Disadvantage and access to primary health care for youth in New Zealand. Are our current health strategies reducing barriers?

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Abstract

New Zealand has had several major changes in its economic, health and welfare systems over the past two decades. Successive governments have made adjustments that have had negative effects on the health of specific population groups. There is now clear evidence that lower socio-economic status has a major impact on the health of New Zealanders, especially the more disadvantaged groups such as Maori and Pacific Islanders. Youth as an age group is too often ignored in discussions about disadvantage and health inequalities. Yet young people have special needs in relation to their developmental stage - transition between child and adulthood; their potential for behaviours identified as ‘at risk’; and the impact that those behaviours may have on their future health. In 2000, the then Minister of Health, Annette King, released The New Zealand Health Strategy (2000) which has as a key principle improved health for disadvantaged New Zealanders. A pivotal part of this strategy is increased funding and improved access to primary health care, but youth are not recognised as having specific needs. Therefore, although this Strategy is addressing the needs of some disadvantaged groups, there remains much to be done to meet the needs of disadvantaged youth in New Zealand.

Key Words: Youth health, New Zealand, Socio-economic disadvantage

Introduction

New Zealand has had several major changes in its economic, health and welfare systems over the past two decades. There is now strong evidence that socio-economic status has a major impact on the health of New Zealanders, especially the more disadvantaged groups such as Maori and Pacific Islanders. Successive governments have introduced changes that have had a negative effect on income of deprived groups (Barnett, 2001). In this article, the failure of a health system designed around market competition to deliver equitable and efficient primary health care is discussed and linked to the aims of the New Zealand Health Strategy, released by Annette King, Minister of Health, in 2000. A pivotal part of this strategy is primary health care with opportunities for nursing to take a stronger leadership role. Part of this role is being aware of the impact of social policy on health, especially for disadvantaged groups.
The focus of this article is the special needs of youth - that is to say young people aged between 15 and 25 years (Gidley & Inayatullah, 2002), and in particular the needs of young students attending a local tertiary institute. It is argued that although the New Zealand Health Strategy (King, 2000) is addressing the needs of some disadvantaged groups, primary health workers need to recognise that changes in primary health care are not always addressing the specific needs of another disadvantaged group, the youth of New Zealand.

History of Primary Health Care in New Zealand

Over the past 70 years, General Practitioners (GPs) in New Zealand have generally been self-employed in for-profit small businesses, with charges for services increasing over the years. In the 1940s, major health reforms were introduced but the government of the day was unsuccessful in setting a funding cap (Crampton & Starfield, 2004) and since this time, governments have been partly subsidising GP practices (Crampton, Dowell, & Woodward, 2001). In 1993, the payment system changed, permitting GPs to contract for services. This was introduced in an attempt to gain control over the primary health care budget and help direct the area in which GPs worked (Crampton & Starfield). Waldegrave, Stephens, & King (2003) note how, in response to these changes, GPs grouped together to form Independent Practitioner Associations (IPAs).

The IPAs were able to negotiate directly with the Ministry of Health for their contracts and consequently were able to co-ordinate innovative care. However, there was very little change in the cost to the public. Approximately 60% of funding for IPAs was from government sources with the remainder 40% being paid by the patient (Crampton, Davis, & Lay-Yee, 2005). Another concern with the IPAs was that there was minimal provision for community involvement, a concept that is central to the World Health Organisation vision of primary health care and health promotion (Crampton et al., 2001).

International Trends

Government funding of general practice varies between countries but GPs are the main providers of primary health care in the Western world (Palmer, 2000). In the United Kingdom, GPs have a capitation scheme based on the level of deprivation in an area, plus fee for service (Hyndman, Holman, & Pritchard, 2003). In the United States, competition was introduced in the 1990s to encourage efficiency and control costs, while anticipating the
delivery of a quality service (Barnett, Coyle, & Kearns, 2000; Segal, 2000). Unfortunately, expecting market forces to control cost and deliver appropriate health care failed to take into account welfare cuts, reduced housing subsidies and an increase in casual employment, leading to greater disparity between the wealthy and the poor (Barnett et al., 2000).

Despite the obvious failures of this system governed by market forces, it was introduced into other Western countries, for example, Australia, Sweden and Germany (Hyndman et al., 2003). This approach has not improved the health of people in deprived areas of developed countries or in low to middle income countries (Barnett et al., 2000; Hyndman et al., 2003). The underlying cause of failure was a conflict between service culture and market culture; health professionals found they were unable to deliver quality care under the economic constraints imposed by their managers (Hyndman et al., 2003; Segal, 2000).

The New Zealand Health Strategy

Social justice, protection of vulnerable populations and attaining the highest standard of health are basic human rights (Dwyer, 2005; Easley, 2006). In recent years successive governments have made radical changes that have resulted in poorer health outcomes for vulnerable populations such as Maori and Pacific Island people (Barnett, 2001). The New Zealand Health Strategy (King, 2000) is a major policy document for the New Zealand Government. Its vision is to improve the health of all New Zealanders, but in particular the health of disadvantaged and vulnerable groups. It sets out seven principles plus key goals and objectives for addressing health needs and reducing the disparities between different populations.. The Ministry of Health and District Health Boards are implementing the Strategy to address these health inequalities and to improve the health of all New Zealanders.

The Primary Health Care Strategy

An improvement in the delivery of primary health care is a key objective of the overall Health Strategy, leading to the development of the Primary Health Care Strategy (King, 2001). Both Strategies are based on the Alma Ata Declaration (World Health Organisation, 1978) that aims to: reduce inequalities in access to primary health care, reduce access costs, work with local communities, develop the primary health care workforce, promote population health and develop a non-profit primary health infrastructure. Key concepts are to reduce disparities and support disadvantaged groups through the development of Primary Health Organisations (PHOs).
PHOs are designed to be non-profit umbrella organisations and are charged with providing co-ordinated and comprehensive care to people enrolled in their organisation (King, 2001). The service is also expected to provide effective health promotion and health maintenance programmes (Crampton, et al., 2005; King). Funding is from the Ministry of Health to the District Health Boards (DHBs) who distribute the funds according to perceived population needs (King). The Primary Health Care Strategy includes extra funding for specific programmes, innovative service delivery and targeting of disadvantaged groups, for example advertising a Quit smoking programme or initiating diabetes screening (King). It is argued that measuring quality of primary health care delivery is possible through evidence-based, population-focused indicators, especially if practices are computerised (Gribbon, Coster, Pringle, & Simon, 2002). However there is still some debate about what the term ‘quality’ means in this context.

Disadvantage, Poverty and Health

Economic deprivation causes negative patterns of behaviour and can lead to separation from normal social contact (Sloggett & Joshi, 1998). Poverty is strongly linked with poor health (Barnett, 2001; Berkman & Kawachi, 2000; Gwatkin, 2000; Wagstaff, 2002). Poverty also is linked with a shorter life expectancy and an increased risk of intellectual disabilities (Leonard et al., 2005; Sloggett & Joshi).

The interaction between poverty and health is very complex; the physical determinants which affect health include geographical location and housing because where people live has been found to have an impact on health (Latkin & Curry, 2003; Leonard et al, 2005). Unemployment or poorly paid employment and lack of education also have negative effects on health through a number of pathways including physiological stress (Macintyre, Ellaway, & Cummins, 2002). Negative effects from smoking, lack of exercise, obesity or nutritionally poor food can add to the above issues and lead to ill health (Cooper, Hill, & Powe, 2002). Cultural and social factors can also affect health in positive or negative ways but there is a constant correlation between low income and poor health (Blakely, 2002; National Health Committee, 1998; Wagstaff, 2002).

However, being in a low-income bracket does not necessarily mean poor health for an individual or their families. Vetter and Matthews (1999) argue that although poorer people have higher rates of almost all diseases, the fact that people have a very low income does not in itself cause disease. As outlined above there are many other factors involved.
Berkman & Kawachi (2000) and Hefford, Crampton, & Foley (2005) refer particularly to education levels, area of residence and type of employment. It is noted also that being healthy is linked with the strength of individual and community social networks. Strong social support in a deprived area has a positive effect on health in spite of poverty and deprivation (Cattell, 2001).

Despite the above findings, most research on this subject serves to establish a strong link between poverty and ill health (Blakely, 2002; Lynch, Kaplan, & Salonen, 1997; Wagstaff, 2002). In New Zealand there is significant disparity between the health of Maori and Pacific Island populations compared to Pakeha populations. For example, life expectancy for Maori is approximately nine years less than for other New Zealanders (Hefford et al., 2005; King, 2000; Ministry of Health, 2004) while income levels for Maori and Pacific Island people are disproportionately lower than for the European population (Ministry of Health).

Youth Health

The group chosen as an example for this article are young people under 25 years with particular attention given to the needs of young students who attend a local Student Health Centre attached to a tertiary institution. The city is located in the North Island of New Zealand and has a population of approximately 45,000 people. Most of these students are living on the ‘student allowance’ and have a ‘student loan’. Anecdotally, it appears that a significant number of those attending the Health Centre have not attended any health clinic since they were children. They are not in the habit of seeking the services or advice of a Registered Health Practitioner when unwell. Generally they cope with illness with advice from friends and whanau (family) as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice for people who are living on a very low income; the cost of seeing a Health Practitioner or collecting a prescription is the reason given for non-attendance (Barnett, 2001).

In an attempt to encourage use of GP services by low-income earners, a Community Services Card (CSC) was introduced in the early 1990s. The card reduced the cost of GP visits and also greatly reduced prescription charges. It was issued on the basis of income level, age, benefits received and medical need (Crampton et al., 2001). However, only 77% of people entitled to a CSC actually applied for one and Pacific Island people were much less likely to have applied than any other ethnic group (Hefford et al., 2005).
Currently many students visiting the Student Health Centre do not have a CSC although the overwhelming majority are eligible for one as they are living on student allowances and student loans and therefore have an income below the threshold of $22,157. The fact that cost is a barrier to students accessing health care links with research by Crampton et al. (2001) that shows reducing the cost of health care to disadvantaged groups increases the use of primary health care. Prompt primary health care helps to avoid costly admission to hospital (Buetow et al., 2004; Jackson & Tobias, 2001).

However, research by Barnett (2001) concludes that non-attendance at the level of primary health care for Maori and low-income populations is a very complex issue; cost constraints are significant but non-attendance cannot be explained by the financial cost alone. At the Student Health Centre, a significant minority of students who do have a CSC still do not access the free services. Some students will attend the nurse-led clinic to seek advice, often with a group of friends as support. Once they feel more comfortable at the Student Health Centre the student may then see the GP, but frequently students make an appointment but do not arrive.

Buetow et al. (2004) point out that poor households face not only social and transport difficulties but also have concerns about a primary health care system that may be culturally insensitive. Many of the conventional ways of determining health status do not fully encompass the Maori concept of hauora (health); for Maori, hauora includes the spiritual, physical, mental, environmental and whanau (Durie, 1985).

Cultural Needs

In New Zealand, Maori and Pacific Island people have high rates of hospitalisation for infections, asthma and diabetes. These conditions are preventable or easily treated if diagnosed and properly managed at an early stage at the primary health care level (Jackson & Tobias, 2001). Maori and Pacific Island people have a strong need to feel safe and to have a sense of trust in their health professional (Kiro et al. 2004). These issues are recognised in the Primary Health Strategy (King, 2001) and are addressed by increased subsidies for PHOs in areas of greater deprivation and having community and local iwi (tribal) leaders included in decision-making processes (Hefford et al., 2005). But there is some risk that if a PHO does not successfully involve the local community, especially local Maori and/or Pacific Island leaders, then the main aims of the Primary Health Strategy will not be met (Crampton & Starfield, 2004; Crisp, Swerissen,& Duckett, 2000; Wise & Signal, 2000).
Youth Needs

Student and Youth Health services were not specifically mentioned in the Primary Health Care Strategy (King, 2001) therefore the Student Health Centre was not invited to join either of the two PHOs set up in the local region in 2003. This has meant increased disadvantage to youth living in the region and in particular many of the students. The GP is only available at the Student Health Centre during the semester and students are frequently new to the city and do not have a family GP. Unfortunately, the number of GPs in the city is dropping, causing difficulties for many new people who need to register with a GP and PHO.

Young people under 25 years make up approximately 25% of local urban population and often have difficulty accessing low-cost health care that is sympathetic to their need to be treated in a confidential and respectful manner (McDonagh & Viner, 2006). The local Youth Health Trust offers a culturally acceptable service to young people but is constrained by continual concerns over funding. The Sexual Health Clinic is poorly attended by youth, partly because it is held at the hospital and too public for young people.

Eighteen months ago, the District Health Board held discussions with the community on the needs of youth in the local area. The proposal was to combine the current fragmented services to form a more appropriate and co-ordinated low cost service for young clients. A draft proposal plan is due to be released in the next few weeks.

Nurses working in primary services need to be aware that the increased emphasis on primary health may not be addressing the needs of disadvantaged youth. Youth have their own specific health needs as they move from childhood; they are at higher risk of a mental health disorder, contracting a sexually transmitted disease or indulging in substance abuse (Collins, 2006; Michaud, 2002) but adolescent health and well-being has been largely overlooked in the past. However, the Ministry of Health has recently commissioned a survey of the nation’s youth for their views on health, and hopefully this information will lead to an increase in appropriate and equitable services for the youth of New Zealand.

Conclusion

Major changes in New Zealand’s economic, health and welfare systems over the past two decades have caused considerable disruption and deprivation to the social and economic status of the population. The negative effects have been seen in the area of health,
particularly for those population groups who were already at some socio-economic
disadvantage, for example Maori or Pacific Island people. Successive governments have
been unable to substantially improve the health outcomes for these groups.

The current Labour Government launched a Health Strategy in 2000, which was designed to
help disadvantaged groups regain lost ground. A pivotal part of this Strategy was its links
with the Primary Health Strategy (King, 2001), with PHOs being charged with addressing
inequalities in health and improving the health of disadvantaged New Zealanders.

This article offers a critique of the relationship between disadvantage and health, using youth
health as an example of a disadvantaged group. Although the needs of Maori and Pacific
Island people are recognised by the Ministry of Health and some progress is being made in
these areas, youth of all cultures have specific health requirements that have been largely
ignored by national and local governing bodies. New Zealand’s young people deserve to
have their needs acknowledged and addressed through their own Youth Health Strategy.

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