**‘Going the Extra Mile’: A descriptive exploratory study of Primary Health Services based in the Experiences of Pacific Primary Health Organisation Service Managers and Providers**

**Abstract**

INTRODUCTION: This exploratory study is part of a larger evaluation of the primary health care strategy in New Zealand, using a mixed methods research approach. The aims of this qualitative arm of the research were to identify how far the delivery of the PHCS through the operation of Primary Health Organisations (PHOs) were working in terms of service provision and delivery from the service providers’ and managers’ perspectives.

METHOD: The exploratory study was conducted using a case study design and in-depth interviews with service managers and health providers at six Pacific-led PHOs. A review of the literature on primary healthcare was conducted prior to undertaking the research. In this literature review, several themes were noted from the review of policy documents providing background to the development of primary healthcare in New Zealand.

CONCLUSION: The themes from interviews suggest that there was a positive response to the lowered cost of healthcare from the providers and managers interviewed in the Pacific-led primary health services, mirroring the findings of the larger evaluation report of PHOs (Cumming et al., 2005). The availability of ‘wrap around’, holistically-based, accessible services which were delivered by culturally responsive health providers who were considered to ‘go the extra mile’ for their clients, was the predominant theme in accounting for the increased uptake and use of the services.

***Introduction***

There are many barriers that have been identified to Pacific peoples’ access and use of health care in Aotearoa New Zealand. ‘Pacific Peoples’ within the context of the present study’ is an umbrella term used to describe those residents and citizens living in New Zealand who self-identify culturally with one or more of the predominant Pacific cultures living in New Zealand. The Pacific cultures represented in the present New Zealand population include: Western Samoa, Tokelau Islands, Cook Islands, Niue and Tonga. Western Samoa remains the largest Pacific Peoples ethnic group in New Zealand with 48.7% of the Pacific people’s population (144,138).  Cook Islands Maori 20.9% (61,839 people). Tongan 20.4% (60,333 people) and Niuean 8.1% (23,883 people) (Minister of Health & Minister of Pacific Island Affairs, 2010). Pacific peoples are disproportionately represented in the most deprived areas of the country and have poorer health status than other New Zealanders (Pack et al., 2013). Thus, Pacific citizens and residents in New Zealand are a key priority group for the primary health services, given the focus on reducing inequalities in health. The PHCS was implemented by the Labour Government in New Zealand in the mid-2000s. The services established were evaluated to determine what the impact was on the delivery of primary health care services nationally and the resulting changes in the health of local geographic populations of enrolled residents. The PHCS had a focus on services for Pacific peoples provided by Pacific peoples, active involvement of Pacific communities in service delivery, further building of Pacific provider capacity, the formation of Pacific-led services, and leadership at a national level. All providers of PHOs were to identify, reach out to and address Pacific health needs (King, 2001).

***Accessibility of Services and Long-term Health Conditions***

A review of the literature on primary healthcare was conducted prior to undertaking the research. In this literature review, several themes were noted from the review of policy documents providing background to the development of primary healthcare in New Zealand, which were considered alongside international frameworks for primary health development. Concerns about accessibility to health care, influenced by increases in the prevalence of chronic conditions and an ageing provider workforce have dominated the literature on primary health service evaluations worldwide (Hogg, Rowan, Russell, Geneau, & Muldoon, 2008). Recent frameworks for primary healthcare internationally have emphasised the service delivery aspects guided by principles of “comprehensiveness, integration and accessibility” (Hogg et al., 2008, p. 308). In the Canadian and New Zealand contexts, indigenous populations have been consulted out of which new models of healthcare provision have developed. These models are designed to tackle the social determinants of health which inevitably impact in terms of poorer health outcomes and lower life expectancy than for European service users (Barnett and Barnett, 2004). Under Treaty of Waitangi, the founding charter between Maori and Pakeha in New Zealand, partnership, participation and protection are guiding principles, which necessitate a focus on identifying and addressing inequities in health as in other areas of life.

 Barriers to accessing primary health care in New Zealand continue to revolve around the cost of seeing a general practitioner, with the ‘survival strategies’ of service users including delaying seeking care, lack of uptake of medication and putting others in the family first, such as children and elderly (Barnett & Barnett, 2004).

 Alongside these principles underpinning health models, the broader focus in primary healthcare has been on community empowerment, education and demographic and cultural aspects of health (Hogg et al., 2008). Western models of health care involving diagnosis and treatment often do not conform to the cultural norms and ways of Pacific service users and their extended families (Fono).Pacific models of healthcare to address these differences need to integrate principles of choice, sel- determination, and culturally relevant models of health care delivery. This has been achieved in the field of mental health care by translating information into Pacific languages, providing choice of provider, a range of support services and integrating hospitality as part of the care (Agnew, et al, 2004).

***Primary Health Care in New Zealand***

In terms of the Primary Health Care Services history in New Zealand, in February 2001, the New Zealand government released the Primary Health Care Strategy (PHCS) with the aim of improving the health of New Zealanders and reducing health inequalities. The five to ten year vision of the Strategy was to shift primary health care (PHC) services to focus more on the health of the population by: providing services which are easy to access; improving and maintaining their health; and coordinating their on-going care (King, 2001). Underlying this vision was a greater emphasis on the role of community participation in health improvement. PHC was seen to encompass a wide variety of services, including health promotion and preventive care, which necessitated the involvement of a wide range of health professionals (multidisciplinary teams) in the service delivery model.

To achieve the vision, the Strategy emphasised six key directions for the future development of PHC in New Zealand:  Work with local communities and geographic populations of enrolled residents  Identify and remove health inequalities  Offer access to comprehensive services to improve, maintain and restore people’s health  Co-ordinate care across service areas  Develop the primary health workforce  Continuously improve quality using good information (King, 2001).

A large number of PHOs were established between 2002 and 2005 whose brief was to address these aims. By mid-2008 there were 80 PHOs in operation, with additional funding to the value of $2.2 billion having been provided for further PHC service developments since 2001 (Cumming & Mays, 2009). Early evaluations have noted the unique way in which each PHO has been adapted to the communities in which they have developed. The contribution of social workers to establishing PHO services based in social justice principles within these evaluations have indicated a synergy between social work and primary health care aims, given that both are ideally structured and delivered by culturally relevant principles that acknowledge the holistic nature of health which includes the role of spirituality, community and family participation in healthcare (Pack, 2008).

This comprehensive, holistic, model acknowledges the importance of four facets of primary care service delivery that is prefaced on the importance of the patient and treatment provider relationship, awareness of the ‘whole person’, gender, culture and family (Hogg et al., 2008, pp. 310-11). To evaluate the model, provider satisfaction is considered pivotal as treatment providers, when satisfied with the services they are working within, are found to be more open to alternative processes and a holistic and individually tailored approach when working in primary healthcare (Hogg et al., 2008, p. 312).

 ***Research Aims***

The two main aims of the exploratory study were i) To identify the environmental and organisational context that impacted treatment providers and service managers of the PHOs and ii) To identify the structural aspects of the policy and governance of the practice agency and its impact on the delivery of services by the provider, and, therefore, its impact on health outcomes.

 In undertaking this exploratory study, our research team comprising four Pacific health researchers, had earlier completed the interviews and transcribed the audio recordings, with the author invited as a senior research fellow, to analyse the data, report the major themes from the interviews, and to develop recommendations that were to sit alongside the larger mixed methods study on Pacific patients and their families perspectives of the same PHOs. As I had been involved earlier in the establishment, development and service management of a culturally led PHO that was not part of the research, the team requested my involvement as they valued my background to provide a rich and depth knowledge of the field of PHO development.

***Ethical Approval***

 The overarching study received Research Ethics Approval from Victoria University of Wellington’s Research Ethics Committee .The following steps were incorporated in relation to the collection of the qualitative data:  Potential participants were given the right to decline to be interviewed.  Participants were given the right to withdraw their involvement or their contributions at any time.  A transcript of each interview was sent to the participant for perusal and amendment, unless the participant waived this requirement.  Data was to be stored securely for ten years.  Every effort was made in the analysis and reporting to protect the identification of the individual participants.  Māori and Pacific researchers were used as advisors throughout each phase of the research to address culturally sensitive aspects of the research (Cumming et al., 2005).

***Research Design and Methodology***

An exploratory, descriptive, qualitative research design and methodology were used to explore the service managers and provider’s perspectives of the structure and the day to day operation of their PHOs. The researchers adopted a case study approach based in Yin’s description of case study (Yin, 2009). Each PHO was considered to be an example or a ‘case’, in the sense that each PHO had developed uniquely in terms of its management structure/governance, service establishment and delivery due to a range of factors such as geography, size of resident population, funding or budget and local health demographics. Yin (2009) discusses the importance of triangulation in case study research in terms of the potential for assembling different narrations on a theme. Thus we were able in the current study to incorporate service managers’ views to explore how the service set up and structure impacted the service delivery from a health provider’s perspective within each PHO. A case study research approach enabled the context and structure of each PHO to be described alongside the accounts of health providers/managers and brought together with the service user accounts in the broader research project. The range of services provided and how the services were delivered were able to be identified within each PHO site by the service managers and providers. Thus it was possible to frame comments about how the services were meeting or not meeting the needs from the differing perspectives of multiple stakeholders.

***Recruitment of Participants***

The qualitative data collection included:  A first phase of in-depth interviews in 2003-5 with a sample of practice staff and those working in key stakeholder organisations.  A second phase of interviews in 2006 and 2008.  A third phase of interviews was held between 2008 to early 2010.

This article reports combined interviews from all three phases of interviews with service providers and service managers.

The selected organisations were contacted by the researchers to invite participation. Interviews were targeted to a range of staff working within the organisations, including: board members (nurse representatives, general practitioners (GPs) as board representatives and their chairs; practice staff (GPs and nurses); and community workers (e.g., health promoters, community health workers and youth workers). The first phase of Pacific interviews took place between 2003 and 2005 during the initial establishment of the PHOs. All phase one Pacific interviews were open-ended and conducted in person, using an interview guide based on themes identified by a Steering Committee as part the lead Evaluation (see Barnett, Smith, & Cumming, 2009, for details).

A second phase of Pacific interviews took place between 2006 to early 2008. Qualitative data from these interviews captured PHOs experiences arising from the additional rollout funding to Interim PHOs for those aged 18-24 years (July 2005); 45-64 years (July 2006); and those aged 25-44 years (July 2007).

Phase three of the interviews during 2008-2010 reported trends in the Pacific and Access PHOs’ experiences in relation to the implementation and subsequent review and refinement of their initial establishment plans, looking towards the future. Pacific interview participants from all phases received a koha or gift for their participation.

A fact sheet inviting participation was sent to all PHOs and practices outlining the aims and objectives of the evaluation. The participants were asked to meet the interviewers for approximately an hour to discuss the initial positive response to the Primary Health Care Strategy and the changes needing to address any concerns about its implementation. It was made clear that participation was voluntary, that all information provided by individuals and practices would remain confidential to the researchers and that no individual or organisation would be identifiable within the final report or subsequent publications.

 From this letter and fact sheet, Pacific-led PHOs and those PHOs with high Pacific resident populations (hereafter, Pacific PHOs) were followed up to negotiate participation in this part of the evaluation.

***Interview Guide***

Four main sections were included in the topic guide for the interviews: i) the provider or manager’s understanding of the primary care reform history, ii) the fees charged in practices and the costs involved in service set up and delivery, co-ordination, community engagement; and iii) provider recruitment, professional development, morale, and retention.

iv) The role of the Strategy in relation to reducing Pacific health inequalities in illness management and health outcomes were inquired about from the participants’ roles and experiences within the PHO’s structure.

 Where there were difficulties identified, participants were advised that these comments would be collated and presented in a de-identified way. The final report commissioned by The Ministry of Health in New Zealand made recommendations to be followed up in future policy development (Pack et al., 2013).

**Data Collection** **and Analysis**

All interviews were recorded and transcribed in line with the confidentiality agreement. A thematic analysis of the transcripts was conducted by the author and was subsequently peer-reviewed by the team. Thematic analysis is a method of identifying patterns within data in which there are a number of instances of the same theme occurring within a data set (Braun & Clarke, 2006, p. 82).

 There were several frames for analysing the data thematically. These frames for data analysis included: The interview questions or topic guide, themes from the literature review, the broader findings of the study with service users and their families; and the key goals and directions identified for the Primary Health Care Strategy (Cumming et al., 2005).

The data were analysed for emergent trends using the topic guide as a lens by which rich description in each area of the daily life within a Pacific PHO, was reported. Themes or patterns within the data were identified using inductive reasoning which means the themes were linked to the data themselves but were not prescribed by the pre-existing coding framework or the researchers’ interests or frames of reference (Patton, 1990). The broader implications of the patterns identified in the earlier part of the study were analysed for significance in the process of the interviews with service managers and treatment providers (Patton, 2002) and in relation to the wider PHO evaluation reports (Barnett et al., 2009; Croxson, Smith, & Cumming, 2009; Cumming et al., 2005; Cumming & Gribben, 2007; Raymont & Cumming, 2009; Raymont, Cumming, Gribben, & Boustead, 2013). A further frame of analysis used to interpret the findings was the key goals and directions identified for the Primary Health Care Strategy (Cumming et al., 2005). Particular attention was given to the participant’s understanding of the Pacific Health report: ‘Ala Mo’ui’: Pathways to Pacific Health and Well-being 2010-2014 (Minister of Health and Minister of Pacific Island Affairs, 2010). As a consequence, particular attention was paid to models of care for Pacific patients and the role of caring for service users who were un-used to communicating in English (Cumming et al., 2005).

***Findings: Numbers of Participants and PHO Sites Covered***

In phase one of the interviews, two Pacific PHOs agreed to participate and six individuals were interviewed. The relatively small number of PHOs identified at stage one of the project reflects the fact that many PHOs had not been established or were just establishing their services by 2004-5.

 In phases two and three, four Pacific PHOs in total agreed to participate and eleven individuals were interviewed in total. One of the Pacific PHOs declined to participate due to time commitments as they were dealing with the grief and loss of residents’ family members following the Tsunami in Western Samoa when approached to participate initially.

 Following an initial contact by telephone an information sheet and consent form was s sent to each individual who agreed to participate.

***Themes from the Interviews***

The following section presents the themes from the interviews conducted with managers and service providers. These themes were related to: i) Lowered costs of healthcare ,ii) Publicising the availability of services offered; iii) Access to a Range of Services; iv) An Ethic of Care and ‘going the extra mile’ for clients; v) Holistically based /Integrated Models of Care; vi) Incorporating Culturally Appropriate Models of Well-being; vii) Relationship with Community: PHO Partnerships with NGOs Residents and Local Communities: viii) Building Workforce Capability, Providing Services in a shared language. Due to the differing perspectives of the groups of participants, some themes were more figural for one group for example the managers, than for service providers. In some themes both groups were in agreement about the issues. Therefore in some themes managers’ perspectives predominated, in others service providers’ views predominated.

***Lowering the costs of healthcare***

There was an enthusiastic response to the lowered cost of healthcare from the stakeholders interviewed. Reducing the costs of medical consultations was a primary motivation for practices to become involved in the PHOs initially. As one manager of a Pacific-led PHOs explained during the first round of interviews in 2005:

*‘…You know the first benefit is to us is no or low cost and they [patients] don’t pay.’ Manager*

The CEO from another Pacific PHO discussed in 2009 that the fee paying structure still offered a means of providing a targeted approach to those patients most in need of low or no-cost consultations.

‘*PHO I think it’s a success with 90 plus percent enrolment throughout the country plus Pacific people, people are saying that they [lowered costs] are the advantage of PHOs. Low cost consultation fees I think is the main product … So a lot of people have enrolled and are making use of the services.’ Manager/CEO*

***Publicising the availability of low cost services***

The availability of low cost health care was not, however, widely known in the local community initially, which necessitated promotion of the PHO service. There was also a need to publicise the specific services that were offered. Information dissemination about how patients could enrol themselves and their family members in order to obtain access to low or no cost consultations, lower prescription fees and other services, was part of the implementation strategy of each of the PHO managers interviewed. For example, the use of promotional campaigns on Pacific Radio spoken in a range of Pacific languages was one way of publicising the availability to an audience of Pacific clients that was discussed at interview with one urban Pacific-led PHO. Community meetings with local groups were another way in which this PHO publicised the range of services their organisation offered. Fono (Pacific term for gathering of key stakeholders) that were organised by this PHO provided an opportunity to distribute more general information about health promotion to a range of audiences in face to face mode. It was considered important to follow up any presentations to answer queries and to hold meetings with the professional groups working at the PHO:

*‘We have a very strong Samoan Residents’ Association and we tell them about health stuff and PHO as well and then we also have a meeting of other nurses of different communities and we tell them about the PHO.’ Manager*

***Access to a Range of Services***

Access to a range of other services such as free transport to treatment and lower prescription costs were important incentives to establishing a PHO. This widespread appeal was seen by participants as a means of improving access to comprehensive health care services for residents. Another PHO organised ‘health days’ to introduce a range of health services to local residents including their promoting their own services:

*‘…we just have a health day, we go to a hall and stakeholders are invited to come and display their information and tell people about the services that they provide’. Manager*

***An Ethic of Care and ‘going the extra mile’ for clients***

 The attitudes of Pacific PHO staff towards their work were reported by participants to differ from the business orientation of many medical practices who worked from a business-centred model. Partly this difference in philosophy was thought to stem from the values underpinning PHOs being supported by charitable trusts. A workplace based in a shared enthusiasm for helping under-resourced communities was the major motivation described by one general practitioner working in a PHO where 97% of local enrolled population is described as ‘low income and Pacific Island’ :

*‘The philosophy of this practice is improved access with lower fees… affordability has always been an important part of the organisation really for us and for other members of the PHO… We provide a free taxi service for people who can’t get to their appointments as well. We have access to free PHO funded prescriptions.’ GP*

Altruism, and the ‘not-for profit’ motivation to remain working within the PHO was seen by PHO health workers as important for putting funds back into community, as the same general practitioner interviewed suggested:

 *‘I’m a salaried GP so I don’t get the financial incentives, it’s not my business that I’m safeguarding, that’s a different model from the sort of third sector where there’s a long history of community ownership and not- for- profit being part of the way that we operate’. GP*

***Holistically based /Integrated Models of Care***

A community model of care facilitated by the PHOs was described as a positive development across the providers interviewed. This model consisted of several elements - remaining small enough to know the local community which enabled treatment providers to remain aware and responsive to locally defined needs. Co-ordination of services and communication across practices meant that duplication of services in a geographic area could be avoided as the following excerpt from an interview with a general practitioner in a Pacific-led PHO illustrates:

*‘You know it’s good to have that sort of relationship because of referral- we’re basically seeing people from the same community. It helps avoid duplication of services and knowing what people are doing, having input with different families without knowing that each other is involved in, which I think happened a lot more under pre-PHOs.’ GP*

 ***Incorporating Culturally Appropriate Models of Well-being***

Pacific PHOs looked at health more holistically deriving from social inequalities and so they actively advocated on behalf of patients. A nurse who was interviewed described advocating with income support agencies on behalf of sickness and invalid beneficiaries who could not afford to see a general practitioner for review of their medical condition to avoid a cessation of weekly income benefit payments. She encouraged those patients with long-term or complex presentations who had debts to pay to continue coming to the practice for treatment despite lacking the means to pay for their health care. This kind of advocacy was common and was seen as part of the responsibility of providers in the Pacific Models of health earlier reviewed. (Agnew et al, 2004). The Treaty of Waitangi principles aimed to guide the health care delivery in New Zealand to ensure equity of uptake of services and satisfaction of the service user’s healthcare experience as far as possible (Barnett and Barnett, 2004).

***Relationship with Community: PHO Partnerships with NGOs Residents and Local Communities: Building Workforce Capability***

The establishment of PHOs was seen as a positive move by its managers as it provided an opportunity to collaborate to provide culturally appropriate services designed and delivered by Pacific clinicians. As one manager of a Pacific health discussed at interview, it was envisaged that PHO funding would build capability in the workforce for care of Pacific by Pacific.

*‘As services move into the community, we are organising the Pacific community to work as a team. Pacific people need to work together as a team that is how it works best.’ Manager.*

***Providing Services in a Shared language***

Another Pacific-led PHO used the services of a medical specialist to run a clinic to see patients who had been screened by a self-administered patient questionnaire to identify health issues. This consultant was unique in being able to speak a number of Pacific languages which enabled him to engage more easily with the majority of patients at that service. The shared language was an important means of building relationship with Pacific clients.

This is in contrast to comments made by non- Pacific PHOs in interviews about the difficulty of engaging with Pacific communities when the process was not relational (e.g. – one PHO mailed out of about 5000 letters to Pacific families and received less than 100 responses). It illustrates the importance of understanding how to engage Pacific and the value that Pacific practices bring in their capability to do this. Establishing processes and protocols for making decisions and acknowledging shared values, including the spiritual dimensions of care, aided success, as a CEO of a Pacific PHO explains:

*‘We’re bound by a common philosophy… I think fundamentally in essence we are a Christian organisation bound by a set of Christian values that hold us together in quite hard times and they are around all of those things, you know like…, integrity, respect… we do have hard times and we have our difficulties and battle but we try to work through them and there is a lot of passion. It’s still trying to work through that respect and just wanting the best for our community.’ CEO/Manager*

***Collaboration, Co-ordination and Team work across Services***

Since joining the Pacific PHO a common experience amongst participants was improved communication between diverse social and statutory agencies to avoid the silo-effect of services acting independently of one another. These social connections and networks enabled more comprehensive wrap-around services to be offered to Pacific patients.

*‘The difference between [name of another PHO] and [name of participant’s Pacific PHO] is the community focused, community driven, focus on, you know, the health needs of the people. Whereas [name of other PHO] is very much doctor driven now….’* GP

Having a manager who shared a vision and philosophy of working with under-resourced communities was seen to be advantageous by colleagues working at the same PHO as a shared vision of the local community was facilitated. A common purpose for continuing to work within the PHO was a ‘passion’ for work with what were considered to be under-resourced communities. As one participant commented:

*‘Our manager [name] who is Māori understands where the lower socio-economic people are coming from. She has a passion for this population here. And that’s why we are getting that support because we know that she’s there because of that passion’. Nurse*

Another participant who worked as a general practitioner in a not for profit PHO described this collaboration as ‘a collective approach to providing a service’. This was seen by those interviewed as being part of this shared vision for work in the PHO:

‘*We are not alone as a Pacific Islander within this PHO. We are here working alongside others and do collectively have a very strong communication strategy, making sure the population focus on their needs.’* GP

***‘Barriers’: Longer Consultations working Holistically with Social Problems***

Initially there was enthusiasm about the funding available for services to improve access. There were many initiatives that participants considered were working effectively in terms of people accessing the health care they required. However, high and complex patient needs inevitably increased the length of consultations which impacted on workload of the PHOs’ treatment providers such as general practitioners and nurses, as the following comment from a general practitioner working in a Pacific PHO illustrates:

 *‘The heavy workload is helping them [patients] with social issues, so, sickness benefit, housing, all immigration issues. There is a lot of expectation that we will help them with that. We do quite a lot of it which prolongs our consultation time with the doctor or nurse. There are social workers in public health that we pass things on to...very nice to have social workers except that their contracts are all around youth... But the strategy needs to cater for elderly and social issues a bit better’*. GP

General practitioners working in Pacific-led PHOs found that they needed to take longer to explain medical screening procedures prior to undertaking them with Pacific patients. This work needed to be done in face to face mode as contact by telephone and letter did not work as effectively with Pacific patients. The unavailability of funded transport to treatment was seen as an obstacle by a clinical manager/general practitioner of one Pacific PHO who was interviewed:

….*’We had a lot of DNA’s [did no attends] and she[nurse] said to me yesterday that she thinks transport has got something to do with it and that if we could provide transport, that would really help.*’ GP

 Social problems were tackled by the nurses interviewed. For example, one nurse who had an established relationship with local social services organised food parcels from a local food bank for a patient who had not been eating an adequate diet due to lack of money to spend on grocery items. The lack of food had meant that he had become dizzy and fallen from scaffolding at work resulting in a trip to the local hospital’s accident and emergency department. Through the PHO’s nurse liaising with the accident and emergency department at the local hospital, the reason for the accident was clarified with the patient and advocacy arranged with the social services.

***Discussion***

 Participants in the Pacific-led PHOs have suggested in this study the need to consider co-ordinated approaches to health care which are comprehensive, culturally appropriate and flexible to respond to local needs. These approaches derive from traditional Pacific beliefs which include ‘going the extra mile’ to meet the consumer where they live in a diversity of local and cultural contexts. The importance of incorporating Pacific values and ways of being in primary health cannot be underestimated in the uptake of services (Agnew et al, p.ix). Previous studies provide evidence that community-based models of intervention contribute to positive health outcomes (Barwick, 2000). The service providers interviewed mentioned a number of Pacific models they drew from in their work that were used alongside clinical models of assessment and treatment. Many of these frameworks adopt a focus on wellness in the community, and are underpinned by an ethos of altruism, interpersonal relationship and social inclusion. Building trust and support at the first point of contact requires what has been termed ‘a roundabout Pacific rapport building approach’ which is learned by healthcare providers in practice rather than in theory (Agnew et al, 2004 p.ix). This approach involves ensuring that patients feel comfortable in their surroundings as an integrated part of the health service delivery. Rapport building to engage patients and their families is considered an important requirement when working with Pacific peoples (Agnew et al, 2004). Pacific models and modes of service delivery are distinct from western models of care and remain implicit in the practices of the health care providers who use them. These styles of service delivery follow the principles underpinning the Government’s strategic direction for Pacific health care. These principles are: • Respecting Pacific Culture • Valuing Family • Quality health care • Working together (Ministry of Health, 2010 p.5). These findings align with Hogg et al’s (2008, p. 312) framework in the comprehensiveness of service provision and co-ordination remaining key considerations in the provision of primary health care services.

***Conclusion***

To explore the experiences of the primary health care strategy in relation to the Pacific-led PHOs is to ask the question of the values underpinning Pacific approaches to health care. The quality of relationship between providers and patients, altruism and an ethic of care that transcended prescribed roles and responsibilities were part of what participants discussed as making their organisations unique. Spirituality and a holistic approach are key aspects of Pacific models of healthcare (Agnew et al, 2004).

In relation to equity, questions about the adequacy of service need to be addressed, particularly for Pacific populations, and those from more deprived areas. In particular, we need additional evidence on how, and to what extent, the health of those with lower consultation rates could be improved and to further assess what evidence there is that those with higher consultation rates obtain equivalent benefits. In the meantime, effective teamwork which includes the sharing of resources and expertise are all part of the work ethic used by those who manage and provide service within the Pacific PHOs. This principle has enabled them to cope with the shortfalls in funding, although at times resources are stretched when it comes to dealing with existing patients and implementing new programmes.

Overall the results from this exploratory study reveal that the implementation of Pacific PHOs has provided the ability for better communication between various parties from the Board down to those working at community level. For providers in the Pacific-led PHOs the increased range of services offered and the efforts in health promotion, advocacy and education in programmes has meant expanded roles and responsibilities. The expectation of work in these PHOs can sometimes test the reality for some of the providers interviewed and is clearly impacting on the recruitment and retention of staff as the role is less bounded and consultation times longer due to the complexity of assessing social issues that inevitably impact health and wellbeing. The use of Pacific language was considered an important component of engaging successfully and working well with Pacific patients. Further research is needed to more clearly delineate what is uniquely Pacific in the approach of the Pacific PHOs.

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