



PUBLIC HEALTH IN A PRIMARY HEALTH CARE SETTING

Public Health Directorate

Ministry of Health

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This is a 'working document' able to be used for discussion around primary health care.

It is the second document of three written to assist public health and primary care providers work more closely together and with the community on population based programmes. The two other documents are:

A Bird's Eye View of Public Health

A Guide to Developing Health Promotion Programmes in a Primary Health Care Setting

These may be accessed from the MOH website: www.moh.govt.nz

Further comments may be directed to:

Locality Managers based in Auckland, Hamilton, Wellington, Dunedin
Public Health Directorate
Ministry of Health

PURPOSE OF DOCUMENT

The New Zealand Health Strategy has as its aim to reduce inequalities in health and improve overall health status of the population. The Primary Health Care Strategy sets out how this will happen in a primary care setting. This will require population approaches to be used in primary care. It will be necessary for a range of players in the health sector to understand the way both public health and primary care are delivered. This document is designed to assist those who work in these two complementary paradigms to better understand each other's perspective in order to facilitate co-operative working relationships.

The audiences for this document include:

- District Health Boards (DHBs)
- Primary Health Organisations (PHOs)
- Public Health Service Providers (government and non government)
- Health professionals
- Policy makers e.g. the Primary Health Care Strategy Implementation group
- Community groups
- Non Government Organisations (NGOs)
- Ministry of Health.

INTRODUCTION

Primary health care as described in the Primary Health Care Strategy (PHCS) is wider than the currently delivered general practice services. It includes some population-based services that are best delivered in a primary care setting. The new style of primary health care will require new skills and competencies and a degree of co-operation and co-ordination across the health sector not previously achieved. Exciting new opportunities exist to deliver services in an innovative way using a range of health professional skills.

The vision for the Primary Health Care Strategy is:

- 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.

Implementation of this strategy will occur gradually by establishing Primary Health Organisations. Health services will be re-oriented so that primary health care is:

- Developed through community participation
- Universally accessible
- Centrally placed in the New Zealand health system
- The first level of contact with the health system.

Primary health care services will be organised around the needs of a defined population. Primary Health Organisations will be responsible for delivering a range of services, including:

- Improving and maintaining the health of the population, and
- First line services to restore peoples' health when they are unwell.

The focus of primary health care will therefore extend beyond treatment and support services to include a more comprehensive disease prevention and health promotion approach. This will require a collaborative and multi-disciplinary approach. Community leaders and health professionals from all parts of the health care system such as primary care, public health, Non-Government Organisations (NGOs) and District Health Boards (DHBs) will need to change the way they work together as the mix of services provided broadens (Ministry of Health 2001).

This document sets out an approach to working together. Commonly used definitions and the specific features of public health and primary care are described. The rationale for the two paradigms working together is outlined and points of interface identified. Opportunities for engagement between public health and primary care in a primary health care setting are described.

BACKGROUND

The elements and perspectives to consider in the new primary health care environment include:

- Population health
- Primary health care
- Public health
- Inequalities in health
- Health promotion
- Treaty of Waitangi
- Māori perspectives
- Pacific perspectives
- Organisational structures - Primary Health Organisations, Public Health Service Providers (PHSP).

This section briefly describes these terms so that a common understanding of them can be reached.

Population Health

Population health considers the health of groups, families and communities. Populations may be defined by locality, by biological criteria such as age and gender, by social criteria such as socio-economic status or by cultural criteria such as whānau. A population health approach takes account of all the determinants of health and how they can be tackled. It integrates all activities of the health sector (public health, mental health, personal health, disability support) and beyond. Both personal health and public health can contribute to a population health approach.

Primary Health Care

The definition used in the Primary Health Care Strategy is (Ministry of Health 2001):

'Quality primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that is:

- Universally acceptable to people in their communities.
- Involves community participation.
- Integral to and a central function of New Zealand's health system.
- The first level of contact with our health system.'

These concepts were first described in the Alma Ata declaration of 1978 (WHO 1978).

'primary health care is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part of both the country's health system, of which it is a central function and main focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.'

Currently, primary health care in New Zealand is mainly associated with general practice or primary medical care. The above definitions are broader and include other health providers and individuals, families and communities.

Public Health

Public health is defined as *'the science and art of preventing disease prolonging life and promoting health through the organised efforts of society'* (Acheson 1988). Public health services are delivered to whole populations, or sub groupings of the whole population, at national, regional and local levels. They include health protection and health promotion. Specific elements of public health services are usually called 'programmes', as they often combine several mechanisms or approaches for action to tackle a health issue.

Health protection services are often not visible, and not appreciated until they are needed by individuals or fail whole populations. Clean water, sanitary living conditions, an environment free from pollution and danger and a team able to respond to health needs in a civil emergency are often taken for granted. Health protection services also enforce public health legislation - designed to protect the health of the population. This includes the requirement to notify certain infectious diseases, smoke free legislation and so on. Regulatory action is not included in PHO responsibilities. However a PHO health promotion plan may include making submissions for instance, to local government on health issues influenced by their annual plans.

Health promotion is described below.

Inequalities in Health

Significant inequalities in health exist among different groups of New Zealanders. For example, Māori, Pacific peoples and people from lower socio-economic groups have worse health and die younger than other New Zealanders. The reasons for health inequalities are complex and generally beyond the control of the groups most affected (Ministry of Health 2002).

The wider determinants of health underlie many health inequalities. They include:

- Age, sex and hereditary factors
- Individual lifestyle factors
- Social and community influences
- Living and working conditions
- Gender and culture
- General socio-economic and environmental conditions.

Inequalities in health exist throughout life across several dimensions, including:

- Socio-economic status
- Ethnic identity
- Geographic place of residence
- Gender.

Success in reducing health inequalities will mean a fairer and more inclusive society, better health and well being for the population as a whole and a stronger economy (Woodward and Kawachi 1998).

Interventions to tackle health inequalities can be considered at four levels:

- ***Structural*** – tackling the root causes of health inequalities, that is the social, economic and cultural and historical factors that fundamentally determine health
- ***Intermediary pathways*** – targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health
- ***Health and disability services*** – undertaking specific actions within the health and disability services
- ***Impact*** – minimising the impact of disability and illness on socio-economic position.

Interventions at these four levels should be undertaken nationally, regionally and locally by policy makers, funders and providers (Ministry of Health 2002). Primary care providers and their communities can be involved at a local level as well as providing input into policy development e.g. Responsible Gambling Bill or the design of new housing areas.

Health Promotion

Health promotion is the term given to planning, implementing and evaluating activities that promote health and well being in communities (Ministry of Health 2002a).

The Ottawa Charter is an international model on which health promotion planning is based and defines health promotion as (WHO 1986):

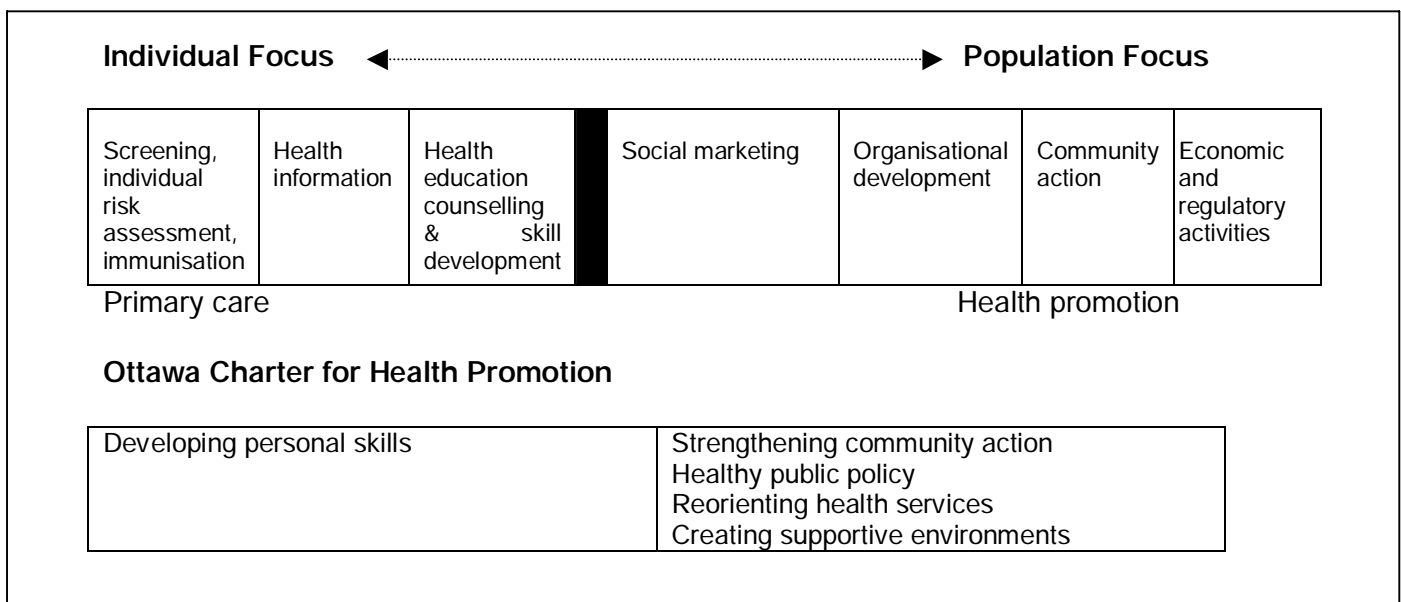
'the process of enabling people to increase control over and improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to realise aspirations, to satisfy needs and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to wellbeing.'

The Ottawa Charter groups health promotion strategies and techniques into five action areas:

- Building healthy public policy
- Re-orienting health services
- Creating supportive environments for health
- Strengthening community action
- Developing personal skills.

Table 1 illustrates a range of activities used to improve individual and population health, the settings in which they occur and the providers associated with them. It also shows how this links with the Ottawa Charter. These activities can be combined as elements of a whole programme, but may be delivered by different providers in a range of settings. All are needed to achieve improved health outcomes.

Table 1: Some activities used to improve individual and population health



Treaty of Waitangi

The Treaty of Waitangi is the founding document of New Zealand and describes the special relationship between Māori and the Crown. The Treaty relationship to date has been based on the principles of partnership, participation and protection. *He Korowai Oranga: The Māori Health Strategy* (Ministry of Health 2002b) describes the application of these principles in the health and disability sector as:

Partnership: working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

Participation: involving Māori at all levels of the sector in decision-making, planning, development and delivery of health and disability services.

Protection: working to ensure that Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

The Treaty allows for Māori to be able to define and provide for their own health priorities and to improve their capacity to develop and deliver services for their own communities. As providers of health services on behalf of the Crown, PHOs have an obligation to ensure Māori in their community are included in designing, developing and delivering appropriate health services designed to improve health status and reduce health inequalities.

Māori perspective

Māori have a long history of maintaining population health through concepts such as tapu, noa and rahui. One way of describing the balance of factors required to maintain health is the model developed by Mason Durie - Whare Tapa Whā (Durie 1994):

- Te taha wairua – spiritual health including the practice of tikanga Māori generally.
- Te taha hinengaro – emotional and psychological wellbeing of whānau and individuals within it.
- Te taha tinana – physical aspects of health.
- Te taha whānau – the social environments in which individuals live.

Complex 'models', developed over generations capture the many elements and values important to wellness for particular whānau, hapū and iwi.

Two other perspectives important in a public health context are:

- Te ao turoa – the environment: the relationship between Māori and te ao turoa is one of tiakitanga (stewardship). It is the continuous flow of life source. Without the natural environment, the people cease to exist as Māori.
- Te reo rangatira – expresses the values and beliefs of people and is a focus of identity. The root of all cultures is language and te reo is a vital expression of rangitiratanga.

Health is viewed in an holistic way. Public health and primary care services are historical 'divisions' within a Western paradigm. They are not consistent with the

continuum required to address health issues from a Māori perspective. Beyond that a continuum of past, present and future is a dimension integral to a Māori view. Western attempts to address health issues frequently neglect the historical context in which these issues have arisen.

Thus a treaty partnership and common understanding of the rights of tangata whenua to control their own health and development is fundamental to Māori population health (J Carr personal communication 2002).

Pacific Perspective

The Pacific concept of health is holistic. In addition to physical, mental and emotional well-being, spiritual beliefs, family and social connected-ness, language, land and culture can also influence health. The Pacific community in New Zealand is heterogenous, and the cultural integrity and protocols of each ethnic group must be respected and adhered to, when delivering services or addressing any health issue.

Primary Health Organisations (PHOs)

PHOs are the health service structure that will provide primary health care to an enrolled population. Key points are:

- Work with those population groups that have poor health or are missing out on services. This must be based around Treaty of Waitangi principles.
- They will be funded by DHBs for the provision of a set of essential primary health care services to those people who are enrolled.
- At a minimum these services will include approaches directed toward improving and maintaining the health of the population as well as first line services to restore health when people are unwell.
- PHOs will be expected to involve their communities, iwi/Māori communities in their governing processes and service design and evaluation in a meaningful way.
- All providers and practitioners must be involved in the organisation's decision- making, rather than one group being dominant.
- PHOs will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
- While primary health care practitioners will be encouraged to join PHOs, membership will be voluntary.

Public Health Service Providers

Public health services are provided by:

- 12 public health units attached to District Health Boards
- A network of Non-Government Organisations that usually have a specific area of expertise, such as the Heart Foundation, Aids Foundation and the Cancer Society
- Iwi providers
- Pacific providers
- Territorial Local Authorities.

PRIMARY CARE MEETS PUBLIC HEALTH - TWO PARADIGMS

Specific Features of Primary Care Services

Primary care has as its main focus, actions to improve the health of the individual. General practitioners (GPs), nurses and associated staff deliver these services and manage referrals to other primary care services including diagnostic laboratory services, imaging services and support services such as meals on wheels and home help. They also refer to appropriate secondary level specialist services.

Other primary care (first point of contact) services include community pharmacy, physiotherapy, dental health, family planning, sexual health, midwifery and traditional healers.

Specific Features of Public Health Programmes

The main focus of public health programmes is collective action to improve the health of populations rather than treating diseases, disorders and disabilities in individuals.

Public Health Action:

- Takes place at many levels throughout the health sector and beyond.
- Can be planned and implemented in collaboration with other sectors.
- Can advise other sectors on the health impact of their activities and where necessary regulate these.
- Can support other parts of the health sector to take a population health approach to service planning and delivery (Ministry of Health 2002a).

Public Health services are currently organised into these 13 categories (Ministry of Health 2000a):

- Physical environments
- Food Safety and Quality
- Communicable diseases (including immunisation and screening)
- Social environments
- Well Child
- Non communicable diseases
- Prevention of alcohol and other drug related harm
- Tobacco control
- Nutrition and physical activity
- Sexual health
- Mental health promotion
- Injury prevention
- Public health infrastructure (including health information).

These groupings will be useful when considering how public health and primary care can relate to each other.

The paradigms analysed

Over the last century public health and primary care have developed in isolation and functioned separately *'to the detriment of society and the professions themselves'*

(Cashman 1999). It is only recently that integration of public health and medical care systems has been recognised as the '*...best hope not only for improving the health of all our citizens, but also for closing the 'health gap' between socio-economically disadvantaged groups and the rest of the population*' (Rundell 1994).

In the following three tables some differences and similarities between public health and primary care are identified (Bhopal 1995). Although this analysis is based on the UK National Health System there are many points of relevance to New Zealand. This information can be used as the basis of discussion between public health and primary care professionals to arrive at a common understanding of the two paradigms.

Table 2: Some resources of public health and primary health care

Source: Bhopal 1995

Public Health	Resource	Primary Care
<ul style="list-style-type: none"> Care of Populations. Environmental, social, organisational and legislative interventions are of dominant importance 	Perspective	<ul style="list-style-type: none"> Care of individual patients on practice list. Medical interventions are of dominant importance.
<ul style="list-style-type: none"> Health requires organised efforts of society. Prevention is better than cure. 	Professional Attitudes	<ul style="list-style-type: none"> The consultation is the fundamental basis of health care. The care of the sick is the prime role, and prevention has a role.
<ul style="list-style-type: none"> Public Health Sciences (epidemiology, medical statistics & other disciplines e.g. social sciences, community development, health promotion) Organisational and management issues. Policy making. Administrative networks. Health status of large populations. 	Knowledge	<ul style="list-style-type: none"> Broad, clinical knowledge. Local patterns of disease. Communication with individuals. Personal circumstances of families / individuals. Local community and its services.
<ul style="list-style-type: none"> Epidemiological and health services investigations / research (& other disciplines eg social sciences, community development, health promotion) Report and policy writing. Administration. Communication with professional services Committee work. 	Skills	<ul style="list-style-type: none"> Investigation and management of clinical problems. Consultation / communication. Small group leadership skills. Practice management. Medical audit.
<ul style="list-style-type: none"> Information on populations and health in large areas (incl needs assessment). Access to health authority resources (N/A in NZ). Access to non-medical staff, such as finance, computing. 	Information and Material	<ul style="list-style-type: none"> Practice registers and disease registers. Information on individuals. Access to local networks and primary care team.

Table 3: The common agenda and illustration of the two approaches

Source: Bhopal 1995

Public Health Approach	Agenda	Primary Care Approach
<ul style="list-style-type: none"> • Serve whole population. • Combination of methods including social and environmental policy change. • Mass approaches to education. • Educate educators and policy makers. • Seek expansion of funding base for prevention. • Take responsibility for organisational aspects at district / regional and national level. 	<p>Improve health and prevent disease</p>	<ul style="list-style-type: none"> • Serve patients on a register. • Focus on patient's illnesses and risk factors. • Prevent by medical intervention. • Lifestyle change by education. • Undertake specific, but increasing range of activities in prevention.
<ul style="list-style-type: none"> • Evaluation of the structure, process and outcome of services. • Based primarily on epidemiological and demographic data, and on economic concepts. 	<p>Effectiveness and efficiency of services</p>	<ul style="list-style-type: none"> • Audit of clinical work and practice organisation. • Based partly on subjective reviews of staff and patients.
<ul style="list-style-type: none"> • Emphasis on needs of those who make no demands <i>and of populations and communities.</i> 	<p>Assessment of health needs</p>	<ul style="list-style-type: none"> • Based mainly on demands of patients and contractual obligations.
<ul style="list-style-type: none"> • Focus on disease causes, means of disease prevention, and on processes and outcomes of health care <i>and health / illness of population groups.</i> 	<p>Research</p>	<ul style="list-style-type: none"> • Focus on management of common health problems, and on structures and processes of primary health care.
<ul style="list-style-type: none"> • Develop local health policy and adapt and implement national and regional health policy. 	<p>Policy making and implementation</p>	<ul style="list-style-type: none"> • Develop practice policy, and adopt and implement health authority policy.

Table 4: Some obstacles to the achievement of the common agenda

Source: Bhopal 1995

Inter-professional <ul style="list-style-type: none">• Persistence of historical rivalries• Failure to achieve mutual understanding of roles and goals• Inequality of esteem – perceived or actual• Unrealistic expectation
Administrative <ul style="list-style-type: none">• Mismatch between the geographical areas served by public health doctors and other workers and general practitioners / primary health practitioners• Tension created by the overlap in the role of public health doctors and general practitioners as purchasers (Not applicable in NZ)
Philosophical and ethical <ul style="list-style-type: none">• Conflict between need based and demand based approaches to care.• Conflict between immediate needs of the patient and those of potential patients.• Conflict between priority setting and rationing, and doing the best for the patient.
Practical <ul style="list-style-type: none">• Shortage of staff in public health medicine in relation to needs at primary care level.• Rapidly increasing sphere of responsibility of general practitioners / primary health practitioners.

Improved understanding of the different perspectives of public health and primary care is essential if PHOs are to achieve their purpose and the vision of the Primary Health Care Strategy is to be realised.

RATIONALE FOR PUBLIC HEALTH AND PRIMARY CARE WORKING TOGETHER

There are many strategies and structures that describe the expectations to be met by the primary health care sector:

- New Zealand Health Strategy
- Primary Health Care Strategy
- He Korowai Oranga – the Māori Health Strategy
- District Health Board Community and Public Health Advisory Committees
- Mental Health Promotion – draft strategy
- New Zealand Disability Strategy
- Pacific Health and Disability Action Plan
- Achieving Health for All People – the Public Health Strategy

There is therefore a mandate for the whole health sector to work together in the primary care setting. This paper deals with the relationship between public health and primary care only, but could well be applied more widely.

The National Health Committee identified these reasons for strengthening primary health care in New Zealand (National Health Committee 2000):

- Well-documented health inequalities in New Zealand highlight an urgent need to take action to address them.
- Evidence that a good proportion of illness and premature death is potentially preventable by health sector intervention.
- Evidence for inequities in access to primary medical services and subsequently to publicly funded flow on services including laboratory and pharmaceutical services.
- A stated commitment by successive governments to a greater focus on health promotion and disease prevention in the publicly funded health system.
- A planned shift to DHBs in which joint funding and hospital care provision roles presents a risk that hospitals may become the focus of DHBs at the expense of primary health care.

Table 5 shows some of the differences between current primary care settings and the proposed Primary Health Organisations (Ministry of Health 2001).

Table 5: Differences between current primary care services and the vision

Source: Ministry of Health 2001

OLD	NEW
Focus on individuals	Looks at health of populations as well
Provider focused	Community and people focused
Emphasis on treatment	Education and prevention important too
Doctors are principal providers	Teamwork – nursing and community outreach is crucial
Fee for service	Needs based funding for population care
Service delivery is mono-cultural	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non health agencies

Understanding the differences and similarities between primary care and public health is important if an integrated cohesive and effective primary health care system is to become a reality. The goal of integrating public health and primary care into one system is to improve the health of populations and reduce health inequalities through a team approach (Welton et al 1997).

POINTS OF INTERFACE BETWEEN PUBLIC HEALTH AND PRIMARY CARE

A population health approach

A population health approach takes into account all the determinants of health and how they can be tackled. It integrates all activities of the health sector (public health, mental health, personal health, disability support) and beyond. Both personal health

and public health can contribute to a population health approach and can tackle the wider determinants of health in reducing inequalities (Ministry of Health 2002).

The determinants of health, modified from Dahlgren (1991) include:

- Age sex and hereditary factors
- Individual lifestyle factors
- Social and community influences
- Living and working conditions
- Gender and culture
- General socio-economic and environmental conditions.

Much good work is already being undertaken in these points of interface:

1. Immunisation – individuals are offered immunisation in primary care settings supported by public health programmes promoting the benefits of reducing vaccine preventable disease. The success of immunisation for the population is dependent on a sufficient number of individuals being immunised to benefit the whole group.

2. Screening – national programmes for breast and cervical screening are delivered by primary health care providers. The National Screening Unit supports these with population-based activities such as health promotion, monitoring and evaluation.

3. Communicable disease control – Public Health Units are notified of cases of certain communicable diseases by primary care providers and others. Public health workers follow up contacts of index cases where relevant and monitor the pattern of illness in each community so that appropriate measures can be taken to protect the health of the population.

4. Health Promotion

Well Child/Tamariki Ora – providers deliver clinical screening, surveillance and education (promoting and facilitating immunisation) and support services to children their families and whānau from birth to five years.

Smoking cessation – smokers are encouraged and supported to quit by primary care providers and offered assistance via cessation services such as the QUIT programme. New Zealand's national tobacco control policy supports this through smoke-free legislation, taxation and health promotion to develop smoke-free environments and encourage change in attitude and behaviour.

Health Promoting Schools/ Kura Waiora promotes health and well being in schools. This programme is setting based rather than issue based with priorities identified by the school community. Guidelines have been developed for school communities on hearing preservation, food and nutrition, mental health and smoke-free environments.

5. Intersectoral Action

Safer Community Councils comprising representatives from community organisations work within their communities to create safer environments.

Healthy Cities programmes are based on community health development initiatives. They are usually facilitated and supported by local city councils.

Many other points of interface exist based around specific health issues or population groups. Primary care and public health providers working together on such issues have the opportunity to prevent crises rather than be constantly responding to them.

Health promotion programmes and approaches

Health promotion aims to reduce the impact of the wider determinants of health by changing behavioural patterns, addressing social circumstances and reducing the impact of environmental exposures.

Figure 1 compares the relative contribution of the wider determinants of health and health services on early death in the US. As can be seen behavioural patterns e.g. smoking and diet leading to obesity contribute to 40% of early deaths. An estimated 10% of preventable mortality could be avoided by better availability or quality of medical care (McGinnis 2002).

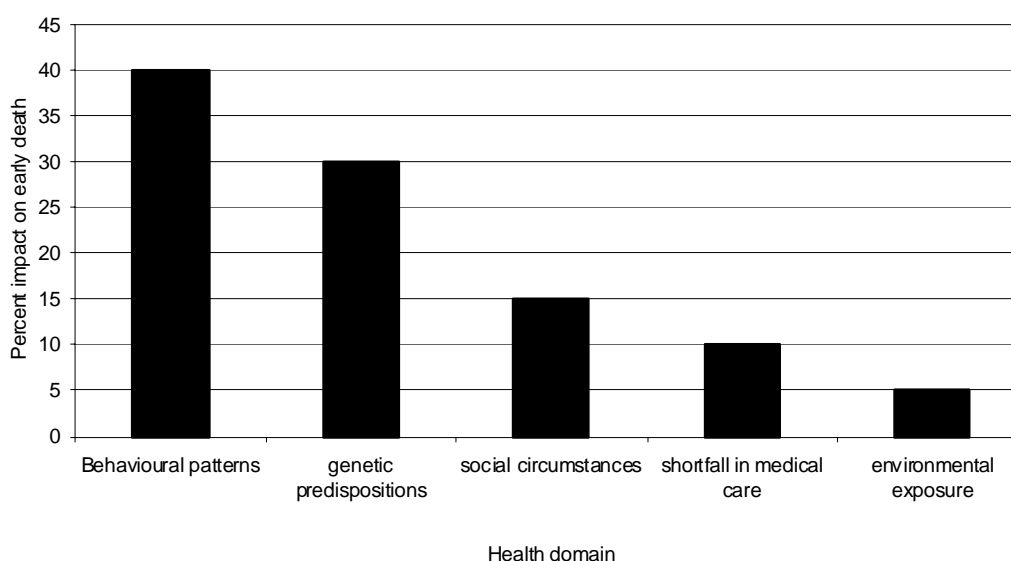


Figure 1: *Impact of the wider determinants of health on premature death in US*

Source: McGinnis 2002

The way in which the determinants of health interact contributes to ultimate health outcome. For example whether genetic predisposition to diabetes is expressed can be determined by environmental exposures or behavioural patterns. In addition the consequences of behavioural choices can be affected by social circumstances (McGinnis 2002).

Health promotion is about working with people, communities and marginalized groups to build on strengths to address issues they identify as important, with support from public health and primary care providers.

OPPORTUNITIES FOR ENGAGEMENT

There are many opportunities for public health and primary health care to work together to achieve the broad vision of the Primary Health Care Strategy. This can be conveniently divided into three organisational levels:

Local provider level

Public health service providers and primary care service providers can work together with communities to integrate both health promotion and health protection activities. The main areas of interface (examples in the previous section) are:

- Immunisation
- Screening
- Communicable disease control
- Health promotion activities.

Health promotion activities in a PHO setting could include:

- Early interventions for alcohol and drug dependence.
- Contributing to a community coalition working to get speed humps and other traffic calming measures in a neighbourhood where many patients of your live.
- Developing a petition asking for a local bar to be made smoke free.
- Sponsoring and promoting a 'walk for life' regular walking programme.
- Organising an exercise session for 'fit fatties' and have staff available during the programme.
- Preparing and speaking to a submission to your regional council calling for the retention/introduction of a fluoridated water supply.
- Mental health promotion programmes to reduce stigma and discrimination

Other opportunities exist in:

- Health information management - surveillance, monitoring and audit.
- Working to develop and support community involvement in PHO settings.

Regional (DHB) level

- DHBs have overall responsibility for implementing the Primary Health Care Strategy through the establishment of PHOs. By working with communities, public health and primary care providers over this process there will be 'joint ownership' of the outcomes.
- The development of PHO health promotion programmes should be planned with communities and DHBs to reflect local needs. Best use of resources will be achieved by building on existing programmes and utilising existing networks.
- Ministry of Health Public Health Directorate staff have broad public health knowledge. Their advice and support is available to improve understanding about how to achieve a population health focus.

Central Policy Level (MoH)

- The Primary Health Care Strategy Implementation Group (PHCSI) will have ongoing input from a range of Ministry Directorates including Mental Health, Māori Health and Public Health. This will help 'join up' the sector.
- Networking across other central government agencies with an interest in the wider determinants of health, such as Ministry for Social Development, Treasury, Ministry of Education, Ministry of Housing, Ministry of Labour.
- Explore shared training and workforce development across both primary care and public health sectors. Ideally a shared training will improve understanding of the two paradigms creating an effective integrated workforce.
- Consider the research and evaluation needs of the emerging PHOs and plan for evaluation of the major change in the health sector that the PHCS is introducing.
- Strengthen region-wide and nation-wide networks of DHB and Ministry of Health officials to improve understanding of the central role that primary health care has in the health sector and that population health services are an integral part of primary health care.

SUMMARY

The New Zealand Health Strategy and the Primary Health Care Strategy are being implemented. The overall goal is to improve the health status of the population and reduce health inequalities among different populations.

Key aspects include re-orienting health services so that:

- Primary health care has a central role in the health sector.
- Population health services are part of primary health care.

This is to be achieved through the establishment of Primary Health Organisations that:

- Focus on patient/community need.
- Provide a comprehensive range of services to improve population health from personal care to health promotion.
- Genuinely engage with the community of interest (Matheson 2002).

Traditional professional misunderstandings between personal health and public health providers need to be addressed in order to successfully achieve this. Each paradigm has much to offer the other and strong integrated collaborative working relationships are needed to achieve the overall goal. A common vision is needed requiring political will and leadership so that:

'...Through clinical preventive medicine clinicians can help individuals lead healthy lives; through community driven public health, clinicians and others can help whole communities become healthier' (Cashman 1999).

Treatment services contribute significantly to improving the health of populations and will always be needed. Effort is also needed to prevent ill health and promote wellbeing.

Uniting primary care and public health in a Primary Health Organisation framework strengthens each paradigm with the potential to improve the health status of the population and reduce health inequalities. The points of interface of the two paradigms are an important place to start building from.

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