Disparities in care

Key Concepts

- Māori require enhanced access to quality primary care services.
- Programmes targeted at the most vulnerable enhance care for all patients.
- Non-targeted programmes may not reduce disparities and can in fact increase them.

Māori require enhanced access to quality primary care services. It is widely known that Māori have a greater burden of illness.[1,2,3,4,5] This is greatest in areas where primary care providers have significant influence such as cardiovascular disease, diabetes, smoking-related lung diseases, cancers and avoidable hospital admissions.

So how is primary care doing?

Cardiovascular Disease

Pharmaceutical Warehouse data indicates that in 2007 there were 732 dispensings of statins for every 1000 Māori over the age of 35 years (Table 1). It is unknown if this level is appropriate but it is less than that of Europeans who have a lower prevalence of cardiovascular disease in this age group and Pacific peoples who have a similar prevalence of cardiovascular disease.

Table 1: New Zealanders dispensed statins in 2007

Ethnicity	Dispensings per 1000 people aged over 35 years
Pacific peoples	1080
European + other	829
Māori	732
Asian	440

Diabetes

There were 452 dispensings of metformin for every 1000 Māori over the age of 35 years (Table 2). As expected this is higher than dispensings for Europeans but it is less than that for Pacific peoples.

Table 2: New Zealanders dispensed metformin in 2007

Ethnicity	Dispensings per 1000 people aged over 35 years
Pacific peoples	835
Māori	452
European + other	254
Asian	245

Screening and early diagnosis of diabetes is essential for effective management and prevention of complications.

The Get Checked programme ensures that every New Zealander with diabetes can have a free annual check. In an audit of selected DHBs and PHOs by the office of the

Examples of disparity

A nationally representative study in 2001/2002 of primary care by Crengle et al[7] indicated examples of disparity in care between Māori and non-Māori. However, it is important to note that while the findings are of interest, the authors did identify a number of caveats, including differences in age of participants–nearly half of all Māori visits were for patients under 25 years of age, compared to only 30% of non-Māori visits.

- Māori, although representing 15% of New Zealand's population, accounted for only 12% of visits to GPs.
- Doctors reported lower levels of rapport with Māori patients.
- The mean length of consultation time for Māori patients was 13.7 minutes, compared to 15.1 minutes for non-Māori.
- Tests and investigations were ordered in 21.0% of Māori visits, compared to 25.4% of non-Māori visits.
- Age-specific rates of ordering blood lipid and glucose tests were lower for Māori in the 35–44, 45–54 and 55–64 age groups.
- Among patients with a diagnosis (either existing or new) of chronic obstructive respiratory disease, 62.6% of Māori received a prescription for a respiratory drug compared to 71.0% of non-Māori.
- Follow-up within three months was recommended for 54.6% of Māori and 57.5% of non-Māori visits.
- Referrals were less common for Māori (14.7%) than for non-Māori (16.2%).

Disparities have also been identified in several other New Zealand studies.[8,9,10,11,12]

auditor general, the coverage rates for Māori continued to fall short of the annual targets set by the DHBs (Table 3). The coverage rates (the percentage of the estimated eligible population participating in the programme) for Pacific peoples were high in 2006, with rates exceeding the DHB targets.[6]

Table 3: "Get Checked" coverage targets and actual results for the year ended 31 December 2006

	Māori		Pacific Peoples	
DHB	**Target %**	**Actual %**	**Target %**	**Actual %**
Auckland	60	31	60	105
Capital & Coast	45	39	80	83
Counties Manukau	63	53	100	125
Hawke's Bay	45	42	65	74
Otago	41	29	66	98
Tairawhiti	60	46	90	163

Once in the Get Checked programme, Māori received similar access to the recommended treatment for people with diabetes.

COPD

Despite the high prevalence of smoking in Māori and the resultant higher incidence of COPD, Māori received less dispensings for tiotropium than Europeans but more than Pacific peoples (Table 4).

Table 4: New Zealanders dispensed tiotropium in 2007

Ethnicity	Dispensings per 1000 people
European + other	38
Māori	24
Pacific peoples	9
Asian	3

Asthma

Although Māori children have more hospital admissions than European children and present with more serious symptoms, the preventer to reliever ratio is significantly lower than for European children (Table 5).

Table 5: New Zealand children aged under 12 years dispensed asthma preventers and relievers in 2007

Ethnicity	Preventer to reliever ratio
European	0.7
Asian	0.7
Māori	0.4
Pacific peoples	0.4

What actually reduces inequalities?

Programmes targeted at the most vulnerable enhance care for all patients. Lieu et al reported on a programme aimed at improving care for children with asthma from low income families.[13] They found that better care was delivered by practices with high cultural competence scores (a composite measure that included policies for access and equity as well as cultural competence training for clinicians) combined with clinical audit and feedback to clinicians. "Better care" was defined both by ratings from parents and reviews of the medical records and prescription data. This positive impact was felt by all children with asthma including those from minority groups.

Non-targeted programmes may not reduce disparities and can increase them. In an ACC pilot programme, increasing subsidies for GP and radiology visits was found to result in only a small increase in access by Māori and people on low-incomes, and similar increases in access by all other patients.[14] Therefore the relative disparity in access remained.

These studies point to a need for a comprehensive approach to cultural competence and targeted services, if Māori are to achieve equitable access and use of primary care services. With support, practices can begin to eliminate inequalities in care.

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