Chapter 5: Primary Health Care Providers

Introduction

'Primary health care' refers to the professional health care that people receive in the community and is the first point of contact with the health care system. A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups.

The introduction of the Primary Health Care Strategy in 2001 (Minister of Health 2001), followed by the establishment of Primary Health Organisations (PHOs), set a new direction and vision for primary health care services in New Zealand. Although many primary health care services are provided by general practitioners (GPs), the Primary Health Care Strategy places a greater emphasis on further developing the roles of a broader multidisciplinary primary health care team: GPs, nurses, pharmacists, and allied health professionals (including physiotherapists, dietitians, psychologists, counsellors, occupational therapists and community health workers).

PHOs are the local structures which deliver and co-ordinate the wide range of services provided in primary health care by health professionals. Between July 2002 and July 2007, the government provided new funding to PHOs in order to reduce the cost of visits to GPs and prescriptions. This funding was available for all New Zealanders enrolled in PHOs from 1 July 2007.

The 2006/07 New Zealand Health Survey included a range of questions designed to monitor the primary health care system in New Zealand. Three components of primary health care were measured in the survey, based on Starfield's framework for monitoring primary health care:

- access
- comprehensiveness
- continuity and co-ordination (Starfield 1998).

Participants' experience of primary health care in the previous 12 months was also measured by asking whether they had been treated with respect and dignity, listened to carefully, and had their health care discussed as much as they wanted.

The term 'primary health care provider' is used in this report to refer to the GP clinic, student health clinic, 24-hour accident and medical centre or nurse clinic that the survey participant (or the parents of child participants) reported they go to *first* when feeling sick or injured.

Appendices 5 and 6 describe how to access data presented in this chapter, as well as additional results available online.

Access to primary health care providers

The Primary Health Care Strategy aims to ensure that all New Zealanders have access to primary health care providers when they need them by reducing barriers such as cost and location and ensuring appropriateness of the service for the client.

This section reports findings from the 2006/07 New Zealand Health Survey that can be used to examine issues relating to access to primary health care providers in New Zealand.

What were the survey questions?

In the 2006/07 New Zealand Health Survey, adult participants and parents of child participants were asked whether they had a health practitioner or service that they usually go to *first* when they are feeling unwell or are injured.

If adult participants answered yes to this question, they were also asked about the type of provider it was (e.g. a GP clinic), which health care workers they had seen, their use of services at that place over the previous 12 months, and whether they were able to see this primary health care provider when they needed to.

Only participants who had a GP clinic, student health clinic, 24-hour accident and medical centre or nurse clinic they go to first when feeling unwell or injured have been included in the analyses.

Further information on the use of and access to GPs and practice nurses specifically, as well as oral health care workers, is included in Chapter 6.

Has a primary health care provider

Nearly all children (97.4%, 96.8–98.0) and nine out of ten adults (93.3%, 92.8–93.8) had a primary health care provider (a GP clinic, student health clinic, 24-hour accident and medical centre or nurse clinic) they go to first when feeling unwell or injured.

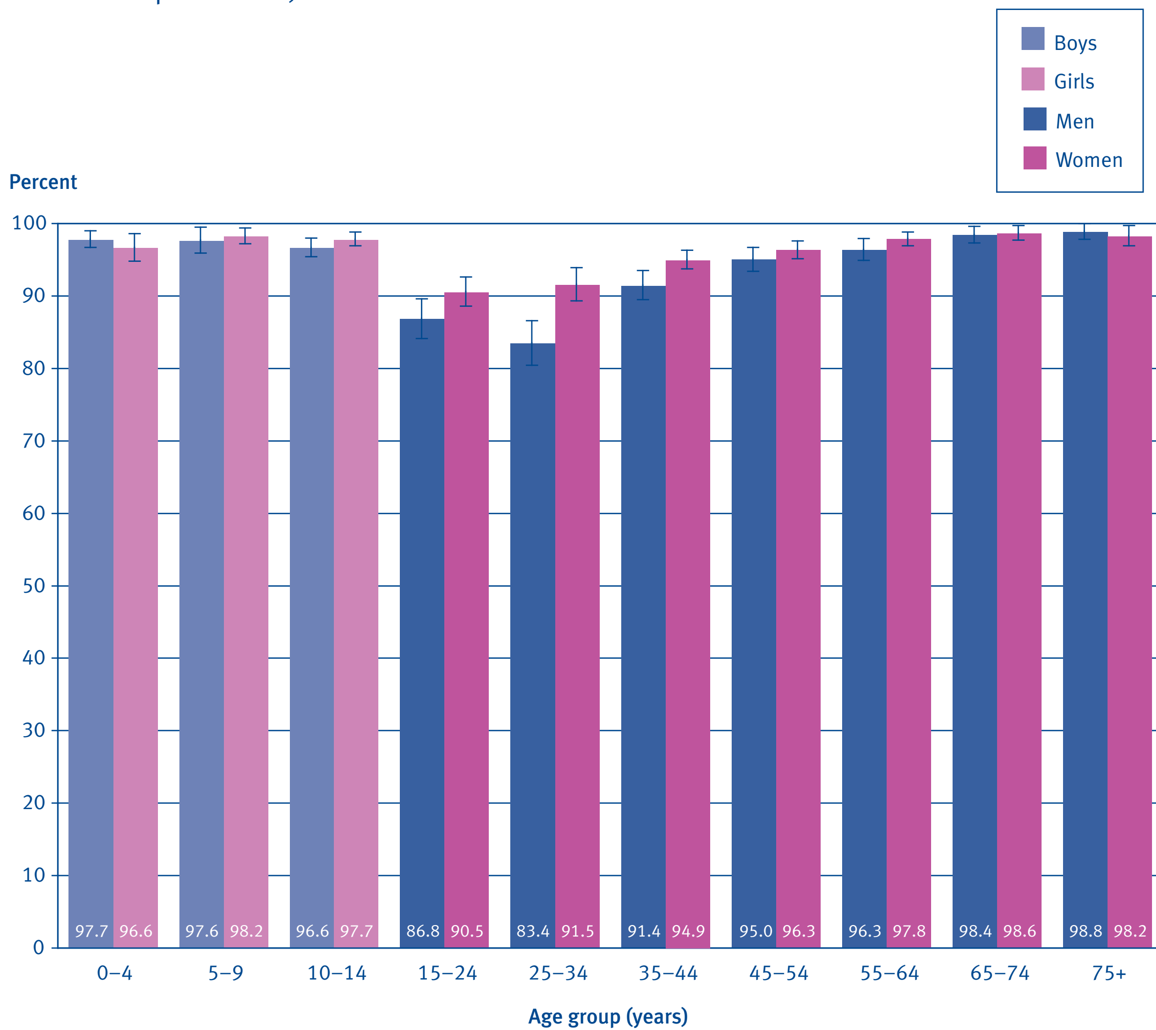
After adjusting for age, boys and girls were equally likely to have a primary health care provider they go to first when feeling unwell or injured. Women (94.1%, 93.3–94.8) were significantly more likely than men (90.5%, 89.6–91.5) to have a primary health care provider they go to first when feeling unwell or injured.

For almost all children (99.0%, 98.6–99.3) and adults (97.8%, 97.2–98.3) the primary health care provider they go to first is a GP clinic.

Has a primary health care provider, by age group

Children and adults aged over 45 years were significantly more likely than adults aged 15–44 years to have a primary health care provider they go to first when feeling unwell or injured (Figure 5.1). Women aged 25–44 years were significantly more likely than men of the same age to have a primary health care provider they go to first.

Figure 5.1: Has a primary health care provider, by age group and gender (unadjusted prevalence)

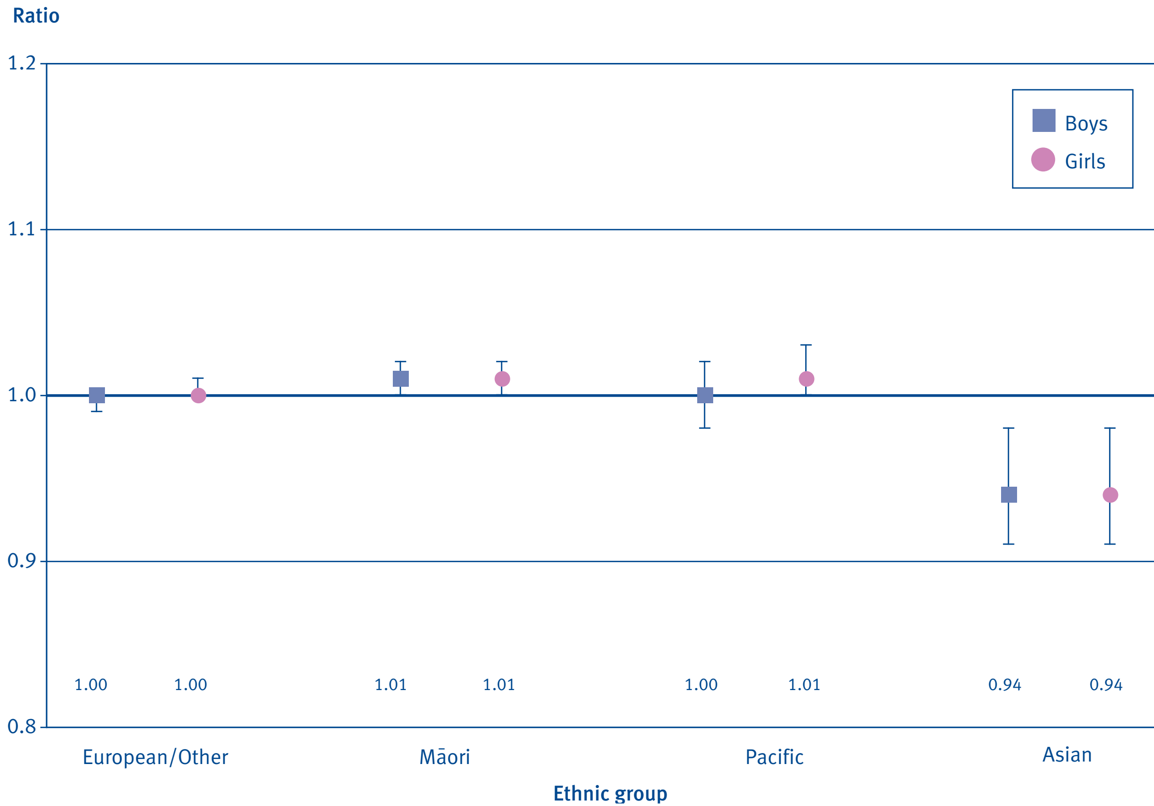


Source: 2006/07 New Zealand Health Survey

Has a primary health care provider, by ethnic group

After adjusting for age, Asian boys and girls were significantly less likely than boys and girls in the total population to have a primary health care provider they go to first (Figure 5.2).

Figure 5.2: Children who have a primary health care provider, by ethnic group and gender (age standardised rate ratio)

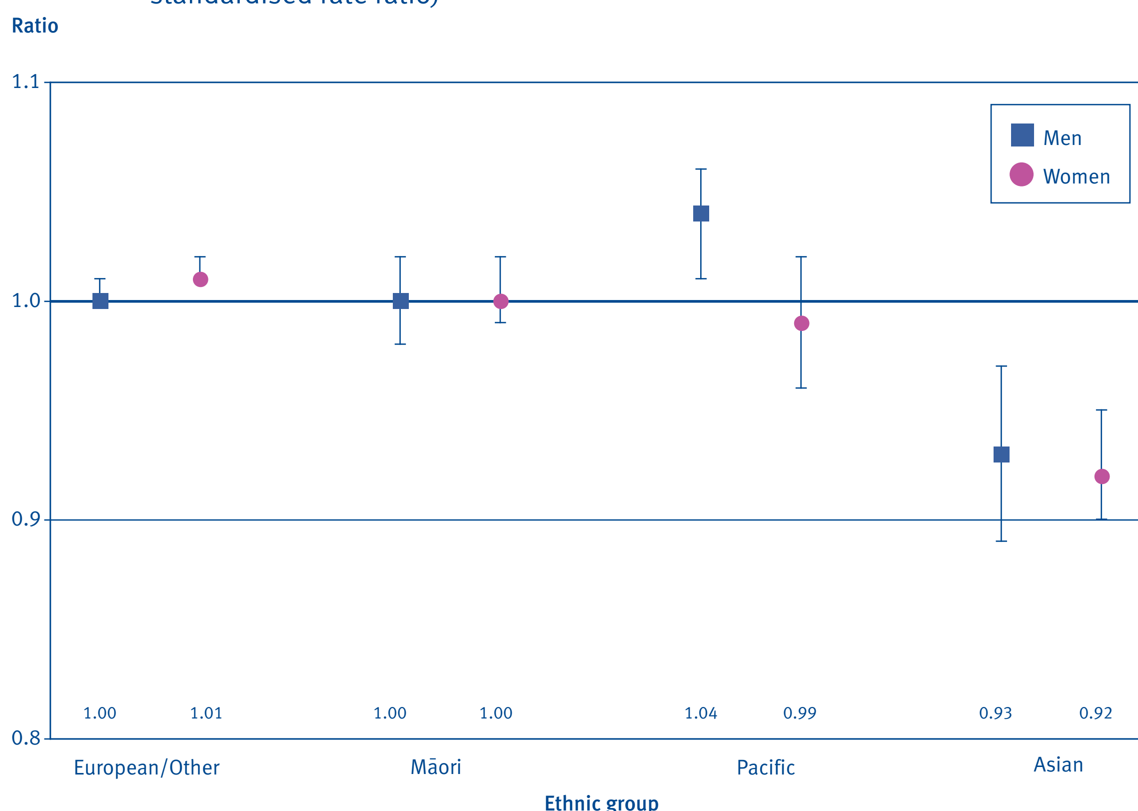


Source: 2006/07 New Zealand Health Survey

Notes: Age standardised to the WHO world population. Reference group, with a rate ratio of 1.0 (indicated by the bold line), is the total male or female population aged from birth to 14 years. Total response standard output for ethnic groups has been used.

Asian men and women were significantly less likely than men and women in the total population to have a primary health care provider they go to first when they are feeling sick or injured (Figure 5.3).

Figure 5.3: Adults who have a primary health care provider, by ethnic group and gender (age standardised rate ratio)



Source: 2006/07 New Zealand Health Survey

Notes: Age standardised to the WHO world population. Reference group, with a rate ratio of 1.0 (indicated by the bold line), is the total male or female population aged 15 years and over. Total response standard output for ethnic groups has been used.

Has a primary health care provider, by neighbourhood deprivation

Women living in neighbourhoods of high deprivation (NZDep 2006 quintile 5: 92.1%, 90.2–94.0) were slightly less likely to have a primary health care provider than women living in neighbourhoods of low deprivation (NZ Dep 2006 quintile 1: 95.8%, 94.1–97.5). This pattern was evident, but not statistically significant, for men as well.

Has a primary health care provider, by DHB area

The proportion of children who had a primary health care provider they go to first was significantly higher in the Bay of Plenty / Taranaki / MidCentral DHB area compared to the national rate, while this proportion was significantly lower in the Waikato DHB area (Table 5.1).

The proportion of adults who had a primary health care provider they go to first was significantly higher than the national rate in the following DHB areas:

- Northland / Tairawhiti / Hawke's Bay / Lakes / Whanganui
- Counties Manukau
- Bay of Plenty / Taranaki / MidCentral
- Nelson Marlborough / West Coast / South Canterbury / Otago / Southland.

The proportion of adults who had a primary health care provider they go to first was significantly lower in the Auckland and Waikato DHB areas (Table 5.1).

Table 5.1: Children and adults who have a primary health care provider, by DHB area (unadjusted)

DHB area	Prevalence in children (95% CI)	Number of children	Prevalence in adults (95% CI)	Number of adults
Northland / Tairawhiti / Hawke's Bay / Lakes / Whanganui	98.2 (96.5–99.2)	113300	96.6 (95.8–97.5) +	363000
Waitemata	97.1 (95.0–98.5)	101100	92.8 (91.0–94.5)	351400
Auckland	96.1 (92.8–98.1)	71800	91.1 (89.0–93.2) –	293900
Counties Manukau	96.9 (94.9–98.3)	107700	95.3 (93.9–96.6) +	307100
Waikato	95.4 (93.4–97.4) –	72700	90.9 (88.7–93.2) –	235800
Bay of Plenty / Taranaki / MidCentral	98.8 (97.8–99.5) +	97300	95.7 (94.4–97.0) +	336300
Wairarapa / Hutt Valley / Capital and Coast	98.5 (96.5–99.5)	88100	93.5 (91.7–95.3)	324100
Canterbury	96.6 (93.2–98.6)	87700	92.1 (90.0–94.1)	341600
Nelson Marlborough / West Coast / South Canterbury / Otago / Southland	98.4 (95.0–99.7)	92500	95.5 (93.9–97.1) +	375300
New Zealand total	**97.4 (96.8–98.0)**	**832200**	**93.8 (93.3–94.3)**	**2928500**

Source: 2006/07 New Zealand Health Survey

Notes: Estimates indicated with a + are significantly higher than the national rate, and estimates indicated with a – are significantly lower than the national rate. Data are based on direct survey estimates and could be confounded by different population characteristics in each DHB. Due to small sample size, some DHB areas have been combined. Survey population is the estimated resident population living in permanent private dwellings at 31 June 2007.

The remainder of this section only includes results for adults, as only the adult questionaire included extra questions on primary health care.

Reason for choosing primary health care provider

The most common reasons given by adults for choosing their primary health care provider were:

- they were the closest health care provider (46.6%, 45.2–48.0)
- I was referred to them by a friend or relative (28.8%, 27.5–30.1)
- they were willing to spend more time discussing my health (8.5%, 7.8–9.3)
- it was cheaper than going to another health care provider (6.0%, 5.4–6.6).
- I felt more comfortable talking to someone who understands my culture (5.7%, 5.1–6.2).

Use of primary health care provider in the previous 12 months

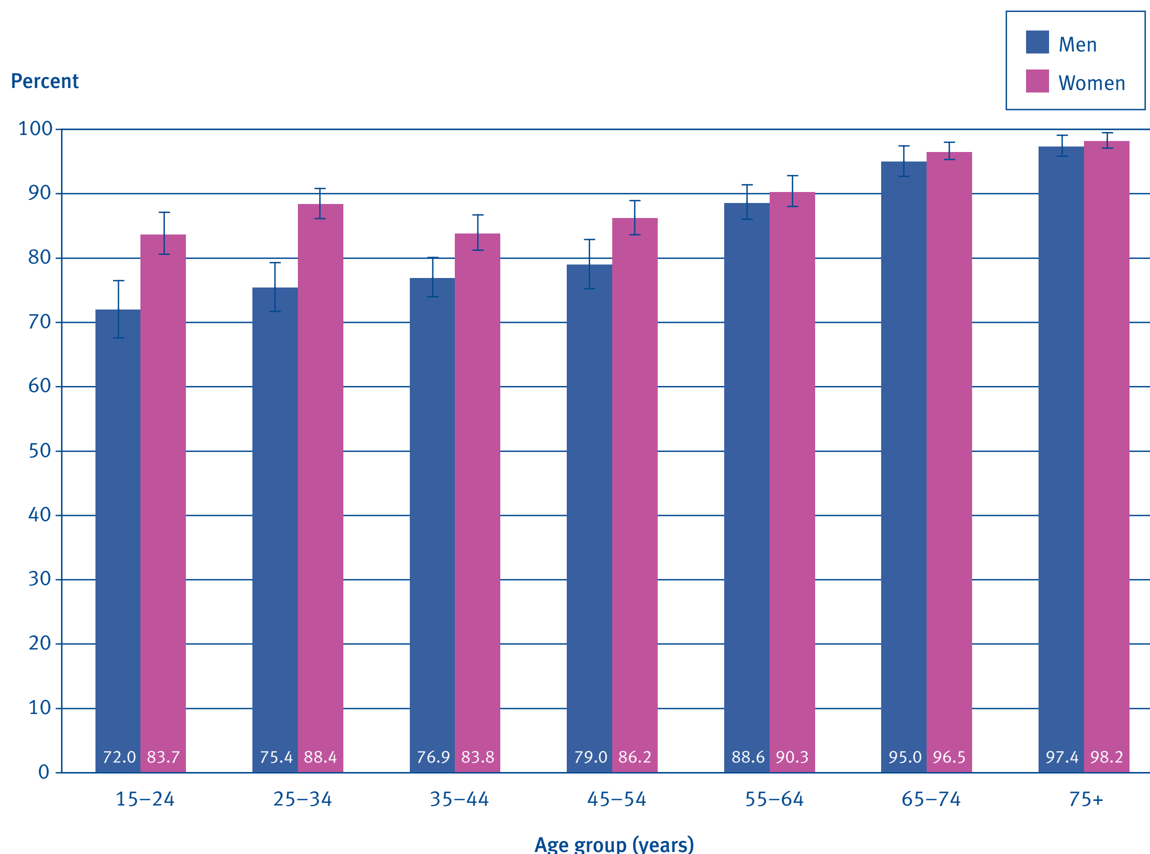
Five out of six adults (84.7%, 83.7–85.6) saw a health care worker from their usual primary health care provider about their own health in the previous 12 months.

After adjusting for age, women (87.4%, 86.2–88.6) were significantly more likely than men (79.6%, 78.1–81.2) to have seen a health care worker from their usual primary health care provider in the previous 12 months about their health.

Use of primary health care provider in previous 12 months, by age group

The proportion of adults who saw a health care worker from their usual primary health care provider in the previous 12 months generally increased with age. Adults aged over 65 years were significantly more likely than younger adults to have seen a health care worker from their usual primary health care provider about their own health in the previous 12 months (Figure 5.4).

Figure 5.4: Adults who saw a health care worker from their primary health care provider in the previous 12 months, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

Use of primary health care provider in the previous 12 months, by ethnic group

Asian women (SRR 0.94, 0.89–0.98) were significantly less likely and European/Other women (SRR 1.01, 1.01–1.02) were more likely than women in the total population to have seen any health care worker at their usual primary health care provider in the previous 12 months. There were no other significant differences by ethnic group.

Use of primary health care provider in the previous 12 months, by neighbourhood deprivation

There were no significant differences by neighbourhood deprivation in terms of the proportion of adults who saw a health care worker at their primary health care provider in the previous 12 months.

Able to see primary health care provider within 24 hours

Four out of five adults (82.3%, 81.4–83.1) who had seen their primary health care provider in the previous 12 months reported that there was no time when they were unable to see their primary health care provider within 24 hours when they wanted to during this period. The 17.7% (16.9–18.6) of adults who could not see their primary health care provider within 24 hours when they wanted to in the previous 12 months equates to 436,300 adults.

When adjusting for age, women (20.8%, 19.8–21.9) were significantly more likely than men (15.4%, 13.8–16.9) to report that they had not been able to see their health care provider within 24 hours when they wanted to.

Māori women were significantly more likely than women in the total population (SRR 1.26, 1.12–1.40) to report that they had not been able to see their health care provider within 24 hours when they wanted to.

Adults in the most deprived neighbourhoods (NZDep2006 quintile 5: 78.8%, 76.6–80.9) were less likely than adults in the least deprived neighbourhoods (NZDep2006 quintile 1: 82.4%, 80.2–84.7) to have been able to see their primary health care provider within 24 hours in the previous 12 months.

Comprehensiveness of primary health care

The Primary Health Care Strategy envisages a primary health care sector which promotes a comprehensive approach to health, moving beyond just treating ill health. Comprehensive care in primary health includes services that promote and preserve health (eg, vaccinations and nutrition advice) and services that can identify disease at its early stages (eg, screening, blood pressure and diabetes checks).

This section measures how well primary health care providers in New Zealand promote and preserve health, by considering the provision and type of health advice and health checks received by adults who had seen a primary health care provider in the previous 12 months.

What were the survey questions?

In the 2006/07 New Zealand Health Survey adult participants with a primary health care provider were asked which health checks and discussions (listed on a show card) they had had at their primary health care provider or that had been arranged by their primary health care provider in the previous 12 months.

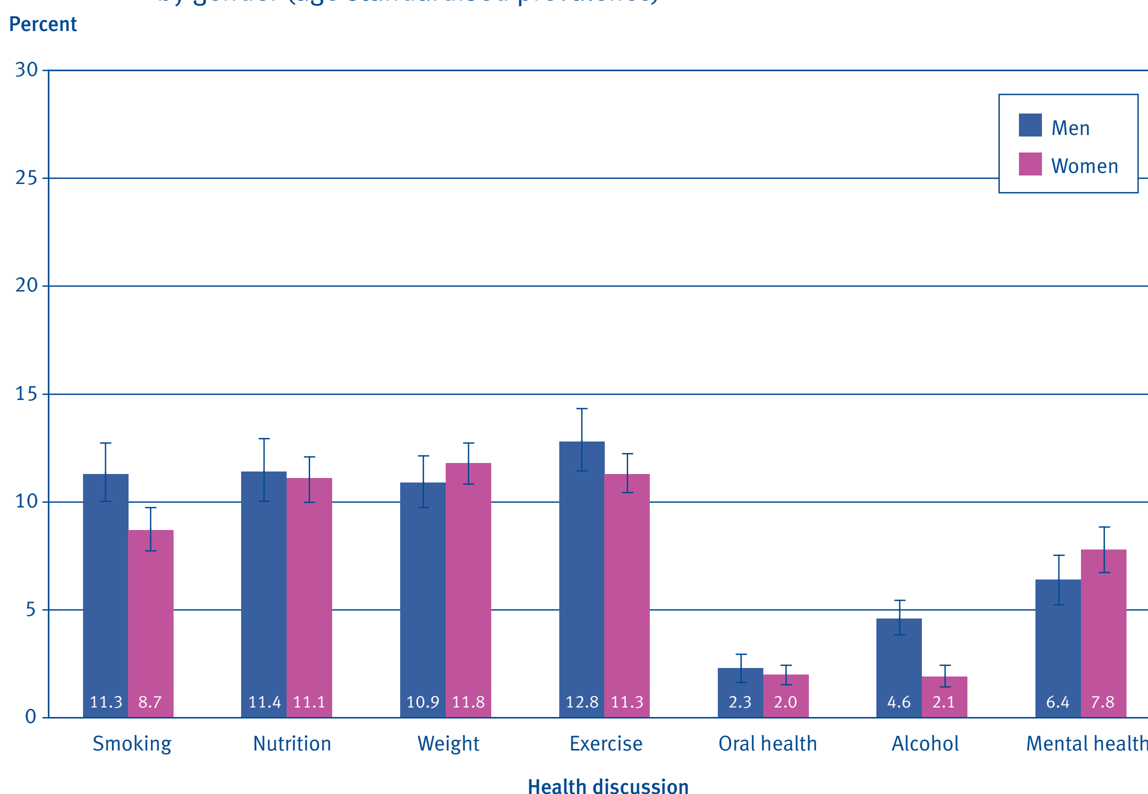
All female participants aged 20 years and over were also asked whether they had had a mammogram in the past two years or a cervical smear in the past three or five years.

Health discussions with primary health care provider

Exercise (12.5%, 11.6–13.3), weight (11.9%, 11.1–12.7), nutrition (11.4%, 10.6–12.2) and smoking (9.5%, 8.7–10.2) were the subjects most commonly discussed with adults who saw their primary health care provider in the previous 12 months.

When adjusting for age, men were significantly more likely than women to report that their primary health care provider had talked with them about smoking and alcohol in the previous 12 months (Figure 5.5).

Figure 5.5: Health discussions with primary health care provider in the previous 12 months, by gender (age standardised prevalence)



Source: 2006/07 New Zealand Health Survey

Two out of five (37.9%, 35.5–40.3) adults who were smokers reported that their health care provider had talked with them about smoking in the previous 12 months. One in four (24.2%, 22.7–25.7) adults who were overweight or obese reported that their health care provider had talked with them about their nutrition, exercise or weight in the previous 12 months.

Health discussion with primary health care provider, by age group

Overall, discussion of health behaviours with primary health care providers tends to increase in middle age, then decrease in the older age groups.

Health discussion with primary health care provider, by ethnic group

Pacific adults were significantly more likely than adults in the total population to have their primary health care provider discuss their smoking (SRR 1.99, 1.55–2.44), nutrition (SRR 2.74, 2.26–3.22), weight (SRR 2.78, 2.37–3.20), exercise (SRR 2.66, 2.30–3.03), oral health (SRR 3.97, 2.51–5.43) and alcohol use (SRR 3.85, 2.71–4.99) in the previous 12 months.

Māori adults were significantly more likely than adults in the total population to have their primary health care provider discuss their smoking (SRR 1.84, 1.63–2.06), nutrition (SRR 1.39, 1.24–1.54), weight (SRR 1.48, 1.31–1.66), exercise (SRR 1.37, 1.22–1.53), oral health (SRR 1.55, 1.11–1.98) and alcohol use (SRR 1.51, 1.16–1.85) in the previous 12 months.

Asian adults were significantly more likely than adults in the total population to have their primary health care provider discuss their nutrition (SRR 1.52, 1.25–1.78) and exercise (SRR 1.35, 1.10–1.59).

European/Other adults were significantly more likely than adults in the total population to have discussed their mental health (SRR 1.10, 1.07–1.13) with their primary health care provider in the previous 12 months.

Health discussion with primary health care provider, by neighbourhood deprivation

Both men and women in NZDep2006 quintile 5 (most deprived) were significantly more likely than men and women in quintile 1 (least deprived) to have discussed smoking and weight with their primary health care provider.

Women in NZDep2006 quintile 5 were significantly more likely than women in NZDep2006 quintile 1 to have discussed exercise, nutrition and oral health with their primary health care provider. Men in NZDep2006 quintile 5 were significantly more likely than men in NZDep2006 quintile 1 to have discussed alcohol use with their primary health care provider.

There were no significant differences by neighbourhood deprivation in terms of the proportion of men and women who had discussed their mental health with their primary health care provider.

Prevention of cancer – mammograms and cervical smears

Procedures that identify disease at an early stage before it causes ill health are an important part of comprehensive primary health care services. For women, the provision of regular mammograms and cervical smears is a measure of the comprehensiveness of service provided by their primary health care provider.

Mammograms (a type of breast x-ray) are used to identify early breast cancer. Finding breast cancer early means a woman has a better chance of surviving the disease. In New Zealand, BreastScreen Aotearoa, the national breast-screening programme, provides a free mammogram every two years to all women aged 45–69 years to help check for early breast cancer. Outside the screening programme, women of any age can have a mammogram in order to investigate a breast problem or if they are at high risk of developing breast cancer. Primary health care providers can make referrals for mammograms outside the breast-screening programme if needed (eg, if a breast lump is identified) as well as referring women to the breast-screening programme if they are eligible.

A cervical smear test is a screening test to detect abnormal changes in the cells of the cervix, which, if not treated could develop into cancer. Treatment at an early abnormal stage is usually very effective in preventing cervical cancer. In New Zealand, the National Cervical Screening Programme provides all women aged 20–69 years who have ever been sexually active with a free cervical smear test every three years. Cervical smears are usually carried out by primary health care providers. Women who have had a hysterectomy with both the uterus and cervix removed do not usually need to have smear tests and have been removed from the following analyses.

It is important to note that the results presented here do not reflect uptake of either the national breast or cervical screening programmes. This is because they include women who have had mammograms or cervical smears for other reasons (eg, they have a family history of breast cancer or they have had a previous abnormal cervical smear).

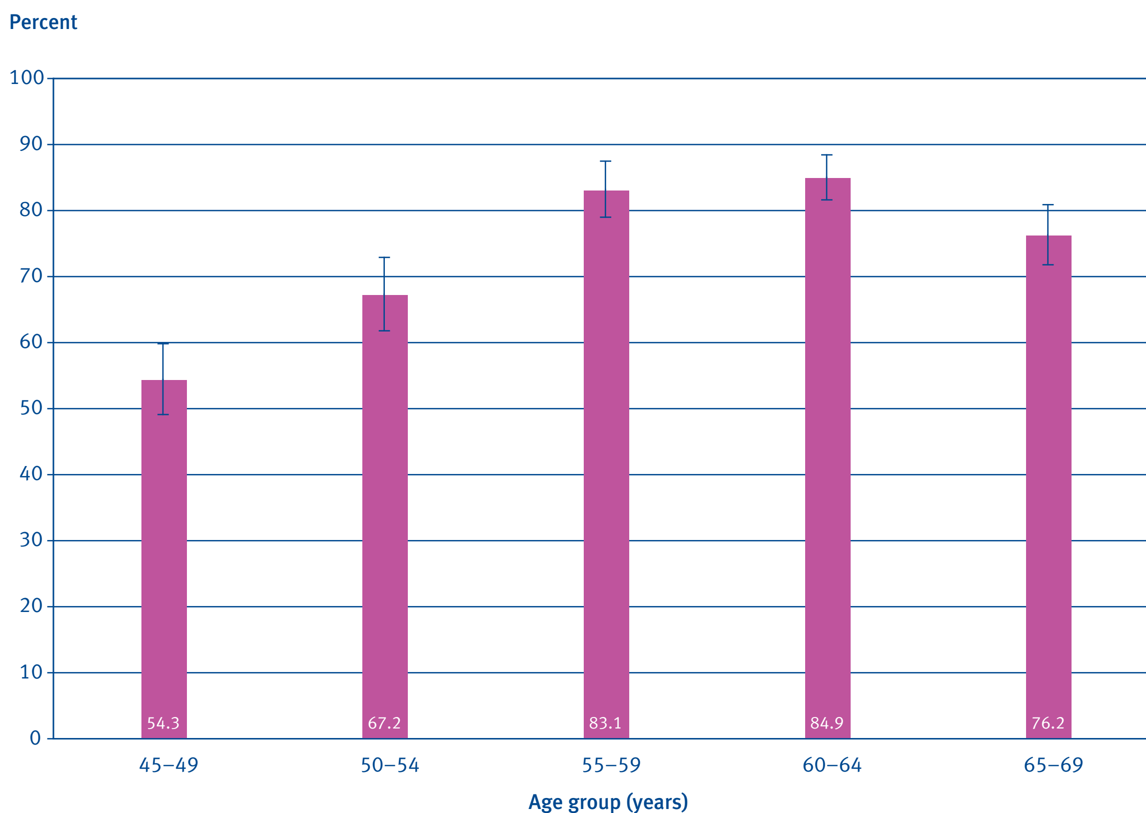
The analyses here only include women who report that they have a primary health care provider they go to first when feeling sick or injured (that is, not the total population).

Seven out of ten (71.2%, 69.0–73.5) women aged 45–69 years who have a primary health care provider reported having had a mammogram in the previous two years. Eight out of ten (79.6%, 77.9–81.3) women aged 20–69 years who have not had a hysterectomy and have a primary health care provider reported having had a cervical smear in the previous three years.

Mammogram and cervical smears, by age group

Women aged 55–64 years were more likely to have had a mammogram in the previous two years than those aged 45–54 years or 65–69 years (Figure 5.6).

Figure 5.6: Women aged 45–69 years (with a primary health care provider) who have had a mammogram in the previous 2 years, by age group (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

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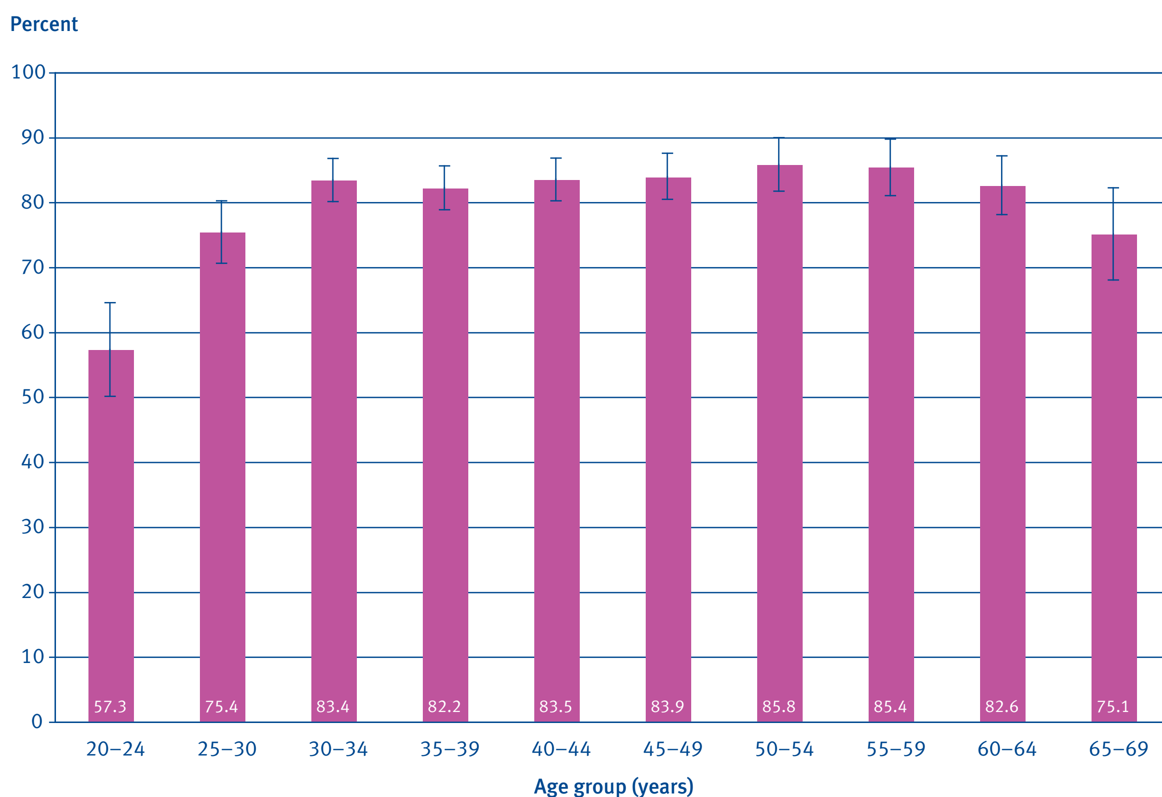
Women aged 20–29 years were less likely than women aged 30–64 years to have had a cervical smear in the previous three years (Figure 5.7).

Figure 5.7: Women aged 20–69 years (with a primary health care provider) who had a cervical smear in the previous 3 years, by age group (unadjusted prevalence)



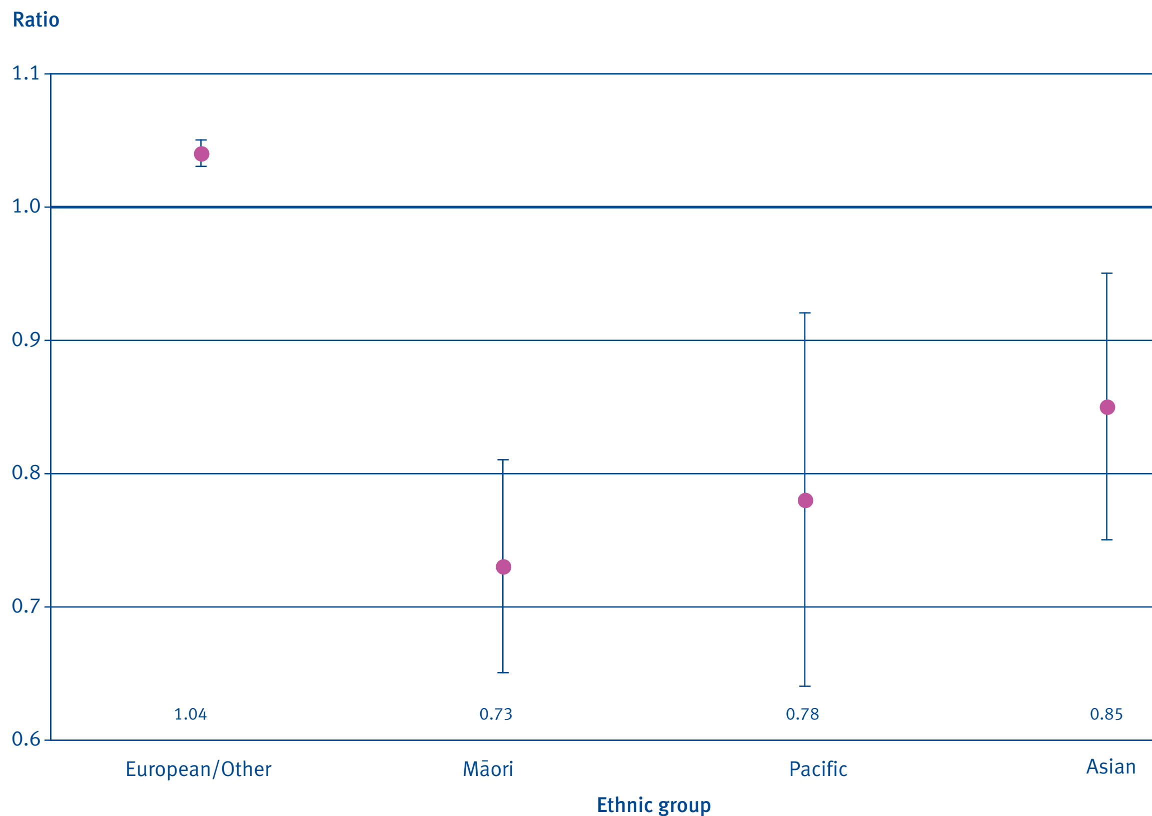
Source: 2006/07 New Zealand Health Survey

Note: Excludes women who have had a hysterectomy

Mammogram and cervical smears, by ethnic group

Māori women aged 45–69 years were less likely than the total female population aged 45–69 years to have had a mammogram in the previous two years, as were Pacific and Asian women. European/Other women aged 45–69 years were more likely than the total female population aged 45–69 years to have had a mammogram in the previous two years (Figure 5.8).

Figure 5.8: Women aged 45–69 years (with a primary health care provider) who have had a mammogram in the previous 2 years, by ethnic group (age standardised rate ratio)

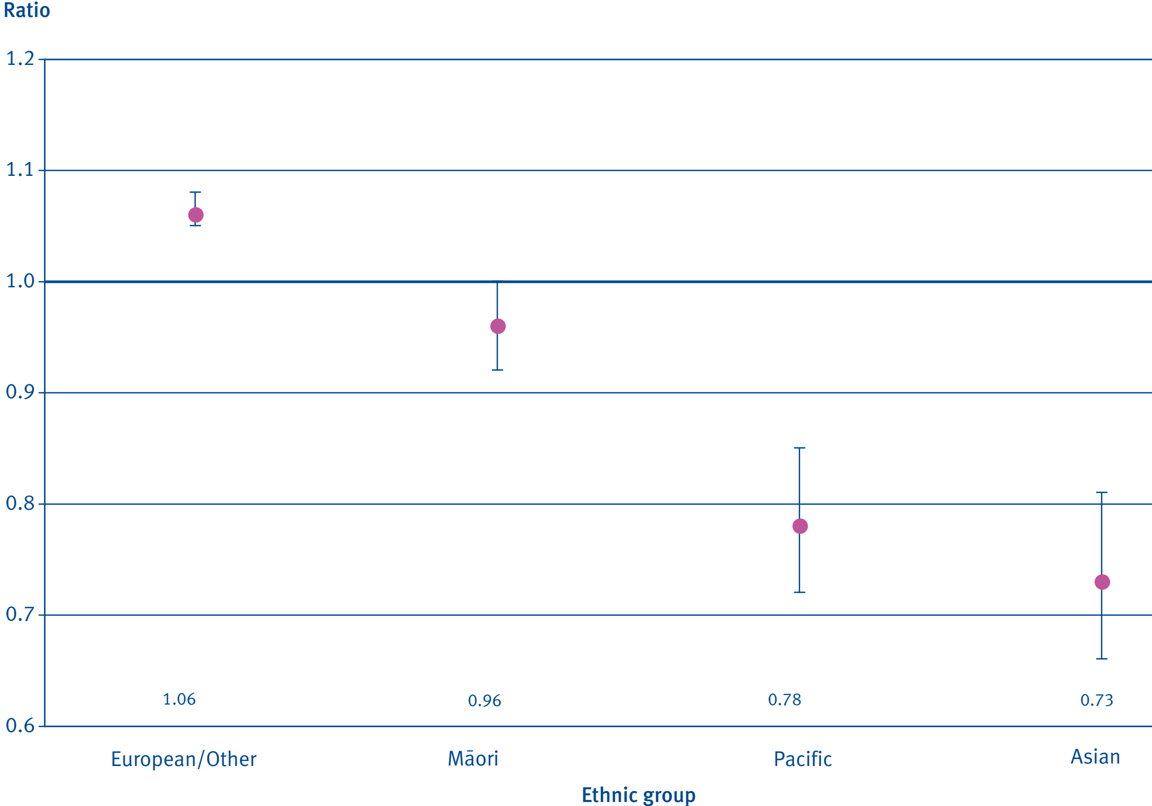


Source: 2006/07 New Zealand Health Survey

Notes: Age standardised to the WHO world population. Reference group, with a rate ratio of 1.0 (indicated by the bold line), is the total female population aged from 45-69. Total response standard output for ethnic groups has been used.

Pacific and Asian women aged 20–69 years were less likely, and European/Other women aged 20–69 more likely, than the total female population aged 20–69 years to have had a cervical smear in the previous three years (Figure 5.9).

Figure 5.9: Women aged 20–69 years (with a primary health care provider) who have had a cervical smear in the previous 3 years, by ethnic group (age standardised rate ratio)



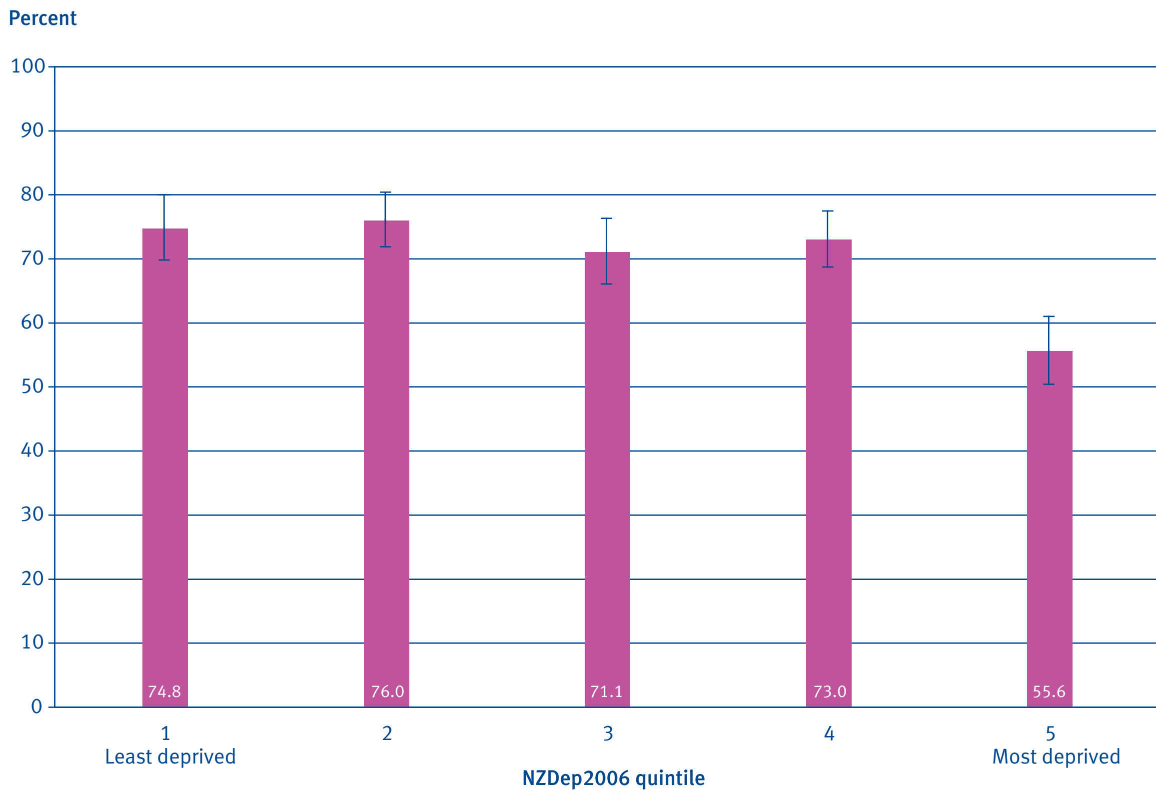
Source: 2006/07 New Zealand Health Survey

Notes: Age standardised to the WHO world population. Reference group, with a rate ratio of 1.0 (indicated by the bold line), is the total female population aged from 20-69 years. Total response standard output for ethnic groups has been used. Excludes women who have had a hysterectomy.

Mammogram and cervical smear, by neighbourhood deprivation

Women aged 45–69 years in NZDep2006 quintile 5 (most deprived) were significantly less likely than those in quintiles 1–4 to have had a mammogram in the previous two years (Figure 5.10).

Figure 5.10: Women aged 45–69 years (with a primary health care provider) who have had a mammogram in the previous 2 years, by NZDep2006 quintile (age standardised prevalence)



Source: 2006/07 New Zealand Health Survey

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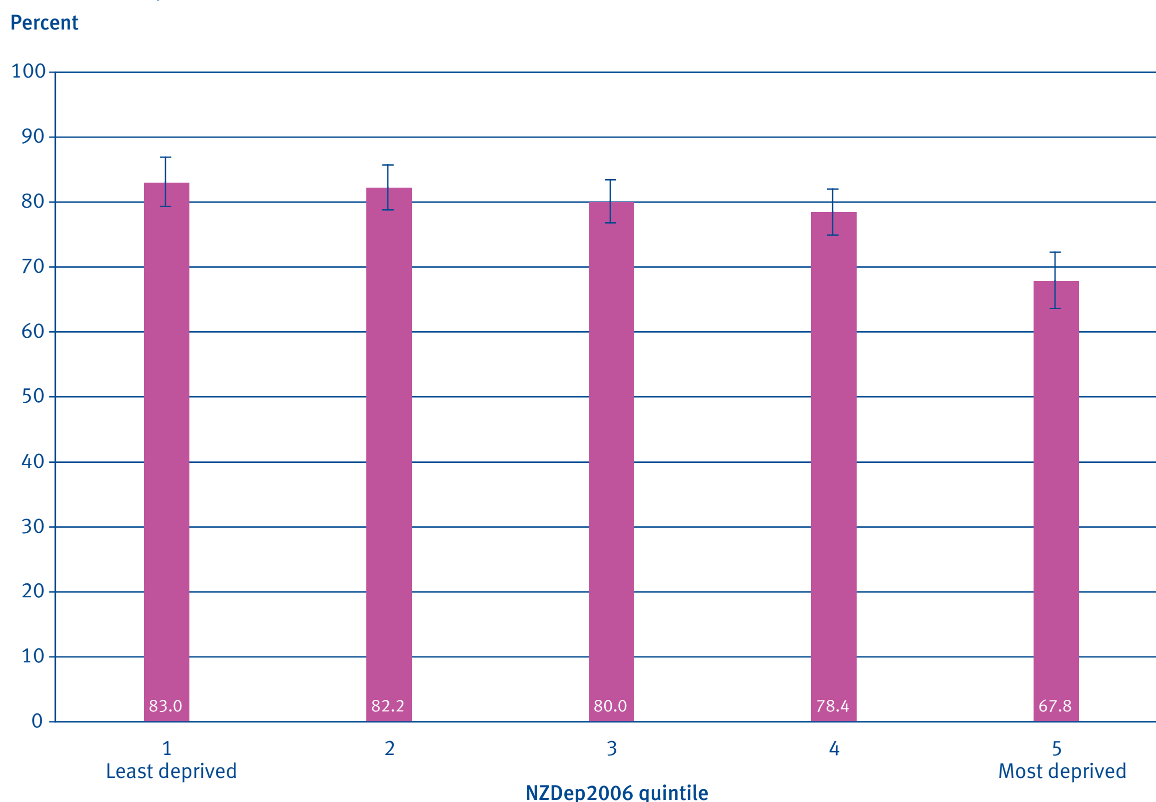
Women aged 20–69 years in NZDep2006 quintile 5 (most deprived) were significantly less likely than those in quintiles 1–4 to have had a cervical smear in the previous three years (Figure 5.11).

Figure 5.11: Women aged 20–69 years (with a primary health care provider) who have had a cervical smear in the previous 3 years, by NZDep2006 quintile (age standardised prevalence)



Source: 2006/07 New Zealand Health Survey

Note: Excludes women who have had a hysterectomy

Prevention of ill health – influenza vaccination

Influenza is a significant public health issue in New Zealand. Each year, influenza has a large impact on our community, with 10–20% of New Zealanders infected. Some of these people become so ill they need hospital care, and a small number die. Influenza also has a financial impact, particularly in workplaces, and can potentially overwhelm both primary health care and hospital services during winter epidemics.

In New Zealand, adults aged 65 years and over and anyone under 65 years with one or more chronic health conditions can have a free influenza vaccination.

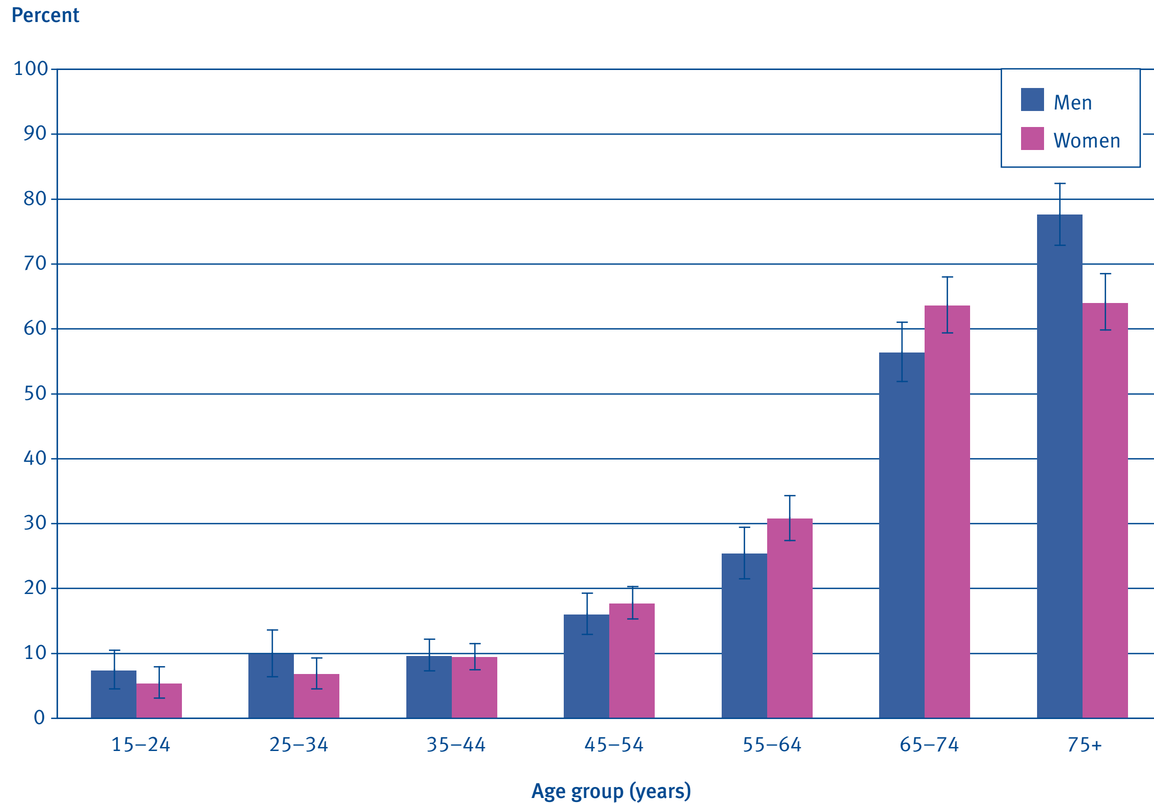
Data presented here are only for influenza vaccinations carried out by participants' primary health care provider and will underestimate the level of influenza vaccination in the total population as they may exclude vaccinations provided by employers.

Approximately one in four adults (23.0%; 22.0–23.9) had an influenza vaccination at their primary care provider in the previous 12 months. There was no significant difference between men and women, adjusted for age.

Influenza vaccination by primary health care provider, by age group

Influenza vaccination in the previous 12 months increased with age (Figure 5.12). Adults aged 65 years and over had a higher prevalence of having had an influenza vaccine carried out by their primary health care provider in the previous 12 months compared to other age groups, with men aged 75 years and over having the highest prevalence.

Figure 5.12: Influenza vaccination by primary health care provider in the previous 12 months for adults, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

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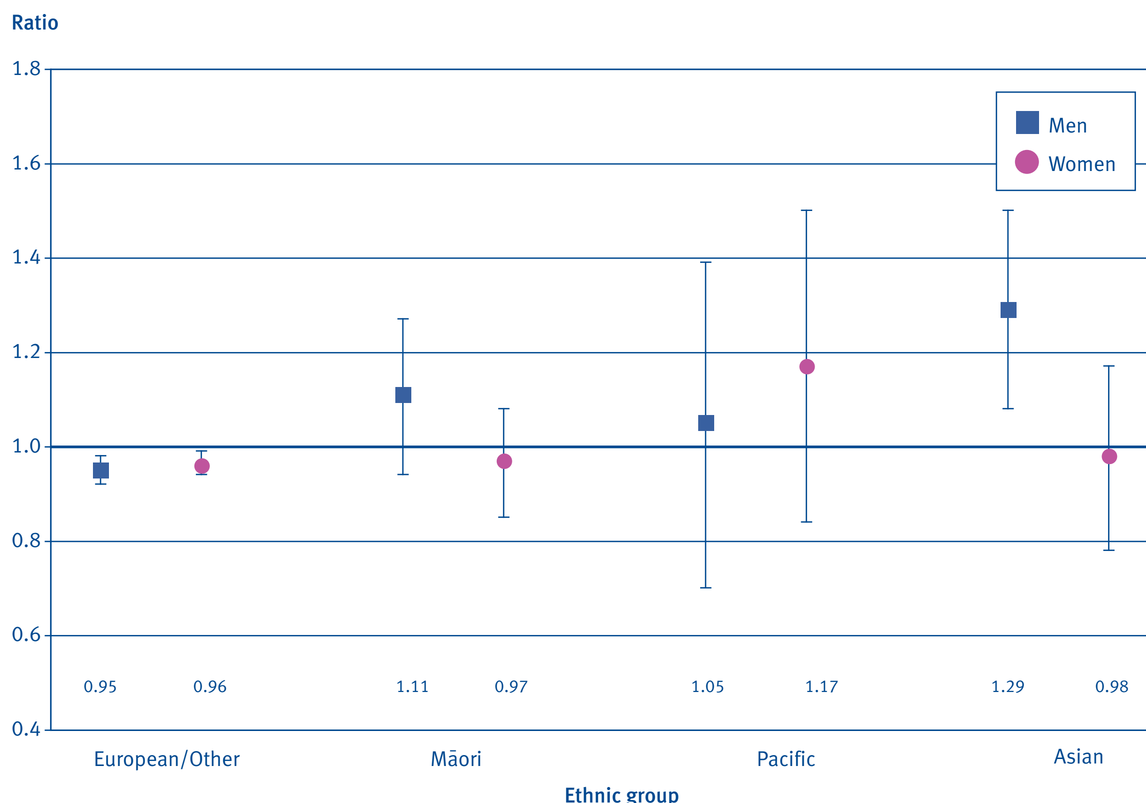
Influenza vaccine by primary health care provider, by ethnic group

Adjusted for age, European/Other men and women were less likely, and Asian men more likely, to have had an influenza vaccination carried out by their primary health care provider in the previous 12 months compared to men and women in the total population (Figure 5.13).

Figure 5.13: Influenza vaccination by primary health care provider in the previous 12 months for adults, by ethnic group and gender (age standardised rate ratio)



Source: 2006/07 New Zealand Health Survey

Notes: Age standardised to the WHO world population. Reference group, with a rate ratio of 1.0 (indicated by the bold line), is the total male or female population aged 15 years and over. Total response standard output for ethnic groups has been used.

Influenza vaccination by primary health care provider, by neighbourhood deprivation

There were no significant differences by neighbourhood deprivation in terms of the proportion of men and women who had an influenza vaccine carried out by their primary health care provider in the previous 12 months.

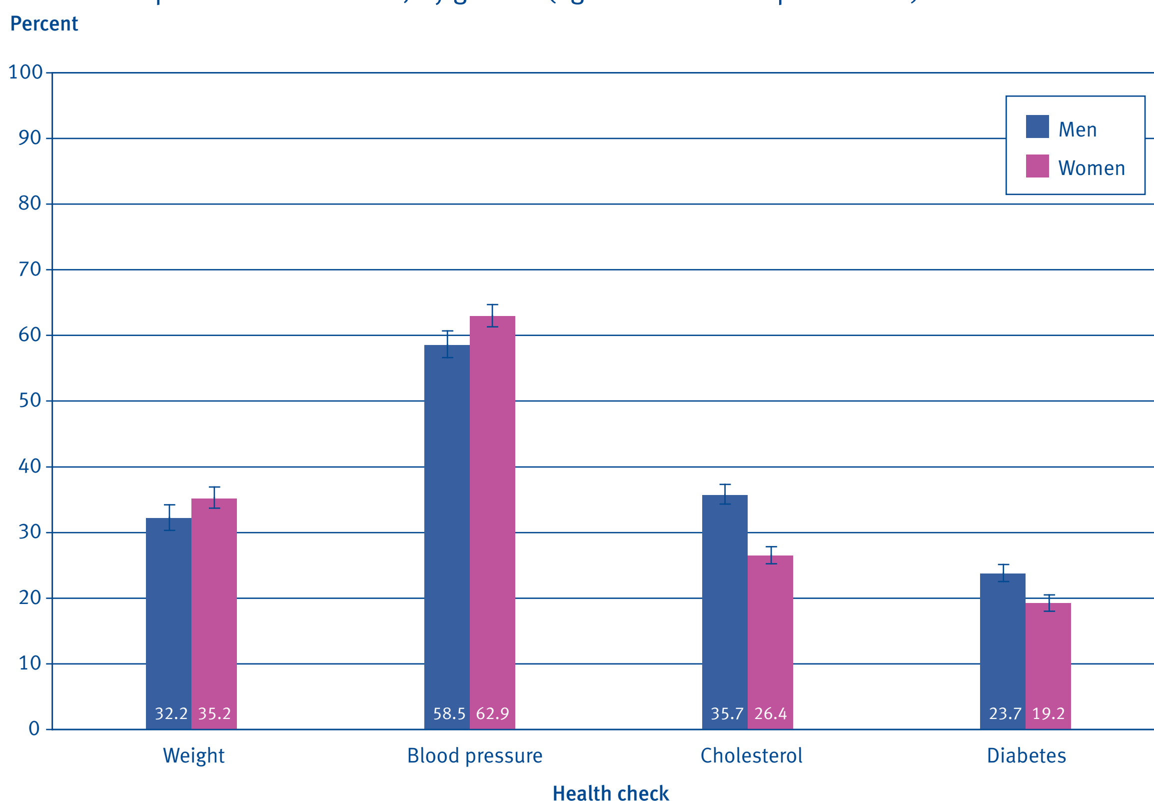
Health checks at primary health care providers

Health checks can either identify disease at an early stage enabling treatment, or ensure that a diagnosed health condition (eg, high blood pressure or diabetes) continues to be treated appropriately. Health checks reported here are for weight, blood pressure, cholesterol and diabetes.

The most common health check carried out or arranged by primary health care providers was a blood pressure check, with two-thirds of adults (64.4%, 63.1–65.7) who had seen a primary health care provider in the previous 12 months reporting having had their blood pressure checked.

After adjusting for age, men were more likely than women to have had a cholesterol test or a diabetes test in the previous 12 months. Women were more likely than men to have had a blood pressure test and their weight checked in the previous 12 months (p-values < 0.05) (Figure 5.14).

Figure 5.14: Health checks for adults who had seen a primary health care provider in the previous 12 months, by gender (age standardised prevalence)



Source: 2006/07 New Zealand Health Survey

Health checks at primary health care provider, by age group

Overall, the prevalence of having a health check in the previous 12 months increased with age. In particular, both men and women over 45 years of age were significantly more likely than younger adults to have had a blood pressure, cholesterol or diabetes check. Men over 45 years were more likely to have had their weight checked compared to younger men. There were no significant differences in the proportion of women who had their weight checked across the age groups.

Health checks at primary health provider, by ethnic group

Overall, European/Other men were less likely to have had a health check in the previous 12 months compared to men in the total population (weight SRR 0.95, 0.92–0.97; blood pressure SRR 0.98, 0.97–1.00; cholesterol SRR 0.98, 0.96–0.99; diabetes SRR 0.92, 0.89-0.95). Apart from blood pressure checks, European/Other women were less likely to have had a health check in the previous 12 months compared to women in the total population (weight SRR 0.96, 0.94–0.98; cholesterol SRR 0.96, 0.94–0.98; diabetes SRR 0.88, 0.85–0.91).

Māori (SRR 1.10, 1.01–1.19) and Pacific (SRR 1.57, 1.39–1.76) women were more likely to have had their weight checked in the previous 12 months compared to women in the total population. Pacific men (SRR 1.33, 1.13–1.53) were also more likely to have had their weight checked.

Pacific men (SRR 1.09, 1.01–1.18) and women (SRR 1.12, 1.01–1.23) were more likely to have had their blood pressure checked compared to men and women in the total population.

Pacific women (SRR 1.32, 1.10–1.54) and Asian men (SRR 1.27, 1.14–1.40) were more likely than women and men in the total population to have had their cholesterol checked.

Māori, Pacific and Asian men and women were all more likely to have had a diabetes check in the previous 12 months compared to men and women in the total population.

Health check at primary health provider, by neighbourhood deprivation

Women living in NZDep2006 quintile 5 (the most deprived areas) were more likely to have had a weight and diabetes check in the previous 12 months compared to women living in NZDep2006 quintile 1.

Men in NZDep2006 quintile 1 were significantly more likely than men in NZDep2006 quintile 5 to have had a cholesterol check in the previous 12 months.

Continuity and co-ordination of primary health care

Continuity in primary health care means that people have a health care provider they usually see, who provides health advice and referrals to secondary services when needed, and who they may form important relationships with over time. Sometimes, people have diverse health needs and may use a number of services provided by different providers in various settings. It is important that there is co-ordination of care between these services, so that the best possible total package of care is provided to the people using health services. Primary Health Organisations (PHOs) were established with the vision of providing continuity and co-ordination of care for their enrolled populations.

This section looks at how well primary health care providers in New Zealand provide continuity and co-ordination of care for children by looking at whether children have the same primary health care providers as their parents. For adults, this section also considers whether adults usually see the same GP or nurse at their primary health care provider, whether they have changed primary health care provider in the past year and why, and if any visits to medical specialists were followed up by their primary health care provider.

What were the survey questions?

In the 2006/07 New Zealand Health Survey parents of child participants were asked whether their child's primary health care provider was the same as their own.

Adult participants who saw a primary health care provider in the previous 12 months were asked whether they would usually see the same GP or nurse every time, and whether they had changed their usual primary health care provider in the previous 12 months, and if so, why.

If an adult participant had seen a medical specialist in the previous 12 months, they were also asked whether their primary health care provider had discussed the specialist visit with them afterwards.

Children attend the same provider as their parents

Most children (92.2%, 91.1–93.3) had the same primary health care provider as their parents or caregivers. There were no significant differences by age, gender, ethnicity or neighbourhood deprivation.

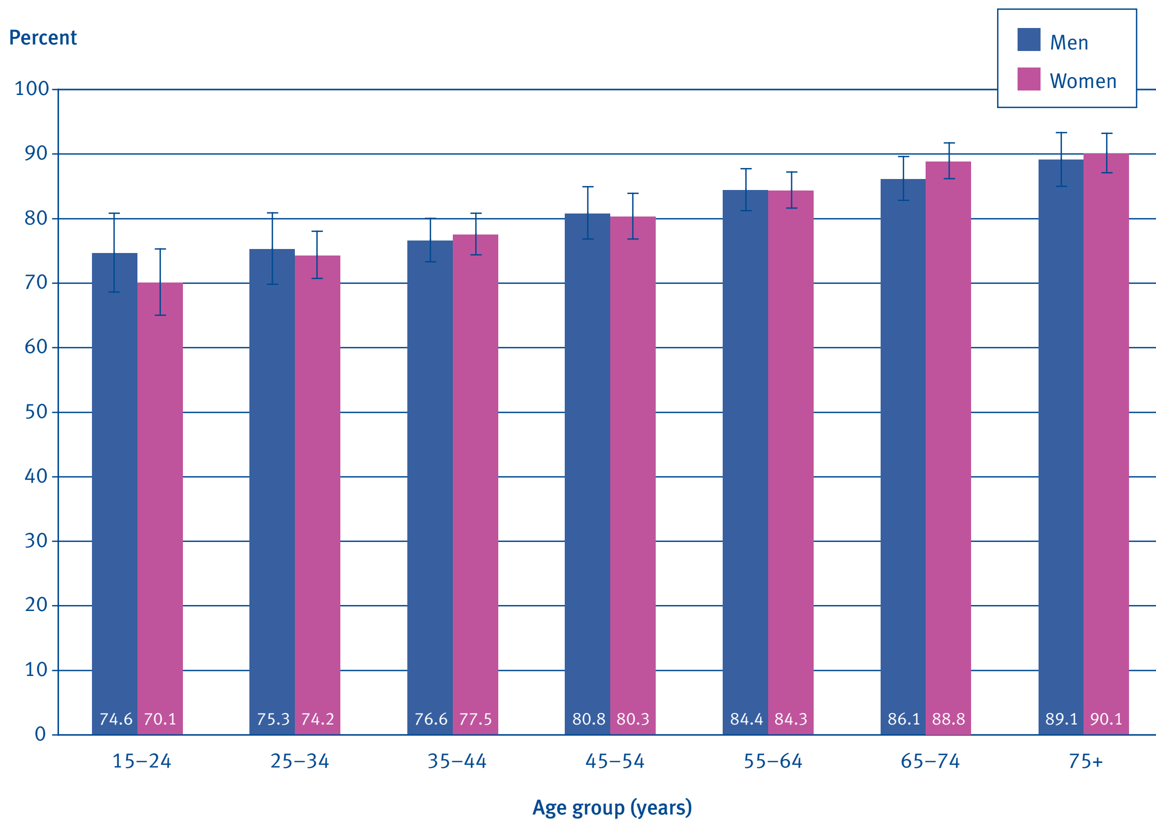
Usually see the same GP every time

Four out of five adults (79.8%, 78.7–80.9) who saw a GP at their primary health care provider in the previous 12 months reported that they usually see the same GP every time. There was no difference between men and women in the proportion who usually see the same GP every time, adjusted for age.

Usually see the same GP every time, by age group

Young people were less likely to see the same GP every time compared to adults over 55 years of age (Figure 5.15).

Figure 5.15: Adults who usually see the same GP at their usual primary health care provider, by age group and gender (unadjusted prevalence)

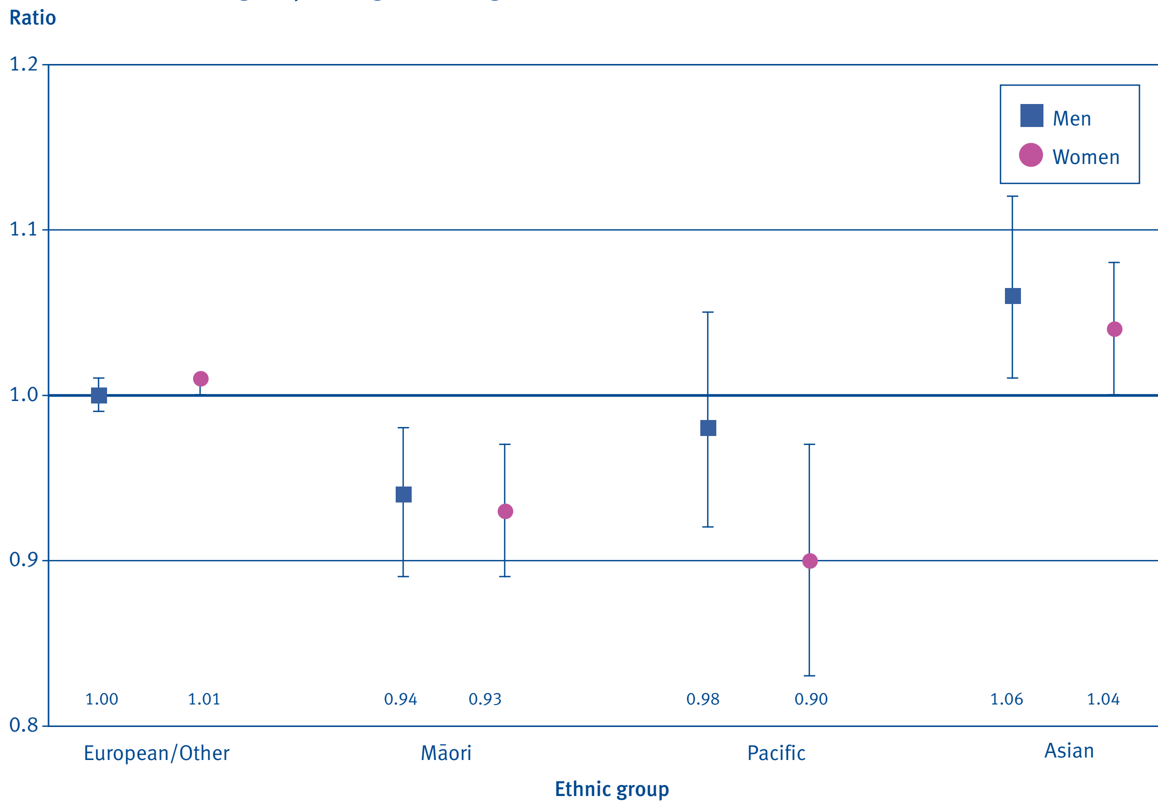


Source: 2006/07 New Zealand Health Survey

Usually see the same GP every time, by ethnic group

Māori men and Māori and Pacific women were less likely than men and women in the total population to see the same GP every time, while Asian men were more likely to see the same GP (Figure 5.16).

Figure 5.16: Adults who usually see the same GP at their usual primary health care provider, by ethnic group and gender (age standardised rate ratio)



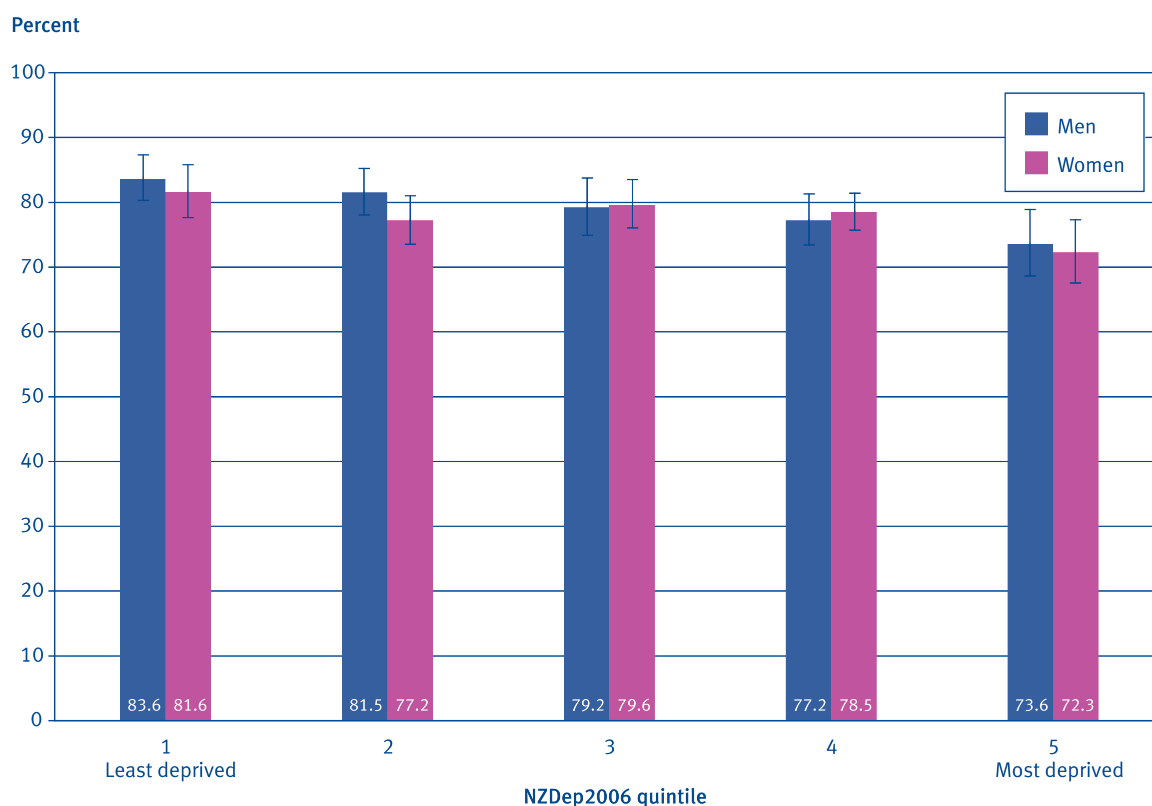
Source: 2006/07 New Zealand Health Survey

Notes: Age standardised to the WHO world population. Reference group, with a rate ratio of 1.0 (indicated by the bold line), is the total male or female population aged 15 years and over. Total response standard output for ethnic groups has been used.

Usually see the same GP every time, by neighbourhood deprivation

Men and women in NZDep2006 quintile 1 (least deprived) were more likely than those in quintile 5 (most deprived) to see the same GP every time (Figure 5.17).

Figure 5.17: Adults who usually see the same GP at their usual primary health care provider, by NZDep2006 quintile and by gender (age standardised prevalence)



Source: 2006/07 New Zealand Health Survey

Usually see the same nurse every time

Almost half (46.8%, 44.8–48.8) of all adults who saw a nurse at their primary health care provider in the previous 12 months reported that they usually see the same nurse every time.

After adjusting for age, Māori men (SRR 1.16, 1.01–1.30) were more likely than men in the total population to see the same nurse every time. There were no significant differences in the proportion of adults who usually see the same nurse by age or neighbourhood deprivation.

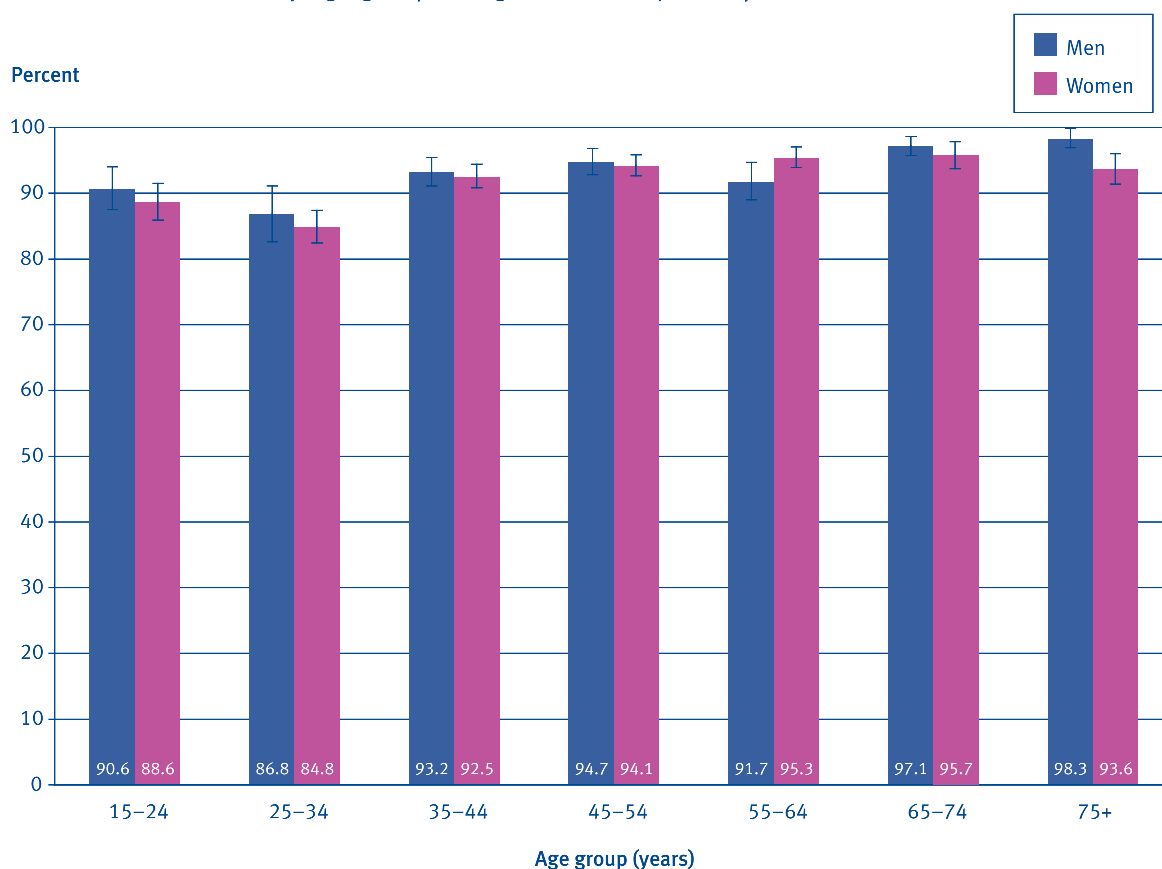
Did not change primary health care provider in the previous 12 months

Nine out of 10 adults (92.2%, 91.6–92.8) who saw a primary health care provider in the previous 12 months reported that they had not changed their usual primary health care provider in that time. There were no significant differences by gender.

Did not change primary health care provider in the previous 12 months, by age group

Women aged 25–34 years were more likely to have changed their primary health care provider in the previous 12 months than women aged 35 years and over (Figure 5.18).

Figure 5.18: Adults who did not change their primary health care provider in the previous 12 months, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

There were no significant differences in the proportion of adults who changed their primary health care provider in the previous 12 months by ethnicity or neighbourhood deprivation.

Of the adults who had changed their primary health care provider in the previous 12 months, the main reasons for changing were:

- I moved to a new area (50.8%, 46.1–55.4)
- my doctor moved / retired / closed the practice (13.8%, 10.4–17.3)
- I found a provider I felt more comfortable with (other than for reasons of culture or language) (12.9%, 9.7–16.1)
- I wanted a higher standard of health care / more professionalism (7.8%, 5.3–10.3)
- I couldn't get an appointment when needed (5.5%, 3.3–7.7).

Visits to medical specialists were followed up by primary health care provider

Two out of five (40.1%, 38.3–41.9) adults with a primary health care provider, and who had seen a medical specialist in the previous 12 months, had had a follow-up discussion with their primary health care provider after the specialist visit.

Asian (SRR 1.48, 1.29–1.67), Māori (SRR 1.15, 1.03–1.26) and Pacific (SRR 1.54, 1.29–1.80) adults were significantly more likely than adults in the total population who saw a medical specialist in the previous 12 months to have had their visit with a specialist discussed by their primary health care provider. There were no significant differences by age or neighbourhood deprivation.

Experiences of primary health care

One of the visions of the Primary Health Care Strategy is for a primary health care system that is community- and people-focused. An individual's overall experience of care is an important aspect of quality of care, and helps to assess the extent to which care is people-focused.

In this section, experiences of primary health care are measured by looking at whether individuals were treated with respect and dignity, whether they were listened to by the primary health care professional, and whether their health care professional discussed their health care and treatment as much as they wanted.

It is important to note that other factors that influence the experience an individual has, such as the quality of diagnosis and treatment of ill health, are not included here.

What were the survey questions?

In the 2006/07 New Zealand Health Survey, adult participants who saw a primary health care provider in the previous 12 months were asked how frequently their health care professionals treated them with respect and dignity, listened carefully to what they had to say, and discussed their health care and treatment as much as they wanted.

Treated with respect and dignity by primary health care professional

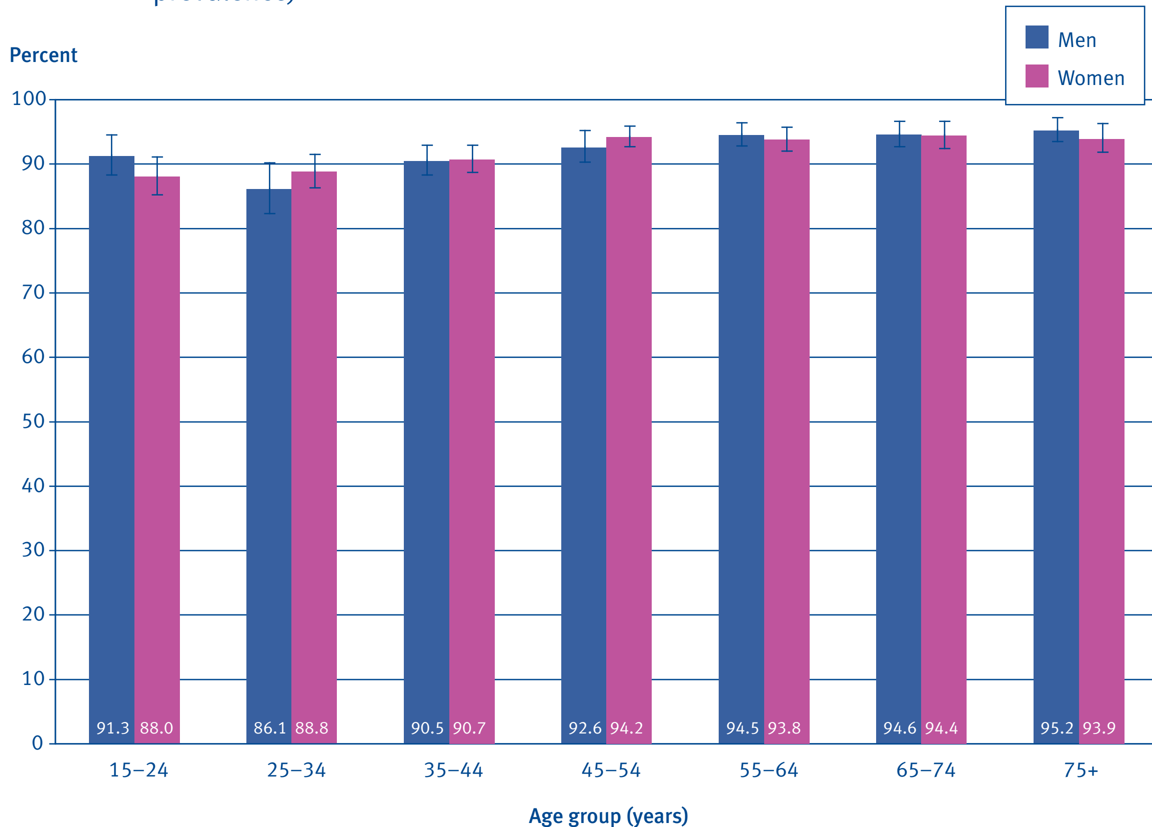
Nine out of ten (91.7%, 91.0–92.4) adults who saw a primary health care provider in the previous 12 months reported their health care professional had treated them with respect and dignity 'all of the time', while a further 6.7% (6.1–7.3) reported they had been treated with respect and dignity 'most of the time'.

There were no significant differences in being treated with respect and dignity by gender, adjusted for age.

Treated with respect and dignity, by age group

Men and women aged 25–34 years were less likely to report they had been treated with respect and dignity 'all of the time' than men and women over 55 years of age (Figure 5.19).

Figure 5.19: Adults who were treated with dignity and respect 'all the time' in the previous 12 months by their health care professional, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

Treated with respect and dignity, by ethnic group

Asian (SRR 0.95, 0.92–0.97), Pacific (SRR 0.95, 0.92–0.99) and Māori (SRR 0.97, 0.95–0.99) adults were significantly less likely than adults in the total population who saw a primary health care provider in the previous 12 months to report that their health care professional treated them with respect and dignity 'all of the time'.

Treated with respect and dignity, by neighbourhood deprivation

Adults in NZDep2006 quintile 5 (most deprived) (88.0%, 86.2–89.8) were significantly less likely than those in quintile 1 (least deprived) (94.0%, 92.4–95.6) to report that their health care professional treated them with respect and dignity 'all of the time'.

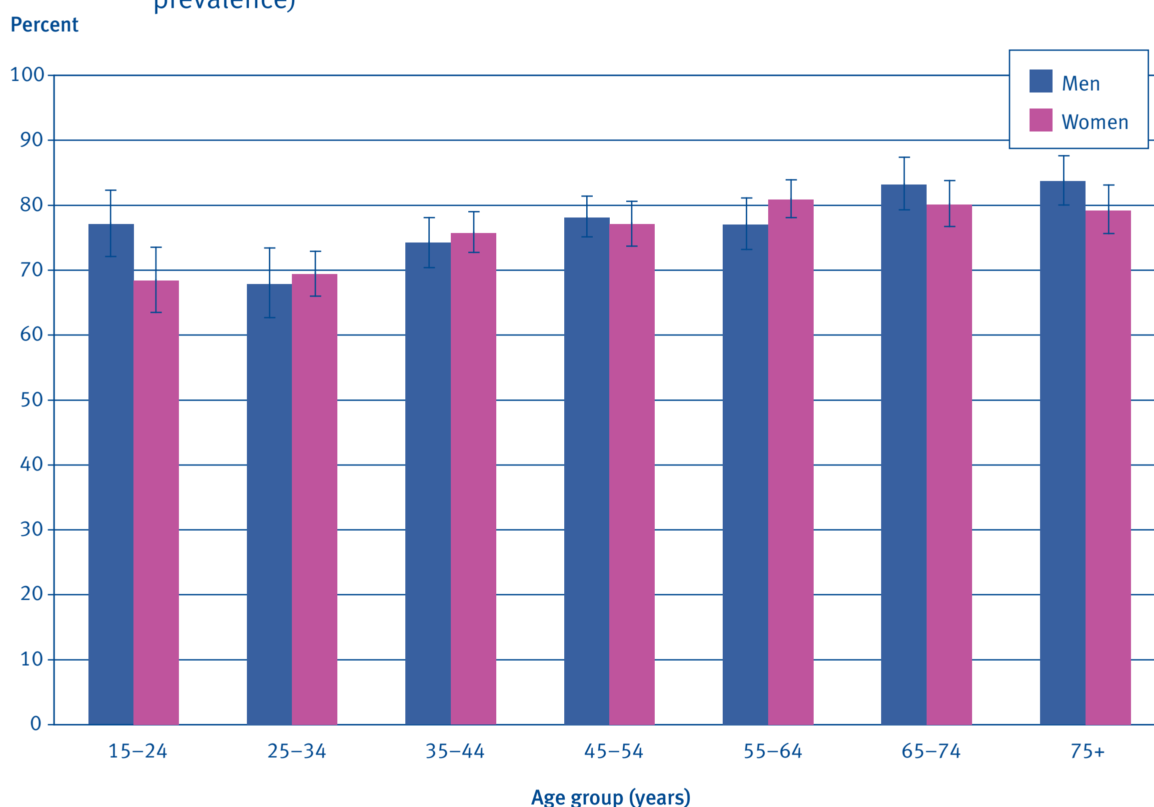
Listened to carefully by primary health care professional

Three out of four (75.9%, 74.7–77.0) adults who saw a primary health care provider in the previous 12 months reported that their health care professional listened carefully to what they had to say 'all of the time'. A further 19.8% (18.7–20.8) reported their health care professional listened carefully to what they had to say 'most of the time'. There were no differences by gender, after adjusting for age.

Listened to carefully, by age group

Men aged 25–34 years and women aged 15–34 years were least likely to report that their health care professional listened carefully to what they had to say 'all of the time' compared to men and women in all other age groups (Figure 5.20).

Figure 5.20: Adults whose primary health care provider listened carefully to what they had to say 'all the time' in the previous 12 months, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

Listened to carefully, by ethnic group

Māori women (SRR 0.93, 0.90–0.97) were significantly less likely than all women who saw a primary health care provider in the previous 12 months to report that their health care professional listened carefully to what they had to say 'all of the time'.

Listened to carefully, by neighbourhood deprivation

Adults in NZDep2006 quintile 5 (most deprived) (70.5%, 67.9–73.0) were significantly less likely than those in quintile 1 (least deprived) (76.9%, 74.3–79.6) to report that their health care professional listened carefully to what they had to say 'all of the time'.

Adequate discussion of health care by primary health care professional

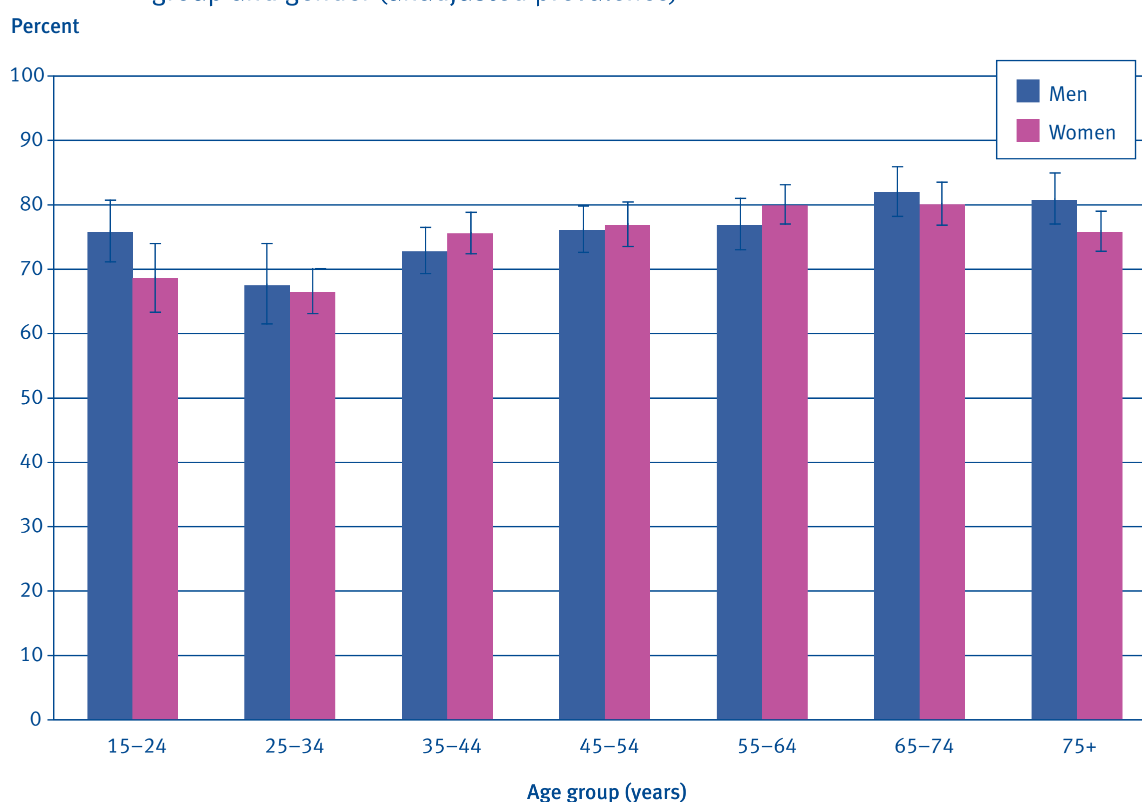
Three out of four (74.8%, 73.7–75.9) adults who saw a primary health care provider in the previous 12 months reported that their health care professional discussed their health care as much as they wanted 'all of the time'. A further 18.8% (17.7–19.8) reported their health care professional discussed their health care as much as they wanted 'most of the time'.

There were no differences by gender in the discussion of health care, adjusted for age.

Adequate discussion of health care, by age group

Men aged 25–34 years and women aged 15–34 years were least likely to report that their health care professional discussed their health care as much as they wanted 'all of the time', compared to men and women of other ages (Figure 5.21).

Figure 5.21: Adults whose primary health care professional discussed their health care and treatment as much as they wanted 'all the time' in the previous 12 months, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

Adequate discussion of health care, by ethnic group

Māori (SRR 0.96, 0.93–0.99) and Pacific (SRR 0.93, 0.87–0.98) adults were significantly less likely than adults in the total population to report that their health care professional discussed their health care as much as they wanted 'all of the time'.

Adequate discussion of health care, by neighbourhood deprivation

Adults in NZDep2006 quintile 5 (most deprived) (71.1%, 68.5–73.7) were significantly less likely than those in quintile 1 (least deprived) (76.5%, 74.3–78.7) to report that their health care professional discussed their health care as much as they wanted 'all of the time'.