Case study 6: Non-profit NGO delivers convenient health care

Recognising that many people in high needs areas get the health care they need only if you make it easy for them, an Auckland non-profit NGO brings related services together for greater effectiveness.

The **Mangere Community Health Trust** (MCHT) was established in 1993 to solve the socio-economic determinants of health in the community of Mangere. The Trust offers a large range of services – all developed to fill significant gaps in delivery of health services in the community. These include an integrated general practice and pharmacy, an x-ray plant and soon-to-commence mammography service.

The Mangere Community Health Trust's latest collaborative venture will make treatment for diabetes more accessible and convenient for local people by "wrapping services around the patient" in one location. Its sister trust, the **Mangere Health Resources Trust** has just completed building a multimillion dollar health care facility to be opened in November 2011. This will house, along with a range of health care services, a multidisciplinary diabetes hub.

The new diabetes centre brings together a range of specialists previously scattered across different locations. MCHT will provide the dietician, podiatrist, mental health service, smoking cessation programme, oral health service, in addition to a retinal screening unit. The Sky City Trust funded the initial purchase of the retinal cameras. **Counties Manukau District Health Board** will provide access to the ophthalmology department's portable laser so eye surgery can take place in Mangere. The new diabetes hub will make services more convenient and cut down on delays caused by letters of referral to Middlemore and the Super Clinic, and other traditional barriers to treatment.

Michael Lamont, CEO of the Mangere Community Health Trust, explains the philosophy behind the collaboration this way: "If you put all the services together, people know 'that's where I go for X'. They don't have to travel all over the city or to the Super Clinic, which is some distance away. Currently many people lack transport so do not turn up for appointments, and seek treatment only when their condition has significantly deteriorated. There's some talk of 'virtual' Integrated Family Health Centres, but I believe that in a community such as Mangere where transport is a major issue for many residents, physical co-location will be more effective."

The relocation of diabetes services into the new building will allow a neighbouring service for at-risk and offending youth, the **Mangere Genesis Youth Project Trust**, to expand into one of the two adjacent premises owned by the Resources Trust. There are already strong connections between the two organisations as the socio-economic determinants of health[1] manifest in a range of problems seen by health care providers and youth offending. The social workers and sworn police officers based within Genesis see the same issues in the youth referred to them. Examples include hearing difficulties caused by glue ear, poor housing leading to chronic illness, drug and alcohol substance abuse, and relationship issues.

"You can't deal with just one of their issues, as they are interconnected," says Michael.

[1] *The Social, Cultural and Economic Determinants of Health in NZ*, National Health Committee, June 1998.

Michael is enthusiastic about *Better, Sooner, More Convenient* changes in primary healthcare that are encouraging closer team work and collaboration between GPs, nurses, pharmacists, and others involved in the delivery of health care and social services.

Mangere Community Health Trust became a PHO in 2003 when this was the political "flavour of the month", but it lost this status in recent PHO amalgamations. This could have lost the community the services previously funded by the PHO Services to Improve Access (SIA) funding, as these were not going to be funded under the new PHO arrangements. These included a radiology service, dietician, nutritionist and podiatrist.

"When we suggested to the DHB that neither the community nor the DHB wanted to lose these, the DHB agreed and now contracts with us directly to keep these going. They are effectively paying twice, which is not particularly sensible," says Michael, who is never-the-less pleased that the services can be continued under the auspices of the Trust.

"Now that we're not a PHO, we have a bit more freedom to respond to community needs," says Michael.

South Auckland's needs include 'third world' rates of rheumatic fever, which pose an on-going problem for the large Māori and Pacific population in this area. The simplest intervention is the preventive one of diagnosing and treating Streptococcal A throat infections, which may lead to rheumatic fever and potentially rheumatic heart disease.

"There are issues around diagnosis and management of Strep A," says Michael.

"GPs treat it extremely well once the child presents. While sore throats are common and most are viral, a strep throat diagnosis requires a throat swab to be analysed at a laboratory, on referral from general practice. The result takes a few days, by which time it may be difficult to find the child to treat the infection. To circumvent this, national guidelines recommend that children of Māori or Polynesian descent are given antibiotics when they present with a sore throat, irrespective of whether the infection is viral or streptococcal."

Because of these national guidelines and the need for convenience, GPs will give antibiotics without waiting for test results. Michael believes this could be better addressed with near-patient testing to diagnose more accurately and quickly treat streptococcal sore throats.

"This technology is now available. It needs to be simple, so we are proposing to introduce a quick test service on a **marae** in Mangere. There are 200 residences around the marae and we taught a keen 'Aunty' how to swab sore throats. So if a child has a sore throat, they can have the swab done by Aunty and if it is positive for Streptococcus A, they can go to the GP knowing they need antibiotics," explains Michael.

Mangere Community Health Trust feels so strongly about the advantages of the quick test service, it is currently funding it from its own cash reserves. (They've even shown the Minister of Health how to demo it for a Select Committee.)

While some have reservations about rapid tests, Michael is enthusiastic about research on near-patient testing that The Heart Foundation and the New Zealand Guidelines Group sourced from other countries. The NZ AIDS Foundation (NZAF) and Body Positive also advocate for greater use of near-patient testing.

"At the moment, testing is an essential ingredient in the way forward to identify people living with HIV. The only organisations that do rapid testing [for HIV] are the NZAF and Body Positive, and that is, in a single word, appalling," says Bruce Kilmister, CEO of Body Positive.

"There needs to be a national discussion on testing in this country.....because there needs to be a national standard and national consistency."[2]

Michael Lamont believes New Zealand could also learn from international funding approaches. Norwegian funding processes bring health, social and community funding together in one pot administered by a regional council. Michael gives examples of how these decisions are inter-related and impact on each other in ways that benefit communities, but he suggests starting with less radical funding changes in New Zealand.

"Ideally, we should have one DHB in Auckland now that we have one Super City. People don't know the rules about where the boundaries are – they go to the closest or most convenient," says Michael.

An example Michael uses to illustrate this is Otahuhu, which is in the Auckland DHB area.

"It's 30kms to Auckland Hospital from Otahuhu and only 4kms to Middlemore, so where do you think most people go? This creates a significant bureaucratic workload around the inter district funding flows (IDF). Money and resources would be more effectively used if diverted to primary health care services and non-profit providers," he suggests.

Boundary issues exist based on cultural differences too.

"Tongan people want to go to a Tongan provider – they don't know or care if the Tongan provider is out of a DHB area," says Michael.

For many non-profit NGOs, significant costs are also tied up in reporting on multiple contracts. Michael says many of the DHB contracts his NGO has, still measure processes.

"We need to be outcomes-focused and move away from process. For example, with diabetes, your desired outcomes could be preventing blindness, or avoiding limb amputations through terrible circulation."

Michael sees another collaborative opportunity to support young families within this community in the birthing area, which could help take pressure off the hospitals.

"Due to demand at Middlemore, most women are sent home 4-6 hours after birth, but re-admission rates are high and breastfeeding levels are low. A non-profit organisation like us could provide a stand-down unit where mothers and babies could stay for three days, so support staff could spend time to help them in the early days," says Michael.

He suggests that with the right funding arrangements, Mangere Community Health Trust could do even more by providing a birthing unit for around 1,300 local women who have level-one uncomplicated births each year. Michael believes this would be particularly attractive to Pacific people, who make up about 60% of the local community.

"Many of them have seen their older parents die in Middlemore Hospital, so they are not keen to go there to give birth," he explains.

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[2] Quote from: *'Building bridges: NZAF and Body Positive'*, published in Express, September 2011, p4.

Together with **HSA Global**, Mangere Community Health Trust has developed another innovation to support collaborative health services. Its shared clinical notes and health record uses cloud computing to enable different health professionals to change and add to a patient health record. Patients also have access via a portal and can control who they share information with. For example, if they were in hospital they could give access to their treatment team. Michael sees real value in patients seeing their records.

"If patients had a bit more information, they'd take better care of their health," he says.

More information: www.mangerehealth.org.nz

This is one of the 15 case studies profiled in *How NGOs Make a Difference to Health Care in the Community* – a 96-page report from the Health and Disability NGO Working Group, Jan 2012.

The case studies cover acute nursing services, health information services, virtual practices, youth one-stop-shops, mental health networks, community development approaches, cardiac rehab, Whānau Ora and Asiasiga models of care, and more – from North to South.

See www.ngo.health.govt.nz for more of the report.