake bites, injuries, all degrees of trauma, high risk pregnancies. In this presentation, I will focus on my work over 11 years with the problem of malnutrition and also health promotion: training and supporting Mayan 'comadronas' midwives, and Mayan health promoters to deal with health emergencies, promote health and support community development projects.
Option 3: Prescribing
(Free standing presentations)

Green prescriptions – using today’s model for tomorrow’s primary health care

Friday 31 May: 1430 – 1455,
Frank Taplin Room, MFC

Diana O’Neill is senior advisor Health
at Sport and Recreation New Zealand
(formerly the Hillary Commission).

A dose of physical activity works wonders for many of the population health objectives listed in the Ministry of Health’s Primary Health Care Strategy. A green prescription (GRx) is written advice for a patient to be more active as part of their health management.

The green prescription model is a proven and effective way of reaching and increasing activity levels of at risk populations. The processes and partnerships involved in GRx will be outlined and ‘hot off the press’ patient survey results revealed.

Challenges that have faced the GRx team since nationwide implementation in 1998 will be addressed, solutions summarised, and future issues discussed.

The development of a new, innovative, primary health care-focused, pharmacy model

Friday 31 May: 1530 – 1555,
Frank Taplin Room, MFC

John Dunlop is with Comprehensive Pharmaceutical Services.

The government’s Primary Health Care Strategy, the development of District Health Boards and Primary Health Organisations have created opportunities for pharmacy to re-examine its role and the manner by which it provides existing and new models of care.

The development of a corporatised pharmacy model with no direct access by the public has enabled at least one organisation to begin to grow meaningful relationships with national organisations responsible for providing pharmaceutical services for their patients. These organisations include the Department of Corrections, Māori iwi and mental health providers.

The corporate environment has provided the resource for such a model that is developing three distinct and successful arms.

- A sophisticated and computerised supply organisation able to deliver medicines to any point in New Zealand in a timely and accurate manner.
- A high-tech data collection and information resource designed to provide detailed information on prescribing habits and patient medicines use, and relate this data to disease state and demographic detail.
- A pharmaceutical care focus to reduce the patient's exposure to drug-related morbidity and mortality and improve quality of life.

Government direction and one organisation's desire to provide the most cost-effective, patient-focused, medicines-related health care are encouraging the concurrent development of innovative pharmaceutical services.
The future role of pharmaceuticals in primary care

Friday 31 May: 1600 - 1625,  
Frank Taplin Room, MFC

Dr Edward Watson is medical director at Pharmacia New Zealand.

Data from the Tufts Institute in the United States indicates that in relative terms the total spend in the health budget of doctors and hospitals in the United States is declining, whereas the total spend of pharmaceuticals is increasing. Politicians in the United States therefore favour cost cutting of the pharmaceutical spend, whereas health outcome experts contend that the decline in spend on primary and secondary health is due mostly to the increasing spend in new pharmaceuticals. Increasingly in New Zealand the government is not funding new drugs. What is the implication for New Zealand?

The future trends in prescribing would indicate that the role of the primary care physician in prescribing is going to decline: potentially doctors will only diagnose. This is distinct to the role of the pharmacist whose role is destined to expand.

In this changing paradigm of medical treatment patients are getting more information on health from sources other than their doctor. The pharmaceutical industry has a pivotal role in terms of health outcome research relating to new treatments and also the sharing of information sources both with the doctor but more importantly directly with the patient.

The pharmaceutical industry is research driven and potentially in the future more research will be based in primary care. How prepared is primary care in New Zealand to accept the opportunity?
Option 4: Working with Mental Health Organisations  
(Free standing presentations)

**Wellington's primary and secondary mental health liaison programme**

**Friday 31 May: 1430 – 1455,**
Air New Zealand Suite 2, Town Hall

Dr Helen Rodenburg and Valerie Bos are with Wellington IPA.

Peter McGeorge is with Capital & Coast DHB.

This presentation will present the results from the ongoing evaluation and development of the Primary and Secondary Mental Health Liaison Programme which was set up to address interface issues between general practice and Capital & Coast Health – Mental Health Services.

The Primary and Secondary Mental Health Liaison Programme is run jointly between WIPA, Capital & Coast Health – Mental Health Services and Wellington Mental Health Consumers Union Inc. The programme was set up in 1998 to address interface issues between primary and secondary mental services.

The initial aim of the programme was to address the barriers that prevented people to move from secondary mental health services to general practice for their ongoing clinical care. A number of arrangements were established to ensure this transfer was a successful transfer: governance (GPs, Capital and Coast Mental Health and consumers), enrolment with a capitation fee for consumers’ chosen GP, GP education, a mental health liaison worker, a formalised care plan and evaluation. Since the first person transferred in October 1998, there are now 230 people enrolled with 100 GPs. In 2001 there were a number of features added to the programme in response to our evaluation: shared care, a Mental Health Liaison Community Co-ordinator (to provide liaison for non-clinical mental health needs) and GP referral for enrolment.

**Mental health NGOs working with primary health – a vision for future development**

**Friday 31 May: 1500 – 1525,**
Air New Zealand Suite 2, Town Hall

Hugh Norriss is a general manager at Wellink Trust.  
Gary Platz is a consumer advisor at Wellink Trust.

Wellink Trust has a vision of becoming a fully integrated mental health service for a set number of enrolled mental health consumers. This vision is based on a holistic and recovery focused philosophy and a desire to have meaningful and active consumer participation in all parts of service delivery and service design. Wellink’s holistic philosophy incorporates the links between physical and mental health, and therefore we welcome any new primary care arrangements that allow us to work more closely with GPs.

This presentation will outline Wellink’s vision and philosophy in detail, and explore how this could be incorporated into a mental health/primary care organisational structure and the change process that needs to take place to reach this goal. We will also present our model of consumer governance and involvement for a mental health service. The presentation is targeted at GPs, IPAs and primary health care specialists who wish to work more formally with community based mental health NGOs.

Feedback from the participants at the session will be particularly welcome.
The St Luke’s shared care project: preliminary results

Tom Woods, shared care liaison nurse, St Luke’s CMHC.

This was a collaborative project between Auckland Healthcare and ProCare for clients of one of the central Auckland CMHCs, St Luke’s. It was funded by the Health Funding Authority as a National Integration pilot project.

The aims were to discover whether a specific model of shared care, liaison-attachment:

- is a practical model for New Zealand
- provides better clinical outcomes and quality of life
- gives client and GP satisfaction
- uses more or less health care resources.

The model was chosen after consideration of international experience and local resources. Overall, the model of shared care was demonstrated to be practical, well liked by clients and GPs and to have a range of positive outcomes.

This was a randomised controlled clinical trial of shared care using Clinical Nurse Specialists (CNS). The control group had usual CMHC care continued. Clients all had serious and long-term mental health problems in the community, having been CMHC clients for at least six months. GPs received both general education sessions and specific support around the care of each patient. A shared care contract was agreed between the client, GP, and CNS. A client-held record book was established.

Outcome measures included measures of symptoms, functioning, quality of life, satisfaction, resource utilisation and physical health, plus focus group feedback.

Working with the third sector

Marion Blake is CEO at Platform.

Platform is a national umbrella group of mental health and disability NGO service providers. The Primary Health Care Strategy is seen by many NGOs as an opportunity for a more integrated approach to health care in New Zealand.

The non-government sector is currently providing a significant amount of funded and non-funded health support to communities across New Zealand. Much of the work of the NGOs is focused to specific contracts, that is, mental health, public health or disability. However at a local service level it is often hard to differentiate where these boundaries occur as most organisations are working with whole individuals or with whole families.

In New Zealand mental health NGOs provide nearly all community based services and account for one third of the Ministry of Health’s mental health funding. There is significant interest in developing new and strong relationships with primary health organisations as they are evolving and developing.
General practice delivers about 85 percent of primary health care. As the Government moves to implement the Primary Health Care Strategy it is important to recognise the place of general practice as the cornerstone of primary health care in New Zealand.

The NZMA supports the aims of the Primary Health Care Strategy, such as improving access and quality and introducing new services, which can be achieved by building on the existing strengths. It is vital that we build on the initiatives and heed the lessons of the past decade, rather than attempt to create a completely new system.

How can we ensure a fair system? How achievable is a completely free primary health care system? Is $400 million enough to implement the first three years of the Strategy? How important is the interface between the public and private health sector? Are PHOs the best way to deliver services?

The New Zealand Medical Association (NZMA) is the largest doctors’ organisation in New Zealand, with around 5000 doctors. The NZMA advocates on behalf of doctors and their patients on a wide range of health policies and issues.

Health Care Aotearoa (HCA) is a national network of community-based providers of comprehensive primary health care. HCA was formed in 1994, when the market model in health was being strongly promoted. Managed care was the rage. Against this tide, HCA members – initially only 12 groups – continued to promote our core values, dating back to South Africa in the 1940s:

- community ownership and governance
- comprehensive care, including health promotion and education
- teams of health professionals
- captitated funding, with registered populations
- an emphasis on those people who had historically missed out on primary health services
- services being accessible, affordable and culturally appropriate
- a preference for universal free-to-the-user primary health services, but, if targeting must continue, a more robust and fair targeting mechanism
- a commitment to quality improvement.

I will trace the growth in size of HCA, the interest in us by politicians and officials, the development of our quality improvement programme, and a programme to help set up new centres.

By the late 1990s we were being invited to sit around the HFA table – primary care developments, capitation and funding formulae, budget-holding, service specifications. IPAs could be ICOs, then PCOs, then PHOs. The current primary health strategy is a natural evolution of that process – with some significant modifications by the current government.

In 2002 HCA is now seen, not as an aberrant group, but part of the mainstream in primary care – its members exemplifying what a PHO could look like, and its values now echoed in official policy.

As one journalist said – from fringe to fad!
The College of Nurses has a strong commitment to developing primary health care as a means of improving the quality of life for New Zealanders. As nurses we are critically aware that good health and quality of life are sustained and maintained by a myriad of non-medical services and non-medical therapeutic encounters. Successful implementation of the primary health care strategy is vitally important to the College of Nurses and represents the expression of long held goals for improving individual and community health.

This presentation will consider primary health care in New Zealand from both a national and international perspective. Workforce issues, professional competence and the need for collaboration and teamwork are part of the solution to primary health care and these will be discussed, particularly as they relate to general practice.

In the context of the implementation of the Primary Health Care Strategy there are a number of additional factors that need to be considered to ensure all New Zealanders have access to primary health care. A pathway to the future that all understand and support must be developed.
Option 6: Information Technology
(Free standing presentations)

Routinely collected primary care data: pitfalls and potential

Friday 31 May: 1430 – 1455,
Air New Zealand Suite 1, Town Hall

Deborah McLeod is a research manager at the
General Practice Department, Wellington School
of Medicine and Health Sciences.
Donna Cormack is with the Department of
General Practice, Wellington School of
Medicine and Health Sciences.
Tom Love is with Wellington IPA.

A range of data is now routinely collected in general practice. Analysis of routinely collected data has the potential to inform future strategies and developments in primary care by providing information. Information is needed to identify health needs, to plan and evaluate new initiatives and new interventions.

The HURA study is a research partnership bringing together Māori health researchers, public health researchers, and primary care researchers from the Wellington School of Medicine along with a primary care organisation, the Wellington Independent Practitioners Association (WIPA). The HURA study is a Health Research Council funded study.

The aim of the HURA study is to further elucidate the relationship between ethnicity, socioeconomic deprivation and utilisation of primary health care services. A key strength of the study is the use of routinely collected data sets. Since its foundation in 1995 WIPA has placed considerable emphasis on information systems in general practice.

The pitfalls and potential of routinely collected data sets will be discussed in the context of the HURA study. Challenges faced by the HURA team and solutions explored will be described including: involving practices in research, consent and data ownership issues, adding ethnicity data to registers, extracting the data and defining a common denominator for registered and casual patients.

ARC view

Friday 31 May: 1500 – 1525,
Air New Zealand Suite 1, Town Hall

Matthew Davey is the information and
technology manager at South Link Health.

There is a large amount of health information held in different databases across New Zealand. Because many of these databases hold an NHI to identify patients, they can be amalgamated into one large data source. Due to the sensitive nature of information held in these data sources, the NHI must be encrypted and other identifying information removed. This data source can then be examined, revealing the relationships at an individual non-identifiable patient level.

Through the use of the Geographic Information System and the process of geocoding, this data can be represented on a digital map so that it can be presented in a meaningful, understandable manner. This information can then be examined, revealing spatial relationships that were previously hidden. This information can be further examined and compared against data sources which have a spatial aspect, but are not recorded by patient (eg, census data and practice locations).

South Link Health and the Royal New Zealand College of General Practitioners Research Unit (RNZGPRU) have collaboratively undertaken a project to allow the examination of data in this manner. South Link Health’s age/sex register, which holds details on 439 GPs’ patients, has been geocoded and encrypted. A wide variety of other data sources, such as diabetes reviews and secondary care event data, have been amalgamated into the age/sex register. A variety of tools have been developed to allow the creation and examination of maps from this data.

It is hoped that this project will give an accurate, meaningful picture of the current state of the health and the relationships that affect the health of New Zealanders.
WestKids Kidslink – the integration of health providers to develop a database for sharing Well Child and immunisation information across regions

Friday 31 May: 1530 - 1555, Air New Zealand Suite 1, Town Hall

Trish Lawther is project manager, Integration, at WestKids.

Background
WestKids is a joint venture between the West Auckland community providers, primary care and hospitals. WestKids was established under a company structure with equal shareholding by Auckland Healthcare (Starship Hospital) and Integrated Primary Care Services (the West Auckland IPA). Pasifika Fono, Plunket, Te Whānau O Waipareira Trust and Waitemata Health (the local HHS) have subsequently joined the board of WestKids and are not shareholders.

WestKids delivers child health services through funding agreements with organisations on the board. In addition WestKids has a strong focus on analysis of children's health care needs and provision, and the facilitation of clinical best practice amongst community, primary and secondary providers. WestKids acts as an integrator, co-ordinator and facilitator.

Abstract
In April 2001 WestKids received Ministry of Health approval and funding to put in place a child health information solution for West Auckland that would have the ability to share information across regions. Work was already under way at Waikato Hospital to develop a software solution with Orion Systems and Counties Manukau DHB had begun the Otaara Health Well Child Project using Orion Systems Disease Management software.

This presentation will describe how the integration of many organisations achieved the development of Kidslink whilst individually WestKids and CMDHB had a different approach.

The role of national shared service groups in supporting the work of DHBs and providers in meeting the needs of their populations

Friday 31 May: 1600 - 1625, Air New Zealand Suite 1, Town Hall

Ann Bodkin is manager with SSSG, Corporate and Information Directorate, Ministry of Health.

District Health Boards are required to use the services of the national service agencies (Health Benefits and Shared Support Services Group) in the administration of their service agreements, payments and monitoring.

This session will:
- outline the services currently provided by these two groups
- describe how they fit into the overall process of planning, funding and monitoring services
- explore with participants how planners, service developers, agreement managers and shared service staff can work more closely together to ensure the most effective and efficient administration of health funding.
Doing it differently to make a difference

Friday 31 May: 1430 – 1630,
Lion Harbourview Lounge 2, MFC

Rose Lightfoot is clinical advisor/education
coordinator at First Health, Auckland.
Members of the Ministry of Health Primary
Health Care Nursing Advisory Group.

The extensive contribution that primary health care nursing can make to reducing inequalities, achieving population health gains, promoting health and preventing disease is yet to be fully realised. To achieve the vision and goals inherent in the Primary Health Care Strategy new working relationships need to be negotiated and new systems and processes need to be established. For the nursing profession, this presents an opportunity to critically evaluate and redefine the scopes of practice, to address the current constraints to effective practice, and to ensure that nurses are strong, effective and visible members of the primary health care workforce.

This workshop will explore the following themes:
• nursing governance and leadership
• organisational issues, including service delivery, employment and funding
• education and career frameworks.

Partnership, participation and protection will be used as principles to guide the development of new relationships with tangata whenua, communities of interest, and between health providers as we move forward. Key recommendations as to how DHBs and PHOs and provider organisations can work to ensure the full potential of nursing is utilised will be presented for discussion, to guarantee that we do things differently to make a real difference in health outcomes.
Option 8: Diabetes
(Workshop)

Diabetes in primary care: how could we improve on what we already have?

Friday 31 May: 1430 – 1630, Green Room, Town Hall
Dr Sandy Dawson is chief clinical advisor, Health Services, Clinical Services Directorate at the Ministry of Health.

This workshop reviews the substantial improvements in the quality of primary care in New Zealand that has been associated with the ‘Get Checked’ programme run by primary care organisations. It summarises the New Zealand experience with clinical audit and feedback in diabetes, and the additional clinical value for people with diabetes that results from relatively protected time with a nurse or doctor to review the important aspects of an evidence-based guideline, and plan the year ahead.

The value of this simple intervention is reflected in the quality of care for each individual, but also in the quality initiatives that have developed as a result of collective information available to clinicians in primary care organisations about the risk factors in this population. The primary care organisations that have developed ‘Get Checked’ programmes have a sound and demonstrably world-class foundation for increasing the effectiveness and scope of primary care.
Integrated services – objectives and pitfalls

Friday 31 May: 1430 – 1630,
Square Affair Suite 2, Town Hall

Dr Lannes Johnson is chair of IPCS, and board member of Waitemata DHB.
Mary-Anne Boyd is with the Waitemata DHB.

This will be an interactive discussion on how to initiate, manage and sustain integration projects. It has been proven (Counties Manukau District Health Board and Pegasus) that primary care interventions significantly reduce costs within secondary care, for example, average length of stay and number of admissions.

Issues highlighted
1. Local experience – working with problems:
   • project overload
   • compliance
   • information requirements
   • monitoring.

2. Essential ingredients:
   • no cost to the patient
   • GP fully reimbursed
   • robust management, evolution and information technology.

3. Fiscal challenges, for example, diabetes:
   • fragmented funding
   • people power issues and the non population-based funding environment
   • non-sustainable funding, a large negative – how to achieve buy-in.
Option 10: Māori Providers
(Workshop)

Where to now for Māori providers?

Friday 31 May: 1430 - 1630,
Square Affair Suite 1, Town Hall

Joe Puketapu, Te Matarau
Poster Display

Posters on topics of interest to registrants will be displayed in the Town Hall auditorium.

Nurse Maude Association community-based Leg Ulcer Clinic

An integrated approach to leg ulcer management in Christchurch has been established by the Nurse Maude Association community-based Leg Ulcer Clinic. Practice is based on the ‘New Zealand Guidelines for Leg Ulcer Management’ developed in 1999.

The majority of patients referred are managed within this nurse led clinic. Support, advice and consultation is provided by Professor Roake, Vascular Surgeon, who attends a joint clinic every six weeks. A multi-disciplinary approach has been adopted with other specialist services involvement which include dermatology, dietetics, lymphoedema specialists, plastic surgery, diabetes podiatrists and hyperbaric medicine.

Sport and Recreation NZ: Green Prescriptions

A dose of physical activity works wonders for many of the population health objectives listed in the Ministry of Health’s Primary Health Care Strategy. A Green Prescription (GRx) is written advice for a patient to be more active as part of their health management.

The Green Prescription model is a proven and effective way of reaching and increasing activity levels of at risk populations. The processes and partnerships involved in GRx will be outlined and ‘hot off the press’ patient survey results revealed.

Marsden and Chelsea Day Care Trusts

This is a not for profit charitable trust, with two day care services for people with dementia who are living at home with family carers.

Raeburn House (North Shore Community Health Network Inc)

A needs assessment project is currently being conducted by Raeburn House. Raeburn House is a community support, resource and information centre with an emphasis on the promotion of mental well-being. The purpose of the project is to examine in-house and published literature and consult the North Shore community to identify ways in which the house can best provide services and strengthen community networks that are needed to improve their mental well-being. Professional health care providers and other people working in the community sector are being included in the development and implementation of the project.

Newtown Union Health Service

Primary Focus – the future of primary health care
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Primary Focus – the future of primary health care
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