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Executive Summary

This paper has been prepared as an information document for the National Health Committee. Its purpose is to describe Māori primary care services, the mechanisms used to fund these services, the issues that currently face Māori primary care services and introduce some discussion about future development for these services.

The paper has been developed from a review of available literature, key informant interviews and my own experience and knowledge of this sector.

The key features of Māori primary care services are:

1) services are provided by Māori, for Māori
   - governed and operated by Māori organisations or groups
   - the fundamental principles that guide the philosophy and development of the services are Māori (kaupapa Māori)
   - Māori cultural values, beliefs and practices (tikanga Māori) are used in the development and delivery of services
   - have mechanisms in place that ensure the community has input into the services and the service is accountable back to the community
   - utilise (where possible) Māori staff
   - provide services that are high quality, affordable, accessible and acceptable to the clients

2) two philosophical approaches frame the services
   - positive Māori development
   - the use of a Māori model of health and well-being

3) demography
   - serve predominately but not exclusively Māori clients
   - have higher numbers of young people and fewer elderly people on their registers
   - have a high proportion of clients in low socio-economic groups
   - clients health status reflect the well documented national health status of Māori
   - traditionally Māori have received less primary care and are over-represented in secondary care services
   - clients face many of the barriers to care that are described in the international literature

4) description of Māori primary care services
   - variable size: small providers delivering one or two programmes to large providers delivering a wide range of services and programmes
   - some providers have preferred provider status with funders, others do not have this status
   - size of client base varies from several hundred to ten thousand

5) location

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1 19 people representing 12 services / organisations were interviewed
Māori Primary Care Services: A Paper Prepared for the National Health Committee

- within a variety of Māori organisations (iwi, hapū, urban Māori groups and independent of these groups)
- urban within a large cities to very rural geographical location

6) services / programmes provided
- community health programmes focusing on health promotion, health education and screening
- intervention / clinical services e.g. general practice, midwifery, counselling, dental etc.
- disability support services
- mental health services
- traditional healing services
- training and workforce development

7) Methods of delivery of services
- within kaupapa and tikanga Māori (see above)
- on site at the health services offices
- wide variety of community locations and venues
- mobile and suitcase clinics
- may have informal or formal relationships with other providers offering services they are not able to provide
- refer to employment, training and other social service organisations to ensure that these needs of their clients are met
- general practices may or may not be part of the Māori primary care services range of programmes. If they do not provide general practice services themselves they may have good relationships with local general practitioners

8) May be part of the pilot Māori integrated care organisations or looking at developing relationships with similar non-Māori organisations

9) Staffing
- staffed with a wide range of people
- community health workers / kaiāwhina essential
- workforce development is a critical issue

Key issues that face Māori providers are:

1) Issues with Funding Authorities
- contract specifications often inconsistent with Māori models and approaches to service delivery
- monitoring frameworks inconsistent with Māori models and approaches to service delivery
- changes in the nature of the relationship between funders and providers
- provides without preferred provider status
- national standardisation of contracts

2) Special needs of Māori
- Māori services are effective at addressing many of these needs. Doing so is more costly in both monetary and staffing resources but achieves health gain

3) Funding levels
- may be inadequate for the high level of poor health and the way that services are delivered
4) Enrolment and registers
   - two year limit for active patient status
   - managing highly mobile, casual and ‘double dipping’ patients
   - informing the community

5) Information requirements
   - lack of information feedback from the HFA
   - need for rigorous information on
     ⇒ socio-demographic information
     ⇒ health status, morbidity and mortality information and health issues
   - management of information provided to the HFA, intellectual property ownership issues

6) Workforce development
   - high demand for workers
   - need for increasing the knowledge and skill base of workers

7) Information technology
   - capability of software
   - need for support to develop IT capability within providers

8) Impact of socio-economic changes and changes in the secondary and tertiary care services

9) The incorporation of traditional healing into primary care
   - should traditional healing be incorporated alongside western allopathic primary care services? What would this partnership look like?
   - how would these services be funded?

10) Rural providers
    - different needs in different communities in the rural environment
    - cost associated with rural location
    - increased costs associated with workforce development
    - difficulty attracting staff

11) Small and non-preferred provider services
    - relatively high cost of administration / management
    - administrative and management functions often provided by programme staff rather than people with dedicated management skills
    - constraint of the opportunity to develop (new services and expansion of pre-existing services) without preferred provider status
    - uncertain future

Community health programmes (health promotion, health education, screening), disability support services and mental health services are funded on a contract by contract or ‘bulk funding’ model. Primary medical services (general practitioner) services are funded through fee-for-service, capitation or bulk funding. The majority of providers felt that funding levels were inadequate. In respect to general practice services all three mechanisms currently have serious flaws which are fully discussed in the relevant sections of this report.

A population based approach in primary care is necessary to facilitate greater health gains. Māori primary care providers currently utilise a population focus within their services. Future
development in Māori primary care should focus on ensuring that they have the opportunity to develop their community-oriented primary care focus.
Introduction

Background
The National Health Committee is currently undertaking a work programme, which examines primary health care services. The objective of the project is

‘to advise the Minister of Health with an independent assessment of primary care services: • that would deliver the greatest benefit to the health of population groups, and groups of the population - with particular regard to groups at risk or disadvantage having regard to available resources; and • whether primary health care services funded by the Health Funding Authority (HFA) are a fair and wise use of resources’ (1).

I was approached by the National Health Committee (NHC) and asked if I would prepare a paper that focused on Māori models of primary health care provision.

Definition of primary care used in this paper
The NHC’s definition of primary health care states that primary health care is ‘local, first contact care for people that is accessed by self referral. It compromises a range of services, delivered by a range of health practitioners, designed to keep people well and out of hospital, from the promotion of health, screening for disease to diagnosis and treatment of medical conditions’ (1).

This definition has been used in this paper. A wide variety of services are provided by Māori primary care services. See the section entitled ‘What Services are Delivered’ for a description of the range of services.

Terms of Reference
The terms of reference for this paper are (1)
1) To describe different models of Māori primary health care and the evidence of what works well in different localities for different population groups
2) To determine the most effective primary health care funding mechanisms that could best facilitate improvement in health status, particularly for disadvantaged people
3) To describe how current models of primary health care and their funding systems can best achieve improvement in health outcomes through population based approaches in primary health care. This review will examine the questions:
   • what is a population approach in primary care settings?
   • why use a population based focus for primary health care?
   • will this reduce health inequalities and if so, how?
   • how can a population based focus be achieved?
   • what are the barriers and prerequisites
   • what are the specific funding issues limiting population based approaches e.g. targeting, CSC, public health service funding ringfence

Prepared by Dr. Sue Crengle July 1999.
This paper has been prepared by undertaking a review of the (limited) available literature (for example literature found in journals, books and evaluations) and conducting key informant interviews with 19 people working within 12 Māori primary care services. One interview was conducted over the telephone. All other interviews were face-to-face. The range of services represented by participants include:

- services that are operated by hapū, iwi, urban Māori Authority or are independent of either of these groups
- small services that provide a limited number of programmes to large providers who offer a wide range of primary care services
- primary care services that do not include a primary medical care (general practice) service and
- services which are located within urban, rural or a mixture of urban and rural environments
- services that have a relationship with the developing Māori Integrated Care Organisations (MICO’s) and those that do not have this relationship and staff who work within MICO

The people who have participated in the interviews have had the opportunity to review and comment on a draft of this paper. Their comments have been incorporated into this document.

Types of service excluded from this paper

Although some Māori primary care services also provide disability support services and mental health services I have not focused on these types of services in any detail in this paper. It must be remembered however that they are an integral feature of some Māori primary care services.

Māori providers that have not been considered in this paper include those providing primary care services from within non-Māori organisations, for example Plunket kaiāwhina. Public health programmes such as cervical screening education programmes have also been excluded unless these are conducted within the auspices of the Māori primary care provider. Māori organisations who focus on specific public health promotion / education / information areas, for example Te Hotu Manawa Māori are not included in this paper.
Background to Māori Involvement in Primary Care

Māori have been involved to varying extents in the provision of primary care and public health since the time of Maui Pōmare, Tutere Wirepa and Te Rangihiroa (Peter Buck). Early Māori community involvement in health was exemplified by the work of the Māori Councils and Māori health inspectors in the early 1900s (who provided leadership and public health regulation enforcement). Other examples include the Women’s Health League (established in 1931) who provided information on hygiene, nutrition, disease prevention and parenting, and the Māori Women’s Welfare League (established in 1951) who focused on housing, education, health and discrimination in urbanised communities.

The 1970’s marked the beginning of a cultural renaissance for Māori with increasing political action directed to reaffirming the Treaty of Waitangi, addressing grievances, facilitation of Māori self-determination and participation in society’s processes. By 1984 calls for recognition of the Māori worldview, increased partnership with the Crown and self-determination had grown. Hui Taumata (1984) called for a decade of positive Māori development within a framework of Māori self-sufficiency and control. The main focus of Hui Taumata was economic development but social policy and development was also discussed.

Māori health was receiving similar attention within the Māori community. By 1984 several important initiatives had been started including marae and community based clinics at Waahi marae, Ruatoki, and Whaioraga Trust. Hui Whakaoranga (2) emphasised a positive approach to Māori health, confirmed Māori health philosophy and models, discussed Māori health care programmes, and advocated for Māori health initiatives such as marae and community based clinics and programmes designed to meet Māori health needs as defined by Māori people. Hui participants also expressed their desire for greater participation in the allocation and distribution of health resources and financial support for Māori health initiatives.

Over the rest of the decade the number of Māori health initiatives slowly increased. There were a variety of programmes but several common themes are apparent: the programmes were based on Māori models of health, focused on health promotion (rather than emphasising ill-health and its treatment), were driven by Māori and strove for self-determination (3). The hui Te Ara Ahu Whakamua in Rotorua in 1994 reiterated the importance of cultural identity, self-determination, economic and social factors, whānau, wairua, bodily and mental health as components of Māori well-being. The hui called for the recognition of diverse Māori reality, increased involvement of Māori at all levels of the health sector, and restated the belief that services provided by Māori, for Māori would achieve health gains that seemed to elude ‘mainstream’ providers.

Over the same decade (1984-94) there were also significant developments in the Crown’s response to Māori. These advances included increasing Government recognition of Māori rights, acknowledgement of Māori grievances, inclusion of the Treaty of Waitangi in Crown papers, the establishment of various Māori health committees and units, recognition of Māori
health as a health gain priority area and the development of policy guidelines for Māori health.

In 1991 the Government announced a programme of health reform (4). One area of health reform that offered significant opportunity for Māori was in the provision of health services. ‘Whaia Te Ora mo te Iwi’ (5) outlined the Crown’s objectives for Māori health. These objectives underwrote policy directions for Regional Health Authority and Public Health Commission purchasing strategies (6), which have been reiterated in subsequent Policy Guidelines (7, 8).

By the time the health reforms were enacted the decade of Māori development had afforded some groups the opportunity to develop and manage Māori health programmes and services (especially health promotion and education), and develop workforce and management skills. Many groups were ready to enter the market and successfully did so. Contracts for pre-existing services were negotiated. Other groups negotiated contracts for new services. These included health promotion, health education and community health programmes as well as contracts for the provision of primary medical care (general practice). As a result there are around 200 Māori health service providers today, many of whom provide primary care health services. In general, the development of the initial programmes/services occurred after the community, in partnership with people or groups interested in health, identified areas of need. Subsequent development of services has occurred as a result of negotiation with funders after further health needs have been identified or as a result of health services submitting responses to requests for proposals by various funding authorities (e.g. HFA, ACC). The identification of local community need is a key feature of Māori primary care service development.

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2 Not all of the providers in this figure are located within Māori organisations. Some are located within tauiwi ('mainstream') organisations such as HHS’s.
Models of Māori Primary Health care

General Philosophy and Approach to Providing Services

The central belief of Māori primary care providers is that ‘by Māori, for Māori’ services will result in positive health gain for Māori. What constitutes a by Māori, for Māori service? By Māori, for Māori services are

- operated by Māori organisations / groups which are governed by Māori
- based on kaupapa Māori and utilise tikanga in the development and delivery of their services / programmes
- accountable to the Māori community
- utilise (where possible) Māori staff
- and provide the Māori community with high quality services that are affordable, accessible and appropriate.

Two philosophies underpin Māori primary care services: the use of a Māori model of health and positive Māori development.

The use of a Māori model of health (rather than the Western paradigm illness model) as a basis for developing and delivering health services to Māori is a critical feature of Māori health services. The most widely used model is that of Durie (9). ‘Te Whare Tapa Whā’ which describes four dimensions of health: taha wairua (spiritual health), taha tinana (physical health), taha hinengaro (mental health) and taha whānau (family health). This model forms the basis of the kaupapa 3 and approach to service delivery adopted by many Māori primary care services. Essentially in order for an individual be healthy all four facets must be healthy. That is, a person cannot be considered healthy unless all four dimensions are vital and thriving.

However, as documented at the hui Te Ara Ahu Whakamua (10), Māori working within the health sector believe that the economic, cultural (including land and tino rangatiratanga), education and employment factors which impact on the health of an individual and their whānau must be addressed when considering their health and well-being. Maximising the well-being and health of Māori requires attention to these determinants, and health gain cannot be separated from positive Māori development.

Positive Māori development refers to Māori social, economic and cultural advancement within a framework of Māori self-sufficiency and Māori control (11). The commitment to positive Māori development further widens the scope of Māori health services and their staff.

This has several important ramifications for the manner in which services are developed and delivered.

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1 kaupapa: fundamental principles
Although an individual may access a service with a particular specific health or illness need, this particular need cannot be seen in isolation from the other dimensions of health. Ideally all the needs of the person will eventually be identified and programmes/services, which can assist the person to meet these needs, will be accessed.

What do current Māori Primary care services look like?

**Demographic Information**

Māori people are the major users of Māori primary care services. However, services can also be utilised by non-Māori clients. General practice services located in urban areas in particular may have a proportion of their registers made up of non-Māori clients. Many of the non-Māori clients are from lower income families. The demographic characteristics of Māori clients using these services match the demography of Māori around the country. There are higher numbers of children and young people, and fewer older people. Many of the clients have low incomes. The health status of Māori involved with Māori health services reflects the national Māori health status. Information on the health status of Māori is widely available and not repeated here. Information about Māori utilisation of primary care services varies. Malcolm (12) in his analyses of rates of utilisation and expenditure on primary medical care and related services found that practices with primarily Māori and low income clients had significantly fewer rates (per annum) of consultation. Per capita expenditure of GMS, ACC, pharmaceutical and laboratory subsidies were also lower than the national average. In contrast, Davis et al (13) analysed data from the 1991-92 WaiMedCa survey of general practitioners and found that Māori patients attended their general practitioner at the same rates as non-Māori. They concluded that given the poorer health status of Māori this in fact represented a relative under-utilisation of primary care by Māori. The 1996/97 National Health Survey also provides information on primary care utilisation (14). This survey reports that percentages of people visiting a GP were similar in Māori, Pākehā, and Pacific peoples but Māori were more likely to visit a GP more than 6 times per annum. Māori were also more likely to report needing to see a GP but not seeing one in the previous year. These findings suggest that Māori are not utilising general practitioner services at rates consistent with the level of health need in the community.

Lower immunisation coverage rates amongst Māori children (15) and lower rates of up-to-date cervical screening provide some evidence to support the assertion that Māori under-utilise preventive care. Under-utilisation of both acute and preventive medical care is thought to be one of the factors underlying the over-representation of Māori in secondary care statistics (16). A large body of international literature describes the barriers to accessing care that are faced by people from lower socio-economic groups (17, 18, 19, 20, 21, 22). Many of these barriers have also inhibited Māori access to primary care. Māori health service providers’ efforts to reduce these barriers are wide-ranging and include:

- providing general practice services which have low user co-payments
- delivering programmes/services at a range of venues in the community, mobile general practice services

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4 A user co-payment is the fee paid by the patient for seeing the doctor.
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- flexibility with appointments systems
- providing health promotion and health education in ways which are appreciated and understood by Māori (effective delivery)
- proactive outreach and follow-up of people
- providing transport assistance and assistance when dealing with other services
- integration of community health and general practice services with a focus on health promotion and education
- employment of Māori workers and
- delivery of services using commonly understood Māori beliefs, values and practices.

Provider Size

The size of Māori providers is variable with contacts priced from tens of thousands of dollars to over a million dollars. However there are only a handful of providers who have contracts valued over one million dollars. Most providers are of small and moderate sizes. This has important implications.

The HFA has recently instituted a preferred provider status policy. Preferred providers are providers that the HFA prefers to deal with. These providers tend to be the larger providers. This has limited the smaller providers and the future of non-preferred providers is uncertain. How contract negotiations with providers who have small and moderate size contracts will be undertaken is a question that requires consideration.

The size of populations who also receive services from Māori primary care services also varies depending on the nature of the service / programme and the size of the local community. Some services (for example sexual health services, cervical screening education programmes and well child programmes) are contracted deliver specific services to several hundred people on an annual basis. Māori general practice services tend to have larger client bases - numbering in the thousands. The largest services have between four and ten thousand registered clients. This is a key difference from Independent Practitioner Associations (IPA’s - organisations of general practitioners) which can be responsible for providing primary care to tens to hundreds of thousands of registered patients.

Provider Location

Māori primary care services are located within a variety of Māori organisations.

Some are part of the services developed and delivered by hapū, iwi or urban Māori Authority organisations. Examples include Raukura Hauora (from Tainui), Hauora Whānui (from Ngāti Hine), Te Oranganui Iwi Health Authority and Te Korowai Hauora (from Hauraki). Wai-Health are the health services of Te Whanau o Waipareira Trust, an urban Māori Authority based in West Auckland.

Other Māori primary care services are located within Māori communities but are independent of local hapū, iwi or urban authority organisations. Examples include Te Puna
Regardless of whether they are managed by hapū, iwi, urban Māori authorities or are managed independently, all Māori primary care services have structures and mechanisms in place that ensure that the community is able to have input into the development and function of the service. These structures and mechanisms also ensure that the services are accountable back to the community. In addition they provide a vehicle for local community health concerns and needs to be brought to the attention of the health services. Consequently the services can then take action to address these concerns. Another important feature of Māori primary care services is the involvement of kaumātua who provide guidance and support to the organisations and their workers.

Māori primary care services are situated in a number of different geographical locations. Some are based within urban areas, for example Wai-Health and Te Puna Hauora are situated in different areas in Auckland, Te Waipuna Primary Medical Services is in Wanganui, and Te Puna Manawa is located in Dunedin. A number of services are based in very rural regions, for example Hauora Ngāti Porou on the East Coast. Others cover geographical areas that include a mixture of towns and rural environments, for example Te Korowai Hauora and Hauora Whānui. The geographical area serviced by the health services can pose specific challenges. This is particularly so for health services who deliver programmes in rural areas. These are discussed in more detail in the section ‘Issues for Rural Providers’.

What Services Are Delivered?
It must be noted that different Māori primary care services have different ways of conceiving the range of services they provide. A broad categorisation of the range of programmes/services delivered by Māori primary care providers is described below. The groupings described are based on the nature of the service and (more loosely) on funding streams. It should be emphasised that the boundaries are arbitrary and often there is overlap between the different programmes. For example, rangatahi programmes may include a doctor or nurse to provide clinical services as well as health promotion and education by nurses or community health workers.

1) Intervention / clinical services
   • counselling and intervention programmes for specific issues such as sexual abuse, anger management and substance abuse
   • general practitioner services.
   • midwifery services
   • dental services

2) Community Health Programmes (health promotion, health education and screening programmes)

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3 Tipu Ora was developed within the tribal areas of Te Arawa but is not an iwi based service and has been provided in other areas as well as the Te Arawa area.
Māori Primary Care Services: A Paper Prepared for the National Health Committee

- targeting specific age groups
  - tamariki ora (well child) services
  - health checks to kohanga reo, kura kaupapa and kura tuarua
  - rangatahi (youth) health
  - kula / koroua (older persons) services for example screening for specific health issues such as hypertension and diabetes, health education programmes, exercise and healthy eating programmes

- targeting specific health issues
  - healthy kai and nutrition programmes
  - women’s health (cervical screening and mammography)
  - asthma
  - diabetes
  - health promotion and opportunistic screening at community events such as hui, cultural events, sporting events etc.
  - smoking
  - exercise
  - alcohol and other substance abuse education and health promotion (with or without counselling services). Please note these fall within Mental Health Services.

3) Disability Support Services
- programmes / services for people with disabilities e.g. home help services for the elderly, sheltered workshop, job training and residential care for people with physical and intellectual disability

4) Mental Health Services
- residences and respite care for people with psychiatric illnesses
- community support e.g. home help support services, community support workers
- (Alcohol and other drug services)

5) Traditional healing services such as mirimiri, rongoa and other traditional healing practices. It is important that traditional healing services are available for use by Māori. There are a number of questions that need to be resolved. For example, is it appropriate for traditional healing services to be located within primary care services? How should traditional services be funded and who by? At the present time some services have people skilled in traditional healing working within their services, others refer people to local healers. These services are not currently funded by the Health Funding Agency.

6) Training and Workforce development programmes
Some services have begun training programmes in health areas. Examples include the training of iwi or community support workers in the disability and mental health areas and community training programmes in kai / nutrition and child health.

Some Māori primary care services provide a small number of the programmes / services described above. Few are providing the full range outlined above. Others provide an intermediate number of programmes / services.
How do Māori primary care services deliver their services?

As stated in earlier sections positive Māori development, Māori models of health, the employment (where possible) of Māori staff and the delivery of services using kaupapa and tikanga 6 Māori are essential components of the way that Māori primary care services deliver their services. These features will not be discussed further in this section.

Non-Māori primary care services providing the same type of services tend to have a similar framework or mechanism for delivering their services. For example, well child services delivered by Plunket are provided in the same manner around the country. Similarly the model through which general practice services are delivered are similar regardless of the doctor or nurses working within the service. There is much greater variation in the manner in which Māori primary care services deliver their programmes. This reflects the variation in the range of programmes provided by different primary care services and the fact that Māori services deliver their services based on the tikanga of their area and/ or organisation and on the expressed desires and needs of their local community. I am unable to simply describe 'the' model through which Māori primary care services are provided. What I hope to describe are the diversity of approaches currently undertaken. I propose to discuss other primary care services first and then general practice services.

Community Health Programmes

(Health promotion, health education and screening programmes)

The services and programmes are actually delivered from a number of sites including on marae, in the service's offices, buildings or mobile clinics, at people's homes, kohanga reo, kura and at the sites of hui, sports days, cultural events, and other local community events and venues. Some services, particularly those that cover large areas, have multiple offices or bases.

The commitment to raising health awareness and knowledge and making health services more accessible to members of the Māori community underlies the willingness of Māori services to provide their programmes in a diverse range of sites. This flexibility has been accompanied by positive outcomes. For example Māori whänau enrolled in well child services provided by Māori groups (which home visit for all checks) are more likely to remain engaged with the service and immunisation services provided in the home have achieved high immunisation coverage rates (23).

Some provider's address gaps in the range of health services they offer by referring clients to other providers that offer the services they are not currently providing. Consistent with the belief that Māori health services are able to cater for Māori people in a more appropriate, effective manner, there is often a preference for using other Māori providers. However, as several participants noted they would only refer to services that they believe provide quality services.

6 tikanga - values, beliefs, customs or practice

Prepared by Dr. Sue Crengle July 1999.
They may also refer to local non-Māori providers. If this happens, staff (particularly community health workers / kaiāwhina) from the Māori provider often maintain close contact with the client. In this role they are able to provide support and if necessary advocacy for the client.

Referral to local non-Māori primary care services can be ad hoc or on a more formalised basis where there has been negotiation of the governance relationship between the two services. In addition, entry and exit processes and the roles and responsibilities of staff within each service have been clearly defined and agreed upon. Maternity services (provided by independent midwives with obstetrician back-up) are a regularly cited example of formalised agreements between Māori primary care services and external providers.

Other areas where Māori services have successfully negotiated relationships with local non-Māori services include Tipu Ora and a diabetes education and support programme delivered by staff of Te Puna Hauora. This programme, in which trained staff from Te Puna Hauora work with Māori patients referred by general practitioners belonging to the local IPA, has seen significant improvements in diabetes management. Other services are currently exploring the possibility of relationships with groups such as IPA’s and First Health. The outcome of these explorations is awaited.

The development of strategic alliances and partnerships has been found to be a useful way of increasing the range of services that Māori clients have access to. It can also be viewed as a useful way of increasing the number of Māori whom have access to the services offered by the Māori provider. This can only happen if the other partner (Māori or non-Māori) is prepared to inform their Māori clients of the services available. The details (governance, referral processes etc.) of these relationships require careful consideration and negotiation.

However, the development of partnership relationships with local non-Māori providers is not an area that all Māori providers wish to pursue. In some circumstances developing such relationships has been problematic, largely due to mistrust of Māori services, limited understanding of the potential value of Māori services, and limited specification of Māori health goals in non-Māori contracts with the HFA. In general terms it appears that these difficulties are resolving and it is hoped that future progress will allow these relationships to be established if that is the path that both Māori and non-Māori providers choose to take.

Referral to agencies and services providing a range of training and employment, justice and other social services also occurs. Some Māori primary care services are located within organisations that also provide these services e.g. Te Whānau o Waipareira Trust.

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7 Support and advocacy for clients who enter public health services such as hospital outpatients or hospital admissions is a key task for community health workers / kaiāwhina in many Māori health services.

8 Processes associated with the referral of a client to the external service, expectations of communication.

9 Māori kaiāwhina work alongside Plunket and Public Health nurses to provide comprehensive well child and whānau services to Māori whānau.

10 Personal communication L. Marsden 29/6/99.
make referrals to external agencies (Māori, non-Māori and Crown agencies such as WINZ).

General Practice Services
A number of the Māori health services have identified a need to include General Practitioner (primary medical care) services in range of services they offered. Some, believing that providing a general practice clinic would improve Māori clients access to medical care and would also attract a client base to the other services they delivered, included general practice clinics within their services from the outset. Others, preferring to establish non-general practice primary care services in the first instance, developed general practice services after they had established a credible relationship in the community through providing a range of health promotion and public health services.

Historically, doctors who were not employed by the Māori health service sometimes provided general practitioners (GP’s) services. In this situation the doctor would claim General Medical Subsidy (GMS) on his or her own behalf. An example is that in the early part of 1991 Te Whānau o Waipareira Trust provided health checks to tamariki in local kōhanga reo. The doctor component of this service was provided by local GP’s who worked from their own practices, claimed GMS for each child seen and were accompanied by staff from Te Whānau o Waipareira Trust. Other Māori services began providing GP services by developing a relationship with a local GP(s) who would conduct clinics on the site of the Māori health service (often marae based services). This GP would also claim their own GMS. This model has become less common as Māori health services have developed.

Several mechanisms for providing general practice services currently exist. Some services run their own general practice clinics, employing full-time doctors and practice nurses. Others (particularly services located in smaller towns or rural settings) have general practice services available for a limited number of sessions per week. Doctors involved in this type of service are either employed full-time by the Māori service (and work at a number of different sites) or are employed part-time by the Māori service and work part-time within their own (or another doctors practice). Some services that do not currently employ general practitioners have good working relationships with local general practitioners. For example, nursing staff from Hauora Whānui work closely with local general practitioners.

Most general practice services operate from a base clinic. These clinics provide the range of services found in other General Practices across the nation. Without exception all Māori general practice clinics have lower patient co-payments than non-Māori clinics (except for Peoples Centre and Union Health Clinics). Lower fees are a direct result of the health services commitment to making primary care more accessible (through increased affordability). The lower level of co-payment has significant ramifications for the services. Māori general practice clinics do not get higher levels of funding than other practices around the country. As a result the health services are effectively subsidising the services they provide. These issues are further discussed in the section on funding mechanisms.

Prepared by Dr. Sue Crengle July 1999.
Some services also provide general practice services at sites distant from their home bases. These are delivered either as ‘suitcase clinics’ where the staff and a ‘suitcase’ of equipment travel to other locations and hold clinics. Mobile clinics are also used by some services. These vehicles are fitted out and equipped to provide general practice services. Obviously suitcase and mobile clinics are only available on specific days and times. At other times clients needing medical assistance need to travel to other venues.

Mobile general practice services are more costly for services to provide. Travelling time and vehicle wear and tear are significant cost factors. In addition the number of clients seen at each site may be lower than would be seen at permanent urban or township locations (an additional cost factor for those services funded through the GMS fee for service system). Access to information and maintaining records is also more difficult for mobile services. Laptop computers with regular downloading of records is the most effective way of maintaining information records, but is another cost which services providing remote and mobile clinics have to bear.

Not all Māori primary care services currently provide general practice services. Some of these services are seeking to develop general practice services. Others question whether it is necessary for the Māori service to have general practice care. Primary medical care (general practice) is an integral part of primary health care. People still need medical care and will continue to do so despite high quality health promotion, education and other community health programmes. While personally believing that having a general practice is desirable for Māori primary care services, I can also see that it is possible to have access to medical care services that are not owned and operated by the Māori primary care services. This could be achieved by having good relationships with local general practices / IPA’s. How the service provided to Māori clients by these general practices would be funded requires careful consideration. Would the general practice/IPA receive the funds? Would the Māori primary care services receive the funds and then have an arrangement with the general practice/IPA? Given that many Māori primary care service established general practices because pre-existing clinics were not adequately meeting the needs of Māori, how would the performance of the general practice/IPA be monitored and evaluated? Mechanisms to ensure that these general practices were providing high quality services that were culturally appropriate, affordable, accessible and acceptable to Māori clients would have to be in place. In addition mechanisms to ensure that ‘cream skimming’, under and over-servicing did not occur would also have to be implemented.

Māori Integrated Care Organisations

Recent evolution in Māori primary care has seen the development of Māori Integrated Care Organisations (MICO’s). These organisations have various governance structures that include representatives of the hapū / iwi groups and Māori providers in the region. This ensures that both the aspirations and concerns of the local community are represented at governance level and the MICO is clearly accountable to the local community.

At this time MICO’s, having completed major consultation processes, strategic planning and early development work, are beginning to act as purchasers / contract managers. Some MICO’s have focused on new contracts, others are / will be taking over the management of
pre-existing contracts. Although positioned under the umbrella of the MICO, individual providers remain autonomous, running their businesses within their own kaupapa and tikanga.

These pilot organisations are still in formative stages and undoubtedly their structure and function will evolve further. However, at the present time the functions of MICO’s appear to include:

1) tendering, negotiating and securing new contracts and in a few instances managing existing contracts (although existing contracts tend to continue to be managed by the provider group themselves)
2) standardising reportage requirements for contracts and fulfilling reportage requirements for new contracts on behalf of the providers
3) developing and assisting providers with activities such as
   • the development of best practice guidelines
   • undertaking the activities necessary for accreditation with Health Care Standards
   • the organisation of ‘clinical forums’ which cover a variety of areas including developing policy and procedure about co-ordination of care, clinical supervision and continuing education for workers within various services and programmes
4) identifying ‘gaps’ or areas where the MICO can provide resources to assist provider groups. For example, workforce development and management resources development
5) development of an Information Technology (IT) strategy
6) marketing and profiling of the MICO itself and the individual provider groups
7) fostering relationships and promoting Māori health initiatives with external organisations such as HHS’s, other funding agencies such as ACC and other health organisations e.g. First Health, IPA’s and local community health trusts. In addition to developing relationships, some MICO are actively involved in local integration projects such as disease management and immunisation. In these projects MICO have key roles such as promoting the collection of ethnicity information, incorporation of Māori frameworks and providing information about Māori health and health needs in the local area.

The ultimate vision for MICO’s would be to assume purchasing and monitoring responsibility for all Māori health in their region.

Current issues facing MICO’s include
• a lack of a clear committed policy within the HFA to the MICO concept. People are not sure whether the MICO strategy is one which will be continued into the future
• The HFA’s move towards national consistency in contract specifications. There is concern that this move towards national consistency may negatively impact on the ability of contracts to cater to local needs
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- MICO’s that are currently reliant on the Māori Provider Development Fund for funding are not sure how long this funding will continue. Current MPDF funding is allocated yearly on a competitive basis.

Staffing

A variety of staff are employed within Māori primary care services including doctors, nurses, midwives, managerial and administrative staff. In addition many services employ community health workers / kaiāwhina. It is preferred to have Māori staff wherever possible and in most services community health workers, managerial, administrative and many of the nursing staff are Māori. In some areas, most notably with doctors and midwives, the lack of a sizeable Māori workforce means that non-Māori staff are employed in these positions. Māori governance of Māori organisations ensures that Māori kaupapa and tikanga are integral to the operation of both the organisation and the daily practice of staff. Thus, the employment of non-Māori staff does not appear to cause difficulty for the services as long as these staff are content to work in a health service that is driven by the philosophies and desires of the Māori organisation, are willing to work within a model based within Māori concepts of health and Māori approaches to service delivery, and are able to practice in a culturally safe manner.

Community health workers / kaiāwhina play a major role in the health services which employ them. They are usually members of the local community, have significant networks within that community and represent the ‘face’ of the Māori service within the community. They have a number of roles including providing health information, co-ordinating and undertaking health promotion and education activities, some clinical roles (for example checking baby heights and weights in Well Child Services, ‘finger prick’ testing for glucose levels), advocacy and support for people / whänau, and if necessary transport. This is not a complete list of the various roles that community health workers / kaiāwhina undertake. The reader is referred to work by Te Puni Kokiri (24), Penney (25) and Crengle (23) for further descriptions of community health workers roles. Generally there is a move away from generic community health workers who are expected to have a wide knowledge base to community health workers who focus in more specific areas for example child health, kuia / koroua health.

Nursing staff roles are varied. Some have specific roles (for example nursing working within Well Child Programmes), others function more as visiting Public Health / District / Practice nurses (for example the nurses working in Hauora Whänui). All have health promotion and health education roles.

Many Māori primary care services have staff who are dedicated to administration and management functions. In other services, particularly providers who only deliver a small number of programmes, administrative and management function may be done by staff who are also involved in service delivery. This can place pressure on the staff involved

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11 rather than driven by the professional person as tends to happen within Western primary care models
particularly if the time required for administration impacts on service delivery (and vice versa).

Many Māori working within the health sector have been involved in the sector for significant lengths of time. However the rapid development and evolution of Māori health services since 1992/93 has resulted in a demand for a larger workforce. Consequently some staff have had to develop skills and acquire experience rapidly. With the on-going evolution of Māori health services, workforce development continues to be a major issue.

Current Issues for Māori Primary Care Providers

Māori primary care services face a variety of issues. Some of these issues are universal. Others face issues that are specific to their service, either as a result of the location of their services (e.g. rural services) or their size (small providers). The following section address universal issues, followed by issues for rural providers and issues for small providers.

Universal Issues

HFA issues

The quality of the relationship between Māori providers and the HFA throughout the country is quite variable.

The issues described by Māori providers include:

1. Contract specifications: Service specifications in HFA contracts usually reflect Western paradigms and do not reflect Māori models or Māori approaches to service delivery. The term of the contract (often one year) means that some providers operate in an environment of uncertainty about on-going funding. This can have a negative impact on both the staff and the service provided.

2. Monitoring of contracts: similarly, the frameworks used for monitoring performance against contract specifications are not able to adequately capture the range of work actually achieved by providers. Outputs are usually used as the basis for monitoring. Providers are keen to see outcomes used for monitoring purposes. Consideration also needs to be given to how monitoring frameworks can be developed in order to reflect both the way Māori providers work and the full range of work they actually undertake. In one area, the output requirements (which may be reasonable for a moderate – large urban location) do not appear to take account of the rural location and the number of staff employed. There are also anecdotal accounts of providers exceeding their outputs during the year and being asked to stop seeing clients as the service has met their requirements for the year!

3. A perception that the HFA is solely interested in purchasing services that fall within its own priority areas. This sometimes results in the HFA refusing to fund programmes that meet local community needs / health issues, which have been identified by communities and the health service providers.

4. A perception that the HFA has become less flexible in its relationship with Māori providers. Specifically, several providers have described early relationships with the
HFA which were based on the HFA asking what the community needed, what programmes were priorities to provide and working with primary health care services to ensure these programmes were implemented. Some providers feel that the approach of the HFA is now ‘this is what we want you to do and this is how you are going to do it’.

5. There is also a perception that it is much more difficult to develop and provide new services and programmes. This appears to be more of an issue for providers who do not have preferred provider status, particularly small and moderate sized providers.

6. Lack of a clear policy strategy for some current Māori health strategies, particularly for Māori Integrated Care Organisations (MICO’s)

7. In at least one regional area, the purchasing of services has been ad hoc and has not been based on a needs assessment. This has resulted in areas with a significant Māori population having no Māori services.

The Special Needs of Māori

Many Māori may be considered to have special needs from health services. Low socio-economic status is associated with a raft of barriers to care. Culturally determined preferences for receiving services (for example preferences for hui (group) education sessions, for receiving services at marae or other community settings, for health information to be provided in culturally appropriate forms and for Māori staff) also impact on the utilisation of services and the success (or not) of services in bringing about health gain. Māori primary care services are effective at addressing many of these needs but doing so often requires more intensive staff and time resources. Opinions vary throughout the country as to whether the extra resources necessary to address these needs are adequately met through current contractual and funding arrangements.

Many Māori providers spend considerable time undertaking ‘social work’ functions with their clients. This type of task is common in the day to day work of community health workers, child health service workers, disability support workers and substance abuse service workers. The provision of these services is not always included in contract specifications and funding. However, the workers in health services cannot simply ignore these needs. To do so would be inconsistent with the Māori models of service provision.

Funding Levels

Criticism of funding levels and calls for increased funding are common heard throughout the health system (both Māori and the so-called mainstream). Funding has been mentioned at times throughout this document and will be discussed further in the funding mechanisms section.

Enrolment and Registers

It is generally accepted that enrolment of patients and the maintenance of registers by general practices will be instituted. The key issue with registers are the two year limit time period used in deciding if patients are active users of the practice; the potential administrative and financial burdens placed on practices who cater for people who attend infrequently or
are highly mobile, and how ‘double dipping’ will be managed and addressed. Informing the community about enrolment (registration) is also a key issue. These issues are fully discussed in the funding mechanisms section.

**Information Requirements**

The HFA requires significant levels of reporting and information from Māori providers. Concerns expressed by Māori providers focus on two areas: lack of information available to providers from the HFA and ownership/control of information provided to the HFA.

Some providers have expressed concern about a lack of feedback from the HFA regarding the reporting they have made to the HFA and the information they have provided. Providers would like to have feedback on the reports. They would also like to receive information (both national and local) from the HFA. Receiving rigorous information about the socio-demographic characteristics, health status (baseline levels and trends), morbidity and mortality information and health issues for their community would assist providers with monitoring their own performance and identifying key areas for programme development.

Some providers have also expressed a desire to be able to track the movements of their clients through various components of the health service e.g. through outpatients clinics, hospital admissions etc. Some hope that the NHI will eventually enable them to do this.

Other concerns revolve around the management of information and intellectual property ownership issues. Commonly asked questions include
- what happens to the information when it reaches the HFA?
- what use is the information put to? People expressed concerns that information may be used in ways that are damaging to Māori, may be used for purposes other than those for which it was originally collected, may be able to access by other people, or may not be used for any purpose at all (in which case why bother collecting it?). In one area providers are required to collect ethnicity information but are not required to report it to the HFA.

**Workforce Development**

Workforce development is a key issue. Demand for Māori health workers is high and will continue to grow in the foreseeable future. There is a need for both increasing the numbers of Māori involved in all areas of the health workforce, and for increasing the knowledge and skill base of people already involved in the workforce. There has been an increase in the range and number of training programmes available (for example training for community health workers). In some professional areas e.g. medicine active measures to recruit Māori are underway and have started to bring results. Other professional areas still have very low numbers of Māori staff e.g. dieticians, physiotherapy.

Continuing training and up-skilling for staff employed in Māori services is a priority area. However, the impacts associated with releasing staff for training may have a significant effect on Māori primary care services. Staff away at training are not available to undertake their
usual work which is covered by their co-workers or by locum staff. Locum staff may be difficult to attract, are more costly and may not be as efficient. Having other staff cover the workload of colleagues on training may have a negative impact on the services. These are greater issues for small and rural providers (see below).

Information Technology

Some providers mention difficulties finding software which is able to collect and manage information (clinical and administrative) about their activities and services in an integrated manner. This seems to be a particular problem for larger providers who wish to be able to integrate information from different programmes including general practices. Current medical software is not able to adequately perform these tasks.

Lack of familiarity and experience with information technology is another area mentioned by some providers. Māori Provider Development Funding has assisted in this area recently. However, some providers still need support with IT.

Some of the MICO’s are currently working with providers within their organisations to further develop information technology capability, particularly the use of IT media for filing reports etc.

The Potential Impact of Changes in Socio-Economic Factors on Health

The last fifteen years has seen significant changes in socio-economic status. The average disposable incomes for many Māori have fallen. The gap between the wealthiest and the poorest in our communities has grown. There is a clear relationship between socio-economic status and health (26 27). Populations which have the greatest difference in income (between high and low socio-economic groups) also exhibit the greatest differences in health status. Falling incomes and increasing discrepancy indicate that there may be an associated reduction in health status amongst low socio-economic groups (and therefore many Māori). If this occurs it will have a significant effect on Māori primary care services. Consideration needs to be given to how we will monitor for these potential health impacts and if there is evidence that these changes are occurring, how will Māori primary care services be assisted to address these increases in health need?

Changes in the Secondary and Tertiary Sector

Several changes in the secondary and tertiary sectors have impacts on primary care services. Most Māori make use of the public health system. Some services are no longer available through the public health system. Access to other services has been reduced through the use of criteria and booking systems that require a certain level of morbidity before the person is eligible to be seen in the public sector. While it is agreed that these systems may accelerate the access of some people into the system, the people who are not

12 Locum staff may be unfamiliar with the service, do not have in-depth knowledge of the clients and may not have as good rapport with clients as permanent staff
eligible will continue to be managed in the primary care sector until they meet eligibility criteria. Additionally there has been a trend to reduced length of hospital admission. This may require primary care services to have a greater role in post-discharge care. If these changes do result in an increase workload for primary care services, this impact will be felt by Māori providers and may cause an increase workload in illness management with a potential reduction in health promotion and wellness services (unless increased funding allows for expansion of the former).

**National Standardisation**

The HFA’s desire to standardise contracts at a national level may impact on Māori primary care services ability to provide services which meet the needs of their local communities in ways that are appropriate for use in their communities. How this tension will be resolved remains to be seen.

**Incorporation of Traditional Healing into Primary Care**

It is important that traditional healing is available to people who wish to utilise these services. The issues described on page 17 require attention and discussion.

**Issues for Rural Providers**

The different communities cared for by Māori primary care services may have different needs and preferences. Tailoring the services for their different communities can be more challenging for rural providers than their urban counterparts.

Rural services have to cover a much greater distance. This increases the cost of providing the service (time spent travelling by staff, running costs and increased wear and tear on vehicles). Several rural providers question whether these increased costs are adequately factored into their funding. Difficulties associated with accessing information and ensuring that stored information is kept up-to-date also face rural providers who delivering services at a number of sites.

Many rural providers face workforce issues that are not faced by urban services. Attracting staff (particularly in very rural sites) is difficult. This is particularly so for medical practitioners and for locum staff covering staff on training, holidays etc. One informant commented that rural nurses face issues relating to the availability of back-up advice for clinical decisions. That is, in isolated situations the nurse may not be able to readily access back-up advice and support. She commented that if nurse prescribing is introduced appropriate training and back-up for nurses will need to be available.

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13 Rural providers also note that their clients face many difficulties not faced by urban populations. For example having to travel great distances for lab tests, x-rays, outpatients services and hospital admissions. Appointments may also be given without taking into account the travelling required e.g. early morning or late afternoon appointments. Family also have greater expenses when supporting hospitalised whānau members - the cost of staying away from home etc.
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Rural providers also face difficulty arranging training for staff. Training usually occurs at sites distant from the location of the provider. Staff are away from the service for longer periods and the cost of sending staff to training is higher.

Contact with other Māori providers is also more difficult for rural providers. Contact with other providers is an important way of sharing information, experiences and gaining peer support.

Issues for Smaller Providers

Smaller providers have relatively higher administration/management costs. These duties may be undertaken by one of the staff who also delivers the service. There is often insufficient time to undertake both tasks within the ‘normal’ working week.

Smaller providers may also face difficulties undertaking the processes needed for accreditation.

Some smaller providers (and providers who do not have preferred provider status) believe that their opportunities to develop / undertake new services has become severely constrained. The sustainability of these providers into the future is unclear. It seems that these providers will need to develop strategic alliances with other providers to ensure their sustainability.

Summary

Key Features of Māori Primary Care Services

The key features of Māori primary care services are

1) services are provided by Māori, for Māori
   • operated by Māori organisations or groups
   • the fundamental principles that guide the philosophy and development of the services are Māori (kaupapa Māori)
   • Māori cultural values, beliefs and practices (tikanga Māori) are used in the development and delivery of services
   • have mechanisms in place that ensure the community has input into the services and the service is accountable back to the community
   • utilise (where possible) Māori staff
   • provide services that are high quality, affordable, accessible and acceptable to the clients
2) two philosophical approaches frame the services
   • positive Māori development
   • the use of a Māori model of health and well-being
3) demography
   • serve predominantly but not exclusively Māori clients

Prepared by Dr. Sue Crengle July 1999.
• have higher numbers of young people and fewer elderly people on their registers
• have a high proportion of clients in low socio-economic groups
• clients' health status reflect the well documented national health status of Māori
• traditionally Māori have received less primary care and are over-represented in secondary care services
• clients face many of the barriers to care that are described in the international literature

4) description of Māori primary care services
• variable size: small providers delivering one or two programmes to large providers delivering a wide range of services and programmes
• some providers have preferred provider status with funders, others do not have this status
• size of client base varies from several hundred to ten thousand

5) location
• within a variety of Māori organisations (iwi, hapū, urban Māori groups and independent of these groups)
• urban within large cities to very rural geographical location

6) services / programmes provided
• community health programmes focusing on health promotion, health education and screening
• intervention / clinical services e.g. general practice, midwifery, counselling, dental etc.
• disability support services
• mental health services
• traditional healing services
• training and workforce development

7) Methods of delivery of services
• within kaupapa and tikanga Māori (see above)
• on site at the health services offices
• wide variety of community locations and venues
• mobile and suitcase clinics
• may have informal or formal relationships with other providers offering services they are not able to provide
• refer to employment, training and other social service organisations to ensure that these needs of their clients are met
• general practices may or may not be part of the Māori primary care services. If they do not provide general practice services themselves they may have good relationships with local general practitioners

8) May be part of the pilot Māori integrated care organisations or looking at developing relationships with similar non-Māori organisations

9) Staffing
• staffed with a wide range of people
• community health workers / kaiāwhina essential
• workforce development is a critical issue
Key Issues

1) Issues with Funding Authorities
   • contract specifications often inconsistent with Māori models and approaches to service delivery
   • monitoring frameworks inconsistent with Māori models and approaches to service delivery
   • changes in the nature of the relationship between funders and providers
   • provides without preferred provider status
   • national standardisation of contracts

2) Special needs of Māori
   • Māori services are effective at addressing many of these needs. Doing so is more costly in both monetary and staffing resources but achieves health gain

3) Funding levels
   • may be inadequate for the high level of poor health and the way that services are delivered

4) Enrolment and registers
   • two year limit for active patient status
   • managing highly mobile, casual and ‘double dipping’ patients
   • informing the community

5) Information requirements
   • lack of information feedback from the HFA
   • need for rigorous information on
     ⇒ socio-demographic information
     ⇒ health status, morbidity and mortality information and health issues
     ⇒ management of information provided to the HFA, intellectual property ownership issues

6) Workforce development
   • high demand for workers
   • need for increasing the knowledge and skill base of workers

7) Information technology
   • capability of software
   • need for support to develop IT capability within providers

8) Impact of socio-economic changes and changes in the secondary and tertiary care services

9) The incorporation of traditional healing into primary care
   • should traditional healing be incorporated alongside western allopathic primary care services? What would this partnership look like?
   • how would these services be funded?

10) Rural providers
    • different needs in different communities in the rural environment
    • cost associated with rural location
    • increased costs associated with workforce development
    • difficulty attracting staff

11) Small and non-preferred provider services
    • relatively high cost of administration / management
Looking to the future

It would appear that Māori primary care services with preferred provider status will be sustainable into the future. The major concern is how the sustainability of smaller and non-preferred providers who are providing high quality effective services can be secured?

I believe that in order to survive these providers will need to develop formal strategic alliances. These alliances could be either with pre-existing preferred providers or new alliances amongst themselves.

In order to achieve this whilst preserving the autonomy of the individual Māori primary care services the development of this alliance organisation will need to be carefully implemented. The major issues needing clarification and agreement from the outset are:

- a governance body that allows representation from all providers and the community
- autonomy of providers to deliver their services according to their tikanga
- how the input of the providers and community will be incorporated into negotiations with funders for renewing pre-existing services and contracting for new services
- how will circumstances where two providers deliver the same service / programme be managed
- how will new services be ‘shared’ across the different providers
- clear negotiation and agreement on referral processes (entry across to the other service and transfer back to the initial service) of one service’s clients to another.

The development of such an organisation has the following advantages:

1. provides collective power to the individual Māori primary care services strengthening their position and sustainability
2. provides the organisation with a larger registered population base
3. the alliance organisation could provide management and administrative support to the individual providers (for negotiating contracts, reporting requirements, accreditation etc.)
4. the organisation could also assist with collation and dissemination of information required by providers, workforce development, development of best practice guidelines etc.

The model has similarities to models around the country at the moment, in particular to some of the MICO’s. The key feature is that the alliance organisation is not seen as a purchasing organisation that purchases the services of local providers, but rather as part of the provider group (a “support” organisation). The key roles of the support organisation are to support providers to deliver their services, work with providers and the community to identify unmet health needs and facilitate the development of services to meet these needs.

A proposed structure could be
Funding Mechanisms
This section is divided into three parts. The first part makes some general comments about funding. The second part considers the funding of community health programmes, disability support and mental health services. The final part discusses funding for primary medical care (general practice) services.

General Comments
Three major funding mechanisms are currently employed: fee for service (general practices and maternity services), capitation (general practice and in some instances maternity services) and funding for individual programmes contract (community health, disability support, mental health and very occasionally general practice services). In some instances the funding for all the individual programmes may be amalgamated into a single contract (a form of bulk funding).

Many providers interviewed had concerns about the level of funding, feeling that this level was inadequate. Universally providers felt that the levels of funding failed to take account of:

- the poorer health status and higher levels of health need amongst their clients and consequently the greater time and resources that were necessary to assist clients with their health needs
- the increased time, staff and other resources that are necessary to deliver services based in kaupapa and tikanga Māori
- the increased time, staff and other resources that are necessary to effectively deliver services which reduce ‘barriers to care’ and to locate and deliver services to some members of the Māori community (particularly the group termed the ‘hard-to-reach’)
- the increased time necessary to deliver programmes / services in a diverse range of locations (rather than from one site)
- the complexity of issues (including social, psychological, financial and other factors) that affected peoples health and their ability to appropriately address their health issues and the time and resources necessary to assist people with these issues. It is imperative that these issues are addressed.

The simple responses to many of these issues include arguments that services need to be aware of what are ‘appropriate’ activities for them to be undertaking and to resist the temptation to undertake activities that are ‘inappropriate’. These responses fail to take into account two important points.

Firstly, Māori primary care services are committed to a health model that reflects Māori paradigm. This model demands that whānau, spiritual, mental, economic and other factors that impact on a person’s health status and ability to act on health concerns are addressed. It is unrealistic to expect people to attend cervical smear education and screening clinics (or take their children to clinics for routine immunisations) when they have more pressing concerns about the standard of their housing, having enough money to feed their children or the health of their grandparent. Assisting people to address their most pressing concerns allows them to participate in other health related activities or programmes.
Secondly, the expressed desire of policy makers and health funders to improve access to services by the ‘hard-to-reach’ must be meet with a recognition that services which successfully achieve this goal are going to require more resources (staff, time and money).

There was also great concern about user co-payments in general practices. The Māori general practices have deliberately kept their co-payments as low as possible because financial barriers are one of the factors which limit access to and utilisation of primary medical care (general practice). Lack of increases in funding for general practices (either in the GMS, capitation rates or those practices that are ‘bulk funded’) have put great financial stress on many providers as they have found that their overheads have increased. Some providers have also noted that, with reductions in household’s disposable income levels, the level of unpaid co-payments has increased. Some providers find themselves faced with a static level of funding, falling income from user co-payment and increasing overheads. Providers have been very reluctant to increase patient fees. As a result services have been effectively subsidising patients care to greater and greater levels and their (provider’s) levels of unpaid debt have increased.

Policy initiatives (the Free-for-Under 6’s policy) to reduce financial barriers have had limited impact on Māori services and their clients. This policy only affected general practices that were claiming GMS and capitated services. Those that are bulk funded had no increases in funding. Furthermore, the increases in GMS had most impact with children whose families did not hold community service cards. As many of the families using Māori services are Community Service Card holders the scope of funding increases was again smaller for Māori general practices. Finally, the financial relief (reduction in user co-payment) that this policy delivered to children and their parents was limited. Since their inception Māori general practices have not charged for seeing children. All children in this age group are seen free regardless of Community Service Card Status. Consequently, there was no financial benefit to Māori whānau using Māori general practice services. As a result most Māori practices report that the policy made no / minimal difference to the numbers of young children seen in their practices.

Community Health Programmes, Disability Support and Mental Health Services

Single Contracts for Services and ‘Bulk Funding’.

Community health programmes may be funded in two ways. Each programme may be funded on separate contracts, requiring separate negotiations and monitoring processes. Or, (if providers have more than one such programme) the contracts for each programme may be collapsed into a comprehensive contract. The use of the term ‘bulk funding’ refers to contractual arrangements where the funding for a number of programmes is collated into a comprehensive contract. In situations where a provider has a number of contracts, the use of

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14 ‘New Zealand Now: Incomes’ (Statistics New Zealand, 1998) describes an increase in income inequality between the years 1982 and 1996. Average household equivalent disposable income in the bottom two deciles stayed stable, middle deciles decreased and the highest decile significantly increased.
‘bulk funding’ seems sensible. Contract negotiations, funding payments and monitoring processes can be undertaken simultaneously for all contracts.

There are three issues surrounding the contractual process for community health programmes.

Firstly, many providers believe that the frameworks used for purchasing community health programmes are not appropriate for use with Māori services. As noted earlier Māori models of primary care are founded within Māori concepts of health / well-being, providing comprehensive holistic care using kaupapa and tikanga Māori. On the other hand contracts are based on western frameworks and service specifications (for example the National Well child / Tamariki Ora Schedule) which are not capable of adequately capturing the work of Māori services (23, 25, 28).

Similarly, monitoring frameworks currently based on outputs rather than outcomes also fail to capture the actual work of these programmes or the outcomes they deliver.

Finally there are concerns about the current move towards nationally consistent contracts and monitoring. While acknowledging the potential benefits from nationally consistent contracts and monitoring there are serious questions about how nationally consistent contracts will cater for programmes which are delivered in ways consistent with the needs of a local community and the tikanga of that community. Furthermore, how does this move to national consistency interface with the ‘local solutions for local problems’ approach?

Funding for these contracts currently comes from a variety of sources including personal health, disability support services, mental health and possibly from public health. Most of the funding comes from personal health. The ringfence on public health funding is seen as a barrier and some people believe that money should be available from public health funds, particularly to fund more health promotion, education and screening. Other public health services such as health protection, communicable disease surveillance and environmental health are not considered here.

This method of funding is appropriate for use with these services. However, the issues described and covered in the general comments must be considered and addressed in order to ensure that services are adequately funded to deliver services in appropriate ways to achieve desired outcomes.

Primary Medical Care (General Practice) Services

Three mechanisms for funding primary medical care services are currently employed: bulk funding, fee-for-service and capitation.

‘Bulk Funding’

In some situations ‘bulk funding’ is also used to fund general practice services. That is, the general practice is bulk funded with the level of funding determined by the amount previously claimed through General Medical Subsidy (GMS). There are no other specific criteria (for
example criteria used in the capitation formula) used for determining the level of funding. With capitation general practice providers can receive increases in the amount of funding if the number of registered clients increases. However, no increases in funding are automatically available under this bulk funding arrangement. Neither are bulk-funded practices able to claim GMS. Consequently, if the number of registered clients increases there is no way to increase the level of funding of the service (except to successfully negotiate an increase in the amount of bulk-funding which to date has not happened). Practices on this type of funding are therefore limited in their ability to grow and develop their practices.

One practice has overcome these difficulties by negotiating an agreement with a local Accident and Medical centre. The A + M centre sees their overflow — people who are not able to be seen at their own clinic. The Māori service meets the cost of the consultation at the A + M centre. The service is able to afford this at the current time by prudent financial management. This is a pragmatic solution to this problem. However, it is not clear whether it is sustainable if there are major increases in client base resulting in an escalating use of the A + M centre (and therefore escalating costs to the Māori service paying for these consultations). Consideration also needs to be given to issues around ensuring continuity of care for on-going health conditions.

In addition there is no way that increases in utilisation (as people begin to use services in a regular manner and as more previously unrecognised disease is discovered) can be taken into account with this type of funding. Therefore this type of funding would not appear to be satisfactory for general practice services. However, if the above issues were resolved and could be incorporated into the funding levels this could be a reasonable funding mechanism.

**GMS Fee for Service**

The General Medical Subsidy (GMS) system allows medical practitioners to claim a set fee from the State whenever they see patients meeting particular criteria. GMS is available for adults with community service cards or high user cards and children. For children, the level of the subsidy varies depending on age and whether their parents hold Community Service Cards (CSC). Apart from the increases implemented with the Free-for-Under 6’s policy there has been no increase in GMS for many years. In order for a health service to claim GMS the patient must be seen in person by the general practitioner. In addition to GMS subsidies for immunisation delivery and Practice Nurse salary are also available.

Aside from the concerns about the level of GMS subsidy and user co-payments (discussed above) there are several other issues with this funding arrangement including:

1) The level of subsidy does not allow for the multiple health problems faced by many Māori clients. It is not possible to claim extra GMS for extended or complicated consultations. The High User Card (HUC) is available to people who have more than 12 consultations per annum. However, many people with complex health needs consult their doctor less than twelve times a year, but still require extended consultation times. The HUC is not available to these patients. In addition, if a
person already has a CSC the HUC does not confer additional financial benefit to
the person or the provider.

2) Receiving payment on the basis of the number of people seen can result in the doctor/
practice being driven by the necessity to see a certain number of people rather than
being driven by the health needs of their clients theoretically resulting in

- a reluctance to address all health issues in one consultation if the consultation
  is likely to be extended. People may not return for the subsequent
  consultation and therefore some of their health needs remain unmet
- the potential to over-service other clients. Some people may be asked to
  return for follow-up visits which are not completely necessary

3) There is no incentive to make increased use of practice nurses as general
practitioners must see patients in order to receive remuneration. Some providers on
GMS have expressed a desire to increase the role of nursing staff in direct patient
care but are not able to do this as it would lead to a reduction in GMS based
funding. The advantages of increasing the nursing role include

- if the nurse is able to attend to simple, routine matters the doctor is then able
  to spend more time with people who have more complicated health issues
- people who have simple, routine reasons for seeking consultation often have
  to wait to see the doctor. Increased use of the practice nurse may reduce
  waiting times

4) Less predictable incomes from GMS. As the level of income from GMS depends on
the number of patients seen there are variations in the level of income depending on
the consulting patterns and habits of the clients and the time of year

5) There is a further theoretical disadvantage of GMS encouraging a focus on illness and
discouraging practitioners to undertake preventive health measures. If preventive
health measures are encouraged there will eventually be less demand for general
practitioners curative services in the future

Capitation

With capitation based funding providers receive an amount per annum per patient.
Arguments used in favour of capitation include that it:
1. removes the ‘having to see people’ driver to derive income which is inherent in the fee
   for service model
2. encourages general practice to provide high quality care and focus on preventive
   services, health promotion and health education
3. encourages practices to develop the role of nurses as independent practitioners.

Practices are required to maintain a register of patients. This register is made up of patients
who have actively registered with the practice as their primary care provider and who have
been seen in the practice within the previous two years. The register is regularly ‘cleaned’ to
remove people who have not been seen in the previous two years and those who have died
or transferred elsewhere. However it is not uncommon for people, particularly for young and
middle aged men to see their general practitioner less frequently than every two years. As
these people are repeatedly moved on and off the register an administrative burden is also
placed on the practice and financially disadvantages both patient and provider when people
who have been removed from the register re-present for care. The provider is disadvantaged because they are seeing a person who they are not funded to see. The patient may be disadvantaged if the provider chooses to pass this cost on to the patient in the form of a higher user co-payment. A further register related issue is the mobility of the Māori population. High mobility is a feature of some Māori whānau. If they are out of the area of their general practice and go to another practice, how is this cost recouped from the capitated practice (so called double dipping) and what impact does the administrative cost of addressing this issue have? In a similar manner how does capitation cater for non-registered patients who attend the practice? What are the administrative costs for catering for these clients, how are they met, and are these costs passed onto patients in the manner described above?

A funding formula is applied in order to determine the level of payment received by a practice. The factors taken into consideration when determining a practice’s funding are

- the age characteristics of the practice population. More money is received for the young and the elderly. The age groups with the highest user of health services are those over 65, particularly those over 75 years (29). Māori life expectancy is 68 years for Māori men and 73 years for Māori women (compared with 73 and 79 years for non-Māori men and women respectively). However, Māori in middle years often have a high number of chronic conditions that require careful attention and complicated medical consultations. The extra care required by Māori in these age groups is not addressed in the age related adjustments of the capitation formula.

- gender

- Community Service Card status. However the use of Community Card Status is a poor proxy measure for socio-economic status. As Gribben (29) notes a significant percentage of people eligible for CSC do not actually hold them. Moreover, many of those holding cards have not renewed them - thus they are invalid. He also notes that holding a CSC is a poorly associated with the presence of chronic conditions. Thus, the CSC is also a poor proxy measure of health status.

- the number of people with current High User Cards (HUC). This would appear to be a proxy measure for health status. In order to be eligible for a HUC a patient has to have received 12 consultations per annum. However, as reported by Gribben (29) the average number of consultations (CSC holders and non-CSC holders) without chronic conditions is 2.78 and for those with any chronic illness is 6.63. Therefore the use of 12 consultations per annum as the threshold for gaining a HUC effectively excludes many people with chronic conditions and is therefore a poor indicator of health need in the general community. The higher health needs of these people are not factored into the capitation formula.
Four other factors require consideration.

Firstly, one of the arguments used in favour of capitation is that it encourages general practice to provide high quality care and focus on preventive services, health promotion and health education. The rationale for this belief is that if the practitioner undertakes these activities the registered population will be healthier and therefore will make less use of the practice (thereby increasing the ‘income’ of the provider). However, it can be argued that in a population that has high levels of morbidity (much of which is undiagnosed) this rationale may be flawed. Māori under-utilise primary care (12, 13). If Māori general practices are successful at increasing Māori access to primary medical care there will in fact be an increase (rather than a reduction) in the use of these services at least in the short to moderate term. Similarly, if Māori services successfully implement screening, health promotion and health education programmes there will also be an increase (at least in the short to moderate term) in the utilisation of their services as more previously undiagnosed or inadequately managed morbidity is discovered and comprehensively managed. Thus initially the opposite of the theorised effect will occur. Furthermore as described above the current funding formula will not adequately fund Māori providers for the increase in morbidity and care needed in their registered population.

The second point concerns the possibility of providers preferentially registering people with low health needs while discouraging people with high health needs from registering. Alternatively, providers may not encourage registered people with high health needs to appropriately seek care (‘cream skimming’). It is extremely unlikely that Māori providers will indulge in these types of behaviours. However, if other practices in their local area do behave in this manner, Māori practices may well find themselves with even higher proportions of high health needs patients. Given that the current funding formula does not adequately cater for health status this behaviour has the potential to have significant implications for Māori primary medical care services.

The third point that requires consideration is whether ethnicity should be included in the capitation funding formula. If ethnicity was included in the formula, practices would receive extra money for each patient of certain ethnic groups, enrolled in the practice. Arguments against including ethnicity in the formula are based on the belief that health status disparities between ethnic groups are adequately accounted for by socio-economic status. However, there is a growing body of information that suggests that socio-economic status alone is not sufficient to account for ethnicity-linked differences in morbidity, mortality or illness management and ethnicity should be included in the capitation formula. For example, Smith and Pearce (30) concluded that socio-economic status accounted for only 20% of the excess mortality burden carried by Māori men. Differences in health service utilisation and management of illnesses would appear to play a role in the excess mortality burden. Evidence that specific conditions may be managed differently for people from different ethnic groups is available. Mitchell (31) concluded that ethnicity-linked differences in the prescription of asthma preventive drugs was most likely to reflect institutional racism. Similar differences in access to medical interventions has been described in relation to access to coronary artery bypass grafts (32, 33). The underlying reasons for these differences are likely to be a complex reflection of differences in access / utilisation of services and
differences in management. The additional funding would allow practices to develop and implement strategies that improved access / utilisation of services. Similar strategies to facilitate patients journeys through pathways of care and improve the management of chronic conditions could also be developed.

Finally, when registration / enrolment is introduced it will be necessary to undertake a comprehensive education programme aimed at the community. The notion of registering with a regular provider is foreign to some members of the community. Some people have several providers who they currently use and others do not use any regular providers. It will be necessary to explain the reasons for enrolment and the implications of being enrolled with a specific provider.

Budget holding

At least one provider has begun budget holding for pharmaceuticals, laboratory services and maternity services. In line with the experience of other groups which have been budget holding for pharmaceutical and laboratory services this groups has found that while savings were made in the first two years; savings after that time were markedly reduced. Budget holding for pharmaceutical and laboratory services raises many questions for Māori providers such as:

- are the populations receiving care in Māori general practices of sufficient size to make budget holding a viable proposition (particularly for risk holding)?
- given that many of the clients of Māori services have multiple medical problems or are at higher risk of developing many diseases how is this increased need for laboratory services adequately factored into the size of the budget? Basing the size of the initial budget on the previous pharmaceutical spend may be an inadequate method of establishing this. Problems may ensue if, for example, Māori patients who had previously seen a number of different providers began to use the Māori general practice as their regular provider. Similar difficulties may arise if patients who had previously been erratic with picking up and taking medicines began to use medications regularly. Both these outcomes (regular care provider and routine use of medication) are desirable outcomes that may be more likely to be achieved once a person is attending Māori services.
- how are potential increases in demand for laboratory and pharmaceutical services incorporated into budgets. Effective health promotion, education and screening will reveal previously unidentified morbidity in the population. Additionally once people are attending a regular source of care earlier identification of illnesses is likely and will impact on the demand for pharmaceutical and laboratory services.

‘Budget holding’ for community health programmes is covered in the contract for service / bulk funding section above. The notion of budget holding for these services is merely an extension of the bulk funding concept, with the provider being given an amount of money and specifications for what is to achieved with that money. They are then able to use the money however they see fit in order to achieve the specified outputs/outcomes. Budget holding for these services has fewer drawbacks. A perceived major advantage of budget holding is that it allows the Māori primary care services to determine how it will spend the

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15 Identifiable by using the doctors Medical Registration number on prescriptions
funds it receives. Aside from philosophical considerations of whether the transfer of risk to service providers and the community, which is inherent in the notion of budget holding, is desirable or is in accordance with the Treaty of Waitangi, one other point requires consideration. What population size is necessary to adequately and safely carry risk, particularly for a population that is at relatively high risk for many things anyway?

I believe that for general practice services capitation is the most appropriate funding mechanism provided that the issues surrounding the development of an appropriate funding formula are resolved. The higher health needs of Māori arising from socio-economic and health status factors must be incorporated meaningfully into the funding formula. This would ensure that Māori primary medical services are funded to meet the needs of their clients. Capitation must not be used as a universal mechanism to drive down the cost of primary medical care as this would have the greatest impact on those with the highest health needs.

**Population based approaches in primary health care.**

There is no doubt that the provision of comprehensive appropriate primary care should be able to achieve health gains that elude a health system that focuses on secondary and tertiary care and interventions for individuals with illnesses. Focusing on primary, secondary and tertiary medical care which emphasise interventions for illnesses in individuals will not be sufficient to bring about the population health gains that are necessary. I believe that primary care services must avoid this error by expanding their focus on health promotion, education and screening while maintaining services that treat illnesses and other health issues in primary care. In order to bring about population health gain a population-based approach is required. A population-based approach would require the provider to take responsibility for the health of all members of the community, not just those that actively use their service. The provider would also have to deliver services that promoted health as well as treating ill-health.

Māori primary care services already provide services within a population-based framework. This approach (population based) appeals to Māori providers as it is consistent with Māori approaches to health service provision which have always emphasised health, well-being and the provision of community health programmes which incorporate health promotion, education and prevention. Additionally, Māori primary care services are delivering services in ways that are acceptable and appreciated by the Māori community. These services also address a number of the barriers to care faced by 'disadvantaged' groups that are described in international literature.

Detailed evidence of gains in health outcomes is limited for a number of reasons: collection of information relating to outcomes is limited and the time period that most Māori primary care services have been operating (since 1992/93) is insufficient to collect evidence on outcomes. However, there is some evidence that the Māori primary care services are achieving health gain or are likely to see evidence of health gain in the future. Immunisation and cervical smear coverage are higher in Māori providers (23, 24, 34). There have been
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significant improvements in diabetes control in some practices (35) and Māori are participating in programmes which foster healthy lifestyles at various sites around the country.

How can further population based health gains for Māori be achieved by Māori primary care services? Firstly, the issues described throughout this paper should be considered and resolved. If these issues were adequately resolved it would be possible to further develop Māori primary care services into what is referred to as community-oriented primary care.

Community oriented primary care ‘is a way of providing primary care which is focused on care of the individual who is well or sick, or at risk for illness or disease, while focusing on promoting the health of the community as a whole or any of its subgroups’ (Abramson, 36). In order to achieve this there has to be incorporation of public health tools and approaches with primary care practices, a connection between primary care and the community it serves, and a theoretical base that recognises that health and illness result from factors at all levels of human organisation (molecular to societal) (37).

There are four key steps in developing community-oriented primary care (36, 37, 38). These are defining the community, identifying and prioritising health care needs, designing and implementing an intervention and evaluation and programme monitoring.

Defining the community begins with taking responsibility for a community as a whole. More detailed description involves documenting demography, epidemiology, health statistics, and an inventory of the resources that are currently present in the community. Māori providers have already begun this task.

Identifying and prioritising health needs requires the input of the community as well as health workers, a prerequisite that is already a feature of Māori services. They also have a prior history of developing health services from a recognition of need in the community. With appropriate support and information Māori providers will be able to further their description of their community, identify and prioritise needs, undertake further service development and evaluate the services they provide.

The incorporation of community development approaches into community-oriented primary care (COPC) is consistent with and will help to achieve goals of positive Māori development.

I believe that a COPC model for primary care is likely to bring about population health gain and can be utilised with Māori primary care services. COPC has the potential to allow Māori primary care services to

• maintain a Māori philosophical approach to health and well-being (Māori models of health and positive Māori development)
• maintain and potentially increase the involvement of the community in the local health services
• continue the development of local solutions for local problems
• continue to deliver services within the ‘by Māori, for Māori’ model and

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continue to provide and potentially increase the range of community health programs as integral components of their services.

Some Māori services are operating a limited form of COPC embedded in a framework of Māori values, beliefs and practices which will be able to be developed into a full COPC model providing there is adequate support, information and the issues described below are addressed. These services are the larger services that deliver a comprehensive range of programmes. Smaller Māori primary care services will need to develop strategic alliances and partnerships with other services (see ‘Looking to the Future’ section) in order to develop into a COPC service.

Issues that constrain the further development of COPC within Māori primary care services include:

- having access to adequate information to assist within needs identification and prioritisation
- access to resource people who can assist with analysis of information and needs analyses for example demographers, epidemiologists etc.
- limited skills and experience in evaluation and monitoring and limited access to external people with these skills
- contractual specifications and monitoring frameworks from funding bodies that may not be consistent or appropriate for use with a COPC model
- funding systems which do not adequately support the COPC model at this time.

Funding constraints have been discussed earlier in this paper. I believe that capitation for primary medical care (general practice) services (providing the issues around funding formula, registration / enrolment and administration are adequately resolved) is the funding mechanism that is most appropriate for use in Māori providers and the COPC model. Funding for community health programmes and other components of Māori primary care services (and COPC) require review. New Zealand, when compared with other OECD 16 countries, currently spends a relatively small proportion of its Vote Health on primary care (39, 40). The incorporation of community health programmes and population-based approaches will require increased primary care funding. This may be achieved by reorienting funding from secondary and tertiary services. Removing the ringfence from public health funds may also be necessary. The ringfence on public health spending means that this money is not available to primary care services. However given that many of the community health programmes can be viewed as public health activities the validity of maintaining this ringfence is questionable. It should be noted that I am not recommending those funds for public health activities such as disease surveillance and environmental health is removed from the public health ringfence. These activities are beyond the scope of this paper.

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