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**AUCKLAND REGIONAL PUBLIC HEALTH SERVICE**  
**ARPHS feedback on ADHB December 2008**  
**Long Term Conditions Forum**

Thank you for this opportunity to provide feedback on the minutes and notes from the ADHB Long Term Conditions Forum held in December 2008. This forum was attended by Doone Winnard and Andrew Lynch from the ARPHS Health Promotion in PHOs team and Caroline Tichbon on behalf of the wider Health Outcomes team and the Tamaki Transformation programme.

We commend ADHB on the work it is doing to consider the practical implementation of a Long Term Conditions framework. We believe that sound integration of personal and public health perspectives and services in the health sector response to Long Term Conditions will be pivotal to improving health outcomes and reducing disparities. It is in this context that the following feedback is offered.

The following submission represents the views of the Auckland Regional Public Health Service and does not necessarily reflect the views of the three District Health Boards. Please refer to Appendix 1 for more information on ARPHS.

ARPHS understands that all submissions will be available under the Official Information Act 1982, except if grounds set out under the Act apply.

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## 1. Strengthening community action and participation

‘Strengthening community action and participation’ is one of the four key workstreams of the Long Term Conditions (LTC) Framework proposed by ADHB<sup>1</sup>. In reviewing the framework in preparation for the LTC Forum, ARPHS staff anticipated that the discussion about actions under this work stream would be centred on the community as a collective and, as indicated in the Framework, involves harnessing NGO and community leadership. We saw such actions as particularly relating to the health promotion, illness prevention end of the care continuum outlined. Indeed in Jane O’Halloran’s presentation early in the Forum she talked about the need to consider both preventing LTC and living well with LTC.

However as indicated in the summary notes from the Forum, the vast majority of comments and proposed actions discussed in the small group that was allocated this topic related to the coordination of care and services for individuals and families effected by long term conditions (i.e. living well with LTC); there was little discussion relating to work directed at the earlier stages on the care continuum. In other words it was mostly about ‘care in the community’, rather than complementing that with ‘action by the community’ to promote health and prevent those long term conditions which are preventable (with acknowledgement that not all of them are). We would strongly argue that both care in the community and action by the community are important.

We note that the first of the six goals of the draft Ministry of Health LTC framework is to reduce the incidence of LTC including reducing disparities in this incidence. The Ministry framework acknowledges that communities need to be enabled to identify risks or barriers to health within their own contexts, and to develop locally driven solutions, on the understanding that these community driven actions are more likely to result in sustainable change. Consequently, we think it is important that the ADHB proposed framework enables and facilitates action in both care in the community and action by the community.

The inclusion of health promotion as a work stream in PHOs provides the opportunity for health promoters to work alongside primary health care clinical teams to identify community needs and support and enable such a community response. Health promoters can support a two-way communication channel that facilitates exchange between communities and organisations working within them and clinical teams. This has the potential to capitalise on all the information gleaned daily in primary care consultations that could inform health promotion planning, while health promoters working in and with the community could feed back information to enable health services to be more responsive to those who currently minimally engage with them.

The strengthening of community participation, at all levels of primary health care organisations, is also a key tenet of the Primary Health Care Strategy. It is important in this context to differentiate between and value both consumer participation, which is important in quality improvement activities, and community participation which is meant to be a feature of PHO governance<sup>2</sup>. Concepts of levels of participation are

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<sup>1</sup> as circulated in preparation for the LTC Forum

<sup>2</sup> See further Pat Neuwelt’s PhD Thesis, available from the SoPH.

also important, with the recognition that participation that is meaningful will be necessary to significantly influence LTC management and prevention, rather than participation which is tokenistic. Meaningful participation may require investment in enhancing the community's ability to do so, again an area where health promotion has an important role.

## **2. Systems for referral and feedback**

There were a lot of comments at the Forum, reflected in the summary notes, about the need for better systems for patient/whānau referral and feedback. However these comments largely relate to this being an issue between general practice teams and hospital services, while in fact similar issues apply to coordinating and linking general practice teams with social service and community agencies. Given that LTC management is intended to be more holistic than medical management, and include attention to wide-ranging aspects of health as reflected in the Te Whare Tapa Wha model of health<sup>3</sup>, these broader linkages also require attention. To address social and cultural needs may frequently involve organisations or services outside of the traditional health system, and appropriate infrastructure and processes are also required for these referrals if they are to be effective.

Such partnerships are important not only in aiming to support those with LTC to 'live well' but also in preventing LTC. There are international examples of commentary about the enablers needed for the development of partnerships between primary care clinicians and community organisations that attempt to strengthen preventive care<sup>4</sup>.

## **3. 'Empowering primary care'**

Issues raised in previous ARPHS feedback on the ADHB Primary Health Care Plan about the definitional difference between 'primary care' and 'primary health care' are pertinent here. Although the elements of the Framework listed under the workstream 'Empowering primary care' are pertinent to general practice teams, we would assume that this workstream is intended to reflect broader primary health care teams that would include allied health professionals, community health workers, health promoters and primary health care managers. Discussions at the Forum were still very doctor and nurse centric, but we believe that all of these other groups need to be involved in the elements listed in the framework - programmes of learning about LTC, using collaborative quality improvement approaches and targeting services according to need.

In considering empowering this broader primary health care team, defining the concept of working in partnership is also important. John Key recently stated in his address at Ratana Pa that 'partnership is about seeing things from each other's perspectives. A partnership is not just about being next to one another. It is more

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<sup>3</sup> mental, emotional, cultural, social, and spiritual needs

<sup>4</sup> For example, Woolf S, Krist A, Rothemich S (2006) Joining hands: Partnerships between physicians and the community in the delivery of preventive care. Virginia Commonwealth University: Virginia.

than that' (NZ Herald Sat Jan 24 2009, P A6). An early draft of the Ministry LTC framework suggested that primary health care will have a significant role in 'identifying opportunities to integrate relevant allied health services into community-level health care e.g. pharmacy, physiotherapy, dietetics, podiatry'. This will require those allied health professionals actually being part of the decision-making teams who are planning community-level health care, rather than having others make decisions about their contribution on their behalf. This will give them the chance to advocate for the contribution they can make more broadly to primary health care goals, rather than simply providing isolated services that others (who may not fully understand what they might have to offer) decide is appropriate. Allied health care workers and specialists can work in 'health-promoting ways' that engage people in being healthy in ways that are appropriate to their setting and professional role – i.e. they can contribute to preventing LTC as well as helping people live well with LTC.

### 3. Working intersectorally

It is widely acknowledged, including in the Ministry of Health's LTC Framework, that inequalities in the social determinants of health are fundamental to health status inequalities, and also that non-health sectors such as media and industry organisations influence knowledge and behaviours of the community. Work with sectors such as local government, education, housing, justice along with the commercial sector is therefore vital to achieve the goals of the ADHB LTC framework.

However most of the comments relating to intersectoral work in the Forum summary appear to relate primarily to working with organisations from other sectors at the level of coordinating services for individuals with LTC (see further Point 2 above), rather than for the collective community. Again this is where health promoters in PHOs could play a significant role. Planning and commissioning is frequently challenging enough within the health sector with its many components, with intersectoral responses requiring another whole level of engagement and organisation. ARPHS staff believe that the LTC framework needs to actively support this higher level intersectoral engagement to effectively address LTCs. The approach for the Auckland district could build on the learnings from the Tamaki Transformation experience<sup>5</sup>.

### 4. Focus on outcomes

There was not a lot of discussion about outcomes at the Forum but one of the areas of outcome measurement mentioned in the Forum summary is that of 'patient satisfaction'. As increasing attention is being given to quality improvement in primary health care, we believe it is timely to consider whether 'satisfaction' is really a primary concern. For example, would some kind of measure of patient/whānau empowerment or enablement as an outcome of service provision fit better with the self-care philosophy of LTC management<sup>6</sup>? Questions about whether the patient and their

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<sup>5</sup> see Sarah Marshall's work

<sup>6</sup> An example of such a tool is the 'Patient Enablement Questionnaire' (Howie J, Heaney D, Maxwell M, Walker J (1998) A comparison of a Patient Enablement Instrument (PEI) against

whānau understand better their condition and its management and feel more in control of what is happening to them may give more valuable information than current patient satisfaction questionnaires.

## **5. Further stakeholder engagement**

In preparation for the planned future whole system workshops noted in the consultation document, we suggest that further consideration could be given to the question of what other stakeholders could be invited to participate who have not been part of the consultation so far. Given the burden of disease material presented at the workshop, perhaps stronger involvement of those affected by mental health conditions and musculoskeletal disorders could be appropriate. A population health approach also considers the smaller and more vulnerable groups alongside those who loom large in the overall population data, so for instance the refugee community, those with disability, those living with HIV could be more actively engaged. The issue of differentiating consumer and community is also relevant here; our observations from the December LTC suggest that consumer representation was much more apparent than explicit community representation. We believe that continued efforts to achieve wide engagement in this important work to address LTC will reap benefits for both the ADHB and the communities it serves.

Thank you for the opportunity to make this submission.

Yours sincerely

Handwritten signature of Frank Booth in blue ink.

Frank Booth  
Service Manager  
Auckland Regional  
Public Health Service

Handwritten signature of Andrew Lindsay in blue ink, with the date 02/02/09 written below it.

Andrew Lindsay  
Medical Officer of Health  
Auckland Regional  
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## **Appendix 1 - Auckland Regional Public Health Service**

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards), with the primary governance mechanism for the Service resting with Auckland District Health Board.

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary concern is to improve population health rather than deliver personal health services. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, outstanding infrastructure needs, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.

Policy to affect health gain is often marginalised to medical care. Health, however, is influenced by a broad range of policy decisions and is therefore a multi-sector responsibility and not solely the responsibility of the health sector. Statutes such as the New Zealand Public Health and Disability Act, Local Government Act, Resource Management Act and Building Act (amongst many others) all have elements designed to deliver outcomes promoting, protecting and maintaining the health of the community. Planning and policy decisions by central government, local government, non-government agencies and the commercial sector can have a large impact on health outcomes. ARPHS, therefore, has a role to play in policy advocacy. Population health and wellbeing can be improved if policy decision makers are considering long term outcomes. ARPHS aims to influence public policy to create a supportive environment for the communities of Auckland.