

**Intersectoral Community  
Action for Health (ICAH)  
Evaluation**  
An Overview

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MANATŪ HAUORA

## Abbreviations

AIMHI	Achievement in Multicultural High Schools Initiative
DHB	District Health Board
FTE	Full-time equivalent
HNZC	Housing New Zealand Corporation
IAPCP	Improving Access to Primary Care in Porirua (later PIA)
ICAH	Intersectoral Community Action for Health
KCHGT	Kapiti Community Health Group Trust
MAPO	Māori Co-Purchasing Organisation
NEW	Nutrition, Exercise and Weight – a Health Promotion programme in Counties Manukau
PHEW	Police, Health, Education and Welfare agency representatives – the working party of YIP
PHICS	Porirua Health Information Communication System
PHLT	Porirua Health Links Trust
PHO	Primary Health Organisation
PIA	Porirua Improving Access initiative (formerly IAPCP)
PUCHS	Porirua Union and Community Health Service
WIPA	Wellington Independent Practitioners Association
YIP	Youth Interagency Project

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# Contents

Abbreviations	iii
ICAH Authorship	iv
Acknowledgements	iv
Executive Summary	viii
Background	viii
Evaluation methodology	viii
The four ICAH sites	x
Analysis	xiii
Conclusions	xv
Introduction	1
Background	3
History	3
Goals and objectives	4
Demographic profiles	4
Methodology	6
Evaluation objectives	6
Methodology	6
Limitations	10
Literature Reviews	12
Effectiveness factors	12
Conclusions	15
Porirua ICAH	17
Development	17
Governance	19
Funding and funders	19
Roles	20
Key objectives and progress against them	22
Impacts	25
Subprojects	27
Kapiti ICAH	51
Development	51
Governance	51
Funding and funders	51

Roles	53
Key objectives and progress against them	53
Impacts	56
Subprojects	59
<b>Counties Manukau ICAH</b>	<b>63</b>
Development	63
Governance	64
Funding and funders	65
Roles	66
Key objectives and progress against them	66
Impacts	67
Subprojects	67
<b>Northland ICAH</b>	<b>75</b>
Development	75
Governance	75
Funding and funders	76
Roles	76
Key objectives and progress against them	76
Subprojects	77
Impacts	81
<b>Analysis</b>	<b>84</b>
Comparisons and contrasts	84
Critical success factors and barriers to success	89
Summary	98
<b>Conclusions</b>	<b>100</b>
Reducing inequalities	100
Impacts on health and disability outcomes	101
Harnessing wisdom, developing capacity	103
Evaluating programmes and transferring learning	104
Where to from here? ICAH in the PHO environment	105
Key lessons from the ICAH evaluation	107
Key implications for the future development of ICAH initiatives	109
<b>References</b>	<b>111</b>
<b>Appendix 1: List of Informants and Stakeholders Interviewed</b>	<b>114</b>

## List of Tables

Table 1:	ICAH evaluation framework	9
Table 2:	Funding for Porirua ICAH	19
Table 3:	Porirua ICAH projects and activities	20
Table 4:	PIA and PHICS funding package and service components	34
Table 5:	Funding, Kapiti Community Health Group Trust (KCHGT), ICAH project	52
Table 6:	Funding for Counties Manukau DHB's ICAH, 2001–2004	66
Table 7:	Funding for the Far North ICAH	76
Table 8:	Porirua	114
Table 9:	Kapiti	114
Table 10:	Counties Manukau	115

## List of Figures

Figure 1:	Quarterly total use rates (GP, nurse), by practice – excluding MeNZB consults	39
Figure 2:	Quarterly total use rates (GP, nurse), by practice – Māori and Pacific peoples	40
Figure 3:	Quarterly total use rates (GP, nurse), by practice – other ethnic groups	40
Figure 4:	Quarterly total use rates (GP, nurse), by quarter, by practice – NZDep quintile five	41
Figure 5:	Type 2 diabetes case detection – annual reviews completed vs Ministry of Health diabetes prediction	43
Figure 6:	Diabetes control by ethnicity	43
Figure 7:	Diabetes retinal screening	44
Figure 8:	Ambulatory-sensitive hospitalisations (0–74 years), for Porirua City, 1994/95–2004/05	45
Figure 9:	Ambulatory-sensitive hospitalisations (0–74 years), by NZDep groups, 1994/95–2004/05	46
Figure 10:	Ambulatory-sensitive hospitalisations (0–74 years), by ethnic group, 1994/95–2004/05	46

# Executive Summary

## Background

This report presents a process and impact evaluation covering the entire three-year period of the Intersectoral Community Action for Health (ICAH) evaluation from July 2001 to June 2004. The findings from previous reports are brought together here.

Intersectoral health initiatives have been evolving internationally for some decades, and within New Zealand over the last 20 years. Intersectoral action for health has been defined as, 'A *recognised relationship* between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to *achieve health outcomes, (or intermediate health outcomes)* in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone' (Harris et al 1995).

The ICAH projects described in this evaluation began in response to local community concerns about health issues in Porirua, Kapiti, Counties Manukau and Northland. They were funded by the Ministry of Health, and in deciding where to establish ICAH sites, priority was given to geographical communities with a population greater than 10,000 in areas of high relative deprivation (NZDep96 index deciles 8–10) with Māori comprising over 20 percent of the population and with significant health disparities between Māori, Pacific and other populations. The projects were to use principles of community engagement and development and so needed to be in places where the community was willing and able to engage in intersectoral approaches. Finally the projects were intended to tackle the wider determinants of health status, as well as improving access to health and disability services.

Current ICAH programmes in Porirua, Kapiti, Counties Manukau and Northland offered an opportunity to compare and contrast intersectoral community action for health in four very different contexts. Differences included the size and type of the target population, cultural diversity, geographical location and spread, and the history of community, iwi and hapū development and health action. In addition to these pre-existing differences, the establishment of the projects offered diverging models for implementation and development because of the differing membership of governance and working groups, models of community engagement, choice of subprojects, sectors engaged in the alliances, approaches to needs assessment, degrees of access to the Ministry of Health as a partner and access to establishment resources.

## Evaluation methodology

The Ministry of Health set the overarching goals for the ICAH projects viewed as a whole, but each project was shaped by the history and nature of alliances in its individual setting. This resulted in different emphases. The overall objectives of the ICAH projects were to: a) improve health and disability outcomes in the community, particularly for Māori, for Pacific peoples, and for population groups who have worse outcomes; b) develop initiatives that address health outcomes, broadly understood; c) harness the support and involvement of local authorities, iwi and agencies responsible for health, housing, transport and education; d) harness the wisdom and



expertise of local communities, including providers, alongside that of policy makers, planners and funders; e) develop intersectoral capacity for successful joint community action across sectors; and f) pilot and evaluate the current initiatives so the lessons learned could be included in guidance to District Health Boards (DHBs).

The objectives of the ICAH evaluation included assessing whether the ICAH programmes had a positive impact on health and disability outcomes, particularly those for populations experiencing worse health outcomes; identifying critical success factors for the projects; and assessing the process and outcomes of one subproject in each ICAH.

A 'realistic evaluation methodology' was adopted for this ICAH evaluation. This methodology recognised that the relationship between an intervention and its outcome is contingent on the context. Contextual information was therefore an important part of the evaluation.

The evaluators developed fourteen key questions to meet evaluation objectives. Both qualitative and quantitative methods were used to gather information. Qualitative methods included key informant interviews; participant observation; and analysis of programme documentation. Quantitative methods included analyses of demographic, social, economic and cultural determinants of health; economic analyses of costs to various parties; and before-and-after comparisons to document the impact of changes arising from the actions of ICAH groups, where appropriate, given intervention logic.

A number of analytic frameworks were developed to identify performance indicators relevant to the projects. A literature review identified the key determinants of effective community-based intersectoral action for health. These key determinants were used as the basis for drawing conclusions about the success of the ICAH initiative.

The literature review had identified three broad categories of intersectoral initiatives: first, overarching or settings-based, second, issues-based and third, case-management based. Six key factors were also identified as important for determining the effectiveness of community-based intersectoral action for health. First, sectors or organisations (including community groups) recognise the necessity to work together to achieve their goals; second, there is support in the wider community for action; third, the participating organisation each have the capacity to take action; fourth, relationships enabling action are defined and developed between the participating sectors or organisations; fifth, actions are planned and implemented to the satisfaction of each participating sector and organisation; and finally, systems are in place for demonstrating whether the expected outcomes are being achieved and sustained.

## The four ICAH sites

Four ICAH programmes were considered in this evaluation.

### Porirua

Porirua Healthlinks Trust (PHLT) evolved from a joint project with the Kapiti region involving representatives of the Porirua and Kapiti communities and the Ministry of Health. PHLT activities include representation on various community and government agency committees and advisory bodies, project development, community consultation and facilitation, and submission and report writing. Progress has been made on all five of the ICAH's key areas for strategic action: a) intersectoral action on health; b) improved equity and fairness; c) greater acceptability of services; d) better access to services; and e) better integration of services.

The Porirua Improving Access (PIA) initiative was developed as an ICAH subproject to improve access to primary care. The PIA initiative involved setting up a mobile primary care nursing and community health workforce, improving access to general practitioner (GP) consultations, and establishing the Porirua Health Information and Communication System (PHICS) project.

Under the PIA initiative, each provider employed strategies that were intended to reduce financial, information and transport barriers to primary care. All providers spoke about a growth in the demand for access to services that was due to increasing community awareness. The outreach mode of service delivery was reported to have improved access for hard-to-reach clients. In addition, collective action across the PIA workforce and between participating providers also developed over the period of the evaluation. Two important outcomes were expected as a result of PIA funding, namely increased primary health care use rates for all groups (especially Māori, Pacific peoples and people living in deprived areas) and a decline in the rate of ambulatory-sensitive hospitalisations. In the case of GP and nurse use, increased rates did occur, but not at the expected time, and not in all PIA practices. In the case of ambulatory-sensitive hospitalisations, rates remained reasonably steady during the period when the new funding streams were introduced, halting previous increases in rates. The key critical success factors identified in the evaluation of the PIA were leadership, experience and workforce development. The initiative was also successful in fostering innovation and reducing barriers to access.

The Porirua Health Information and Communication System (PHICS) was funded as part of the PIA initiative. It aimed to provide information on health and disability services to the general population as well as supporting information sharing and links between services. In October 2004, PHICS launched a website and an 0800 helpline. The success or otherwise of PHICS had yet to be formally evaluated, but anecdotal feedback suggests that there was growing awareness of its role in the community. The project appeared to be maturing and adding value to other information-sharing strategies in Porirua.

## **Kapiti**

The Kapiti Community Health Group Trust (KCHGT) evolved from the community consultation groups set up to advise the Health Funding Authority in the 1990s. The KCHGT provided a focal point for health and disability needs, advocating for better health and disability services and outcomes, and informing the community on health and related issues. Its key aims have been to advocate for publicly funded health and disability services that work fairly for everyone; to work with health and other sectors to achieve policies that improve health and reduce disparities; to ensure health and disability services are available and easy to access; and to ensure that all communities know what health and disability services are available.

The impacts of the KCHGT have included enhancing community capacity via its own organisational development and through its relationship with other community organisations; developing effective partnership and relationships in the health sector that will lead to continuing impacts on the way health services are delivered in the area; positive impacts on health service provision, through its role in advocacy and relationships with the DHBs; and limited impact on the health of Māori, Pacific and low-income people as well as on the social and economic determinants of health.

The Otaki Community Health Worker project was selected as the Kapiti subproject to evaluate. This mobile outreach service aimed to improve access to primary care services for the people of Otaki, particularly for Māori. The service employed two part-time community health workers who have identified appropriate services for clients and facilitated their referrals; supported clients accessing services, including providing transport for those with none otherwise available; built positive relationships and networked with local services; and worked alongside the other health workers. Service use was used as an intermediate outcome marker for the Otaki Community Health Worker project, but failure to record all the required details meant use rates could not give a full picture of this work.

## **Counties Manukau**

The Counties Manukau ICAH project began its life in 2000 as a 'health action zone', a British community action prototype that sought to address health and social disparities. However an intersectoral approach to public health and social problems had already been developing in the South Auckland region over the decade preceding the ICAH initiative.

The Counties Manukau ICAH has funded a project manager for interagency liaison development. The project manager also manages the ICAH intersectoral initiative – the Youth Interagency Project (YIP) – and plays a role in other intersectoral projects such as the Healthy Housing pilot programme.

YIP had two phases. Phase one focused on working in partnership with the South Auckland Achievement in Multicultural High Schools Initiative (AIMHI) to improve the health, welfare and wellbeing outcomes for students attending the AIMHI schools. Phase two aimed to improve health, education and wellbeing outcomes for alternative education students and teenage mothers (not necessarily attending either the AIMHI or alternative education schools).

There are already measurable improved health outcomes from the YIP subprojects. The YIP subprojects may also be contributing to reducing health inequalities by improving health for the most disadvantaged groups, given that the YIP projects are delivering to high deprivation areas and to high Māori and Pacific peoples population areas.

The AIMHI initiative has been subject to ongoing evaluation since its inception. The first two evaluation reports largely focused on the establishment process. The final evaluation report was not completed in time for use in the ICAH evaluation, but anecdotal feedback from the AIMHI school co-ordinator indicated that intermediate outcome measures were best in those schools where the development investment was highest, and that strong and effective relationships have developed between the AIMHI Healthy Community Schools initiative's key stakeholders (schools, Education, Health, Welfare and contributing non-government agencies).

The Healthy Housing pilot programme was a joint housing–health initiative between Housing New Zealand Corporation (HNZC), Counties Manukau DHB and the Auckland DHB. The overall aim of the pilot (run from January 2001 to June 2002) was to reduce overcrowding and improve the health of householders living in HNZC homes in the selected priority areas of Otara, Mangere and Onehunga. The evaluation of the Healthy Housing pilot programme found an increase in visits to GPs, outpatient clinics and emergency departments, and a 33 percent (statistically significant) reduction in hospital admissions in the intervention households compared to a geographically matched control group. The reduction in hospital admissions was linked to these families having accessed health care earlier than in the past. The establishment of extensive collaborative relationships with health and social agencies, many of which were based on formal memoranda of understanding, was also identified as a significant outcome of the programme. Feedback to this current evaluation indicated that the ICAH co-ordinator had played a vital part in helping to keep this complex pilot programme on track.

## **Northland**

The final ICAH to be established was in Northland. Te Hiku o Te Ika ICAH was formed in June 2001, following discussions between the Ministry of Health, Northland Health Ltd, Te Taitokerau Māori Co-Purchasing Organisation and three Māori health provider organisations in Te Tai Tokerau. The three Māori health provider groups – Te Hauora o te Hiku o Te Ika, Te Rūnanga o Te Rarawa and the Kia Mataara Society Inc (Whakawhiti Ora Pai) – shared roles and responsibilities through a partnership relationship. ICAH's three objectives were first, to improve health and reduce outcome inequalities for Māori and other communities with poor health status; second, to build on the existing capability and capacity of Māori and other communities; and finally, to facilitate an intersectoral approach which promotes community based strategies to address the concomitant social and economic factors associated with poor health.

Te Hauora o te Hiku o Te Ika, Te Rūnanga o Te Rarawa and the Kia Mataara Society Inc formed intersectoral relationships with other services depending on the needs of their three subprojects. The Ahipara Youth Project, and Tu Maia at Kaitaia College and Ahipara Primary were school-based subprojects which focused on strengthening the infrastructure of the education environment. Hei Oranga i te Whenua was a gardening and nutrition initiative for whānau based in the remote Far North. Hei Oranga i te Whenua is evaluated below.

The Far North ICAH is focused on predominantly Māori communities, and although the timeframes were too short for most measurable outcomes, key informants indicated that all projects were improving skills and community development. Because Hei Oranga i te Whenua targets a small community, statistically significant changes in health outcomes would not be identifiable, so the evaluation was largely dependent on the narratives of participants and stakeholders. Significant changes in health-related behaviour have been reported for the participants in this project. Increased physical activity and improved nutrition were the intermediate indicators that have been successfully modified by the project, but additional outcomes included whānau development and the transfer of traditional (and modern) knowledge. Side benefits of modifying risk behaviours (such as limiting smoking) have also been identified for some whānau participating in this project.

## **Analysis**

The four ICAH initiatives took different approaches to governance. Two groups had formally constituted governance groups and two had informal structures. Formal governance structures have a major potential advantage: representation. While formal governance does not ensure representation, it creates a context in which representation issues can be addressed. With the exception of the Far North, all sites experienced difficulties in maintaining Māori participation in their governance groups (and, where relevant, Pacific peoples' participation).

Needs assessments were used by all the ICAH sites. Community participation in the needs-assessment process was highly valued, resulting in long-term buy-in from the community to the priorities identified. However, despite good needs assessments, prioritising workloads and projects within resource constraints presented difficulties for the ICAH groups.

Funding for these projects has mainly been directed towards supporting the development and capacity of the intersectoral groups. The projects have also been well supported 'in kind' by participating agencies and provider groups. DHBs reported that hidden costs in meeting the Ministry of Health's reporting requirements have been onerous, and the groups themselves have supplied high numbers of voluntary hours. The total cost of the projects is therefore much greater than is shown by the funding provided, although commitment to the projects by their communities and partners is shown in the additional support offered.

It is critical for new projects to address the relationship between funding and capacity. In some cases the funding may be needed to build capacity, and the funder may need to delay expectations of specific outcomes to be delivered – especially when participants need to develop new and innovative ways of working together. Participants and key informants commented on both the need for long-term financial security for the projects and the need for ongoing fundraising for operational costs.

The importance of the six critical success factors for intersectoral projects identified by the literature has been confirmed by this evaluation. Establishing a mandate for partner engagement was critical. Partnerships have developed differently in each site. Partnerships, especially if diverse and potentially conflicting, need an investment of time and resources and need to be reviewed as needs change.

High-level support is valued in these projects and was critical to their establishment, but is seen as vulnerable to changes in political climate. Localised relationships work better than distant ‘head office’ ones. At the same time, high-level support must not overpower local and community decision-making. Community support is also crucial to the success of ICAH. Consultation and developing relationships may be time consuming. Community expectations may also create tensions when they have to be balanced against limited funding, the need for prioritisation, and funder or accountability requirements.

Identifying appropriate community subsections to engage in the projects as part of project design and development would help in the early development of partnerships. Voluntary capacity may limit community participation in the work of ICAHs. Several projects have experienced funding stresses, with participants reporting having difficulty finding funds for operational needs. The personal skills of key partners, and project staff, have been critical to project success.

Partner organisations work together more easily when there is stable staffing. Without stability, more time and investment are required to build partner relationships. Staff turnover has the potential to affect project development, whether it occurs within partner agencies or within the ICAH itself. Having relationships clearly defined may minimise the impact of staff turnover. Relationships take longer to develop where an atmosphere of trust and respect is lacking. Relationship development should be considered when developing project timelines. Relationships change and develop over time, but not always as a result of formal review.

Balancing the need to develop community and organisational infrastructure with the need to plan and implement activities requires timeline flexibility. Prioritisation has been particularly difficult in the higher needs communities.

Investing the time to develop appropriate reporting templates at the beginning of projects has the potential to save large amounts of time later on. Reporting needs to take an appropriate proportion of paid worker time relative to the available funding and other activities, and to be generic when funding comes from more than one source. Developing an intervention logic that identifies appropriate intermediate indicators may help make reporting more meaningful.

Project development may be enhanced by the early establishment of a shared understanding by funders, ICAHs and evaluators of programme logic. Such a shared understanding would assist in the development of positive relationships between funders and ICAH and ICAH partners.

## Conclusions

All the ICAH initiatives showed evidence of working towards reducing inequalities, including those experienced by Māori. They varied both in their strategies to do this, and in their levels of intervention.

All the ICAH projects have developed initiatives that intended to address health outcomes, broadly understood. The levels of delivery vary at which projects aim to influence health outcomes. Some projects have focused more on health services, others more on health determinants. They have the potential to improve health and disability outcomes over time because they can consider the broad determinants of health, they can work across sectors to address these, and they can draw on community wisdom in finding solutions. Strong leadership and management are needed to maximise the possible outcomes. The full impact of many projects is yet to be realised.

All the projects were intersectoral. Relationships were formed with other parts of the health and non-health sectors to take action on health issues; however they engaged with varying sectors, in accordance with their local settings and identified needs. Counties Manukau had the clearest and most long-standing intersectoral alliance which was further built on through ICAH. It takes time for relationships to develop and trust to be built so that groups can work together effectively. Sufficient time and resources need to be allocated to this. In some cases relationship development can be regarded as an outcome – or at least an intermediate indicator. In places like Porirua, where there was a long history of community action but a lack of trust in government agencies, relationship development and the success of the needs-assessment process (where community views and wisdom were respected and valued) were critical in developing a base for further action.

All groups drew on community wisdom, although again this was done in differing ways. Kapiti and Porirua offered the clearest models for community engagement. Porirua demonstrated ways of meeting the challenges of engaging where the community has a large population and is culturally diverse. In Kapiti, the involvement not only of the Kapiti Coast's different geographical communities, but also the much-praised 'whole of community' approach adopted in their engagement, offers a positive model to DHBs accessing community views on health services and issues. In Counties Manukau, the ICAH was not a community-driven initiative. However, there was community engagement both in needs assessments and in the subsequent development of specific projects. In the Far North the wisdom harnessed for the project included traditional knowledge, with the actions of the Hei Oranga i te Whenua co-ordinator ensuring that this knowledge is passed on to the next generation despite the dislocation of rural–urban–rural migration.

The piloting and evaluation of the initiatives has been a significant component of the ICAH programme. The evaluation of particular projects has proven easier than estimating the overall impact of the projects. Early engagement is necessary so that the groups and evaluators can identify the programme logic in a way that makes the identification of intermediate indicators easier. This means investing in early relationship development between the evaluation team, the groups and the funder, to strengthen the projects and, concomitantly, the evaluation.

Finally, part of the rationale for developing these projects was to harness and value local knowledge and expertise. Thus far the ICAH project has allowed for local priority setting and the Ministry of Health's contracting process has facilitated this. It is critical that this openness is maintained as the contracting is devolved to DHBs.

The evaluation team believes that positive outcomes have resulted from the Ministry of Health's investment. Continuing support for these initiatives will enable the Ministry to realise a full return on that investment. In particular, there is significant support for a dedicated intersectoral initiator role within DHBs. The ICAH initiatives are inherently long-term developmental projects that tend to require long lead-in times.

The ICAH initiatives began before the introduction of DHBs in 2001 and the development of primary health organisations (PHOs) from the following year. The future for ICAH projects may be closer alignment with DHBs and PHOs, although the question remains about whether ongoing funding will be available, beyond normal DHB and PHO budgets.



# Introduction

This report provides an overview of the evaluation of four Intersectoral Community Action for Health (ICAH) initiatives in New Zealand.

Intersectoral action for health has been defined as:

*A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone (Harris et al 1995).*

The main justification for intersectoral action in the literature is

that the determinants of the health of populations and communities are diverse, complex and multifactorial – beyond the capacity of the health sector to influence on its own .... Intersectoral action for health involves building constructive relationships with people and agencies from outside the health sector, in an effort to jointly influence these broader determinants (Maskill and Hodges 2001, 3–4).

The New Zealand Intersectoral Community Action for Health (ICAH) programme was 'introduced into areas which [we]re identified by the Minister and the Ministry of Health as requiring specific focus in order to see health improvement and reduction of disparities' (Ministry of Health Undated). It was based in part on the Health Action Zones model. Health Action Zones began to be established in the United Kingdom from 1998 in areas of relative social deprivation and poor health status. They were partnerships of health authorities, local authorities and other agencies aiming to work together to improve health and health services (Maskill and Hodges 2001).

Four ICAH sites were established in Northland, Counties Manukau, Kapiti and Porirua. The programme was one of a number of health initiatives to address goals in the New Zealand Health Strategy. These goals included reducing inequalities in health status and developing Māori health along with healthy communities, families and individuals (Ministry of Health Undated). The initiatives also contributed to achieving the overall aim of whānau ora in the Māori Health Strategy as well as addressing key priorities in the Pacific Health and Disability Action Plan (Ministry of Health Undated).

In June 2001, the Public Health Consultancy of the Wellington School of Medicine was contracted by the Ministry of Health to undertake an evaluation of the ICAH projects. The evaluation was carried out between July 2001 and June 2004 and was subsequently extended when the Porirua Improving Access (PIA) project evaluation was continued for a further year. Each ICAH was quite different and each developed a variety of subprojects. The evaluation described and analysed the progress of each ICAH as well as making comparisons between the four.

This report is an overview of the evaluation. It is based on progress and final reports of the evaluation (Martin et al 1 November 2001; Martin et al 15 January 2003; Martin et al 18 July 2003; Martin et al December 2003, Martin et al 2005). In addition, a number of evaluations of subprojects of the ICAHs have been drawn on (Voyle 2002; Clinton et al 2005; Gifford et al 2006). The report begins by giving some background to the development of ICAH, followed by the methodology of the evaluation. It details each of the ICAH projects and their subprojects before discussing critical success factors for intersectoral initiatives and setting out the key findings and conclusions of the evaluation. The report ends with some implications for the future of ICAH initiatives.

# Background

## History

Intersectoral health initiatives have been evolving internationally for some decades. Up to and including the 1980s, these initiatives mostly consisted of professionals implementing predetermined programmes by working to secure the support and co-operation of communities. Since the late 1980s, a more collaborative model has arisen involving the development of health initiatives through partnerships which include the community (Maskill and Hodges 2005). In the United Kingdom after the 1997 election of a Labour government a significant number of new intersectoral health projects were government funded. The most important of these were Health Action Zone projects in areas of high socioeconomic deprivation. These projects aimed to foster local-level intersectoral collaborations in response to health inequalities and apparent service fragmentation (Maskill and Hodges 2005).

Within New Zealand, a number of intersectoral initiatives have developed over the last twenty years. Ten were identified in a 2001 literature review, while an updated 2005 literature review included descriptions of 33 New Zealand initiatives (Maskill and Hodges 2001; Maskill and Hodges 2005). The initiatives were grouped into three categories:

- overarching area- or settings-based initiatives (Healthy Cities projects; and Health Promoting Schools; the Health Action Zones in the United Kingdom also fit into this category)
- issues-based initiatives (Community Alcohol Action programmes; Safer Community Councils; Community Injury Prevention Programmes; Community Nutrition Programmes; and the Otara Health and Housing initiative)
- case-management services (Strengthening Families initiatives; Family Service Centres; and Wraparound services) (Maskill and Hodges 2001).

The ICAH projects began in 1999 in response to local community concerns about health issues, together with Ministry of Health and Health Funding Authority concern about health disparities alongside a government commitment to reducing inequalities.

The first projects to be established were in Porirua and Kapiti, where the catalyst was the strong local submissions in 1999 with regard to where a new tertiary hospital should be situated. When the decision to site the tertiary hospital in Newtown was made public, the Minister of Health also announced funding for a project aimed at improving health and disability outcomes for people in Porirua and Kapiti.

In South Auckland an intersectoral approach to address the area's public health and social problems had already been developing over the preceding decade. The Ministry of Health, the Health Funding Authority and the Counties Manukau DHB were all committed to addressing the high health needs of the region by further facilitating the development of intersectoral initiatives. An agreement to develop an ICAH was negotiated between the Ministry and DHB and signed in December 2000.

Northland was the last of the four ICAH programmes to be established. Its inclusion in the programme was announced by the Minister of Health in November 2000, and a contract was signed in June 2001 with local providers.

In deciding where to establish ICAH sites, priority was given to geographical communities with a population greater than 10,000 in areas of high relative deprivation (NZDep96 index deciles 8–10) with Māori comprising over 20 percent of the population and with significant health disparities between Māori, Pacific peoples and other populations. The projects were to use principles of community engagement and development so they needed to be in places where the community was willing and able to engage in intersectoral approaches. Finally, the initiatives were intended to tackle the wider determinants of health status, as well as improving access to health and disability services.

## Goals and objectives

The overall objectives of the ICAH initiative were set by the Ministry of Health. These objectives were to:

- improve health and disability outcomes in the community, particularly for Māori, for Pacific peoples and for population groups who have worse outcomes
- develop initiatives that address health outcomes, broadly understood
- harness the support and involvement of local authorities, iwi and agencies responsible for health, housing, transport and education
- harness the wisdom and expertise of local communities, including providers, alongside that of policy makers, planners and funders
- develop intersectoral capacity for successful joint community action across sectors
- pilot and evaluate the current initiatives so the lessons learned could be included in guidance to DHBs.

## Demographic profiles

Inequalities in health, including ethnic inequalities, are primarily caused by structural inequalities in the distribution of and access to the determinants of health, compounded by differential access to and quality of health care (Ajwani et al 2003, Ministry of Health 2002). The following demographic data illustrate the high needs of the ICAH communities.

An overall picture of socioeconomic position can be given using the New Zealand deprivation index NZDep2001. Most of the ICAH geographical areas had high proportions of the population living in the relatively more deprived deciles 8–10, ranging from 65 percent to 91 percent, compared with the national average of 30 percent. The exceptions were the Northern ward of Porirua (0 percent in deciles 8–10) and the rest of the Kapiti Coast District (ie, excluding the Otaki census unit, where 11 percent are in deciles 8–10).

Ethnicity in New Zealand is strongly associated with underlying socioeconomic status and health inequalities. Structural inequalities create and maintain ethnic inequalities in health (Robson 2004), and institutionalised racism plays a role (Ministry of Health 2002). The Māori populations in the ICAH areas were mostly higher than the New Zealand average of 14 percent, with high areas from 16 percent to 17 percent in the Counties Manukau wards, 21 percent and 29 percent in the Eastern and Western wards respectively of Porirua; 30 percent in Otaki; and 40 percent in the Far North. Lower-than-average Māori populations were seen in the Northern ward of Porirua (7 percent) and the rest of the Kapiti Coast District (9 percent). The Pacific populations were lower than the New Zealand average (6 percent) in the Northern ward of Porirua (3 percent), the Kapiti Coast District (2–4 percent) and the Far North (2 percent), but greatly exceeded the average in the Counties Manukau wards (24–53 percent) and the Western and Eastern wards of Porirua (13–46 percent).

Income is the single most important modifiable determinant of health (National Health Committee 1998). In the ICAH areas, the 2001 personal income was generally lower than the national average of \$25,403, ranging from \$18,609 to \$22,759. Exceptions to this were seen in the Northern ward of Porirua (average personal income \$36,661) and the rest of the Kapiti Coast District apart from Otaki (\$26,400), where income was higher than average. Māori income ranged from \$16,033 in the Far North to \$21,572 in Porirua. Pacific income fell within this range, at around \$17,550.

Uptake of income support (other than superannuation) mostly exceeded the New Zealand average of 20 percent, with high areas ranging from 24 percent in the Papatoetoe ward of Counties Manukau to 41 percent in the Eastern ward of Porirua. Exceptions to this were again seen in the Northern ward of Porirua (10 percent) and the rest of the Kapiti Coast District (16 percent). Māori uptake ranged from 39 percent in Counties Manukau to 51 percent in the Far North, and uptake for Pacific peoples ranged from 34 percent in Counties Manukau to 39 percent in Porirua.

Damp, cold and crowded housing conditions have direct detrimental effects on mental and physical health (Howden-Chapman and Carroll 2003:84, 145). There were high proportions of people living in crowded housing in all project areas except for the Kapiti Coast District and the Northern ward of Porirua.

# Methodology

## Evaluation objectives

In June 2001, the Ministry of Health contracted the Public Health Consultancy of the University of Otago to undertake an evaluation of the ICAH projects. The agreed evaluation objectives were to:

- assess whether the programmes, initiatives and projects of ICAH had, or were likely to have, a positive impact on health and disability outcomes
- assess whether the programmes, initiatives and projects of ICAH have had, or are likely to have, a positive impact on health and disability outcomes for population groups experiencing worse health outcomes in the communities involved
- identify critical success factors for the projects and the relative importance of these; reasons why they were not successful in part or all of their aims; and factors critical to the New Zealand context
- assess the process and outcomes of one subproject in each ICAH region. For Kapiti and Porirua the evaluation was directed by the Ministry to focus on the primary care access subprojects established in Porirua and Otaki. In Northland, the subproject to be evaluated (Hei Oranga i te Whenua) was selected with the agreement of the Northland ICAH, the Ministry and the Public Health Consultancy. In Counties Manukau it was agreed to focus on the Youth Intersectoral Project initiative.

## Methodology

A review of New Zealand and international literature on community-based intersectoral initiatives for health had been published by the Ministry of Health in 2001 (Maskill and Hodges 2001), and an updated review in 2005 (Maskill and Hodges 2005). These provided an important base of information for the ICAH evaluation.

Further literature was sought on developments in evaluation methodology. 'Realistic evaluation methodology' was subsequently adopted for this ICAH evaluation. According to the realistic evaluation approach, the setting is as important as the intervention when evaluating social programmes. Realistic evaluation was developed in the late 1990s and seeks to understand why a programme works, for whom and in what circumstances, as summarised in this formula: context + mechanism = outcome.

The context of a programme or initiative includes its personnel, place and history. The programme creates mechanisms for change by modifying the capacities, resources, constraints and choices facing participants and practitioners. Realistic evaluation acknowledges that the relationship between the mechanism and outcome is dependent on its context. A programme introduces new ideas or resources or both into existing social relationships. Evaluators need to investigate the extent to which existing structures enable this or prevent it from happening. Effective evaluation will report the degree to which the context–mechanism–outcome under scrutiny does or does not work. This will provide information for future policy development.

Applying the realistic evaluation approach in the context of this ICAH evaluation included collecting contextual information and data describing the 'mechanisms' of the ICAH interventions, undertaking both process and outcome evaluations, and drawing on both qualitative and quantitative methods.

The evaluation team also discussed with each project governance group or steering group how to make the evaluation of direct use to them. These discussions centred on the analytic frameworks (see Table 1 below) which were refined to represent the groups' views. There was also a commitment to share the early versions of evaluation reports with providers before these were submitted to the Ministry of Health.

## **Key questions**

The project used the following fourteen major evaluation questions, which were refined and developed into interview guides as the project progressed. Given the differences between the ICAH projects, not all questions were relevant in every situation, and additional applicable questions were developed for the individual sites.

- Is ICAH having (or likely to have) a positive impact on health and disability outcomes?
- Is ICAH having (or likely to have) a positive impact for those with worse health outcomes? In particular, is the ICAH having a positive impact for Māori, Pacific peoples, and low income people?
- Has the ICAH project achieved the objectives set by its governance group?
- What is the nature of the partnership within the ICAH project?
- Has the ICAH group helped participants achieve their objectives (ie, the objectives of the organisations they represent)?
- Is the intersectoral process helping or hindering the achievement of the ICAH project objectives?
- What factors helped the ICAH project?
- What factors hindered the ICAH project?
- Which of these factors are transferable to another community?
- Has the ICAH project addressed social, economic and cultural determinants in health?
- Has the ICAH project applied Treaty of Waitangi principles?
- Has the ICAH project incorporated the needs of Māori, Pacific peoples, and low-income people?
- Has the ICAH project enhanced community capacity?
- What has the ICAH project cost?

## Data sources and collection

To provide a baseline from which to carry out the evaluation, the historical context, community context and project history for each project were constructed using a wide range of available documentation, including minutes of meetings, early drafts of project plans, and community descriptions from councils. Participants and community informants were also interviewed to get a broader community view. Some interviews were taped, from which notes were taken. For most interviews, detailed notes were taken at the time of interview.

Key documents were collected for all the projects using the secondary data collection guidelines in the project plan. Additional documents were provided by key informants. Field researchers in each location attended ICAH meetings and community meetings (where possible) as participant observers.

The project used the fourteen major evaluation questions above, which were refined and developed into an interview guide as the project progressed. Given the differences between the four ICAH projects, not all questions were relevant in every instance. For the final round of key informant interviews the focus was on impacts to date, and interview guides were specific to each project.

Data were collected on the following:

- context – including descriptions of the demographics, community development history, health services and health determinants in the project locations
- process – including buy-in, participation and partnerships
- costings – including funding of the projects from central government and costs to participating organisations and individuals
- outcomes – including health determinants information
- equity impacts – for example, how the projects address the needs of those with worse health outcomes
- sustainability – including effective management, leadership and intersectoral co-operation
- subprojects – relating to such measures as acceptability and accessibility.

The evaluators used both qualitative and quantitative methods to gather this information. Qualitative methods included analysis of programme documentation; key informant interviews;<sup>1</sup> and participant observation. Quantitative methods included analyses of the demographic, social, economic and cultural determinants of health; epidemiological analyses of primary care and hospital morbidity; economic analyses of costs to various parties; and before-and-after comparisons to document the impact of changes arising from the actions of ICAH groups, where appropriate, given intervention logic.

<sup>1</sup> A list of informants and stakeholders interviewed is given in Appendix 1.



As well as evaluating each ICAH project overall, one subproject was assessed in each area. These subprojects were:

- Porirua ICAH subproject: Porirua Improving Access initiative
- Kapiti ICAH subproject: Otaki Community Health Worker Project
- Counties Manukau ICAH subproject: Youth Interagency Project
- Northland ICAH subproject: Hei Oranga i te Whenua.

In addition, a number of independent evaluations of other ICAH subprojects have been undertaken by other groups, such as the outcomes evaluation of the Counties Manukau Healthy Housing pilot programme (Clinton et al 2005), and these were also drawn on.

## Analytic frameworks

The following evaluation framework was developed by using key New Zealand and international frameworks to identify performance indicators relevant to the projects. These frameworks were discussed with each of the ICAH groups at the outset of the evaluation.

**Table 1:** ICAH evaluation framework

Analytical parameters	Suggested performance indicators	Data sources
Treaty of Waitangi	Evidence of meaningful Māori involvement in the project Evidence of active support for the advancement of Māori aspirations Evidence that priority is given to improving Māori health outcomes, including by mainstream organisations Evidence of capacity building in Māori organisations (hapū, iwi, pan-tribal)	Programme documentation Key informant interviews Focus groups
Reducing health inequalities	Evidence of community action around socioeconomic determinant(s) Increased diversity of service availability Service use Reduction in avoidable hospitalisations Differential analyses to identify who benefits Analyses by ethnicity, gender, education, socioeconomic status (eg, NZDep2001 or Community Service Card status) will be dependent on quality of recording	Stakeholder interviews and records Programme documentation Key informant interviews Focus groups New Zealand Health Information Service records
Effectiveness	Evidence that projects have specified and achieved objectives Assessment of inclusiveness of processes Evidence of co-ordinated activity by agencies Evidence of leadership development Evidence of resources shifting to areas of greater need, or towards the priorities identified by the projects Evidence of capacity building	Stakeholder interviews and records Programme documentation Key informant interviews Focus groups

<b>Analytical parameters</b>	<b>Suggested performance indicators</b>	<b>Data sources</b>
Acceptability	Consultation, needs assessment, information gathering methods used Extent of coverage in processes and participation in projects Evidence of responsiveness to Māori, Pacific peoples and low-income people	Programme documentation Key informant interviews Stakeholder interviews Focus groups
Accessibility	Evidence of participation in projects Knowledge of availability of services	Programme documentation Provider and practitioner records Key informant interviews Focus groups
Efficient management	Evidence that programme has developed to the required standard Evidence of sound management practices (including financial management) Developed within available resources Links developed with appropriate agencies Type, timeliness and adequacy of reporting	Programme documentation Programme financial records Key informant interviews Stakeholder interviews

An additional framework, Te Pae Mahutonga, was used for analysis of the Far North ICAH. Te Pae Mahutonga, or the Southern Cross, is a Māori symbol of navigational guidance, and Mason Durie's model for Māori health promotion uses the symbolism of its stars to represent key task for health promotion and essential elements of Māori development and health (Durie 1999).

The key determinants of effective community-based intersectoral action for health which were identified by the preceding literature reviews (Maskill and Hodges 2001; Maskill and Hodges 2005) were used as the basis for drawing conclusions about the success of the ICAH initiatives.

## **Limitations**

The following limitations of the evaluation should be noted.

Given the substantial differences between the purpose and structure of each ICAH, comparison was difficult and not all findings may be able to be generalised from one situation to another.

Delays in establishment of the projects in turn delayed their evaluation. In addition, the literature acknowledges that considerable time and resources may be necessary for projects to fully develop and outcomes may also take time to be seen and be able to be assessed. Undertaking this evaluation in the first two to three years after establishment was therefore early for such complex initiatives. However, the purpose was not to assign a 'pass/fail' grade, but to draw lessons from these pilots which could be useful for other initiatives.

Other changes have occurred in the broader health environment during the period of the evaluation, particularly the development of primary health organisations (PHOs). In the case of the Porirua Improving Access (PIA) project especially, this has limited the ability to attribute changes specifically to the effects of the ICAH projects.

Again with regard to PIA, primary health care use data have only been collected relatively recently, and there were limitations in its reporting (in particular, nursing outreach data and some community health worker activity may have been under-reported). Both these factors affect the data interpretation. However this evaluation has stimulated the improvement of data collection, and provided a baseline for future monitoring.

This evaluation did not attempt to directly gain the perspective of users of ICAH initiatives.

## Literature Reviews

A literature review of New Zealand and international literature on community-based intersectoral initiatives for health was published by the Ministry of Health in 2001 (Maskill and Hodges 2001). This was updated in 2005 (Maskill and Hodges 2005). This section summarises the important findings of those reports.

The initial literature review (Maskill and Hodges 2001) identified the key determinants of effective community-based intersectoral action for health using case study material from 10 examples of community-based intersectoral initiatives for health. Nine of these initiatives were New Zealand-based, and one initiative (Health Action Zones) was based in the United Kingdom. These initiatives had three common factors. All were:

- community-based
- attempting (at least in part) to influence the underlying determinants of health
- working across sectors (either directly or through referral to other sectors) (Maskill and Hodges 2001: 12).

The initiatives fell into three broad categories:

- overarching or settings-based (such as Healthy Cities and the United Kingdom health action zones)
- issues-based (such as community nutrition or injury prevention programmes)
- case management-based (such as Strengthening Families and Family Service Centres) (Maskill and Hodges 2001: 12).

### Effectiveness factors

A number of factors were identified in the literature as important for determining the effectiveness or 'success' of community-based intersectoral action for health, and it was suggested these could be used as a basis for prioritising proposals for new initiatives. The factors have been grouped under six headings below (Maskill and Hodges 2001: xx–xxiii).

#### All partners agree on the necessity for intersectoral action

- All partners (government agencies, non-government agencies, community groups, etc) agree they should work together.
- The intersectoral action presents a 'win-win' situation where all partners benefit.
- All partners have a shared vision of what they want to achieve.
- All partners give their full support and mandate to the intersectoral action and accept it as part of their core business.

### **Support exists in the wider community**

- There is high-level political support (central or local government).
- There is an appropriate legislative environment (eg, ability to share budgets).
- There is a supportive economic environment (there is economic growth and resources are not too scarce).
- The prevailing public-policy environment facilitates collective action rather than individualism.
- There is a supportive organisational environment.
- The initiative is consistent with the sociocultural beliefs, current concerns and attitudes of the target community, including their priorities for action.
- The timing is right.
- The location for the intersectoral action is appropriate (eg, other sectors have to be available to collaborate with).

### **Capacity exists to carry through the planned action**

#### **Partner organisations**

- There is widespread support among all levels of staff within partner organisations.
- Activities associated with the initiative are part of staff's job descriptions.
- Staff involved in intersectoral planning and management groups are able to make decisions on behalf of their organisations (and it is clear who is able to do so).
- The power to make decisions rests at the local, rather than national, level.

#### **Community participation**

- Existing community organisations (eg, NGOs, voluntary agencies, businesses, Māori organisations) are involved in partnerships and are not ad hoc groups of 'grassroots individuals' with no existing networks.
- Māori initiatives use existing Māori networks such as marae and kōhanga reo and have buy-in from the local Māori community.
- The current literature review did not find any evidence concerning conditions that are favourable to Pacific peoples' participation in intersectoral initiatives for health.

#### **Resources**

- All partners (including community representatives) have sufficient resources and support to participate in the initiative.
- Extra staff time for collaboration and extra resources for infrastructure and administration are allocated (although financial savings may also be made in some instances).
- At least one full-time local co-ordinator is employed, as well as regional or national co-ordinators or both for initiatives that are located more widely.

- Administrative assistance is provided to co-ordinators.
- Long-term funding is assured so initiatives can be properly developed, infrastructures are built and projects have time to 'work' (this usually takes several years because of the time it takes to establish partnerships and work collaboratively).
- There is long-term funding so that skilled staff are attracted and they do not have to spend too much time fundraising at the expense of facilitating the initiative's activities.
- There is long-term funding so that partners do not become disillusioned and mistrustful (eg, where one partner is the funder).

### **Personal skills**

- Staff employed on the initiative (eg, co-ordinators) have a wide range of skills, knowledge and experience in areas such as community development, health promotion, communication, negotiation and management.
- Frontline initiative staff are locals.
- Training is given early on to staff in areas they are less familiar with.

### **Relationships enabling action are defined and developed**

- The roles of, and relationships between, partners are agreed and clearly defined.
- There is trust and respect between partners.
- Well-resourced systems are in place for collaborative working.
- Systems are in place to enable relationships to be regularly reviewed and renegotiated if necessary.

### **Agreed actions are planned and implemented**

- A planning and development phase is undertaken, including an assessment of the local community's needs and existing services and programmes.
- Strategies and action plans are agreed and, ideally, put in writing (eg, in a memorandum of understanding).
- A manageable number of activities are undertaken so success is achieved while community and organisational infrastructure is built up.
- The responsibilities of each partner are defined with regard to what actions they will undertake.
- Partners share accountability for programme successes and failures.

### **Outcomes are monitored**

- Progress is monitored so that partners can make decisions about their future support.
- Initiatives are given time to 'succeed'.

## Conclusions

In terms of judging the effectiveness of the New Zealand intersectoral initiatives, it was found to be comparatively rare for evaluators to measure broader health status outcomes (such as morbidity and mortality) produced by the initiative. Reasons for this included the methodological difficulties and costs involved in collecting or accessing suitable data, plus difficulties in interpreting results (ie, whether health gains occurred because of the initiative or because of other factors). However there were indications of broader health outcomes resulting from some community-based intersectoral initiatives, and examples of positive intermediate outcomes such as changes in people's health-related knowledge, attitudes and behaviour. Intersectoral initiatives have also led to changes in various aspects of the physical, economic, social and policy/legislative environment (Maskill and Hodges 2001: xxiv).

Many of the New Zealand issues-based and case management intersectoral initiatives reviewed appeared to have been effective for disadvantaged people – at least in terms of achieving intermediate outcomes. This was less clearly so for the overarching initiatives, partly because evaluations of these tended to focus on processes and the overall functioning of the initiative rather than on outcomes for individuals. This last group also had some difficulty getting good 'grassroots' community participation, including from socially disadvantaged people (Maskill and Hodges 2001: xxvi).

A number of roles were identified for the Ministry of Health and DHBs in partnering with intersectoral initiatives. These included taking a leadership role in supporting the concept of intersectoral initiatives while at the same time avoiding setting priorities or agendas for what should be community-determined action; providing adequate and stable funding for a sufficient length of time to enable initiatives to be effective (at least 3–5 years and probably longer); funding evaluations of initiatives; and developing flexible 'best practice' guidelines (Maskill and Hodges 2001: 140–1).

Local authorities and other health and social agencies are among those with potential to be partners in intersectoral initiatives. Where there are existing networks, relationships and structures, these can be used and built on (Maskill and Hodges 2001: 142).

'Community participation' is a key goal of community-based intersectoral initiatives. This has generally worked better in initiatives that aimed to engage existing local community organisations as partners, and less well where projects have tried to involve more loosely defined 'grassroots' community members (perhaps because of their lack of available time, resources and motivation, particularly for those who are socially disadvantaged) (Maskill and Hodges 2001: 142).

The review found that New Zealand evaluations of intersectoral initiatives generally used naturalistic (as opposed to quasi-experimental) research techniques, including interviews, focus groups, observation and document analysis. These enable thorough documentation and analysis of the sometimes complex processes involved in implementing intersectoral initiatives. In some cases it is also possible to measure intermediate or end outcomes. However, attributing causality may be difficult (Maskill and Hodges 2001: 143).

The updated literature review (Maskill and Hodges 2005) presented subsequent research on the six 'success factors' above, and gave an overview of the one United Kingdom and 33 New Zealand initiatives which had been evaluated between 1980 and 2005. Wide variation was noted in the kinds of philosophical principles, structures, systems and people that formed the basis of intersectoral initiatives, although three key structural or organisational components were relatively common:

- an activation phase, involving processes such as identifying the need for a project, matching funding to projects, building and facilitating project relationships and participation, creating project structures, negotiating vision and planning, and creating activities
- a consolidation phase, including skill development, accessing people with community development knowledge and skills, developing a project culture, sharing project experiences, managing conflict, accessing resources, developing knowledge, and carrying out evaluation
- a transition phase, including completion of the funding term and a focus on issues linked to organisational change and sustainability. A number of New Zealand intersectoral initiatives were found to have continued for a number of years after their initial funding ended, either through receiving ongoing funding from the original sponsor, or by obtaining sustainable funding from elsewhere. Other initiatives became mainstreamed into other organisations, reverted to working on a voluntary basis, or ceased altogether (Maskill and Hodges 2005: 7–8, 11).



# Porirua ICAH

## Development

The Porirua and Kapiti ICAH projects began as one initiative. A key catalyst was the decision to site the new regional hospital in Newtown, Wellington as opposed to Kenepuru in Porirua, for which the local community had strongly lobbied. In October 1999 the Minister of Health (Rt Hon Wyatt Creech) announced the establishment of the Porirua Kapiti Health and Disability Services Integration Project (later called the Healthlinks Project), an initiative aimed at improving health and disability outcomes for the people of Porirua City and the Kapiti Coast.

The Ministry of Health contracted Healthlinks to provide advice on how health and disability services, organisations and funding could be better integrated to improve health outcomes in the Porirua and Kapiti region. The Ministry was to lead and fund the project and, in conjunction with the community, identify existing problems and priorities and explore solutions and opportunities to address these problems. Two specific outputs were sought: advice to the Health Funding Authority on identifying new or enhanced services to be purchased by the Authority in 2000/2001, and the development of a health and disability plan for Porirua and Kapiti.<sup>2</sup> The project was intended to facilitate two main sets of outcomes: the development of whole community initiatives to target health problems resulting from lifestyle choices; and the development of information flows and strategic alliances between providers to achieve better co-ordination of services and reduced duplication of resources.

The Ministry initially identified three phases to the project. Phase one (to be completed by March 2000) was the development of a medium to long-term Porirua Health and Disability Plan. Phase two (to be completed in 2000/2001) was the implementation of a number of specific integrated initiatives (including diabetes, asthma, primary Pacific health care, and additional core outpatient services) and the development of a Kapiti Health and Disability Plan. Phase three was the implementation of the agreed components of the Porirua and Kapiti plans. Subsequently it was decided that the Porirua and Kapiti plans would be prepared concurrently.

<sup>2</sup> The Health Funding Authority was a single national purchaser of health and disability services, established in 1997 from the amalgamation of four Regional Health Authorities. Following the New Zealand Public Health and Disability Act 2000 and the introduction of DHBs the following year, the responsibility for purchasing and providing services was devolved to DHBs.

The original Terms of Reference and the structure proposed for the project by the Ministry were taken to the community for discussion and development. Participants in the research reported that the process used at this early stage of the project was critical to later success. The Ministry representative contributed significant time and took both a facilitative and a leadership role (for example, acting as a senior sector advisor, participating in meetings and providing expertise in analysis and project management). Appropriate community players were identified, and remained committed to the project. Porirua City Council, Ngāti Toa and others also suggested greater intersectoral involvement and a focus on the determinants of health, not just health services. The appointment of a manager for the project, although an employee of the Ministry, was also negotiated with the community.

In mid-2000, with the approach of the completion of phase one, a strategic planning day was held. At this point, representatives of the two communities identified that the differing needs and priorities of the two communities would best be managed by each community co-ordinating their project independently and coming together as necessary. Subsequently, Porirua and Kapiti continued as autonomous sites and developed into ICAH projects. The Porirua ICAH was formally established by a service agreement contract between Porirua Healthlinks Trust and the Ministry of Health in June 2001.

The Porirua health needs assessment was published in August 2000 as *The Porirua City Health and Disability Report and Plan* (Porirua Kapiti Healthlinks Project 2000b). The report outlined the demography of Porirua City along with its existing health and disability status and health and disability services, as well as what was perceived to be needed to improve health in the area. Recommendations included:

- funding continued intersectoral action by Māori, Pacific peoples, Porirua City Council and other communities in Porirua to improve service co-ordination, responsiveness, and health and disability outcomes
- ensuring that the Health Funding Authority, DHB and hospital and health services involve local providers and key representatives of Māori, Pacific peoples and other communities in developing new services to enable these groups to take an active role in advising the DHB on strategies to address health improvements
- equitable and fair population-based funding
- additional funding to develop and support health promotion that is effective for Māori, Pacific peoples and people in more deprived areas
- additional primary care services, including piloting services that would be substantially free for those in greatest need
- developing and funding specific Māori and Pacific services and increasing the acceptability of other services for these groups
- funding improved access to, and better co-ordination of, maternity services
- improvements to child and youth services
- improved services for older people
- improved access to prescribed medicines by funding pharmaceuticals so that they are free or substantially free to people eligible for a Community Services Card

- improved access to specialist medical and surgical services, including emergency services, at Kenepuru Hospital, including frequent and convenient public transport services to both Kenepuru and Wellington hospitals
- equitable access to disability support services and better integration of these services
- improved access to mental health services (Porirua Kapiti Healthlinks Project 2000b).

Key informants were consistent in their views regarding this report:

- it was community driven and the process for consultation was very good
- this was the first time the community had been able to access quantitative data to support previously held beliefs about health needs in Porirua
- the leadership on the project was empowering and enabled community members to learn public health and health advocacy skills
- the recommendations reflected the community view on what was needed in Porirua.

## Governance

The original Project Management Committee (governance group) included the mayors and a councillor from both Porirua City and Kapiti Coast District; kaumātua from Ngāti Toa, Te Āti Awa ki Whakarongotai and Ngāti Raukawa; Pacific peoples' representatives; taurahere representatives; representatives nominated by community groups (including Kapiti Community Health Group Trust, Porirua Healthy Safer Cities Trust, Porirua Health Partnership and Porirua Community Health Group); and a Ministry of Health representative.

Governance of the independent Porirua ICAH has been provided by both the Porirua Healthlinks Trustees and the Healthlinks Committee. The nine registered trustees held responsibility as the legal entity of Healthlinks and managed employment, financial matters, policy development and the like. The Healthlinks Committee represented the wider community (including Pacific peoples, Porirua Health Plus, Porirua Healthy Safer City Trust, Porirua Community Health Group, Porirua City Council, Ngāti Toa, taurahere and so forth) and also included a Ministry representative. The function of the Healthlinks Committee was to gain community participation and feedback on matters such as prioritising community projects, to provide an opportunity for community feedback to inform needs assessments, and to discuss community concerns.

## Funding and funders

**Table 2:** Funding for Porirua ICAH

Contract funding (excluding GST)	Porirua Healthlinks Trust ICAH project			
	June year			Total three years (excluding GST)
	2001–02	2002–03	2003–04	
Funding received	\$145,629	\$214,240	\$369,232	\$729,101
Ministry of Health		\$139,222	\$181,002	
PHICS funding		\$53,333	\$160,394	

Other income		\$20,413	\$6,978	
Grants			\$17,658	
Interest received	\$297	\$1,272	\$3,200	

Source: Financial Statements. Audited TL Reilly & Associates; Porirua.

Over the three years of the evaluation Porirua Healthlinks Trust (PHLT) participants stated that funding was sufficient to carry out the tasks required of the organisation. However, there was concern about the sustainability of the funding needed for a longer-term community development approach. This has been a particular concern with the passing of the contracting relationship from the Ministry of Health to the DHB, because possible DHB deficits may affect service provision at the provider level which may in turn impact on the capacity to support ICAH-related positions.

During the three-year evaluation period PHLT has been successful in accessing additional funding from a range of sources, such as Te Puni Kōkiri, the Lotteries Foundation and Capital & Coast DHB. They have also managed to extend funding by collaborative arrangements (eg, rent-free premises) from Regional Public Health in exchange for receptionist duties.

Trustees were asked about how much voluntary time they had contributed: most trustees spent a considerable time attending meetings, consulting with their respective communities and generally being an advocate for their particular interest group. The Ministry of Health ICAH manager also donated considerable time as part of the Ministry's support of these initiatives.

In addition to voluntary time there were participation costs such as paper, telecommunications and transport. Participants commented that the level of commitment needed by volunteers limited participation by those who were required to be in full-time employment. There appeared to be a subset of trustees who also attended regular DHB committee meetings and community network meetings, which extended their participation of voluntary time over and above that of other members.

## Roles

During the period of the evaluation, Porirua ICAH had several roles. First, Porirua ICAH was involved in a number of longer-term high-priority projects, as detailed in Table 2.

**Table 3:** Porirua ICAH projects and activities

Project	Related activities undertaken by PHLT
Kenepuru Hospital redesign	Made submissions to Capital & Coast DHB Facilitated public forums Participated in meetings between PHLT and DHB Participated in steering groups

Project	Related activities undertaken by PHLT
PHO development	<p>Provided input into community representation on PHOs</p> <p>Provided opportunity for community feedback through health forums</p> <p>PHLT has representatives on both PHO boards</p>
Improving primary care access	<p>PHLT led in early development phase (2001)</p> <p>Developed options for progressing project and was a member of the Improving Access to Primary Care in Porirua (IAPCP) working party</p> <p>Played a strong role in the workforce development component of IAPCP</p> <p>Organised seminars with Whitireia Polytechnic</p> <p>Ongoing feedback provided through community health forums</p>
Health Cluster Development (a partnership established in January 2002 between PHLT, Porirua City Council, Capital & Coast DHB and Ngāti Toa working together on health issues for Porirua).	<p>PHLT is a partner member, and has assisted with communication through the Healthlinks website and forums</p> <p>Chairs Health Cluster meetings</p>
PHICS and <i>Allpoints</i> bulletin (PHLT-led): PHICS is an information service designed to operate from a community base, with information flow being an interactive, two-way interface. The system will be accessible 24 hours a day, seven days a week by telephone and website.	<p>Publishes electronic newsletter (<i>Allpoints</i>) at least weekly to a minimum of 450 individuals and over 200 recipient organisations</p> <p>PHLT has developed the plan (with strong community input), secured funding, and manages the project</p>
Porirua Community Health Forums (PHLT-led)	Quarterly forums organised and facilitated by PHLT
Defeat Diabetes Project	<p>Assisted with funding application</p> <p>Assisted with resource development (eg, availability of physical activity programmes)</p> <p>Provided support and leadership for the project</p> <p>Assisted with public presentations</p>

Second, PHLT has been involved in several projects on a shorter-term basis, or in projects that have commenced within the last 12 months of the evaluation. These projects included:

- fundraising and advocacy work with the Ear Van Trust in 2003/04 (short-term)
- a review of maternity services in Porirua in conjunction with the Ministry of Health in 2003 (short-term; completed)
- Creative Spaces Project (a community mental health project using art as therapy), strongly supported by PHLT in its initial phase
- Capital & Coast DHB and Porirua Community Youth Health Project, led by PHLT
- a Health Promotion Day, 'Creeffest', led by PHLT (which may be ongoing)
- the Disability Support Group, led by PHLT (established 2003/04).

Third, Porirua ICAH has participated in or organised community representation on a number of community and government agencies such as Waitangirua Action Group, Housing Action Porirua, Mental Health Local Advisory Group, community representative for Tumai PHO, various hospital advisory groups and Porirua Association of Māori providers.

## **Key objectives and progress against them**

PHLT had a vision of providing community leadership and a sustainable voice for the priorities of the people of Porirua, with the aim of improved services and better health and disability outcomes. A wider health determinants focus was identified as a necessary approach to improving health outcomes.

The goals and objectives for the Porirua Healthlinks project were derived from the recommendations in the Porirua Health and Disability Plan, and were developed in strategic and annual plans.

The key areas for strategic action within the plans were intersectoral action on health, improved equity and fairness, greater acceptability of services, better access to services and better integration of services.

Progress against these five key areas, with their appended objectives, is discussed below.

### **Intersectoral action on health**

The objectives are to:

- support intersectoral action to improve health outcomes and better address the wider factors that influence health
- enable the communities of Porirua to influence the health-related agendas of government and community agencies, and of providers
- develop and maintain an effective PHLT project infrastructure.

PHLT has been an active participant in existing intersectoral groups. Action has mainly been focused on influencing strategic policy development at a local government level and at DHB level. In addition, PHLT continued to provide feedback to all sectors through the Porirua Community Forums held quarterly. PHLT also participated as a representative in sector groups other than health,<sup>3</sup> and participated in projects and at times facilitated activities that integrate a number of sector groups.<sup>4</sup> The Trust also played a role in lobbying for appropriate community representation on a number of

<sup>3</sup> PHLT has a representative on the Waitangirua Action Group, Housing Action Porirua, and Achievement Porirua (an education group).

<sup>4</sup> Intersectoral work at this ICAH site includes networking, gathering information and providing advice, building capacity, and providing support at the community and local provider level. PHLT has built significant relationships with local and central government agencies and with mana whenua. These relationships provide opportunities for working across sectors and with a range of interest groups.

advocacy or advisory groups. Maintaining effective representation on such a wide range of groups has been a challenge for a small community agency.

### **Improved equity and fairness**

The objectives are to:

- advocate for planning and funding for health and disability services to take account of the wider factors that influence health and service needs
- achieve preventive services (including health promotion) that are effective for Māori, Pacific peoples and people on low income
- promote equitable service levels regardless of whether the need is because of a disability or a personal health problem.

PHLT has influenced policy at a strategic level, for example regarding services to be provided at Kenepuru Hospital. Activities included writing submissions and responding to various strategic and annual plans, such as the Porirua City Council Annual Plan and Capital & Coast DHB plans, as well as initiating reports with other partners, including the Markers project to develop indicators of trends in health status in Porirua.<sup>5</sup>

Health providers described the role of PHLT as ongoing and as 'keeping talking to the community', ascertaining community needs and advocating these on behalf of the community. However, there were some tensions over PHLT's role at a provider level, with some providers cautioning that they didn't see a role for PHLT 'in telling them how to do their job'. Needs for this advocacy and communication role differ depending on the size and strength of the provider, with one smaller provider commenting on how useful it was to have PHLT 'keeping them informed'.

At a funder level there was strong acknowledgment of PHLT's advocacy role and a need to see this as part of an ongoing process of representing a community voice. Relationships between the DHB and PHLT would need to be improved to give full effect to this goal.

PHLT worked with Regional Public Health to review the regional preventive services and the responsiveness of these services to Māori, and Pacific peoples.

### **Greater acceptability of services**

The objectives are to provide:

- services and service providers that are culturally acceptable and competent
- a choice of provider, so that people can choose culturally acceptable primary and community service providers, including Māori providers and providers from each Pacific group.

<sup>5</sup> The Markers project was initiated by PHLT (in consultation with Capital & Coast DHB) as a mechanism for monitoring changes in health outcomes for Porirua. The Markers project is currently not being progressed as the DHB is exploring other mechanisms and frameworks for measuring outcomes.

Greater acceptability of services has been achieved by having effective links with the Māori and Pacific communities. This enables PHLT to receive feedback, thereby enhancing their role as advocates. However it has been difficult for PHLT to maintain effective links with Pacific peoples. Links with Māori have at times been problematic, although not to the same extent. Several strategies have been implemented to rectify the problems with representation, such as meetings with Ngāti Toa and the establishment of a Māori caucus group for PHLT made up of Ngāti Toa and taurahere representatives. Pacific representation remained a wider issue (ie, within the broader health sector, not just confined to representation on PHLT) and was to be strengthened for the Porirua community with the establishment of a Pacific reference group to represent the diverse interests of Pacific peoples. The current Pacific members of PHLT have also targeted several Pacific peoples in the Porirua community to join the PHLT committee. These strategies have had varying degrees of success and the issues of effective representation are ongoing. However, Māori and Pacific peoples have been represented in PHLT governance throughout the evaluation.

Community needs have been identified through a range of processes, including community seminars, workshops and forums. Community feedback was communicated to funders and providers in a variety of ways, including through a facilitation process, report or submission writing, face-to-face meetings, and through a range of media. A key criticism of this feedback process from members within PHLT, and from community health and social service providers, has been the difficulty of accessing and representing the 'flax- or grassroots community voice'.

### **Better access to services**

The objectives are to:

- achieve better access to health and disability services through better information about what is available
- achieve better access to primary care services by those people with the greatest need
- achieve better access to accident and emergency, outpatient and hospital inpatient services at Kenepuru and other hospitals.

Early success was achieved by securing an improved bus service from Porirua City to Kenepuru Hospital. Initially the bus service included a service between Kapiti, Kenepuru and Wellington, which has now been discontinued (through lack of use) and replaced with a subsidised transport system co-ordinated between primary and secondary care services. The Improving Access to Primary Care in Porirua project was evaluated separately as a subproject of this ICAH initiative.

### **Better integration of services**

The objectives are to ensure that:

- health promotion services are well co-ordinated with primary services
- services are better integrated from the perspective of patients.



Early PHLT progress reports to the Ministry of Health (October 2001–March 2002) stated that better integration of services would be addressed by implementing the Porirua Health Information Communication System (PHICS). Given that the PHICS project has just been launched, this evaluation was unable to determine its effectiveness as an intervention in improving integration. PHLT identified a range of other actions in which it was involved that resulted in networking, and sometimes joint activity, across community agencies and providers. Examples included the Defeat Diabetes Project (partners are Regional Public Health, Healthlinks, Porirua City Council, Maraeroa Health Clinic, Ora Toa, Tumai mo te Iwi and Sport Wellington), and the Transport Committee (consisting of the two Porirua PHOs, Kenepuru Hospital, Capital & Coast DHB and PHLT).

## Impacts

Using the analytic boundaries of the ICAH evaluation framework, the Porirua ICAH has had the following impacts.

PHLT has developed over a period of significant change for the health sector, but most of the changes that have occurred have been conducive to the overall objectives of the ICAH projects – for example, the emphasis on inequalities in health outcomes, the need to foster broad alliances, and the focus on an intersectoral approach to improving health outcomes. This section comments on process and output indicators of success.

Key informants felt that intersectoral activity was an ongoing process which focused on building effective, supportive and sustainable links. PHLT was building a strong profile within the community to enable this to happen. In addition to intersectoral engagement at a community and provider level, PHLT has built significant relationships with local and central government agencies and with mana whenua. These relationships have provided opportunities for working across sectors and with a range of interest groups. Porirua City Council also has an intersectoral strategic co-ordinating group, with 15 government agencies participating on a regular basis. This group has provided an opportunity to give feedback on health issues for Porirua through the partnership between the Council and PHLT.

The community has expressed a high level of satisfaction with PHLT's performance. There was evidence that PHLT had enhanced community capacity by providing practical support to emerging groups; assisting with the administration and co-ordination of community forums run by a community group; offering effective information networks that enhanced community involvement and participation; using collaborative processes, which encouraged a wide range of involvement from community members; and providing payment for work previously done voluntarily.

Key stakeholders also identified benefits from the partnership, such as assisting the DHB with community consultation and community participation in developing PHOs; working in partnership with Ngāti Toa; and providing support for Pacific peoples' initiatives when requested.

PHLT had a good understanding of the social and economic determinants of health outcomes and was involved in projects that might influence these determinants (eg,

Waitangirua Action Group, Housing Action Porirua, Achievement Porirua). PHLT was also aware of determinants when developing new initiatives (eg, the issue of access to information by poorer populations with no phone and transport was considered in the PHICS plan).

PHLT was particularly aware of the need not only to engage target groups such as Māori, Pacific peoples and low-income groups in any development, but also to step aside and provide space for Māori and Pacific peoples' groups to determine their own priorities and approaches. The strong public support for PHLT by Ngāti Toa has been formally mandated at a meeting between the Māori caucus of PHLT and Ngāti Toa Rūnanga.

In interviews with the chair of the Pacific Forum and a key Pacific community worker, it was identified that PHLT has worked with Pacific communities in a number of ways, including:

- consultation and information sharing with Pacific peoples through various community meetings and through the Pacific Forum
- support of specific Pacific peoples' projects, such as the Pacific Youth Project
- working towards increasing the Pacific governance representation so that support is available for those already on the governance group
- support of Pacific providers – the PHLT manager visits Pacific providers to provide support and information.

However the Pacific Forum chair stated that confusion about the role of PHLT persisted in the wider Pacific community, and that getting community engagement and feedback on issues affecting Pacific peoples was a problem. At times there has been low Pacific representation at meetings.

Examples of other impacts identified as being a direct or indirect result of the ICAH in Porirua were that:

- a submission on the Capital & Coast DHB business case has resulted in greater access to services by the wider population group<sup>6</sup>
- the Waitangirua Action Group project has been targeting a high-needs community
- partnerships were formed and relationships strengthened as partners worked together on the health and cultural festival held at Cannons Creek
- a forum for disability support in Porirua has been established
- Porirua Community Health Group meetings were reaching a wide range of community members
- PHLT assisted with the Porirua Health Plus PHO communication plan, and met with partner representatives to determine a process for governance
- PHLT has also facilitated improved participation for Pacific people

<sup>6</sup> Reduction of barriers to access, including costs, have been considered in the planning of the Accident & Medical Emergency Services at Kenepuru Hospital. Changes to age limitations on medical beds have now been made to include those under age 65.

- there has been an increase in the Māori and Pacific primary health care workforce
- costs to primary health care patients have been reduced under Improving Access to Primary Care in Porirua
- PHLT has, through community consultation, advocated with Capital & Coast DHB for local health services to reflect the full range of community needs
- there has been improved communication in all sectors of the community
- residents of Cannons Creek and lower Porirua East were actively involved in a community renewal project.

## Subprojects

Each ICAH has been involved with a number of subprojects, some of which have been funded or part-funded by the ICAH while others had separate funding sources. One subproject within each ICAH was evaluated as part of the overall ICAH evaluation, and a number of others have been independently evaluated. This section discusses the Porirua ICAH subprojects drawing on information in the full report of the Porirua Improving Access Evaluation (Gifford et al 2006).

### Porirua Improving Access Initiative (PIA)

#### Description

*The Porirua City Health and Disability Report and Plan, 2000* (Porirua Kapiti Healthlinks Project 2000b) identified improved access to primary care as a high priority for improving health and disability outcomes for the people of Porirua. There were some concerns.

- For the number of people resident in Porirua, there are fewer GPs than average across New Zealand.
- Primary care issues of greatest concern were the high total cost of going to the doctor and getting medicines, particularly for people living in the Eastern and Western wards.
- Community groups and providers all wanted an easy way to get up-to-date information about health and disability services, and about staying healthy.
- Despite recent increases in services offered under a Māori kaupapa, community discussion identified the need for more services to be funded through Māori providers, and for mainstream services to become more culturally competent for Māori.
- There are few health and disability services provided by Pacific peoples in Porirua (Porirua Kapiti Healthlinks Project 2000b, xiii–xv).

The recommendations included:

- funding community health workers as part of primary health care teams
- funding an information and service co-ordination centre

- funding free and increased nursing services in general practices, public health and primary providers
- piloting the impact of substantially free general practice consultations, including after hours, and medicines for Community Services Card holders.

The Porirua Improving Access (PIA) project was subsequently set up with the aim of improving access to primary care for people living in Porirua, with a particular focus on reducing health inequalities for Māori, Pacific and low income or high need families. This involved the funding and development of a mobile primary care nursing (outreach nurses) and community health workforce, and improved access to GP consultations. This funding was given to existing service providers to allow an extension of services and was rolled out before PHOs were established. Additional funding was allocated for some training workshops provided by Whitireia Community Polytechnic.

Significant changes have occurred in the health sector during the time of the evaluation with the strengthening and further development of DHBs, the establishment of PHOs, and the greater level of scrutiny and reporting in many health contracts. In addition, the wider policy environment – Local Body Amendment Act, He Korowai Oranga (Minister of Health and Associate Minister of Health 2002), and the Reducing Inequalities Framework (Ministry of Health 2002) – was conducive to the development of the projects.

Five separate contracts with primary care providers were held under this project, namely:

- all four Porirua-based practices belonging to the Wellington Independent Practitioners Association (WIPA); these practices later became part of the Tumai PHO which was established in April 2003, but they continue to be affiliated with WIPA
- Porirua Union and Community Health Service (PUCHS)
- Pacific Health Service
- Maraeroa Marae Health Clinic
- Ora Toa Health Services – referred to collectively as Ora Toa.

All services undertook health education and health promotion activities as part of the PIA project, and provided some transport for patients to GP and specialist appointments and for picking up prescriptions. Other new services are briefly detailed below for each provider.

### **Wellington Independent Practitioners Association (WIPA)/Tumai**

WIPA/Tumai employed about three community access nurses, each of whom had a caseload of about 20 to 30 people. The criteria for referral were not rigid and included patients who had any problem with access including medication changes, newly diagnosed, poor attenders, or chronic illnesses with poor access to diagnostic or treatment services.

A part-time 0.5 full-time equivalent (FTE) team leader was employed. The team leader's main role was to work within a clinical setting with all Tumai primary care

nurses in Porirua to develop ways of ensuring that service outcomes were met which were, and to look for areas of improvement.

WIPA also used funding under this contract to provide weekly nurse-led clinics for high-priority patients. The nurses triaged patients with chronic conditions who were not otherwise accessing services.

PIA funding allowed WIPA/Tumai GPs to be available for consultations arising from nurse-led clinics so that nurses could see high-priority patients. Allocated hours across the GP workforce added up to eight hours per week (equivalent to 0.2 FTE).

### **Porirua Union and Community Health Service (PUCHS)**

PUCHS employed a community health worker (an occupational therapist) to develop and manage an organic garden activity one day a week. In late May 2003 PUCHS employed another community health worker, initially at 0.8 FTE and later at 1.0 FTE, to continue with the garden project and to develop health awareness, group education and support, and community development workshops.

PUCHS employed an additional primary care nurse, which freed up one of the more experienced nurses to spend time each week following-up patients who for various reasons were not easily managing their own care or who were failing to keep appointments.

PUCHS engaged a locum GP from February to July 2003 for four sessions a week – 400 extra hours in total. These additional hours reduced waiting times for patients and eased pressure on other GPs in the service. PUCHS at time of writing had also engaged another GP on a contract basis to work four days a week from 9 am to 2 pm (equivalent to 0.5 FTE).

### **Pacific Health Service**

The Pacific Health Service increased their community health worker hours by 0.5 FTE spread across their existing team of part-time community health workers. Staff reported that these additional hours allowed for increased planning time and more flexibility in responding to client needs. The community health workers worked as part of an integrated team with the nurses and social worker. Their main role was to provide health education information and support. Client advocacy took up a large amount of their time, especially translation and interpreting services, transporting clients, and working across agencies such as Work and Income New Zealand, Immigration and Housing New Zealand Corporation (HNZC) on behalf of clients.

The PIA funding also allowed for an additional Samoan nurse to join existing outreach nurses<sup>7</sup> therefore enabling the five broad population groups of Pacific peoples to be represented.

<sup>7</sup> Nurses and community health workers from this service were already working significantly in the community (eg, churches, houses and schools).

## **Maraeroa Marae Health Clinic**

PIA funding enabled Maraeroa to employ a full-time community health worker to do advocacy and support work such as health advocacy, Work and Income New Zealand advocacy, going with clients to food banks and transporting them to services. Because of increased demand for the service an additional 0.5 FTE worker was appointed in August 2004 funded by PIA. The service provided included intensive one-on-one support, often requiring many interactions or interventions with clients and their families.

No GP services were provided by Maraeroa, but a small amount of funding was initially negotiated with Waitangirua Health Centre for a GP clinic to improve access for those clients from Maraeroa not able to pay for a GP consultation. This initiative was not fully implemented for a range of reasons, and Maraeroa at time of writing were reviewing options for how best to advance low-cost access to GP services for their client base. The Waitangirua Health Centre was funded under the PHO access formula, and as such had reduced fees.<sup>8</sup> However, there was continuing concern at the cost of GP services for this community.

## **Ora Toa**

Ora Toa initially employed a community health worker, but as there was increased demand for clinical nursing services in the community, the funding was diverted into nursing services. The community health worker was then subsumed into the Ora Toa health promotion contract. The community health worker worked well with the PIA nurses, having contact on a daily basis and going together on home visits.

Project funding had enabled Ora Toa to employ outreach nurses in the Cannons Creek, Takupuwahia and Mungavin Avenue clinics. The expanded services include nurse triage, home visits, tracking non-attendance, tracking hard-to-reach patients, nurse specialist clinics, and improved co-ordination with a multidisciplinary approach. The nurses played a strong advocacy role with specialist services and often attended outpatient clinics with patients. Nurse-led clinics were starting to focus on prevention with women's health, asthma and Well Child clinics being offered by Ora Toa.

Funding under this contract enabled Ora Toa to employ an extra GP in their Cannons Creek clinic, and waive patient costs for follow-up visits and prescription-only fees. Two evening clinics were operated in Cannons Creek from PIA funding.

## **The role of Porirua ICAH in PIA**

PHLT saw their role in the project as facilitating community consultation as well as advocacy for community voices. They progressed the project through the developmental phases of community consultation, facilitation with providers and funders to influence purchasing priorities, informing the scope of the project, and reflecting community needs. As the project had progressed, providers 'got on with the job' and PHLT had little direct involvement with PIA after this time.

<sup>8</sup> Fees varied between \$20 to \$22 in this period for a normal consultation for adults.

Most providers described the role of PHLT as 'keeping talking to the community', ascertaining community needs and advocating these on behalf of the community. However, there were some tensions at a provider level, with some saying they didn't see a role for PHLT 'in telling them how to do their job'. Differences were expressed about the need for the advocacy and communication role depending on the size and strength of the provider, with the larger providers not requiring the role, while smaller ones appreciated it.

The Ministry of Health and Capital & Coast DHB strongly acknowledged PHLT's advocacy role and saw a need for an ongoing process of representing a community voice. However a view was expressed by one funding informant that PHLT could have been more proactive in this advocacy and facilitation role.

### **Evaluation methodology**

The Ministry of Health contracted the Public Health Consultancy to undertake the evaluation of the ICAH projects in June 2001 and related subprojects (PIA and Otaki Community Health Worker projects). A new contract was signed in July 2005 to do a further round of data collection for the PIA and PHICS project only, covering the period from July 2004 to June 2005.

The overall objectives of the ICAH evaluation also formed the primary objectives for the evaluation of the PIA (as well as the PHICS and Otaki Community Health Worker projects). Specific research themes were teased out during the baseline evaluation.

- Has the PIA project had (or is it likely to have) a positive impact on health and disability outcomes?
- Has the PIA project had (or is it likely to have) a positive impact on health and disability outcomes for population groups experiencing worse health outcomes in the communities involved?
- Is the PIA funding allowing for innovation or changes to practice?
- How do the Services to Improve Access and PIA funding streams or service components interact?
- Is the PIA project reducing barriers to access?
- What changes have occurred in the workforce as a result of PIA?
- How does the work under PIA reflect integration or co-ordination or both?
- How has the infrastructure of the providers (such as access to facilities and cars) helped or hindered their ability to provide services and be innovative?
- What does workforce development involve?
- How effective has the Whitireia training been?
- What are the pros and cons of the PHICS components?
- What have been the key critical success factors in implementation of the projects?
- What role did the context play in the success or otherwise of these projects?

The evaluators used an input–outcome model to evaluate the PIA project to help identify and prioritise data to be collected for the evaluation. The intention was to use the information collected on primary care use and ambulatory-sensitive hospitalisations to develop a picture of access to care, and to assess the appropriateness of the use of services.

Use of primary care services is a key intermediate outcome because there is evidence that good engagement with appropriate and effective primary care services enhances health outcomes for populations, especially those experiencing worse outcomes initially (Van Norren et al 1989; Crampton et al 2004). Therefore data were collected on use of GPs, community nurses and community health workers. This was analysed (where possible) by ethnicity, gender and socioeconomic position, over the duration of the evaluation.

Where data were readily available, preventive and primary care intervention data such as immunisation rates, screening rates and diabetes checks were also collected and analysed (again by ethnicity, gender, age and socioeconomic position) over the duration of the evaluation. All intermediate outcomes data for Porirua were sourced from Capital & Coast DHB via quarterly monitoring returns as part of contract obligations. The evaluators worked in collaboration with staff at the DHB, sharing knowledge and resources.<sup>9</sup>

Variables excluded from the analysis include prescribing, referrals to outpatient specialist services and laboratory services. Routinely collected pharmaceutical data do not include patient domicile (only the domicile of the provider), and so it was not possible to determine NZDep for patients. Also, it was not feasible to assess the uptake of pharmaceuticals (the proportion of prescriptions presented but not collected). Data were not available from Capital & Coast DHB for outpatient specialist consultations. The research team considered that analyses of overall rates of prescribing and diagnostic tests would not provide relevant information for the evaluation.

The input–outcome model identifies ambulatory-sensitive hospitalisations as a way of monitoring the longer-term outcomes of the project. Ambulatory-sensitive hospitalisations are hospitalisations among those aged 0–74 years that are potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary health care setting (such as vaccine-preventable diseases, early recognition and excision of melanoma, and effective blood sugar control in people with diabetes). Avoidable and ambulatory-sensitive hospitalisations have been used in a number of countries to monitor the effectiveness of primary care and equity of access (Bindman et al 1995; Fleming 1995; Blustein et al 1998; Crampton et al 2000; Majeed et al 2000; Falik et al 2001; Kozak et al 2001; Victorian Government Department of Human Services 2001; Niti and Ng 2003; Oster and Bindman 2003). Analyses are usually

<sup>9</sup> The 2000 Porirua and Kapiti reports used primary care data that were regularly collected by Health Benefits Limited from claims for GP visits (General Medical Services). These data were useful in these reports because they enabled comparisons of the different areas, identifying matters that are now being addressed in the projects. For the evaluation, though, the evaluators decided that it was not appropriate to use the HBL GMS data in the evaluation because they do not capture patient information (addresses, ethnicity) that is crucial for the analyses, they do not capture reasons for the visits, and the data are incomplete because they report only on subsidies claimed, not on all visits.



carried out at a national or state level. Differences between socioeconomic and ethnic groups in ambulatory-sensitive hospitalisation rates have been analysed in some instances.

The purpose of analysing ambulatory-sensitive hospitalisation rates in Porirua was to set up an approach to monitoring changes. The aims of the analysis were to:

- provide a basis for ongoing monitoring of changes in social gradients in ambulatory-sensitive hospitalisations in response to the ICAH interventions
- establish a baseline with which to compare future rates of ambulatory-sensitive hospitalisations
- help evaluate equity of access to primary care and hospital services.

Ambulatory-sensitive hospitalisation data were purchased from the New Zealand Health Information Service for Porirua.

There were limitations inherent in both sets of data which influence interpretation of the findings. The evaluation relied heavily on data collected for contract-management purposes by Capital & Coast DHB. The main reasons for using Capital & Coast DHB data were to reduce the reporting burden on the providers and improve comparability of data between providers participating in the project.

Capital & Coast DHB and providers have worked intensively to improve the quality of use data and for many providers this involved upgrading equipment and upskilling staff. Before the PIA project there was no systematic collection of nursing outreach or community health worker data. This project has provided a means for measuring this activity in a transparent manner. All providers agreed to the collection of these data and business rules around it for consistency.

In interpreting use data it is important to note that PIA funding commenced in November 2002, and capitation funding to Access-funded PHOs commenced on April 1 2003. From April 2003, both funding streams were in effect, and it becomes very hard to make judgements about the independent effects of either funding stream.

Nursing informants and data inputting technicians had commented that nursing outreach data and some of the community health worker activity may be under-reported as it does not fit with an invoicing approach (PMS), which had been how much of the primary care data have been collected previously.

## Findings

Funding for PIA and the PHICS came from Capital & Coast DHB. Table 4 shows the funding package for PIA, including the information component (PHICS). These figures have been reconciled with the contracted amounts for each provider. Over the three years from 2002/03 to 2004/05 a total of \$3,213,318 (excluding GST) was invested in the project. Of this, nearly 38 percent went to the Tumai/WIPA affiliated practices in total over all years, and 47 percent was split across the other PIA providers. The remaining funding was allocated to PHICS and Pro Med.

**Table 4:** PIA and PHICS funding package and service components

Provider	Service components	Total for 2002/03	Total for 2003/04	Total for 2004/05	Total all years
WIPA	Mobile nursing GP visits Practice nurse additional subsidies Workforce development	309,976	464,967	473,252	1,248,195
Ora Toa	Mobile and triage nursing GP visits Community worker Workforce development	151,589	227,384	247,384	626,357
PUCHS	Mobile nursing Community worker Workforce development	141,912	212,868	232,868	587,648
Maraeroa Marae	Mobile nursing Community worker Workforce development	43,363	65,044	85,045	193,452
Pacific Health	Community worker Workforce development	3,822	61,156	77,333	142,311
PHICS	Information service project	444,444			444,444
Pro Med	Pharmaceutical subsidies	22,222			22,222
Total (excluding GST)		1,117,329	1,031,419	1,115,882	3,264,629

Nurses and community health workers across all services routinely contributed voluntary hours to the project. This voluntary time consisted of being called out or taking client phone calls after hours, being stopped for advice 'on the street', attending meetings at lunchtime or after work, working through lunch and tea breaks, doing paperwork outside work hours, and studying for professional development. None of this time was recorded. In some cases patients were given the nurse's home phone number. Although some services had a time-in-lieu policy, extra hours were often not claimed.

Some positions such as outreach nurses and community health workers were funded out of a combined general pool of primary care funding. This enabled among other things full-time positions for nurses and community health workers as opposed to the part-time workforce that existed for some of the smaller providers before PIA funding. What was evident was that the combined amounts available to providers allowed a range of initiatives to be implemented and without PIA funding a decrease in the number and scope of interventions would be inevitable.

The PIA project and Services to Improve Access initiatives of PHOs were funded separately, although they were intended to be complementary and duplication of funding was avoided. The early stages of the PIA project preceded the development of PHOs and of the Services to Improve Access fund. Participants felt that the PIA initiatives allowed for increased diversity in approaches compared with previous approaches. The effect of Services to Improve Access funding on diversity of approach was not a focus of this evaluation and therefore it is not possible to compare the two funding streams in this respect.

### **Service development**

The service components funded through PIA were spread unevenly (per provider) across the five providers but collectively covered all aspects of service delivery originally intended for the project. Each provider employed strategies that were intended to reduce the barriers to primary care as stated in the input–outcome model, these barriers being financial, information and transport related. Each provider also had aspects of improving practice quality included in their contract.

All providers spoke about the growth in the patient demand for access services over time because of increasing community awareness. What was noticeable during this period was the stable nature of the PIA workforce. However in 2005, employment of some workforce categories of appropriate staff was still a problem for some providers. There were gaps in the Pacific and Māori nursing workforce, and the GP workforce. It was apparent that the provision of funding in itself was not enough to secure the appropriate workforce in these areas. There continued to be a significant amount of goodwill demonstrated by both staff and management of providers to ensure access needs were met. For example, weekend and evening work was often done voluntarily and staff attended training in their own time.

During the implementation of the PIA project a number of factors caused delays. These factors included:

- the previous competitive environment between providers
- the previous underfunding of providers relative to the high level of health need and demand for services
- lack of strong working relationships between providers in Porirua
- ongoing restructuring of the health sector which resulted in changes to some of the key health agencies involved in the development of the projects
- the need to carry out further community consultation to be clear about community needs and manage community expectations
- the lengthy process leading up to contract negotiations also delayed implementation
- inability to find suitable staff.

As at June 2005 all the above factors had been resolved. Providers were co-ordinating services between themselves and between the two PHOs. Community engagement had been strengthened through specific projects such as toiora; all contracts had been signed off; and the workforce had been stable over the previous 12–24 months and was increasing in confidence.

### **More appropriate health service provision**

Providers identified benefits for themselves from the projects, including: having enough time to spend with clients to do their job well; having time to build relationship with their clients and within the sector; and having the ability to see clients in the community which allows a better understanding of their health needs. Providers reported that clients were starting to change the way they interacted with services and that the clients had raised expectations, for example of access to outreach and after-hours services.

The outreach mode of service delivery which characterises the PIA and Otaki Community Health Worker projects was reported to have improved access for hard-to-reach clients in several ways. The advantages for outreach staff (nurses and community health workers) of working in the community included being able to talk to people who have not previously accessed services, resulting in the development of relationships with clients. Nurses and community health workers were able to spend an intensive amount of time at a family level providing advocacy, translation or transport services for clients. Working with patients in their home had enabled nurses and community health workers to observe first hand the broader determinants of health and to access support and advocate for the family to change some of the determinants. Working from a family perspective in the home or community provided opportunities to talk to other family members about a range of health issues.

Anecdotal evidence was provided of direct successes in terms of improved access to services, such as reduced GP waiting times and increased flexibility of hours (evening clinics or locum fill-in over lunch hours), which led to a decreased after-hours attendance (as people were being seen during working hours), and noticeable improvements in access for the hard-to-reach with greater frequency of visits and increased phone consultations. Providers reported that patients were now starting to view primary care services differently. In particular, seeing the nurse was viewed as a key part of primary care and having increased choice about how and where services were delivered.

High-needs populations and those experiencing poorer health outcomes such as Māori and Pacific were accessing additional services under the PIA projects. Providers were able to identify a Tiriti o Waitangi framework as part of their intervention logic. Organisations such as Ora Toa and Maraeroa that specifically serve predominately Māori communities have been able to build capacity and develop services to improve access for Māori through the PIA project.

The 2004 baseline report identified difficulties and weaknesses with the PIA project including role confusion, lack of strategic direction, lack of formal arrangements for teamwork between services, lack of data collection against which to measure change, and failure to meet community needs or engage the community (eg, the community garden and quarterly workshops). The 2005 interviews noted a more confident approach with the interventions therefore reducing some of the role confusion.

### **Better practice in primary care**

Collective action across the PIA workforce, and between participating providers, developed over the period of the evaluation. All providers have worked to establish links relevant to their client base. Many links have been made within the health sector and externally. Some of the PIA providers have developed intersectoral partnerships and continued to build on these over the duration of the project.

There had been a notable increase in the knowledge and confidence of the workforce involved with this project. All providers have attended workshops funded by the PIA project and run through Whitireia Community Polytechnic. Workforce development was ongoing and had the commitment of both staff and employers. A number of staff interviewed commented that they received significant support from their organisations both in terms of training but also the trust placed in their ability to implement a range of interventions aimed at improving access.

The ability of providers to describe clear intervention logic developed greatly during the course of the project. At the outset there was no clear and shared understanding of intervention logic. However, by 2005 all participants acknowledged the wider determinants of health and the need to address these if health outcomes were to be improved.

### **Outcomes**

A number of intermediate outcomes were selected for evaluation on the basis that they directly affected health status and could also be influenced by primary care interventions. All intermediate outcomes data were sourced from Capital & Coast DHB via quarterly monitoring returns as part of contract obligations. Ambulatory-sensitive hospitalisations data were analysed as an indicator of health outcomes.

Because other primary care initiatives, such as the development of PHOs, have also affected primary care use rates and ambulatory-sensitive hospitalisations, not all changes documented below can be attributed to the PIA projects. This analysis looks at primary care improvements overall.

## GP and nurse use

Primary health care use rates were measured over a relatively short period and largely serve the purpose of providing a baseline for future monitoring. It should be noted that the collection and use of primary health care use data in Porirua is a relatively recent activity, and hence there is a limited data context in which to understand these findings. In the absence of longer-term trends data at this stage only preliminary observations can be made. Interpretation of these observations is made additionally challenging because of the difficulties of separating the effects of the PIA and Services to Improve Access funding streams.

Two important outcomes that were expected as a result of PIA funding were a) increased primary health care use rates for all groups, especially Māori, Pacific and people living in deprived areas, and b) a decline in the rate of ambulatory-sensitive hospitalisations. In the case of GP and nurse use, increased rates did occur, but not at the expected time, and not in all PIA practices. In the case of ambulatory-sensitive hospitalisations, rates remained reasonably steady during the period when the new funding streams were introduced. This halted previous increases in rates.

In terms of combined GP and nurse use rates, ICAH funding related to primary care access commenced in November 2002, and capitation funding to Access-funded PHOs commenced on April 1 2003. Once both funding streams were in effect, it becomes very hard to make judgements about the independent effects of either funding stream.

The main findings concerning GP and nurse use rates were as follows:

- There was a marked increase in total GP and nurse use in the quarter commencing 1 April 2004 in six of the practices with Improving Access funding (the Ora Toa practices, PUCHS, Waitangirua and Dr Gaus).
- GP and nurse use rates for Māori and Pacific peoples were somewhat higher in some of the practices (Ora Toa practices and PUCHS) which received PIA funding compared with those which were not receiving this funding.
- In the Ora Toa practices and PUCHS, GP and nurse use rates for the Other ethnic group were higher than the rates for Māori and Pacific.
- In the Ora Toa practices and PUCHS, GP and nurse use rates for the Other ethnic group were higher than they were in practices not receiving Improving Access funding.

**Figure 1:** Quarterly total use rates (GP, nurse), by practice – excluding MeNZB consults

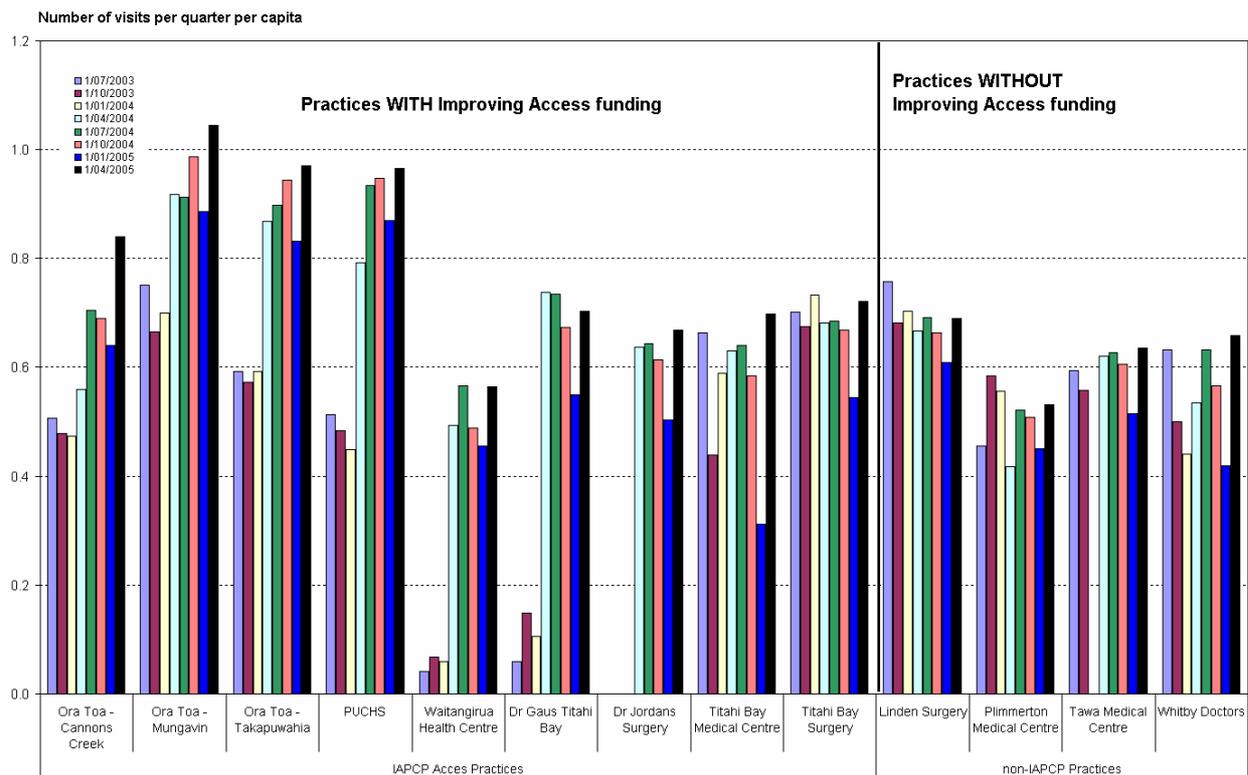
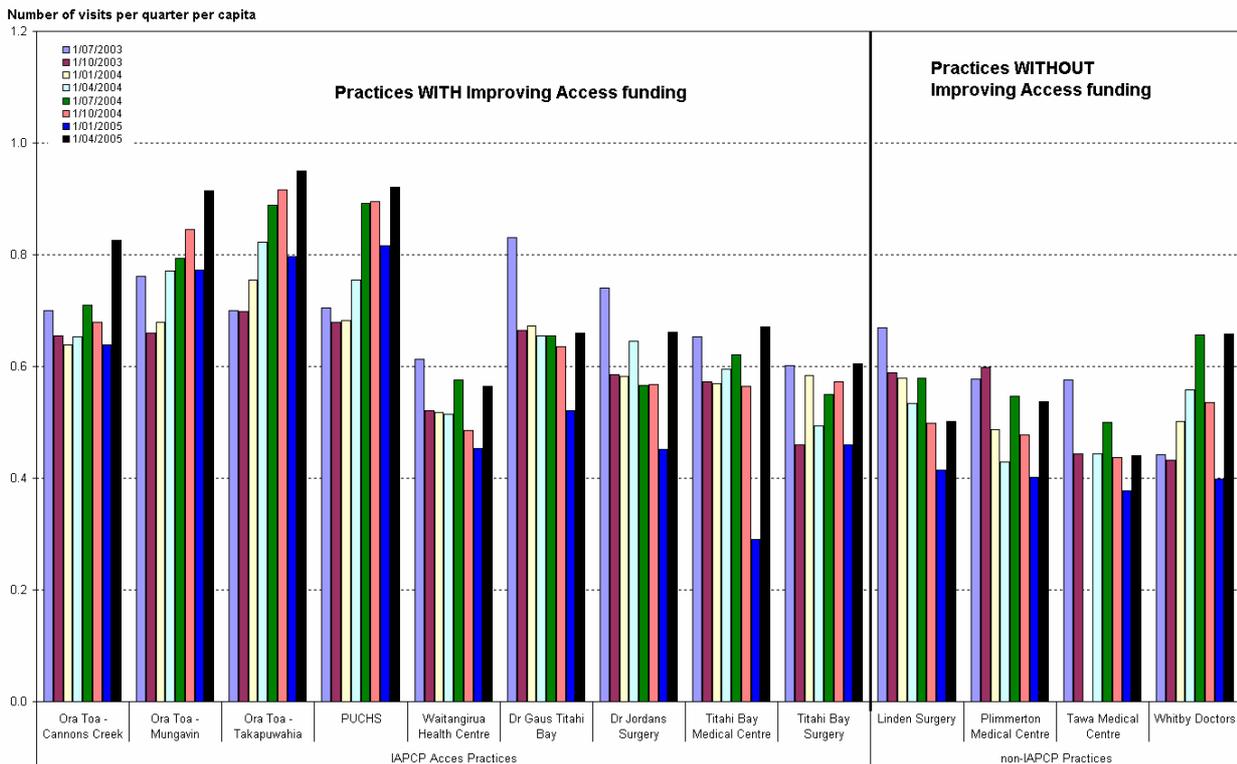


Figure 1 above shows the combined use rates for GPs and practice nurses. The most notable aspect highlighted by the chart was the marked increase in total use in the fourth quarter (commencing 1 April 2004) in six of the practices with Improving Access funding (the Ora Toa practices, PUCHS, Waitangirua and Dr Gaus's). Use rates in practices not receiving this funding stream were relatively stable by comparison, and in the latter quarters were lower than the rates in the Ora Toa practices, PUCHS and Dr Gaus's. Figure 4 demonstrates an increase in use in the April 2005 quarter consistent with the roll-out of the MeNZB campaign.

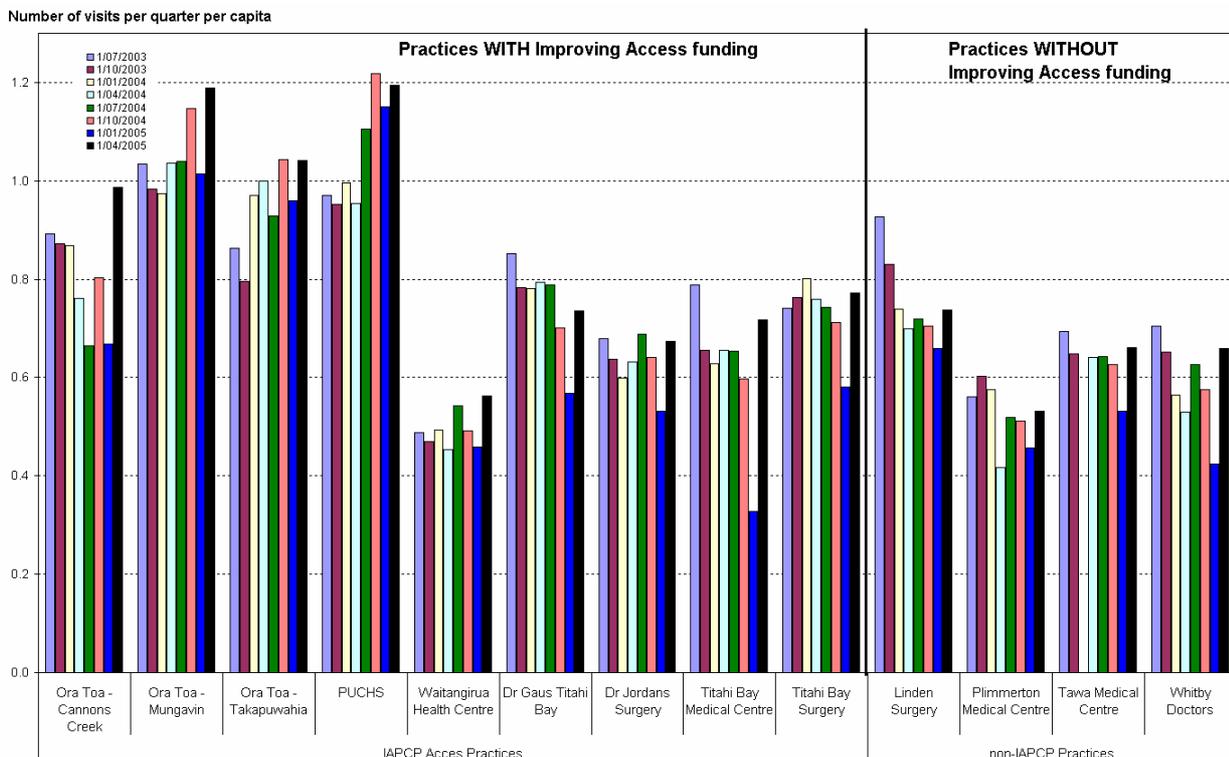
The use differences between practices may partly reflect the greater tendency for the Health Care Aotearoa-affiliated practices (such as Ora Toa and PUCHS) to make use of and record nurse consultations than was the case in traditional practices (such as Dr Gaus's). The tendency to use and record nurse consultations is partly driven by the greater reliance on capitation-funding mechanisms in Health Care Aotearoa-affiliated practices and is partly driven by an organisational commitment to make greater use of nurses. It seems likely, judging from the data, that there were use-data capture problems during the first three quarters in the Waitangirua and Dr Gaus practices. For these reasons comparisons of use within a practice over time may be more reliable than are comparisons between different types of practice. Both the level of use and the increase in use over time are more marked in the Health Care Aotearoa practices than the non-Health Care Aotearoa practices (regardless of Access or Interim status). This may reflect organisational culture more than it does the Access/Interim distinction. These comments and qualifications apply also to the following observations on use by ethnic group.

**Figure 2: Quarterly total use rates (GP, nurse), by practice – Māori and Pacific peoples**



\* Excluding MenZB consultations.

**Figure 3: Quarterly total use rates (GP, nurse), by practice – other ethnic groups**

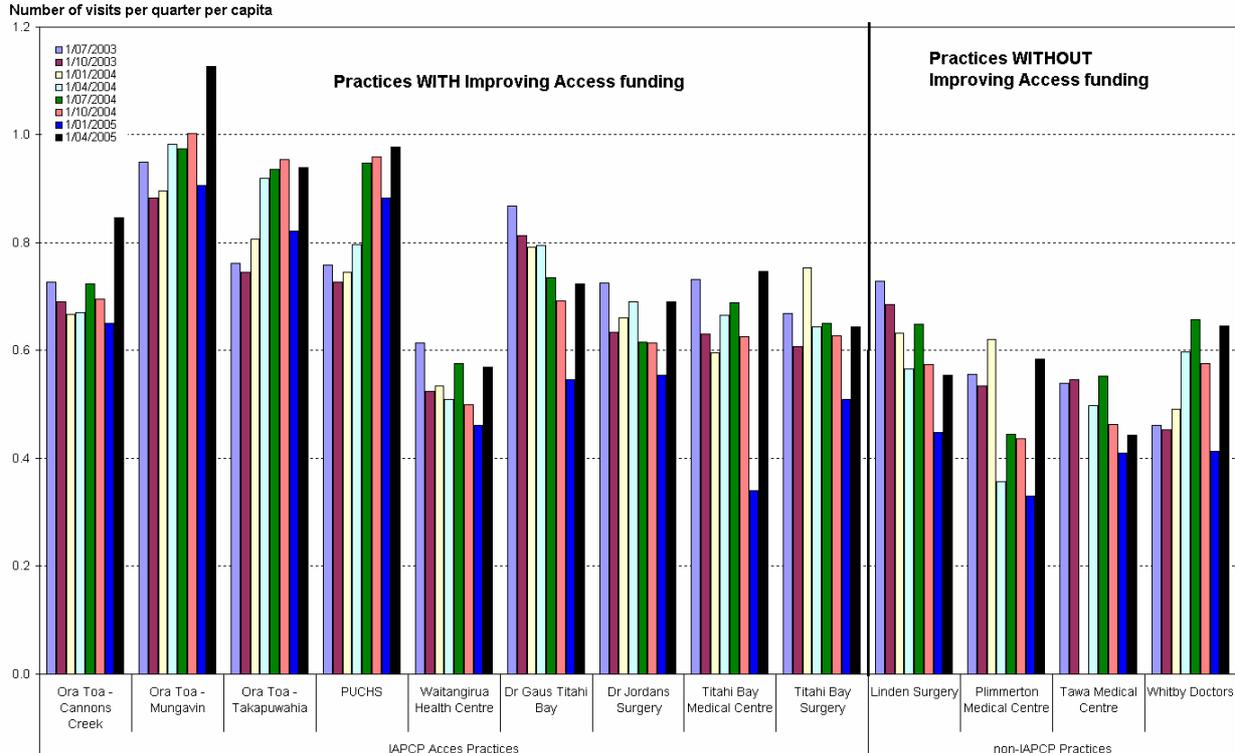


\* This group includes all non-Māori and non-Pacific people; excluding MenZB consultations.



When analysed by ethnic group, a difference was apparent in the use rates for Māori and Pacific between Ora Toa practices and PUCHS (which received Improving Access funding) and practices which were not receiving Improving Access funding (Figure 2); in the former practices rates (in the later quarters) were generally greater than 0.8 visits per quarter per capita, and in the latter practices they were generally fewer than 0.6 visits per capita per quarter. In the Ora Toa practices and PUCHS, use rates for the Other ethnic group were higher than the rates for Māori and Pacific peoples (Figures 2 and 3). In the Ora Toa practices and PUCHS rates for the Other ethnic group were higher than they were in practices not receiving Improving Access funding (Figure 3). There was a suggestion of a downward trend in use for both the Māori and Pacific group and the Other group in some of the non-PIA practices (Figure 3).

**Figure 4:** Quarterly total use rates (GP, nurse), by quarter, by practice – NZDep quintile five



\* Excluding MeNZB consultations.

The pattern for NZDep quintile five (Figure 4) was intermediate between that of the Māori and Pacific peoples group (Figure 2) and that of the Other ethnic group (Figure 3).

## Diabetes detection and control

Diabetes annual check data are an indicator of attempts to track people with diabetes who have had their diabetes identified and have received an annual check. There may be people with diabetes detected who have not had an annual check, hence the 'annual check' data have some limitations. The predicted number for the district or for a PHO was based on a model, developed by the Ministry of Health in 2002, that used national disease prevalence data. This report focused on type 2 diabetes since this was mainly monitored and managed at a primary care level.

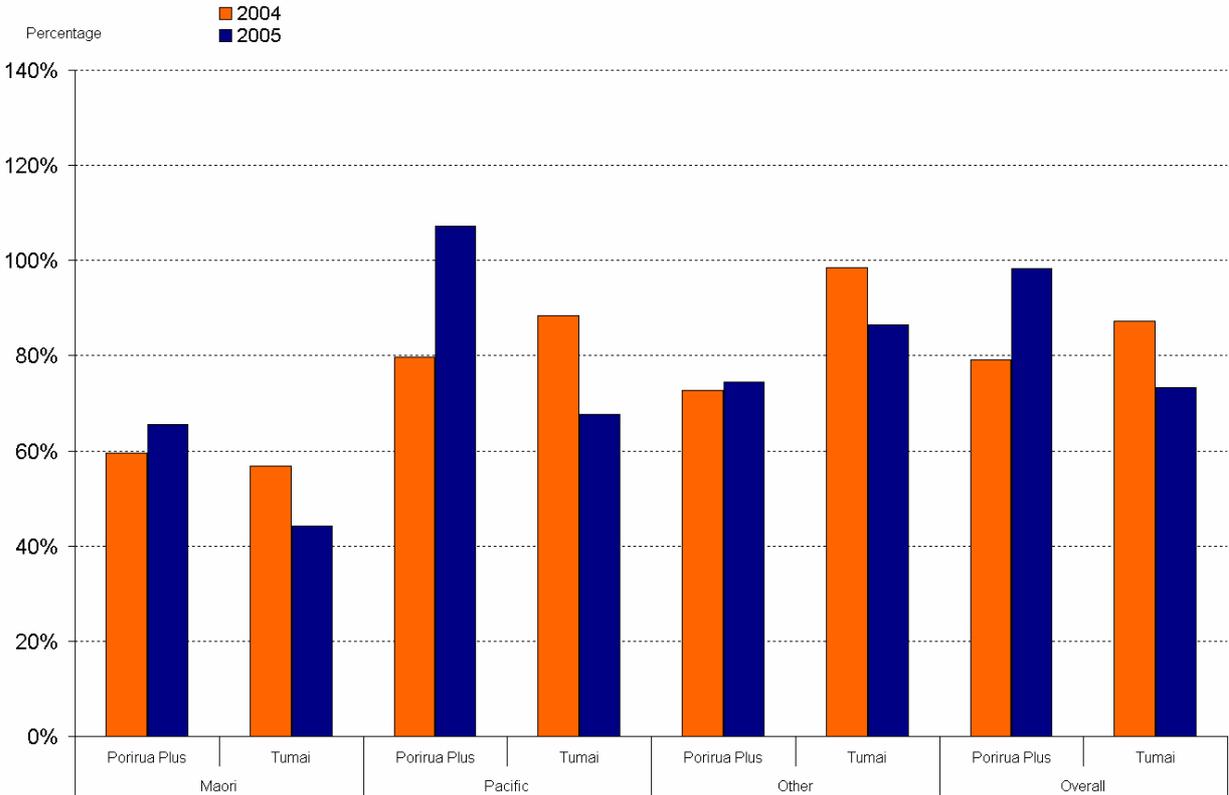
Diabetes 'case management' was the terminology used nationally to describe the level of poor diabetes control. An HbA1c greater than 8 percent reflects relatively poor diabetes control, requiring active 'case management'. In this analysis, we have chosen to report relatively good blood sugar control (HbA1c less than 8 percent) as it reflects the outcomes that the Capital & Coast DHB was aiming for. The results for 'control' are affected by new diabetics being identified and joining the programme. The percentages of 'control' and retinal screening were calculated using the number of annual reviews as the denominator.

Figure 5 shows the number of people with diabetes in each PHO who received an annual check, expressed as a percentage of the predicted number of people with diabetes. The relatively high percentage overall reflects a high rate of identification against the model. Overall case detection was lowest for Māori (Figure 5). These Porirua data compare favourably with national figures from 2004 derived from the national Get Checked Programme, where 36.9 percent of Māori and 65.5 percent of non-Māori had access to the Programme. These percentages are calculated as proportions of people estimated to have diagnosed diabetes (Ministry of Health 2006).

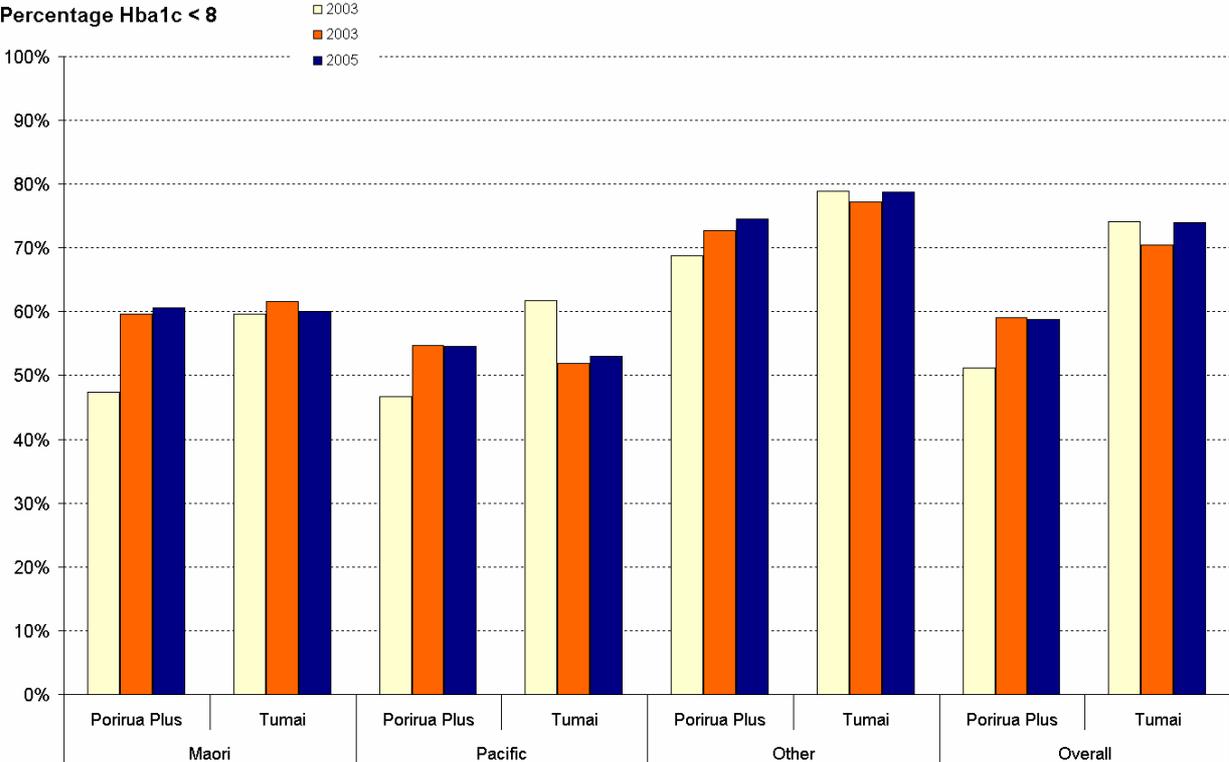
Overall diabetes control (HbA1c < 8 percent) was poorest in the Pacific group (Figure 6). The Porirua diabetes control data are comparable with national figures from 2004 derived from the national Get Checked Programme, where 59.7 percent of Māori and 73.2 percent of non-Māori had HbA1c < 8 percent (Ministry of Health 2006b).

Retinal screening rates were similar in all ethnic groups (Figure 7).

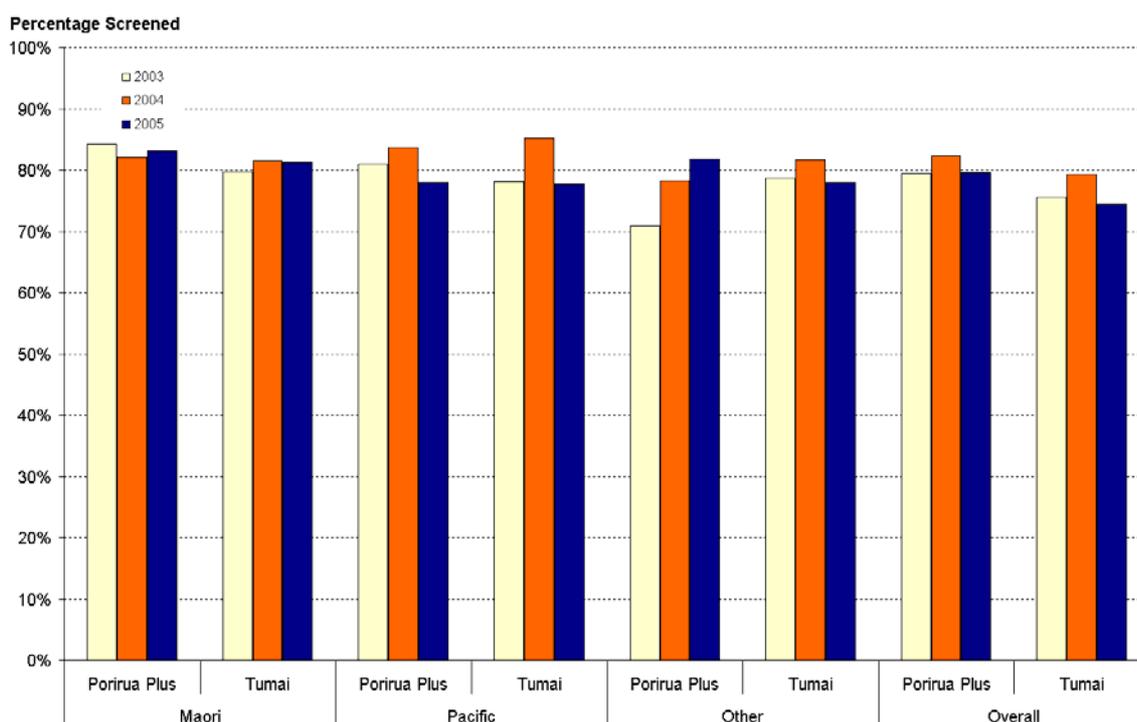
**Figure 5:** Type 2 diabetes case detection – annual reviews completed vs Ministry of Health diabetes prediction



**Figure 6:** Diabetes control by ethnicity



**Figure 7:** Diabetes retinal screening



### Emergency department use

After-hours use data were not available because data were collected at the After Hours Medical Centre, which was not a participant in the PIA project. Furthermore, the practice management system used by the After Hours Medical Centre was a non-standard GMS claiming or payment system that did not allow data extraction in the format required by the ICAH evaluation. This clinic was closed from 1 July 2005 and after-hours services were moved to Kenepuru Accident and Medical Centre at Kenepuru hospital.

Attendances at both Kenepuru and Wellington hospitals show that:

- emergency department use rates increased between 2004 and 2005 for Māori, non-Māori non-Pacific and the under fives, but remained relatively stable for Pacific peoples
- rates were consistently higher for males than for females.

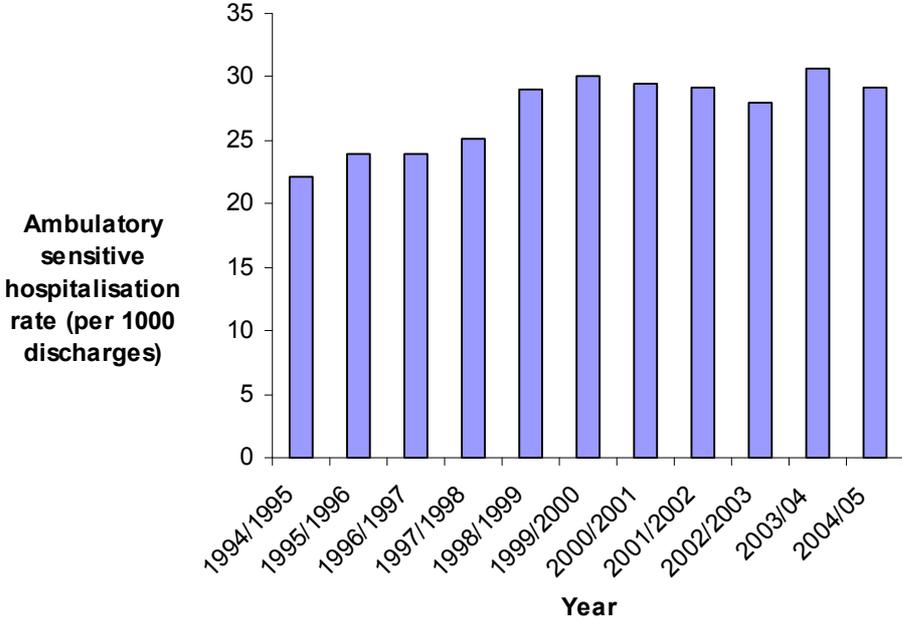
### Ambulatory-sensitive hospitalisation

For Porirua, ambulatory-sensitive hospitalisations increased between 1994/95 and 2004/05 (Figure 8). There were much higher rates of ambulatory-sensitive hospitalisation for people living in the most deprived areas compared with those living in the least deprived areas (Figure 9), and for Māori and Pacific peoples compared with non-Māori and non-Pacific peoples (Figure 10). These findings suggest that: a) Māori and Pacific peoples, and people living in socioeconomically deprived areas, have greater need for hospitalisation than those living in less deprived areas; b) at a local level, the public hospital system responds, at least in part, to the higher level of need

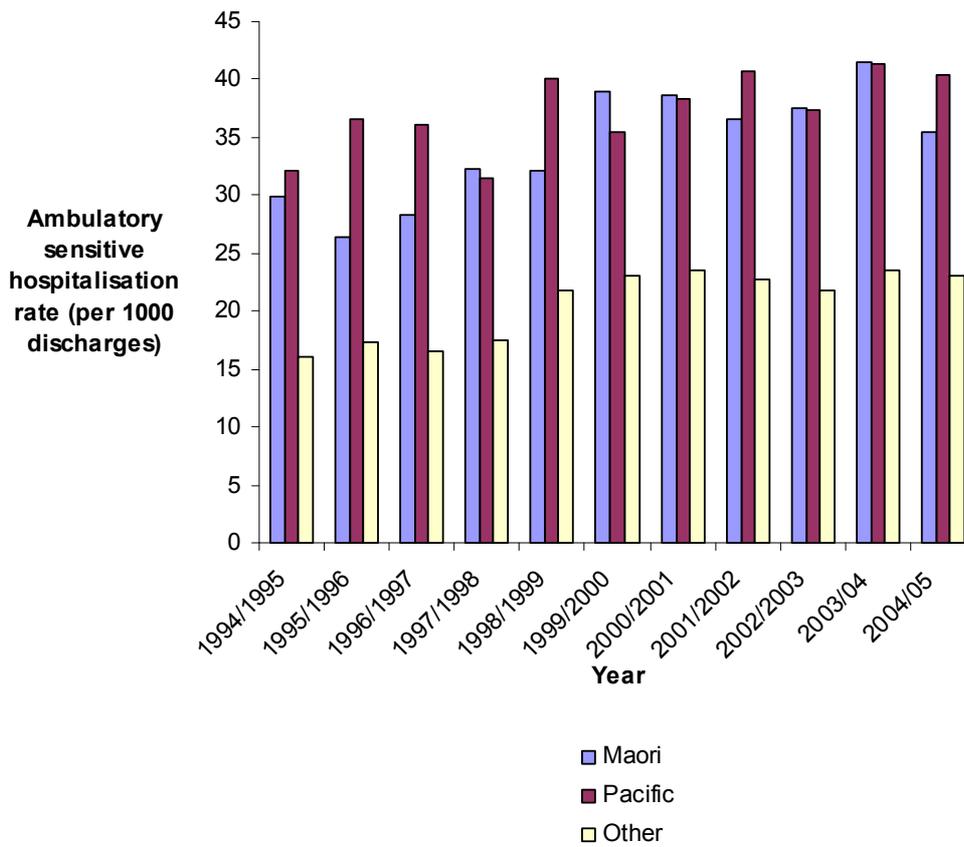
amongst people living in socioeconomically deprived areas; and, c) primary care services face considerable challenges in reducing inequities in access to services, and in service provision, that result in a pronounced socioeconomic gradient in ambulatory-sensitive hospitalisations.

The trends demonstrated in Porirua mirror to some extent national trends in age standardised ambulatory-sensitive hospitalisation rates. Nationally there was a trend for increasing rates between 1988/89 and 1995/96, following which rates stabilised. In Porirua the same increase in rates was observed up until 1998/99, following which rates stabilised (Ministry of Health 2005). The very large discrepancy between Māori and Pacific peoples' rates and non-Māori and non-Pacific peoples' rates observed in Porirua is also mirrored in national data.

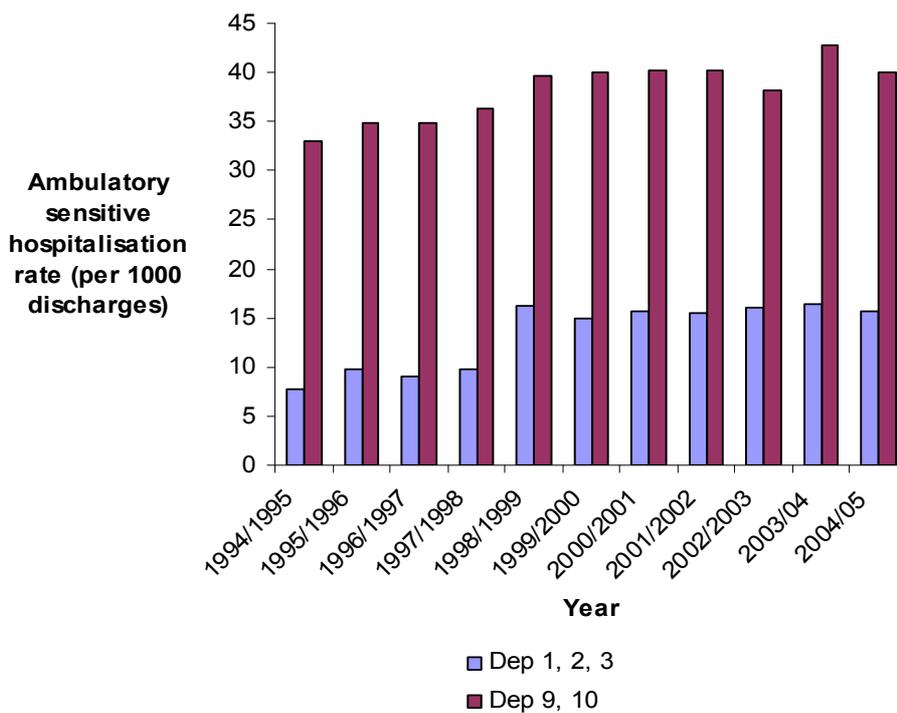
**Figure 8:** Ambulatory-sensitive hospitalisations (0–74 years), for Porirua City, 1994/95–2004/05



**Figure 9:** Ambulatory-sensitive hospitalisations (0–74 years), by NZDep groups, 1994/95–2004/05



**Figure 10:** Ambulatory-sensitive hospitalisations (0–74 years), by ethnic group, 1994/95–2004/05



## **Critical success factors**

The key critical success factors identified in the evaluation were leadership, experience and workforce development. The leadership provided by the Ministry of Health and the DHBs had been vital in establishing this project. The willingness to work closely and collaboratively with providers to develop the necessary reporting structures was just one aspect of this. Strong community leadership had also been exhibited by providers who were willing to work collaboratively and show initiative. There were some good examples of collaboration in the community, although some informants report that there was a need for collaboration to be developed further.

Those agencies who were already experienced in this work were in a position to extend the vision of community engagement to include more innovative approaches to improving primary care access. However, some of these approaches were not immediately successful and required reworking.

The provision of funding for workforce development had been important in fostering interprovider relationships and had provided an opportunity for self-directed training geared specifically to the primary care workforce needs.

## **Implications**

The PIA project was a government initiative, supported from the outset by the Ministry of Health. Results of this evaluation indicated that the initiative has been successful in fostering innovation and reducing barriers to access. The main implication for the Ministry of Health is that if this style of primary health care provision is to be sustained, there is a need for ongoing dedicated funding which allows for flexibility of approach.

Capital & Coast DHB had made a large investment in this project in terms of commitment to the kaupapa, intensive management of the contracts and improving the quality of data provided by way of quarterly monitoring reports. The foundations of this initiative have been laid, and its maintenance would be relatively easy given adequate funding. It is important to note that there had been a deliberate approach to prevent any potential for double funding so all Services to Improve Access initiatives were additional to and separate to PIA services, staff and projects. The main implication for Capital & Coast DHB is that PIA funding would need to be sustained if this initiative is to continue.

There have been significant transaction costs for PIA providers with almost two years' lead-up time before contracts are signed, as well as major new management requirements for recruitment, reporting and participation in community consultation and feedback, and in the evaluation process. These additional requirements were largely unfunded. New staff were in place and providers were developing trust, familiarity and cohesion within and across providers and communities which are necessary for effective outreach work. Outreach had been successful in identifying more need and creating better links with the result of more demand on practice-based staff. There had been limited ability to expand, which is due to facilities, recruitment difficulties and the like. The gains made on the ground would be relatively easy to maintain, given ongoing funding.

## **Porirua Health Information Communication System (PHICS)**

### **Description**

The Porirua Health Information Communication System (PHICS) was funded as part of the PIA project with the aim of providing information on health and disability services to the general population, and supporting information sharing and links between services. The need for this had been identified by the Porirua health and disability plan (Porirua Kapiti Healthlinks Project 2000b).

### **Findings**

#### **Service development**

A total of \$444,444 was allocated to PHICS in the 2002/03 financial year. Healthlinks took responsibility for finalising the plan for PHICS, establishing the provider representative and community governance group, and recruiting a project co-ordinator to plan and oversee its establishment. An interim working party was set up to advise on the PHICS project. Healthlinks was able to mobilise various provider groups and community representatives within Porirua to gain a broad view on what was needed from a community perspective. Participants included tangata whenua, other local Māori, Pacific peoples, new settlers, social service providers, health providers, the Citizens Advice Bureau, WIPA, Capital & Coast DHB, and Porirua City Council.

A project co-ordinator was appointed for a three-month period in August 2002, and the PHICS Report and Plan was produced in December 2002. This document formed a proposal to Capital & Coast DHB for the establishment of PHICS, describing the preferred model of service delivery and including an establishment plan. The model was a multifaceted approach that interfaces closely with existing services, networks and infrastructures.<sup>10</sup> The system was designed to operate from a community location.

The PHICS project was aimed at contributing to improved health outcomes for those high-need consumers involved in these projects by providing information to support access to primary health care services. PHICS was to provide access to electronic and hard copy information and be accessible 24 hours a day, seven days a week by phone and website. The issue of access to information by people with no phone or transport was considered in the PHICS plan. A range of options were discussed for the dissemination of information.

In March 2004 the website was not operational and there had been delays in implementing the current business plan. Obvious tensions existed between the manager and some members of the advisory group. This compounded existing delays; for instance, the advisory group would not accept parts of the action plan put together by the manager in early 2004, and additional work was needed to meet governance requirements. In 2005 the funder identified that intensive management by the Porirua Healthlinks Governance Board and Capital & Coast DHB had resulted in the launch of the project in October 2004.

<sup>10</sup> The model is similar to that used by the Pathways project in Hamilton.



The PHICS advisory group<sup>11</sup> provided valuable guidance during project development. As a result, lessons learned from the early stages of PHICS have been integrated into plans for the future, specifically returning to the original vision of PHICS as community owned and present in the community. PHLT were facilitating discussions with a number of community groups to get feedback on how information could be better provided in the community, and were intending to send out 'foot soldiers' to talk to people in the community about their knowledge and experience of PHICS.

## Inputs

PHICS, launched in October 2004, included a website and an 0800 helpline.<sup>12</sup> These provided a 'physical presence' for PHICS in the community. A project manager was employed at the time. The project manager's tasks were to keep the website updated and looking 'right' for Porirua; to decide how to manage calls received by the helpline; and to look at how to ensure mobility of the information (how and where it could be provided in a community setting). By the time the project manager resigned in April 2005 PHICS was fully operational and the main ongoing tasks were maintenance of the website and receiving calls from the helpline. These tasks fell to PHLT staff.

The manager of PHLT identified strengths of the PHICS initiative in terms of the context and the concept. The contextual strengths included the parallel process of PHO development and strengthening of community consultation which supported information sharing activities in general. PHLT could refer 0800 callers to PHO contacts with confidence. The concept of PHICS itself was strong, despite teething problems, and it fitted well with other information-sharing strategies carried out by Healthlinks.<sup>13</sup>

The success of PHICS had yet to be formally evaluated, but anecdotal feedback suggests that there was growing awareness of the role of PHICS in the community. One example of community awareness was seen at a recent Defeat Diabetes hui where it was suggested by a hui participant that PHICS facilitate the gathering of key messages from the hui which could then be posted on the website.

Difficulties experienced by PHICS include: the early departure of the project manager, fragmentation of contracting for PHICS and PHLT information sharing activities, and the existence of a gap between what PHICS provided and the original vision of a community-owned service.

<sup>11</sup> A subcommittee of the PHLT governance board.

<sup>12</sup> The 0800 calls are received by PHLT staff and referrals are made as appropriate.

<sup>13</sup> Health information sharing is one of the objectives in the Healthlinks 2005–2006 Annual Plan. Activities planned for 2005–2006 included publication of an electronic bulletin *Allpoints*, monthly community forums, and articles published in local newspapers.

The early departure of the project manager did not cause a problem with project implementation as the website and helpline were fully operational at the time of the project manager's departure. But the job of website maintenance then fell to the PHLT staff, and other commitments made it difficult for them to fulfil these requirements. This meant that, as at October 2005, there were some gaps in the information available with new material not being included and some material out of date. At the time of interview, in November 2005, PHLT were writing a job description for the appointment of a website technician to carry out maintenance functions and ensure mobility of information.

The contract for PHICS was separate from the contract for PHLT (and its information-sharing activities as mentioned above). This fragmentation means two sets of contract relationships and two sets of reporting requirements for information sharing. Ideally the PHICS component would be seated under the information-sharing activities in the PHLT contract and both would be funded as one. To some extent, PHICS was also separated from the reality of the information-sharing *process* which was as much about relationships and trust as about providing a mechanism such as the website and helpline. Increasing community ownership and community presence of PHICS would help bring it closer to the original vision from which PHICS began.

The PHICS advisory group met in September 2005 and identified that there was a gap between what PHICS provided and the original vision of a community-owned service. Community ownership was always supposed to be a critical component of the PHICS so that information would be delivered in places where people meet (outreach) such as libraries, churches and schools. There would not be a requirement to 'come to a building' to get the information. The core of PHICS wasn't originally about the website or 0800 number. As a result of the September meeting, increased emphasis had been placed on community ownership and this aspect was to be written in the job description for the website technician.

### **Outcomes**

PHICS had yet to be formally evaluated and data were not available to the evaluators on use of the services, although audits had been done by Capital & Coast DHB. The brief of this evaluation was to provide an update on progress with PHICS, and not to formally evaluate the service. However, the PHICS project appeared to be maturing and adding value to other information-sharing strategies in Porirua. The intensive management received from PHLT and Capital & Coast DHB has allowed PHICS to benefit from lessons learnt from early difficulties, and plan for improvements.

# Kapiti ICAH

## Development

As noted under the Porirua ICAH, the Kapiti project began jointly with Porirua. However following the development of Porirua and Kapiti Health and Disability Reports and Plans in August 2000 (Porirua Kapiti Healthlinks Project 2000a; Porirua Kapiti Healthlinks Project 2000b), the Porirua and Kapiti Healthlinks groups restructured so that each group could focus on the separate needs of its own community. In Kapiti, the Kapiti Community Health Group Trust (KCHGT), working with Te Āti Awa ki Whakarongotai and Ngāti Raukawa, took responsibility for the Kapiti Healthlinks work.

## Governance

Governance of the ICAH has been provided through the KCHGT which itself developed from the community reference groups set up to advise the Health Funding Authority in the late 1990s. The Trust's Board is made up of elected representatives of each of the wards of the Kapiti Coast District Council and an appointee of the Council, with provision for an additional three appointed members. The trust deed allows for representation from the three local iwi, although by iwi choice there has been a partnership approach rather than formal representation during the period of the evaluation.

A subcommittee (originally called the Steering Group, now named the Management Group to more accurately reflect their tasks) met monthly to support the ongoing work of the Healthlinks manager and executive assistant. The management meetings had an operational focus, and the Trust was kept well informed of the operational activities, including financial matters. The manager and executive assistant employed by the Trust worked to the annual plan, and progress and activities by the Trust were monitored against both the five-year strategic plan and the annual plan.

## Funding and funders

The Ministry of Health funding for the project for the 3½ years of the evaluation period was \$66,666 annually. In addition, the Trust has received an annual grant from the Kapiti Coast District Council. The 2003 funding from the Capital & Coast DHB acknowledged their role in PHO development and their contract to undertake fundraising for the enhancement of the Kapiti Health Centre.<sup>14</sup>

The Ministry of Health ICAH manager commented that the 'cost is tiny, the return is enormous' and regarded it as 'a cost-effective intervention in a well-off community'. Funding received is set out in **Table 4**.

<sup>14</sup> Enhancement includes such things as landscaping, decoration, and outdoor furniture.

**Table 5:** Funding, Kapiti Community Health Group Trust (KCHGT), ICAH project

	Year ended 30 June				Total 3.5 years	
	2001 (half-year)	2002	2003 budget	2004 contracted	Excluding GST	Including GST
Ministry of Health contract	\$36,185	\$64,804	\$66,666	\$49,525	\$217,180	\$244,328
Grants received (Council, DHB, etc)		\$4,444	\$20,779			
Other income (interest received, etc)		\$747	\$4,444			
Total	\$36,185	\$69,995	\$91,889			

Note: This table was compiled from KCHGT accounts for 2001/02 and 2002/03 and the contract agreed with the Ministry of Health for January 2001–June 2004 (2nd schedule, version of January 2002). There are minor inconsistencies.

Over the three years of the evaluation, participants have expressed concerns about their ability to access sufficient funding to do the job. One informant commented in 2004 that there is always tension through having insufficient paid staff and therefore high demands on volunteers. With the passing of the contracting relationship from the Ministry of Health to the DHB, the KCHGT has been concerned to make sure that it was not jeopardising its ability to access additional funds from the DHB. The KCHGT has often been successful in accessing grants for specific contracts while still facing concerns about base operational costs.

Trustees have estimated their contribution of voluntary hours: the average appears to be around 10 hours per month per trustee. The range is from three to four hours per month for those trustees who attend the monthly meeting but do not participate in additional activities, and up to 20 hours for those involved in the Management Group and/or representing the Trust at other meetings. There was some variability: recorded hours for the final months of the project showed that voluntary hours were down, although some of the active trustees did not provide information for this period. For those on the Management Group, the regular hours per month are five hours' meeting attendance and additional time for reading associated papers. This is probably an underestimate when considering the high investment of hours at times such as when PHO development was at its highest, and for those trustees on the Community Reference Group for the hospital redevelopment project. In addition, the Ministry of Health ICAH manager donated time as part of the Ministry's support of these initiatives. A subset of trustees also attends regular DHB committee meetings and community network meetings, which again extended their hours.

In addition to the voluntary hours, the cost to the Trust – transport, paper (to print out emailed reports) and telephone, including computer access – may be several hundred dollars a year. MidCentral DHB informants also commented that the cost to them in terms of their staff time is high given that the Trust represents such a small part of their population.

## **Roles**

The KCHGT activities have clearly related to its objectives (see next section). There have been regular activities that are directly aimed at specified objectives, such as quarterly forums; community database and newsletters; health sector newsletters; and submissions and report writing. The Trust has also played a major role in some key health developments for the region over the three-year evaluation period. The most significant of these were involvement with the Kapiti PHO development and the transformation of Paraparaumu Hospital into the Kapiti Health Centre. The KCHGT was involved in the planning and development of the Otaki Community Health Worker project, but did not play a direct role in its implementation or ongoing monitoring and the project is independently funded. Another planned project was the establishment of a health information service for Kapiti, as recommended by the Healthlinks report (Porirua Kapiti Healthlinks Project 2000a). In 2002, the KCHGT had found funding for the development of a business case for this project, and by the end of the evaluation period had found funding to initiate it.

Over and above the Ministry of Health base project funding, the KCHGT has also obtained funding for several other short-term projects such as seminar on 'Ageing Well in the Community' and pamphlets on PHOs and about Otaki access to health services.

## **Key objectives and progress against them**

The goals and objectives for the Kapiti ICAH project were developed from the recommendations in their 2000 Health and Disability Plan and incorporated into subsequent strategic and annual plans. The key strategic aims of KCHGT/Healthlinks are to:

- advocate for publicly funded health and disability services that work fairly for everyone
- work with health and other sectors to achieve policies that improve health and reduce disparities
- ensure health and disability services are available and easy to access
- ensure that all communities know what health and disability services are available.

Progress against these four strategic aims, with their appended objectives, is discussed below.

## **Advocacy**

To advocate for publicly funded health and disability services that work fairly for everyone, KCHGT objectives are to:

- achieve an effective advocacy relationship with health policy and funding agencies (Ministry of Health, Capital & Coast and MidCentral DHBs)
- achieve effective two-way communication with the communities of the Kapiti district
- advocate resources and services that respond to the identified needs of the communities.

The KCHGT has had representatives on several DHB advisory groups, provided feedback on the DHB business and strategic plans, and made submissions on policy documents. The KCHGT now has a formal memorandum of understanding with Capital & Coast DHB. The DHB informants (both governance and management) reported that they highly valued the work of the KCHGT, and that having an established functional community advocacy group made their job of community consultation easier. A former Ministry of Health representative described the Trust's relationship with the Ministry as a 'mature contracting relationship'.

The KCHGT had maintained a dialogue with the community throughout the period of this evaluation by hosting regular community forums and rotating them around the four localities of the Kapiti Coast to encourage as wide a range of local participation as possible. Participants reported the forums to be valued processes. The Trust maintained an extensive database which was used to keep the community informed both of Trust activities and of health issues as they arose. It has also provided community newsletters and media releases, and participated in community network meetings. In addition to these formal community communication mechanisms, each of the trustees had their own links and connections with the communities they represented. Trustees and management also accepted speaking engagements to raise the profile of the work of the Trust. A DHB informant reported a 'level of information sharing that was exceptional' with regard to PHO development. The KCHGT shared information via its database and newsletters as well as organising and facilitating public meetings.

The KCHGT has been a strong and effective advocate for resources and action to meet community needs. Informants from both MidCentral and Capital & Coast DHBs commented on their effectiveness in this role. In the case of Capital & Coast, they were credited with 'reshaping the DHB's objectives'. They have continued to liaise with Capital & Coast via the community steering groups to ensure that the needs of Kapiti people were considered in the hospital redevelopment processes at Kenepuru and the Wellington Hospital site. The KCHGT has made submissions on Capital & Coast DHB's Māori Strategic Plan in association with Te Rūnanga o Āti Awa ki Whakarongotai, and has participated in the Horowhenua and Otaki Health Services review. It has also established a process for prioritising key policy submissions.

### **Improving health and reducing disparities**

To work with health and other sectors to achieve policies that improve health and reduce disparities, KCHGT objectives are to:

- ensure that key policies that affect health and wellbeing (eg, education, income, employment, transport) are informed by effective consultation with local communities and providers
- work with the two DHBs and providers to achieve better access to health and disability services so that use is equitable in relation to need.

The KCHGT has worked with Kapiti Coast District Council to ensure that the community's health needs are considered in local body policy. However, their priority was to work within the health sector, and they did not seek out opportunities to work across sectors. Trustees' personal links and networks, however, meant that community health concerns were taken into other sectors.

The Otaki Community Health Worker subproject and the KCHGT's participation in development of the Kapiti PHO have both included a focus on access to those with higher health needs. The Trust manager has also contributed to the MidCentral DHB consultation for the Horowhenua and Otaki Health Services Review, again maintaining a focus on health equity.

### **Ensuring availability and ease of access**

To ensure health and disability services are available and easy to access, KCHGT objectives are to:

- advocate to policy bodies for locally available services, and better transport to health and disability services
- establish good communication with service providers about what people need.

The KCHGT had continuing concerns over equitable health service access for the people of Otaki. The Trust engaged with both of the DHBs and, more recently, with WIPA and MidCentral DHB, to ensure that the services WIPA provided to Kapiti patients under Capital & Coast DHB contracts were also available for Otaki patients, who fall outside the Capital & Coast boundary. The Trust has advocated for choice for the people of Otaki with regard to cross-boundary issues, and has produced a question-and-answer pamphlet for Otaki residents on their health services. An early success for the Trust was the provision of a bus service for Kapiti people to Kenepuru and Wellington (the service was cancelled as it was underused). The Trust has secured carparks for Kapiti carers taking outpatients to hospital appointments, and the Trust has also secured appointment times that would allow Kapiti outpatients to travel at non-peak times. The KCHGT has continued to have a high level of involvement in the community steering groups for the development of the Kenepuru and Wellington hospitals redevelopment projects, and has participated in the Horowhenua and Otaki Health Services Review.

Providers' views had been surveyed and included in the Healthlinks report. Kapiti Healthlinks has established an extensive database used for communicating with providers (and others). Providers were invited to attend the regular community forums, and have been well represented at these. The database itself was regularly surveyed to identify new or continuing issues that needed addressing. PHO development heralded an increasingly strong connection with providers, one of the results of which has been an increase in the number of health sector workers (or retired health professionals) on the Trust itself. This has improved both understanding and relationships.

### **Informing communities**

To ensure that all communities know what health and disability services are available, the KCHGT's objective is to:

- advocate one source of reliable, updated information about the availability of health and disability services.

The KCHGT has worked throughout the evaluation period to develop a comprehensive health and disability information service for the district. At the end of this period it had finally succeeded in accessing funding to progress this. The Trust has developed pamphlets for Kapiti people to answer critical questions about their health services, as well as using an electronic information sharing system.

## Impacts

Impacts of the KCHGT's activity during the three years covered by the evaluation period included:

- enhancing community capacity via its own organisational development and through its relationship with other community organisations
- developing effective partnerships and relationships in the health sector that will lead to continuing impacts on the way health services are delivered in the area
- making positive impacts on health service provision, through its role in advocacy and relationships with the DHBs
- impact on the health of Māori, Pacific peoples and low-income people
- limited impact on the social and economic determinants of health.

## Enhancing community capacity

The community forums that the KCHGT facilitated have had a positive impact on health sector integration and co-ordination. One informant commented that the Trust is 'making significant progress at achieving this' by providing a mechanism to keep 'the public agencies fronting up and accountable to the community'. The KCHGT has also provided a chance for health providers to meet and share common concerns. Comments from informants included: 'GPs are listening much more to [the] community now', and, 'primary care services are easier to access'.

DHB and community informants reported that the 'KCHGT is out there working the community and therefore the community is more informed'. They are 'enhancing community capacity by improving access, and by linking people to services – also by their whole of community approach – they work with priorities from the [Healthlinks] report, and continue to support the key priority groups'.

It also appeared that the capacity of the Trust itself was growing. As the group operations and processes became more effective, community capacity appeared to be growing. Informants reported that a high level of knowledge and expertise of health-system processes had been developed within the Trust because of the long-term commitment from both workers and volunteers. Each of the projects has enhanced relationships and skills. The most recent was the fundraising project, which increased the Trust's knowledge of potential funding sources for activities within their community.



## **Developing effective partnerships and relationships**

A significant amount of time has been invested into building relationships within the various parts of the health sector (Ministry of Health, DHBs, iwi and community), which has resulted in an ability to respond quickly and effectively to changes in the health environment.

DHB informants noted that the KCHGT has made a major contribution in facilitating contact with the community. Without the Trust, the DHBs would have to relate to a lot of small groups, whereas the inclusive approach of the KCHGT facilitates access to these groups. The Trust has also taken community views to the wider health sector and developed its own policy so that it did not simply react to pressures from the health sector but proactively represented community views. Health sector partners confirmed this approach and acknowledged that Trust priorities and DHB priorities were not always the same. The Trust was conscious of the risk that if in future it is housed in a DHB-owned facility, and is funded by the DHB, it may be more difficult to be seen to be autonomous.

The establishment of a position in Capital & Coast DHB of a relationships manager for Kenepuru was the result of the KCHGT's advocacy. This person spent 40 hours a month in contact with the Healthlinks groups, thus ensuring that there was 'a voice for Kapiti and Porirua at the table at management level'. Before this position was established, Kapiti was 'thirteen different services in six different buildings with no common voice'. The role of the relationships manager has now been extended across the district.

## **Positive impacts on health service provision**

Key informants within the community, as well as the KCHGT's partners, confirmed that the Trust has made a significant impact in its two major areas of work: the PHO development and the Paraparaumu Hospital redevelopment. For both of these projects the role of the Trust was seen to be critical to the level of success enjoyed by the projects.

The KCHGT played a pivotal role in the development of the Kapiti PHO, first by identifying potential PHO models for the Kapiti Coast and then by ensuring that community views were incorporated in the development. The Trust developed its own guiding principles for a suitable PHO for the district, facilitated public meetings (well attended by providers as well as other community members) and engaged with provider organisations and iwi to progress the debates around PHO formation. Observers and participants credited the Trust with shaping this development. The chair of the Trust also chaired the establishment group, and her 'excellent' skills, combined with the organisational skill of the Trust's manager, were said to be critical to the success of the process. One informant commented that without the KCHGT, 'Kapiti would have had a PHO but it wouldn't have been as smooth and wouldn't have had co-operation and co-ordination'. Thus, gains in access to health services provided by the PHO are partly due to the work of the Trust.

The KCHGT has also had a significant impact on the health services available for its community through its role in the three hospital redevelopment projects. The initial

proposal from Capital & Coast DHB on the hospitals redevelopment project intended that the first stage would begin in Newtown and Kenepuru, with Paraparaumu to start later after community consultation. The KCHGT challenged that plan, and the Paraparaumu redevelopment happened in parallel with the others. In the end, the Kapiti Health Centre in Paraparaumu was the first to open, in October 2003. If the Trust had accepted the delay and the others had run over budget, Kapiti may well have ended up with less than the original proposal. The Kenepuru redevelopment now has 106 inpatient beds rather than the six planned in an earlier proposal. This dramatic shift in policy also resulted from the impact of community advocacy. While it is unclear how much of this change was due to KCHGT or Porirua Healthlinks or both, there is no doubt, according to a DHB informant, that they contributed to this outcome.

Informants suggested that the KCHGT's contribution to the Paraparaumu Hospital redevelopment had a dramatic impact on the quality of the new centre. The fundraising work meant that the environment was 'community owned' (in that the community had contributed to it) and more attractive and welcoming than it would otherwise have been. The Trust also kept a watching brief on the services to be offered in the new centre. Any increase in the number of services offered locally would benefit those people who had difficulties accessing services. Although there had been no expansion of services at the time of this evaluation, neither had services been lost. The Trust's successful work on this project is likely to have a positive impact on the health outcomes for the whole community by maintaining the availability of these services within the community.

The Trust also played a role in ensuring Hora Te Pai (the Māori health provider) was on the health centre site, which would enhance the ability of that service to act as a gateway to the health centre's services and therefore contribute to maintaining – and perhaps improving – the health of its client population.

The KCHGT itself was now housed in the new facility, which informants believed would enhance the Trust's community profile and make it more visible in the community.

### **Impact on the health of Māori, Pacific peoples and low-income people**

The Trust's paid employees were seen to be demonstrating a high commitment to ensuring that the needs of low-income people and Māori are included in Trust priorities and appropriate links are maintained, but there were mixed views about whether the Trust as a whole is committed to and able to incorporate the needs of these groups.

In addition, some doubts were expressed about the Trust's ability to incorporate the needs of low-income people, particularly because of difficulties in ensuring representation for this group within the Trust. A health sector informant stated that the Trust is 'struggling to include inequalities. It remains in actions in their plans, but is not something they spontaneously put up'.

### **Limited impact on social and economic determinants of health**

The KCHGT has had limited participation in cross-sectoral activities (that is, activities with groups other than health sector groups). It valued these connections, but health links were given the highest priority. A cross-sectoral process includes informal

information sharing, so little evidence of impact on social and economic determinants of health has been reported. Trust and Management Group meetings have, however, shown interest and action on housing (eg, contact with Housing New Zealand Corporation relating to housing for mental health consumers), transport (albeit to health services) and environments for healthy living (such as cycleways).

The inclusion of Hora Te Pai on the campus of the new health centre was seen as having an impact on the cultural determinants of health: 'This has enhanced the relationship between the Māori provider and other providers in the district so that it is now seen as a first line primary health care provider.'

One informant commented that because the funding was from the Ministry of Health, the Trust needed to focus on health services not the broader determinants of health though they could play a key role in lobbying other ministries. Another commented that more work on social and economic determinants could be done in the future, depending on priorities identified from the Healthlinks report: 'They [the KCHGT] need to look at the Healthlinks document to see what they should work on next.'

## **Subprojects**

### **Otaki community health workers**

#### **Development**

The Kapiti Healthlinks report (Porirua Kapiti Healthlinks Project 2000a) identified lack of access to information and services (including transport to existing services) as problems for Otaki, with its greater geographical distance from secondary services and higher needs population. The need for improvement in access to primary care was also a high priority as a means of improving health and disability outcomes. The report contained a number of recommendations, of which the Otaki Community Health Worker project was selected for implementation.

Key informants at the time of the project implementation expressed some concern about the Otaki Community Health Worker project as the funded recommendation. A number of other recommendations were included in the Kapiti Healthlinks report, and the selection of this one as a priority was questioned. More than one informant (representing more than one of the original partners) stated that their perception was that what was needed was community nursing services rather than a community worker. However, a member of the original project team informed the evaluator that the need for a nurse, as opposed to a community worker, was only raised in the working group and in subsequent meetings, rather than in the original community consultations. Informants also identified barriers to service at the medical centre and concerns about the configuration of primary care services in Otaki. Some doubts were expressed about whether this project would be able to address these concerns.

The Ministry of Health convened a working group to move this project towards implementation. The group first met in April 2001 and included representatives from the Ministry of Health, MidCentral DHB, KCHGT, Te Rūnanga o Raukawa Incorporated Health Services, Otaki Community Health Trust, Social Workers in Schools and the

Otaki Medical Centre. Agreement was eventually reached that the service should be focused on providing information, developing links between services, providing transport (or information on transport) support and advocacy. Funding for the project was devolved to MidCentral DHB.

The working party took longer than planned to resolve issues about the shape of the service and to decide on a preferred provider. The form of the project eventually agreed on was that the service should be provided by Te Rūnanga o Raukawa Incorporated Health Services, because they had the existing organisation structure to provide management for the service without the costs associated with setting up a new organisation. To ensure local ownership and guidance there was to be a co-management relationship with Ngā Hapū o Otaki. In the initial stages of the project there were some delays while the substance of this relationship was agreed and appointments made to the position. Key informants commenting on the delays believed that it was worthwhile to invest the time necessary to reach agreement and a satisfactory service specification. Two part-time community health workers were appointed and began work in April 2002.

The Kapiti Community Health Group Trust played a significant role in the working group that developed the service specification, but since the contract was formally accepted, their role has been limited. The service specification described it as a mobile outreach service to improve access to primary care services for the people of Otaki, with particular regard to improving access by Māori.

## **Resources**

The Otaki Community Health Worker project received a total of \$178,269 over three years, which covered the costs of one FTE community health worker, supervision for the worker, the lease of a car to provide the mobile service, and an administrative fee for the provider. There had been a large in-kind contribution by the provider, Ngā Hapū o Otaki, who has co-managed the project, and the MidCentral DHB, as the project development had been demanding of time and resources.

Two part-time workers were appointed to the community health worker roles in April 2002. The appointment of the two workers was seen as allowing for flexibility, with each also being able to provide cover for the other when leave was taken: when one of the workers took long-term leave the other worked full-time in her absence. Both underwent a one-month orientation, during which they worked alongside other workers from Raukawa Incorporated Health Services and also participated in Te Korowai Aroha training. The two community health workers were appointed at 0.6 FTE each to allow for a full-time service, while having some overlap for attending meetings and passing client information to each other.

The initial appointments were for a three-month trial, after which there was to be a review of the service specifications. This was delayed because of leave of absence for one of the workers. There had been significant staff turnover, with four women having worked in the roles in the two years of operation. Both of the original appointees have since left the service. The first moved to another role within Te Rūnanga o Raukawa Incorporated Health Services having upskilled, and this was seen as a significant

achievement in terms of capacity building. The second resigned because of other commitments that conflicted with the community health worker role. The current appointee had taken the role as a full-time position.

## **Services**

The community health workers have provided a referral and support service and transport for patients with no other transport available; built positive relationships with local services; identified appropriate services for clients and facilitated their referrals; and worked alongside the other kaimahi of Te Rūnanga o Raukawa Incorporated Health Services.

In Otaki the vehicle for the community health workers had been a highly valued part of the service. All the community health workers have been committed to identifying alternatives to transporting clients to appointments themselves, but – particularly for their older clients – this had been a crucial part of the service they offer. A positive aspect of transporting clients has been that the time together could be used informally to identify further issues and client needs, and attending appointments with clients meant the community worker was there as an advocate should that prove necessary.

Networking was a significant focus of the community health workers' activities. They had undertaken significant linking within the health sector, both within and outside Otaki, researching for clients where services are available north or south, which ones were most readily accessible, and organising transport for them. They had taken a systemic approach; for example, encouraging a counsellor to begin work in Otaki, so that the service was available locally. They had also liaised with other government agencies to meet the needs of clients, including Housing, Work and Income New Zealand, and the Accident Compensation Corporation. They had built extensive links with local agencies, including the Otaki Health Camp and Te Wānanga o Raukawa. (Some of these links have been specific to the particular worker, however, with the turnover in staff meaning that new relationships must be built.)

## **Outcomes**

In terms of health outcomes from the Otaki Community Health Worker project, ambulatory-sensitive hospitalisations data were not collected because the population of Otaki was too small to make analysis of such data meaningful. Instead, service use was taken as an intermediate outcome marker.

Community health workers have been required to record details of their patient contacts, where the referrals have come from, and where they have been referred on to another provider. The workers themselves have acknowledged that they have not always recorded all the details required, so the use rates present only a partial picture of their work.

The number of clients receiving the service remained consistent for most of the period of the evaluation, with 37 in the first quarter for which there are records and 44 in the final quarter of 2003/04. In the third quarter of 2003/04 there were 84 clients recorded in one quarter. Community health workers were clear from the time the project was

established that they wished to have open days, or hui, on particular health issues as a way of increasing their client contacts. The numbers in this third quarter represent an increase brought about by establishing such open days. The clients provided with services have been more likely to be women, with few clients under 30. The service has largely reached Māori clients.

The number of client contacts per quarter varied considerably over the period of the evaluation, and did not record whether contacts occurred while transporting clients to specialist appointments and staying with them or were a brief information or referral contact. This made it difficult to draw conclusions. The lowest quarter recorded 64 contacts, and the highest 141. Such a variation is likely to be the result of gaps in service at times of staff turnover or staff taking leave, given that there was only one full-time equivalent worker providing the service.

# Counties Manukau ICAH

## Development

An intersectoral approach to public health and social problems had already been developing in the South Auckland region over the decade preceding the ICAH initiative there. The Health Funding Authority (and its predecessor) had been a long-standing advocate, initiator and doer in the region's efforts to develop programmes that were based on constructive intersectoral and community alliances. Legacies of the pre-DHB period included health-promoting schools, community alcohol action, injury prevention, family service centres and wraparound services. The Manukau City Council had also been an active long-term sponsor of the intersectoral approach, as evidenced by its long-running (since 1988) 'Healthy City' Project. The City Council houses the multisector umbrella group, the Manukau Strategic Planning Group.

The Counties Manukau ICAH project began its life under the Health Funding Authority in 2000. It was modelled on the British prototype of Health Action Zones, which are a community development initiative intended to address health disparities. In the second half of 2000, following discussions between the Ministry of Health and the Counties Manukau DHB, there was a move away from the Health Action Zones approach. An agreement about the ICAH initiative was subsequently negotiated and a contract signed in December 2000. The ICAH funding was targeted at enhancing the capacity of that region's DHB to participate in intersectoral activities that aimed to reduce the region's health status inequalities. The DHB agreed to employ a project co-ordinator to specifically work on intersectoral liaison and to implement a school-based pilot project using a health care facilitator.

In January 2001 the DHB appointed a project manager, funded through ICAH, for the purposes of 'interagency liaison development'. This was the second such appointment: another intersectoral project manager was also employed by the DHB and funded through its general purposes funding allocation. Both shared the responsibility of overseeing the various intersectoral projects that the Counties Manukau DHB was involved in.

A systematic process was reported to have been used to develop intersectoral services and to engage the community in this development. The process included the following elements:

- establishing individual intersectoral working parties
- developing linkages with other sector groups, non-government organisations and service providers through a process of consultation and enlisting their involvement as required
- accessing community involvement via a 'series of provider focus groups' to help develop the projects in 'innovative ways'
- assessing needs, identifying service gaps and addressing key performance indicators for monitoring and evaluation purposes

- preparing background papers and documents for stakeholder consultation purposes
- ensuring ‘across the board’ Māori and Pacific peoples’ participation in the ICAH projects in terms of sector, provider and community involvement.

In the first year of the ICAH, funding also covered the salaries of staff involved in the Finlayson Park School pilot programme. This programme had begun before ICAH and was aimed at optimising students and their whānau and families’ access to, and use of, health and welfare services, so that students could participate fully in school and educational opportunities. Evaluation showed the programme made little headway towards improving liaison and co-operation across agencies (Voyle 2002), and the pilot was not extended.

The May 2002 Agreement for Service between the Ministry of Health and the Counties Manukau DHB continued funding for the ICAH project manager and replaced the Finlayson Park School pilot with the Youth Interagency Project (YIP) to address the recognised needs of young people in the area. YIP subsequently generated a number of youth-focused intersectoral projects which will be discussed below.

## **Governance**

As already noted, intersectoral collaboration preceded the introduction of the ICAH initiative in Counties Manukau. Many of the government-sector representatives interviewed for the ICAH evaluation indicated that they had had a relatively long history of working together on issues of mutual interest. A change in government and a concomitant shift in government policy were seen to have created a mandate that further strengthened government sector agencies’ ability and willingness to work together. The ICAH governance group, the Intersectoral Steering Group (also called Intersectoral Liaison Group), established in January 2002, was thus formed around this long-standing alliance.

Sectors participating in the Intersectoral Steering Group included:

- Counties Manukau DHB
- Manukau City Council
- Ministry of Social Development
- Child, Youth and Family Service
- New Zealand Police
- Ministry of Education
- Te Puni Kōkiri
- Ministry of Pacific Island Affairs
- Work and Income New Zealand
- Housing New Zealand Corporation
- Strengthening Families Forum
- Tainui Māori Co-Purchasing Organisation Trust.



The Intersectoral Steering Group met every two months, with Counties Manukau DHB's intersectoral project managers taking responsibility for arranging the meetings. Although the Intersectoral Steering Group's terms of reference were contained in the strategic plan and early documentation, participants appeared to have had limited awareness of the terms of reference. Governance procedures and reporting process were (by agreement) informal (eg, action points were recorded rather than formal meeting minutes). The DHB's written reports and interviews with the intersectoral project managers indicated that the overall strategic objective of the Intersectoral Steering Group has been to implement joint projects, establish effective relationships through the transfer of information, share training opportunities and conduct regular networking meetings (Counties Manukau 2004).

The ICAH focused on the Youth Interagency Project (YIP). All projects arising from the YIP were managed by specific working parties, drawn from representatives from relevant government and non-government agencies. Although the structure of the YIP appeared to have suited most of its members, a small number of stakeholders suggested that the overall YIP governance 'arrangement' has been 'too loose'. These critics tended to see the Intersectoral Steering Group/YIP arrangement as neither more nor less than a 'historical alliance of intersectoral funders'. The lack of a formal governance structure for YIP (eg, lack of meeting minutes, 'sketchy' briefings and 'unchanging agendas') was identified as a possible reason for what one stakeholder claimed was a recent downturn in attendance numbers at the YIP meetings. This same stakeholder suggested that a formal governance structure might help strengthen members' commitment and attendance.

## **Funding and funders**

Table 6 shows the resources and inputs expended on the ICAH project throughout the three-year evaluation period. The table also includes the sum paid by AIMHI<sup>15</sup> to Counties Manukau DHB for the latter's two intersectoral project managers to oversee the health component of the AIMHI initiative.

<sup>15</sup> The AIMHI co-ordinator has been responsible for contracting Counties Manukau DHB's project managers' services. AIMHI has a memorandum of understanding with the Ministry of Education for the delivery of funds that the AIMHI co-ordinator administers (W Gavin, AIMHI Co-ordinator, email correspondence: 4 November 2004).

**Table 6:** Funding for Counties Manukau DHB's ICAH, 2001–2004

<b>Agencies</b>	<b>2001/02 \$ (GST inclusive)</b>	<b>2002/03 \$ (GST inclusive)</b>	<b>2003/04 \$ (GST inclusive)</b>
Counties Manukau DHB / Ministry of Health (1st contract) <sup>1</sup>	200,000		
Counties Manukau DHB / Ministry of Health (2nd contract) <sup>2</sup>		195,000	195,000
Counties Manukau DHB <sup>3</sup>	Unknown	Unknown	Unknown
Ministry of Education / Counties Manukau DHB contract for AIMHI Healthy Community Schools initiative	25,000	25,000	25,000
<b>Total</b>	<b>225,000</b>	<b>220,000</b>	<b>220,000</b>

1 This first contract sum covered the salaries of the Finlayson Park School pilot programme staff in addition to the ICAH co-ordinator.

2 This sum covered the ICAH co-ordinator's salary and reporting costs, including quarterly reports, annual and strategic plans.

3 Costings data were requested from Counties Manukau DHB for evaluation purposes on a number of occasions. Some costings were given to the evaluator in the early part of 2003, but the DHB subsequently questioned the correctness of those data and asked that it be withdrawn. The required data were never provided.

## Roles

The role of the ICAH project manager in Counties Manukau has been to manage the ICAH intersectoral initiative, the Youth Interagency Project (YIP), attend various intersectoral forums and play an important project management role in the Healthy Housing pilot programme (a joint initiative between Housing New Zealand Corporation, the Counties Manukau DHB and the Auckland DHB).

## Key objectives and progress against them

The principal goal of the ICAH Interagency Liaison Project, as described in the Ministry of Health's Agreement for Service with the DHB (dated February 2001), was to:

Improve the health status of a specific group of people in Counties Manukau by working more co-operatively with a range of Crown agencies. This will occur by defining common goals that are shared between the agencies and developing implementation plans to address these goals in a more comprehensive manner.

The Counties Manukau DHB Strategic Plan for the ICAH for 2002–2004 (Counties Manukau DHB 2002) set out five strategic actions for the ICAH initiative, each with associated goals. The Strategic Actions were:

- intersectoral action for health
- improved equity and fairness
- greater acceptability of services
- better access to services
- better integration of services.

## Impacts

The impact of the Counties Manukau ICAH is predominantly seen through the impact of its subprojects (see following section). This section briefly summarises the short-term impacts of the ICAH initiative overall in the Counties Manukau region. Overall some 36 stakeholders were interviewed about their knowledge and perceptions of the Counties Manukau ICAH initiative. Three evaluation reports were also considered: the Finlayson Park School Pilot evaluation (Voyle 2002), the AIMHI Full Service Education pilot programme evaluation (Thomas et al 2003), and the Healthy Housing pilot programme evaluation (Auckland UniServices 2003).

Stakeholders were generally confident and optimistic that the ICAH would make 'tangible' and 'measurable' improvements on health (and social) inequalities in the long term. In 2001 stakeholders thought it 'unrealistic' to hope for measurable change in the three-year evaluation period, as the region's social and health inequalities were too longstanding and systemic 'to gain any real traction' in the short-term. By 2003 the Ministry of Health was of a similar opinion. Feedback by way of interviews and evaluation reports did, however, suggest that quantifiable progress had occurred over the ICAH's three-year lifetime, particularly in relation to the Healthy Housing pilot programme and to a lesser quantifiable extent in the AIMHI Healthy Community Schools initiative.

## Subprojects

A number of projects were developed under the Counties Manukau ICAH umbrella.

### **Interagency liaison development project co-ordinator**

The Counties Manukau DHB employed two project managers (one of whom was funded by ICAH) to participate in, develop and manage its various intersectoral interests and projects, including the:

- Interagency Steering Group
- Manukau City Council Strategic Forum
- Strengthening Families Forum
- Healthy Housing pilot programme
- Mangere Home Visiting Service
- Youth Offending Team Strategy
- Counties Manukau Health Council (Community Health Forums)
- Te Puni Kōkiri Working Party for 'Project P' (Methamphetamine)
- project manager of Counties Manukau DHB intersectoral projects.

## Healthy Housing Pilot Programme

The Healthy Housing pilot programme was a joint housing–health initiative between Housing New Zealand Corporation (HNZC), Counties Manukau DHB and the Auckland DHB. The overall aim of the pilot (run from January 2001 to June 2002) was to reduce overcrowding and improve the health of householders living in HNZC homes in the selected priority areas of Otara, Mangere and Onehunga.

Of 988 HNZC homes in the Otara, Mangere and Onehunga areas, 534 (54 percent) were found to be overcrowded (as assessed by a crowding ratio), reported to be ‘significantly higher’ than expected.

A range of interventions were used to improve residents’ health, including modifying HNZC houses (eg, by adding insulation or ventilation, or by extending houses), and facilitating contact between residents and health and social support agencies. In total, 848 interventions were made to 619 properties. The two most common interventions were improvements to ventilation and the installation of insulation materials; a number of properties were also extended.

The pilot programme was subsequently ‘rolled out’ to other priority areas in South Auckland. The DHB’s ICAH-funded project manager jointly developed, implemented and now manages this programme with the HNZC project manager.

## Impacts

An evaluation of the pilot study, using a combination of quantitative and qualitative research methods, found the following (Auckland UniServices 2003):

- There was a 9 percent increase in visits to GPs in the 12 months following the intervention households’ first joint assessment. Conditions specifically targeted in the assessment (mainly immunisation, diabetes care and skin infections) accounted for much of that increase.
- There was a 33 percent (statistically significant) reduction in hospital admissions in the intervention households compared to a geographically matched control group. Visits to outpatient clinics and emergency departments, on the other hand, increased. These and the increased primary health care visits were interpreted as ‘early care-seeking’ and to be likely contributors to the decreased hospital admissions.
- There was increased awareness of infectious diseases, particularly meningococcal meningitis.
- In the evaluation sample of 47 households, 45 had a crowding ration after intervention of two or fewer, with the average reducing from 2.76 to 1.62 people per bedroom.

- Collaborative relationships were established between 46 different health and social agencies, many of which were based on formal memoranda of understanding. The many client referrals and follow-ups showed the effectiveness of these intersectoral relationships. The relationship between public health nurses and tenancy managers to undertake the household joint assessments reportedly worked well. The evaluation report also indicated that Housing Corporation New Zealand and DHB representatives had worked well together, a finding that has been further supported by this evaluation.

The Healthy Housing pilot programme has since been extended to Wiri in the Counties Manukau region, as well as to other parts of New Zealand. Evaluation continues. The report of the first year of the outcomes evaluation (Clinton et al. 2005) found:

- Providers had evidence that participants in the programme were experiencing a greater sense of wellbeing physically and psychologically; were participating in family, community and social life to a greater degree; and housing-related illness had reduced.
- Evidence of collaboration between and within agencies had emerged at all levels.
- From the providers' perspective, obstacles to the success of the programme included 'no shows' by tenants at assessment meetings; the availability of ongoing funding; the risk of recurrence of the original problem; and delays to the process of interventions. A further obstacle was the impact on and relationships with HNZN Neighbourhood Units. These units carry out the ongoing management of HNZN housing stock, allocation and tenancy payment. The impact of the workloads created by the Healthy Housing pilot programme on the tenancy managers, turn over of tenancy managers, insufficient stock of large houses and unaddressed maintenance problems were all identified as barriers to the programme.
- The majority of households that were interviewed for the evaluation concluded that their experience with the programme had been a positive and beneficial one for their health and wellbeing. The most common outcomes identified included: increased empowerment; a reduction in illnesses such as asthma; improved comfort of their home; and a general sense of social wellbeing and functioning within the household.

### **Finlayson Park School Project**

Finlayson Park School is a low-decile school with a very high proportion of Māori and Pacific students (63 and 27 percent respectively at the time of the project). ICAH funding was used to employ a health facilitator in January 2001 to pilot a project at the school based on public health nursing principles (including both public and personal health service components). In the latter stages of the pilot a 0.3 FTE public health nurse was also appointed. The key goal was to optimise students and their whānau and families' access to, and use of, health and welfare services, thereby assisting students to participate fully in school and educational opportunities. The programme also included a focus on liaison and co-operation between agencies.

## Impacts

The project was piloted for a year. An evaluation (Voyle 2002) found the main achievements of the pilot programme were:

- the valuable contribution that it made to the 2001 MMR Immunisation Campaign and the ear health and hearing programme, mainly through improvements in access to parents and whānau, and teachers
- the special needs form and database that were established to help facilitate better follow-up of the school's highly transient student and parent population.

The main weaknesses identified by the evaluation (Voyle 2002) were:

- the premature cessation of the 'working partnership committee' meetings, which reportedly ended three months after the establishment of the pilot, leading the evaluator to conclude that the anticipated enhanced liaison and co-operation across agencies was never fully explored
- the 'heavy' reporting requirements for what was 'a relatively short-term contract'.

Since intersectoral collaboration was a fundamental principle underpinning the ICAH initiative, the Counties Manukau DHB management considered the lack of improvement in liaison and co-operation across agencies was a major shortcoming of this programme, and the pilot was therefore not extended.

## Youth Interagency Project (YIP)

An Agreement for Service between the Ministry of Health and Counties Manukau DHB, signed 28 May 2002, established the Youth Interagency Project (YIP) and replaced the Finlayson Park School pilot. YIP originated under the auspices and sponsorship of the Manukau Strategic Planning Group. It was the product of extensive intersectoral consultation and consensus that (a) the region's youth were a population with high needs; (b) few initiatives were specifically geared to meet those needs; and (c) youth programmes offered the greatest potential to improve the population's social, health and educational outcomes. Agreement was reached in May 2002 that in developing the YIP, Counties Manukau DHB would consult with and seek the participation of relevant community groups, as appropriate, and 'involve community development as an important process in reducing inequalities' (Agreement for Service 2002:7).

The needs of youth in Counties Manukau were a key priority for all the agencies participating in the Interagency Steering Group which led to the development of the YIP. The YIP working party included Police, Health (including the ICAH project co-ordinator), Education and Welfare agencies' representatives, and hence became known as PHEW. PHEW was responsible for both driving and providing the oversight for YIP's initiatives. The goals of YIP were:

- to support interagency action to improve health outcomes and wellbeing for AIMHI students, alternative education students and teenage mothers
- to improve equity of access and acceptability of services for AIMHI students, alternative education students and teenage mothers

- to co-ordinate the intersectoral response in the event of traumatic incident
- to improve the integration of services for young people through improved intersectoral collaboration.

The YIP has since generated a number of youth-focused intersectoral projects which are described below.

### **The AIMHI Healthy Community Schools Initiative**

The largest and most long-standing YIP project is the Healthy Community Schools<sup>16</sup> project, established as part of the AIMHI initiative running in nine schools.<sup>17</sup> In 2002 the Ministry of Education's AIMHI co-ordinator contracted the services of the two Counties Manukau DHB's intersectoral project managers for a two-year period to co-ordinate the development of the Healthy Community Schools initiative in all nine AIMHI schools, including the three in the DHB's region.

The establishment of school nurse-operated health services in AIMHI schools is part of the larger Healthy Community Schools initiative. As noted earlier, Healthy Community Schools is funded by the Ministry of Education. The pilot commenced in January 2002 with per year funding ranging from \$50,000 for the smallest schools to \$109,000 for the largest schools,<sup>18</sup> plus additional funding for related property development to staff and accommodate student support services. By December 2003, \$1,308,510 had been spent on the AIMHI schools' Full Service Education initiative, of which \$573,577 (44 percent) was provided by the Ministry of Education while schools provided \$743,933 (56 percent). Funding covered both capital development (health and welfare service facilities) and service provision (nurses, social workers, community workers).

The AIMHI Healthy Community Schools initiative focused on 'strengthening and enhancing the health, welfare and social services within the AIMHI schools' (Counties Manukau DHB Youth Interagency Project Undated, 5). It involved co-ordinating the upskilling of the AIMHI school nurses to enable them to implement a Year 9 students' needs assessment tool, and to develop school-based health promotion programmes such as Nutrition, Exercise and Weight (NEW) and Keeping Schools Safe initiatives.

### **Activities**

The first component of the initiative aimed to improve the health, education and social outcomes for students in the AIMHI schools. Project activities to this end between January 2001 and June 2004 were:

<sup>16</sup> Alternatively known as the 'Full Service Education' (FSE) initiative.

<sup>17</sup> The AIMHI is a Ministry of Education programme established in 1996 in nine low-decile secondary schools in the Porirua, Central Auckland and Counties Manukau regions. The principal aim of AIMHI is to raise the achievement levels of Māori and Pacific students.

<sup>18</sup> The amount distributed varied according to a school's roll size (W Gavin, email correspondence, 4 November 2004).

- health and wellbeing centres established
- year 9 assessment tool developed and implemented
- first-year assessments completed; second-year ongoing
- common strategic planning day for school nurses held (2003)
- school nurses' training needs identified
- training programme completed
- health and wellbeing databases established and refined in schools 2001–2003
- stocktake of health services completed to identify potential links to support school's health and wellbeing centres (2002)
- ongoing efforts continued to establish linkages between school health and wellbeing centres and PHOs.

The second component of AIMHI, initiated in 2002, aimed to improve access to appropriate health services and programmes for young people with obesity, nutrition and weight issues. Associated activities were:

- Healthy Community Schools two-day summit held (September 2002)
- student needs analysis completed (survey of school community)
- working party established – meets monthly
- development of the NEW initiative: strategies identified to reduce obesity among students; specific project objectives developed; Diabetes Trust a key development partner (Woolston and Sinclair 2004)
- funding accessed through Manukau City Council for fitness educator to run lunchtime fitness sessions at Southern Cross campus
- Counties Manukau DHB agreed to fund the initiative for twelve months in three schools (June 2004); other funding sources continued to be sought.

## Impacts

By the end of 2003 services provided in the AIMHI schools, through the Full Service Education initiative, included the following:

- all nine AIMHI schools had an operational health centre linked to a local general medical practice, of which six were staffed by registered nurses and three by enrolled nurses
- six schools had an eye-testing programme established (provided by the Optometry Department of Auckland University)
- seven had on-site dental services
- all nine schools' year 9 students had undergone comprehensive health and wellbeing assessments
- seven of the schools were participating in the NEW programme (all three in the Counties Manukau DHB region)
- four schools had established school health councils



- six schools were providing access to an on-site social worker
- eight schools had community liaison and student mentoring personnel in place
- four schools were providing access to a Māori support worker.<sup>19</sup>

In 2002, 731 year 9 students received a comprehensive health assessment. Those assessments showed that:

- 46 percent of students required referral on to other health services, mainly PHOs, sexual, mental and dental health services and drug and alcohol services
- 29 percent of students required referrals to social services, including social or community workers, the Children and Young Persons Service or counselling services
- 13 percent of the students failed their vision tests (some students had not been aware of the problem until tested)
- 12 percent of students had hearing difficulties
- 27 percent of the students assessed in two schools had a body mass index (BMI) of over 30 (considered obese) and another six were over and above the 'obese' range (Woolston and Sinclair 2004).

The AIMHI schools NEW project is only in the early stages of implementation in some schools. Lack of funding has been a contributing factor to the delay, particularly to the implementation of the NEW lunchtime school fitness programmes. AIMHI school nurses reports to the NEW working party and schools' reports to the AIMHI schools co-ordinator showed some schools have made concerted efforts to have their tuckshops serve healthier food options and reduce the amount of 'junk food' sold to students. Two schools had been awarded National Heart Foundation Heartbeat awards. Others had removed their soft-drink vending machines (meaning a loss of revenue to these schools), while several schools had established student health councils.

### **The C3 Secondary Schools Postvention Project**

In response to an increasing number of traumatic incidents and cluster suicides in Counties Manukau, this project focused on secondary schools in the region. The aim was to establish a postvention (referring to the time following a traumatic incident) community interagency crisis team to identify training needs and provide training to address those needs. C3 refers to the cultural, community and clinical considerations that agencies need to incorporate into their postvention responses.

This project was initiated in June 2002. A working party was established, but progress seemed to be limited. As at June 2004, the project was on hold awaiting the completion of an internal review by the Ministry of Education and a decision about whether the Ministry had the capacity to participate in the project.

<sup>19</sup> Data provided by W Gavin, AIMHI schools' co-ordinator.

### **The Intersectoral Gaps Scoping Project**

This project was initiated in June 2003 with joint funding from the Wellington-based High Complex Needs Group and a Ministry of Social Development initiative. The aim was to reduce the number of young people with high needs who 'fell through the gaps' of the social system and services. By June 2004, the project had been scoped, a survey of 1200 service providers completed (with a 21 percent response rate) and an agreed planning process was being developed.

### **The Alternative Education Students' Initiative**

A working party for this project was established in December 2002 with the aim of improving the health, education and social outcomes for young people in alternative education settings by ensuring that the students were appropriately connected to health and social services. An AIMHI-commissioned alternative education students' health report was completed and a strategic planning day held in June 2003. The Centre for Youth Health services was engaged to provide support services for students and there were ongoing efforts to secure a link with PHOs.

### **The Teenage Pregnancy/Parenting Project**

The principal objectives of this project were to prevent teenage pregnancy by improving co-ordination and sharing of best practice between preventive services, and to improve educational outcomes for teenage mothers by ensuring their connection to appropriate health, education, welfare and social services. Addressing these aims included ongoing consultation with experts and young people. An information pack outlining available services for young people was developed and distributed. Architectural plans for a teen unit were completed, with agreement for it to be established at Tangaroa College. Funding for this was being sought from the Ministry of Education.

# Northland ICAH

## Development

Northland was the last of the four ICAH sites to be developed. At the end of 1999, Northland Health Ltd (the then Crown-owned health provider for the Northland region) contacted the Minister of Health requesting information about the Health Action Zone proposal and Northland's possible involvement in such a programme. Subsequently the Minister of Health announced the establishment of a Northland Health Action Zone in November 2000.

Eight months of discussion involving the Ministry of Health, Northland Health Limited, Te Taitokerau Māori Co-Purchasing Organisation and three Māori health provider organisations in Te Tai Tokerau – Te Hauora o Te Hiku o Te Ika, Te Rūnanga o Te Rarawa and the Kia Mataara Society Inc (Whakawhiti Ora Pai) – resulted in a contract for the establishment phase of Te Hiku O Te Ika Intersectoral Community Action for Health in June 2001. The actual project contract was signed off in May 2002.

## Governance

The Northland ICAH programme was a joint venture of the three Māori health providers above, linked in a partnership relationship. These organisations represented and were accountable to the five iwi of Te Hiku o te Ika, namely Te Aupouri, Ngāti Kahu, Ngāti Kurī, Ngāi Takoto and Te Rarawa. An interim Project Steering Group – composed of representatives from each of three Māori providers, Te Taitokerau Māori Co-Purchasing Organisation and the Ministry of Health – was established to guide the establishment phase of the project.

Because of the three-year timeframe and the limited amount of money involved, it was decided to share the ICAH roles and responsibilities among the three provider groups rather than establish a new specific organisation, and to allocate the funding to each provider group which would then be responsible for its own particular project or projects. Te Rūnanga o Te Rarawa, through its Te Oranga health provider, received and distributed the funding to all three providers without deducting for its administration services. Whakawhiti Ora Pai was the centralised administration point of contact, the minute writer and the collator of the required reports. Each organisation had one person who was their representative at ICAH meetings and who was responsible for keeping the ICAH informed about subproject developments and progress to date. Decisions about each subproject, however, belonged to the management level of the specific organisation.

These arrangements reflected the collaboration of three organisations which work in a relatively isolated geographical area, have a shared understanding of tribal roles and boundaries, and a combined commitment to improving the health status for the people in Te Hiku o Te Ika.

## Funding and funders

Funding received for the ICAH is set out in Table 7.

**Table 7:** Funding for the Far North ICAH<sup>20</sup>

Ministry of Health contract	Calendar year (excluding GST)				Total 3.5 years	
	2001	2002	2003	2004	Excluding GST	Including GST
Establishment	\$45,000				\$45,000	\$50,625
Ongoing		\$155,556	\$133,333	\$111,111	\$400,000	\$450,000
Overall	\$45,000	\$155,556	\$133,333	\$111,111	\$445,000	\$500,625

Voluntary and in-kind contributions were difficult to record. The garden services were a good example. As each garden was established, a 'Gardening Goodies' package was given. The cost of each item in the package was easy to ascertain and calculate, but donated items – such as ground-treated posts, seedling bases and seedlings, watering cans, petrol, extra compost and the use of trucks and trailers – were not costed.

Informants reported that voluntary costs were high and establishment processes were subsidised by participant groups. Extra time was spent on this project by the co-ordinators and other staff members who helped with the original proposal, attended meetings, consulted with the community and incorporated this project's needs into their own workload. The cost in worker hours had been at least that of a half-time worker for each of the three groups.

## Roles

The ICAH group has been active only in its relationship with its health sector funder. The group built on pre-existing relationships to ensure that contracted reporting requirements are met with regard to each of the three projects, and that relationships were maintained with the funder and with the evaluation team.

Responsibility for subprojects arising from ICAH funding rested with the three provider groups.

## Key objectives and progress against them

The three objectives of the Northland ICAH were to:

- improve health and reduce outcome inequalities for Māori and other communities with poor health status in Te Hiku o Te Ika
- build on the existing capability and capacity of Māori and other communities in Te Hiku o Te Ika, with particular focus on Māori and community engagement

<sup>20</sup> Note: Table based on sighted contract documentation.

- facilitate an intersectoral approach which fosters better working relationships across sectors and promotes community-based strategies to address the concomitant social and economic factors associated with poor health.

All three projects have used their ICAH funding to establish projects aimed at meeting the health and wellbeing needs of their communities. The projects are ‘by Māori for Māori’ initiatives with innovative approaches to meeting the needs of local communities. All three projects have specifically focused on improving skill and capacity.

Intersectoral links were evident in each of the projects. Tu Maia has strengthened pre-existing relationships between Te Rūnanga o Te Rarawa, Work and Income New Zealand (by using Taskforce Green funding to pay community workers) and the Ministry of Education. The Ahipara Youth programme worked with the Safer Community Trust. The gardening programme has established very positive and mutually beneficial relationships with a range of other groups.

## **Subprojects**

Three subprojects were funded by the Northland ICAH, one being established by each of the three provider groups which formed the ICAH who then combined with other sectors and agencies relevant to the specific projects. The projects were chosen on the basis of the regional health profile and the Northland DHB health needs assessment as summarised in the ICAH establishment plan (Joint Venture Partners 2001); collective community requests; and the priorities of the organisations involved.

The three projects are outlined below. Hei Oranga i te Whenua was assessed as part of the overall ICAH evaluation; information on the other two subprojects was drawn from reporting to the DHB.

### **Hei Oranga i te Whenua**

Hei Oranga i te Whenua was a gardening and nutrition initiative for whānau, based in the remote Far North, two hours away from the shopping centre in Kaitaia. Whānau have been steadily returning home after two generations of living in cities, and the gardening project was seen as a way of increasing local resources while reviving local knowledge about creating and establishing a sustainable resource.

Whakawhiti Ora Pai has linked with the local Māori Women’s Welfare League, Early Childhood Centres and Kaitaia businesses to develop and establish a training programme re-establishing the traditional concept of each whānau having a home garden. This was seen as a way of increasing local resources while reviving local knowledge on creating and establishing a sustainable resource. Other groups that have been involved in Hei Oranga i te Whenua included the local gardening clubs, rūnanga, weavers, the Department of Conservation, marae, schools, kōhanga reo, Work and Income New Zealand and local nurseries.

The goal of re-establishing or developing home gardens was to foster and stimulate:

- whanaungatanga (connections through extended family)
- whenua kaitiakitanga (guardianship of land) and an understanding of the use of natural resources and seasonal climate needs
- whānau, hapū and iwi activity
- physical activity
- personal satisfaction
- use of natural resources at low cost
- a keen sense of responsibility that contributes to community identity and self-worth.

The kuia consultant group for Whakawhiti Ora Pai identified the project priorities as:

- gaining community support, which is essential for the gardens to be successful
- a focus on young parents learning the skills and knowledge from kuia and kaumātua
- sharing the knowledge of tūpuna to guide the wellness of rangatahi
- use of the whenua to encourage more self-worth and generate self-determination for oneself and one's whānau.

The part-time co-ordinator's role for this project was to help the communities to use their skills, share knowledge and affinity for the land, support members to access resources, encourage community networks, and share strategies to ensure the continuation of the project. A regular newsletter has been established and is well received.

Hei Oranga has worked on the foundations of whānau, building on local knowledge that was declining. Under the project, home gardens have been re-established, shelter places for seedlings set up, the economic use of 'grey' water<sup>21</sup> encouraged, and community relationships fostered as small groups worked together on one garden. The Hei Oranga project has encouraged physical activity, gaining or expanding knowledge of the soil and local climate, how seedlings are cared for and other issues involved in holistic health. Neighbourhood links have also been strengthened, and newcomers included.

Initially five new gardens were established. In 2003 this was increased to 10 gardens, and now there are 20 gardens. The individual garden areas have also been increased as more land is cleared for cultivation.

## **Tu Maia**

Te Rūnanga o Te Rarawa recognised the need for security and support for third form students who were not achieving educationally and socially at Kaitaia College, the main secondary educational facility in the Far North. They therefore chose as their project a student support programme called Tu Maia. The programme was developed by Te Rūnanga o Te Rarawa, Kaitaia College, Kaitaia Intermediate, Kaitaia Primary and the Far North Rural Education Activities Programme.

<sup>21</sup> The recycled use of household washing water.

Supporting the development of youth who were struggling in the education system was seen as a positive way to help turn 'failing' students towards gaining skills and confidence to increase their future options. Whānau involvement with decision-making in the school also encouraged parent participation, and goal planning with whānau and their youth enhanced their mutual relationship skills.

Tu Maia began at Kaitaia College and was extended to Ahipara Primary School in June 2002 because of behavioural and other issues identified by the schools and community.

Tu Maia provided adult support in classes. The duties of the support worker included:

- modelling appropriate behaviours when information or instructions were not clear
- giving individual support to students with behaviour or learning difficulties
- liaison with and support for teachers in the classroom
- liaison with parents and whānau for strategies to support students at home.

Each school has had two support workers operating in four classrooms at each site. The ICAH funding (supported by Taskforce Green funding) provided training for the support workers (ten people over the period of the evaluation). The high number of personnel changes was due to the lack of Taskforce Green funds at times and the fact that doing this job assisted the volunteers towards other employment and training opportunities.

Feedback from Kaitaia College staff indicated an obvious advantage for the Ahipara Primary students involved in Tu Maia before coming to Kaitaia College. They requested that these programmes be maintained, developed further and extended to other classrooms and homes. The teachers have also reported the need for more support workers.

Tu Maia has developed not only the skills of the students, but also the skills and self-esteem of volunteer adults. Indications of the impact of the project included improvement in the students' self-esteem (commented on by the teaching staff at Kaitaia College), reduction of absenteeism (with a 95 percent steady attendance at Kaitaia College), demonstration of increased social skills, and, for some, academic improvement.

### **Ahipara Youth**

Te Hauora o Te Hiku o Te Ika focussed on the needs of the youth in Ahipara, addressing community concerns about children lacking direction, youth wandering the streets and increasing numbers of teenage pregnancies. Activities that had purpose and meaning for the young people were identified by the community as essential. To achieve this, a collaborative approach was taken between members of the Far North Safer Communities, Strengthening Families co-ordinator, community police, local schools, community volunteer groups and marae, with Te Hauora o Te Hiku o Te Ika co-ordinating the overall project as part of the ICAH group.

Three consultation hui in 2001 decided to address community concerns about at-risk youth by providing short residential programmes targeting young people aged 10–18 years residing in the Ahipara area. The residential programmes aimed to:

- assist youth to strengthen their sense of identity, knowledge and understanding of their Māoritanga
- strengthen and promote youth development (self-esteem, skills and education)
- provide youth peer support, advocacy and (where necessary) programmes for life skills, recreation and vocational development.

In early 2003 a training camp for eight volunteer team leaders was held, followed by three youth camps. A three-day camp in June 2003 was attended by 25 children, a four-day holiday camp in July that year was attended by 30 children, and a five-day holiday camp in September was attended by 28 children. The youth project also provided educational programmes focusing on safe driving and drug and alcohol education.

The programmes provided:

- an emphasis on whanaungatanga and a kaupapa that supports activities focused on tikanga Māori and physical practical skills
- access to te reo Māori and other cultural mechanisms (eg, taiaha, kapa haka)
- activities determined by youth, but supervised and guided by appropriate leaders
- a safe environment for learning and development
- the opportunity for personal development through challenge and adventure
- strengthening and developing whānau, with a particular focus on Māori.

The Ahipara Youth project camp in April 2003 worked on developing not only the physical skills of the children, but their ability to work in teams, to share their ideas with one another and to respect the group's rules. Of the youth-focused events the Ahipara Youth project has provided, the holiday camps in 2003 were the activity most affirmed by the whānau and students. However it is hard to measure the increase in self-esteem of a child or young student, or the wairua of teamwork that alters the wellness or resilience of a whānau even if it does not add to the tangible benefits of income or resources.

The Ahipara Youth programmes were suspended in 2004 after the ICAH Te Hiku o Te Ika co-ordinator resigned. The new employee hoped to develop programmes with a wider target group, introducing this age group to information technology using computers and so on, but further developments did not take place within the time of the evaluation.



Both youth-based subprojects (Tu Maia and Ahipara Youth) have expressed concerns about the need for more parental support and engagement. All the children involved in these subprojects are from high-need whānau, and some difficulties have been encountered in involving the parents with the projects. However the structure had been put in place and more parents were involved now than when the projects were first established.

## Impacts

A key objective of Te Hiku o Te Ika ICAH was to have a positive impact on the health and disability outcomes of the local communities. All the providers were population-focused rather than disease-based, so there was a 'whānau wellbeing' philosophy through the three subprojects.

Te Hiku o Te Ika ICAH worked with a high-need, predominantly Māori population, and addressed health determinants by encouraging the development of community strength through increasing options and educational and social skills. All the projects were run by Māori with a focus on Māori beliefs and values. All the workers used their organisations and whānau links to provide support, advocacy and assistance as and when required. The three provider groups of the ICAH felt that the subprojects were already having a positive impact on the health and disability outcomes in the Far North region, despite the delayed start. Each project was at a different stage, but all appeared to be fulfilling the outcomes of a community helping itself with constructive and proactive support. There was also a clear expectation that many of the tangible positive impacts would continue past the brief timeframe of the ICAH project.

Benefits identified were that programmes are:

- community-based initiatives
- transferable (with moderate changes) to other areas
- linked in that they address socioeconomic issues
- focused on whānau wellbeing
- proactive and aim for future changes while acknowledging past lessons.

## Te Pae Mahutonga

Mason Durie's model for Māori health promotion, Te Pae Mahutonga (Durie 1999), has been used as a framework to identify the impacts of Te Hiku o Te Ika ICAH in general, and the Hei Oranga i te Whenua subproject in particular. Te Pae Mahutonga, or the Southern Cross, is an ancient Māori symbol of navigational guidance. The four central stars can represent the four key tasks of health promotion (Mauriora, Waiora, Toiora, Te Oranga), while the two pointers are essential elements of Māori development and health (Ngā Manukura and Te Mana Whakahaere) (Durie 1999).

### **Mauriora: access to te ao Māori**

All three projects worked predominantly with Māori people, had access to te ao Māori local resources and acknowledged that a secure cultural identity was a critical prerequisite for increased individual health and overall community development. Participation in the project has reaffirmed values of tikanga and respect for traditional knowledge, and has fostered a respect for traditional values.

A major focus of all the projects has been on sharing Māori knowledge and enhancing Māori esteem. A consequence of this philosophy has been the re-introduction of traditional Māori knowledge; for example, of the seasons for planting, harvesting, resting, reaping and fishing.

### **Waiora: environmental protection**

All the projects have included a Māori world view of the environment, with a resurgence in working with and understanding of the immediate environment, care of the earth and knowledge of the stars and seasons. The Hei Oranga project has used natural resources such as sunshine, water, earth, compost and seeds, at low cost.

### **Toiora: healthy lifestyles**

All the projects were working to change high-risk behaviours and give participants more healthy options.

The Hei Oranga programme increased physical activity for all participants with a move away from television sets to the gardens. Participants have also been inspired to try different ways of using and preparing vegetables with a clear focus on fun and reward. Several whānau who smoked have made their garden plots smokefree and this rule applied to everyone. Neighbours have joined together, with physically active and emotionally relaxing results.

### **Te oranga: participation in society**

People with improved life skills have a greater opportunity to participate in their own lives and their communities. Some ambivalence was expressed by respondents to the question of whether the ICAH project had improved participation in society. While each organisation acknowledged the learning experience achieved through participation in the ICAH, they felt that the ICAH process was a form of communication they already used. In an area of isolation with very high need and low socioeconomic levels, working with one another maximised the benefits to and for the community.

## **Whanaungatanga**

A family working together for the good of everyone is a common practice in this area, although the idea of everyone working on a garden was a bit different because people had not done this sort of work for a while. The main impact discussed in the interviews was the inclusion across age groups and whānau groups, where members of the community not linked or involved with the marae, sport clubs or a specific religion could join in this project. The Hei Oranga project has facilitated a 'safe environment' for various groups of people who would not otherwise have a cause to be associated, thus generating new relationships and discussions about collaborative gardening and some elements of gardening competitions. The gardening project also provided a sense of responsibility that contributed to community identity and self-worth.

## **Ngā manukura me te mana whakahaere: autonomy and leadership**

Both of these concepts are long-term goals for all three projects. Although relationship development with the Ministry of Health was somewhat fraught early on, participants valued their ability to choose their own priority projects within the funding constraints. The devolution of the monitoring function from the Ministry of Health locally to Northland DHB has been a positive development.

Before the start of these projects, the communities already had strong connections and a core group of committed volunteers. Community leadership has developed with the knowledge and skill base of the area contacts and of those starting the plants and organising the seedling nurseries. The gardeners' skill base and development towards autonomy increased as the co-ordinator informally delegated roles to various individuals. All the interviewees saw the ICAH project as enhancing and increasing community capacity.

# Analysis

This section presents comparative findings across the four ICAH sites with regard to governance, needs assessments, inputs and resources, selection of projects, and progress against objectives. The analytic frameworks described in the methodology section were used, along with the Ministry of Health's Intervention Framework for Reducing Inequalities in Health (Ministry of Health 2002). A further section of the analysis uses the six critical success factors identified in the original literature review to review the processes and impacts of the four ICAH projects.

## Comparisons and contrasts

### Governance

#### Key findings

- Addressing the issues of governance and operation of the groups in the establishment phase is critical.
- Groups that established formally constituted governance groups appeared to have less difficulty in developing and maintaining reporting processes, and in negotiating changes as the projects developed and evolved.
- With the exception of the Northland ICAH, all the sites experienced difficulties in maintaining Māori and Pacific peoples' participation in their governance groups.

All four ICAH groups took the approach recommended by Maskill and Hodges' literature review of working with existing community structures, although each took a different approach to establishing a governance structure of their own. The two groups that had formally constituted governance groups, Kapiti and Porirua, had some common experiences and some variations. In each case pre-existing health advocacy groups were restructured through participation in the initial Porirua Kapiti Health and Disability Services Integration Project. Kapiti drew their governance group from the geographical communities, whereas Porirua attempted to draw in representatives from different ethnic communities and interest groups in their area (including the pre-existing health advocacy groups). Both groups experienced a high voluntary workload, and, especially in Kapiti, cost barriers to participation by lower socioeconomic groups were a concern.

In Counties Manukau, the project leaders and intersectoral partners chose not to establish a totally new governance group for the ICAH, but to work within the framework of a long-standing intersectoral alliance, largely consisting of representatives from relevant government agencies. Community participation was not formalised at the overall governance level, but rather was established at the individual project level.

The Far North governance group was not formally constituted and consisted of representatives from three Māori health providers from the area in a joint venture. The establishment of the ICAH was a further link consolidating existing whānau and formal ties. The three projects were operationally owned by the individual health providers, not the ICAH. While these arrangements respected the autonomy of the pre-existing groups and limited the meeting burden for participants, it meant there was no process for managing changes in a group's participation or representation.

The major advantage of formal governance structures lies in the issue of representation. While it does not ensure representation in itself, it creates a context in which those issues can be addressed.

With the exception of the Far North, all sites experienced difficulties in maintaining Māori peoples' participation in their governance groups. Those areas with significant Pacific populations also had difficulty achieving Pacific participation at governance level. However all projects had a focus on the needs of Māori, Pacific peoples, and low-income people.

Prioritisation was also a problem. Even where there were high-quality needs assessments, the prioritising of workloads and projects presented difficulties for the ICAH groups.

## Needs assessments

### Key findings

- Community participation in the needs assessment process is highly valued, resulting in long-term buy-in from the community to the priorities identified.
- Community-based groups are in a good position to support the needs-assessment process for DHBs, because they can access high-quality information about community concerns and priorities for health service development.
- Despite good needs assessments, prioritising within those needs and within resource constraints may still be difficult.

The needs assessments that had been undertaken for Porirua and Kapiti (Porirua Kapiti Healthlinks Project 2000a; Porirua Kapiti Healthlinks Project 2000b) were universally valued in their communities for the detail provided and the 'community ownership' of the recommendations. In Counties Manukau the needs assessment carried out by Counties Manukau DHB was also extremely thorough and valued by its other intersectoral partners, and conclusively identified 'youth' as a key priority area. The YIP project managers have continued to carry out needs assessments specific to their key communities and the youth-related projects developed under ICAH. In the Far North the DHB had completed its own needs assessment and this was used in the development of the project plans.

It did not always prove easy to move from the needs assessment to identifying priorities for the ICAH funding. Three groups reported some degree of difficulty in prioritising projects. Where the funds for these projects were small, prioritisation issues included choosing a project from a list of priorities that fitted the amount of funding available, as well as choosing the major health priorities for the area to invest in.

## Inputs and resources

### Key findings

- Adequate funding is needed for the establishment phase of projects (sometimes this is longer than predicted), and for those required to monitor or administer such projects on behalf of the Ministry of Health.
- Funding for capacity building may be required in some projects.
- All projects were supported by high 'in kind' support from partners.
- Key informants perceived the projects as providing good benefits for small costs.

The Ministry of Health funding for these projects has mainly been directed towards supporting the development and capacity of the intersectoral groups. The literature review identified a key success factor as having paid staff whose role is to progress the project. In Kapiti and Porirua the funding enabled the appointment of paid staff to progress the recommendations of the Healthlinks reports. In Counties Manukau the appointment of a project manager to work specifically on intersectoral projects using this funding was highly valued across the sectors, and improved the health sector's ability to engage in intersectoral projects. In the Far North, rather than using the funding to appoint one co-ordinator between the three groups, the funding was delivered to the three health providers to maximise the amount available for the projects themselves. The three projects have provided considerable benefit there. However it is possible that some of the development and reporting problems with the ICAH would not have occurred if a proportion of the funding had been used for promoting the project itself.

In Porirua and Kapiti the partner councils have consistently provided additional funding. The projects have also been well supported 'in kind' by participating agencies and provider groups. This form of support has ranged from assistance with accounting procedures (both paying salaries and providing auditing services), through to providing rent-free accommodation. The groups themselves have also supplied high numbers of voluntary hours. This means that the total cost of the projects is much more than is shown in the tables supplied, and commitment to the projects by their communities and partners is evidenced in the additional support offered.

In Counties Manukau some of the projects have been jointly funded with other sectors. Such co-operation is critical to the development of truly intersectoral action. Joint funding of projects that are expected to have combined health, welfare and education outcomes makes sound budgetary sense.

DHBs reported hidden costs in monitoring and supporting the projects. The meetings and processes required to meet the Ministry of Health's reporting requirements have been reported as onerous in a number of places.

With the exception of the Improving Access to Primary Care in Porirua project, the funding amounts were small, and key informants reported good benefits for relatively little cost. An early key learning from Porirua about the amount of funding was a comment that the money was ‘not too little and not too much’; that is, not too little to do anything with and not too much to make accountability demands beyond the capacity of the group.

The relationship between funding and capacity is a critical one for new projects to address. In some cases the funding may need to address the issues of capacity building, which will delay expectations in terms of developing specific outcomes. This is especially the case when you are asking people to develop new and innovative ways of working together. The cost of doing business in communities at this level will vary greatly. For example, it may be necessary to cover meeting and travel costs in order to enable low-income people to participate.

Participants and key informants commented on the need for long-term financial security for the projects, the need to do ongoing fundraising for operational costs (for some projects only), and the sometimes heavy reporting requirements for relatively small amounts of money.

## Objectives and progress against them

### Key findings

- Developing a shared understanding of programme logic as part of the programme planning may help clarify complex relationships between determinants of health and particular health outcomes.
- Setting realistic timeframes for measuring progress is important for addressing complex objectives.

The overall objectives of the ICAH programme were to:

- improve health and disability outcomes in the community, particularly for Māori, Pacific peoples and population groups who have worse health outcomes
- develop initiatives that address health outcomes, broadly understood
- harness the support and involvement of local authorities, iwi and agencies responsible for health, housing, transport and education
- harness the wisdom and expertise of local communities (including providers), along with that of policy makers, planners and funders
- develop intersectoral capacity for successful joint community action across sectors
- pilot and evaluate the current initiatives so the lessons learnt can be included in guidance to DHBs.

The key objectives for each individual project were expressed in the contracts between each of the groups and the Ministry of Health. In Porirua and Kapiti, related objectives were listed in their strategic and annual plans.

In Kapiti and Porirua the objectives were set in a formal strategic planning process, which was developed out of the reports and plans. In the Far North the objectives were set from the needs assessments by the individual health providers. Porirua continued to review objectives on an annual basis, but there was some question about the effectiveness of this process because it appeared there had not been good prioritisation of projects or any rationale for selection (Porirua was not alone in reporting issues with prioritisation).

In general there has not always been a good marriage between the Ministry of Health's objectives, those of the ICAH and those of the individual ICAH projects. It would appear that there has not always been a common understanding of the determinants of health and their relationship to health and health disparities. This will be discussed further in the section on programme or intervention logic.

Some participants and stakeholders expressed concern at their inability to make a measurable impact on health outcomes and inequalities within the evaluation timeframe. Some informants commented that given the other factors affecting such outcomes, the projects themselves are unlikely to make measurable impacts. All reported that they felt their work was likely to have a positive impact both on health outcomes for their population and on inequalities. However, all groups expressed the unreasonableness of expecting measurable outcomes in the three-year evaluation timescale.

### **Treaty of Waitangi**

Taking a Treaty of Waitangi perspective, three principles (derived from the 1988 Royal Commission on Social Policy) are commonly applied to assess whether health services are addressing Māori health needs: partnership, participation and protection (Durie 1998).

Working in partnership is interwoven with Māori desire to achieve their own aspirations, or *tino rangatiratanga*. In the Far North, where the project is entirely Māori-driven, the Treaty relationships have been those between the three providers and the Ministry of Health. The providers have not always felt that this relationship supported the achievement of their aspirations. The establishment phase of the project took longer than planned for and was complicated by long-distance relationships. The devolution of the contract to Northland DHB has helped resolve some of these issues. By dividing the funds between the three groups, the aspirations of each were advanced by the implementation of key projects meeting their own priorities.

Evaluators in the other three sites reported that when discussing the level of participation in the projects, Māori informants emphasised the importance of choosing both the *level* at which they participate and the *way* in which they participate. For example, two iwi chose to work together in a partnership model with the Kapiti Community Health Group Trust rather than taking up positions on the Trust, with the partnership model ensuring that Māori aspirations were not lost within a mainstream community organisation.



In all cases, Māori have participated at all levels of project and programme development, although as earlier noted, there were difficulties maintaining Māori participation in the governance groups (except in Northland).

There has been some criticism of both process and outcome in terms of how Māori participation has been facilitated, but in each ICAH ongoing relationships and processes were available and used for reviewing and improving relationships. Meaningful engagement has also taken place at the subproject level, particularly in such matters as PHO development in Kapiti and Porirua, and the projects serving Māori communities in Counties Manukau.

The evaluators also found evidence of the advancement of Māori health aspirations in all four of the ICAH groups. The chairpersons of the Trusts in Porirua and Kapiti met regularly with the iwi rūnanga chair in their area, which ensured that these groups were working together where Trust and iwi aspirations coincided. Porirua Healthlinks Trust also has a Māori caucus at governance level. Both Trusts have supported Māori health initiatives in their areas. In Counties Manukau, where the intersectoral partners at governance level have been government agency representatives, Māori participation has been at a Crown agency level rather than at an iwi level, although the Tainui Māori Co-Purchasing Organisation has also had some involvement.

In terms of ‘protection’, all the ICAH initiatives can be said to be working to promote Māori health and reduce inequalities as noted above.

## **Critical success factors and barriers to success**

The six critical success factors identified by Maskill and Hodges’ literature review have been used to identify the transferable learnings from the ICAH projects, and barriers or difficulties that have occurred. Each is discussed in turn below. In addition, this evaluation has identified a seventh critical factor: the definition, development and agreement of a programme or intervention logic.

The literature review did not prioritise any of the critical success factors as being in essence more important than any other. Their order appears more chronological. Therefore the relative importance of each of these critical success factors could be seen to depend on which stage in their life cycle the projects are at.

### **1. All partners agree they should come together**

#### **Key findings**

- Establishing a mandate for partner engagement is critical. Partnerships have developed differently in each site.
- Partnerships, especially if diverse and potentially conflicting, need an investment of time and resources and need to be reviewed as needs change.

Although these projects were labelled ‘intersectoral community action for health’, not all have succeeded in both engaging their communities and developing partnerships with

non-health sector stakeholders. The four ICAHs represented a spectrum of intersectoral action. At one end of the spectrum, Porirua and Kapiti are health-sector focused, and engage with other health partners to work for the health and wellbeing of their communities. In the centre of the spectrum is the Far North, where the health provider groups have used this funding opportunity to engage other sectors at the project level, but their core business remains the provision of health services. Counties Manukau is at the other end of the spectrum, with intersectoral action seen as core business by the partners, but not involving communities in governance. In the other three sites the contracted groups are health-sector focused, and while they acknowledge and understand the social and economic determinants of health, their major focus for action is within the health sector.

The evaluators found evidence of agreement to act together in all project sites. Some agreements were based on formal contracts and/or memoranda of understandings and terms of reference; in others the agreements were more informal. Within the partnerships there was clear support for intersectoral action in all sites: the partnerships with local bodies in Porirua, Kapiti and Counties Manukau were supported by their mayors, and the councils offered operational support as a demonstration of their commitment to the intersectoral process.

Where the structures and processes have not been formalised there was some evidence of difficulties in reaching agreement to come together. Partners did, however, identify benefits in working together. They have also been able to make effective progress on their agendas. Interviewees reported that establishing positive partnerships takes a long time, and that the nature of partnerships changes as individuals come and go.

Some variability was found in respondents' views of the degree to which partners shared a vision in these projects. In some cases the vision was seen as project-specific rather than for the ICAH overall, and key informants thought that confusion over the roles of the ICAH in the community may restrict potential opportunities and benefits for partner groups. Key informants also reported difficulties in maintaining a shared vision. It was seen as essential for the vision to be clear so that new partners know whether it is worthwhile to join. This means that commitment to the vision needs to be readdressed with new members, and staff turnover has sometimes made this necessity burdensome for long-term members.

## **2. Wider community supports projects**

### **Key findings**

- High-level support is valued in these projects, and was critical to their establishment, but is seen as vulnerable to changes in political climate. Localised relationships work better than distant 'head office' ones.
- At the same time, high-level support must not overpower local and community decision-making.
- Community support is crucial to the success of ICAH. Consultation and developing relationships may be time consuming. Community expectations may also create

tensions when they have to be balanced against limited funding, the need for prioritisation, and funder or accountability requirements.

The evaluators discovered evidence of high-level support for these projects in Porirua, Kapiti and Counties Manukau, but less evidence in the Far North. High-level political support appeared particularly strong in Counties Manukau, with the Manukau Strategic Planning Group encompassing several government agencies, including the Manukau City Council. The ability to share budgets was also evident in Counties Manukau ICAH.

The mayors of Kapiti and Porirua were co-chairs of the original project group, and their support for the projects has been ongoing. The councils provide support (both financial and in-kind) for these groups, and the provision of rent-free and low-rent accommodation by Capital & Coast DHB for Kapiti has been highly valued. The DHB has also provided both in-kind and financial support. The Tu Maia project in the Far North has shown the ability to budget share, with Work and Income New Zealand providing funding via Taskforce Green to support the community workers in schools.

Relationships with the Ministry of Health varied. Proximity to Wellington meant Porirua and Kapiti ICAHs had a direct relationship, with Ministry personnel attending meetings and being readily accessible for advice. In Counties Manukau and Northland, the relationship with the Ministry was initially more distant, and at times difficult. In Counties Manukau, the DHB expressed some satisfaction when the Ministry's contract management role moved to the Auckland office. Similarly, Northland communication difficulties with the Ministry were improved when the reporting line changed so that the ICAH reported to a Northland DHB co-ordinator, who in turn reported to the Ministry of Health. The new localised process also supported a closer working relationship between Te Hiku o Te Ika ICAH and the DHB.

The Ministry of Health's commitment to ongoing funding for all ICAHs was perceived by the groups themselves as an indication of continuing support for this approach. Concerns were expressed about the possible vulnerability of continuing support for intersectoral approaches to addressing health inequalities if changes occur in the political climate, and whether other government agencies shared the health sector's commitment to this approach.

There may be some tension between the need for wide and high level support for intersectoral projects versus ensuring the decision-making power remains at the local level. Tensions between Ministry of Health partners and DHB partners were experienced in some places. In Porirua and Kapiti, the Ministry of Health manager took a leadership and advisory role and attended many of the Trust meetings in both places. In Porirua, the Ministry's manager also frequently acted as the Porirua Healthlinks Trust representative on other committees. This dual role had impacts within the community and on the relationship between the Trust and the DHB, sometimes resulting in other agencies being confused about the manager's role and sometimes placing barriers in the way of collaboration, because providers and the DHB did not want Ministry of Health involvement at such an operational level.

Engaging Māori and Pacific peoples to participate in mainstream projects appeared to be difficult in some areas. Key informants reported that Māori and Pacific participants have high demands on their time, whether they are community representatives or agency representatives.

Community support was clearly crucial to the success of ICAH sites. Adequate community consultation and development of relationships is time consuming and may slow the pace of implementation. However comment with regard to the PIA project noted this was a community development initiative, and it was appropriate that 'these things are done properly rather than hastily entered into'. While community support is essential, there may also be pressures with managing community expectations and balancing these against the need to prioritise ICAH work, limited funding for projects, and funder or accountability requirements.

### 3. Capacity is developed and sustainable

#### Key findings

- Partner organisations work together more easily when there is stable staffing; without this, more time and investment are required to build partner relationships.
- Identifying appropriate community subsections to engage in the projects as part of project design and development would help in the early development of partnerships.
- Voluntary capacity may limit community participation in the work of ICAHs.
- Several projects have experienced funding stresses, with participants reporting having difficulty finding funds for operational needs.
- The personal skills of key partners, and project staff, have been critical to project success.

#### Partner organisations

The literature review identified factors necessary for successful action among participating partners, including widespread support from all levels, activities should be part of job descriptions, and the ability to make decisions should rest at the local level (where the intersectoral activity is happening). The key project where this factor was relevant was the Counties Manukau ICAH. The appointment of the ICAH-funded intersectoral project manager was seen as having provided real impetus to intersectoral initiatives in Counties Manukau. The findings of the independent evaluations of AIMHI and the Healthy Housing pilot programme, together with this ICAH evaluation, suggest that sound project management and the presence of solid and effective working relationships between the two principal sectors involved have been an important contributing feature in these two success stories.

The role taken by the Ministry of Health's ICAH manager in the Kapiti Community Health Group Trust and the Porirua Healthlinks Trust has been highly valued. In the Far North, the shift of relationship to the DHB was viewed positively as it was seen as overcoming some of the problems of geography, confirming that local decision-making is critical for such initiatives.

Partner organisations in the projects have experienced difficulties where there has been staff turnover and new individuals have taken up the role on intersectoral projects. Long-term partnerships are consequently highly valued.

### **Community participation**

The three sites focusing on community engagement in their work (Porirua, Kapiti and Northland) have all collaborated extensively with existing community organisations, as recommended in Maskill and Hodges' literature review. An example of collaboration was working with Māori networks, including iwi. The literature review found no evidence specific to conditions favourable to Pacific peoples' participation, but key informants praised Porirua and Counties Manukau for their efforts to involve the Pacific community. Heavy time demands, high staff turnover in participating agencies and competing demands for potential Pacific participants were all identified as barriers to Pacific participation in these projects. The Porirua project, in particular, has throughout its life maintained a Pacific caucus, but attendance has not always been high. Continued work on strengthening relationships with the Pacific communities in Porirua appears to be paying off, with informants expressing confidence that Pacific participation was increasing.

In Kapiti the relationship between the Kapiti Community Health Group Trust and iwi was written into the Trust deed, with places available on the Trust should iwi choose to take them, but iwi have instead chosen a partnership model rather than working from within. It would appear that with some joint activities (such as the Kapiti PHO development), the relationship between the iwi and the Trust has strengthened.

Both Ngāti Toa, as mana whenua to the Porirua community, and taurahere (Māori who are from other iwi) have had a formal governance partnership with the Porirua Healthlinks Trust since the establishment of the ICAH project. In addition, Māori have participated as management, and support staff and a Māori caucus made up of staff and governance meets to provide a support network and discuss issues relevant to Māori.

Māori provider groups in the Far North are closely engaged with their communities. The projects have been delivered 'by Māori for Māori', with a focus on community development and retention of customary Māori knowledge. The three organisations are Māori health providers and over 80 percent of the project participants are Māori.

The Counties Manukau ICAH project has never laid claim to being either a community development or community action initiative. The ICAH, therefore, is first and foremost a government agency-driven initiative. However, community engagement work has taken place around the development of specific projects.

Difficulties in assuring community participation in some places appear to be to do with notions of what a community is; for example, whether groups are perceived as being 'representative' and, if so, whether they are representing a geographical, ethnic or cultural community. If further work is to be done in intersectoral community action for health, then it may be worthwhile to identify appropriate community subsections to engage in the projects as part of project design and development.

Community participation may be limited by the capacity of volunteers. For example, the Porirua Healthlinks Trust relied on voluntary committee members who were already extensively involved in their communities and not always able to give the time commitment needed to support the increasing workload engendered by the ICAH. Kapiti informants commented on the costs (both financial and time) of volunteering, and that these may exclude some people from being able to participate. They also noted the difficulties of matching voluntary resources to priorities. This includes volunteer capacity and skills, but also their willingness to undertake 'unattractive' tasks.

## **Adequacy of resourcing**

### **Funding**

In all cases the funding provided by the health sector has been highly valued. Funding has enabled the development of innovative projects, and in some cases the funding itself appears to have enabled a role that the agencies may otherwise have been unable to take up. However, all projects had occasions when resources were stretched and contracts may not always have covered the full costs of projects. In all cases the in-kind support from partners was perceived as having made as much of a contribution to the success of the projects as the ICAH funding itself.

Further work on accessing funding for projects prioritised by communities would help the ICAH projects to achieve their objectives. Health agencies working on the NEW initiative were disappointed by the Ministry of Health's decision not to fund any part of the piloting or implementation of the NEW initiative in Counties Manukau, and Kapiti continued to search for funding for an information service throughout the life of the evaluation.

The continuation of funding for all four sites is now seen as recognition of what has been achieved to date, and an acknowledgement that the intersectoral initiatives are likely to take more than three years to make any measurable impact.

Where costs are shared in intersectoral projects, project managers are sometimes required to meet different reporting requirements from different funders, thereby increasing the transaction costs faced by small agencies. Agreement is needed between agencies on generic reporting or already heavy reporting processes can become overwhelming.

### **Personal skills**

The personal skills of project co-ordinators have been a critical success factor in all the ICAH sites. Key informants, stakeholders and project participants gave high praise to the project staff employed in all four sites. Some concerns were expressed about the difficulty in recruiting staff with the right skills base where these resources are scarce, and project development was delayed in places where there were either difficulties in recruiting or where there was staff turnover. However, many of the projects have succeeded in attracting high-calibre staff who have stayed throughout the life of the projects.

The personal skills and attributes of staff and/or governance members on the projects identified by key informants include:

- the 'right' individuals with the mandate to co-ordinate and develop relationships
- extensive knowledge of the public sector and how to engage with them
- highly developed organisational skills
- 'good ideas' and good at getting things done
- highly effective on the ground at getting other sectors involved with 'what are essentially health issues' (eg, the NEW initiative)
- flexibility and resilience
- an ability to engage with Māori or Pacific communities or both, or making sincere efforts to consult with Māori and Pacific agency representatives
- good community links (including with iwi)
- very hard-working.

#### **4. Relationships enabling action are defined and developed**

##### **Key findings**

- Staff turnover has the potential to affect project development, whether it occurs within partner agencies or within the ICAH itself. Having relationships clearly defined may minimise the impact of staff turnover.
- Relationships take longer to develop where an atmosphere of trust and respect is lacking. Relationship development should be considered when developing the timelines for the project development process.
- Relationships change and develop over time, but not always as a result of formal review.

In all cases the relationships between partners have been agreed and defined. In Kapiti, relationships are defined in the Trust deed; in other cases, relationships are part of the contracting relationship. Not all relationships have developed in an atmosphere of trust and respect, which has meant that some projects took longer than expected to develop. Rather than stating that trust and respect are prerequisites, it is critical that project plans acknowledge the time and commitment that are necessary to develop such an atmosphere.

In Counties Manukau, government policy shift has facilitated the coming together of agencies to work together at both the strategic and operational level. Agencies have reached a general consensus that no single agency can address the deep-seated, systemic problems underpinning the socioeconomic disadvantage found in some parts of the Counties Manukau region.

In the Far North the original partners were clear about the shared responsibility, but following change in personnel in one agency there appeared to be less certainty.

## 5. Actions are planned and implemented

### Key findings

- Balancing the need to develop community and organisational infrastructure and to plan and implement activities requires considerable flexibility of timelines.
- Prioritisation has been particularly difficult in the higher needs communities.

Needs assessments were available in all ICAH areas. However the planning processes to undertake prioritisation and implementation have not been without difficulties in some sites. There have been significant delays at various stages in the planning and development of some of the projects, but all the groups have been able to develop strategic plans and implement activities. In many cases the delays reflected the time needed to undertake project and relationship development at the same time. Maintaining a focus on priorities, and balancing these against the need to be responsive to current issues, may be difficult at times.

Kapiti and Porirua wrote strategic and annual plans and have monitored them in their reports to the Ministry of Health, local government and their communities. Counties Manukau DHB developed a model of joint initiative work on the YIP for 'delivering a process for systematic, sustainable, change' rather than a service as such. The joint initiatives process has involved the establishment of a working party drawn from relevant sector representatives, the identification of target group needs, working through the issues and setting objectives, then breaking the work up into 'manageable chunks' before drawing up a memorandum of understanding to delineate tasks and responsibilities where the relationships need to be formalised. This conformed closely to the recommendations for successful intersectoral action.

Apart from the Far North, where each provider has selected one project to implement, there has been concern about the number of activities undertaken by the ICAH groups. Key informants in Porirua and Counties Manukau expressed concerns about difficulties in prioritisation, leading to over-investment of time on some contracts at the possible expense of others.

The planning and development stage of projects often took longer than predicted, with tension between the expectations of the community once funding had been announced and the time taken to bring the projects to fruition. This situation had some bearing on the groups' credibility within their communities.

## 6. Outcomes are monitored

### Key findings

- Investing the time to develop appropriate reporting templates at the beginning of projects has the potential to save large amounts of time later on.
- Reporting needs to take an appropriate proportion of paid worker time relative to the available funding and other activities.
- Reporting needs to be generic when funding comes from more than one source.



- Developing an intervention logic that identifies appropriate intermediate indicators may help make reporting more meaningful.

The progress of all the ICAH projects has been regularly monitored via quarterly reports to the local communities, ICAH partners and Ministry of Health, and through the ICAH evaluation. The reporting process has had its problems. The Ministry of Health has found that the reporting templates used have sometimes failed to provide sufficient detail. The ICAH groups, and in some cases DHB managers, have found that the amount of paid worker time that reporting requires is high in relation to the amount of funding provided, and that Ministry of Health requirements for information have not always been clear.

Developing a model of intervention logic in partnership with the funder and evaluator at the establishment phase of projects might go some way towards developing reporting templates that are meaningful and useful, both to the funder (in terms of the overall objectives of the programme) and to the groups (as it would better enable them to report on their activities, and the impacts of these).

In Kapiti and Porirua the Healthlinks reports provided a baseline against which the groups have measured their own progress and have reported to the Ministry. A large number of activities and recommendations are covered in the reports, many of which are, however, outside the control of the Porirua Healthlinks Trust and Kapiti Community Health Group Trust. In these cases the trusts have asked the relevant DHB or health providers to report to community forums, so that progress continues to be made on implementing the recommendations of the reports. Reporting in the Far North was shifted from the Ministry of Health to the DHB, which was seen as more appropriate, but the issues of an appropriate reporting template had still not been resolved at the end of this evaluation.

Respondents saw the confirmation of further funding for these projects as critical to allow the projects time to succeed. Most informants expressed concern about the ability to make a difference to health and disability outcomes within the timeframe of the evaluation, particularly in sites where there were significant delays in the establishment phases of the projects. Additional time was needed to establish the necessary relationships where pre-existing relationships had not existed or where partners experienced high staff turnover.

Monitoring of outcomes and equity impacts for complex intersectoral interventions has been extremely difficult. Often the important outcomes are influenced by many factors, and attributing outcomes to specific actions in small programmes is just not possible. A reasonable timeframe is also required before outcomes will be seen, and some implementation delays shortened the timeframes for both the projects and their evaluation. However, participants and stakeholders interviewed for the evaluation are confident that projects will make a difference in the long run in terms of improved health and outcomes.

## 7. Programme or intervention logic is developed

### Key findings

- Project development may be enhanced by the early establishment of a shared understanding by funders, ICAHs and evaluators of programme logic.
- Such a shared understanding would assist in the development of positive relationships between funders and ICAH and ICAH partners.

We have identified the development of a programme or intervention logic in the early stages of a project as another critical success factor. Where clear programme logic is mutually developed and understood by partners, project development and direction may be enhanced.

Ministry of Health documentation states that the ICAH initiatives were based on the principles of community engagement and development and were intended to tackle the wider determinants of health status, as well as access to health and disability services, by engaging in intersectoral approaches. Not all the ICAH groups shared an understanding of what constitutes 'intersectoral', either in terms of the partnerships or in terms of their actions. It is sometimes hard to infer the further development of this programme logic from the selection of activities and priorities in the programme.

The contracting process with the Ministry of Health appeared to involve the development of contracts for projects that were priorities for the groups and that fitted the budget available, and Ministry staff acknowledged that the boundaries for the programme were defined after the establishment of some projects.

Counties Manukau is the one example of clear programme logic mutually developed and understood by the partners. YIP resulted from extensive intersectoral consultation and agreement that: a) the region's youth have a high level of unmet need, b) few initiatives were designed to address this need, and c) youth have the most to gain from intersectoral collaboration. Youth are a primary target client group for most of the participating government agencies and so it was in the interests of all parties to work together.

With the exception of Counties Manukau there have been difficulties in establishing an agreed and understood programme logic in these ICAH projects. In some cases, governance members have developed clear programme logic but the understanding has not been shared by all their partners, particularly with regard to the expectation of a focus on inequalities and determinants of health. In other cases, staff or partner turnover has undermined the development of such intervention logic and shared understanding.

### Summary

Reviewing the analysis section, it can be seen that the four ICAH sites varied widely in their structures and modus operandi.

The degree of community and intersectoral involvement varied. Counties Manukau had the greatest intersectoral partnerships and emphasis on addressing the broader determinants of health, but did not involve the community at governance level. Porirua and Kapiti were health-sector focused and engaged with other health partners to work for the health and wellbeing of their communities. They also involved community organisations in their governance. The Northland ICAH sits somewhere in between. Its projects engaged with other sectors although the providers' core business remained the provision of health services. Governance was not formally constituted in the Northland ICAH.

Strong community participation in needs assessment resulted in long-term buy-in from the community to the priorities identified. However prioritisation within needs and resource constraints still proved difficult.

Adequate funding and financial security are essential for these projects. This includes sufficient funding to support the time necessary for establishment phase and for capacity building. The literature review found that a key success factor is paid staff whose role is to progress the project, and this was borne out by the evaluation. Porirua, Kapiti and Counties Manukau all had paid staff. The Northland ICAH chose not to appoint a co-ordinator. This was to maximise the funding for the projects themselves, but development and reporting problems might have been lessened if some funding had been used to promote the project itself.

There has not always been a good fit between the Ministry of Health objectives, those of the ICAHs and those of individual ICAH projects. Developing a shared understanding of programme logic as part of early programme planning may help direct the development of projects and strengthen their ability to make progress towards desired outcomes. However, realistic timeframes and expectations of what an ICAH alone can achieve are necessary for measuring outcomes.

High-level support was critical to the establishment of these projects and greatly valued. Localised relationships worked better than distant ones. At the same time, there is a need for clarity of roles. High-level support must not overpower local and community decision-making.

Relationship building is an essential component of successful partnerships and takes time. Relationships and personnel can be expected to change over time and staff turnover necessitates ensuring new staff understand and share the project vision.

The critical success factors identified by the literature have been relevant to all the ICAH sites, although it is also clear that within these boundaries, widely different developments may emerge.

## Conclusions

This final section returns to considering how successful the ICAH initiatives have been in meeting overall Ministry of Health objectives. We also draw together overall conclusions about the initiatives, their possible future and the lessons they could provide for DHBs and other organisations considering developing similar programmes.

### Reducing inequalities

An important objective of the ICAH initiatives was that they improve health and disability outcomes for Māori, Pacific peoples and other population groups with poor health and disability outcomes. Funding for the ICAHs came from the Ministry of Health Reducing Inequalities Contingency Fund.

The Reducing Inequalities Intervention Framework (Ministry of Health 2002) notes a number of factors influence the demonstrable health inequalities within New Zealand:

Addressing these socioeconomic, ethnic, gender and geographic inequalities requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health. This approach requires both intersectoral action that addresses the social and economic determinants of health and actions within health and disability services themselves (Ministry of Health 2002, vii).

Four levels of intervention to improve health and reduce inequalities are recognised: structural, intermediary pathways, health and disability services, and individual impact of disability and illness.

At the structural level, healthy public policy can be used to address the root causes of inequalities such as racism, poverty and unemployment. At an intermediary level, community action and the development of personal skills can be used to address factors such as the environment, behaviour and access to resources that determine inequalities. At the level of the health system, the health sector can be reoriented to focus on prevention, thereby avoiding the development of illness and disability. At the impact level, a number of different strategies can be used to reduce the impact of illness and disability, such as the development of personal skills and advocacy for appropriate policies (Signal et al 2003).

All the ICAH initiatives showed evidence of working towards reducing inequalities, once again varying in their strategies and levels of intervention.

At the structural level, Porirua Healthlinks Trust and Kapiti Community Health Group Trust both made submissions on health and local body strategies affecting health services and health determinants. Key informants said these have been effective in informing (and in some cases modifying) policy.

The Achievement in Multicultural High Schools Initiative (AIMHI) and Healthy Housing pilot programme in Counties Manukau, and Tu Maia in the Far North, were addressing disadvantage at the structural level by tackling the resources available to disadvantaged groups.

Intermediary pathways (targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health (Ministry of Health 2002)) was the level at which the ICAH projects were taking the most action. Counties Manukau, in particular, was having a direct impact on creating supportive environments, both in communities via the Healthy Housing pilot programme and in the schools via AIMHI. Tu Maia in the Far North was also reported to be creating supportive environments.

In terms of the development of personal skills, the three Far North projects made their biggest contribution in this area, and in the long term would be expected to have significant impacts on maintaining the health of participants via this pathway. AIMHI was also affecting personal skills.

Kapiti and Porirua ICAHs were most engaged in action at the health and disability services level. They challenged health developments and maintained a focus on equity of access to health services to ensure that the health system does not increase health disparities via unequal access. The primary care projects in Porirua and Otaki were reported to be having an impact in this area already. The AIMHI project and the Healthy Housing pilot programme in Counties Manukau have both had an impact at this level by increasing access to primary care.

There is possibly less action at the individual level of the reducing inequalities framework than at others, as would be expected given the nature of the projects. The Diabetes Cluster in Porirua and the Healthy Housing pilot programme (although more oriented towards the other levels of action in the framework) would have some impact on reducing inequalities by improving access to health care and hence limiting the impacts of health and disability. Community outreach primary care projects may also work on this level by increasing access to preventive health services.

In summary, all groups have developed initiatives, at differing levels, that focus on the health of disadvantaged groups. Together they are addressing the four levels of intervention identified by the Reducing Inequalities Intervention Framework and as such could be expected to be contributing to improving health outcomes and reducing inequalities.

## **Impacts on health and disability outcomes**

All the ICAH projects have developed initiatives that intended to address health outcomes, broadly understood. However any improvements in health and disability outcomes in the community cannot be solely attributed to the ICAH initiatives because of concomitant changes in other aspects of the health system (eg, the introduction of PHOs). In addition, the full impact of the projects may be yet to be realised, given the relatively short timeframe of this evaluation. The level(s) at which projects aim to influence health outcomes varies. Some have focused more on health services and others more on health determinants.

The Kapiti Community Health Group Trust and the Porirua Healthlinks Trust have both had an impact on the provision of health services to their populations, at both primary and secondary level. Protecting the access of Porirua and Kapiti residents to services is likely to have long-term benefits for these communities. Kapiti's involvement not only meant that the Kapiti Health Centre project was completed well before the original business plan proposal, but also that a more acceptable service ensued, including greater integration of once disparate services. Both the Kapiti and Porirua trusts continued to engage with the DHB over the Kenepuru redevelopment, and by providing detailed feedback to the DHB have again had a major impact on accessibility (through protecting the services).

Neither of these groups purported to represent the community, but both have played a critical role in facilitating access to community views for the DHB. Without them, the DHB's task of community engagement would be much more difficult. The trusts have engaged with both the PHO development process and the process for community representation on PHO boards. They offered alternative models for management of community representation, which may have further lessons for the DHB and primary care providers about such processes in the future.

The delayed start in the primary care projects in Porirua meant that only a report of the first year is available. However, the qualitative data clearly suggests that a positive impact is expected from this project, and the analysis of a further year's data should reveal the impact of the improvements in access to primary care in this community.

While Counties Manukau ICAH stakeholders considered it unrealistic to see measurable health outcomes within the evaluation period, there is some evidence to support their optimism that improved health and reduced inequalities would be seen in the longer term.

YIP was leading to early identification and intervention in young people's health needs. This could be expected to improve health outcomes. The evaluation of the Healthy Housing pilot programme (Auckland UniServices 2003) showed clear evidence of its impact on participants' health. There was an increase in visits to GPs, outpatient clinics and emergency departments, and a 33 percent (statistically significant) reduction in hospital admissions in the intervention households compared to a geographically matched control group. The reduction in hospital admissions was linked to these families having accessed health care earlier than in the past. The establishment of extensive collaborative relationships with health and social agencies, many of which were based on formal memoranda of understanding, was also identified as a significant outcome of the programme. Feedback to this current evaluation indicated that the ICAH co-ordinator had played a vital part in helping to keep this complex pilot programme on track.

The Far North ICAH is focused predominantly in Māori communities, and although the timeframes are too short for most measurable outcomes, responses from key informants show that the projects were all improving skills and contributing to community development. Because Hei Oranga i te Whenua targets a small community, statistically significant changes in health outcomes will not be identifiable. However changes in health-related behaviour have been reported for the participants in this project. Increased physical activity and improved nutrition are the intermediate indicators that have been successfully modified by the project, but additional outcomes include the transfer of traditional (and modern) knowledge, and whānau development. Side benefits of modifying risk behaviours (such as limiting smoking) have also been identified for some whānau participating in this project.

The ICAH initiatives should be in a good position to improve health and disability outcomes over time because of their ability to consider the broad determinants of health, to engage and work across sectors to address these, and to draw on community wisdom in finding solutions. Strong leadership and management will be needed to maximise the possible outcomes. Greater understanding by participants of programme or intervention logic would help with project prioritisation and tracking of their results. Sufficient, stable, long-term funding will also be necessary to ensure the success of projects and the realisation of their full potential benefits to health.

### **Harnessing wisdom, developing capacity**

Three overlapping goals of the ICAH initiatives are considered here, namely that they:

- harness the support and involvement of local authorities, iwi and agencies responsible for health, housing, transport and education
- harness the wisdom and expertise of local communities, including providers, alongside that of policy makers, planners and funders
- develop intersectoral capacity for successful joint community action across sectors.

All the projects were intersectoral in terms of forming relationships with other parts of the health sector and other sectors to take action on health issues; however they engaged with varying sectors, in accordance with their local settings and identified needs. Counties Manukau had the clearest and most long-standing intersectoral alliance which was further built on through ICAH. We note again that it takes time for relationships to develop and trust to be built so that groups can work together effectively, and sufficient time and resources need to be allocated to this. This will in turn produce dividends later. For example, anecdotal feedback from the AIMHI school co-ordinator indicated that intermediate outcome measures were best in those schools where the development investment was highest, and strong and effective relationships appeared to have developed between initiative's key stakeholders (schools, education, health, welfare and contributing non-government agencies).

All groups drew on community wisdom, although again this was done in differing ways. Kapiti and Porirua offer the clearest models for community engagement, with Porirua demonstrating ways of meeting the challenges of engaging where the community is large (in terms of population) and diverse (culturally). In Kapiti, the involvement not only of the Kapiti Coast's different geographical communities, but also the much-praised 'whole of community' approach adopted in their engagement, offers a positive model to DHBs for accessing community views on health services and issues. In Counties Manukau, the ICAH was not a community-driven initiative. However, there was community engagement both in needs assessments and in the subsequent development of specific projects. In the Far North the wisdom harnessed for the project has included traditional knowledge, with the actions of the Hei Oranga i te Whenua co-ordinator ensuring that this knowledge is passed on to the next generation despite the dislocation of rural–urban–rural migration.

Once again relationships take time to develop. In some cases this can be regarded as an outcome, or at least as an intermediate indicator. A State Services Commission's report (State Services Commission 2004) and the Ministry of Health's literature review (Maskill and Hodges 2001) both emphasise the need for relationship factors such as a history of successfully working together, and an atmosphere of trust and respect. In places like Porirua, where there is a long history of community action but a lack of trust in government agencies, relationship development and the success of the needs-assessment process (where community views and wisdom were respected and valued) were critical in developing a base for further action.

The ICAH projects have successfully harnessed the support of partners – although in some cases greater focus has been placed on the wisdom of communities, while others have emphasised the wisdom of planners and providers across sectors. Counties Manukau has had a major effect on the development of intersectoral capacity for successful action across sectors. Partner feedback indicated that the dedicated cross-sectoral workers were highly valued: it appears that the ICAH managers have contributed towards other sectors achieving their agencies' objectives and to these partners having included health objectives into their sectors' agendas. Porirua and Kapiti provide a model for community action and community engagement across the health sector. They have also engaged in intersectoral activity, although not at the level of leadership apparent in Counties Manukau. In Northland, partnerships have been specifically focused around the subprojects which developed.

## **Evaluating programmes and transferring learning**

The Ministry of Health's final objective for the ICAH initiatives was to pilot and evaluate the current initiatives so the lessons learned could be included in guidance to DHBs.

The evaluation of particular projects has proven easier than estimating the impact of the projects overall. The 2005 literature review (Maskill and Hodges 2005) updated for this report outlines possibilities for monitoring the impacts of complex interventions, suggesting that early engagement is necessary so that the groups and the evaluators can identify the programme logic in a way that makes the identification of intermediate indicators easier.



When the evaluation began it had not been decided what subprojects would be evaluated in Counties Manukau and the Far North. The evaluation period was to be three years, with both process and impact evaluation to be carried out on the designated projects. Because of delays in contracting and project development, the evaluation was not able to review three years' work on all the projects. Also, the development of an overall programme logic and evaluation model – as proposed in the project plan – has not been possible after it became clear that the projects were very different in conception and implementation. The formative evaluation and participatory action research processes outlined in the original tender for this process may have offered early assistance in project development at some of these sites. Investing sufficient funding in early relationship development between the evaluation team and the groups, alongside the funder, may have served to strengthen the projects and the evaluation.

A last comment on these processes relates to the nature of the contracting process. Part of the rationale for developing these projects was to harness – and value – local knowledge and expertise. The initial contracting processes by the Ministry of Health were sufficiently open to allow for local priority setting. This did not always suit the evaluation team, who would have liked clarity earlier about what it was they were supposed to evaluate, but it has been very important to achieving buy-in at the local level. The health action zone evaluation reports suggest that a late change from a bottom-up priority setting process to a top-down contracting process was detrimental to those projects. Thus far, the ICAH project has allowed for local priority setting, and the Ministry of Health's contracting process has facilitated this.

The evaluation team believes that positive outcomes have resulted from the Ministry of Health's investment, and that continuing support for these initiatives will enable them to realise a full return on that investment. In particular, there is significant support for a dedicated intersectoral initiator role within DHBs. In all of this it needs to be emphasised that the ICAHs are inherently long-term developmental projects that tend to require long lead-in times and sufficient time to realise the benefits of concerted intersectoral action.

## **Where to from here? ICAH in the PHO environment**

The ICAH initiatives began to develop in 1999–2000, before the introduction of DHBs in January 2001, and before the publication of the Primary Health Care Strategy (Minister of Health 2001) which saw the establishment of PHOs from July 2002 onwards. There are now 81 PHOs covering most of the country (3.9 million New Zealanders).

The first of six key directions for primary health care which underpin the Primary Health Care Strategy is 'work with local communities and enrolled populations' (Minister of Health 2001). PHOs are to work to improve the health of their communities by focusing services on defined populations rather than just the individuals who seek care. To achieve this, 'Primary health care needs to involve participation by people in the communities covered .... Services will then be more likely to reflect needs and priorities that are set by the people, not just by providers' (Minister of Health 2001, 7). In addition, PHOs are required to include some community members on their governing bodies and demonstrate that there are processes to identify community needs and to

allow community members and service users to influence the organisation's decisions (Minister of Health 2001). Such community involvement has been crucial to the success of ICAH sites. It has included involvement in needs assessments (although these were not carried out by the ICAHs themselves); a role in governance in the case of the Porirua and Kapiti ICAHs; and community engagement and participation in project development. All provide examples of ways in which communities can also be involved in PHOs. The first report of the evaluation of the Primary Health Care Strategy found that the community appeared to be well represented at board level in PHOs (Cumming et al 2005). In addition, many PHOs had a formal process for community groups to provide input to the Board. There were also multiple formal and informal mechanisms for interaction between PHOs and the general community, including various types of community groups and the use of relevant personal links. Māori representation and community participation were also strong.

Besides their base capitation funding (and funding for management and health promotion), PHOs are also eligible for Services to Improve Access funding. The Guidelines for Services to Improve Access proposals (Ministry of Health website <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-sia>) state:

A key priority for implementation of the *Primary Health Care Strategy* is to reduce barriers for the groups with the greatest need through additional services to improve health and improving access to existing first-contact services. The Strategy also identifies the need for encouraging developments that emphasise multi-disciplinary approaches to services and decision-making, including the co-ordination of services with secondary care, public health and other community-based services.

Services to Improve Access (SIA) funding is available for all Primary Health Organisations (PHOs) to reduce inequalities among those populations that are known to have the worst health status: Maori, Pacific people and those living in NZDep index 9–10 decile areas. The funding is for new services or improved access and is additional to the main PHO capitation funding for general practice-type care.

To obtain Services to Improve Access funding, PHOs must develop service proposals and have these supported by their DHB, which must in turn obtain approval from the Ministry of Health in order to receive funding. The amount of funding for which a PHO is eligible is determined according to the age, gender, ethnicity and deprivation of the enrolled population of the PHO.

A number of the ICAH subprojects would appear to fit Services to Improve Access criteria, such as AIMHI, the Otaki Community Health Worker project and PIA. It should again be noted, however, that the funding stream for ICAH was additional to Services to Improve Access funding (and PIA, for example, was developed so as not to overlap with Capital & Coast DHB Services to Improve Access services).

The ICAH projects are also broader than primary care, to which Services to Improve Access funding applies. However they sit well within DHB objectives under the New Zealand Public Health and Disability Act (New Zealand Government Reprint as at 20 March 2006), including:

- 22(1) (a) to improve, promote, and protect the health of people and communities
- (b) to promote the integration of health services, especially primary and secondary health services
- (e) to reduce health disparities by improving health outcomes for Maori and other population groups
- (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services.

Intersectoral collaboration is also promoted under DHB functions set out in the Act:

- 23(1) (b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities
- (m) to collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes.

The future for ICAH projects may therefore be closer alignment with DHBs and PHOs, although a question remains about whether ongoing funding will be available, beyond normal DHB and PHO budgets.

## **Key lessons from the ICAH evaluation**

Overall conclusions drawn from the evaluation are here summarised.

- The four ICAH sites have each developed quite differently in response to a variety of local factors, including:
  - the varied size, make-up and needs of their target population
  - the history of community, iwi and hapū development and health action
  - which sectors and organisations partnered together
  - governance models
  - the nature of community engagement
  - the choice of subprojects
  - resources.

All are broadly meeting their own and the overall ICAH objectives. Such intersectoral initiatives may therefore be expected, and should be encouraged, to develop local variations and solutions to meeting the same objectives.

- Following on from this, a variety of models can be expected to achieve successful intersectoral initiatives. This evaluation included both ‘bottom up’ and ‘top down’ models. The former emphasised strong community involvement in directing the development of the ICAH (Porirua, Kapiti, Northland). In contrast, successful intersectoral relationships already existed in Counties Manukau at an agency level, and community involvement was drawn in as projects were developed.
- Various governance models have emerged. Issues around governance and operation of ICAH projects need to be clearly addressed during the establishment phase. Groups that established formally constituted governance groups appeared to have less difficulty in developing and monitoring reporting processes, and in negotiating changes as the projects developed and evolved.
- Needs assessment and prioritisation are essential to provide direction for ICAH projects.
- Developing a shared understanding of programme logic as part of the programme planning may help clarify complex relationships between determinants of health and particular health outcomes, and thus assist in better achieving the desired outcomes. It is also necessary to set realistic timeframes for measuring progress against complex objectives.
- Adequate funding is needed to establish an ICAH. The establishment phase may take longer than predicted. Ongoing funding is required to sustain projects, including funding for administration and monitoring, and in some cases, capacity-building.
- The importance of the six critical success factors identified by the literature is supported by the findings of this evaluation. This evaluation has also identified a seventh critical success factor. Conversely, failing to achieve these factors is likely to be experienced as a barrier to the success of ICAH. Key points relating to each success factor are reiterated below.
  - *All partners agree they should come together*: Establishing a mandate for partner engagement is critical. Developing partnerships takes time and resources, and they require review as needs change.
  - *Support in the wider community*: Community support is crucial to the success of ICAH. High-level support is valued, but must not overpower local and community decision-making. Changes at organisational and structural levels require time to develop new relationships and renegotiate roles.
  - *Capacity development and sustainability*: Stable staffing within partner organisations enhances their ability to work together. Voluntary capacity may limit community participation in ICAH. The personal skills of key partners and project staff have been critical to project success. Adequate funding is required to sustain projects.
  - *Relationships enabling action are defined and developed*: Relationships take time to develop, and do so best in an atmosphere of trust and respect. Relationships change and develop over time.
  - *Actions are planned and implemented*: Prioritisation is essential, but may be difficult especially in high-needs communities. Flexibility of timelines is required to balance the need to develop community and organisational infrastructure, and to plan and implement activities.

- *Outcomes are monitored*: Developing an intervention logic that identifies appropriate intermediate indicators may help make reporting more meaningful. Appropriate reporting templates need to be developed at the beginning of projects. Reporting requirements need to be relative to the amount of funding and paid worker time, and should be generic when there is more than one funding source.
  - *Programme or intervention logic*: This seventh critical success factor was identified by this evaluation. Project development and direction may be enhanced by the early establishment of a shared understanding of programme logic by funders, ICAHs and evaluators.
- All the ICAH projects have developed initiatives that intended to address health outcomes, broadly understood. They have the potential to improve health and disability outcomes over time because of their ability to consider the broad determinants of health, to engage and work across sectors to address these, and to draw on community wisdom in finding solutions. Strong leadership and management are needed to maximise the possible outcomes.
  - All the ICAHs have developed initiatives that focus on the health of disadvantaged groups. Together they are addressing the four levels of intervention identified by the Reducing Inequalities Intervention Framework and as such could be expected to be contributing to improving health outcomes and reducing inequalities.
  - However any improvements in health and disability outcomes in the community cannot be directly attributed to the ICAH initiatives because of concomitant changes in other aspects of the health system (eg, the introduction of the Primary Health Care Strategy).
  - In addition, the three-year timeframe of the evaluation is a short time in which to see changes to health outcomes. ICAHs are inherently long-term developmental projects which will require sufficient time to fully realise the benefits of concerted intersectoral action.
  - The ICAH initiatives began before the introduction of DHBs and the establishment of PHOs. ICAHs would appear to sit well with DHB objectives of population health, integrated services, intersectoral collaboration, reduced disparities and community participation. Some aspects of ICAH would also fit under Services to Improve Access within PHOs. Therefore ICAHs should be encouraged to more closely align with DHBs and PHOs in the future. The ongoing funding source(s) of ICAH must also be considered.

## **Key implications for the future development of ICAH initiatives**

The six critical success factors identified in the literature, with the addition of a seventh critical success factor – intervention logic – can be used to plan an effective ICAH initiative. In particular, an effective initiative will recognise:

- the time it will take to develop and define community and organisational partnerships
- the importance of these partnerships
- that adequate funding encompasses establishment, administration, projects, monitoring and capacity-building

- that funding must take into account the likely (and potentially lengthy) timeframes for establishment and outcomes
- that using intervention logic will assist in planning, prioritisation and identifying appropriate outcomes
- that reasonable timeframes must be allowed for projects to develop and outcomes to be achieved.

Formal governance appears to be an advantage, and should be addressed during the establishment phase.

Effective ICAH initiatives are in a good position to improve health and disability outcomes over time because of their ability to consider the broad determinants of health, to engage and work across sectors to address these, and to draw on community wisdom in finding solutions.

Strong leadership and management, at all levels, are necessary to maximise the potential outcomes.

Further integration of ICAH initiatives with DHBs and PHOs should be encouraged.

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## Appendix 1: List of Informants and Stakeholders Interviewed

**Table 8:** Porirua

Organisation	Number of interviewees	Number of interviews
Ministry of Health	2	5
Capital & Coast DHB – board	1	2
Capital & Coast DHB – staff	3	3
PHLT committee and chairs	7	14
Porirua City Council – staff	1	1
Māori Providers Group	1	1
Pacific Peoples Co-ordinating Group	1	1
Regional Public Health	1	1
PHLT staff	3	11
Community informants	4	4
Primary care staff	9	17
PHLT project staff	2	2

**Table 9:** Kapiti

Organisation	Number of interviewees	Number of interviews
Ministry of Health	2	4
Capital & Coast DHB – staff	5	5
MidCentral DHB	3	4
Rūnanga	2	2
KCHGT staff	2	6
KCHGT trustees	5	10
PHO	1	1
Community informants	3	3
Primary care providers	5	11

**Table 10:** Counties Manukau

Agency represented or concerned	Number of interviewees	Number of interviews
Counties Manukau DHB intersectoral project managers (2)	2	9
Counties Manukau DHB other staff	3	4
Ministry of Health, Auckland office	1	3
Ministry of Health, Wellington office	1	2
New Zealand Police, Otahuhu Office, youth officer		1
Ministry of Social Development senior advisor	1	1
Work and Income New Zealand public relations advisor	1	2
Housing New Zealand Corporation senior advisor	1	2
Ministry of Education AIMHI co-ordinator	1	3
Finlayson Park School pilot programme health facilitator	1	1
Tainui Māori Co-Purchasing Organisation contracts manager	1	1
Te Puni Kōkiri senior analyst	1	1
Southern Cross campus nurses	1	2
Full Service Schools' evaluation principal researcher	1	1
Diabetes Trust nurse co-ordinator lifestyle	1	1
Manukau City Council Healthy Cities co-ordinator	1	1
Tangaroa College principal	1	1

### The Far North

Early interviews with regard to project establishment were carried out with staff from:

- Te Rūnanga o Te Rarawa
- Te Hauora o Te Hiku o Te Ika
- Whakawhiora Pai
- Kaitaia College staff and board member.

Background information was also collected from an in-depth analysis of the Far North communities involving Kaitaia, Ahipara, Te Kao and Te Hapua undertaken by nursing students and staff from Te Tai Tokerau MAPO Trust (four members), and interviews with staff from Northland Health Limited.

From August 2002, when Hei Oranga was confirmed as the focus project, interviews were carried out with:

- kaumātua
- kuia
- marae committees
- teachers
- representatives of the Māori Women's Welfare League
- Māori wardens
- other community members.

Six workers from Whakawhitiora Pai were interviewed, and the three nursing students from this area were always happy to help with information from neighbours and whānau as the project developed.

Stakeholder interviews included:

- Far North District Council staff
- Department of Conservation staff
- local businesses.

Community leaders were interviewed, both religious leaders and those on various trust boards.

Health sector interviewees included the DHB contract manager (interviewed three times) and a Ministry of Health informant.