The time for Equity is now – discussion paper

Equity is a co-requisite for excellence in healthcare alongside the goals of quality, safety, effectiveness and efficiency.

Or as noted by Bearman and Clark in their 2007 editorial in the British Medical Journal[1],:

> ..... *initiatives to improve quality will be incomplete unless inequities are reduced as performance improves.*

Equitable health care is a matter of **fairness**, a concept that is fundamental to New Zealanders and to the organisation of our system of health care.

Equity in these terms means providing equal healthcare to those who have the same health 'need'. Inequity is the failure to provide care to patients despite having the same health need.

However, inequity persists in many Western countries, including New Zealand, where indigenous peoples and ethnic minorities receive care of a lesser standard or intensity and poorer outcomes despite demonstrably higher health needs.

New Zealand studies have confirmed that in general Maori continue to have lower life expectancy, greater illness rates and higher rates of disability than other New Zealanders[2,3]. So what lies behind the paradox of Maori having higher health needs but actually receiving lesser health services than European New Zealanders?

The most recent information from primary care practices shows that once the age of patients is taken into account, Maori have attended general practitioners at least the same rates as Europeans over the course of the last 5 years (the period over which data has been available). However the same databases show that Maori do not receive equal access to influenza vaccination, age-appropriate immunizations, cervical or breast screening[4]. This lesser quality of care is not related to deprivation as European patients in most DHBs receive similar levels of care whether or not they reside in high need areas (NZDep quintile 5).

Furthermore large, nationally representative studies have also found lower quality primary care offered to Maori in many circumstances. For example in general practices Maori receive less consultation time with their GPs, fewer referrals to specialists and fewer investigations[5].

Similar issues of inequity are seen in most parts of the New Zealand health system from hospitals, to pharmacies, home help services, mental health services, and even in higher rates of adverse events in hospitals but lesser levels of assistance after injury from treatment[6].

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[1] Bearman A & Clark J. *Performance measurement and equity: To maximise benefits and minimise harm, equity must be built in from the start* BMJ2007;334:133

[2] Hauora IV: Maori Standards of Health IV – see www.moh.govt.nz

[3] Blakely, T., et al., *Decades of disparity: widening ethnic mortality gaps from 1980 to 1999.* NZMJ, 2004. 117(1199): p. U995

[4] Data obtained from DHBNZ January 2009 on Primary Care Performance Management Programme results by DHB with the 'high need" group disaggregated into 3 groups (Maori; Pacific; non-Maori, non-Pacific Quntile 5). Adjustment for age where appropriate.

[5] Crengle S, Lay-Yee R Davis P Pearson J. *A comparison of Maori and non-Maori patient visits to doctors. NatMedCaReport 6*; 2002, available from www.moh.govt.nz

[6] Davis P, Lay-Yee R, Dyall L, et al 2006. *Quality of hospital care for Māori patients in New Zealand: retrospective cross-sectional assessment.* The Lancet 367: 1920–25

Only part of the reason for this is due to differences in income, age or educational achievement of different groups, while some is due to differences in contact with risk or protective factors (such as smoking, place of residence, type of work etc).

There is also a problem of cultural concordance between the health care providers who mostly reflect the dominant Western cultural point of view, and Maori patients who bring their own worldview to the consultation[7].

The impact of this lack of concordance has been well described by New Zealand researchers including Professor Bruce Arroll (disparities in treatment but not diagnosis of depression[8]); Dr Ricci Harris (the relationship between experiences of racism and health status[9]) and especially McCreanor and Nairn in the their 2002 paper in the NZ Medical Journal which reported on European GP views of Māori patients[10].

So what works to improve access and outcomes?
There is some good news from New Zealand with examples of primary care providers and secondary care services that have achieved equity in outcomes even where their patient base is predominantly Māori and/or Pacific peoples.

How is equity achieved?
To achieve equitable access and outcomes it is necessary to address many barriers simultaneously. The alternatives of addressing single factors (cost, transportation, community consultation) have been shown to be ineffective [11 12].

Qualitative research has identified barriers to care from the Māori perspective from interview data[13]. From this work, a conceptual framework was developed to help address the issue of barriers for Māori. The framework comprised four key areas:

- the range of costs of care
- the communication skills of the provider
- structural barriers to care, and
- the cultural fit between the patient and the provider.

The overlapping nature of each of these barriers and the greater impact of each barrier for patients with disabilities were also identified in the research, meaning that, to be effective, interventions should address all barriers.

Barwick[14] confirmed that the more successful interventions aimed at reducing health disparities demonstrated systematic, intensive, multifaceted and/or multidisciplinary approaches.

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[7] Jansen P, Smith K. *Maori experiences of primary health care: Breaking down the barriers*; NZFP 2006; 33(5): 298-300

[8] Arroll B et al. *Depression in patients in an Auckland general practice.* NZMJ 2002;115

[9] Harris, R, et al. *Effects of self-reported racial discrimination and deprivation in Māori health and inequalities in New Zealand: cross-sectional study.* Lancet, 2006. 367(9527): p. 2005-9.

[10] McCreanor, T. and R. Nairn, *Tauiwi general practitioners talk about Maori health: interpretative repertoires.* NZMJ, 2002. 115 (1167): p. U272

[11] NHS/U of York. *Review of the research on the effectiveness of health service interventions to reduce variations in health*, in NHS Centre for Reviews and Dissemination 1995, University of York

[12] Beach MC, Cooper LA, Robinson KA, et al. *Strategies for improving minority healthcare quality.* Technology assessment No.90 Agency for Healthcare Research and Quality; 2004. (www.ahrq.gov/clinic/epcsums/minqusum.pdf)

[13] Jansen P. *Maori consumer use and experience of health and disability and ACC services.* VuW Symposium, Wellington; April 2006. (http://ceed.vuw.ac.nz/pdfs/PeterJansenPDF.pdf)

A review of interventions to improve health carried out by the UK National Health Service Centre for Reviews and Dissemination found that the following characteristics were associated with positive outcomes:

- Systematic, multifaceted and intensive approach
- Appropriate needs assessment
- Multi-disciplinary teams
- Use of face-to-face interaction and
- Culturally appropriate methods

Evidence that a multi-faceted programme incorporating cultural competence policies and training could improve care for minority populations comes from Lieu *et al*[15] who reported on a programme aimed at improving care for children with asthma from low income families. 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 the 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, demonstrating that programmes targeted at the most vulnerable will enhance care for all patients, while programmes aimed at the mainstream often increase disparities.

Likewise a New Zealand example comes from BreastScreen South, which has maintained equitable levels of screening by addressing the barriers noted above and remaining focussed on eliminating inequalities (presentation to inequalities symposium, Tairawhiti DHB 2009).

Single item or non-targeted interventions do not.

Evidence that non-targeted and single facet programmes do not reduce disparities comes from several New Zealand reports including the ACC pilot programmes[16]. In these pilot programmes increased subsidies were provided for GP and radiology visits, but only a small increase in access by Māori and people on low-incomes was found, and similar increases in access by all other patients occurred as well. As a result the relative disparity in access to services remained.

Similarly the Reducing Inequalities Contingency Fund was to fund 35 projects across the country that met specific criteria. Projects included those aimed at outreach initiatives (15), reductions in patient charges (12). An evaluation of the projects by Gribben[17] found that:

- Consultation rates increased for all, not just for the target population
- Hospital ED and outpatient visit rates increased
- Ambulatory sensitive admission rates were unchanged
- The use of cervical smears was unchanged
- "Did Not Attend" rates at secondary care were diminished by only one project

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[14] Barwick H. *Improving access to primary care for Maori and Pacific peoples.* A literature review commissioned by the Health Funding Authority. Wellington: Ministry of Health; 2000. (www.moh.govt.nz/moh.nsf/0/4F31BB21AD92F9F0CC256F3F0073DB3E/$File/HFAimprovingaccess.pdf)

[15] Lieu TA, Finkelstein JA, Lozano P. *Cultural competence policies and other predictors of asthma care quality for Medicaid-insured children.* Pediatrics 2004;114:e102-e10.

[16] ACC News. Issue 98 February 2007. Available from www.acc.co.nz

[17] Gribben, B. Improving access to primary health care: an evaluation of 35 reducing inequalities projects. 2005, Ministry of Health: Wellington

Both these New Zealand reports highlight the need for comprehensive approaches focused on the needs of priority populations (the most disadvantaged in our community). Without targeted approaches disparities will persist.

I invite the Interim Board of the advisors to:

1. **Commit** to an open discussion about the inequities in the health care system
2. **Incorporate** the central goal of ***equity*** into deliberations about safety and quality
3. **Note that multi-facetted interventions aimed at priority populations with open reporting and committed leadership have been shown to be effective in eliminating inequity.**
4. **Consider how** proposals to the Board might include an assessment of their impact on equity of access, equity of use, equity of experiences and equity of outcomes.
5. **Further resolve** that any proposals:
    a. are **targeted to those with the greatest unmet health needs, and**
    b. should address the range of barriers experienced by priority groups, and
    c. are delivered with open accountability arrangements that include a requirement to show delivery of **a high level of service to *all* New Zealanders in the population that is served.**

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