Potential for health gain equity
Nina Scott, Ross Lawrenson

Health inequities are generated by the health sector as well as by wider social, economic, and political systems, and are a problem affecting everyone in society. Unfair and avoidable differences in health outcomes between the haves and the have nots, especially for New Zealand children, is very topical. The use of ambulatory sensitive hospitalisations (ASH) rates to assess the impact of policy changes is also topical. The article in this issue of the NZMJ by Matheson et al examining inequities in ASH rates associated with health policy changes, tells a complex and important tale. The authors demonstrate that for children aged 0–4 inequities between ethnic groups in preventable hospitalisations can, and have been significantly and rapidly reduced. Further, the same policy and practice environment that saw a large and rapid reduction in inequities for 0–4 year olds resulted in improvements at the total population level and gains for all ethnic and socioeconomic groups in the same age band. The potential for health gain by achieving equity in ASH rates for all age groups is enormous.

Matheson et al (in this issue of the Journal) demonstrate the value of analysis by ethnicity and Deprivation and illustrate that over a 12-year period the most dramatic differences in ASH rates are between ethnic groups and by social class. Despite excellent progress, there remain large and unacceptable inequities in ASH rates between the most and least privileged ethnic and socioeconomic groups of 0–4 year old New Zealand children. Achieving equity in ASH rates would see avoidable hospitalisations for Māori and Pacific 0–14-year-olds fall from 3,783 and 4,508 per 100,000 respectively to 3,199. There is clearly large potential for gain for these children. There is an even larger potential for gain by achieving equity in ASH rate in the 45–64 year age group. Equity would see the rate for Pacific peoples drop from 8,754 to 2,821 per 100,000. Māori rates would drop from 6,312 to 2,821 per 100,000. Rates for the most deprived groups would drop from 4,112 to 1,707 per 100,000. Because Māori and Pacific populations are dramatically over-represented in highly deprived groups, depicting ASH rates by ethnicity for different levels of deprivation would show the effect of deprivation more clearly. It would also have been helpful to know the influence of rurality, as this has been shown to be an important factor in other studies.

ASH rates are used as a measure of access to primary care services. Associations have been shown with measures such as the number of general practitioners per population, the number of primary care centres or the number of visits to primary care. Of course other factors influence ASH rates, including access to the determinants of health such as housing and income. Accessibility of hospital ED, out-of-hours provision and model of general practice also influence ASH rates. A major concern in the UK has been the reduction in continuity of care due to general practitioners withdrawing from out-of-hours care. PHO enrolment rates for Māori and Pacific populations are less than optimal. Further, the cost of accessing a GP is a known barrier for these groups. For example, results from the New Zealand Health Survey found that Māori were almost twice as likely (at 23.1%) as non-Māori (at 12.8%) to not visit a GP because of cost, at some time in the last 12 months despite having a medical problem. Greater inequities were seen for not seeing a GP due to lack of transport, not going to after hours clinics due to cost or transport and not filling
a script due to cost. The custom of charging patients to enroll with a practice may also be a significant issue for some.

The authors have linked changing ASH rates with a raft of policy changes—initially by a Labour Government and then, more recently, a National-led coalition government in conjunction with the Māori party. One does have to question whether the policy changes actually made a difference to the delivery of primary care. Smith in her 2009 review noted that, while PHOs had been good at engaging with communities, they had not paid sufficient attention to how services were delivered by their primary care providers. We should note that despite the government support for primary care and the initiation of the Primary Care Strategy, access to general practice actually reduced, with the number of FTE general practitioners per 100,000 population, shrinking from 78 in 2002 to 74 in 2012 (MCNZ Statistics). The extra capitation funding to general practice allowed GPs to reduce their average hours of work from 42 hours per week to 37.3 hours in the same period—a reduction of 11%. There has been no change in the number of primary care clinics. The Health surveys of 2002 and 2012/13 have shown the percentage of patients seeing their GP in a 12-month period has not changed for Māori and New Zealand Europeans. However, use by Pacific reduced from 75% to 72% for Pacific men and 83% to 77% for Pacific women (Health Survey 2002 and 2012). Of course in the same period we have seen a huge investment in hospital services. Probably $3 billion in capital has been spent on new hospital buildings around the country since 2002. We have seen a 60% increase in the number of specialists and 69% increase in house officers/registrars (MCNZ statistics).

We have also seen targets for provider arms of DHBs to make ED more accessible, and this has led to substantial increases in ED attendances.

Given that, if anything, there has been a reduction in resource in primary care and a substantial increase in hospital capacity, it is good to see that ASH rates have fallen for most. When considering the difference between children and adults, it is important to remember that the key conditions for children include: dental; otitis media/upper respiratory tract infections; asthma; gastroenteritis; pneumonia and cellulitis/skin infections. Some of these conditions are very sensitive to changes in housing. One initiative over the last 10 years has been to ensure better insulation and heating of houses for families most at need—ie with children or the elderly. It maybe that a change in incidence of respiratory disease in young children is partly due to the fall in ASH rates for this age group. On the other hand, despite targets for CVD and diabetes in adults, the reduction in access for Pacific adults and the increase in ASH rates is a great concern, as is the continued inequities between Māori and ‘Other’ rates.

It is clear that further equity-focused policy and practice are urgently needed to speed up improvements toward achieving equity in ASH rates. The question is what should be done. We can see from the list of policy initiatives that the response has been fragmented and seems ad hoc. Inequities in the social determinants of health, such as income and housing, need to be addressed alongside health system improvements.

We agree with Milne et al that increasing funding and access to primary health care will not, by itself, reduce ASH rates. Rather, until we have a comprehensive strategy for improving primary care, the...
wide disparities are likely to continue. We need to consider the model of care. Some research has suggested that physician-owned practices are more efficient, while practices with more nurse practitioners—or physician associates—per physician have higher ambulatory care sensitive (ACS) rates. We also need to tackle the chronic shortage of general practitioners, particularly in rural and more socially deprived areas. This needs to be a long-term strategy. Currently one could argue that if the desired outcome is a generalist primary-care trained medical workforce then our medical schools are failing the health services. We also need to dramatically increase the number of general practice trainees and ensure that funding is targeted to practices in the areas that are most needy. We also need to ensure that funding, monitoring and reporting is equity focused. The primary care Integrated Performance and Incentive Framework (IPIF) has been acknowledged to be lacking in the equity area. Current IPIF funding could incentivise the creation of further inequities by rewarding focus and the achievement of targets for ‘easy to reach’ groups. For example, the IPIF targets for cervical screening, smoking or immunisation could be met for the total population even if Māori and Pacific rates were to decrease.

Finally, we need to get more sophisticated in our analysis of the influences of general practice on the whole health system.

Currently we have a wide variety of practices: large and small; practitioner-owned; community trusts and corporates; practices with different mixes of medical, nursing and allied health staff. Only by linking these characteristics to changes in the health system usage will we be able to ensure that we see positive changes to the wide outcome disparities between Māori and Pacific, and ‘Other’ New Zealanders.

The cost of the gap between rich and poor is estimated to cost the British government £39 billion per year. So as well as being avoidable and fixable, unjust and bad for social cohesion, inequities are expensive. We need to build on the policy work that has seen a reduction in ASH rates for our youngest age groups, and make a concerted effort to create an equitable primary care system, rather than the ad hoc, market-driven model we have at the moment.

There is a strong imperative for the government and Ministry of Health to take action and make wise decisions in good time.

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