

Working Together for Better Primary Health Care

Overcoming barriers to workforce change and
innovation

**Report to the Minister of Health from
the Workforce Taskforce**

May 2008

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DHBNZ Primary Health Care Steering Group
DHBNZ Workforce Group
General Practice Leaders Forum
General Practice Nursing Alliance
Health Care Aotearoa
Independent Practitioners Association Council
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EXECUTIVE SUMMARY

Barriers to primary workforce effectiveness

The Taskforce identified the principal barriers to primary health care workforce effectiveness in the following areas:

- The funding model
- Organisational structures
- Professional leadership
- Training
- Quality improvement

Failure to appreciate the interdependence of all five is itself a significant barrier to achieving greater collaboration and focus on the goals of the primary health strategy. The barriers operate in a context of traditional attitudes, values and ways of working.

Recommendations for overcoming the barriers

In view of the importance to New Zealand of primary health care and rapidly escalating pressures on its workforce, the Taskforce urges prompt consideration of and action on its recommendations. The recommendations in this report must be seen as complementary to initiatives for workforce sustainability.

Recommendation 1

Realignment of funding to enable innovation

That the Director-General of Health review the primary health care funding model in parallel with the review of the funding formulae to ensure that both the model and the formulae:

- achieve the intent of the Primary Health Care Strategy
- create incentives for the organisational changes envisaged in the Primary Health Care Strategy, in particular as they relate to PHOs
- facilitate equitable access to funding by all primary health care providers of first contact services under the Primary Health Care Strategy which recognizes that delivery is through teams of health professionals
- support multi-disciplinary working in primary health care service delivery.

Recommendation 2

Structure – investment for expansion and training

That, in order to resolve issues of capital investment for the providers of primary health care:

- the Ministry of Health develop a primary health care sector capital investment strategy which identifies capital investment solutions for expansion, training and retention of the workforce that can be implemented for a variety of ownership structures and adapted for local needs
- the Ministry of Health and primary health care leaders support a group of selected general practices to make an application to the Commerce Commission, for clearance for acquisition under Section 66 of the Commerce Act, in order to get an indication of whether such an amalgamation would be seen as likely to result in a substantial lessening of competition.

Recommendation 3

Professional leadership and clinical governance

That, to provide professional leadership and clinical governance:

- a) The Ministry of Health and DHBs work with professional bodies and the Medical Training Board to jointly develop an evidence-based vision for the roles of the workforce providing primary health care which meet service needs.
- b) The DHBs work with the primary health sector to develop a nationally consistent approach to the development of primary health care nursing.
- c) The Ministry of Health establish an allied health advisory position to provide expert advice and lead the development of the allied workforce.
- d) The PHOs be required to promote and support the establishment of effective clinical governance structures and processes within primary health care providers.

Recommendation 4

Training for primary health care

That, to improve training in primary health care:

- a) Nurse educators, the Nursing Council of New Zealand, PHO leadership groups and the CTA, with facilitation from DHBs, develop an explicit, nationally consistent career framework or pathway for education and training of nurses for primary health care practice which:
 - takes account of the continuum of learning, including undergraduate preparation, postgraduate specialisation and continuing education
 - includes accessible, affordable and appropriate postgraduate certificate and diploma programmes for primary health care nurses.

- b) The Medical Training Board and providers of training for other health professionals identify the capabilities and attributes for collaboration and teamwork to be included in medical curricula and recommended to trainers of other health professionals.
- c) The Ministry of Health fund and evaluate selected primary health care pilots to assess the clinical effectiveness of multi-disciplinary learning and collaborative practice and demonstrate:
- the capabilities and attributes required by health professionals to work in multi-disciplinary teams
 - leadership and team work
 - information sharing across professional groups
 - partnership with consumers
 - recognition of the roles and strengths of the different health professions.
- d) The DHBs engage with the Practice Managers and Administrators Association of New Zealand and other primary health care stakeholders to develop an educational pathway for practice management.

Recommendation 5

Quality improvement – a timely opportunity

That the Quality Improvement Committee be asked to lead the development of a consistent national framework and programme for continuous quality assessment and improvement in primary health care and:

- assist PHOs to promote a culture of quality improvement based on clinical governance amongst primary health care providers through meaningful incentives
- work with DHBs and PHOs to implement this national framework with service providers
- establish effective linkages between quality improvement programmes in primary and secondary care.

BACKGROUND

The Minister of Health agreed that the Workforce Taskforce would focus on the primary health care workforce for its second task. The primary health care sector is in a process of significant change as it responds to influences such as the increasing demands of chronic disease, co-morbidity and an aging population. The process of change was given added momentum with the release of the Primary Health Care Strategy (the Strategy) in 2001. In the face of increasing shortages of health practitioners, the sector must make the best use of the current workforce and ensure its sustainability.

Discussions with the Ministry of Health, District Health Boards (DHBs), and key organisations in the primary care sector revealed a concern that some of the workforce related changes envisaged by the Strategy may not be occurring as consistently or rapidly as intended. The Minister of Health therefore requested that the Taskforce identify barriers to the effective use of the primary health care workforce in implementing the Strategy. The terms of reference for the task are included as Appendix 1.

In order to ensure the necessary expertise to undertake the task, the Taskforce co-opted five additional members with specific experience in primary health. The full list of Taskforce members participating on this task is included in Appendix 2.

In investigating barriers to change in the way the present workforce delivers primary health care services, the Taskforce heard from a wide range of organisations, groups and individuals in the sector. Taskforce members also visited several primary health care providers representing different models of service delivery.

The time frame for completion of this task was six months. It was not feasible within that time for the Workforce Taskforce to identify and address every barrier to change affecting the primary health care workforce. Rather, the focus has been on the main ones for which clear actions can be taken to overcome those barriers.

The Taskforce has also been unable to consult with all interested parties in the sector or incorporate all perspectives in the time frame for completion of the report. In the time available, the Taskforce was unable to give adequate consideration to issues specific to Maori, Pacific and rural populations and accordingly took a high level approach to the task. Further work is required to identify issues and barriers to primary health care workforce change and innovation that have specific relevance to Maori, Pacific peoples and rural areas.

The Taskforce is aware that there is a considerable amount of work being undertaken relating to primary health care and implementation of the Strategy. In particular, the Ministry of Health and DHBs have a number of work streams and associated groups dedicated to improving primary health care service delivery. It is intended that the recommendations of this report will complement other work in the sector.

INTRODUCTION

The Primary Health Care Strategy heralded a radical change to the delivery of primary health care services. The vision of the Strategy is for people to be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services are now expected to focus on better health for their population and to actively work to reduce health inequalities within their populations.

Changes introduced through the Primary Health Care Strategy

Implementation of the Strategy has a ten year time frame and involves the following changes to the structure and delivery of primary health care:

- a broadening of the focus of primary health care from the health of the individual to include the health of populations
- a shift in focus from the primary health care provider to the community and consumers
- a shift in service delivery emphasis from doctors as the main providers to a teamwork approach involving other health professionals
- broadening of the scope of service from an emphasis on treatment of illness to include prevention of illness and health promotion
- a shift from fee-for-service funding to a blended model of population-based capitation funding and co-payments
- greater connection of providers to other health and non-health agencies rather than working individually¹.

Primary health care delivery was re-structured around Primary Health Organisations (PHOs), which are funded by DHBs to provide essential primary health services. PHOs are not-for-profit organisations and were always expected to vary in their size and structure, according to the needs of their community. Their establishment intended to encourage practitioners to work together across traditional professional boundaries to improve the quality of health care and to engage the community in service delivery.

Workforce implications of the Primary Health Care Strategy

There are a number of workforce implications inherent in the changes to primary health care service delivery brought about by the Strategy.

New ways of working

There is an explicit expectation of a collaborative, multi-disciplinary approach to primary health care service delivery. While GPs and nurses are still seen as the main providers of primary health care, the strategy states that no single practitioner can completely meet an individual's needs.

¹ Ministry of Health (2001). *The Primary Health Care Strategy*. Wellington: Ministry of Health.

Service delivery is expected to be through multi-disciplinary teams which may include other health professionals such as pharmacists, physiotherapists, Maori health workers, health promotion workers, dietitians, psychologists and midwives. In addition, the health promotion and protection aspects of the Strategy require links with public health services.

Development of the primary health care workforce

The Strategy seeks to match services to population need and, therefore, has implications for the number, mix, distribution and education of the primary health care workforce.

It is explicitly stated in the Strategy that primary health care nursing is crucial to its implementation. Expansion of the primary health care nursing role requires clarification of the required capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements.

The Strategy has implications for health workers who are commonly located outside general practices and their need to be linked with primary health care services. Many primary health care services are provided by non-government organisations and these, too, need to be working collaboratively with PHOs.

Barriers to workforce change and innovation

The Strategy creates an environment that allows greater flexibility and innovation in the way the primary health care workforce delivers services. The intent was for an emergent, organic process, with the nature of PHOs and service delivery being driven by local need. The result has been significant variability with examples of excellence in service delivery and workforce innovation in some areas but little change in others.

Through its consultation, the Taskforce has identified a range of barriers to change in the way the workforce delivers primary health care services. Some reflect historical practice, some result from prevailing attitudes and misconceptions, and others have arisen as unintended consequences of the implementation of the Strategy.

The following five key areas emerged as containing barriers to workforce change:

1. The funding model
2. Organisational structure and function
3. Leadership at different levels of the sector
4. Training of primary health care clinicians and management
5. Quality improvement and assessment.

Primary health care is a complex system and the barriers identified in this report do not operate in isolation. Because they interact in many ways and at many levels,

their interrelationships must be taken into consideration when implementing actions to address the barriers.

This report makes a number of recommendations to overcome the identified barriers. It does not present all possible solutions but rather key areas for action to facilitate change and innovation.

THE FUNDING MODEL

The Strategy injected an additional \$1.7 billion over six years to support primary health care and reduce cost barriers to accessing services. DHBs contract with PHOs to administer this funding to service providers. It includes capitation funding for 'first contact' services as well as funding for specific services such as *Services to Improve Access, Care Plus*, health promotion, rural premiums and management services. Capitation funding does not cover all the costs of first contact service delivery and practitioners charge co-payments on a fee for service basis.

The move from fee for service to capitation funding was one of the most significant changes brought about by the Strategy. It was intended to reduce inequalities, encourage multi-disciplinary approaches to care, and bring a focus on wellness rather than illness.

The funding introduced with the Strategy overlays a complicated array of historic funding streams. These include funding for district health nurses, iwi providers, lead maternity carers, public health services, after hours services, rural immunisation programmes, pharmacy and others. There are also other funding streams outside the health sector, for example from the Accident Compensation Corporation (ACC).

Barriers to change

Access to primary health care funding

The Taskforce heard repeated concerns from a range of stakeholders that the current funding model limits the scope of the workforce to change the way it delivers services. Overall, the funding model was seen as fragmented and siloed and not providing sufficient incentives and flexibility to achieve the changes to service delivery envisaged in the Strategy.

While capitation funding allows flexibility in first contact service delivery it has not been enough in itself to bring about the desired change in practice. Despite the intentions of the Strategy, capitation funding through PHOs largely goes to GP services with limited access for nurses and other health professionals².

Much of the public funding for other health professionals, for example physiotherapists, is available only through secondary care channels. Allied health practitioners working in the primary health sector are unable to directly access the primary health care funding streams and must charge a full fee for service or access ACC funding.

² Health Services Research Centre (2005). *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy*. Wellington: Victoria University of Wellington.

Contracting

Service contracts pose barriers to workforce development in terms of their duration and in specifying the involvement of certain professions. The relatively short term nature of many contracts discourages investment in service development, training and infrastructure due to the uncertainty of future funding.

The contracting framework between DHBs and PHOs tends to be prescriptive, with high compliance requirements and minimal delegation of authority. This limits the ability of PHOs to encourage multi-disciplinary collaboration and foster the development of new ways of working. Current contract mechanisms lack incentives for better alignment of services provided by different groups of health professionals.

Compliance activities take up a lot of time that health practitioners could otherwise spend on service delivery. While larger practices may have the resources to employ management and administration staff to complete compliance requirements, in many smaller practices these tasks fall to the practitioners.

Solutions

The Ministry of Health will soon review the funding formulae for PHOs. The Taskforce believes that at the same time the entire funding model for primary health care services should be critically examined with the view to making it more adaptable to new ways of providing services.

PHOs should have greater responsibility for the allocation of funding and have the flexibility to contract primary health care services outside general practice. The desirability of making PHOs, rather than general practices responsible for enrolling patients and maintaining the population register should be examined.

Contracts must be of sufficient duration to enable providers to plan and deliver services and develop infrastructure. Compliance requirements need to be streamlined and minimised to ensure time available for service delivery is not compromised.

The important role of PHOs in the development, operation and support of the primary health care sector needs to be recognised. Some PHOs will require support from the DHB to develop the necessary capability and infrastructure to undertake this role effectively.

Recommendation 1

That the Director-General of Health review the primary health care funding model in parallel with the review of the funding formulae to ensure that both the model and the formulae:

- **achieve the intent of the Primary Health Care Strategy**
- **create incentives for the organisational changes envisaged in the Primary Health Care Strategy, in particular as they relate to PHOs**

- **facilitate equitable access to funding by all primary health care providers of first contact services under the Primary Health Care Strategy which recognizes that delivery is through teams of health professionals**
- **support multi-disciplinary working in primary health care service delivery.**

ORGANISATIONAL STRUCTURE AND FUNCTION

The Strategy introduced PHOs to the primary health care environment, with the intention that they would foster greater community involvement and multi-disciplinary collaboration in service delivery. From its inception, the Strategy was designed to be evolutionary in nature. The Ministry of Health provided some guidelines on the establishment of PHOs but deliberately refrained from being prescriptive, allowing them to develop in response to local need and local forces within the primary health care sector.

The result has been the formation of 82 PHOs which vary greatly in their make-up, operation and geographical boundaries. The degree of change at the service delivery level also varies greatly across the country. The Strategy envisages an integrated, inclusive team approach to best utilise the various skills of general practitioners, nurses, allied health professionals and other stakeholders such as NGOs and secondary care specialists. The Taskforce heard differing views as to how well this approach is actually being implemented.

Currently, primary health care is largely delivered by private small businesses owned and operated by GPs. A number of other ownership models exist, such as community trusts, iwi, local authorities and DHBs. There are some excellent examples of innovative service models in New Zealand, including co-location of services, community outreach services and clinics, provided under various ownership structures and philosophies.

The Taskforce considered a range of structural barriers to change that exist at the general practice, PHO and DHB levels. Some are historical and have been perpetuated in the new environment and others have emerged as a result of changes introduced by the Strategy.

Barriers to change

The complex chain of Ministry of Health, DHB and PHO responsibilities in primary health care lacks clarity. It has also inhibited innovation at a local level as the strategic intent and priorities for health improvement of the various parties are not all aligned at the governance or operational levels.

The overall structure of primary health care is governed by a complex system of PHOs, DHBs and service management organisations operating within cumbersome and convoluted contracting processes with uncertain responsibilities and reporting difficulties. The result is a complex adaptive system which responds to policy in ways that vary widely and are difficult to predict.

General practice

General practice has traditionally operated on a small business model with little separation between governance and management. The model has typically involved a small number of GPs who own the business and employ other staff such as primary health care nurses and administration staff. Tensions may arise between

the revenue goals of a private business and the Strategy goals of low cost access to health care delivered by a range of health professionals.

The Taskforce heard differing opinions on whether the employer/employee relationship between GPs and primary health care nurses limits the development of the nursing role. The Taskforce believes the development of the nursing role is more related to the personalities and relationships within a practice than the employment model.

The traditional model and scale of general practice can create barriers to effective strategic planning as owner-operators are absorbed in service delivery, with little time left to focus on development. Physical space is often limited and many practices cannot afford to add additional rooms to accommodate nurse consultations or allied health professionals. There is also a critical lack of space for teaching GP registrars and Nurse Practitioner interns and for accommodating practice placements for medical and nursing students. This lack of space was repeatedly raised in submissions to the Taskforce as a significant barrier to training, recruitment and service development.

A lack of capital investment has prevented practices from evolving and growing to meet the needs of their enrolled populations and provide multi-disciplinary service delivery. Amalgamation of practices would be a means of achieving growth and economies of scale, particularly in rural areas. However there are questions around whether this would contravene the anti-competitive practice rules of the Commerce Act 1986.

Primary Health Organisations

The effectiveness of PHOs is variable across the country. The Strategy intended that PHOs would differ to some degree in order to respond to the needs of their local communities. While it was appropriate initially that the Ministry of Health was not prescriptive in how PHOs should develop, the Taskforce considers that there is now a need for greater consistency and guidance on their form and function.

There are some PHOs that have engaged well with general practice, for example through practice specific projects funded through *Services to Improve Access*, participation in clinical governance structures, and practice specific investment and support. This engagement has resulted in general practice in these areas becoming a more viable and collaborative structure that is producing a range of improved patient health outcomes. In addition effective linkages have been formed with providers of health, disability and education services and partnership projects have developed with local government to create local solutions for the enrolled population.

However, in other cases, PHOs have acted merely as a funding conduit with little impact on the operation of general practices. Relationships with other health and disability providers have not strengthened and an awareness of working collaboratively for the health of the patient has not progressed. PHO governance is variable in terms of quality assurance standards and accountability to their communities.

The PHO structure has introduced further administration and technology burdens on general practices. Increased compliance requirements have created cost barriers to providing accessible services, especially in small and rural communities. A lack of skilled practice management personnel has also hampered effective use of the workforce.

Non-Government Organisations

NGOs play an important part in the delivery of primary health care services, yet their participation in the PHO environment to date has been limited. They employ trained primary health care practitioners who could provide a valuable workforce resource to the sector. The limited relationship between the NGO and PHO sectors to date means the available workforce is not being used to its full potential.

For many PHOs the focus to date has been on internal performance and developing sustainable relationships with their general practice members. The NGO sector is diverse and extensive and its potential for developing a holistic spectrum of primary health care has not been fully explored. The intent of the Strategy to reduce inequalities sits well with NGOs and appropriate incentives would facilitate the development of partnerships with PHOs.

District Health Boards

PHOs are the vehicle for DHBs to deliver the Strategy and the two have to be aligned to make the best use of the primary health care workforce. DHBs have a wider focus than PHOs and there is a perception that they are often focused on other priorities. It is important that DHBs involve the primary health care sector in planning processes for service delivery and workforce development, but this does not appear to happen consistently. There was a widespread belief expressed to the Taskforce that DHBs do not fully understand the sector or their own role and relationship with PHOs.

Solutions

The tensions between the business model of general practice and the publicly funded health system must be recognised and better managed. General practices, and other service providers, need to have the willingness and flexibility to adapt to fit the changing primary health care environment. It is important that PHOs work with service providers to explore the opportunities for innovation offered through the Strategy.

Adequate facilities are necessary for the development and effective functioning of multi-disciplinary team work. Access to capital investment is necessary for general practices to evolve and develop. There is no shortage of capital and a variety of potential sources are available, including corporate investment and partnership approaches with PHOs, DHBs and local government. While local solutions will need to fit local needs, a national strategy on capital investment and infrastructure development, prepared in conjunction with the sector, would provide consistency and guidance.

There has been much speculation in the sector on how the Commerce Act 1986 applies to amalgamation of general practices but, as yet, there has been no official ruling. It is timely for a test case to be taken to the Commerce Commission to determine under what circumstances amalgamation of general practices is possible under the rules of the Commerce Act.

The Taskforce believes DHBs should work closely with PHOs and involve them in planning for primary health care for the population. There are examples of excellent relationships where PHOs are involved in the District Annual Plan process and this provides a useful approach to achieving alignment between the two structures. It is important that all primary health care providers incorporate the goals and principles of the Strategy into their strategic plans.

Developing the capacity and capability of the primary health care workforce requires DHBs and PHOs to work together to support their practices in developing business processes and greater collaboration in service planning and delivery. Good relationships between DHBs and PHOs are necessary for the resolution of any issues arising in the course of implementing the Strategy.

DHBs are currently involved in a range of workforce development initiatives in primary health care. It is important that the sector feels involved in this work and that progress is clearly communicated.

Recommendation 2

That, in order to resolve issues of capital investment for the providers of primary health care:

- **The Ministry of Health develop a primary health care sector capital investment strategy which identifies capital investment solutions for expansion, training and retention of the workforce that can be implemented for a variety of ownership structures and adapted for local needs.**
- **The Ministry of Health and primary health care leaders support a group of selected general practices to make an application to the Commerce Commission, for clearance for acquisition under Section 66 of the Commerce Act, in order to get an indication of whether such an amalgamation would be seen as likely to result in a substantial lessening of competition.**

LEADERSHIP

As with any change process, successful implementation of the Strategy requires strong leadership at all levels of the primary health care sector. However, these roles do not appear to be clearly defined or aligned and the vacuum in leadership has resulted in plethora of poorly co-ordinated groups and committees working on primary health care development (see Appendix 3).

The organisational and professional landscape of the primary health care sector lacks coherence, with the players each having their own particular focus. From submissions to the Taskforce, there is a need for clear and visible leadership to achieve the common goal of the Strategy and the new ways of working it requires. Leadership is also specifically needed to develop the primary health care workforce.

Barriers to change

National leadership

Lack of clear national leadership in the implementation of the Strategy is not surprising given the number of 'players' with diverse interests, often operating in relative isolation from one another. This has resulted in much of the variability that is evident in the sector today. For example, the Ministry of Health established PHOs but does not require that all primary health services be provided through PHOs. The leadership role played by DHBs in primary health care in their districts varies, as does the role and operation of PHOs at the local level.

While a certain amount of variability is to be expected, and is desirable if services are to meet the needs of their local populations, there should also be some national consistency in the implementation of the Strategy. The lack of clear national leadership has resulted in fragmented, ad hoc development across the country.

In terms of the primary health care workforce, no clear vision has been articulated as to what is required to meet the needs of communities now and into the future. While collaboration and team work are specified as a means to achieving the Strategy, nationally there has been a lack of coherent leadership in translating this approach into practice. The change to capitation funding created an environment where these ways of working could occur, but active leadership is required to actually make them happen.

Professional leadership

As a result of their historic role in primary health care service delivery, GPs have largely set the direction of general practice in responding to the Strategy. Submissions to the Taskforce indicate that, overall, GPs have made little change to the way they work.

In submissions to the Taskforce, medical groups were alone in maintaining that team work was established and functioning well in general practice. By contrast, nursing, allied health and NGO groups were almost unanimous in their view that it was not.

These groups felt they had little influence on the way services are delivered or even on their own roles and ways of working.

The Strategy explicitly noted that the need for primary health care nurses would increase and that they had a crucial role in its implementation. However, the diversity of nursing roles and fields of practice is reflected in a fragmented leadership structure. This fragmentation has reduced the effectiveness of nursing leadership in developing the role of primary health care nurses.

The absence of representation of allied health professions within the Ministry of Health and the many DHBs was seen as a significant barrier to their involvement in implementation of the Strategy.

Clinical governance

Clinical governance can be described as a system through which *“organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish³”*

Clinical governance provides a strong leadership framework for the continuous improvement of care. It is not the role of a single practitioner within a service, but requires a team approach to implementing best practice and improving patient care. Effective clinical governance processes require input from the range of practitioners involved in patient care, along with managers, and promote a collaborative, multi-disciplinary culture.

Many primary health care providers do not have any formal clinical governance structure and staff often have little practical experience with it. This inhibits the development of multi-disciplinary working and best use of the workforce.

Solutions

Given the complexities of the primary health care sector and its relationships with communities, political will and leadership is critical for effective change. The Ministry of Health and DHBs should take a more active and visible leadership role in implementation of the Strategy. A clear vision for the workforce would provide direction for PHOs and providers in developing services in line with the Strategy. The Ministry of Health and DHBs need to be more explicit in articulating their expectations regarding workforce and ways of working and support PHOs in managing these changes at the service delivery level.

The current ad hoc approach to the development of primary health care nursing is unacceptable. Whilst nursing professional and educational organisations are essential for the development of the profession, greater leadership from DHBs and PHOs will be required to establish roles and frameworks which would allow primary

³ Scally G, Donaldson L. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61-65

health care nursing to achieve its true potential. It is important that this work is carried out collaboratively across the country to ensure a single, nationally consistent framework.

Allied health professions are currently represented in some DHBs and the Taskforce believes that this approach should be extended across all DHBs and involve primary health care services. This would provide a voice and a point of contact for allied health practitioner groups to engage with the primary health care sector. Similarly, representation for allied health is required in the Ministry of Health at the same level as that for nursing and general practice.

The concept of clinical governance needs to be promoted and adopted throughout the primary health care sector. Leadership from PHOs will be required to ensure appropriate clinical governance structures and processes are embedded in all service providers.

Recommendation 3

That, to provide professional leadership and clinical governance:

- a) The Ministry of Health and DHBs work with professional bodies and the Medical Training Board to jointly develop an evidence-based vision for the roles of the workforce providing primary health care which meet service needs.**
- b) DHBs work with the primary health sector to develop a nationally consistent approach to the development of primary health care nursing.**
- c) The Ministry of Health establish an allied health advisory position to provide expert advice and lead the development of the allied workforce.**
- d) PHOs be required to promote and support the establishment of effective clinical governance structures and processes within primary health care providers.**

TRAINING

The Taskforce acknowledges that a range of health professionals and service managers are involved in the delivery of primary health care. While submissions relating to training concerned medicine and nursing only, it is likely that similar issues face other health professionals. The Taskforce does not feel sufficiently briefed on the training of other disciplines to make specific comment or recommendations in that regard but the barriers and solutions discussed below may apply to other health professions.

Population and health trends require a reconsideration of the traditional content and method of training delivered to students and graduates in key disciplines in primary health care. The traditional model of training doctors and nurses focuses on preparing them to work in hospital environments. This model does not meet the demands of an aging population, the rise in chronic disease and co-morbidities, and the emphasis on treatment in the community.

Primary health care requires a workforce with skills and competencies to implement primary and population health services in the community. Practitioners need to be flexible, contextually responsive, innovative and engaged in a process of life-long learning. As stated in the Strategy, no one practitioner or type of practitioner can be expected to fully meet an individual's health needs. Service provision must therefore shift to a multi-disciplinary, collaborative approach with an emphasis on team working.

Barriers to change

Facilities

As noted above, many primary health care providers are constrained in their ability to provide student placements due to a lack of space. It is critical that the sector develops sufficient infrastructure to enable students to receive the training and experience in community-based services they require.

Undergraduate training

Positive experiences in undergraduate training are an important contributor to a student's decision on where to specialise following graduation. Primary health care is currently disadvantaged within medical and nursing education, with students receiving little exposure at undergraduate level.

Learning is a process that takes place in 'communities of practice' and the lack of clinical placements leaves those who do wish to pursue a career in primary health ill-prepared for this type of community-based work. In the case of nurses, the availability of orientation and induction programmes to primary health care is variable.

Inter-professional education

The uni-disciplinary training of health professionals is a barrier to effective team work and collaboration in the work place. It is not reasonable to expect graduates to automatically work as effective members of multi-disciplinary teams when they have been trained in professional isolation. Students need to understand the role and capabilities of other disciplines and how they fit in the continuum of care. Inter-professional learning at the under-graduate and post-graduate levels provides a way of preparing health professionals to work collaboratively.

It is acknowledged that some inter-professional education exists at the post-graduate level, but funding favours uni-disciplinary training. There also appears to be a reluctance on the part of some registration authorities to accredit inter-professional training courses as part of continuing education.

Practice management training

There is currently no uniform training for practice managers. Poor practice management affects the efficiency of business processes and administration of the practice. Many administrative tasks continue to fall to health practitioners, which is an inefficient use of their time and skills.

Solutions

The establishment of an educational pathway for primary health care in medical and nursing curricula, including clinical placements in community primary health care settings, would improve the capability of graduates to work in the field. It would also increase the visibility of primary health care and its importance to overall health outcomes. The Medical Training Board is well placed to facilitate this process.

The development of a standard induction and orientation programme would facilitate entry of nurses to primary health care. The programme should be developed and run by DHBs in conjunction with the Nursing Council of New Zealand, with specific funding from the Ministry of Health Clinical Training Agency (CTA).

The Workforce Taskforce supports vocational training for all GPs. In addition, health professionals need to be trained in team working skills to prepare them for working in the current health environment. Capabilities that enable effective teamwork and collaboration should be embedded as central components of health curricula. Inter-professional learning opportunities should be provided in under-graduate and post-graduate education and supported by professional organisations.

These solutions cannot be implemented without appropriate facilities in the primary health care providers to support student placements. It is important that the issues around service provider infrastructure be addressed not just to enable practice development but also to ensure training for future primary health care practitioners.

Students also need to learn in inter-professional environments in the community and such placements may have to be created where they do not already exist. The establishment of multi-disciplinary primary health care pilots would serve the dual

purpose of providing collaborative learning environments and demonstrating a model of multi-disciplinary practice.

There is a need for a training pathway for practice management and administration staff. The development of nationally recognised education programmes would provide consistency in skills and management approach for service providers.

Recommendation 4

That, to improve training in primary health care:

- a) **Nurse educators, the Nursing Council of New Zealand, PHO leadership groups and the CTA, with facilitation from DHBs, develop an explicit, nationally consistent career framework or pathway for education and training of nurses for primary health care practice which:**
 - **takes account of the continuum of learning, including undergraduate preparation, postgraduate specialisation and continuing education**
 - **includes accessible, affordable and appropriate postgraduate certificate and diploma programmes for primary health care nurses.**
- b) **The Medical Training Board and providers of training for other health professionals identify the capabilities and attributes for collaboration and teamwork to be included in medical curricula and recommended to trainers of other health professionals.**
- c) **The Ministry of Health fund and evaluate selected primary health care pilots to assess the clinical effectiveness of multi-disciplinary learning and collaborative practice and demonstrate:**
 - **the capabilities and attributes required by health professionals to work in multi-disciplinary teams**
 - **leadership and team work**
 - **information sharing across professional groups**
 - **partnership with consumers**
 - **recognition of the roles and strengths of the different health professions.**
- d) **The DHBs engage with the Practice Managers and the Administrators Association of New Zealand and other primary health care stakeholders to develop an educational pathway for practice management.**

QUALITY IMPROVEMENT AND ASSESSMENT

The New Zealand Health Strategy identified quality improvement as a cornerstone of a high-performing system. Quality results from the interactions of individuals, teams, organisations and systems⁴. A safe and effective health system requires systematic quality improvement and assessment processes to ensure services meet a high standard of health care and contribute to improved health outcomes.

High quality providers are typically more successful at retaining and recruiting staff than providers of low quality services. They are also more likely to make effective and efficient use of their workforce.

Barriers to change

Lack of a national quality framework

Submissions to the Taskforce revealed that there is no national quality improvement framework for primary health care. To date Ministry of Health quality improvement work streams have focused on hospital services. So too has the work of the Quality Improvement Committee (QIC), a statutory committee appointed by the Minister of Health.

There are quality programmes in the primary health care sector but they tend to focus on certain aspects of quality improvement. For example, the Cornerstone accreditation programme developed by the Royal New Zealand College of General Practitioners is a well supported quality programme for general practice. The focus of this programme is on systems and the practice environment and includes only limited aspects of clinical care. Similarly, the Performance Management Programme focuses on a narrow realm of clinical quality and some financial indicators.

The lack of national leadership for quality improvement in primary health care has resulted in ad hoc, poorly defined and sporadically implemented quality improvement processes by PHOs and service providers. In the absence of systematic planning, policy and monitoring of quality improvement, many providers do not engage in formal quality improvement activity at all.

Poor understanding of quality improvement

The primary health care sector tends to focus on quality assurance and financial accountabilities and there appears to be limited understanding of the concept of continuous quality improvement. Until this is clearly understood, and actively promoted by DHBs, PHOs, and communities, the primary health care workforce is unlikely to reap the benefits of improved patterns of working.

⁴ Ministry of Health (2003). *Improving Quality (IQ): A systems approach for the New Zealand Health and Disability Sector*. Wellington: Ministry of Health

Funding for quality improvement programmes

The implementation of quality improvement programmes is not without cost and it is important that sustainable funding be available. Short term funding of quality initiatives has resulted in an inability to maintain quality systems and lost opportunities to develop a quality focused workforce.

Incentives are necessary to encourage service providers to invest in quality improvement systems. Without tangible benefits and returns it may be difficult to encourage many in the sector, particularly smaller providers, to engage in continuous quality improvement.

Evaluation of quality improvement initiatives

A sound methodology is needed for evaluating the outcomes of quality improvement initiatives. Without reliable evaluations, successful and innovative initiatives are not identified and communicated to other providers. As a result, they are not taken up and implemented in other areas, contributing to the ad hoc approach to quality improvement. Failure to learn from and promote successful initiatives developed by others results in inefficient use of resources and lost opportunities.

Solutions

The Taskforce believes QIC is an appropriate body to provide national leadership and direction for quality improvement in primary health care. However, it will require a significant input of primary health care sector knowledge and experience. A framework and programme for quality improvement in primary health care should be developed by QIC as an equal priority to existing programmes. Additional resources should be allocated for the development and implementation of the primary health care programme as required.

The framework would be used by PHOs to build a quality improvement culture in service providers that encompasses workforce utilisation. Indicators for monitoring quality improvement activity must be established by PHOs, initially focusing on process until quality systems are adequately embedded. Consideration should be given to providing incentives for service providers to adopt continuous quality improvement processes. These incentives may be reputational, financial or otherwise but must be meaningful to the providers.

Because of the risk of adverse clinical events at the interface between primary and secondary services, there should be effective links between their quality improvement programmes.

QIC and the Ministry of Health need to work together to develop a reliable evaluation framework for quality improvement in primary health care. Mechanisms for communicating the results of evaluations across the sector should be developed so that service providers can learn from the experience of others.

Recommendation 5

That the Quality Improvement Committee be asked to lead the development of a consistent national framework and programme for continuous quality assessment and improvement in primary health care and:

- **assist PHOs to promote a culture of quality improvement based on clinical governance amongst primary health care providers through meaningful incentives**
- **work with DHBs and PHOs to implement this national framework with service providers**
- **establish effective linkages between quality improvement programmes in primary and secondary care.**

APPENDIX 1

Workforce Taskforce

Terms of Reference for Second Task

Objectives

The Workforce Taskforce was established in May 2006 by the Minister of Health as a standing committee to provide him with independent advice on the implementation of actions necessary to improve the capability of the health workforce to deliver services in the future.

The establishment of the Taskforce was in response to the Minister's desire for effective action to improve the delivery of health services by the workforce.

Accountability

The Taskforce is established by, and accountable to, the Minister of Health.

Second Task

The Taskforce's second task will focus on primary health and achieving the changes necessary to deliver services in line with the Primary Health Care Strategy in the context of workforce pressures.

Problem definition

Population changes and labour market trends indicate that the health sector will not have sufficient workforce in the future to continue to deliver services in the way they are now. Workforce pressures will affect the ability of the health sector to meet the changing needs of the New Zealand population, in particular, high needs communities and people with chronic conditions. Therefore, different means of delivering services and utilising the available workforce need to be identified and implemented.

A strong primary health care sector is central to improving the health of New Zealanders through improving access to health care, reducing inequalities in health status, and reducing demand on secondary services. The Primary Health Care Strategy introduced new structures and funding mechanisms to the delivery of primary health care.

However, changes in the way services are delivered and the ways in which health professionals and support staff work are still needed to ensure the sector can meet future demand. The reasons behind the slow pace of change relating to the workforce and ways of working require examination in order to identify how to intervene most effectively.

Task specification

The second task is to provide independent advice to the Minister on implementing actions that will facilitate positive change in how the primary health care workforce delivers services.

In particular, the Taskforce will:

- identify barriers and disincentives to making the best use of the primary health care workforce in responding to the Primary Health Care Strategy
- identify levers that will encourage positive change and innovation in the way the workforce delivers primary health care services.

The task may include consideration of:

- further development of multi-disciplinary working in a patient-centred environment
- professional, organisational and managerial cultures
- workforce productivity, flexibility, and devolution of roles and tasks within and across the health professions
- the development of new roles
- structural, work practice and funding issues
- accountabilities.

Reporting

The Taskforce will provide a written report to the Minister on the findings of the project and recommendations for facilitating positive change in primary health care service delivery.

Membership

The Taskforce comprises a core of eight members, including the Chair. Original members of the Taskforce were appointed by the Minister for a term of up to two years. The Taskforce has the ability to co-opt members with particular expertise for specific tasks after consultation with the Minister.

The membership of the Taskforce for the second task will be finalised following consultation with the Minister and key stakeholder organisations in the health sector. Members need to be innovative and strategic thinkers who will make specific recommendations to achieve change.

Secretariat Support

Secretariat and administrative support for the project will be provided by the Ministry of Health.

The Taskforce will meet monthly or as otherwise determined by the Chair. Meetings may be held face to face or by teleconference. Minutes of each meeting will be kept and shall record the issues discussed, and the decisions and recommendations reached.

Performance measures

The Taskforce will provide the Minister of Health with advice on the specified project, within six months of commencement, to the Minister's satisfaction. The Chair will brief the Minister on progress with the project as required by the Minister.

All advice is to be based on research, evidence, analysis and consultation with parties likely to be affected by the advice.

Conflicts of interest

Should a member of the Taskforce face a conflict of interest so significant that they believe they will be prevented from reaching an impartial decision, they must declare a conflict of interest and withdraw from discussion and decision-making.

APPENDIX 2

WORKFORCE TASKFORCE MEMBERSHIP

Standing Members

Mr Len Cook

Government Statistician from 1992 to 2000, and National Statistician of the United Kingdom from 2000 to 2005. Currently Chair of the Medical Training Board.

Associate Prof Margaret Horsburgh

Associate Professor of Nursing in the School of Nursing and former Associate Dean (Education) in the Faculty of Medical and Health Sciences, University of Auckland. Currently a director of a Primary Health Organisation.

Dr Frances Hughes

Adjunct Professor - UTS Sydney, WHO Pacific Island Mental Health Network, practicing mental health nurse, Director of MH NGO and health policy consultant. A member of the Health Workforce Advisory Committee, and its Medical Reference Group.

Dr Robert Logan (Chair)

Specialist physician and the Chief Medical Advisor at Hutt Valley District Health Board.

Dr David Stewart

Endocrinologist and former Assistant Vice-Chancellor for Health Sciences, University of Otago.

Dr Jim Vause

A general practitioner for 25 years, member of the Quality Improvement Committee and the DHBNZ PHO Performance Management Programme Advisory Committee, National Screening Advisory Committee and the RNZCGP Quality Board. Kai Tahu is his iwi.

Ms Suzanne Win

Originally trained as a nurse and has been involved in the health and disability system for 39 years. Currently Chair of Nelson Marlborough DHB, member of DHBNZ Chairs Executive and Chair of Careerforce.

Co-opted Members for the Task

Mr Martin Chadwick

Physiotherapist, Deputy Lead Auditor for the Physiotherapy Board of New Zealand. Currently Project Manager for Waikato DHB working on quality improvements within the Emergency Department at Waikato Hospital and linkages to other services.

Ms Judith MacDonald

Originally trained as a nurse, currently Chief Executive of Whanganui Regional PHO in Wanganui

Dr Tim Medicott

Retired general practitioner and current trustee of Mornington Primary Health Organisation in Dunedin.

Ms Rosemary Minto

Nurse Practitioner and Director, Digitalis Group Ltd providing primary health care nursing consultancy services. Past Chair of the New Zealand College of Practice Nurses.

Ms Maree Munro

General Manager, General Practice Support, Pinnacle Group Ltd, Hamilton. Chair of Practice Managers and Administrators Association of New Zealand (PMAANZ).

APPENDIX 3

ORGANISATIONS AND GROUPS INVOLVED IN PRIMARY HEALTH CARE

The Workforce Taskforce identified the following groups and organisations involved in primary health care. While it is not an exhaustive list, it is intended to give some idea of the number and diversity of groups with an interest in primary health care.

System level

Ministry of Health
District Health Boards
Primary Health Organisations

Sector leadership

Independent Practitioners Association Council
General Practice Leaders Forum
Rural GP Network
Expert Advisory Group on Primary Health Care Nursing

Professional organisations

New Zealand College of Practice Nurses (NZNO)
College of Practice Nurses Aotearoa (NZ)
General Practice Nursing Alliance
New Zealand Nursing Organisation
Nursing Council of New Zealand
New Zealand College of Midwives
Midwifery Council of New Zealand
Royal New Zealand College of General Practitioners
Medical Council of New Zealand
New Zealand Medical Association
Allied Health Professional Associations Forum
Practice Managers and Administrators Association of New Zealand

Primary Health Care Strategy Implementation

MOH/DHB Primary Health Care Steering Group
Primary Health Care Strategy Implementation Taskforce

PHO organisations

PHO Alliance
Health Care Aotearoa
PHO Community Council

Educational and training

Universities and polytechnics
Clinical Training Agency
Nurse Educators in the Tertiary Sector (NETS)