

## **CABINET BUSINESS COMMITTEE**

### **PRIMARY HEALTH CARE STRATEGY: ACCELERATING CHANGE (PAPER 2)**

#### **PROPOSAL**

This paper contains proposals to accelerate the development of primary health care service delivery models and to sustain and improve low cost access as part of the ongoing implementation of the Primary Health Care Strategy.

#### **EXECUTIVE SUMMARY**

1. This paper is the second of two papers on primary health care. The first paper reported on the Primary Health Care Strategy's key achievements to date (SDC Min (08) 10/3 refers).<sup>1</sup>
2. Much has been done to achieve the vision and key directions of the Primary Health Care Strategy. Notably, this has included greater utilisation of primary health care by those with high health need, lower cost to the public for general practice and pharmaceutical services, the establishment of more than 80 primary health organisations (PHOs), and enrolment of almost all of the New Zealand public in PHOs. Indeed, the building blocks are in place for fundamental improvements to the health system.
3. While much has been achieved, much remains to be done to fulfil the goals of the Strategy. This is especially true with regard to better coordination with other community-based providers, improved linkages with hospitals and specialty providers, achieving greater reductions in patient co-payments more universally, a greater emphasis on public health and preventive care, and addressing the determinants of health, including behavioural and environmental factors.
4. Reductions in user co-payment charges have been a major achievement of the Primary Health Care Strategy. However, there is a need to explore options for removing remaining cost-barriers and to increase engagement of hard to reach communities. We must ensure that gains in reducing cost barriers to access are not eroded through incremental increases in user co-payment charges over time.
5. Changes in service delivery models have occurred, especially where the smaller targeted funding streams have been well used, but are by no means universal. The more substantial First Contact funding stream has not led to expected changes in service delivery models. The reasons for this are complex. Current incentives on providers to adopt new service models are weak, and DHBs and PHOs have limited leverage.
6. The keys to addressing these concerns are:
  - positioning PHOs to lead change
  - increasing DHB engagement in primary health care development
  - exploring funding and policy options to enable change and strengthen incentives

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<sup>1</sup> This paper is also part of a suite of health system Cabinet papers on the Long-Term Systems Framework, District Health Board (DHB) co-operation and collaboration, Quality, Safety and Improvement, eHealth, Value for Money, and Workforce.

- strengthening performance incentives, and monitoring and accountability mechanisms
7. The next phase of implementation will focus on accelerating the development of service delivery models that maintain and improve access in a low cost environment, provide a stronger emphasis on prevention and coordinated management of long-term conditions, provide for better coordination and integration of service delivery from a service user's perspective, and fully utilise the existing workforce.
  8. I recommend that you direct the Ministry of Health to:
    - a) provide a progress report to the Cabinet Social Development Committee by end of December 2008 on the development of service models for multi-disciplinary family health centres to be tested during 2009/10.
    - b) report to you by end of March 2009 on the sustainability of the primary health care funding framework, including: the mix of universal and targeted funding streams; appropriate mechanisms for ensuring access for people for whom user co-payments are a barrier; and the ongoing affordability for the Government.
  9. I will report to you on improvements to governance and accountability mechanisms, and strengthened performance management systems as part of my 30 June 2009 report back on the extent to which the Strategy is meeting the Government's objectives.

## BACKGROUND

10. This paper is the second of two papers on primary health care. The first paper reported on the Primary Health Care Strategy's (the Strategy) key achievements to date (SDC Min (08) 10/3 refers).<sup>2</sup>
11. The New Zealand Health Strategy (NZHS) define the need to improve population health and reduce inequalities. A strong primary health care system is fundamental to achieving these NZHS goals. It provides first level care for most people, and is the point of referral to other community and hospital services. Primary health care is a significant committer of broader health sector resources through referral pathways. Through timely intervention, and appropriate referrals, primary health care contributes to the overall efficiency of the health system by managing demand for relatively expensive hospital-based services.
12. The Primary Health Care Strategy, which was launched in 2001, set out a ten-year vision for primary health in New Zealand:
 

*People will 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 will focus on better health for a population, and actively work to reduce health inequalities between different groups.*
13. The Strategy identified six key directions to achieve this vision:
  - work with local communities and enrolled populations
  - identify and remove health inequalities
  - offer access to comprehensive services to improve, maintain and restore people's health
  - co-ordinate care across service areas

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<sup>2</sup> This paper is also is part of a suite of health system Cabinet papers on the Long-Term Systems Framework, District Health Board (DHB) co-operation and collaboration, Quality, Safety and Improvement, eHealth, Value for Money, and Workforce.

- develop the primary health care workforce
  - continuously improve quality using good information.
14. Seven years into the Strategy implementation, it is valuable to examine the extent of progress on the six key directions. Indeed, the health sector can point to a number of successes:
- The establishment of more than 80 primary health organisations, governed by non-profit boards of directors;
  - Enrolment of approximately 95% of the New Zealand public in these PHOs;
  - Lower cost access to general practice and pharmaceutical services;
  - Increased utilisation of primary health care services overall, particularly by high need groups (Maori, Pacific, and those living in deprived areas) who have historically missed out on care;
  - Improved outreach services for hard-to-reach populations and population-based health promotion;
  - Better care planning and coordinated services for those with serious medical conditions and co-morbidities through the Care Plus programme;
  - Establishment of a performance management programme, where there are early signs of improvement in areas such as breast cancer screening and influenza vaccinations for the elderly;
  - Early signs that there are expanded roles for nurses in care coordination and delivery of preventive services; and,
  - Improved information capture such that almost all enrolment records have a valid National Health Index number, ethnicity recording, and geospatial record (longitude and latitude).
15. Although there have been many achievements, there are still aspects of the PHCS that are yet to be realised. A key aspect is the way in which care is delivered. The predominant model of service delivery for primary care in New Zealand has not changed markedly since the inception of the PHCS. Most care is still delivered by GPs in small practices that are not integrated with other community health services or with secondary or tertiary services. This has held back full achievement of the PHCS through:
- Horizontal integration with public health services, well-child, maternity, pharmacy, physiotherapy, radiology and laboratory;
  - Vertical integration with hospital-based speciality care, day surgery;
  - Integration of clinical information creating unified medical records where information can be shared with other clinicians as required;
  - Workforce training opportunities so that future doctors and nurses have a strong primary care footing; and,
  - Prevention models well grounded in the community, including linkages with NGOs and social marketing.
16. A key factor holding back the implementation of new service delivery models is the continued influence of patient co-payments. While more than a quarter of New Zealanders benefit from very low cost access, there are still too many practices that derive one half or more of their income from patient co-payments. This props up a model of care delivery where: GPs are the dominant practitioners because they command higher co-payments; episodic care is rewarded over preventive and longitudinal care; and small practices not well integrated into the overall health system remain the norm.

17. The next phase of implementation will focus on accelerating the development of new service delivery models while maintaining or extending a low cost access environment.<sup>3</sup> Service delivery models need to be able to maintain and improve access, better utilise the existing workforce, place a stronger emphasis on preventive services, better coordinate management of long-term conditions, have stronger linkages with population-based public health and provide for better coordination and integration of service delivery from a service user's perspective.
18. This requires being able to leverage changes to service delivery models across all providers of primary health care, preventive services, community and hospital services from within existing funding streams.

## **ISSUES TO BE ADDRESSED**

### **Linkages with other public health and community-based providers**

19. Improving the health of populations cannot be achieved through general practice alone treating individuals in the way that it has. There is a need to address the broader determinants of health such as improving nutrition, increasing exercise, shoring up housing stock, and educating the public about the value of prevention and early intervention.
20. This requires a focus on populations and communities reinforced by messages delivered by health practitioners delivering care to individuals. Public health units and NGOs such as Plunket need to be more closely integrated with PHOs and PHO providers to enable this change in focus to occur.
21. There are examples of this integration occurring through PHOs and PHO providers:
  - In the Wairarapa, the PHO, which serves the whole district and works closely with the District health Board, has enlisted the support of the Maori Women's Welfare League to identify families with children who have not been vaccinated. This has resulted in improved vaccination coverage rates for the district.
  - In the South Island, BreastScreen South has an agreement with general practitioners whereby GPs are paid an annual fee to enrol eligible women into the programme. This linkage with general practice has resulted in breast screening rates for Maori and Pacific women in this region well above the national average.

### **Development of new service delivery models**

22. General practice provides the bulk of first contact<sup>4</sup> services. It has historically been dependent on user co-payments for the majority of its revenue. Service delivery has centred on high through-put, focussed on treatment of presenting symptoms. *First Contact* capitated funding introduced under the Strategy (\$487.5m in 2007/08) aimed to shift incentives away from throughput and toward pro-active patient care. However, patient co-payments remain a significant funding stream for the sector; this has reinforced the predominant service delivery model.
23. Progress has been made in the introduction of new approaches to service delivery where there have been targeted funding initiatives such as better coordinated care for people with multiple chronic conditions (Care Plus), improved outreach to high need populations (Services to Improve Access), population-based health interventions

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<sup>3</sup> Workforce development and use of information systems and technology are also priorities critical to the successful implementation of the Primary Health Care Strategy, and are covered by separate Cabinet papers submitted for your consideration.

<sup>4</sup> First Contact services are those that can be accessed directly without referral. In primary health care General Practice is the most common First Contact service.

(Health Promotion), and improved access to services for people with mild to moderate mental illness (Primary Mental Health Care). Proposals in this paper aim to build on what has been achieved through these initiatives.

24. The lack of prevention and early intervention means that people are more likely to require more intensive treatment services such as those provided and funded by DHB provider arms. Hence, DHBs bear much of the risk for primary health care providers being slow to adopt new service delivery models through avoidable use of hospital level services. This suggests a need to enable and incentivise DHBs to work more closely with PHOs to introduce measures to accelerate the adoption of new service models.
25. It is difficult for primary health care providers working in relative isolation from each other and the wider health system to develop effective interfaces with other services across a locality or a district. However, much can be achieved if we can successfully build on the leadership and coordination roles of DHBs and PHOs.
26. I believe that PHOs, working in partnership with DHBs, need to be supported and incentivised to lead progress toward new service delivery models in primary health care.

### **Sustainability of low cost access**

27. Reductions in user co-payment charges have been a major achievement of the Primary Health Care Strategy. However, barriers remain for some health care consumers and more needs to be done to engage hard to reach communities. Results from the New Zealand Health Survey<sup>5</sup> show that Maori are more likely to experience cost as a barrier than non-Maori. There is a need to explore options for removing remaining cost-barriers and to ensure that gains in reducing cost barriers to access are not eroded through incremental increases in user co-payment charges over time.
28. In some cases user co-payment charges are already rising. A Fees Review Framework is in place that sets benchmarks for annual GP user co-payment increases. However, this process, although making user co-payment increases more transparent, is not able to constrain growth in costs. Increases provided through the Fees Review Framework consistently exceed future funding track increases, and will continue to do so given multiple inflationary pressures such as wage increases. Nor does it address the wide variance in user co-payment charges that predated the Fees Review Framework.
29. Incentives to keep cost increases low need to be part of primary health care funding systems. However, the development of new service models that make better use of the primary health care workforce could also assist to manage primary health care costs.

## **KEYS TO ADDRESSING THE ISSUES**

### **Positioning PHOs to lead change**

30. Primary Health Organisations are critical to implementation of the Strategy. A minority of PHOs are already fulfilling their expected role in leading implementation of the Strategy. Taupo Lakes PHO is one such PHO.

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<sup>5</sup> A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey, Ministry of Health, 2008.

### **Lake Taupo PHO's approach to developing service delivery models Community Based PHOs as Change Agents for Primary Health Care**

Lake Taupo PHO was determined from the outset not to replicate the status quo, whilst mindful that general practice services remained pivotal to improving population health, Lake Taupo PHO (LTPHO) has worked closely with its communities of interest to build local capacity, develop new services and manage an intensive period of change between July 2005 and the present. LTPHO's change management programme has focused on a number of key initiatives as outlined below.

LTPHO has developed a PHO "hub" and community of "spokes" model. The PHO currently employs eight clinical staff ranging from a social worker to dietitian to community based Nurse Practitioners. Within the community of "spokes" are contracted providers, many of whom have been established as new entities with the support of the PHO. These "spokes" deliver services ranging from Tai Chi and Falls Prevention (funded by ACC) to primary mental health (jointly funded by health and MSD) to health funded services such as podiatry, physiotherapy, lifestyle coaches, medication review services and traditional Maori therapies.

Healthright, a holistic, patient focused approach to the management of long term conditions, is another key development. Healthright includes additional case management funding for nurse led clinics as well as PHO "hub" services such as community nursing and a strong lifestyle intervention and preventative approach including exercise, nutrition, smoking cessation and self management groups based on the Stanford model in the UK. Healthright is a \$1.6 million annual investment by the PHO made up of funding from Services to Improve Access (SIA), Health Promotion, Care Plus, DHB, ACC and MSD, as well as in-kind support from Taupo District Council through a tripartite relationship agreement with Sport Waikato for the free use of TDC owned gymnasiums, community halls and swimming pools throughout the District.

The introduction of integrated solutions for information technology and information sharing has also been a priority for LTPHO. While still some way from a fully-fledged eHealth environment, the PHO now has all six general practices, podiatry, physiotherapy, primary mental health, Taupo Hospital emergency department, as well as its own clinical services on an electronic medical records system. This allows secure messaging for referrals and discharges between the GPs and practice nurses, the PHO "hub", many of the community "spokes" and the Taupo Hospital emergency department. In addition, the PHO has resourced the implementation of an electronic clinical decision support tool in all six general practices and its "hub" services, and has just commenced a pilot with Healthcare New Zealand for assistive technology units for home based monitoring of high need patients in Turangi. This will continue to be a significant area of development for the PHO

LTPHO continues to invest directly in its local providers and community including offering a quality improvement programme run by Health and Disability Audit NZ to its contracted providers at no cost, providing a no interest loan to the Turangi Community Health Centre project and of more recent times forming Pihanga Health 2007 Limited to purchase the two medical practices in Turangi to ensure continuity of general practice services into the future.

31. The majority of PHOs are not as advanced as Lake Taupo PHO, and some do little more than administer funding and/or provide back-office support to general practices that continue to deliver services in the traditional manner. These PHOs are adding little value, and need to be well supported and strongly incentivised to develop quickly to fulfil the role they were established for.
32. The greatest advances have occurred where:
  - PHO roles and goals are closely aligned with the Strategy
  - DHBs are well engaged and have close geographical alignment with a limited number of PHOs or a single PHO
  - there is meaningful engagement of DHBs, PHOs, providers, professionals and communities in planning for primary health care development
  - PHOs have strong leadership – manifest in the capacity to build effective working relationships with funders and providers, and to lead service model development across a diverse range of providers and communities.

33. I want the Ministry of Health to work directly with 'peak' bodies such as the emerging Primary Health Care Advisory Council so that these attributes become more widespread. In doing so it will need to re-examine how the expectations of PHOs are specified in contracts, and ensure that enrolment lies with PHOs rather than with individual providers so that the PHO can make funding decisions that are in the best interests of their enrolled populations as intended under the Strategy.
34. Funding and planning responsibility for a wider range of primary health care services<sup>6</sup>, and more flexibility in how funding is deployed will also enhance the ability of PHOs to lead implementation by developing service delivery models that span the breadth of primary health care. Additionally, making PHOs and their providers financially accountable for the referrals (laboratory, pharmaceutical, and hospital) they make should lead to more efficient resource allocation decisions and has considerable potential for changing service delivery models.
35. PHO ownership of services (eg where a general practitioner might be salaried rather than own their own business), co-location of a range of health and social services in one place, and the use of information technology such as e-mail and telephone triage, are other options that have potential to open up the scope for development of service delivery models.
36. Many of these ideas are already being tried in some places. Some may not deliver anticipated benefits, and those that do will probably only do so under certain conditions. An approach that works in a relatively affluent highly populated urban setting, for example, is unlikely to be well suited to a relatively disadvantaged remote rural setting.
37. The Ministry of Health is working with the sector to maintain the momentum of innovation while improving the quality of evaluation and reporting of results. More specifically, I want the Ministry to identify those situations where the desired primary health care service delivery model is being achieved; evaluate the factors that have been key to their success; and, provide incentives such that other providers and districts can replicate these successful models.
38. Building on this work, I have asked the Ministry in collaboration with the Primary Health Care Advisory Council to develop a model for multi-disciplinary family health centres to be tested in locations beginning in 2009/10. Development of the model will build on best practice principles learned from examples such as Taupo Lakes. This may require a new initiative bid in budget for 2009 for establishment funding. Test sites will be chosen carefully to build on the expertise of the DHB and PHOs in the locality. At least one test site will be in a rural location, where it is proposed to build on the existing success of the Heartland Initiative.

### **Increasing DHB engagement in primary health care development**

39. Some DHBs have recognised the importance of the Strategy to their success, and this exemplified by the approach taken by the MidCentral DHB.

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<sup>6</sup> Primary health care is delivered by a range of providers including private businesses (eg general practice), not-for-profit Non-Governmental Organisations (NGOs), DHB funded services and services funded nationally through fee for service arrangements (eg maternity) or national contracts (eg well child).

### **MidCentral Health's Investment In Primary Health Care Development**

MidCentral Health's Primary Health Care (PHC) Strategy, finalised in 2004, recognised that there was significant room for improvement in health outcomes within the MidCentral district and that this improvement would be achieved through better management of patients in primary health care rather than more or better hospital services.

MidCentral Health established four geographically determined PHOs, with a single management service organisation to support the PHOs. Working closely with its PHOs, MidCentral DHB has, over the last three years, invested significantly in the development of primary health care. In December 2005 MidCentral District Health Board approved \$7.0 million sustainable funding for primary health care development including the establishment of Chronic Care Teams. The Chronic Care Teams link several initiatives across the diabetes, cardiovascular, respiratory, and cancer plans. The proposal was developed with input from primary and secondary health care providers, the services are available at community level, coordinated through local Primary Health Organisations. This aligns with the Strategy's emphasis on the creation of health care teams as the basis for primary health care services. This compares with the traditional concept of primary health care as services provided by a general practice comprising GP, nurse and receptionist. The concept of the primary health care team is multidisciplinary in nature, comprehensive in its services, located in communities and centred on the needs of individuals in partnership with specialist advice and support.

MidCentral Health's investment in PHC has included approximately 70 additional positions, 25 of the new positions are nursing but the investment programme has also seen a diversification of the clinical skill sets available within primary health care. New positions have included dietitians, podiatry, physical activity, smoking cessation, physiotherapy, health promotion, cardiologist, cardiac technicians, and psychology. A key strategy has been grouping these resources into chronic care teams. The DHB has invested significantly in general practice development to support the transition towards chronic care management. Implementation of this approach has been led by a Nursing Development Team who have designed the clinical frameworks for primary/secondary integration.

There has also been investment in diagnostic technology available within primary health care included echocardiogram, ECG machines, defibrillators, exercise treadmill and spirometry. In addition MidCentral has invested in decision support software and additional data analyst capacity within PHOs and the DHB.

This investment is recent and it will be some time before results are fully realised, but positive outcomes are already evident, such as:

- 1000 cardiovascular disease risk assessments completed in first 3 months
- 22,000 visits to chronic care teams in primary care settings in 12 months
- 21% Maori participation rates against 14% for the population as a whole, indicating successful targeting of high needs populations
- diabetes screening rates improved from 45% - 65% over 12 months.

40. There is however, considerable variation in DHB commitment and involvement in the development of primary health care in their districts. I expect all DHBs to engage closely in the establishment of new primary health care service delivery models, and will state this in my communications with them, including my annual letter to DHB Chairs.
41. I also expect DHBs to work closely with their PHOs to produce district-wide primary health care development implementation plans in collaboration with DHB provider arm services, NGOs, providers and communities.

### **Exploring funding and policy options to enable change and strengthen incentives**

42. DHBs and PHOs need to be able to fund the development of new service delivery models. In a fiscally constrained funding environment this means reprioritising existing funding allocation and seeking opportunities to increase productivity/system efficiency.

43. DHBs can direct a greater proportion of their resources to primary health care, as illustrated in the example of MidCentral DHB's approach, and this is to be encouraged.
44. There is a need to ensure that funding models and policy settings, and in particular the substantial First Contact funding stream achieve maximum leverage on development of service delivery models.
45. Flexibility to offer a global budget rather than siloed funding streams to DHBs and PHOs where the ability to manage a global budget effectively can be demonstrated is an option that should be explored. Some funding might still be ring-fenced within a global budget, to maintain traction in priority areas such as long-term conditions management and primary mental health care.
46. A commonly reported impediment to the development of more integrated service delivery is lack of access to one-off transition funding. I want the Ministry to work with the sector to identify and develop options for accessing transition funding and capital investment funding.
47. It is also essential to maintain Government's achievements in removing cost as a barrier to access for many New Zealanders, and to continue to explore options for removing remaining cost-barriers that continue to impede access for the most disadvantaged.
48. I have asked the Ministry of Health to examine underlying cost drivers and the financial incentives faced by providers; the mix of universal and targeted funding streams; appropriate mechanisms for improving access for those people for whom user co-payments are a barrier; and the ongoing affordability for Government. This work also needs to identify opportunities for incentivising the development of service delivery models that have potential to better manage cost drivers. I propose that you direct the Ministry of Health to report to you on these matters by end March 2009.

### **Strengthening performance incentives, and monitoring and accountability mechanisms**

49. To effectively leverage performance, alignment must flow through all players in the health system, including:
  - the Ministry, which holds the Crown Funding Agreements and funds DHBs
  - DHBs, which hold the agreements with PHOs
  - PHOs, which hold "back to back contracts" with providers
  - providers, comprised predominantly of general practices and some Non-Government Organisations (NGOs)
50. The PHO Performance Programme uses performance-based payments to incentivise performance improvement against a range of high priority nationally consistent indicators, such as influenza vaccination coverage for older people. I am currently investing more money in incentive payments for performance in the areas of long-term conditions and reducing inequalities and improved alignment with health targets.
51. Looking further forward I want to see existing performance initiatives aligned and a comprehensive and closely aligned performance management system developed across DHBs, PHOs and providers. This will ensure performance management is more consistent between DHBs, PHOs and providers and that it is more focused on measuring outcomes, rather than inputs.
52. The Ministry will ensure that DHBs are held accountable for performance against implementation of the Primary Health Care Strategy, using a defined set of performance indicators.

53. I want the Ministry to take the actions listed below to improve the level of cooperation and collaboration between DHBs, PHOs and providers:<sup>7</sup>
- support the further development of district or locality health networks<sup>8</sup> that work across hospital and community service boundaries to improve patient outcomes by establishing clearer patient pathways and better communication amongst clinicians and others caring for patients
  - require DHBs to work with their PHOs to collaboratively develop comprehensive district primary health care development plans that demonstrate how desired changes to service delivery models will be implemented
  - explore options for the development of a framework, similar to the DHB Monitoring and Intervention Framework, for DHBs to use with poorly performing PHOs.
54. I will also require that PHO and practice-level performance information is publicly available. This will increase the financial and reputational incentives to improve quality.
55. I will report on progress on strengthening performance management systems and improving governance and accountability mechanisms as part of the report on the extent to which the Strategy is meeting the Government's objectives which will be provided to the Cabinet Social Development Committee by 30 June 2009.

## **FINANCIAL IMPLICATIONS**

56. Some of the funding proposals in this paper would require an additional investment of public funds. If it is agreed to advance the proposals in question, a budget bid will be prepared for the 2009 budget.

## **CONSULTATION**

57. The Department of Prime Minister and Cabinet, Treasury, Te Puni Kokiri, the Ministry of Pacific Island Affairs and the Ministry of Social Development were consulted during the preparation of this paper.

## **HUMAN RIGHTS IMPLICATIONS**

58. This paper does not have human rights implications.

## **LEGISLATIVE IMPLICATIONS**

59. The proposals in this paper are consistent with the New Zealand Public Health and Disability Act 2000. Implementation of the actions does not require legislative change.

## **REGULATORY IMPACT AND COMPLIANCE COST STATEMENT**

60. Not required.

## **GENDER IMPLICATIONS**

61. There are no specific gender implications arising from this paper.

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7 These actions are consistent with the direction that the Long Term System Framework is taking for the whole health system.

8 The term 'health networks' is used to describe the broad array of health professionals and consumers involved.

## DISABILITY PERSPECTIVE

62. The services referred to in this paper are predominantly health services. People with disabilities also access these services. Poor co-ordination of services and a lack of collaboration between agencies compound the difficulties that people with disabilities face.

## PUBLICITY

63. I propose making public statements about my expectations of DHBs and the wider primary health care sector.

## RECOMMENDATIONS

64. I recommend that the Committee:
- a. **Note** that this paper is the second of two papers on primary health care, and that the first paper reported on the Primary Health Care Strategy's key achievements to date (SDC Min (08) 10/3 refers)
  - b. **Note** that Cabinet agreed that the Minister of Health report again to the Cabinet Social Development Committee by 30 June 2009 on the extent to which the Strategy is meeting the Government's objectives, as informed by my July 2008 report, and incorporating key findings from evaluation reports due for release during 2008 and early 2009 (SDC Min (08) 10/3 refers)
  - c. **Note** that the above paper will now also report progress on improvements to governance and accountability mechanisms, and strengthened performance management systems
  - d. **Agree** that Ministry of Health explore options to move PHOs towards more fully integrated service delivery models that can implement primary and population health interventions in collaboration with their DHBs, with geographic boundaries if and as appropriate.
  - e. **Agree** to build on best practice PHO models to ensure full implementation of the New Zealand Health Strategy, the New Zealand Disability Strategy and the Primary Health Care Strategy.
  - f. **Direct** the Ministry of Health to provide a progress report to the Cabinet Social Development Committee by end of December 2008 on the development of service models for multi-disciplinary family health centres to be tested during 2009/10.
  - g. **Note** that I expect that all DHBs to engage closely in the establishment of new primary health care service delivery models and will state in my communications with them, including my annual letter of expectations to DHB chairs.
  - h. **Direct** the Ministry of Health to report the Cabinet Social Development Committee by end of March 2009 on the sustainability of the primary health care funding framework, including: the mix of universal and targeted funding streams; appropriate mechanisms for ensuring access for people for whom user co-payments are a barrier; and the ongoing affordability for the Government.

Hon David Cunliffe  
MINISTER OF HEALTH

