Maori experiences of primary health care:
Breaking down the barriers

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ABSTRACT

Maori patients receive a lesser standard of care than non-Maori from primary health care providers. This is in part the result of non-concordant relationships between the provider and the patient.

When patients are engaged in decisions about their own health care, they are more satisfied with their care overall. Doctors who are aware of their patient's background and understanding of the primary care health system are able to better communicate with their patients, thereby leading to better health outcomes and greater satisfaction.

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Maori disparities in primary health care

The National Medical Care Survey was a study of data collected in 2001 and 2002 from 199 private general practices, 24 physicians in community governed practices, and 21 doctors who worked with Maori providers).[1]

This study shows that although Maori are known to be disadvantaged both economically (over 60% of Maori are in one of the three most deprived deciles) and in terms of health (shorter lifespan, disproportionately high rates of illness and injury), they nevertheless receive less care from GPs. In summary:

- over 60% of Maori patients live in one of the three most deprived NZDep2001 deciles;
- Maori are seen by GPs at a disproportionately low rate, compared with their presence in the general population;
- more Maori visits were graded as urgent, according to the GPs;
- doctors reported lower levels of rapport with their Maori patients;
- doctors spent less time on average with their Maori patients (13.7 min vs 15.1);
- doctors ordered fewer tests and investigations for their Maori patients;
- blood lipid and glucose tests were ordered at lower rates for Maori patients, despite the higher incidence of diabetes and cardiovascular disease in that population;
- follow-up visits within three months were recommended for Maori at lower rates (54.6% vs 57.5%);
- referrals were less common for Maori patients (14.7% vs 16.2%).

By contrast there is little disparity in access to emergency care. For example, Maori and non-Maori have equal rates of access to emergency transport and also to specialist accident-related treatment once a referral has been made.[2] In these situations care is dictated by protocol, that is, what must be done rather than what might be done and no regard is made to other factors such as provider preference, ability to pay, or to provider/

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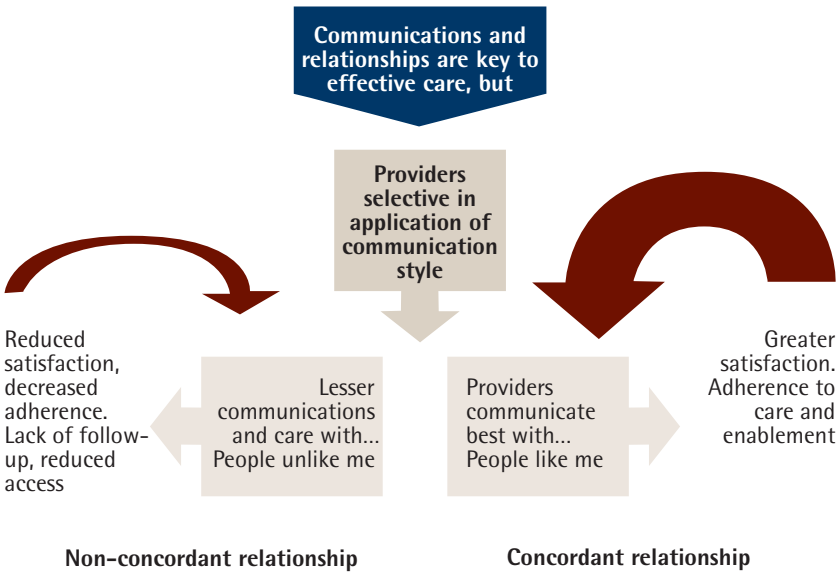
patient relationships. The nuances of communication, developing trusting relationships and continuity of care are not prime considerations in these circumstances. Rather, the patient requires expert timely medical help and expects to receive just that.

However, once the emergency situation has passed, utilisation of services by Maori appears to revert to that seen outside the emergency situation, that is, the barriers for Maori are reinstated, and less than optimal care is provided. This is seen clearly in lower levels of referral of Maori to home help following hospital discharge even when there is no cost to the patient, and the lesser utilisation of complaint services by Maori patients.[1]

Figure 1. The effects of non-concordant relationships on doctor/patient communications



Why do these disparities exist?

There is no single reason why Maori patients receive less care than non-Maori in a primary care setting. However looking to the functions of the New Zealand health care system, patients require knowledge of how the system is organised, who the key players are and the relationships between different parts of the health care system in order to receive the best standard of care. It could be argued that, in general, the health care system provides care that matches the moods and preferences of the most advantaged groups in society. To put it another way, the health care system reflects its origins in a dominant European culture, which values individualism and self-advocacy, and provides care in a manner which advantages certain groups including higher socio-economic groups; non-Maori, non-Pacific groups; and those without disabilities. Those patients at greatest disadvantage in health terms are also those with the least influence on the health care system, and they require greater support from health care providers in order to access needed care. This begins with an understanding and understandable primary care provider.

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The importance of the provider's communication skills

There is extensive literature available to confirm that the greatest impact on patient satisfaction and effectiveness in primary health care is from the communication skills of the provider. Effective communication skills improve the relationships between providers and patients, and these in turn impact on patient understanding, patient satisfaction, and adherence to therapy as well as reducing complaints by patients.[3]

Where the provider and the patient do not share a common cultural background, however, there are increased difficulties in establishing effective communications and relationships. In New Zealand the majority of health care interactions for Maori patients do not involve providers that share their cultural background. Thus, there is great potential for misunderstandings and reduced effectiveness of health care and disturbingly there is also evidence for frank bias against Maori patients.[4]

While communication skills can be taught, overseas studies have shown that providers are selective in how they apply communication skills.[5,6] Studies have shown that when the provider and the patient come from different cultural or racial groups, the patient will receive less discussion, less listening, a lesser standard of care and reduced attention to building and maintaining the relationship.[7] This is depicted in Figure 1.

Summary

Maori continue to have the greatest levels of health inequality in New Zealand, with measures of mortality and morbidity showing significant gaps compared to non-Maori even

after controlling for deprivation. These ethnic differences in health status relate in part to a higher prevalence of smoking and other risk factors, in part to income inequalities, but also in part to barriers to access and treatment and to provider bias as noted in the primary care studies noted above. Even when Maori access primary or secondary health services at the same rate as non-Maori there still exists a significant gap in care received by Maori. The solution to reduced care/lesser access for Maori patients will involve attention to all of the known barriers including costs, the communication skills and attitudes of health care providers, health service funding and policy settings.

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Primary care providers, like other health professionals, may unwittingly provide less care to those with the greatest health needs because of a lack of cultural or social concordance. The lack of a shared background or understanding inhibits the therapeutic relationship, and this in turn impacts on the care received. Training and support for primary care providers may help overcome this barrier to effective primary care as shown in recent studies of asthma care.[8]

Competing interests

Dr Jansen is a lead investigator for Mauri Ora Associates, which has received funding from the Health Research Council, ACC and the Ministry of Health. This article includes material from the literature review for the research project funded by the organisations listed above.

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Primary care – will it survive?

'The American College of Physicians recently warned that "primary care, the backbone of the nation's health care system, is at grave risk of collapse." And indeed, primary care is facing a confluence of factors that could spell disaster. Patients are increasingly dissatisfied with their care and with the difficulty of gaining timely access to a primary care physician; many primary care physicians, in turn, are unhappy with their jobs, as they face a seemingly insurmountable task; the quality of care is uneven; reimbursement is inadequate; and fewer and fewer U.S. medical students are choosing to enter the field.

The great majority of patients prefer to seek initial care from a primary care physician rather than a specialist, but their unhappiness with their primary care experience is growing. At the same time, primary care physicians are expressing frustration that the knowledge and skills they are expected to master exceed the limits of human capability, making it impossible to provide the best care to every patient. The scope of primary care extends from uncomplicated upper respiratory and urinary tract infections to the longitudinal care of elderly patients with diabetes, coronary heart disease, arthritis, and depression – who may also have limited proficiency in English.'

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