

What supports are needed by New Zealand primary care to improve equity and quality?

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ABSTRACT

While some primary care practices have found ways to deliver quality care more equitably to their Māori and Pacific patients, others have struggled to get started or be successful. Quality Symposium attendees shared their views on barriers and success factors, both within the practice and beyond. When practices have collaborated and used their own ethnic-specific data in quality improvement techniques, they have improved Māori and Pacific health and equity. Attendees asked for greater practical support and guidance from the profession and sector. They report a funding gap for services needed by their patients to enable primary care to deliver equitable services for Māori and Pacific people.

KEYWORDS: Equity; quality and safety; health services; Māori health services; Pacific communities; Indigenous health; primary health care

The Equity Explorer recently released by the Health Quality and Safety Commission reminds us all that there are big opportunities for improving health equity within our services and delivering high-quality medical care to all patients.¹ It is well recognised that some of the health gaps between ethnic groups are engendered outside the clinical setting (such as housing), but the Equity Explorer is directed at gaps that are within health sector influence, and we have the opportunity to address these.

In recent years, several reports, evidence reviews and frameworks have identified what actions health care organisations can take to close equity gaps. In particular, the *Equity of Health Care for Māori Framework* and *Pacific and Primary Care for Pacific People: A Pacific and Health Systems Approach* have clearly identified ways to improve quality of care for Māori and Pacific people.^{2,3} We can also benefit from resources from other countries such as the excellent *Finding Answers* programme and its associated website.^{4,5} This website makes it easy to find 10 years of US

research and numerous systematic reviews, and apply it to local circumstances.

Together, these publications²⁻⁵ contribute to clarifying the actions that make a difference for equity and quality. Some are actions that can be carried out by health practitioners (such as relationships, language, referral patterns and support for patient self-management), others apply to organisations (such as systemic approaches to quality improvement, use of data and roles across the health care team) and others are changes that are needed in broader policies (such as workforce development, funding and incentive structures).

These types of approaches fit well with the *Aiming for Excellence* framework to improve clinical outcomes for patients.⁶ Within that framework, they can be used by primary care practitioners and organisations for practice-based quality improvement (QI); that is, systematic, data-guided activities designed to bring about immediate health care improvements.⁷

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Our local research on what influences practices to begin and then succeed at quality improvement to improve ethnic equity complements the national and international picture.⁸ As part of that, attendees at Royal New Zealand College of General Practitioners (RNZCGP) 2013 Quality Symposium were purposively sampled to contribute their views.

Everyone can take an ethnic equity approach to quality improvement

You do not have to be an old hand at QI to put fairness into your work to improve quality. Although there is a wide range of experience in using QI approaches in the sector, all those newer to QI (1–6 years' experience) reported projects that had succeeded in improving ethnic equity.

And ethnic equity is relevant for your practice, no matter what part of the country you work in. The Equity Explorer shows better clinical quality for European New Zealanders compared with Māori and Pacific patients in District Health Boards with very low proportions of Māori and Pacific residents.¹ There is work to do for equity within the health sector right across the country.

Use your own ethnic-specific data to diagnose whether and where you have gaps for your patients

The Quality Symposium attendees said that it was important for practices to look at their own ethnic-specific data for information about quality in their own setting. When practices have entered accurate ethnicity data and have installed data systems that work well, local information enables meaningful ethnic-specific audits and QI projects for the benefit of the practices' own patients.

They suggested that complacency can be a barrier, or there can be a lack of recognition that ethnic inequity could be a local issue. Perhaps we have a New Zealand version of findings from the US. There, US doctors more commonly identify that there are inequities at a national level, less commonly at a wider organisation level, and least commonly identify ethnic equity gaps within their own individual practice.^{9–11}

One of the ways for health professionals to develop skill in this area is to work with peers to examine quality in local clinical performance.²

Focus on quality

Use ordinary QI processes to improve equity and have a local champion, they said. Try to collaborate with others doing similar QI and keep the process simple.

Have the right people involved

They re-iterated that involving communities helps practices succeed in improving quality and equity. Partnership with local Māori communities, working with Māori and Pacific providers, and having a workforce that reflects the diversity of patients contribute to practice success. In this, they echoed the RNZCGP Foundation Standard and the advice from key New Zealand publications.^{2,3,12}

Ring-fence some time for attention

Putting QI for equity outside of normal work is a barrier to improvement. Seeing it as part of routine team activity and ring-fencing a little time for clinical teams and wider staff attention helps make it work well. Although challenging, many practices have found ways, in the words of one, to 'make time' even within existing resources.

Which practice changes have improved quality and ethnic equity?

Improving equity in health services – that is, getting the same, good-quality care to all groups of patients – contributes to improved equity in health outcomes. For example, when Māori women have screening mammograms, the survival outcomes are equitable;¹³ consistent application of diabetes care reduced the HbA1c gap.¹⁴

Symposium respondents reported success across several clinical areas, including cervical and breast cancer screening, diabetes, cardiovascular health and immunisation. They said that the way to achieve the result of the same consistent clinical care across groups is by organising things differently.

In their brief written responses, there was little space for detail; however, published reports describe ways New Zealand primary care has successfully adopted different approaches, often in combination, to deliver the same clinical services to different populations.^{14–18} Techniques particularly relevant for primary care practices and primary care practitioners in New Zealand from the *Finding Answers* trials and reviews^{4,5} are:

- Restructuring the care team – particularly supporting nursing services.
- Delivering education, training and support for both patients and the practice team.
- Enhancing language and literacy services.
- Providing reminders and feedback – for both patients and the practice team.
- Engaging the community.

Sector support

The wider sector and health professions can support practices to improve delivery of equitable, high-quality health care. Peer attention, collaboration and Primary Health Organisation engagement all were reported as supports for successful improvements in quality and equity. Many primary care practices used the flexibility that exists, but tangible support and leadership would help others. They wanted support for problem solving, including pre-formatted QI projects that can be adapted to individual practices. More broadly, they wanted equity improvement to be more visible within the profession, explicitly as a topic for Maintenance of Professional Standards and Professional Development and Recognition Programmes, and supported by registrar training.

The most common issue raised was funding; as an enabler of access to clinic visits and education services, as time for QI processes, and as a practice incentive. Clearly, cost continues to be a barrier for many Māori and Pacific people,¹⁹ and there is a substantial role for national, District Health Board and Primary Health Organisation policies to make services universally affordable.

Conclusion

A core finding of this study is that individual practices often find ways to improve quality and

equity, but that it can be a struggle. Quality Symposium attendees say that greater commitment to quality and leadership for equity in primary care from wider professional and sector organisations, and funding for patient needs, could provide the environment to support more individual practices to adopt QI for equity. That could help all primary care practices in New Zealand play their essential part in improving quality to close our health equity gap.

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COMPETING INTERESTS AND CONFLICTS OF INTEREST

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