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Reducing health disparities through primary care reform: the New Zealand experiment

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Abstract

New Zealand experiences significant health disparities related to both ethnicity and deprivation; the average life expectancy for Maori New Zealanders is 9 years less than for other New Zealanders. The government recently introduced a set of primary care reforms aimed at improving health and reducing disparities by reducing co-payments, moving from fee-for-service to capitation, promoting population health management and developing a not for profit infrastructure with community involvement to deliver primary care. Funding for primary care visits will increase by some 43% over 3 years. This paper reviews policy documents and enrolment and payment data for the first 15 months to assess the likely impact on health disparities.

The policy has been successfully introduced; over half the New Zealand population (of four million) enrolled in new Primary Health Organizations within 15 months. Over 400,000 people (half of them in vulnerable groups) gained improved access to primary care subsidies in the first 15 months. The combined effect of new payment rules and the deprived nature of the minority populations was that the average per person payment to PHOs on behalf of Maori and Pacific enrolees was more than 70% greater than the per person amount for other ethnicities for the period.

The policy is consistent with the principles of the Alma Alta Declaration. Barriers to successful implementation include the risk of middle class capture of the additional funding; the risk that co-payments are not low enough to improve access for the poor; PHO inexperience; and the small size of many PHOs. Transitional equity and efficiency issues with the use of aggregate population characteristics to target higher subsidies are being ameliorated by the introduction of low cost access based on age. A tension between the twin policy goals of low cost access for all, and very low cost access for the most vulnerable populations is identified as a continuing and unresolved policy issue.

Keywords: Disparities; Inequalities; Primary care; Health insurance; Socioeconomic; Access

1. Introduction

In July 2002, the New Zealand government introduced a set of primary care reforms, based on the Alma Ata Declaration's [1] vision of primary health care, aimed at reducing average co-payments, moving from fee-for-service to capitation funding,

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promoting population health management competencies and developing a not for profit organizational infrastructure to deliver primary care. The vision articulated in the Government's Primary Care Strategy document in 2001, which heralded the reforms, states that "A strong primary health care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health" [2].

Many aspects of the package of reforms emphasize access to, and the design of, primary health care as a means of reducing health disparities. This emphasis is striking, in that the mainstream primary health care system has been redesigned with an explicit focus on health inequalities as a guiding principle.

This article briefly outlines what is currently known about health disparities in New Zealand, and describes the key components of the new primary care policy, with a particular focus on the features targeted at reducing disparities, and an analysis of their potential impact. It explores some of strengths and weaknesses of the policy settings. We entered into this review with the aim of addressing the following questions. How does the primary care policy aim to address health disparities? Is the policy likely to deliver improved access to primary care for minority groups? If so, to what extent is improved access to primary care likely to deliver improved health outcomes for these groups? Is the targeting strategy efficient? These questions are particularly pertinent given that, at least in terms of uptake, the policy has been a resounding success, with over half the NZ population enrolled in new primary health organizations (PHOs) after a 15 months period.

2. Methods

We reviewed publicly available policy documents, PHO payment business rules, and the PHO standard contract to gauge the stated intent of government policy. Information on current health disparities was obtained by reviewing recent Ministry of Health publications. We analyzed PHO enrolment and payment data from quarterly extracts from the national enrolment and payment data base for the first 15 months after PHO funding was introduced—the period from 1 July 2002 to 30 September 2003—to assess the impact on access to subsidized care. Access under the new system is compared with access under the previous subsidy policies to assess the impact of policies.

3. Background and context

3.1. Health disparities in New Zealand

3.1.1. Information base

New Zealand has a relatively strong information base from which to study health disparities, including several decades of census ethnicity data, a small area socioeconomic deprivation index [3], and a national hospital discharges database that includes a unique identifier with linked addresses. The deprivation index, NZDep2001, combines nine variables from the 2001 census, reflecting eight domains of deprivation. Each variable was calculated as the proportion of people with the specified deprivation characteristic in each small area, comprising one (or occasionally more) meshblocks. Meshblocks are the smallest geographical units defined by Statistics New Zealand, containing a median of 90 people. Each proportion is age standardized and, where necessary, adjusted for household composition. The index includes income, crowding, educational attainment, unemployment, sole parent status, home ownership and car ownership.

3.1.2. Ethnic disparities

New Zealand experiences significant and enduring health disparities related to both ethnicity and deprivation. The important ethnic minorities in New Zealand for whom significant disparities have been demonstrated are Maori New Zealanders (the indigenous population), who constituted 15% of the total population at the last census (2001), and Pacific New Zealanders (first or second generation immigrants from Samoa, Cook Islands, Tonga, Fiji and the other South Pacific islands) who constitute 6% of the total population. For convenience, the non-Maori, non-Pacific population, which is mainly of European descent, but also includes Asian and other ethnicities, is referred to as other New Zealanders in this article.

Life expectancy among Maori New Zealanders is about 9 years less than other New Zealanders [4]. This gap is higher than the 6 year gap between life expectancy for non-Hispanic Whites and non-Hispanic African Americans in the United States [5]. Mortal-