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Abbreviations

AUT: Auckland University of Technology  
DHB: District Health Board  
PHCS: Primary Health Care Strategy  
PHO: Primary Health Organisations  
TOW: Treaty of Waitangi  
UoA: University of Auckland  
WHO: World Health Organisation

Preface

He aha te mea nui?  
He tangata.  
He tangata.  
He tangata.

What is the most important thing?

It is people, it is people, it is people.

Primary health care has to become more comprehensive to meet current and future community needs! Our passion for more collaborative team working among a wider range of primary care practitioners is driven by observations and stories of people in our communities. Some of them have experience avoidable hospital admissions, distressing levels of anxiety and depression, lack of confidence, low resilience, and/or long term conditions that they do not understand or feel ‘in control’ of as much as they would like. Many are eager to more involved in addressing and managing their own health, supported by the most appropriate people from a more comprehensive primary health care team. We know health outcomes can be better!

We strongly believe too, that the competencies for the future workforce must include interdisciplinary teamwork in primary health care.

While interdisciplinary education is not an end in itself, it provides ways of preparing health professionals to work collaboratively. This is important to address now in New Zealand. This resource booklet is part of creating early stage processes, learning experiences and resources necessary to progress interprofessional learning and interdisciplinary teamwork in primary health care. We are grateful to Moana Oh for research assistance and to our colleagues from AUT University, Waitemata DHB, The University of Auckland, Coast to Coast PHO and Eldercare New Zealand.

Together we can help realise The Primary Health Care Strategy vision of more comprehensive primary health care for better health in communities!

Mary-Anne Boyd: Innovation Manager, Waitemata DHB & Wendy Horne: Deputy Dean, Environmental and Health Sciences, AUT University.

Auckland, April 2008

Building and Enhancing Interprofessional Teams
Definitions

What do we mean by ....?

**Collaboration:** An interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the ways client/patient care and broader community health services are provided (Way et al., 2000, p.3). It implies joint delivery of services aligned to common strategic planning.

**Interdisciplinary:** An approach in which individuals from two or more professions work collaboratively to improve health outcomes. This approach emphasises the connectivity, alignment and collaboration between primary, secondary and tertiary health care services (MOH, 2006). It implies shared assessments, clinical records and client goal setting...patient or community at the centre.

**Interprofessional:** Interaction amongst health professionals which goes beyond merely having members of different professions sharing an environment together (Headrick et al., 1998).

**Interprofessional Education:** ‘Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care’ (CAIPE, 2002)

**Multidisciplinary:** A collection of health professionals who independently contribute their particular expertise in parallel to each other, with minimal interdisciplinary communication except through a key patient care co-ordinator. (Hall & Weaver, 2001). This does not necessarily imply integrated clinical records.

**Teamworking:** Coordinated action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of and respect for others’ roles and functions (WHO, 1988).

**Teamworking/Interdisciplinary/Interprofessional:** For our purposes, these terms will be used interchangeably and are intended to imply the same purpose or meaning as described above.

Introduction

This information booklet is part of Building and Enhancing Interprofessional Teams 2006-2008. It is intended to support learning and touches on national and international information about policies, theory and practice.

For students in interprofessional primary health care placements, your participation is supported by clinical leaders, the board and executives in your host provider organisation, by Waitemata District Health Board, by the leadership of AUT University, and The University of Auckland. It is also actively supported by the Ministry of Health.

You will gain most if you have positive expectations.

Explore similarities with students in your placement. Explore differences and unique perspectives. Take client views as you think and learn about different roles.

Regard yourselves as having equal status within this placement regardless of your roles or programme stage. The learning atmosphere is intended to be cooperative rather than competitive and we want you to seek and use the resources available to you so your experience and joint work is satisfying and successful for you and people served.

**Our focus is to achieve effective interprofessional education that:**

- Works to improve the quality of care/services
- Focuses on the needs and involvement of service users and communities
- Promotes interprofessional collaboration
- Encourages professions to learn with, from, and about one another
- Respects the integrity and contribution of each profession and other key roles such as cultural support roles - and creates contexts in which the possessors of the relevant skills or knowledge are considered to be equal or equally important
- Increases satisfaction for service users and practitioners

(Headrick et al, 1998)
Teamwork is important because:
1. the problems addressed on an everyday basis by primary health care are complex and require a range of skills and knowledge; (one person or role cannot possess them all)
2. groups or teams of people with more than one set of knowledge or skills enhance solutions and resources in local communities
3. it enables all of the involved professionals to work for common goals extending beyond individual medical/clinical services
4. creative thinking and innovation is required

Responsiveness to communities and people’s needs is a key element of primary health care, so services, models, governance and funding vary. Primary health care services include:
- prevention and treatment of common diseases and injuries
- health promotion
- first line health emergency and medical services
- primary mental health care
- medical and interdisciplinary support for people managing chronic conditions
- self management support
- palliative care
- healthy infant and well child development
- primary maternity care and support for wellbeing in families
- rehabilitation services
- referrals to relevant services (eg medical/nursing specialists/hospital services)
- support for community development

Primary care includes personal (individual) services, family and community services and population health services.

Interprofessional learning and team working experiences can help you develop collaborative competencies eg:
- Describe your typical roles/responsibilities clearly to other people
- Recognise and the limits of your role and competence and see these in teamwork context
- Recognise and respect the roles, responsibilities, and competencies of other professions in relation to one’s own.
- Work with other professions to effect change and resolve conflict in the provision of care and treatment or support for community health.
- Work with others to assess, plan, provide and review care and services
- Tolerate differences, misunderstandings, and shortcomings in other professions.
- Facilitate interdisciplinary team meetings
- Recognise interdependent relations with other professions (Barr, 2005)

Background

Teamworking and collaborative practice competencies are increasingly expected of graduates across the health sciences. Rapid advancements in science and technology, and wide acceptance of the effects of demographic, cultural, economic, and social factors on health now require that health professionals have a wide spectrum of knowledge and expertise. No one practitioner can practice effectively across such a complex spectrum (Fagan, 1992), professionals must work together to maximize their collective knowledge and expertise.

Across the New Zealand health sector, key strategic documents promote interprofessional collaborative models of care, asserting both efficiency and effectiveness benefits for stakeholders (MOH 2001, HWAC 2002, NZIER, 2004). District Health Boards (DHBs) acknowledge the need for planning and prioritising of collaborative activity, with DHB now required to ‘actively investigate, facilitate, sponsor and develop co-operative and collaborative arrangements’ (DHBNZ, 2005). Within this process Primary Health Organizations have a critical role.

“Experience tells that team development cannot be fully planned and predicted… there will be spurts of progress and apparent relapses; new insights will develop along the way and carefully formulated programmes will be changed”

– Frances & Young, 1979
The New Mexico Rural Health Interdisciplinary Programme focuses on the development and implementation of interdisciplinary practice. Employers decide what is done at each work site, and what is done to collectively address performance and encourage professionals to adopt teamworking practices (Productivity Commission, 2005). Research indicates there are benefits for organisations implementing collaborative modes of practice and service delivery. Research findings indicate better outcomes for patients (Wasson et al, 2006), greater job satisfaction (Gifford et al, 2002), improved team working and collaboration (Walker et al., 2003), as well as a greater understanding of the roles of other health professionals (Pullon & Fry, 2005, Parsell & Bligh, 1999). If interprofessional collaboration is to emerge in health services, undergraduates must have opportunities to develop interprofessional competency (Taylor, 1997). In New Zealand, as elsewhere, education of health care professionals has occurred in single discipline structures with few opportunities for shared experiential or common learning with other health professional students (VanLeit, 2003). This project is in part a catalyst for change and the universities associated with the interdisciplinary teamwork pilots are actively exploring concepts and styles of interprofessional learning for the future.

Interaction with learners from other health professions is an important element of interprofessional education (Curran, 2004). In order for interprofessional education to deliver benefits, there must be team training and team building opportunities for undergraduates within clinical practice settings (Freeth & Reeves, 2004).

Internationally, learning initiatives to develop undergraduate health professional interdisciplinary competence, are underway, eg in Sweden, Linkoping University; in Canada, the Interprofessional Rural Program of British Columbia fosters interprofessional education and promotes rural recruitment of health professionals (Charles et al., 2006). The New Mexico Rural Health Interdisciplinary Programme offers undergraduates the opportunity to participate in interdisciplinary problem-based learning with particular emphasis on rural health (Geller et al., 2002). Other OECD countries are also working to establish interprofessional educative models (Walker et al., 2003),

**Concepts Of Health**

**Health** is defined and promoted differently by many organisations. The World Health Organisation is the United Nations body that sets standards and provides global surveillance of disease. It defines health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Public health experts consider this definition incomplete, and include effect of nutritional, spiritual, and intellectual factors (Wikipedia). Frankish et al (1996) defines health not simply as a disease free state disease as “the capacity of people to adapt to, respond to, or control life’s challenges and changes”. Other definitions include the concept of resilience.

**Public Health** is defined as ‘the science and art of preventing disease prolonging life and promoting health through the organised efforts of society’ organisations, public and private, communities and individuals (Acheson 1998). Public health is concerned with threats to the overall health of a community based on population health analysis. 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 (MOH, 2003). The population in question can be a small community or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). Public health has many sub-fields, but is typically divided into the categories of epidemiology, biostatistics and health services. Environmental, social and behavioral health, as well as occupational health and safety are also important fields in public health (MOH, 2003).

**Population Health:** Population health is an approach to health that aims to improve the health of an entire population. Populations may be defined by locality (eg Rodney District); biological criteria (eg age, gender); social criteria (eg socioeconomic status); or by cultural criteria (eg whānau). A key focus of population health approaches is the reduction of health inequalities among population groups; these approaches consider a broad range of factors that impact health on a population level such as environment, social structure, resource distribution and other social determinants of health (MOH, 2003).

**Health Promotion** is the process of enabling people to increase control over, and to improve, their health. To reach physical, mental and social well-being, individuals or groups must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Health promotion is not just the responsibility of the health sector, as it goes beyond healthy life-styles to well-being (WHO Website).
Primary Health Care

There are many definitions of primary health care. The World Health Organisation’s Declaration of Alma-Ata (1978) is one of the widely recognised definitions of primary care. The declaration states:

‘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... it forms an integral part both of the country’s health system, of which it is the 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.’

The New Zealand government defines primary health care as:

… the first point of contact New Zealanders have with the health system. A strong primary health care system is crucial to improving the health of New Zealanders. Every day 50,000 children and adults receive advice, treatment, and care from primary health care practitioners.

Primary health services include population health services to improve health, screening and preventive services, whanau ora, customised support for people with chronic health problems, information, assessment, and treatment for health problems.

http://www.moh.govt.nz

Primary Health Care in New Zealand

In New Zealand, definitions of Primary Health care (PHC) reflect concepts first described in Alma Ata Declaration (1978). Primary health care is:

• Any first point of contact with a health care provider or service;
• Scientifically, socially, and culturally appropriate care;
• Accessible to everyone;
• A range of services, knowledge, and skills.

District Health Boards (DHBs) fund and/or subsidize some primary health care services provided to health service consumers resident in their District. There are 21 DHBs and each provides funding for a range of primary health care services and activities including the following:

• Care and treatment when people are ill;
• Supporting people to maintain wellness and stay healthy;
• Reaching those groups within communities who have poor health or those who are unable to access primary health care services easily.

The funding formulae are based on the numbers and characteristics (eg socio-economic status, age, sex, and ethnicity) of the people enrolled with Primary Health Organisations (PHOs) located within the DHB areas.

While traditionally primary health care in New Zealand has been associated predominantly with general practice or primary medical care, modern definitions are broader - encompassing other health provider organisations and individual practitioners, families and communities.

In 2001, the Primary Health Care Strategy (2001) signalled a new pathway for primary health care services in New Zealand. The focus and delivery of primary health care services (see Table 2.) would extend beyond general medical practice to encompass population-based services best delivered in a primary care setting and more comprehensive teamwork.

The new style of primary health care requires new skills and competencies and a degree of co-operation and co-ordination across the health sector not previously achieved. 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, eg Primary Health Organisations, non-government organisations, public health service providers, rural health services, local councils, local networks and consumer health links, intersectoral collaboration.
Table 2. The Structure Of The Health And Disability Sector (2004)
21 District Health Boards

Each DHB board consists of seven elected members and up to another four members appointed by the Minister of Health. This structure allows for a range of perspectives, skills and knowledge. The Minister of Health also appoints a chairperson and deputy chairperson for each board from among the board’s elected and appointed members. Under the New Zealand Public Health and Disability Act, a DHB board has three statutory advisory committees which typically consist of both members of the public and DHB board members. These committees provide a key means for community voices to be heard.

- The Hospital Advisory Committee (HAC)
- The Community and Public Health Advisory Committee (CPHAC)
- The Disability Support Advisory Committee (DiSAC)
- The Māori Health Gain Advisory Committee is an additional committee in some DHBs such as Waitemata DHB.

Board members are responsible for the governance of the DHB. They must work together in the best interests of the health of the DHB’s whole population and in a financially responsible manner. Board members do not manage the DHB. That is the responsibility of the Chief Executive Officer (CEO) who is appointed by the board, and the staff who report to the chief executive. Each DHB has a District level planning and funding group (which build relationships and manages contracts with primary health care PHOs and non-governments organisations) as well as service delivery divisions (provider arms) including hospitals and specialist services.

Coast to Coast PHO Placements

The undergraduate health professional interdiscipilinary placements have been piloted with Coast to Coast Primary Health Organisation (PHO) over 2007 and 2008. Coast to Coast PHO includes Coast to Coast Medical and Health Care, Te Ha O Te Oranga O Ngati Whatua and associated primary health care practitioners (eg pharmacist, physiotherapist) in Wellsford, Rodney District. The PHO serves a population of 13,500 spanning the northern part of Waitemata DHB and the southern part of the Northland District Health Board. Some of the pictures in this booklet are taken during placements at Coast to Coast PHO during 2007 and 2008.
A comparison between conventional primary care and the new approaches identified in The Primary Health Care Strategy is provided in Table 3.

Table 3. Implementing Primary Health Care

<table>
<thead>
<tr>
<th>Conventional</th>
<th>New</th>
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</thead>
<tbody>
<tr>
<td><strong>Focus</strong></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>Health promotion, booked non-acute, acute, long-term &amp; acute on-chronic comprehensive services</td>
</tr>
<tr>
<td>Illness</td>
<td>Health and well being</td>
</tr>
<tr>
<td>Cure</td>
<td>Cure</td>
</tr>
<tr>
<td>Treatment intervention</td>
<td>Patient led, or knowledge sharing &amp; joint decisions</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>Health promotion &amp; treatment</td>
</tr>
<tr>
<td>Episodic care</td>
<td>Continuous care &amp; support, long term view &amp; relationships</td>
</tr>
<tr>
<td>Specific problems</td>
<td>Comprehensive care &amp; service, interdisciplinary team available</td>
</tr>
<tr>
<td><strong>Organisation</strong></td>
<td></td>
</tr>
<tr>
<td>Specialists</td>
<td>General practitioners</td>
</tr>
<tr>
<td>Physicians</td>
<td>Patient, whanau, family, and other practitioner/personnel groups, cultural support, interprofessional</td>
</tr>
<tr>
<td>Single-handed practice</td>
<td>Team approaches including locality PHO teams – eg pharmacist, occupational therapist, physiotherapist, social worker, dietitian, health coach, midwife, whanau ora, health promoter</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td></td>
</tr>
<tr>
<td>Health sector alone</td>
<td>Intersectoral</td>
</tr>
<tr>
<td>Professional dominance</td>
<td>Community &amp; service user participation, respectful relationships</td>
</tr>
<tr>
<td>Passive reception</td>
<td>Self-responsibility, or shared responsibility</td>
</tr>
<tr>
<td><strong>Workforce Preparation</strong></td>
<td></td>
</tr>
<tr>
<td>Silo</td>
<td>Interprofessional education</td>
</tr>
<tr>
<td>Limited or no primary care experience for undergraduate health students</td>
<td>Professional, interprofessional and common learning about, and in, primary health care - rural and urban</td>
</tr>
</tbody>
</table>

based on Coster & Gribben, 1999
Health Policy, Strategies and Charters

Internationally and nationally, there are a number of Charters and health policies and strategies, which influence the delivery of primary health care in New Zealand toward more collaborative modes of practice. This section briefly summarises some of these key influences.

Treaty of Waitangi

The Treaty of Waitangi was signed in 1840 by Māori and representatives of the British Crown. Although the Treaty focused predominantly on property rights - acknowledging sovereignty, citizenship rights and existing native title, contemporary interpretations have widened the scope of application. The main drivers behind this broadening of Treaty interpretations have been the Courts and the Waitangi Tribunal (Oh, 2005).

The Waitangi Tribunal was established under the Treaty of Waitangi Act (1975) to investigate Māori Treaty-based grievances. The Tribunal’s “findings and recommendations [are] expressed in the currency of Treaty principles” (Hayward 2004:29). Derived from the underlying tenets of different Treaty versions, Treaty principles are not intended to supplant the Treaty, but rather to inform its application in contemporary circumstances.


Across the Health and Disability sector the concepts that underpin the three principles, as identified by the Waitangi Tribunal, the Courts and the April Report (1988), are applied. These are:

- Partnership in access, prioritisation and delivery of health services
- Participation within and across all levels of society
- Protection and improvement in (Maori) health and wellbeing

These three principles are currently threaded through many social policies, signifying government intention to work with and across communities and stakeholders, in particular, recognizing Māori rights derived from the Treaty. The Treaty principles guide the formation of these relationships for the purposes of delivering optimum health services (Oh, 2005).

The Primary Health Care Strategy (2001)

The New Zealand Health Strategy sets the platform for the Government’s action on health. It identifies the Government’s priority areas and aims to ensure that health services are directed to ensure the highest benefits for our population, focusing in particular on tackling inequalities in health.

The vision for The Primary Health Care Strategy (PHCS) 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.

The Primary Health Care Strategy identifies seven fundamental principles that should be reflected across the health sector. Any new strategies or developments should relate to the seven principles. These are:

- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi;
- Good health and wellbeing for all New Zealanders throughout their lives;
- An improvement in health status of those currently disadvantaged;
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay;
- A high-performing system in which people have confidence;
- Active involvement of consumers and communities at all levels.

The Government has highlighted 13 population health objectives for the Ministry of Health and District Health Boards (and primary health care) to focus on for action in the short to medium term. These objectives were chosen according to the degree to which they can improve the health status of the population and their potential for reducing health inequalities. The objectives are:

- Reduce smoking
- Improve nutrition
- Reduce obesity
- Increase the level of physical activity
- Reduce the rate of suicides and suicide attempts
- Minimise harm caused by alcohol and illicit and other drug use to both individuals and the community
- Reduce the incidence and impact of cancer
- Reduce the incidence and impact of cardiovascular disease
- Reduce the incidence and impact of diabetes
- Improve oral health
- Reduce violence in interpersonal relationships, families, schools and communities.
Primary health services are now re-oriented toward quality primary health care 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’ (MOH, 2001).

Implementation of the Primary Health Care Strategy has occurred gradually through the establishment of Primary Health Organisations (PHOs). PHOs are the health service structures that provide or coordinate primary health care to an enrolled population. There are now 81 PHOs of varying sizes and structure throughout the country. Key points are:
- PHO decisions, development and delivery of health care services must be based around the principles of the Treaty of Waitangi – partnership, participation and protection;
- PHOs work with population groups that have poor health or those who may not be accessing services;
- DHB fund the provision of a set of essential primary health care services to those enrolled with PHO;
- At a minimum these services include improving and maintaining the health of the population as well as first line services to restore health when people are unwell; (“essential” still has a narrow pragmatic and funding definition and will gradually encompass broader interdisciplinary roles)
- PHOs are expected to involve their communities, in their governing processes and service design and evaluation in meaningful ways;
- All providers and practitioners must be involved in the organisation’s decision-making, rather than one group being dominant;
- PHOs are not-for-profit bodies, and are required to be fully and openly accountable for all public funds that they receive;
- While primary health care practitioners will be encouraged to join PHO, membership is voluntary;

The PHOs and local DHB work in partnership with a wide range of consumers, groups, elements and perspectives to understand the specific health needs and services of their particular community. PHOs and DHB agree on the services and activities the PHOs will undertake to improve health care services in each PHO’s enrolled population. A range of health providers are brought together by the PHO - doctors, nurses, Maori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives, to serve the needs of their enrolled population (MOH Website, 2001). In future the range of health providers will include occupational therapists, podiatrists and others.

The diagram below shows the relationships between Primary Health Organisations, the Ministry of Health, District Health Boards, communities, and other providers in a simplified format.

(MOH, 2007)
The Ministry's role in providing policy advice and ministerial services continues.

The NZPHD Act adopts measures that recognise and respect the principles of the TOW in the health and disability support sector. These measures are a response to the Crown's desire to have greater Maori participation in the health and disability support sector with a view to improving Maori health outcomes, and reducing health disparities between Maori and other population groups. The measures also reflect the Crown's overall partnership with Maori under the TOW and its commitment to protecting Maori health (MOH, 2000).

New Zealand Public Health and Disability Act (2000)


The NZPHD Act dissolved the Hospital and Health Services (HHS) and the Health Funding Authority (HFA) and divided their responsibilities between the District Health Boards (DHB) and the Ministry of Health. DHBs formally came into being on 1 January 2001 and are crown agents. That is, they are required to give effect to Government policy.

The intent of the Act is to strengthen the public health system, achieving the best health and disability support outcomes for New Zealanders, and to reduce disparities between population groups. The NZPHD Act facilitates the achievement of the Government's aims by:

- Establishing DHBs to take a 'population health' focus for their geographically defined populations
- Requiring the development of the New Zealand Health Strategy and the New Zealand Disability Strategy and an annual report to Parliament on the progress in implementing these strategies
- Encouraging co-operation and collaboration between the agencies in the sector with the aim of delivering better care and support
- Strengthening local community input to decision-making about health and disability support services through electing members to DHB.

The NZPHD Act is concerned with entities and arrangements across the health and disability sector. It focused predominantly, however, on the creation of 21 DHBs to fund or provide services for geographically defined populations and to be responsible for public hospitals and other related services. DHBs are also responsible for needs assessment service planning. In addition to funding some services, the Ministry of Health has a key role in monitoring the funding and provision of services by DHBs.

Health and Disability Commissioner Act (1994)

The purpose of the Health and Disability Commissioner Act (1994) is to promote the rights of all health and disability service consumers, ensuring fair, simple and responsive resolution of consumer complaints. The Act was developed in response to the Cartwright Report which investigated poor research practises at National Women's Hospital in Auckland. Under the Act, a newly appointed Health and Disability Commissioner developed the Code of Health and Disability Consumer Rights (1996). The code was necessary because within the accident compensation scheme, consumers had limited recourse for instances of malpractice (Godbold & McCallin, 2005).

The Code sets out ten health consumer rights. These apply to all health services and disability support services in New Zealand, whether you have paid for them or they are free of charge. These include hospitals, doctors, nurses, homeopaths, diagnostic services, special needs assessors etc. The purpose of the Code is to protect health consumer rights and to help resolve complaints.
The Health Practitioners Competency Assurance Act (2003)

The purpose of the Health Practitioners Competency Assurance Act (2003) is to protect the public where there is a risk of harm from the practice of the profession. The Act provides for consistent complaint procedures for all branches of the professions and “mechanisms to assure the public that a registered health practitioner is competent to practise”.

The Act is the government’s response to a series of adverse medical events and public concern over the apparent inability or unwillingness of the health professions to protect health consumers from unfit or incompetent health practitioners.

The potential impact of the Act on interprofessional practice is significant. The Act may challenge the effectiveness of interdisciplinary practice, particularly as effective teamworking requires a blurring around professional boundaries. In legal terms, accountability measures do not blur at the edges consequently, some professionals will be reluctant to share decision-making if they, rather than an identified team, are ultimately accountable.

Ottawa Charter for Health Promotion (November 1986)

The Ottawa Charter was the first international conference on Health promotion, primarily in response to growing expectations of a new public health movement. The Ottawa Charter calls for health promotion, healthy public policy, health environments, strong communities, (culturally) appropriate and understandable health information and health services oriented toward the health needs of the communities they serve.

The Ottawa Charter also advocates the use of holistic models of health and considers these widely applicable in health care, recommending their use in palliative, reproductive and communicable disease management. The Charter refers to ‘holistic needs’ as ‘more than just medical or clinical needs, and like the Māori health model, Whare Tapa Wha, the whanau, family and community are the support mainframe around the individual/service user.1

The ten health consumer rights are:

- You should always be treated with respect, including respect for your culture, values, beliefs and personal privacy.
- No-one should discriminate against you or push you into doing something or making a decision that you are not comfortable with.
- Your care and treatment let you live a dignified, independent life.
- Everyone looking after you should work together to make sure that you are treated with care and skill and that you receive the right services for your needs.
- You have the right to be listened to, understood and receive information in whatever way you need. Where possible, an interpreter should be provided if you need one.
- Your condition should be fully explained to you, to allow you to make choices for possible treatments. You should be given information on the benefits and side effects of treatments and told how long you may have to wait, who will be treating you and any costs involved. You can ask any questions about the services and expect an honest and accurate answer.
- It is your decision whether to go ahead with treatments or not and you are able to change your mind at any time.
- In most situations, you can have a support person of your choice with you if you wish.
- All these rights also apply when you are taking part in teaching or research.

You can make a complaint about any aspect of your care or treatment. You should be given information on the process involved in making a complaint so it is easy for you to do so. Your treatment should not suffer if you do make a complaint.

1 WHO Website, Accessed 15/02/06, http://www.who.int/en/
Although much research about health is biomedical, some of the main determinants of health are environmental and socio-structural. Evidence of health inequalities is well documented. The ways people make sense of birth, death and health problems are closely related to their cultural values and social contexts. There are numerous models of health and healthcare in different parts of the world. Health funders, providers, service users and communities in New Zealand are increasingly focused on developing effective and relevant policies and services that reflect New Zealand perspectives.

Effective primary health care and integrated local, district or regional programmes will adopt models of service delivery appropriate to populations and settings. Some models are briefly outlined below (in no particular order). Workforce preparation should be included as a consideration in planning and implementation. http://www.moh.govt.nz/moh.nsf/0/4A305BD9534765FFCC256CBC0010A6A5/$File/buildingonstrengths05.pdf

**Population health model**

Takes into account wider social, cultural and economic factors determining health. Requires working across government and non-government organisations.

**Socio-environmental model**

Practice of medicine acknowledging the social-cultural and environmental context

**Community development model**

Aims to improve health and resilience of communities by empowering them to work together to identify issues and solve them.
**Whare Tapa Wha**

Maori have a long history of maintaining population health through concepts such as tapu, noa and rahui. There are a number of Maori models of health that describe the balance of factors required to maintain health. The Whare tapa wha model (Durie, 1994) conceptualises Maori health as that of four walls of a house, each representing a different dimension of individual well-being. These are:

- **Taha wairua** - the spiritual side: is considered by many Maori the most essential component of health. Wairua refers to the capacity for faith and wider communion and acknowledges that health is often influenced by intangible energies.
- **Taha hinengaro** - the mental or emotional side: refers to our capacity to communicate, think and feel in a way that can affect our physical health.
- **Taha tinana** - the physical side: refers to physical health.
- **Taha whanau** - the family side: refers to our capacity to belong, to care and to share with those with whom we have a familial connection (pp.69-3).

Complex models, developed over generations and shared by oral tradition, capture the many elements and values important to wellness for particular whänau, hapü and iwi. Two other perspectives important in a public health context are:

- **Te ao turoa** – the environment: the relationship between Maori 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 Maori.
- **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.

**Te Wheke**

Te Wheke’ (the octopus) was presented by Dr Rangimarie Turuki Rose Pere at the Hui Whakaoranga in 1984. Pere uses the symbol of the octopus, with each of the eight tentacles of the wheke representing a different health dimension. The components are:

- Wairuatanga – Spirituality;
- Hinengaro - Mental Health;
- Tinana – Physical;
- Whanaungatanga - Extended Family Across The Universe;
- Mana Ake - The Uniqueness Of The Individual And Extended Family;
- Mauri - Life-Sustaining Principle In People And Objects;
- Ha A Koro Ma A Kui Ma - Cultural Heritage;
- Hatumanawa - Relating To Emotions And Senses.

These concepts are referenced in He Korowai Oranga – Maori Health Strategy (2002). The acceptance of holistic health models at policy level reflects wider international and societal trends toward the use of complementary and alternative health care and other holistic approaches to health.
Recovery model

The ability to live well in the presence or absence of one’s (mental or other chronic/long term) illness. Emphasises the active role of people with health problems or mental illness in improving their lives.
http://www.rethink.org/living_with_mental_illness/recovery_and_self_management/recovery/

Fonofale model

The Fonofale model was created by Fuimaono Karl Pulotu-Endemann as a Pacific Island model of health for the use in the New Zealand context. It is based on a Samoan holistic model that recognizes Samoan people’s health is best nurtured within the social context. The model takes Pacific perspectives and encourages holistic views and greater application of Pacific health models in New Zealand. This means better interdisciplinary collaboration across primary health care, mental health and social services.

Planetree

Promotes the development and implementation of innovative models of healthcare that focus on healing and nurturing body, mind and spirit. Includes knowledge sharing, relationships, architecture and design conducive to effective relationships between users and service providers. Planetree was founded in 1978 in North America by a woman who experienced lack of personalized care in a hospital which threatened to overshadow the benefits of the hospital’s high-tech environment. She took the name from the roots of modern Western medicine -- the tree that Hippocrates sat under as he taught some of the earliest medical students in ancient Greece.
http://www.planetree.org/

Biomedical model

Prevailing in modern Western medicine, this model is based on assumptions that the mind and body can be treated separately; that the body can be repaired like a machine (mechanical metaphor); that technological advances will improve service delivery in this model; that reductionist explanations of disease are predominantly biological (to the relative neglect of social and psychological factors (specific aetiology). It has been argued that while medicine has huge beneficial roles, medicine’s efficacy has been overplayed and self care and interprofessional services have been underplayed. (Nettleton, 1995).
Wellness model

Active process through which individuals become aware of and make choices toward more successful existence. Includes health and occupational satisfaction, creativity, meaning, purpose, choice, opportunity, balance, challenges, growth, equality, potential. This approach is built on combined knowledge from medical, reductionist, holistic, behavioural sciences and is a health promotion model. (Wilcock, p 230, 1998).

Flinders Model of chronic condition self management

Developed in South Australia following integrated care trials. These were initiated after new information systems showed a small proportion of people with chronic conditions were not having their needs met through primary care or specialist services. The SA HealthPlus Trial was one of the larger of the first round Coordinated Care Trials in Australia, enrolling 3,100 clients into its intervention arm. The Problem and Goals assessment was used routinely with all SA HealthPlus intervention clients. A generic set of tools and processes evolved, and there are several trainers in New Zealand who are in regular contact with Flinders University. The Flinders programme is included within some New Zealand development programmes for primary health care nurses, OTs, psychologists and others. The tools and training enable clinicians and clients to undertake structured processes that allow for assessment of self-management behaviours, collaborative identification of problems and goal setting leading to the development of individualised care plans. These care plans are important cornerstones in enhancing self-management in people with chronic conditions. http://som.finders.edu.au/FUSA/CCTU/self_management.htm

Stanford Self Management Model

Designed to enhance regular treatment, The Chronic Disease Self-Management Programme is a workshop given two and a half hours, once a week, for six weeks, in community settings such as PHOs, community centres, Age Concern centers, churches, Marae, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic disease(s) themselves. Topics and themes covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, and, 6) how to evaluate new treatments.

Each participant in the workshop receives a copy of the companion book, Living a Healthy Life With Chronic Conditions, 3rd Edition, and an audio relaxation tape, Time for Healing. It is the process in which the program is taught that makes it effective. Sessions are highly participative, where mutual support and success build the participants’ confidence in their ability to manage their health and maintain active and fulfilling lives.

The Division of Family and Community Medicine in the School of Medicine at Stanford University received a five year research grant from the US federal Agency for Health Care Research and Policy and a Californian State fund to develop and evaluate, through a randomized controlled trial, a community-based self-management program that assists people with chronic illness. The study was completed in 1996. Investigators included Halsted Holman, M.D., Stanford Professor of Medicine; Kate Lorig, Dr.P.H., Stanford Professor of Medicine; David Sobel, M.D., Regional Director of Patient Education for the Northern California Kaiser Permanente Medical Care Program; Albert Bandura, Ph.D., Stanford Professor of Psychology; and Byron Brown, Jr., Ph.D., Stanford Professor of Health Research and Policy. The Program was written by Dr. Lorig, Virginia González, MPH., and Diana Laurent, MPH of the Stanford Patient Education Research Center. http://patienteducation.stanford.edu/programs/cdsmp.html

Chronic Care Model (Wagner)

There are six fundamental areas identified by the Chronic Care Model making up a system that encourages high-quality chronic disease management. Organisations must focus on these six areas, as well as develop productive interactions between patients (who take an active part in their care) and providers backed up by resources and expertise. The changes can be applied to a variety of chronic illnesses, health care settings and populations.

Partnership with clients/consumers as part of the team

Szasz and Hollander (1956) describe three types of relationships between doctors and patients. Their model of ‘adult – adult’ relationships acknowledges that when people have chronic or long term conditions, partnering relationships with the doctor and relevant members of a broader health care team are important... with the service user as a key member of ‘the team’.

Improving service by listening to patient experience

There is a trend to learn from other industries and shift from professionally driven services to more client driven perspectives. Listening for understanding and co-planning service improvements build with people who use services is a developing area of expertise for the current and future workforce.

More holistic services to address mental health needs in primary health care

Mental disorders are a major public health problem. A Christchurch study in the 1990’s (the Christchurch Psychiatric Epidemiology Study) found that 28% of adults in the general population experienced a diagnosable mental disorder in the past six months. The most frequently encountered disorders were: mood disorders (especially depression and dysthymia); substance use disorders (especially alcohol abuse and/or dependence); and anxiety disorders (especially phobias, panic disorder and generalised anxiety disorder). Consistent with research in other western countries, they found that three quarters of those with a recent mental disorder had attended a health (mainly general practice) service, and only about a third had sought help for their mental health problem from any agency. One quarter of those who received treatment got it from specialist mental health or addiction services, and three quarters of the treatment was delivered by GPs.

The World Health Organisation (WHO) recently completed an international study, in 15 different centres in 14 countries.

Asian Health Services

See http://www.asianhealthservices.co.nz/
And Waitemata DHB website

The Innovative Care for Chronic Conditions framework

The World Health Organization has developed an expanded version of the Chronic Care model, the Innovative Care for Chronic Conditions Framework, designed in particular to be relevant to low and middle income countries. It broadens and reframes the Chronic Care Model by organizing the evaluation along macro (policy and financing), meso (health care organization and community) and micro (patient and family) levels of the health care system. This framework is centered in a triad of partnership between the patient, the health care provider and the health care system.

http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/

http://www.who.int/mental_health/epi/magpie/magpie.html

This work has been a base for exploration of relevant models in a range of areas, eg for intellectual disability http://www.wihd.org/current/pdf/Develop:_Modelsoff-HealthCare_05_2007.pdf


3 See: The MaGPIe Study: The Mental Health and General Practice Investigation; Wellington School of Medicine in conjunction with the World Health Organisation. A Centre Collaborating with the World Health Organisation’s multi-centre study of Psychological Problems in Primary Care. Director: Associate Professor John Bushnell; email john.bushnell@otago.ac.nz; http://www.otago.ac.nz/wsmhs/academic/psych/research/magpie.html
Primary Health Care Teams

The focus of current primary health care extends beyond treatment and support services for individuals and families (Whanau) to include comprehensive disease prevention and health promotion strategies. Such approaches require collaboration and interdisciplinary team approaches, and often require working with community leaders and people in other agencies such as Housing NZ and Ministry of Social Development. Community leaders and health professionals from all parts of the health care system - primary care, public health, non-government organisations (NGO) and District Health Boards (DHB) are being encouraged to change to styles of working collaboratively, using teamworking competencies, as the mix of services provided broadens (Ministry of Health 2001). Local authorities such as North Shore District Council, Waitakere City Council and Rodney District Council are also required to develop health plans and engage with local health service providers.

Defining ‘team’

A simple definition of a team is ‘a group of people who make different contributions towards the achievement of a common goal’ (Pritchard & Pritchard, 1994). A more comprehensive definition reads:

‘A team is a group of individuals who work together to produce products or deliver services for which they are mutually accountable. Team members share goals and are mutually held accountable for meeting them, they are independent in their accomplishment, and they affect the results through their interactions with one another. Because the team is held collectively accountable, the work of integrating with one another is included among the responsibilities of each member’ (cited RSGPB Report, 2000).

The WHO (1990) definition of teamwork states teamwork as:

‘Co-ordinated action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of, and respect for others’ roles and functions. On the part of each member of the team, adequate human and material resources, supportive co-operative relationships and mutual trust, effective leadership, open, honest and sensitive communications, and provision for evaluations’.

They found that 24% of general practice attendees had a current mental disorder reaching ICD-10 criteria and another 9% had a subthreshold disorder (clinically significant symptoms, but not meeting full criteria for ICD-10). The commonest ICD-10 diagnoses were depression, generalized anxiety disorder, neurasthenia and problems with alcohol. These disorders are associated with physical and social disability and increased mortality.

A World Health Organisation analysis of the global burden of disease has shown that mental disorders make up five of the ten leading causes of disability worldwide. The level of disability is similar to those experienced by people with chronic physical conditions.

The emotional, social and financial impact on both the individual and society is huge in terms of direct costs of greater use of medical and health care services, indirect costs resulting from days lost from work, and keeping people from usual activities due to feeling ill, and from the “intangible costs” to the individual in terms of the suffering and distress they experience.

General practice management of common mental disorder includes accurate listening and identification of the issues, education, problem solving, and specific psychological interventions such as relaxation and anxiety management, motivational interviewing, cognitive behavioural therapy, goal setting and lifestyle and occupational performance planning. Psychotropic medication (in particular anti-depressants, anxiolytics and hypnotics) may also play a role. Identification and management of common mental illnesses may be difficult to achieve in brief consultations in busy surgeries. Group sessions with two primary health care resource people with relevant competencies eg occupational therapist and/or psychologist and/or physiotherapist and/or pharmacist and/or GP and/or nurse may enable learning from peers, strategies for coping with a range of experiences/ symptoms/issues. Follow-up can be on-line and telephone consultations, peer support, and groups.

See: The MaGPIe Study: The Mental Health and General Practice Investigation; Wellington School of Medicine in conjunction with the World Health Organisation. A Centre Collaborating with the World Health Organisation’s multi-centre study of Psychological Problems in Primary Care. Director: Associate Professor John Bushnell; email john.bushnell@otago.ac.nz; http://www.otago.ac.nz/wsmhs/academic/psych/research/magpie.html

“You must be the change you wish to see in the world.”

– Mahatma Gandhi
Primary health care is flexible and dynamic

Primary health care is anchored in the social contexts of communities and good communication skills and effective relationships are basic to effective practice. Primary care includes primary medical care, infant and well child services, tamariki services, rangatahi/youth services, pakeke/adult services - women’s health, men’s health, health at school and work; healthy aging, older persons services for those at home, in retirement villages or in residential care; rehabilitation, prevention of chronic disease, prevention of hospital admissions and building community and personal resilience (ability to prevent and manage unhealthy levels of stress and to learn from and ‘bounce back’ from adverse circumstances). Teams may be co-located or virtual.

Team working for client-centered primary health care

Some people have discrete issues which are quickly resolved by a receptionist, nurse and/or GP.

For other people, the socio-medical issues are more complex and health outcomes will be much better if assessment and services benefit from a broader range of perspectives. Teamwork and collaborative practice in primary health care are flexible and centred on the needs of service users and groups in the community. Proactive teams rely as much on good informal communication and ‘just doing it’ as on formal referrals. Different teams form around people with particular needs.

A report in 2000 by Royal Pharmaceutical Society of Great Britain (RPSGB) identified several definitions, including one in common usage:

‘All members of staff who provide health care services to a given population registered with one or more general practitioners’.

After consideration it changed to the following:

“…the team in primary healthcare being dynamic rather than static, professional input changing to meet the changing needs of patients and groups of patients in different circumstances”

– RPSGB RP, 2000

Learn About Primary Health Care Team Roles

Primary health care teams vary depending on contexts and needs. Teams may include some of the following roles. Explore and learn more about them...

Acupuncturist/Traditional Chinese Medicine Practitioner;
Acupuncturists treat patients using the philosophies of Traditional Chinese Medicine and aim to restore their good health by bringing about balance in the body. A number of therapies can be used including needle acupuncture, the heating of acupuncture points (moxibustion), massage, exercise, diet recommendations and herbal treatments. Some medical practitioners and physiotherapists examine patients and diagnose health problems using the principles of their discipline and of Traditional Chinese Medicine so they can discuss treatment options with patients and treat as relevant and/or refer patients to other health services when necessary.

Applied mental health worker: Many New Zealanders find they need support, counselling, education and intervention to deal with life challenges such as chronic health problem(s), loss, trauma and addiction. Applied mental health workers use approaches that combine the perspectives of social and health sciences and bring to primary care contexts backgrounds for community development and to help address family violence, trauma and abuse, problem gambling, drug, alcohol and substance abuse, victim support, whanau youth and community work, refugee and migrant services.

Audiologist/Kaititiro Taringa: Audiologists study, identify, measure and treat hearing disorders and loss, and provide aids to help people who have hearing loss. They prescribe, select and fit hearing aids; show people how to use hearing aids; advise on hearing problems; (eg service users, families, employers); educate and advise about hearing conservation; assess workplace and classroom sound levels.

4 Some information sourced from http://extranet.otc.school.nz/Apps/Kiwicareers/jobs/3i.csv/34611a.htm
Clinical Psychologist, Kaitiro Hinengaro: Clinical psychologists examine and assess people’s behavioural and mental health problems. They may provide treatment to address any behavioural or mental health issues, assess the current emotional and lifestyle problems of clients; interview and observe clients and apply therapy to a broad range of issues and clients including children, adults, couples, families and communities. They may also give psychometric and neuropsychological tests to identify problems and to measure clients’ skills and abilities so they can discuss the treatment options with clients; may also assist in group therapy with social skills, anger-management or assertiveness training.

Counsellors / Relationship Counsellor / Guidance Counsellor / Family Counsellor / Sexual Abuse Counsellor: Maori Counsellor / Drug and Alcohol Counsellors / Relationship Counsellor / Guidance Counsellors / Family Counsellor / Sexual Abuse Counsellors / Maori Counsellor / Drug and Alcohol Counsellor: help people deal with their feelings, issues and responses, and assist their clients to decide on action they can take to solve problems. They may specialise in relationship counselling, grief and loss, addictions, family problems or life changes; skills include listening, responding and reflecting; encouraging clients to express their feelings and talk about what is happening in their lives; help clients understand themselves, their needs and how to meet them; discuss changes that could be made, and the consequences of those changes; support clients in making decisions; they may refer clients to specialists, and may run workshops and courses in the community to support proactive stress management, capability building and community development. Look on www.webhealth.co.nz for examples.

“A moment’s insight is sometimes worth a life’s experience.”
– Oliver Wendell Holmes

Dental hygienists: treat gum diseases and help people to maintain good oral and general health by educating about how to prevent oral disease through care of teeth and gums; they examine mouth, teeth, gums and jaws; take and process x-rays; test saliva for signs of gum disease; recognise and treat gum diseases, remove hard and soft deposits; help clients learn about oral health and develop with clients self-care plans for improving and maintaining their oral health for a lifetime: may run education programmes on dental hygiene in schools, kohanga reo, PHOs, make mouthguards for sport; maintain orthodontic appliances for clients; help clients identify any teeth that could benefit from treatment by a dentist.

Dietitian / Pukenga Whakaita Kai / Clinical dietitian, community dietician / Public health dietitian: Dietitians advise people and community organisations about human dietary requirements and they also keep communities informed about food and nutrition. They work for non-governmental agencies such as the New Zealand Heart Foundation and the Cancer Society; make presentations for service and community groups, forums and special interest support groups on the topics of diet and nutrition; advise colleagues in other health professions in primary health care; act as consultants to the food industry and work with people involved in sports and fitness.

Health promoter roles in Primary Health Organisations include working with individuals and groups in a range of everyday settings such as workplaces, schools, play groups, marae, shopping malls. They develop resources, facilitate educational workshops, communication, community development. The focus may be specific such as smoking cessation or much broader in healthy lifestyle support. Talk to the Push Play neighbourhood/community facilitator, smoke free and other health promoters working with the local PHO about their roles, competencies and perspectives. Talk to community members and service users too.

Maori health worker / Kiaiwihina / Caregiver / Community Health worker: People in these roles provide support to whanau and family (particularly Maori communities) and share information about health and wellbeing. They are employed by Maori Health providers and PHOs whose emphasis is on improving access to and quality of health care for Maori. Maori health workers don’t have to be Maori themselves however they must be able to show, or have a clear willingness to quickly learn, skills and knowledge about Maori health issues, culture, local iwi, hapu and whanau development, and customs / Tikanga. Knowledge of Te Reo is an advantage. The majority of Maori health workers work in primary health care within the community, homes, Marae, Kohanga Reo, Family Centres and GP Practices and PHO healthy lifestyle programmes. They may assist whanau to establish links with appropriate resources and services; provide support for whanau, their tamariki/children and Kaumatua; work with groups, families or individuals as part of an interdisciplinary primary health care team supporting personal and whanau decisions; provide education and information about social and health services such as immunisation; raise awareness of health issues and choices; liaise between clients and community agencies; visit community groups, schools and kohanga reo; keep records of health checks.

Medical general practitioner / GP / doctor / family doctor / family physician / primary care physician / Rata Hauora: General practitioners diagnose and treat the health problems of individuals and families in the community. They consult with and examine patients; diagnose and treat acute problems and often treat individuals and families over
an extended period of time; diagnose patients’ problems; treat and refer patients to other health services when relevant; counsel patients; carry out or arrange for special tests; advise on health care and prevention of illness; perform minor surgery; prescribe and give medicines; keep medical records; keep up to date with medical knowledge; visit patients at their homes; fill out medical certificates for patients; liaise with ACC (Accident Compensation Corporation) over accident and injury claims; advise and help patients claim for welfare benefits. General medical practice aims to be patient centred, generalist and evidence based. Some GPs have specific additional expertise/qualifications in areas such as sports medicine, chronic disease management, minor surgery, rural medicine, trauma care5. Liaison GPs have wide networks and knowledge of both specialist services and primary medical care. They act as key communication and liaison points between primary care and specialist services (eg co-planning service improvements, facilitating first specialist assessments, supporting nurse triage of referral to specialist services, following up specific queries, ensuring specialist services provide up to date knowledge and guidelines for GPs) through HealthPoint, continuing education sessions and correspondence.

Medical radiation technologist/MRT (formerly known as radiographer) has skills in diagnostic imaging, safe use of radiation to obtain images for diagnostic use. To produce these images, they need sound understandings of anatomy, physiology, pathology, physics as well as use of medical radiation equipment and clinical techniques. MRTs register to practise with the New Zealand Medical Radiation Technologists Board. Experience overseas suggests that MRT reporting can reduce patient waiting times, release radiologists for other duties and improve the retention of radiographers. Evidence shows that, with appropriate education and training, the accuracy of radiographers in interpreting plain x-rays is comparable to that of radiologists.

Mental health nurse or worker: people in these roles consider the family history of mental health of the person; observe and report on the mental state of patients; administer or monitor prescribed medication; work within an interdisciplinary team of health workers to identify needs, treat, help patients with self-care and other daily activities, give advice and support, run therapy groups, work within the guidelines of the Mental Health Act, liaise with community organisations, support patients and families with mental health issues through rehabilitation and over long term management. Liaison nurses work across specialist mental health services and primary health care teams to ensure smooth transitions, shared care and that people who access specialist mental health services are also accessing primary health care.

Midwife: This role focuses on care for women and their families in pregnancy, childbirth and the first four to six weeks after childbirth. Midwives are on call for women in labour and birth. They have strong understanding of normal childbirth and knowledge of complicated childbirth and neonatal care and when to refer to specialist medical services. They can be employed or set up practice as an independent midwife.

“The test of a team is its capacity to deliver the goods. A team is capable of achieving results that the individuals who comprise it cannot do in isolation. Their diverse talents combine in the team to create results beyond their individual capability”

– Frances & Young, 1979

5 Currently Maori GPs number less than 2.7% and Pasifika Island GPs less than 1% of the GP medical workforce in New Zealand. Efforts to improve GP care to Maori and Pasifika people include GP registrar placements enabling participants to apply clinical knowledge within a Kaupapa Maori and/or Pasifika health provider setting. Placements are intended to build GP medical skills and enable learning about traditional Maori support systems such as whanau, hapu, iwi, families and communities. It is the responsibility of general practitioners to keep up to date with current medical equipment, treatment and information in order to maintain professional standards. The RANZCGP offers vocational training opportunities for general practitioners wishing to become Fellows and to apply for vocational registration with the Medical Council.
Nurse practitioner: enhanced nursing role working in partnership with clients, rather than an extended nursing role with delegated medical tasks. Nurse practitioners have higher qualifications and are able to prescribe pharmaceuticals and green prescription. Nurse practitioners may be able to offer longer consultations/sessions than a GP or practice nurse and spend time assisting patient/family and gain information about their illnesses/health problems and develop management strategies. Nurse practitioners are relatively new and small in number in New Zealand. A recent study showed that GPs in Northland favourably viewed nurse practitioner functions traditionally associated with nursing, such as health teaching, home visiting, obtaining health histories, and taking part in evaluation of care, but less favourably viewed those functions associated with medicine, such as prescribing, ordering laboratory tests, and physical assessment. Effective teams and their consumers/service users will value the range of roles in their own contexts, and learn when each role is most appropriate.

Nurse/ Primary health care nurse / District Nurse / Tapuhi A-Rohe/ Plunket nurse / Tapuhi Tamariki / Public health nurse / Tapuhi a-iwi/ Occupational Health Nurse, School Nurse / Hospice Nurse/ Residential Care Nurse: Nurses contribute to the growth of healthy and resilient communities - primary health care nurses use their knowledge, skills and caring approaches to deliver services for wellness of families and individuals, acute care in the community and at the interface with hospitals and public health; child health including immunisation, well-child checks and programmes, ear health, mental health, adults and children with complex health needs. Primary health care nursing includes planning and providing nursing treatment to people in their homes/ community clinics, one-stop shop health centres; treatments including changing dressings, removing sutures and giving injections; upskilling families on care for ill people at home; proactive review of patients’ progress; connecting patients to appropriate support services in their community; advising people on health care; helping keep terminally ill patients comfortable at home; establishing links with patients’ families, caregivers and other health professionals; they may administer intravenous (IV) therapy in community clinic; overnight primary care unit or in patients’ homes. Plunket nurses and child health nurses provide support for parents in health and parenting, and regularly assess the health and development of children from birth up to the age of five. They also promote breastfeeding; prepare health and parenting education programmes; educate community groups about family health issues; help set up parent support groups; monitor and recognise the signs of child abuse, and refer the child to other professionals as relevant. Practice nurses work with general practitioners to provide assessment, treatment, care and information for patients, support people with asthma, diabetes, cardiovascular disease, depression etc... An experienced practice nurse may work independently within the general practice environment. Practice nurses provide advice and consultation in person and over the telephone; assist with special procedures and minor surgery; educate and provide information; may give cervical smear tests and may set up screening programmes or clinics. Public health nurses do health education, health promotion, health assessment and disease prevention activities in schools and communities.

Natural health therapists consider the stress and lifestyle factors of a client’s problem to help them restore balance to the body and mind through natural healing methods such as special diets, herbal or homeopathic remedies, acupressure, massage or essential oils. They seek the causes of illnesses from a holistic viewpoint (considering physical, emotional, environmental and dietary factors when diagnosing clients) and may suggest a combination of natural methods to assist clients to maintain good health. Some nurses and GPs are also trained natural health therapists.

Occupational therapist (OT): this role is about helping people participate in everyday activities that contribute to their health and well-being, employment, living and learning. “...occupation is everything people do to occupy themselves (self-care), enjoy life (leisure), and contributing to the social and economic fabric of their community productivity”7. Background knowledge and skills include occupational science: anatomy, physiology, psychology, sociology, developmental, medical, surgical, mental health and life stage challenges; chronic conditions; goal setting, problem solving, stress management; motivational techniques and practical life coaching. Occupational therapy has a holistic focus and spirituality component. OTs help people achieve their goals in self-care and other daily activities, assist with employment, work and social and common interest connections, may visit homes to prescribe alterations, assess workplaces and liaise with employers, liaise with community organisations or NGOs to support people and families with mental health/trauma/ injury/chronic disease issues through rehabilitation/restorative programmes. Therapists are registered to practice in New Zealand. They use physical and social activities and support people’s/patient’s own planning to increase a client’s ability and confidence. OTs adapt equipment or arranging housing adaptations to enable clients to be safe and independent, recommend adaptations to motor vehicles to enable clients to drive independently, help identify activities, events, groups and/or equipment to help clients and communities with daily activities.

6 Kinnersley et al. Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting “same day” consultations in primary care., BMJ 2000;320:1043-1048


Optometrist / Kaihanga Mowhiti. Optometrists examine people’s eyes and visual systems to diagnose vision problems and provide correction when required.

Oral health worker. Primary care includes general practice dental surgery, dental therapists and dental hygienists. Therapists work in schools, community clinics and private practices and have skills to examine oral tissues, diagnose dental caries and recognise other oral disease processes. They are able to independently prescribe and administer oral health care to young people up to 18 years of age and provide periodontal care for adult patients in consultation with dentists. Preventive services include cleaning, polishing, scaling and oral hygiene instruction.

Paramedic: Paramedics often perform their roles on the front line isolated from other health professionals – so they require the ability to make complex decisions. Their skills include advanced patients assessment expertise, problem solving in pre-hospital or pre-primary care management of medical and trauma emergencies, risk management, emergency planning and disaster management competencies. Paramedics work in front line ambulance services, community health settings, safety services, emergency management roles, ski fields, and industrial sites.

Pharmacist/Community Pharmacist/ Retail Chemist: Community pharmacists prepare and dispense prescribed medicines and advise on their use and effects. They also sell ‘over the counter’ (OTC) or non-prescription medicines and related goods. Pharmacists are often the first point of contact people have with health professionals. They advise customers on health and medicines, and advise other health professionals on medicine use. Pharmacists prepare prescriptions for customers; mentor customers on the effective use of medicines and other health products and lifestyle choices; sell medical, surgical and sports injury prevention aids, keep records of ingredients held on their premises and of all treatments given; train other health professionals, such as nurses and care workers, on pharmaceutical products; do blood pressure, glucose or cholesterol tests; provide services to nursing homes and private hospitals, communicate with other health professionals in the community to care for patients’ needs; work with specific groups in the community such as the elderly; give talks and lectures on pharmaceutical issues for community groups or organisations, or other health professionals.

Physiotherapist: Physiotherapists are able to assess physical impairments that impact on mobility and activity. They use a range of manual mobilisation and exercise techniques and promote mobility and physical function. Roles include helping rehabilitate people who have experienced sports injuries, trauma or accidents, neurological or cardiopulmonary events, stroke or long term degenerative disorders. Physiotherapists can work with individuals or with groups with a theme.

Podiatrist: Podiatrists diagnose, treat and prevent foot and lower limb problems. Their work includes routine foot care; the care of lower limbs for people with diseases such as diabetes; the diagnosis and treatment of sports-related injuries; nail and skin surgery; they use x-rays and biomechanical assessment, video gait-analysis equipment and other methods to examine patients’ body movements; discuss treatment options with service users; offer advice on foot health and prevention of foot disorders; help patients choose suitable treatment options; treat foot problems, sports injuries and walking or running disorders; perform minor surgery on feet such as ingrowing toenails and wart removal; prescribe and arrange the making of inner soles (orthoses) to correct foot problems; advise people about continuing treatment, foot care and choice of shoes.

Push play facilitator… Facilitators are focused on specific programmes eg active youth… eg aim to assist children (8 to 15 years) and their families into a healthier, more active lifestyles. Highest priority are young people who are in the 95th percentile based on height/weight charts ie overweight for height and overweight (BMI 25+) for their age. Referrals are via a Green Prescription.

Social Worker; Kaimahi Toko i te Ora: Social workers provide advice, advocacy and support to people with personal and social problems. They also help with community and social issues. Work brokers help people make employment decisions and place them in job vacancies. They also establish and maintain contact with employers. Consumer and primary health team information about social, wellbeing, and support groups, agencies & organisations can be found through Web Health on-line or at kiosks in public places.
Evolution of a Team

Tuckman published a team development model in 1965 (forming, storming, norming, performing). He added a fifth stage, adjourning, in the 1970’s. The theory is a helpful explanation of team development and behaviour, noting that as the team develops maturity and ability, relationships establish, leadership style changes.

The original model progresses through four phases. Features of these phases are:

**Forming - stage 1:**
High dependence on leader for guidance and direction. Little agreement on team aims other than received from leader. Individual roles and responsibilities are unclear. Leader must be prepared to answer lots of questions about the team’s purpose, objectives and external relationships. Processes are often ignored. Members test tolerance of system and leader. Leader directs (‘Telling’ mode).

**Storming - stage 2**
Decisions don’t come easily within group. Team members vie for position as they attempt to establish themselves in relation to other team members and the leader, who might receive challenges from team members. Clarity of purpose increases but plenty of uncertainties persist. Cliques and factions form and there may be power struggles. The team needs to be focused on its goals to avoid becoming distracted by relationships and emotional issues. Compromises may be required to enable progress. Leader coaches (‘Selling’ mode).

**Norming - stage 3**
Agreement and consensus largely forms among team, who respond well to facilitation by leader. Roles and responsibilities are clear and accepted. Big decisions are made by group agreement. Smaller decisions may be delegated to individuals or small teams within group. Commitment and unity is strong. The team may engage in fun and social activities. The team discusses and develops its processes and working style. There is general respect for the leader and some of leadership is more shared by the team. Leader facilitates and enables (‘Participating’ mode).

**Performing - stage 4**
The team is more strategically aware; the team knows clearly why it is doing what it is doing. The team has a shared vision and is able to stand on its own feet with no interference or participation from the leader. There is a focus on over-achieving goals, and the team makes most of the decisions against criteria agreed with the leader. The team has a high degree of autonomy. Disagreements occur but now they are resolved within the team positively and necessary changes to processes and structure are made by the team. The team is able to work towards achieving the goal, and also to attend to relationship, style and process issues along the way. Team members look after each other. The team requires delegated tasks and projects from the leader. The team does not need to be instructed or assisted. Team members might ask for assistance from the leader with personal and interpersonal development. Leader delegates and oversees (Delegating’ mode).

Figure 2. Tuckman’s (1965) Team development model
Adjourning - stage 5

Tuckman refined his theory around 1975 and added a fifth stage to the Forming Storming Norming Performing model - he called it Adjourning, which is also referred to as Deforming and Mourning. Adjourning is arguably more of an adjunct to the original four stage model rather than an extension - it views the group from a perspective beyond the purpose of the first four stages. The Adjourning phase is certainly very relevant to the people in the group and their well-being, but not to the main task of managing and developing a team, which is clearly central to the original four stages.

Tuckman’s fifth stage, Adjourning, is the break-up of the group, hopefully when the task is completed successfully, its purpose fulfilled; everyone can move on to new things, feeling good about what’s been achieved. From an organizational perspective, recognition of and sensitivity to people’s vulnerabilities in Tuckman’s fifth stage is helpful, particularly if members of the group have been closely bonded and feel a sense of insecurity or threat from this change.


Client/patient as a team member

Other models may be perceived by clients/consumers, especially people with long term health problems access primary health care over years or decades.

“Interprofessional education occurs when one or more professions learn with, from and about each other to improve collaboration and the quality of care”

– CAIPE
Developmental phases - interdisciplinary health care teams or interprofessional learning teams

Phase I: forming

<table>
<thead>
<tr>
<th>What you might observe</th>
<th>Teambuilding activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superficially share names and background information</td>
<td>Create icebreakers (meet over coffee, BBQ, potlucks, informal discussions)</td>
</tr>
<tr>
<td>Members size up and learn from each other</td>
<td>Discuss formal and potential roles of members, verbalise stated team goals</td>
</tr>
<tr>
<td>Members guarded, some active, most passive</td>
<td>Encourage informal time to get to know one another</td>
</tr>
<tr>
<td>Understand about team membership</td>
<td>New team: discuss and agree on core and secondary team membership. New team member: mentor introduces</td>
</tr>
<tr>
<td>Conflict neither discussed nor addressed</td>
<td>Encourage conflict recognition as an opportunity for creative problem solving</td>
</tr>
<tr>
<td>Treatment intervention</td>
<td>Patient led</td>
</tr>
</tbody>
</table>

Phase II: Norming

<table>
<thead>
<tr>
<th>What you might observe</th>
<th>Teambuilding activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to understand purpose of the team</td>
<td>Discuss the goals as a team</td>
</tr>
<tr>
<td>Attempt to establish common team goals</td>
<td>Discuss and agree as a team</td>
</tr>
<tr>
<td>Mistrust each other; exhibit caution and conformity</td>
<td>Structure opportunities for informal communication about training, values, experience, and duties of each member</td>
</tr>
<tr>
<td>Begin to see role overlaps</td>
<td>Observe members from other disciplines; discuss overlaps</td>
</tr>
<tr>
<td>Know conflicts are present; cover them up or white wash them</td>
<td>Encourage conflict recognition as an opportunity for creative problem solving</td>
</tr>
<tr>
<td>A few members attempt to establish bonds with others who have similar views</td>
<td>Form a subcommittee and include members from different coalitions</td>
</tr>
<tr>
<td>Team establishes ground rules; begins to clarify common roles</td>
<td>Reinforce ground rules; negotiate common roles</td>
</tr>
<tr>
<td>Team may want leader(s) to assume responsibility</td>
<td>Identify informal leadership roles that need to be filled and who can fill them</td>
</tr>
<tr>
<td>Team tries strategies to increase equality of leadership (eg rotating leaders)</td>
<td>Emphasize development of competence for different leadership roles</td>
</tr>
<tr>
<td>Defensive communication and disruptive behaviour increases</td>
<td>At process team meeting, give open feedback and discuss patterns of disruption and solutions</td>
</tr>
<tr>
<td>Team members are frustrated</td>
<td>Promote informal leadership for resolving problems</td>
</tr>
<tr>
<td>Team members compete</td>
<td>Discuss different leadership roles; praise members for individual contributions</td>
</tr>
<tr>
<td>Some members come to meetings late or do not attend them</td>
<td>Review rules for membership (eg attendance at meetings, start and end meetings on time, ignore late arrivals)</td>
</tr>
</tbody>
</table>
### Phase III: Confronting

<table>
<thead>
<tr>
<th>What you might observe</th>
<th>Teambuilding activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can no longer avoid conflicts; some members verbally attack other members</td>
<td>Bring team conflicts to team forum or process leader (if identified) mediates between individuals</td>
</tr>
<tr>
<td>Conflicts of leadership, equality, commitment increase</td>
<td>Identify, clarify, and assign informal leadership roles</td>
</tr>
<tr>
<td>Members feel anxiety over expression of feelings</td>
<td>Encourage expressions of affect – positive and negative</td>
</tr>
<tr>
<td>Address some conflicts directly</td>
<td>Encourage the practice of constructive confrontation; focus on solutions to problems</td>
</tr>
<tr>
<td>Some members withdraw from the team</td>
<td>Review reasons for leaving; may be a symptom of team dysfunction</td>
</tr>
<tr>
<td>Search for leader who will resolve conflicts</td>
<td>Identify members with skills and willingness to assume role of process analyzer</td>
</tr>
<tr>
<td>Functional leaders emerge</td>
<td>Identify and encourage informal leaders</td>
</tr>
<tr>
<td>Realize that power is not equal</td>
<td>Identify all power sources</td>
</tr>
<tr>
<td>Realise that everyone has power for leadership and decision making</td>
<td>Encourage members to recognize and assume power sources they are capable of assuming</td>
</tr>
<tr>
<td>Conflicts lead to constructive confrontation</td>
<td>Help the team (members) discuss and resolve conflicts; regard as opportunity for creative problem solving</td>
</tr>
<tr>
<td>Team re-clarifies goals and roles</td>
<td>As team, update goals; discuss roles and agree</td>
</tr>
<tr>
<td>Form coalitions that change according to needs of the team</td>
<td>Praise this as sign of team’s growth</td>
</tr>
</tbody>
</table>

### Phase IV: Performing

<table>
<thead>
<tr>
<th>What you might observe</th>
<th>Teambuilding activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appreciate differences of members</td>
<td>Encourage this behaviour</td>
</tr>
<tr>
<td>Members encourage and help each other</td>
<td>Identify and encourage as team’s culture</td>
</tr>
<tr>
<td>Increase reality testing; team grows stronger</td>
<td>Schedule open feedback of members to team</td>
</tr>
<tr>
<td>The norm is self-initiated active participation</td>
<td>Praise informal leadership</td>
</tr>
<tr>
<td>Members trust each other and develop strong relationships</td>
<td>Enjoy; offer to mentor new members</td>
</tr>
<tr>
<td>Members meet regularly and come on time</td>
<td>Reinforce as part of team culture</td>
</tr>
<tr>
<td>See conflicts as normal and use as impetus for program improvement</td>
<td>Reinforce as part of team culture</td>
</tr>
<tr>
<td>Emphasize productivity and problem solving</td>
<td>Reinforce as part of team culture</td>
</tr>
<tr>
<td>Members responsible for leadership</td>
<td>Reinforce as part of team culture; assure all informal leadership roles are filled</td>
</tr>
</tbody>
</table>
In times of profound change, the learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

– Eric Hoffer
The benefits of teamwork in primary healthcare

The RPSGB Report (2000) review of the research evidence showed that benefits of teamwork could be classified as:

- A more responsive and patient-sensitive service
- A more clinically effective and/or cost effective service
- More satisfying roles and career paths for primary healthcare professionals.

The most frequently cited advantages of team care over traditional care were:

- Aspects of improved organisation and planning
- Avoiding duplication and fragmentation
- Developing more comprehensive databases leading to better identification of health problems, leading to
- Developing better and more comprehensive healthcare plans.

More responsive and patient-sensitive services

- A team approach to primary healthcare can improve accessibility for patients. Much of the research evidence centres on reducing the general practitioner’s workload and thereby increasing the number of patients who can be seen (Marsh, 1991) and reducing the length of time patients need to wait for an appointment, or enabling a more ‘patient-centred’ consultation (Hasler, 1994).
- GPs sharing home visits with other team members may make it possible to increase the average number of contacts patients have with a health worker, thereby improving patient satisfaction. Teamwork can enable the expansion of the range of services available to patients. This offers more integrated care, reduces duplication, and can be more convenient for the patient. Teamwork can also enable doctors to manage larger list sizes and, through sharing home visits, increase intensive home care to patients who are seriously ill, potentially reducing referral rates to hospital (Marsh, 1991).
- Many Community Health Councils (CHCs) have made a positive contribution to GP services in their area. For example, a model of partnership for Primary Care Groups and CHCs in West Sussex has been developed, which includes looking at potential difficulties and mutual gains, while making proposals for effective joint working (West Sussex Community Health Councils, 1999).

More clinically effective and/or cost effective services

- The advantages to patients and communities of a team approach are said to accrue through a group process of ‘co-operation’, ‘co-ordination’ or ‘collaboration’. When care outcomes of team work were measured, the benefit to the patients and communities of professionals working together was greater than would have been achieved had they worked in isolation. The best patient outcomes were achieved after contact with the least hierarchical team model (Feiger & Schmitt, 1979). Effective team care for chronic illness often involves professionals outside the group of individuals working in a single practice (Wagner, 2000).
- Some randomised controlled trials (Rubenstein et al., 1984; Wood-Dauphnee et al., 1984) have shown that patients treated by a multidisciplinary team in a geriatric service had a lower mortality rate than controls, while team-care of stroke patients resulted in significantly higher scores for motor performance and functional ability than traditional care patients.
- Organisational advantages of multidisciplinary teamwork have impacted favourably on: health surveillance, management of chronic disease, terminal care and the psychosocial impact of illness (van Weel, 1994); in Holland a general practice diabetic clinic (Palm et al., 1993); a practice-based cervical cancer screening call system (Parnell et al., 1993) and preventive care of patients in a severely deprived area of England (Marsh & Channing, 1988).
- Evidence bases have led a number of leading US health organisations to have interdisciplinary teams of co-workers who are able jointly to support large numbers of people in their own homes and communities (eg pharmacist, physiotherapist, nurse, occupational therapist and social work may jointly support hundreds of people by efficiently sharing their knowledge and evolving collaborative practices that work for the communities they are in. Such organisations also commonly ensure that specialist physicians, paediatricians and obstetricians develop collaborative practice models with primary health care teams so they can knowledge share and jointly problem solve with clients and for service improvements.
Some studies have identified improved efficacy through deployment of the skills and expertise of primary care professionals, for example, evaluation of nurse-run asthma and hypertension clinics (Charlton et al., 1991; Charlton et al., 1992; Jewel & Hope, 1988). As well as medical practitioners, other team members can and do contribute directly to making primary care services more cost effective. A recent audit of the introduction of a home-based counselling service found that it had reduced patients’ use of other practice services (Gurney, 1999). Practice pharmacists can promote rational prescribing, manage the drugs budget, and develop and implement repeat prescribing policies (Bradley, 1996). A pharmacist managed, practice-based anticoagulant clinic has reduced waiting times and travelling costs for patients, while improved communication between the GPs and pharmacist reduced the risk of toxicity and treatment failure (Macgregor, 1997). Aside from their role with patients on prescribed medicines, community pharmacists are readily accessible to the public for consultation about self-limiting conditions and some chronic conditions, a quicker option than seeing a doctor (Hassell, 2000).

Enhanced job satisfaction

Teamwork can reduce work-related stress among general practitioners by reducing workload. Being able to spend more time with patients may also reduce stress for the GP (Howie et al., 1992). A large research study on teamworking in the healthcare setting, where the team was defined as ‘a group of people with shared objectives and a unique contribution from each other’, showed that clear benefits of teamworking were improved staff wellbeing and with it, increased performance (Bonnill et al., 2000). Nurses’ involvement in teamwork should increase job satisfaction by reducing perceived alienation, although the extent to which nurses and other members of the team participate in decision-making varies between teams (Cott, 1998). A research project, which explored the role of shared learning involving clinical team case studies, showed that, in those teams where there was more collaborative working, there were clear benefits for patients, carers and the team itself (Miller et al., 1999).

Barriers to teamwork in primary healthcare

Teamwork does not necessarily follow from professionals working alongside one another and some researchers have observed that the path to achieving teamwork may be a long and difficult one (Lamberts & Riphagen, 1975). Structural, historical and attitudinal barriers contribute to the difficulties. In some circumstances teams may perform less effectively than individuals working alone (West & Slater, 1996). The published literature West & Pillinger, 1996) provides evidence of the problems of:

- competing demands
- diverse lines of management
- poor communication
- personality factors, plus
- status and gender effects.

Organisational structure

- Potential organisational obstacles include different lines of management into primary healthcare teams, which can undermine attempts at teamworking West & Slater, 1996, West & Pillinger, 1996; Audit Commission, 1992). Added to this are different payment systems associated with the independent contractor status of some team members. A further barrier in primary healthcare is the lack of any overarching structure, which could provide continuing support and education for teamwork. As with so many areas of work in healthcare, inadequate staff and resources may also constitute a barrier.

Size and location of teams

- Team size can be a critical factor; the increasing size of some extended teams can be disadvantageous (RCGP, 1995). Experience suggests that large teams (greater than 20) are less effective than smaller teams, where it is easier to engage members and communicate effectively (RCGP, 1995; Stott, 1995). Geographical separation can be an issue for some teams and/or members. Teams in general practice may be small when formed around the needs of individual patients.
Internal team factors

- Internal factors include people's inertia, satisfaction with the status quo, and an inability to attract support for innovation. Recognising when facilitation can make a useful contribution can help to overcome these factors (Field & West, 1995).
- The existence of clear objectives, full participation, an emphasis on quality and support for innovation have been found to account for a quarter of the variation between teams in their effectiveness. In particular, clarity of and commitment to team objectives was key in predicting the overall effectiveness of the primary healthcare team (Poulton & West, 1999). ‘Bad processes rarely produce good outcomes’ (Pritchard & Pritchard, 1994).
- A study of competencies in primary healthcare teams found that the majority of teams had a strong commitment to developing teamwork and learning. However, many had trouble in planning strategically for the team’s development. Competing demands were implicated and, from some team members, particularly GPs, lack of appreciation of the need for strategic planning (Usherwood et al., 1996).

Time constraints

- Insufficient time for formal and informal meetings of the team, and the contractual obligations of some important off-site team members, can lead to individual team members not having the appropriate level of contact to fulfil their own and the team’s needs.

‘Teamwork takes time because each new team member multiplies the need for communication and co-ordination’ (RCGP, 1995).

Professional divisions

- Entrenched attitudes of team members can lead to team conflict. These can include lack of understanding and respect for other professional roles. Some individuals or groups may be unable to relinquish positions in a team to other more suitable members, holding on to power or status West & Slater, 1996).

Factors which promote teamwork

The published literature supports the view that effective teamwork is most likely to occur where:
- each team member’s role is seen as essential
- roles are rewarding, and
- there are clear team goals.

Other factors important in promoting teamwork are:
- effective communication
- optimum team size
- recognition of team members’ professional judgment and discretion,
- adequate time and resources.

Teams could be helped by:
- having a shared learning process, and
- working on team development (Pritchard & Pritchard, 1994).

- The creation of integrated nursing teams represents one example in the development of more integrated primary healthcare (Elwyn & Smail, 1999; Rink et al., 2000). Integration has been defined as ‘bringing into equal partnership’ and teamworking as being about ‘sharing skills, not preserving existing roles’.

Group processes

- Good working relationships are built and maintained by team members understanding and acknowledging each other’s skills and roles. Team leadership skills are required. Agreeing a process for resolving conflict assists the identification and management of predictable problems (Borill et al., 2000; West & Slater, 1996). Multidisciplinary activities such as audit, pilot projects, and joint education and training can contribute positively to strengthening group processes (Pritchard & Pritchard, 1994).

Communication

Agreed and easy to use communication channels are essential for successful teamworking, particularly when individuals are not normally located in close proximity to each other. Mistrust, apprehension regarding role encroachment and a lack of understanding of other professions may well be a direct result of previous poor communication (West & Poulton, 1997).

Team members

People who work best in a team environment are those who are not only capable of performing their own tasks but who also possess knowledge, skills and attitudes that support their team (West & Slater, 1996):
- supporting and building on the work of others
- getting along with others, and
Figure 2. Illustrates the flexibility anticipated of contemporary primary health care teams. (RPSGB, 2000:p.12)

Teamworking in primary healthcare

Teamwork in primary healthcare is flexible and dynamic, centred on the needs of patients and carers. This diagram illustrates how teams might form around a particular patient, for example to provide services to:

- Person with diabetes
- Parent with young children
- Person needing dental treatment
- Person with mental health problems

New Zealand example...

<table>
<thead>
<tr>
<th>Examples of teams relevant to several service users / patients / consumers / clients</th>
<th>Primary health care team</th>
</tr>
</thead>
</table>
| Person who falls from horse in local context; GP refers to trauma service and person returns to community for rehabilitation and on-going primary health care | Receptionist/walk in centre  
Primary health care nurse  
General medical practitioner  
Pharmacist  
Midwife  
Health promoter  
Carer – home helper  
Maori health worker |
| Older person with multiple health problems living alone in own home | Therapist  
CONTINENCE NURSE  
HEALTH VISITOR  
Mental health nurse  
Dietitian / Healthy Kai worker  
Optometrist  
Podiatrist  
Local support groups |
| Person with mental health problems | Physiotherapist  
Occupational therapist  
Psychologist  
Mental health nurse  
Optometrist  
Podiatrist  
Local support groups |
| Person with diabetes | Dentist  
Dental hygienist  
Social worker  
Local support groups |
Collaborating and teamworking

“Professionalism has contributed a great deal to modern health care, but has inhibited the ability to achieve cross boundary solutions based on team work” (Braithwaite et al., 1995)

According to Drinka (1996), an interdisciplinary health care team is a group of health professionals from different disciplines who engage in planned, interdependent collaboration. Liedtka (1998) defines collaboration as a process of joint decision-making among interdependent parties involving joint ownership of decisions and collective responsibility for outcomes.

An effective interdisciplinary health care team has the following characteristics:

- Competence
- Mutual trust
- Shared goals
- Defined roles
- Methods for resolving conflict
- Active listening
- Free exchange of ideas
- Clear communication between team members
  
(Drinka, 1996).

The most important aspect of teamwork is that members must work together in a coordinated manner to address the problem(s) at hand. According to Tsukuda (1990), collaboration is based on several assumptions:

- the problem is big and/or complex enough to require more than one set of skills or knowledge;
- the amount of relevant knowledge or skills is so great that one person cannot possess them all;
- the assembling of a group or team of professionals with more than one set of knowledge or skills will enhance the solution to the problem;
- the solution to such a problem, the possessors of the relevant skills or knowledge are considered to be equal or equally important; and
- all of the involved professionals are working for a common goal for which they are willing to sacrifice some professional scrutiny.

Teams can be intentionally built and the skills that enable this process to happen also can be developed”

– Frances & Young, 1979

Oandasan et al. (2004) identify key characteristics and describe the concepts of “collaboration” and “team” as:

1. Sharing. This includes:
   - shared responsibilities;
   - shared decision-making;
   - shared health care philosophy;
   - shared planning and intervention; and
   - sharing of different professional perspectives.

2. Partnership. This includes:
   - two or more actors join in a collaborative undertaking;
   - collegial-like relationship;
   - open and honest communication;
   - mutual trust and respect;
   - each partner is aware of and values the work and perspectives of others;
   - partners pursue a common goal; and
   - a set of shared goals or specific outcomes.

3. Interdependency. This includes:
   - mutual dependency;
   - interdependent rather than autonomous;
   - individual contribution is maximized; and
   - output of the whole becomes much larger than the sum of the inputs of the parts.

4. Power. This includes:
   - shared between team members; and
   - simultaneous empowerment of each participant whose power is recognized by all.

Structured Collaborative Practice

Way et al., (2000) believe all successful collaborations have a common framework. By emphasizing flexibility in model design and implementation, the practice groups will be able to adapt the structure and function of successful collaborative practice in a manner, which preserves the characteristics of partners preferred practice styles and respects the needs of patient population and any geographical variations or limitations.

The essential elements for successful collaboration are:

Responsibility and Accountability

Involve both independent and shared accountability. Shared accountability means that partners actively participate in decision making and accept shared responsibility for the outcomes of the care plan.
**Co-ordination**

Includes efficient and effective organisation of the necessary components of the treatment and patient/service users self management plan. The collaborating team members need to make joint decisions about who will do what to ensure that the treatment plan is carried out in a manner that reduces duplication of effort and prevents fragmentation. Mechanisms used to increase co-ordination include bi-directional consultation, referral and transfer of care. Appropriate use of these mechanisms increases the likelihood that comprehensive Primary Healthcare will occur and guarantees that the most appropriately qualified professional(s) are working with the patient/family and addressing the priority issues from the patient’s perspective.

**Assertiveness**

Involves individual providers supporting the views and perspectives of their own profession with confidence, assured of the value of their own contribution. Assertiveness goes hand in hand with co-operation. The partners’ respect for one another’s professional approach includes the ability to present opinions and viewpoints in a manner that fosters the integration of approaches resulting in unique or synergetic solutions. The co-operation and assertiveness of each partner means that decisions are made based on consensus. Each provider agrees to support the decision and the resulting integrative plan. Consensus is facilitated by the full participation of the partners using a balance of co-operation and assertiveness.

**Autonomy**

Autonomy involves the authority of the individual providers to independently make decisions and carry out the treatment plan. Autonomy is not contrary to collaboration and serves as a complement to shared work. Without the ability to work independently, the provider team becomes inefficient and work becomes unmanageable. Collaborative partners – team members need to fully understand and support practice autonomy, as well as, shared decision making from a liability perspective.

**Communication**

Includes the communication of both content and relationship. Each professional is responsible for sharing with the other providers critical information regarding the patient and issues relating to decision-making. The ability to present information in a manner that is relevant, concise, and timely is critical to the development of a collaborative relationship. As well, the content must be presented and received in context of the relationship. The message will be received differently depending upon how the partners view one another. Feeling superior or inferior, rather than equal, will influence how the information is sent and received. Clear articulation of the purpose for sharing information to provide an overview of what is expected from the partner and the ability to convey knowledge and skill through concrete information sharing are essential components of positive communication between partners. Collaborative communication may sound like “positive arguing” as each partner feels free to voice ideas and concerns; however, respectful listening ensures that both partners receive the joint input needed to make effective patient care decisions. A key component of effective communication is mutual support and affirmation that the partnership is working well. Verbal communication fosters relationship building. Successful collaboration partners build these opportunities into their practice.

**Mutual Trust and Respect**

This is common to and binds all the other elements together.

‘Without trust and respect, co-operation cannot exist. Assertiveness becomes threatening, responsibility is avoided, communication is hampered, autonomy is suppressed and co-operation is haphazard’ (Norsen, 1995)

Each provider must be able to depend upon the integrity of the other as the foundation for their professional relationship (Way et al., 2000:4).

**Co-operation**

Involves acknowledging and respecting other disciplines’ professional opinions and viewpoints while being willing to examine and alter your own professional views and perspectives.
Table 5 illustrates the main features and components of the patient-centred approach. Brown provides the following definition in her paper, “Patients want patient-centred care”. There are:

a. To explore the patients’ main reason for the visit, concerns, and information needs;

b. To seek an integrated understanding of the patients’ world - that is, their whole person, emotional needs, and life issues;

c. To find common ground on what the problem is and mutually agree on management;

d. To enhance prevention and health promotion; and

e. To enhance the continuing relationship between the patient and the doctor. (Stewart, 2001, p 445).

Where there is a secure system, patients may email their service coordinator or GP ahead about the agenda they’d like to address. Following a consultation the GP or other core team member(s) may email a summary of the discussion and provide links to useful New Zealand websites. Janine Bycroft is working with a range of stakeholders to develop Health Navigator as a resource for GPs, service users/consumers and primary health care teams. This will complement other New Zealand information on electronic directory and knowledge sharing resources eg Webhealth and Healthpoint.
The Patient-Centred Clinical Method

Six Interactive Components (Brown, 2004)

1. Exploring both the disease and the illness experience:
   - history, physical, lab;
   - dimensions of illness (feelings, ideas, effects on function and expectations).

2. Understanding the whole person:
   - the person (e.g., life history, personal and developmental issues);
   - the proximal context (e.g., family, employment, social support); and
   - the distal context (e.g., culture, community, ecosystem).

3. Finding common ground:
   - problems and priorities;
   - goals of treatment and/or management; and
   - roles of patient/service user, doctor, other practitioners, other family members.

4. Incorporating prevention and health promotion:
   - health enhancement;
   - risk avoidance;
   - risk reduction;
   - early identification; and
   - complication reduction.

5. Enhancing the patient-doctor/primary health care team relationship:
   - compassion;
   - power sharing and knowledge sharing;
   - healing; and
   - self-awareness.

6. Being realistic:
   - time and timing; and
   - teambuilding and teamwork.

A closely related concept of patient-centred practice is collaborative care, which extends the collaboration to include patients, families, friends, and informal caregivers.

A key aspect of collaborative care and collaborative patient-centered practice is Supporting Self-Care,

Oandasan et al. (2004) identify the following key ingredients of a collaborative patient-centred approach:
   - the sharing of power between partners;
   - the pursuit of goals that are the result of discussion and negotiation; and
   - active participation and involvement of the partners in the process of working together (Curran, 2004).

“A mature team has dealt with thorny questions concerned with control, leadership, procedures, organisation and roles. The team’s structure is finely attuned to the range of activities being undertaken, and individual talents and contributions are utilised without confusion. Team members with a drive for leadership have learned to understand each other and to cope with any feelings of hostility, competitiveness or aggression. The team has managed to become flexible, responsive, orderly and directed.”

– Frances & Young, 1979
<table>
<thead>
<tr>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ad Hoc Task Group</strong></td>
<td>≥ 1 discipline/department/agency. Group selects or agrees on a leader. Rules set by the group. Solves a problem and disbands.</td>
<td>Focus on one issue No elaborate rules Quick and dirty Members capture enthusiasm</td>
</tr>
<tr>
<td><strong>Formal Unidisciplinary Work Group</strong> (eg. doctors from multiple specialties)</td>
<td>One discipline/department/agency Members report to group Individual identities more important than integrated diagnoses Don’t work on team problems Leadership by election or rank Discipline specific care</td>
<td>Members speak same language Final decisions by formal leader Ongoing Rules established to keep order Security of one discipline Solutions may have depth</td>
</tr>
<tr>
<td><strong>Formal Multidisciplinary Work Group</strong> (eg. doctor, nurse, social worker, occupational therapist)</td>
<td>&gt;1 discipline/department/agency Members report to group Individual identities more important than integrated diagnoses Don’t work on team problems Leadership by election or rank Discipline specific care</td>
<td>Final decisions by formal leader Ongoing Rules established to keep order Information from many perspectives Solutions may have breadth</td>
</tr>
<tr>
<td><strong>Interactive Unidisciplinary Team</strong> (eg. nurses from different roles)</td>
<td>One discipline/department/agency Members interact independently Team structures enable collaboration Work on team problems Leadership appropriate to issue/expertise</td>
<td>Members speak same language Share responsibility for leadership More openness More informal collaboration Solutions have depth Members feel empowered Culture encourages creativity</td>
</tr>
<tr>
<td><strong>Interactive Interdisciplinary Team</strong> (eg. doctor, RN, SW, OT, pharmacist)</td>
<td>&gt;1 discipline/department/agency Members interact independently Team structures enable collaboration Work on team problems Leadership appropriate to issue/expertise</td>
<td>Integrated care Share responsibility for leadership Solutions address complex problems Solutions have depth &amp; breadth Members feel empowered Creative approaches to complexity Understand autonomous practice</td>
</tr>
<tr>
<td><strong>Autonomous Practice</strong></td>
<td>Individual decides based on knowledge</td>
<td>Quick, appropriate solutions</td>
</tr>
</tbody>
</table>

Interprofessional Education (IPE)

Interprofessional education (IPE) was constructed in order to meet the challenges of creating a common platform on which health care professionals can work as a team. Around the globe, several definitions exist, many of which overlap one another.

Benefits of IPE

Interprofessional education has been described as learning together to promote collaboration. It involves:

- Socializing health care providers in working together, in shared problem solving and decision making, towards enhancing the benefit for patients, and other recipients of services;
- Developing mutual understanding of, and respect for, the contributions of various disciplines; and
- Instilling the requisite competencies for collaborative practice (Health Canada, 2007).

According to Barr (2005) interprofessional education helps students to develop the following range of collaborative competencies:

- Describe one’s roles and responsibilities clearly to other professions.
- Recognize and observe the constraints of one’s role, responsibilities, and competence, yet perceive needs in a wider framework.
- Recognize and respect the roles, responsibilities, and competence of other professions in relation to one’s own.
- Work with other professions to effect change and resolve conflict in the provision of care and treatment.
- Work with others to assess, plan, provide and review care for individual patients.
- Tolerate differences, misunderstandings, and shortcomings in other professions.
- Facilitate interprofessional case conferences, team meetings, etc.
- Enter into interdependent relations with other professions (Barr, 2005)

In light of increased focus of individual and population health outcomes, Headrick et al., (1998) considered the tension between the need to improve interprofessional practice among different health professional and the demand for broader vision of continuing medical education. The authors argue that the importance of the ability of professionals to work together increases with the complexity of individual patient health needs. More efficient care therefore means ‘doing things right’ and ‘doing the right things’.

Challenges for Interprofessional Education

There are varying definitions of IPE around the world. IPE is innovative and ‘reinvention’ to an extent can be expected to reflect the people, roles and opportunities in different contexts.

Creating a common platform for educators, learners, and professionals is the start to moving toward a unified health care system (CICH, 2007: p.16)

The literature reviewed thus far suggests some conditions for changing attitudes in IPE, (which can be perceived as an intergroup encounter) including:

- Institutional support for participation from the people or organisations that the participants feel to be influential. For prequalification students this may be tertiary education lecturers and leaders; for practicing professionals, it may be their colleagues, managers and/or professional bodies, DHBs, PHOs and Ministry of Health, Ministry of Education, TEC, CTA.
• Participants in interprofessional placements should have positive expectations. Whilst it is important that similarities between the groups are emphasised, differences should also be explored. Contact situations should emphasise the equality of participants on the programme even if they have different status outside (eg doctors, pharmacists and nurses). The learning atmosphere should be cooperative rather than competitive. Additionally, joint work should be successful if intergroup attitudes are to improve.

For positive attitude change to then be generalised the members involved in the contact situation must be perceived as typical.

“Try to forget stereotypes and see each doctor/nurse as an individual. We don’t just communicate with a “doctor” or a “nurse”. There is a human being underneath the uniform!”

– Known. TBA

“Successful organisations are those with people who can work effectively together”

– Woodcock, 1979

An appropriate range of students or professionals should be involved in interprofessional education: this is probably the full set of professionals involved in the provision of a service (eg all members of a core primary care team).

Conclusion

It is evident that there are many gaps in our understanding of stereotype change through interprofessional education and many opportunities for improvement in New Zealand.

Educators, funders and health care organisations and consumer networks should pay explicit attention to designing interprofessional education and comprehensive primary health care models in New Zealand which boost the chances of the planned contact having positive effect. Contact, in other words, is “not enough”.
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Teamworking In Primary Health Care Project 2006-2008

The Teamworking in Primary Health Care project (2006-08) is the first interdisciplinary placement of undergraduate health professionals’ initiative to be piloted in New Zealand. The Teamworking in Primary Health Care project is a joint Auckland University of Technology (AUT) and Waitemata District Health Board (WDHB) initiative, in collaboration with the University of Auckland (UoA) and Primary Health Organisations (PHO) within the Waitemata Health Board district. The project is funded by the Ministry of Health.

The Teamworking in Primary Health Care Project 2006-2008 is a pilot study investigating how planned multidisciplinary teamwork placements and teamwork education can deliver improved interdisciplinary competencies in undergraduate health professionals. Our goals are to:

a. To build a healthcare workforce with teamwork skills
b. Encourage local primary healthcare providers to use teamwork models
c. To support healthcare organisations implementing teamwork
d. To gain support within training institutions for teamwork placements in primary health care
e. To stimulate collaboration and joint planning across and within universities, health services and communities.
f. Share project learnings and recommendations for future health and education sector change.

The overall aim of the project is to develop a teamwork model of interdisciplinary practice that meets baseline requirements while remaining adaptable to the range of contexts within the New Zealand primary health care sector.

“The test of a team is its capacity to deliver the goods. A team is capable of achieving results that the individuals who comprise it cannot do in isolation. Their diverse talents combine in the team to create results beyond their individual capability”

– Frances & Young, 1979

Tools & resources

Team Toolkit – your guide to effective teamwork Level 2

This is a specific workbook designed for use by New Zealand students in interprofessional education Teamworking Placements in 2006-2008. It includes team process summaries; project management overview and tools such as action plans and Gantt Charts; communication activities, tips and techniques; overview of skills and attitudes relevant to successful teams; decision making; meeting guidelines; affinity techniques; force field analyses; SWOT analysis; individual preferences and styles.

Reflective Journaling

Recording your thoughts and experiences in reflective notes throughout all phases of interprofessional education is helpful… eg

• My assumptions before starting
• How role expectations are developed and modified
• How do I experience this?
• How different types of work are organised
• How decisions are made?
• Whose opinion carries weight?
• How it differs for different topics
• Ways the timetable for team projects is established
• How the teamwork project is managed
• How disciplinary boundaries/scopes of practice are negotiated and managed
• How the team evolves
• How team conflicts are managed

Teamworking Projects or Assignments

Each student interprofessional team collaborates to learn about working together incorporating professional knowledge and skills and personal attributes to produce an assignment or project deliverable which demonstrates that the learning outcomes have been met. Outline projects are agreed with the host context and take a population health, health promotion or needs assessment or other primary health care focus. The student teams evolve more detailed design, development and presentation. It is expected that the assignment will be a work in progress from the pre-host site phase of a placement until its conclusion. Students may be creative in how their project or assignment is prepared and presented.
Useful learning e-links

**Teams and leadership – interactive course**

The National Health Service in the UK aims to be based on teamwork. Health professionals from a variety of disciplines work together to deliver health care to patients and communities. All members of the team are equally valuable and essential to the smooth running of the NHS.

Team working means taking responsibility for your own work as well as respecting the contributions of all your colleagues. And good communication is essential to effective team working.

The NHS healthcare skills site has an interactive training course on teamwork and leadership. It covers why teamwork is good for patient care, what makes a good team, how differences affect teamwork, what makes a good leader and how leaders and their teams can work towards safer patient care. You can do the course free online. It includes a completion certificate.

[http://www.healthcarekills.nhs.uk/teams-leadership.html](http://www.healthcarekills.nhs.uk/teams-leadership.html)

**Primary Health Care Strategy for New Zealand**

The Primary Health Care Strategy: This publication summarises the Government’s policy for primary health care and outlines changes including stronger emphasis on teamwork in primary health care.


There is a Primary Health Care Strategy site which has a range of related documents including Health of Older People Strategy, Palliative Care Strategy, Maori Health Strategy and Services to Improve Access.


**Medical education and training in New Zealand: Looking to the future**

Educating and training a medical workforce to provide the best health care for New Zealanders now and into the future is the subject of a report released by the Ministers of Health and Tertiary education today. The Workforce Taskforce Report: “Reshaping medical education and training to meet the challenges of the 21st Century” is the result of six months’ work by the Taskforce, which makes five major recommendations.


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**Health Needs Assessment for New Zealand**

**Background paper and literature review**

Date of publication: December 2000

This publication is not available in hard copy. It is available on the Ministry of Health website in PDF format.

[http://www.moh.govt.nz/moh.nsf/82f4780aa06f8d7cc2570bb006b5d4d/df8f4ff27c434a2acc2569bb000a0ff4/$FILE/HNAbackground.pdf](http://www.moh.govt.nz/moh.nsf/82f4780aa06f8d7cc2570bb006b5d4d/df8f4ff27c434a2acc2569bb000a0ff4/$FILE/HNAbackground.pdf)


Published by the Royal Pharmaceutical Society of Great Britain and the British Medical Association. Partners included Royal College of Nursing, Institute of Healthcare Management, Royal College of General Practitioners, British Dental Association, the Patients Association and the Patient Partnership. Useful resource which includes their definitions, recommendations, a visual model of patient-centered teamwork (page 12), benefits of teamwork in primary healthcare (p 15), constraints, education and training issues, changes in practice and teamworking initiatives.

[http://www.rpsgb.org/pdfs/teamworking.pdf](http://www.rpsgb.org/pdfs/teamworking.pdf)

**The principles and framework for interdisciplinary collaboration in Primary Health Care**

Published by Steering Group for Enhancing interdisciplinary collaboration in primary health care. A framework that fits. EICP. Canada. 2005. Twelve disciplines/organisations were represented on the Steering Group. This is a useful resource that includes definitions, outline of comprehensive consultation process, principles and framework. Principles that underpin interdisciplinary collaboration in primary health care in Canada are:

- Patient/client engagement
- Population health approach
- Best possible care and services
- Access, trust and respect
- Effective communication

The framework describes the characteristics of a systematic approach to primary health care. Seven key elements are required to sustain interdisciplinary collaboration in primary health care:

- Health human resources & funding
- Liability
- Regulation
- Information and communications technology
- Management and leadership
- Planning and evaluation

See: [http://www.eicp-acis.ca/](http://www.eicp-acis.ca/)
The Network towards Unity for Health

The necessity for collaboration between health and social care professions and health and welfare/social care agencies arises from the multiple needs of specific groups of service users, the variety of required service responses to these and the need for effective information exchange and discussion with regards to care planning and delivery.

Poor functional links between agencies has led to a failure of service and increased risk to service users. Examples of this include children’s services (Hudson 2005), care provision for individuals with mental illness (Glasby and Lester 2004), the Bristol paediatric cardiac surgery crisis (UK Department of Health 2001) and the breakdown in communication highlighted in the Every Child Matters (UK Department of Health 2003).

The inability of multiprofessional service groups to communicate has led to a failure to respond to the needs of service users effectively (Conway and Macmillian 2003).

The importance of interprofessional learning and education for health professionals was emphasized in 1988 by the World Health Organisation (WHO 1988) and this drive has been repeated by legislative and policy requirements in several countries, eg ‘Learning together to work together ’ (DH 2000) in the UK, The Inter-professional Education for Collaborative Patient-Centred Practice initiative, supported by Health Canada (Herbert 2005) and public health legislation in France.(Michell 2005).


Team role theories and descriptions – examples of resources

Belbin Team Roles describe the typical patterns of behaviour each of us display when interacting with others in team or group situations. The value of knowing our Team Roles lies in allowing each of us to benefit from self-knowledge and adjust according to the demands being made by the work situation.

http://www.belbin.com/rte.asp?id=8

Margerison-McCann Profiles and concepts are about individuals’ work preferences and the strengths each brings to a team; team management and performance