

## 16 PRIMARY CARE AND MĀORI: FINDINGS FROM THE NATIONAL PRIMARY MEDICAL CARE SURVEY

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This chapter describes key findings from the National Primary Medical Care Survey (NatMedCa) as they relate to Māori health and inequalities.

The National Primary Medical Care Survey was undertaken in 2001/2002 with the aim of describing primary medical care in New Zealand, including the characteristics of primary care provider practices and the staff that work in them, the patients they see, and the problems managed, investigations ordered and treatment offered during visits by patients. The study included private general practices, community governed<sup>1</sup> providers, Māori providers<sup>2</sup>, accident and medical centres and emergency departments. Two reports specifically relating to Māori have been produced: NatMedCa Report 3 described Māori provider organisations and the patients who attended those providers (Crengle et al 2004), and NatMedCa Report 6 provided a comparison of the experience of Māori and non-Māori patients in the primary medical care setting (Crengle et al 2005). Previous publications on this topic have been largely qualitative and focused on differences in the paradigm and processes that differentiated Māori from other providers, or narrative with little information on outcomes of care (see, for example Crengle 1997, 2000; Maniapoto and Gribben 2003). Detailed information on NatMedCa design, and the strengths and limitations of the survey can be found in other reports (Crengle et al 2004; Crengle et al 2005).

In brief, data was collected from a total of 244 general practitioners (GPs) across the country. The practices that these practitioners worked in were divided into three types: Māori providers, community-governed providers and private practices. A range of information was collected about every patient visit during the data collection period (6,384 Māori patient consultations and 33,805 non-Māori consultations). More detailed information about visits (for example the problems seen, tests and investigations ordered and referrals made) was collected from one in every four consultations (1,447 Māori and 7,677 non-Māori consultations).

About 21% of Māori visits were to Māori providers, 73% were to private general practices, and the remaining 6% were to community-governed providers. Māori

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<sup>1</sup> Community governed primary care providers: a full definition of community governed may be found in Crampton P et al (2004). *Primary Health Care in Community-governed Non-profits: The work of doctors and nurses: The National Primary Medical Care Survey (NatMedCa): 2001/02. Report 2*. Wellington: Ministry of Health. URL: [http://www.moh.govt.nz/moh.nsf/wpg\\_Index/Publications-Primary+Health+Care+in+Community-governed+Non-profits+NatMedCa+Report+Two](http://www.moh.govt.nz/moh.nsf/wpg_Index/Publications-Primary+Health+Care+in+Community-governed+Non-profits+NatMedCa+Report+Two)

<sup>2</sup> Māori provider was defined as a provider who met the four Ministry of Health criteria for Māori provider status. These are: is the practice an independent Māori health provider; are your services targeted towards Māori; does the provider have a Māori management structure; and does the practice have a Māori governance structure?

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patients accounted for about 12% of all visits to GPs – disproportionately low compared to the percentage of Māori in the population. Known disparities in socioeconomic status were evident: a greater percentage of Māori had community service cards and a higher proportion lived in high deprivation geographic areas. Māori patients were younger than non-Māori patients. Over 90% of Māori patients considered the provider they attended during the survey to be their usual source of care. This is similar to the percentage seen in non-Māori patients. Fourteen Māori providers participated in NatMedCa. Within these providers 28 staff (21 doctors and seven nurses) participated.

This section summarises some of the findings presented in the NatMedCa reports 3 and 6 (Crengle et al 2004; Crengle et al 2005). It is important to state that these reports only present the results of an initial, simple data analysis. More detailed analysis of the data, including tests of statistical significance, is necessary to confirm the findings suggested by the initial analysis. This work is ongoing.

A number of differences in organisation, governance and management between Māori, community-governed, and private providers were identified in the survey. The majority of Māori and community-governed providers were trusts or incorporated societies; however, the majority of private practices were sole trader, partnership or limited liability companies. All Māori provider practices had separate or external governance or management committees and the majority had community representation in governance and/or management. This finding was similar to that for the community-governed providers but markedly higher than that observed in private practices. A higher percentage of Māori provider practices used computerised patient records, had undertaken formal community needs assessments, and used locality service planning and intersectoral case management than private practices. A higher percentage of Māori providers had written policies on complaints and quality management than private practices. Fees were lower for Māori providers than for private GPs. The number of full-time equivalent medical and nursing staff in Māori providers was lower than that in community-governed and higher than that in private practices. However, employment of community health workers was much more common with Māori providers. Doctors working in Māori providers tended to be female, younger, relatively new to both general practice and to the specific provider organisation. A higher (but still relatively low) proportion were Māori, and a higher proportion had qualified outside New Zealand.

Patients attending Māori providers came from a range of ethnic groups but were predominately Māori (58.9%). About one-third of problems identified in the visit were new problems. A higher proportion of adults aged 25–44 years attending Māori providers had three or more problems managed during the visit than those attending private GPs. Just under one-third (27.1%) of visits resulted in an investigation of any type. More specifically, laboratory tests were requested in 16% of visits and imaging (for example x-rays) were requested in 4% of visits. Over 60% of visits resulted in a prescription being written, and referrals were made in about 18% of consultations.

The findings concerning Māori providers suggest that they are increasing access to care for Māori and support the historical government and funding agency policies relating

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to Māori provider development. The higher percentage of Māori working within Māori providers also lends support to policies regarding Māori workforce development.

For Māori attending general practitioners:

- Māori had slightly fewer visits in the previous year (mean = 6.1) than non-Māori (mean = 6.7)
- visits for Māori patients were shorter
- doctors reported lower levels of rapport with Māori patients
- a higher proportion of Māori visits were deemed by the GP to have high urgency
- while the mean number of problems managed in each visit were similar for Māori and non-Māori, age- and gender-specific rates of new problems managed tended to be higher in the younger age groups, and lower in the older age groups
- tests and investigations were requested in a slightly lower percentage of Māori visits, and slightly more Māori visits resulted in the writing of a prescription.

Several findings raised questions about quality of care. For example, cardiovascular disease (New Zealand Guidelines Group 2003a) and diabetes (New Zealand Guidelines Group 2003b) are more common in the Māori population. The most recent guideline regarding the assessment and management of cardiovascular disease risk recommends that screening (including blood lipid and glucose measurement) begin at age 35 for Māori males and 45 for Māori females (New Zealand Guidelines Group 2003a). Therefore, higher rates of lipid and glucose blood test investigations would be expected in Māori. However rates of requesting lipid and glucose blood tests were lower for Māori in the 35–44, 45–54, and 55–64 year age groups than non-Māori. As a further example, 9.5% of Māori patients who received a new diagnosis of chronic obstructive respiratory disease during the visit were given a prescription for a respiratory drug compared to 77.8% of non-Māori.

Other findings are concerning when one considers the excess burden of disease that Māori experience. For example, the lower mean duration of consultation in all age groups, similarities in the rate of new problem identification in age groups between 35 and 74 years, and the similar or lower rates of tests/investigations in adults (particularly 25–64 year age groups) might all be considered inconsistent with known information about burden of disease and the associated expected findings from a primary care survey such as this.

More detailed analyses, taking into account differences such as age and the number of problems managed in a visit, are required to confirm and understand the findings more fully.

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