

Primary Health Care On The West Coast

Kotahitanga
(Working Together)

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2006 - 2009

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Executive Summary

This plan brings together the West Coast DHB's planned initiatives for the primary health sector in a range of service areas over the next few years. It provides a platform on which to build a comprehensive strategy for the development of primary and community health services, to complement the current reconfiguration of specialist and secondary care services.

West Coast DHB faces a double challenge in delivering primary health care: communities with poorer than average health, combined with greater than usual difficulty in delivering services.

A higher than average need for services

- West Coast residents on average die younger and experience higher rates of many illnesses and injury, in part related to the higher than average levels of socio-economic disadvantage in the West Coast population. Poorer health is also more evident in the Māori population
- Primary health care, including screening for illness, early diagnosis and treatment, and good ongoing management of chronic illnesses is effective in keeping people fit and healthy and in reducing the need for more complex health and support services
- Access to good primary care is particularly important for poorer people and for Māori, as these groups are less likely to use primary health service except in emergencies, more likely to have emergency admissions to hospital and more likely to die prematurely
- If the overall poor health status of the West Coast population is to change, we have to make sure that those at most risk of ill-health get the primary care they need
- If we are to meet the coming challenge of an ageing population, we need to make the very best use of the health dollar and to emphasise prevention and early treatment, to keep people as fit and healthy for as long as possible

The challenges in delivering primary health services

- The West Coast contains a small population scattered in widely dispersed communities over a huge geographic area, with people cut off relatively often from the larger centres by weather. Problems in accessing services are exacerbated by West Coast residents' lower access to cars, phone or private care
- Small, scattered and non-affluent communities mean all health service providers, whether DHB, private or voluntary, find it difficult to maintain a viable operation
- Ongoing difficulty finding and keeping health workers due to professional isolation and greater pressure to be on-call

The need for innovative solutions

We believe that this double challenge must be met with innovation. The West Coast DHB, the most rural in the country, intends to be a Centre of Excellence for rural health services in New Zealand. That means that we intend to use the culture of innovation and self-reliance that exists on the West Coast to develop solutions to the problems inherent in providing primary health services in a rural and isolated environment.

The West Coast DHB's Primary Health Plan 2007-2012 aims to build on existing innovations and strengthen primary health services by:

Giving a stronger focus to primary health services

Strong, effective primary health services are central to the West Coast's health service. Good primary services help people stay healthy by identifying and dealing with illness and disability before they worsen. This health maintenance role will become more important as the population ages and more people are at risk of illness, putting pressure on specialist and hospital services. This change in focus is signalled in the current plans for reconfiguring Grey Base Hospital.

Moreover West Coast DHB must develop its primary health care services and make it easier for high-risk people to use these services, if we are to reduce the differences in health and life expectancy between rich and poor, and between Māori and non-Māori.

The West Coast Primary Health Organisation (PHO) is the main vehicle for tackling health inequalities, improving access and ensuring high quality services are provided by primary health care.

More emphasis on prevention and on early diagnosis and treatment in primary care

This is evident in a number of service areas – West Coast DHB's Chronic Conditions Management Strategy, the various initiatives of the West Coast PHO, and the plans for developing child and youth health services, primary mental health services and older people's services.

Improving primary health services for Māori

The DHB is strongly committed to improving Māori health and thus addressing the inequality of health outcomes that Māori endure. Strong themes are on Māori workforce development, improving the quality of mainstream service delivery and developing care pathways that facilitate an appropriate mix of mainstream and Māori-specific services to respond to patient need. In addition the DHB is strongly committed to working with and knowing its Māori communities, these include local Iwi and also Maata Waka groups throughout Tai O Poutini.

Proactive recruitment of health professionals

The West Coast has the lowest ratio of GPs to patients of any area in New Zealand. West Coast DHB is one of the rural sites for undergraduate placements for Otago Medical School, and will develop this collaboration further. West Coast DHB will also develop its post-graduate training programme in rural general practice. The approach to rural medical education is paralleled by developments in nursing, and we intend to develop a role as the place where a whole range of health professionals trains in the rural or generalist aspect of their professional practice.

Breaking down the professional silos – more generalist nursing roles

West Coast DHB will continue to reduce unnecessary boundaries between primary care professionals by developing more generalist roles. The well-developed Rural Nurse Specialist role provides a template for the development of other generalists. The Neighbourhood Nursing Pilot is another example that will be extended.

Strengthening rehabilitation in the community

Most effort so far has gone into maintaining and strengthening the primary medical and nursing workforce. However there is growing recognition of the importance of the allied health and carer workforce in providing the rehabilitation and support services that keep people fit and healthy and avert the need for acute health services or long-term residential care.

West Coast DHB is working on a new model of care for home-based and residential services, to link them more closely to primary health services and ensure a greater input of allied health and specialist nursing skills. This implies a need for strengthening the allied health workforce and upskilling the paid carer workforce.

Integrating clinical care – specialist outreach and support for primary care

To meet the increasing demand for health-care of the aging population, it is critical that specialist services work closely and smoothly with primary and community-based services. We must retain the critical mass needed to maintain specialist services, in order to provide direct patient services and to provide the advice, consultation and training needed by the primary care sector.

Outreach initiatives include the specialist outreach nurses, the growing role for specialist Health of Older Peoples Services in supporting community-based care, the primary mental health liaison service, and the child health generalist paediatrician.

Organisational integration of primary health, secondary services and long-term support

West Coast DHB is developing some different organisational structures to ensure that people have a smooth path into specialist services and back home again, and that workers in all these sectors are communicating well.

Buller Health, which combines local hospital, general practice and community-based services into one integrated local service, is an example of integration that will be further developed. A similar model of care is being developed for Reefton.

The Community Coordinating Service will link up primary, hospital and long-term support services by acting as a single point of entry for referrals from all these services.

IT support for new models of care

We will further develop IT solutions to link up primary, specialist and community services, and support clinical care in a range of settings. Likely initiatives include expanding telemedicine activity, extending PrISM wide-area network to more providers, and considering the implementation of the InterRAI standard assessment tool for older people.

Conclusion - common themes

West Coast DHB is developing new models of care in primary health to meet the unique challenges of the West Coast and its health needs. Key themes of these models are:

- Giving everyone a fair go - addressing the inequalities in health and disability
- Moving upstream – tackling problems early before they get worse
- Health workers learning from one another across the different healthcare settings and professions, without losing their own expertise

- Making it easy for people to get the care they need, wherever they are
- More porous boundaries – between the hospital and the general practice, the general practice and the health promotion worker, the rest home and the community nurse
- Solid technical backup to support the new models

These themes will form the base of the further development and strengthening of primary health and community-based services, as West Coast DHB moves to reconfigure its secondary and specialist services over the next few years.

1. Introduction

1.1 Purpose, scope and timeframe of the plan

This plan is intended as an initial overall framework for West Coast DHB to guide the development of primary and community services over the period 2007-2012.

Over the next two years we will develop this plan further into a comprehensive strategy for the full range of primary and community-based services, to complement the current reconfiguration of specialist and hospital services (the Grey Base 2020 project).

1.2 How the plan was developed

The plan has been developed collaboratively with people working in the sector and West Coast Primary Health Organisation (PHO).¹ It has been through a long complex process of gestation over the past couple of years. During this period we also prepared other detailed plans that have included changes to primary health – including:

- Te Kaupapa Hauora Māori / Māori Health Plan 2006-2010 (2006)
- The West Coast Chronic Conditions Management Strategy 2006-2009 (2006)
- West Coast Improving Services for the Elderly 2006-2016 ('WISE plan', 2006)
- Primary Mental Health Strategic Plan (2005)
- Child Health Plan 2006
- Youth Rangatahi Plan 2006-2009 (2006)
- Draft Secondary Care Plan (2007)
- Disability Strategic Action Plan 2004-2010 (2004)

This final version of the Primary Health Plan brings together all the thinking and planning that has happened in primary and community-based services over the past couple of years, to show the themes that have emerged. These related plans will be referenced where they relate directly to primary care.

(Suggested) A more detailed background paper describing the current primary health care services, issues and background information will be available at the West Coast DHB website (www.westcoastdhb.org.nz) (*the original big paper, tidied up – yet to be done*)

2. The challenges

West Coast DHB's region is distinctly different from those of other DHBs: it covers a large geographical area, has a sparse population, rugged terrain, many isolated areas, high deprivation and low socio-economic status. These attributes make the West Coast one of the most difficult and expensive areas in New Zealand for any public or personal health service to be delivered.

¹ See Appendix 1 for a list of contributors

Moreover, the high rate of deprivation means that the West Coast population has one of the highest rates of illness and injury in the country and so some of the greatest need for effective and accessible primary health services.

2.1 Higher than average rates of illness and injury

The 2001 West Coast Health Needs Assessment showed clearly the higher levels of illness and injury on the West Coast compared to the national average. This was also confirmed by West Coast DHB's analysis of the health needs of older people, and by many national studies.²

- 2.1.1 Poorer health and shorter life expectancy** - West Coasters on average die younger and experience higher rates of many illnesses than other New Zealanders, including cancer, diabetes, cardiovascular disease and respiratory disease. West Coast men in particular have higher rates of death and illness than the New Zealand average. Residents of the West Coast have the second lowest life expectancy of any region in New Zealand. Children and young people on the West Coast have poorer than average health, especially in terms of dental health, immunisation, smoking and usage of alcohol and other drugs.
- 2.1.2 The impact of deprivation** - poor health is closely linked to high levels of deprivation. The West Coast has the lowest levels of income and educational qualifications in New Zealand. Median personal income is about three-quarters of the national average and a third of the population aged over 15 years has no qualification (compared to about a quarter nationally). West Coasters have relatively less access to cars and phones, which has an impact on accessing services.
- 2.1.3 High rates of injury** - West Coast men have roughly twice the likelihood of death from injury as New Zealand men as a whole. The West Coast has the highest rate of motor vehicle crashes per head of population in the country. Deaths and injury from work-related accidents are also more common than average, with a high proportion of men involved in high-risk jobs such as farming, forestry, mining and fishing.
- 2.1.4 Added disadvantage for Māori** - the Māori population has higher than average rates of death and illness for many conditions, including diabetes, cardiovascular and respiratory disease and lung cancer. This is related to higher rates of deprivation and smoking among Māori but is also independent of this. Māori are disproportionately represented in the older low-income group with chronic illness. In contrast to the rest of the population aged 65 or more years, life expectancy for older Māori did not increase during the 1980s and 1990s and the disparity in health between older Māori and non-Māori has widened. Among men in their 50s and women in their 50s and 60s, Māori are roughly three times more likely to die than non-Māori.
- 2.1.5 Access to effective and preventive/early primary care is critical** – the rising life expectancy over recent decades, particularly among older higher income groups, shows what can be done with lifestyle changes (e.g. stopping smoking) and effective primary care (e.g. hypertension medication, flu vaccination, diabetic

² See References section at the end of this paper for the sources of information for this section

eye checks etc). The challenge for West Coast DHB is to ensure that these are taken up by other groups, particularly low-income people and Māori

2.1.6 Low uptake of preventive primary care by high-risk groups – poorer people did not experience the same level of improvement in health and life expectancy as the overall population during the 1980s and 1990s, and the disparity in health between the advantaged and disadvantaged grew during this period. Disadvantaged groups, including Māori, are less likely to use primary health services except in emergencies, more likely to have emergency admissions to hospital and more likely to die prematurely.

2.1.7 Growing numbers of people needing services – as the population ages, the number of people needing primary health and community-based support services will increase, particularly for chronic diseases.

If we are to meet the coming challenge of an ageing population, we need to make the very best use of the health dollar and to emphasise prevention and early treatment, to keep people as fit and healthy for as long as possible.

If the poor health status of West Coast residents is to change, we have to make sure that those most at risk of ill-health, injury and disability get the primary and preventive care they need.

2.2 The challenges of delivering primary health care

2.2.1 A small population in a huge geographic area - the population is scattered over a huge area in tiny widely dispersed communities. About 41% of the population live rurally (compared to 15% nationally). Only 64% of West Coast residents live within 60 minutes ("the Golden Hour") travel by car from secondary hospital services. Almost all the population live at least 3 hours drive from the tertiary hospital at Christchurch. There is very limited public transport, the cost of travel is high and people can be cut off from the larger centres, such as Greymouth and Christchurch, relatively often by bad weather.

2.2.2 Viability problems – many communities are small, scattered and relatively poor and it can be difficult for private providers, such as general practitioners, pharmacists, dentists or physiotherapists, to establish a viable business. It is also difficult for voluntary organisations, such as support groups and welfare agencies, to maintain operations. The DHB faces the same issue, as the cost of providing primary health services often exceeds the income available through the Ministry's funding formula. The sparseness of population also makes it harder and more costly for the PHO and Community and Public Health to deliver proactive health promotion campaigns.

2.2.3 Difficulties in finding and keeping health workers – the West Coast has the fewest GPs per heads of population of all DHBs – in 2002 there were 52.8 active GPs mainly engaged in general practice per 10,000 people on the West Coast compared to the national average of 78.1 GPs per 100,000 people.³ Turnover has been high among GPs, which has made it difficult for people to get good continuity of medical care.

³ Brabyn, L. and Barnett, R (2004). 'Population need and geographical access to general practitioners in rural New Zealand', *The New Zealand Medical Journal* 10 September 2004, Vol 117 No 1201, URL <http://www.nzma.org.nz/journal/117-1201/1063/>

All primary care health professionals are likely to be called upon to perform a wider range of services than their counterparts elsewhere. Moreover they are likely to be required to do this in greater professional isolation from their colleagues, and with patients whose needs are likely to be higher. Health workers face greater pressure to be on-call, as well as fewer opportunities for family members to find work.

Thus, recruiting and retaining GPs, nurses, allied health staff and other health workers are an ongoing difficulty for all West Coast service providers. The small service size means that losing one individual can have a significant impact on service provision in an area.

Recruitment and retention problems tend to follow a roller-coaster pattern, with an overall trend towards greater difficulty, particularly as many professions fragment into subspecialties.

2.2.4 Impact of seasonal tourist influx – an average of 3,000 tourists arrives on the Coast each day, often more in peak seasons. Overseas visitors' use of primary care and A&E services is significant. This poses a particular challenge for the DHB as we need to plan for the capacity to deal with a population that is distributed differently from the resident population, both geographically (more in South Westland) and in an annual cycle.

2.3 The opportunities

However the unique characteristics of the West Coast also offer opportunities, including:

- A long-standing tradition of self-reliance and innovation
- A long tradition of working together across boundaries to make things happen
- A relatively stable local nursing and pharmacy workforce in recent years, creating a platform on which to base innovation
- Recent improvements to the mix of GPs working on the West Coast. The West Coast DHB is the main provider of general practice services and the main employer of GPs. Since 2004 vocationally registered GPs have been classified as Senior Medical Officers and where they are employed by a DHB they are on the MECA pay-scale, which compares favourably with market rates for salaried GPs
- The small size of local communities and of the health and support services means that innovations can sometimes be put in place relatively quickly and easily
- Having a single Primary Health Organisation makes it easier to collaborate and coordinate
- Well-established active inter-sectoral dialogue among the DHB, local councils, Tai Poutini Polytech and other local and government organisations
- A good collaborative working relationship between CPH, DHB and PHO

3. Changing models of health care

3.1 The national policy context

Three themes emerge from national health policies over recent years:

- **Moving upstream** – the importance of preventive measures and of early diagnosis and treatment, and the importance of the social and economic causes of ill health and disability
- **Integration** – reducing the organisational and professional silos between services, to create a streamlined ‘continuum of care’ that includes primary health, specialist and hospital services, community services, long-term support services and health promotion
- **Innovation** - breaking down the professional and service boundaries to find new models of care and combinations of services and skills

Moving upstream - Government health strategies for at least the past fifteen years have focused on moving the point of intervention in a person’s illness away from the highly specialised end of the continuum of care towards the public health end. Reasoning has been that this results in better outcomes for communities and for individual patients, while resolving their health problems in a less resource-intensive way, and thus making the health dollars go further.

This is reflected in the national strategies for a wide range of health services, including primary health, older people’s health, child and youth health, Māori health, mental health etc.⁴

This is a compelling logic. While there is a difficulty in implementing the strategy without hump funding for the West Coast (at least initially, keeping people out of hospital beds costs money in community services without reducing any costs in secondary care) this logic is nowhere more applicable than on the West Coast.

In an area the size and shape of the West Coast, hospital-based services are simply going to be too far away from communities as a basis for a health strategy. The backbone of a health service response to people’s need must therefore be in public health and community-based services.

Integration – this is reflected in the ‘ageing in place’ strategy, where primary and specialist health services work with long-term home and residential support services and health promotion services to keep older people as fit and healthy for as long as possible in their own homes.

Innovation and breaking down the professional silos – examples of this are innovations in primary health nursing and the restorative models of homecare.

3.2 Our aim - to be a centre of excellence for rural health services

West Coast DHB’s Primary Health Plan reflects the West Coast DHB’s aim to become a centre of excellence for rural health. West Coast DHB’s Strategic Plan 2002-2012 aims for a health service where:

- Prevention of illness and injury is paramount
- There is a meaningful commitment to the idea of “children are the future” with a range of co-ordinated services to keep children well and safe: Mo tatou a mo nga uri a muri ake nei - for us and our children after us

⁴ See Appendix 3 for a list of these national strategies.

- Residents will have access to affordable, equitable, quality primary health care near to where they live
- Primary health care will be provided by multi-disciplinary teams of trained and experienced primary care providers
- Residents have access to specialist health services at the same rate as people in other regions
- Inequalities in health outcome are constantly reducing
- The DHB works collaboratively with other local authorities to ensure physical, social and cultural environments promote and supports the inclusion of people living with disabilities and enable their independence
- Innovative solutions to providing services in our unique rural environment are implemented
- Residents will have access to services that help them remain in their own homes for as long as possible
- Rural health workforce communication / information technology will be used to improve communication in rural communities

Appendix 1 shows the range of services available in West Coast districts and communities in 2006.

4. A Plan for Primary Health Services on the West Coast

To achieve this aim of excellence in rural health services, West Coast DHB's various plans for service changes share a number of common themes:

4.1 A stronger focus on primary and community health care

Strong, effective primary health services are central to the West Coast's health service if we are:

To meet the coming demand on services - good primary health care helps people stay healthy and fit by identifying and dealing with illness and disability before they worsen. This health maintenance role will become increasingly important as the population ages and more people are at risk of illness and disability, putting increasing pressure on specialist and hospital services.

To address inequalities - West Coast must develop its primary health care services and make it easier for high-risk people to use these services, if we are to reduce the differences in health and life expectancy between rich and poor, and between Māori and non-Māori.

4.1.1 The West Coast Primary Health Organisation - the West Coast PHO is the main vehicle by which the West Coast DHB can tackle health inequality, improve access and ensure high quality services in primary health care.

The West Coast PHO, established in 2002, ensures that the community gets the first level care required, by contracting with primary care providers (medical centres or general practices) around the West Coast, and by subsidising for patients the range of health services such practices provide. The PHO also funds health programmes that improve access for the disadvantaged and that target health priorities (such as chronic conditions).

The PHO now has a much greater local focus. The PHO has developed its own vision, focusing initially on what it can do to improve health care for those with chronic conditions. The PHO is in the process of developing its local infrastructure and capability, its networks and reputation.

The DHB's emphasis now is on working collaboratively with the PHO on shared priorities. Neither the DHB nor the PHO will be able to achieve their respective objectives without each other, given the importance of primary care on the Coast.

4.1.2 Reorienting specialist and secondary health care services - primary and community health services must be strengthened and linked more effectively with specialist and hospital services, because the latter will not cope alone with the increase in people with chronic illness and disabilities that we can expect over the next few decades. It is critical to change the focus away from patching people up when they are sick to helping them stay well and dealing with disease and disability to prevent them worsening.

This change in focus is signalled in West Coast DHB's plans for the reconfiguration of Grey Base Hospital (the Grey Base 2020 project) which is

aimed at strengthening the specialist role of secondary services and ensuring they can give support to the primary health sector. (See Secondary Care Plan⁵)

4.2 More emphasis on prevention and on early diagnosis and treatment

4.2.1 The role of the PHO – a key role of the PHO is to develop and implement programmes to improve West Coasters' access to preventive health services such as screening and health checks (e.g. cancer and diabetes screening, blood pressure and cholesterol), immunisations (e.g. childhood and flu), smoking cessation programmes and other initiatives.

This is being done in conjunction with health promotion initiatives being implemented by Community and Public Health, the West Coast DHB and other organisations, such as the Healthy Eating and Healthy Action (HEHA) project, falls prevention programmes and the Neighbourhood Nursing project. The boundaries between primary health care and health promotion are becoming increasingly porous.

4.2.2 Better management of chronic conditions – if people are helped to manage their chronic conditions (e.g. cardio-vascular disease, diabetes and respiratory disease), they are less likely to develop acute illness or complications (e.g. kidney failure, circulatory failure, stroke, blindness etc). The PHO and the DHB are collaborating on a joint programme of work that covers both primary and secondary services to improve this management of chronic conditions, starting initially with cardiovascular disease and diabetes.⁶ The main themes of the West Coast's Chronic Conditions Management Strategy 2006-09 are:

- Link work and funding streams, to enable chronic conditions to be better managed across primary and secondary care, including developing multi-disciplinary teams crossing sectors, as well as evidence based guidelines and pathways of care
- Involve Māori in decisions around chronic conditions management
- A stronger health promotion role for primary health services
- Establish cardiovascular risk screening, regular reviews of high-risk people
- Specialist nurses (cardiac, diabetes, respiratory), supporting primary and hospital services
- Set up cardiac rehabilitation services
- Support for self-management – training, resources, support for voluntary organisations
- Good information systems to support the changes

4.2.3 Strengthening child health and youth services – services for children and young people have a strong focus on prevention and on collaboration with

⁵ West Coast DHB (2006) *Draft Secondary Care Plan*, 31 December 2006

⁶ West Coast DHB (2006). *West Coast Chronic Conditions Management Strategy*

voluntary and community organisations. Examples of this from the West Coast DHB's child and youth health plans⁷ include:

- A range of measures to improve the poor dental health of West Coast children
- Measures to improve nutrition, including breast-feeding, Healthy Eating Healthy Action projects, and Fruit in Schools projects
- Improving immunisation coverage through an outreach service
- Supporting the implementation of Family Start programmes for parent support, as well as better access to family counselling services
- Implementing a hospital response to family violence
- Intersectoral work to improve road safety, the main reason for young people dying
- Encouraging the PHO to extend the free contraceptive service, and other measures to improve access to sexual health services
- Include young people in plans for developing primary mental health services
- Intersectoral action to help reduce rates of smoking and alcohol and drug use

4.2.4 Establishing a primary mental health service – many people seek help from their general practice for mental health problems. Recognising the gap in affordable services for people with mild to moderate mental illnesses, West Coast DHB is implementing a plan for a primary mental health service.⁸ Key aspects of this service are:

- A mobile Brief Intervention Service, offering short-term counselling
- Working with other agencies to strengthen family counselling services
- A liaison service to provide training and support for primary practitioners in managing patients with mental illness (see section 4.7.3)
- Exploring ways of reducing access problems, and the feasibility of a Māori Health liaison worker

4.2.5 A more proactive and preventive focus for older people's services – the West Coast DHB's plan for community-based support services for older people is to change the focus towards actively helping the older person retain their health and fitness. This will be done through falls prevention programmes, smoking cessation, promotion of healthy eating and physical activity, help with socialising, and active rehabilitation.

The vision is that all health and support workers involved with the older person, whether GP, practice nurses, district nurses, home carers or residential care staff, will work together to reinforce this approach.⁹

4.3 Reducing inequalities for Māori

⁷ West Coast DHB (2006) *Child Health Plan 2006*; West Coast DHB (2006) *Draft Youth Rangatahi Health 2006-2009*

⁸ West Coast DHB (2005) *Primary Mental Health Strategic Plan*

⁹ West Coast DHB (2006) *West Coast Improving Services for the Elderly 2006-2016* and West Coast DHB (2007) *Caring for Older West Coasters – a change in focus*

A strong primary health care system is central to improving the health of New Zealanders and, in particular, to removing inequalities in health. The implementation of the Primary Health Care Strategy provides an opportunity to positively affect outcomes for Māori: avoidable hospitalisations, avoidable mortality and chronic care management.

The overall aim for Māori health is whanau ora. As a principal source of strength, support, security and identity, whanau plays a central role in the well being of Māori individually and collectively.

Primary health care services need to be receptive to the needs of Māori. This means primary health care services need to be delivered to Māori in a way that is culturally acceptable and appropriate for Māori. In addition, services need to comprehend the very real health inequalities that exist between Māori and non-Māori on the West Coast.

Ultimately this will indicate that a skilled and appropriately trained workforce be accessible to meet the needs of Māori in the district. The 'whanau ora'¹⁰ service model needs to be recognised and delivered with an appropriate range of services in existence to meet the needs of Māori in the district.

Within the Māori Health Strategy there are six areas that relate directly to primary health care: immunisation, hearing, smoking cessation, diabetes, asthma and injury prevention¹¹

The West Coast DHB's Strategy for Māori health outlines a number of ways in which primary health services will be changed to address the health inequalities faced by Māori. These include:

4.3.1 Increasing investment in Māori health - particularly in areas where inequalities is highest. Examples of this are:

- Rata te Awhina Trust's role in providing a holistic service for whanau ora across the West Coast, including Mother and Pepi, Tamariki ora, Whanau ora, Disease State Management Nursing and mobile primary health nursing services. Cervical screening services, Breastscreen Aotearoa educators and asthma education are also provided. In addition Rata Te Awhina Trust offers a wide and diverse range of free social services available to everyone, including: whanau support, counselling, abuse counselling, budgeting, parenting programmes, youth self esteem and school support
- **The Māori Cervical Screening Health Promoter/Smear Taker and the Māori Immunisation Outreach Service Community Worker**
- The Reefton-based Whānau Nurse (see section 4.5.2)

4.3.2 Monitoring Māori access to primary health services – to ensure that Māori are accessing primary health care, particularly preventive programmes, screening, early diagnosis and management of chronic conditions. The West Coast DHB will continue to monitor health status indicators and the utilisation of primary health services by Māori to see if programmes are having an effect on access and on health. These programmes may be delivered by both Māori providers and mainstream services, and responsibility lies with both the PHO and the DHB to ensure that access improves.

¹⁰ Ministry of Health (Manatu Hauora) (2002) *Whakatataka / Māori Health Action Plan 2002-2005*: Foreword; piii. Wellington: MoH Ministry of Health (Manatu Hauora).

¹¹ West Coast DHB (2006) *Te Kaupapa Hauora Maori – Maori Health Plan 2006-2010*

4.3.3 Working in partnership with Māori to prioritise services

4.3.4 Supporting the development of Māori workforce and services in primary health care. Examples of this are Rata Te Awhina and the Reefton whanau nurse.

4.3.5 Supporting Māori staff working within mainstream primary health services

4.4 A proactive, collaborative and innovative approach to workforce issues

Finding and keeping general practitioners, community nurses and other primary health professionals has been the most crucial issue facing the West Coast DHB. This has been alleviated in recent times, in part by the DHB's decision to take on responsibility for the management of several general practices for which it has been difficult to recruit medical staff. This has enabled the DHB to explore greater flexibility in how services are run and delivered.

However recruiting and retaining medical and other health professional staff is an ongoing problem that West Coast DHB has been tackling in several ways, including a focus on training:

4.4.1 Rural GP training - to ensure the long term recruitment and retention of general practitioners on the West Coast, the Board has supported the establishment of a Postgraduate Rural GP Training Programme. This expands our role of training fifth year medical students, will support our hospital Resident Medical Officer (RMO) workforce, enables those who enjoy the Coast lifestyle to stay on in GP training positions and will create the rural workforce that this and other DHBs require.

There is currently no specific rural general practitioner training programme in New Zealand. Our population and health services make our district ideal for such training. There is no centre in our district with a population greater than 10,000 and our three hospitals offer very different configurations. Our community offers a wide spectrum of disease, socio-economic deprivation and health care needs that are ideal for training purposes.

Training programmes benefit not only those being trained but also their supervisors. Our senior GPs are able to maintain links with academic colleagues. The students bring their new knowledge with them and the GPs can pass on their extensive skills and experience.

Our training programme uses the education resources available through the Royal New Zealand College of General Practitioners (RNZCGP), Universities of Otago and Auckland and the Australian College of Rural and Remote Medicine (ACCRM). That academic excellence, matched to our hands-on healthcare experience, should be a winning combination. (See Appendix 4 for more information)

4.4.2 Other training initiatives - the approach to rural medical education is paralleled by developments in nursing, and the intent is to develop a role as the place where a whole range of health professionals undertakes their training in the rural or generalist aspect of their professional practice.

- **Scholarships and incentives** - the West Coast DHB has a pilot programme of scholarships and financial incentives for trainees. The programme has two aims: to encourage young West Coasters into health careers, and to attract graduating health professionals to come and work on the West Coast. Future directions will include strengthening our relationship with secondary schools to identify and foster appropriate prospects at an early stage and to guide them appropriately, and broadening our approach to include other occupational groups in short supply.
- **Upskilling the long-term carer workforce** – West Coast DHB is exploring ways to enable the upskilling of the carer workforce, both home-based and working in residential care, to link them more closely with the primary and community health workers looking after the client, such as community allied health, district nurses and general practices.¹²

4.5 More generalist nursing roles - breaking down the professional silos

The West Coast DHB has been innovative in developing nursing roles to fill the recurring gaps left by a scarcity of GPs in the more remote areas. This recognises the relative stability, skills and experience of the local primary and community nursing workforce, including public health nurses, practice nurses, district nurses, Plunket nurses and occupational health nurses.

The generalist nursing initiatives build on the skills of these various community nursing roles to create new generic positions that combine the skills of the various community nursing specialities. These new roles include the Rural Nurse Specialist, Whanau Nurse, Neighbourhood Nurse, Nurse Practitioner and Clinical Nurse Specialist.

This move towards breaking down professional silos also counters the ongoing trend in all health professionals towards fragmentation in sub-specialties. While this fragmentation undoubtedly improves specific skills, it presents a challenge for a rural area such as the West Coast. Developing generalist skills enables us to respond more quickly and effectively to the needs of the population. The challenge is how to do this while still maintaining professional competencies.

4.5.1 Rural Nurse Specialists (RNSs) - for many years nurses have provided community, primary health and acute care services to rural and remote West Coast populations, often with limited access to immediate general medical support. The Rural Nurse Specialist (RNS) position was created in the early 1990s in response to this unique service demand and in recognition of the need for more formalised systems and advanced training support for nurses working at the boundary of their scope of practice.

The RNSs work in nine primary health clinics spanning the West Coast from Karamea to the Haast. RNSs undertake assessment, diagnosis and treatment of personal health problems in collaboration with medical practitioners or under the guidance of standing orders. They provide a nurse-led comprehensive primary health care service and carry on-call responsibilities for 24 hours per day, 7 days per week acute health care services to a geographically defined population. They

¹² See West Coast DHB (2006) *West Coast Improving Services for the Elderly*

also provide management of chronic disease states, rehabilitation, palliation, health promotion and health protection services to a population.

The contemporary RNS is Primary Response in Medical Emergency (PRIME) trained, holds qualifications in advanced health assessment and life support and is working towards postgraduate advanced nursing practice qualifications.

4.5.2 The Whānau Nurse - this 0.5 FTE position with a focus on the Māori community was set up in Reefton as part of the Neighbourhood Nurse pilot. The Whanau Nurse provides nursing care that addresses the health needs of a caseload of individuals, families/whanau, schools and groups in a specific community. Care is provided across the lifespan on a continuum encompassing health promotion, disease prevention and disease management. This role carries a particular (but not exclusive) focus on the needs of the local Māori community. The roles of the Whānau Nurse include:

- Assisting local communities to achieve their own vision of health by supporting community development and undertaking population based public health activities with groups, families/whanau and individuals
- Ensuring notifiable diseases are identified and investigated, and measures put in place to minimise risk
- Contributing to optimum health outcomes for the designated population by providing health promotion/protection services

This position is being evaluated as part of the overall evaluation of the neighbourhood nurse pilot.

4.5.3 Neighbourhood Nurses - currently primary health care nursing is provided by several different types of nurse, each with a separate bounded role and accountability (e.g. district nurse, practice nurse, public health nurse). The neighbourhood nurse innovation established a primary health care nurse who provides a comprehensive and integrated continuum of care. The focus is on needs rather than confined by contracts or funding streams and on groups (such as family and neighbourhood groupings) rather than individuals, although the entrée to those groups may come through an individual member in need of nursing care.

The neighbourhood nurses together provide a mix of generalist and specialist skills and seek to refer on when beyond their scope of practice, thus making use of an expanded range of skills and best use of specialist resources. The aim of the innovation is to improve access, reduce inequalities, improve outcomes, reduce travel time for nurses, increase flexibility of care delivery, develop consumer group resources and responses to self care and provide one point of contact for care.

This pilot was trialled for 18 months in Reefton, Dobson and Hokitika in slightly different forms, and is currently being evaluated.

4.5.4 Nurse Practitioners – Rural Nurse Practitioner positions have been considered for the West Coast and have been developed in specific service areas, notably primary mental health. The role of rural Nurse Practitioners is to provide population-based approaches, to improve access for patients and also to offer

real-time collegial support and relief to GPs and Rural Nurse Specialists in rural areas.

4.5.5 Clinical Nurse Specialists and nurse-led clinics – Clinical Nurse Specialists provide nurse-led specialty-focused services across primary and secondary health services. Examples are the cardiac and respiratory nurse specialists, the Health of Older People’s outreach nurse, the sexual health clinical nurse specialists and the cervical screen smear takers. Clinical nurse specialists work in collaboration with general practitioners, hospital physicians and medical specialists to deliver care to assigned patient populations with particular needs.

Rural Nurse Specialists (RNS) work from primary health care clinics providing nurse-led comprehensive primary health care services for a geographically defined population in partnership with general practitioners.

These current nurse-led services prefigure models for future development across general practitioner as well as DHB facilities and in future will include Nurse Practitioner-led services.

4.5.6 Changing GP/Practice nurse roles – Westland Medical Centre - the on-going shortage of GPs on the West Coast prompted an expanded practice nurse role within Westland Medical Centre (WMC). Standing orders were developed to facilitate this expanded role and are designed to ensure that patients receive appropriate care in a timely manner for emergency and acute conditions.

The role of the Practice Nurse at WMC is to promote health, provide screening, perform early intervention including acute, emergency and PRIME care, arrange prescriptions and dispense under guidelines contraceptive medication and medication for chronic conditions such as asthma and hypertension. Practice nurses are expected to be familiar with the target goals for chronic medical conditions such as diabetes, asthma and hypertension and refer their patients for management review by the general practitioner if these targets are not met.

Standing orders have allowed a reasonable after-hours call roster and effective primary care provision with a limited number of general practitioners. Nurses issuing standing orders must accept that they are responsible, accountable and therefore legally liable for their actions. As standing orders cannot cover every clinical ramification the nurses’ use their professional judgement and experience. The medical practitioner issuer of these standing orders is responsible for reviewing and updating the orders to ensure that they remain evidence based.

4.6 A community rehabilitation focus

While the main focus so far has been on maintaining and strengthening the medical and nursing workforce for primary health care, increasing attention is now being given to the importance of good community-based rehabilitation and support services in keeping older people fit and healthy, and averting the need for acute health services or long-term residential care.

This implies greater attention to the skills and role of allied health professionals (including occupational therapists, physiotherapists, social workers, speech language

therapists, psychologists and dieticians), both in terms of the expertise of the individual profession and the impact of the multi-disciplinary team.

West Coast DHB is working on a new model of care for home-based and residential services, so that they are more closely linked to primary health services and have a greater input of allied health, rehabilitation and specialist nursing skills (e.g. wound care, continence, dementia care, stroke rehabilitation).

The needs assessment process for older people is also likely to be linked more closely to the primary health care team, through the Community Coordinating Service (see section 4.8.3).

4.6.1 Strengthening the community allied health workforce – the increased importance of rehabilitation has implications for the development of community allied health services, which need to be addressed in a systematic way. A number of issues need to be explored, such as how small allied health departments can maintain professional competencies and supervise staff who are also part of multi-disciplinary teams in outlying areas.

The possible common ground among the different allied health and rehabilitation professions could be explored, to strengthen their role in primary and community care services.¹³

4.6.2 A new role for home and residential care workers – the moves towards a stronger focus in long-term support services on rehabilitation and on preventing and mitigating illness and disability implies a more skilled carer workforce, and one with stronger links to community allied health and nursing professionals through training and supervision, as well as closer links to the primary health care services.¹⁴

4.7 Integrating services - specialist outreach and support for primary care

If we are to meet the challenge of the aging population and the increase in people needing health care in coming decades, it is critical that specialist services work more closely and smoothly with primary and community-based services. It is important to retain the critical mass of resources needed to maintain an expert specialist service, both to provide direct patient services and to provide the advice, consultation and training needed by the primary care sector.

Examples of outreach activity now in place include:

4.7.1 Outreach nurses for chronic conditions management – the establishment of cardiac, respiratory and diabetes clinical nurses specialists to work with primary health services to improve care and minimise the need for inpatient admission.

4.7.2 Specialist support for community and home-based rehabilitation – the planned changes to older people's services, with a greater rehabilitation focus in

¹³ See, for instance Services for Australia's Rural & Remote Allied Health (SARRAH) at <http://www.sarrah.org.au/>

¹⁴ See West Coast DHB (2006) *West Coast improving Services for the Elderly*

home-based and residential services to keep people well and reduce unnecessary hospital admissions, will entail greater input from specialist Health of Older People's service staff, particularly allied health and nursing.

4.7.3 Mental health and Alcohol and Other Drug Liaison Service – this service is intended to support primary health practitioners with the assessment and management of people presenting to primary health services with mental illness. This is particularly to help with the larger number of people with mild/moderate mental illness. Support includes training and additional funding.

In addition West Coast DHB is exploring ways of establishing shared care arrangements between specialist and primary services, for those people with severe and long-term mental illness, to improve the transfer of care when people leave specialist treatment.¹⁵

Examples of proposed outreach activity include:

4.7.4 Child health generalist paediatrician – the Child Health Plan proposes the going input of a generalist paediatrician into clinical care and community liaison on the West Coast.¹⁶

4.8 Integrating primary, community and secondary services

The West Coast DHB is developing some different organisational structures to ensure that people have a smooth path into specialist services and back home again, and that workers in all these sectors are communicating well. These include:

4.8.1 Buller Health – integrating the health centre and the hospital - the West Coast DHB owns the general practice as well as A&E services, inpatient beds, aged care rest home and hospital level beds and community services (allied health, district nursing, home support, mental health and public health nursing). Most of these are located in a single building (formerly Buller Hospital), but separated by long corridors. Hospital and general practice services formerly had entirely separate reporting lines and organisation.

These have now been combined into a single business unit ('Buller Health'), and new models of care embedded. Work is now under way to examine how the physical facility can best support these models of care, which will probably lead to a case being advanced for capital to undertake this work.

Buller Health is starting to integrate services and procedures with the aim of providing better continuity of care and a sense of seamlessness. Having the medical practice providing doctors' cover to the inpatient unit means that common clinical protocols can be developed and a clinical leadership group monitors and is developing the model of care.

A Buller Health plan has been written, identifying key population factors and critical gain areas and suggesting themes of service delivery improvement. The plan aligns and reflects the overall DHB priorities for health gain and populations, but is specific to the local population.

¹⁵ West Coast DHB (2005) *Primary Mental Health Strategic Plan*

¹⁶ West Coast DHB (2006) *Child Health Plan 2006*

4.8.2 A new model of care for Reefton – Reefton is similar to Westport in that a number of services (hospital inpatient beds, aged care long-term beds and community nursing services) have previously been separately managed and the general practice has previously been in private hands. A model of care is being developed to meet the needs of the Reefton and surrounding community for accessible services and make best use of the existing hospital facilities. It is likely that the model will reflect a similar type of integration as at Buller Health - bringing primary, inpatient and long-term residential and home-based support services together in a way that allows a more flexible use of inpatient beds and more flexible roles for staff. The model is being developed in collaboration with the local community, as well as staff of the existing health services.

4.8.3 The Community Coordinating Service – single point of entry to home-based services - currently the way that people access home and community based services, (such as home help, personal care, carer support, district nursing, community physio, equipment etc) is fragmented and confusing, creating gaps in service and duplication of effort.

The Community Coordinating Service will link up primary, hospital and long-term support services by acting as a single point of entry for referrals from primary health services, hospital wards and the community. It will also support a single clinical record.

This is expected to streamline people's access to home- and community-based services, and ensure that services meet people's needs more effectively.¹⁷

4.9 IT solutions for integrating services

4.9.1 Telemedicine - West Coast DHB is already a significant user of videoconferencing for internal communication, and uses the technology for clinical purposes in mental health and to some extent in paediatrics.

We believe that the further development of telemedicine is of crucial importance to rural areas, and highlight the following areas:

- Peer support, including participation in remote grand rounds, meetings, Clinical Medical Education (CME) sessions
- Training and supervision
- Supporting better decisions about whether to retain a patient on the West Coast or transfer to another centre
- Extending the scope of practice of West Coast based professionals by providing support at the margins

We are very supportive of the project funded by the Ministry to examine the potential of telemedicine to enhance collaboration between an urban DHB and a rural one, and of the particular role played in that project by the Council of Medical Colleges, and look forward to initiatives arising out of the project.

¹⁷ West Coast DHB (2006) *West Coast Improving Services for Older People*

4.9.2 PrISM (Primary Integration Systems Management) – the award-winning PrISM project used the telecommunication infrastructure put in place by the Ministry of Education (to provide broadband communications to schools) to implement a wide area network connecting the DHB's Primary Health Practices and to implement a shared patient administration system for them all. This was done in 2005.

This system is scalable and over time it can be made available to other health providers (GP Practices, NGOs, etc) as well as being applied to other areas of the health system (school based dental services, for example). It is also feasible to make the system available to other DHBs and PHOs.

4.9.3 InterRAI – improving assessment for older people - West Coast DHB is exploring the adoption of the electronically-based InterRAI assessment tool. This national standard tool aims to streamline people's access to home- and community-based services, reduce multiple assessments, enable shared clinical information over primary, community and hospital staff, and enable better management of community and home-based services and expenditure.¹⁸

5. Where to from here?

This plan is an initial collation of the various initiatives planned for the various areas of primary and community-based services.

West Coast DHB is developing new models of care in primary health to meet the unique challenges of the West Coast and its health needs.

Key themes of these models are:

- Giving everyone a fair go - addressing the inequalities in health and disability
- Moving upstream – tackling problems early before they get worse
- Health workers learning from one another across the different healthcare settings and professions, without losing their own expertise
- Making it easy for people to get the care they need, wherever they are
- More porous boundaries – between the hospital and the general practice, the general practice and the health promotion worker, the rest home and the community nurse
- Solid technical backup to support the new models

These themes will form the base of the further development and strengthening of primary health and community-based services, as West Coast DHB moves to reconfigure its secondary and specialist services over the next few years.

What is proposed now is that a formal process be set up to plan for the comprehensive development of primary and community-based services in step with the proposed changes to Grey Base Hospital.

¹⁸ West Coast DHB (2006) *West Coast Improving Services for Older People*

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- *West Coast Strategic Plan 2002-2012* (2002)
- *Disability Strategic Action Plan 2004-2010* (2004)
- *Primary Mental Health Strategic Plan* (2005)
- *Te Kaupapa Hauora Māori / Māori Health Plan 2006-2010* (2006)
- *The West Coast Chronic Conditions Management Strategy 2006-2009* (2006)
- *West Coast Improving Services for the Elderly 2006-2016* ('WISE plan', 2006)
- *Child Health Plan 2006* (2006)
- *Draft Youth Rangatahi Plan 2006-2009* (2006)
- *Draft Secondary Care Plan* (2007)

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Appendix 1 Current Primary Health Care Services

Primary health care services of many types are provided by a wide range of health workers, including general medical practitioners, nurses (practice, district, public health, Plunket, rural nurse specialists), ambulance staff, pharmacists, midwives, dentists, community allied health workers (physiotherapists, occupational therapists, social workers, dieticians, podiatrists, laboratory staff etc), community health workers, as well as by nursing and carer staff in home support services and residential care facilities.

Table A1 shows the distribution of types of primary health workers throughout the West Coast, by district and community.

In addition, West Coast DHB provides the following region-wide services:

Cervical Screening Service - West Coast Regional co-ordination of the National Cervical Screening Programme, based at Grey Hospital with an outreach office at Buller Hospital.

Sexual Health Service - The West Coast DHB Sexual Health service currently has two free health clinics: one in Greymouth and one in Buller. The Sexual Health clinics predominately involve the management of people presenting with Sexually Transmitted Infections (STIs). The service also provides pregnancy testing, emergency contraception, termination referrals, free condoms, sexual health education and counselling. The Buller sexual health nurse has the added responsibility of providing sexual health promotion and education to the Buller Community. The sexual health doctor provides medical management for adult sexual abuse patients.

Immunisation - regular childhood immunisations are provided through all of the primary care practices on the West Coast. There are a number of trained vaccinators who provide these services, some of whom are authorised to vaccinate without a GP present. Year 7 (11 year old) vaccinations are provided by primary care practices. An Outreach Immunisation Service is also now available on the West Coast.

The Immunisation Coordination service (0.65 FTE) provides education, training and support to primary care providers around immunisation, as well as monitoring compliance with the childhood immunisation schedule and cold chain storage and transportation of vaccines. This also includes a Māori Immunisation Community Health Worker. The National Immunisation Register Administrator (1 FTE) registers all newborn babies, reports overdue vaccinations to primary care providers and assists with the monitoring of vaccination coverage rates.

Primary/Secondary Liaison - the GP Liaison role was developed to facilitate integration between the primary and secondary health sector in the West Coast. This involves facilitating the implementation of chronic disease management principles into the local health care system at public health, primary and secondary care level. It also includes improving the provision of elective surgical services, through the development of locally agreed referral guidelines to be used by the primary care sector when referring patients for secondary and tertiary specialist assessment. The GP Liaison also acts a conduit for information and problem solving between the primary and secondary sector.

TABLE A1 West Coast primary health services by location and type, March 2007

Location	Service	Providers	Notes
Buller District			
Karamea	General practice & rural nurse specialist	Karamea Health Clinic	Rural Nurse Specialists act as practice nurse, district nurse, public health nurse etc
	Emergency	St John Ambulance & Karamea Health Clinic (PRIME)	
Ngakawau	Rural nurse specialist	Ngakawau clinic	
	Emergency	Rural nurse specialist - PRIME	
Granity	Emergency	St John Ambulance	
Westport	General practice	Buller Medical Service (DHB owned)	
	Emergency	Buller Hospital A&E & St John ambulance	
	Pharmacy (f)	Buller Pharmacy	Also at Buller Health
	Laboratory tests	?	<i>where are they done/sent?</i>
	Radiology	?	<i>where are they done/sent?</i>
	District nurses (d)	Buller Health	
	Public health nurses (d)	Buller Health?	
	Plunket service	Westport clinic	
	Midwives	Buller Health & independent midwives (b)	
	Dentist	<i>(Currently no dentist)</i>	
	Community allied health	Buller Health - OT, physio, SW	
	Māori Health	Rata te Awhina (c)	
	Sexual health	Clinic at Buller Health	
	Cervical Screening	Outreach office at Buller Health	
Reefton	General practice	Reefton Medical Centre (DHB owned)	
	Emergency	Reefton Hospital A&E & St John ambulance	
	Pharmacy (f)	Masons Healthcare. Also Reefton Hospital	(serviced by Masons Pharmacy Greymouth)
	Laboratory tests	?	<i>where do they go?</i>
	District nurses (d)	Reefton Hospital?	
	Public health nurses (d)	Reefton Hospital?	
	Plunket service	<i>none?</i>	
	Midwives	Independent midwives (b)	
	Community allied health (e)	Visiting OT/PT from Greymouth	
	Māori Health	Whanau ora nurse	

Grey District			
Greymouth	General practice	4 general practices in Greymouth (1 DHB-owned). 1 general practice in Dobson (DHB owned)	
	Emergency	Grey Hospital A&E & St John ambulance	After hours GP service?
	Pharmacy (f)	3 pharmacies in Greymouth	
	Laboratory tests	Medlab South & Grey Hospital	(tests sent to Chch?)
	Radiology	Grey Hospital	
	District nurses (d)	Based at Grey Hospital	
	Public health nurses (d)	Based at Grey Hospital	
	Plunket services	Greymouth clinic & coordination. Cobden, Paroa & Grey valley clinics	
	Community allied health (e)	Grey Hospital - OT, physio, SW, SLT, diet, podiat	
	Dentist/dental therapists	3 dental surgeries	<i>where are dental therapists based?</i>
	Midwives	Grey Hospital & Independent midwives (b)	
	Māori Health	Rata te Awhina (c)	
	Radiology	Grey Hospital	
	Sexual health	Clinic in Grey Hospital	
	Cervical Screen. Coord.	Grey Hospital	
	Immunisation coord. service	Grey Hospital (1.65 FTE)	
GP liaison (Coast-wide)	Grey Hospital		
Moana	Rural nurse specialist	Moana clinic	
	Emergency	Rural nurse specialist - PRIME	
Blackball	Emergency	St John ambulance	
Runanga	Emergency	St John ambulance	
	Plunket clinic	Runanga clinic	

Westland District			
Hokitika	General practice	1 general practice in Hokitika (DHB-owned)	*
	Emergency	St John ambulance & Westland Medical Centre	
	Pharmacy (f)	Westland Pharmacy	
	Laboratory tests	?	<i>where do they go?</i>
	Radiology	?	<i>where do they go?</i>
	District nurses (d)	?	<i>where based from?</i>
	Public health nurses (d)	?	<i>where based from?</i>
	Plunket services	Hokitika clinic	
	Dentists/dental therapists	1 dental surgery?	<i>Where are dental therapists based?</i>
	Midwives	Independent midwives (b)	
	Māori Health	Rata te Awhina (c)	
	Community allied health (e)	<i>Visiting OT/PT/SW from Greymouth?</i>	
Harihari	Rural nurse specialist	Rural nurse specialist clinic	
	Emergency	St John Ambulance & Rural nurse specialist - PRIME	
Whataroa	General practice & rural nurse specialist	Whataroa Health Clinic (<i>DHB owned?</i>)	*
	Emergency	Whataroa Health Clinic - PRIME	
Franz Joseph	Rural nurse specialist	Rural nurse specialist clinic	
	Emergency	St John Ambulance	
		Rural nurse specialist - PRIME	
Fox Glacier	Rural nurse specialist	Fox Glacier clinic	
	Emergency	St John Ambulance & Rural nurse specialist - PRIME	
Haast	Rural nurse specialist	Haast clinic	
	Emergency	St John Ambulance & Rural nurse specialist - PRIME	

Notes	
a	Types of nurses: DN = district nurse, PHN = public health nurse, N = neighbourhood nurse, PI = Plunket nurse, M =midwife
b	Independent midwives provide a hospital & home-based service covering most locations on the West Coast
c	Rata te Awhina provides registered nurses and community workers to provide a service over most of the West Coast for Mother & Pepi, Tamariki ora, Whanau ora, Disease State Management nursing, mobile primary health nursing, cervical screening, Breastscreen Aotearoa educators and asthma education.
d	The practice nurse, district nurse and public health nurse roles are taken by the Rural Nurse Specialist in smaller areas
e	Community allied health: OT = occupational therapy, PT = physiotherapy, SLT = speech language therapy, SW = social work, dietician, podiatry
f	A prescribing service is available through an 0800 number for people who cannot get to a pharmacy

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Appendix 3 The national policy context

The West Coast DHB's Primary Health Plan takes account of the direction of national policy guidelines provided by the Ministers and Ministry of Health. These are available on the Ministry of Health website (www.moh.govt.nz) and include:

The New Zealand Health Strategy (2000)

The New Zealand Disability Strategy (2001)

The Primary Health Care Strategy (2001)

Implementing the Primary Health Care Strategy in Rural New Zealand (Rural expert Advisory group - 2002)

Te Korowai Oranga – the Māori Health Strategy (2002)

Whakatataka Tuarua – Māori Health Action Plan 2006-2011

The Blueprint for mental health services in New Zealand (mental Health Commission, 1998)

The Second New Zealand Mental Health and Addiction Plan for 2005-2015 – Te Tahuhu

[The Health of Older People Strategy \(2002\)](#)

The Child Health Strategy (1998)

Appendix 4 The Rural GP training course

A recent visit from Professor Paul Worley from Flinders University in South Australia gave us additional avenues to work on, including greater involvement of our community in welcoming students/doctors to our district and promoting our local students to the University of Otago's Health Sciences First Year, which is the starting point for Medicine, as well as other health professions: Dentistry, Medical Laboratory Science, Pharmacy and Physiotherapy.

Professor Worley also talked about the 'rural doctors' pipeline' which shows where efforts need to be made at each level to achieve the end product, a high quality rural doctor:

