

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.

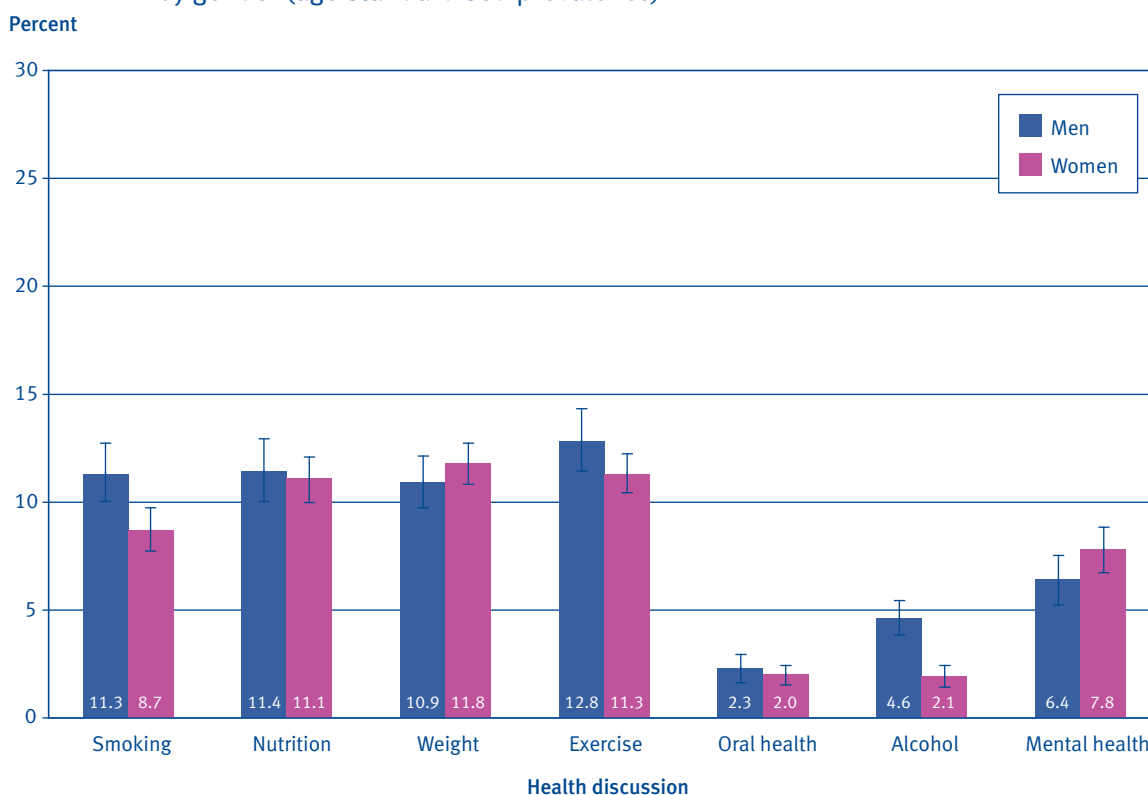
All female participants aged 20 years and over were also asked whether they had had a mammogram in the past two years or a cervical smear in the past three or five years.

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).

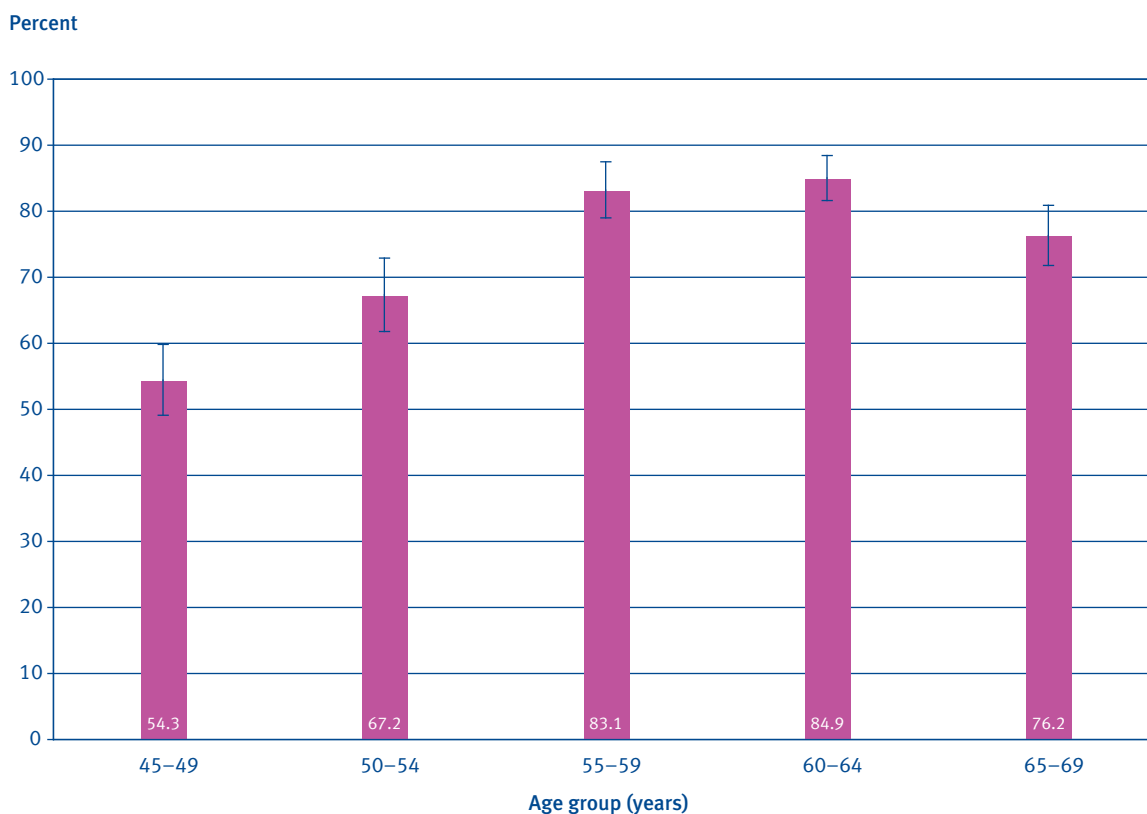
The analyses here only include women who report that they have a primary health care provider they go to first when feeling sick or injured (that is, not the total population).

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).

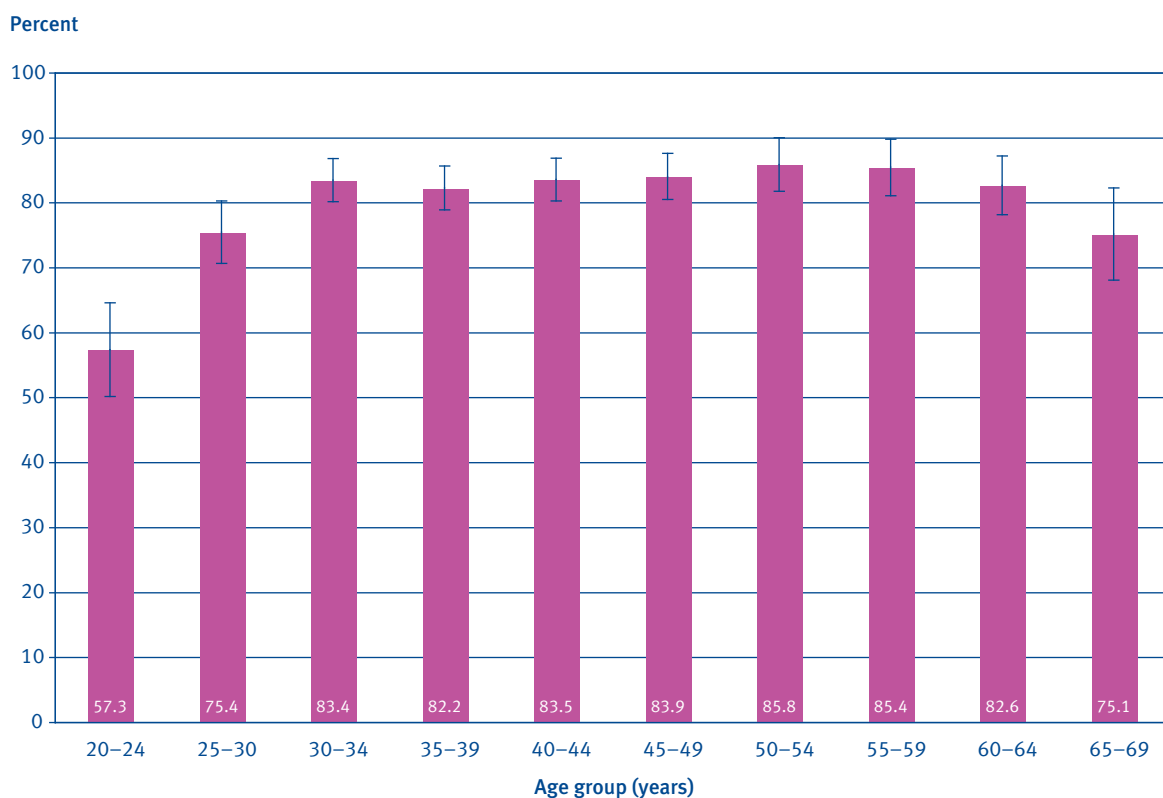
Figure 5.6: Women aged 45–69 years (with a primary health care provider) who have had a mammogram in the previous 2 years, by age group (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey

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)



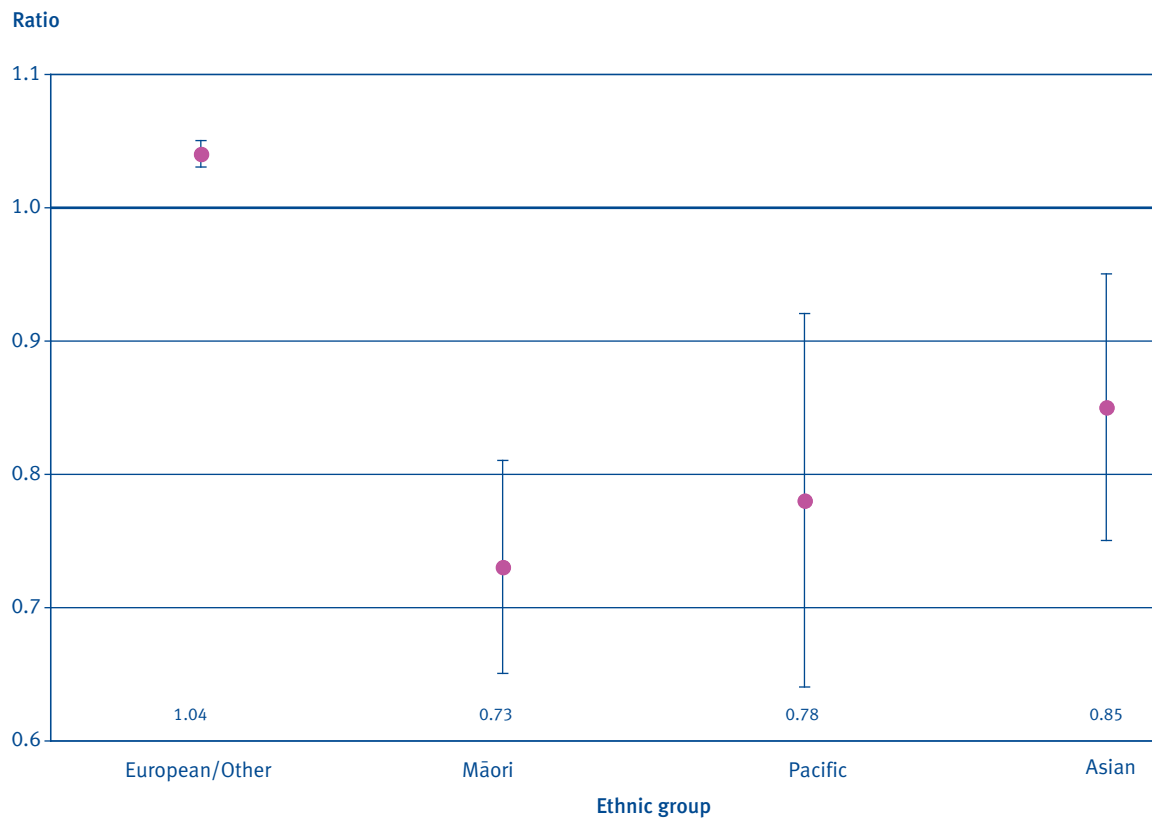
Source: 2006/07 New Zealand Health Survey

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)

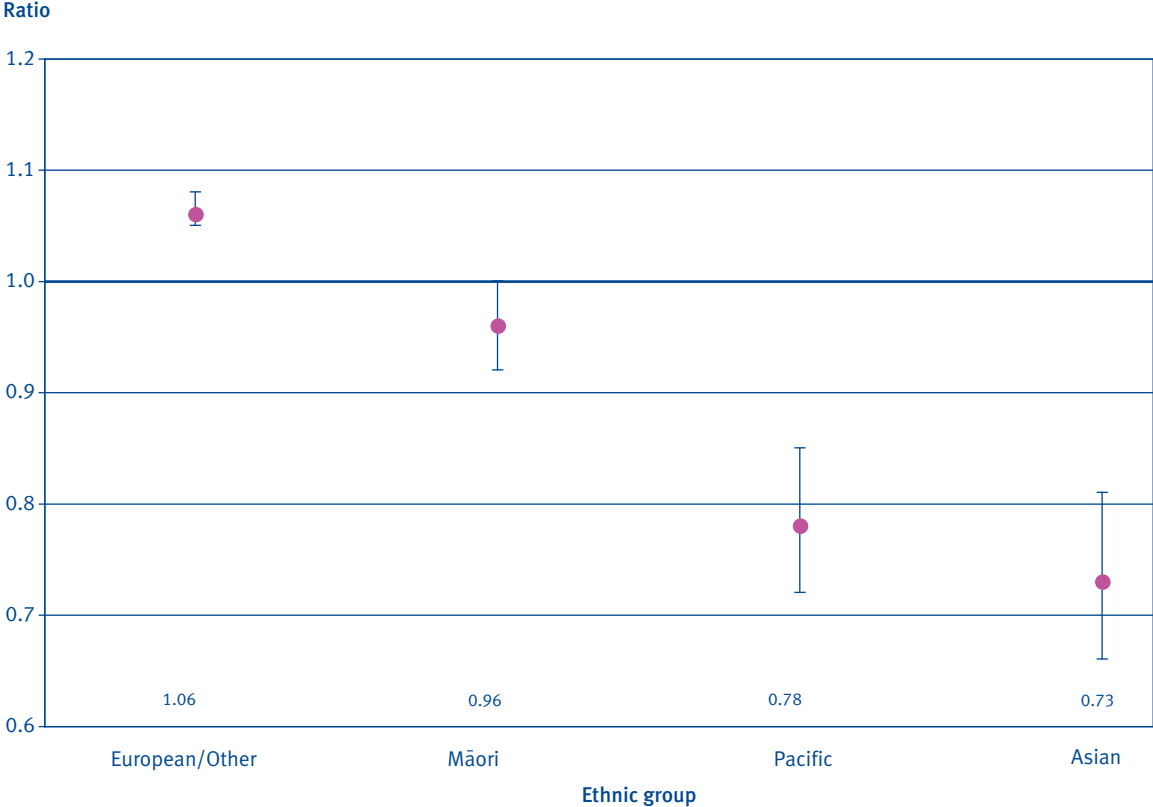


Source: 2006/07 New Zealand Health Survey

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)



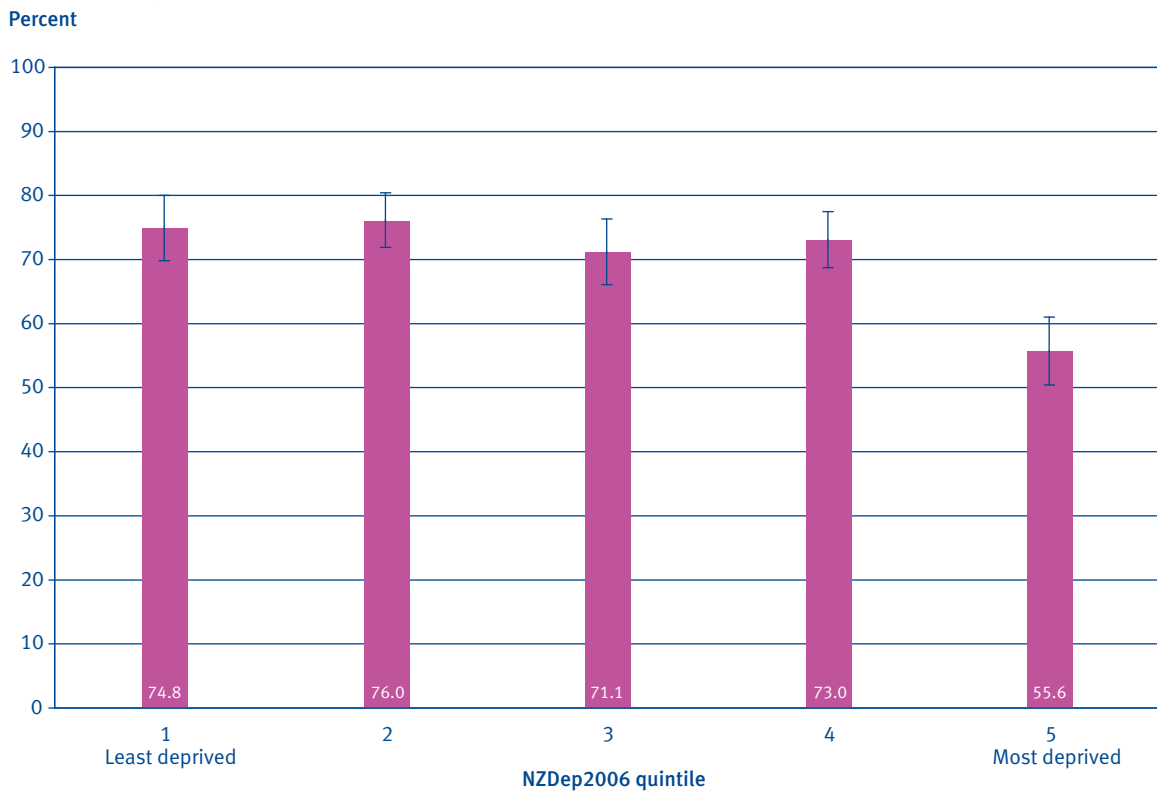
Source: 2006/07 New Zealand Health Survey

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).

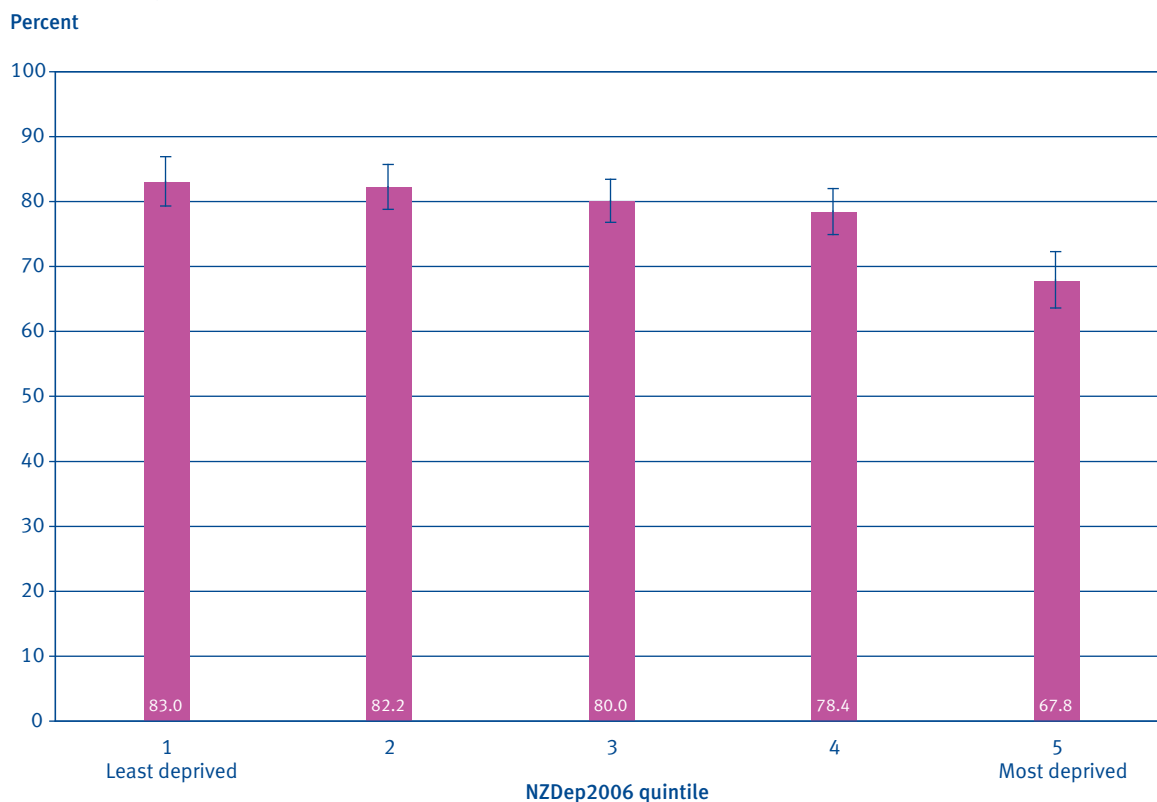
Figure 5.10: Women aged 45–69 years (with a primary health care provider) who have had a mammogram in the previous 2 years, by NZDep2006 quintile (age standardised prevalence)



Source: 2006/07 New Zealand Health Survey

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.

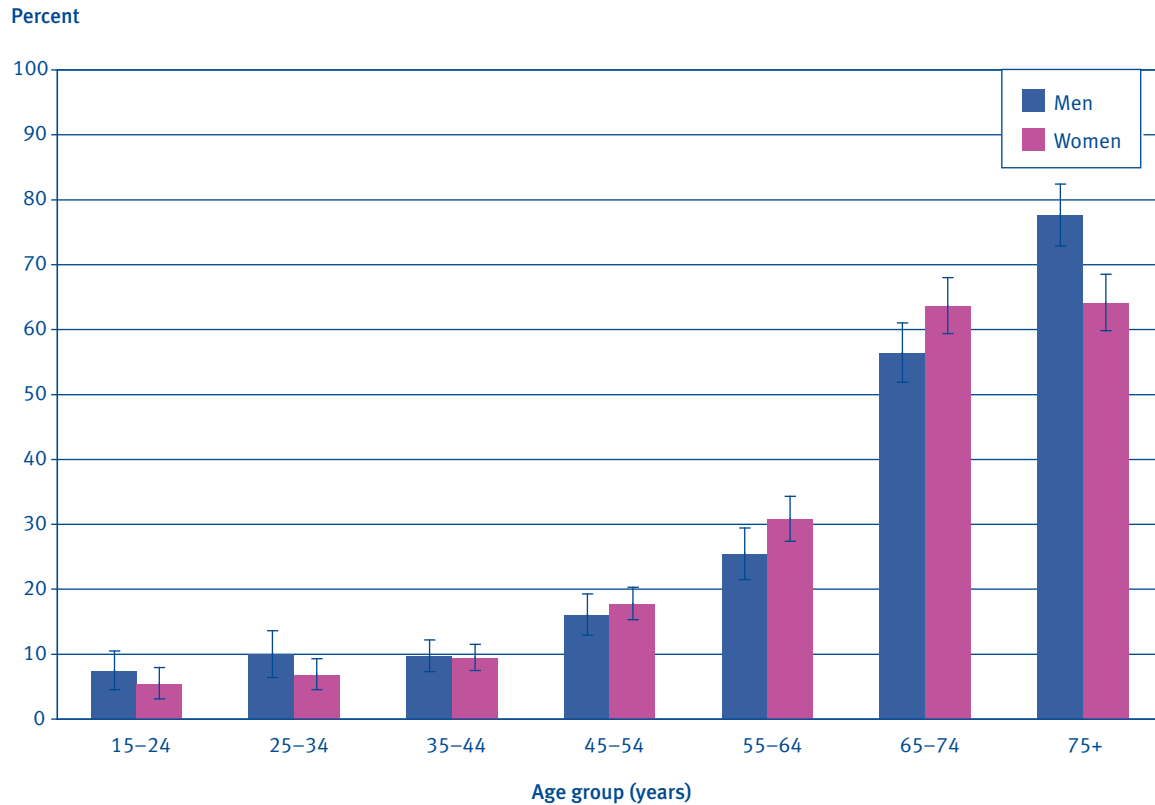
Data presented here are only for influenza vaccinations carried out by participants' primary health care provider and will underestimate the level of influenza vaccination in the total population as they may exclude vaccinations provided by employers.

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)

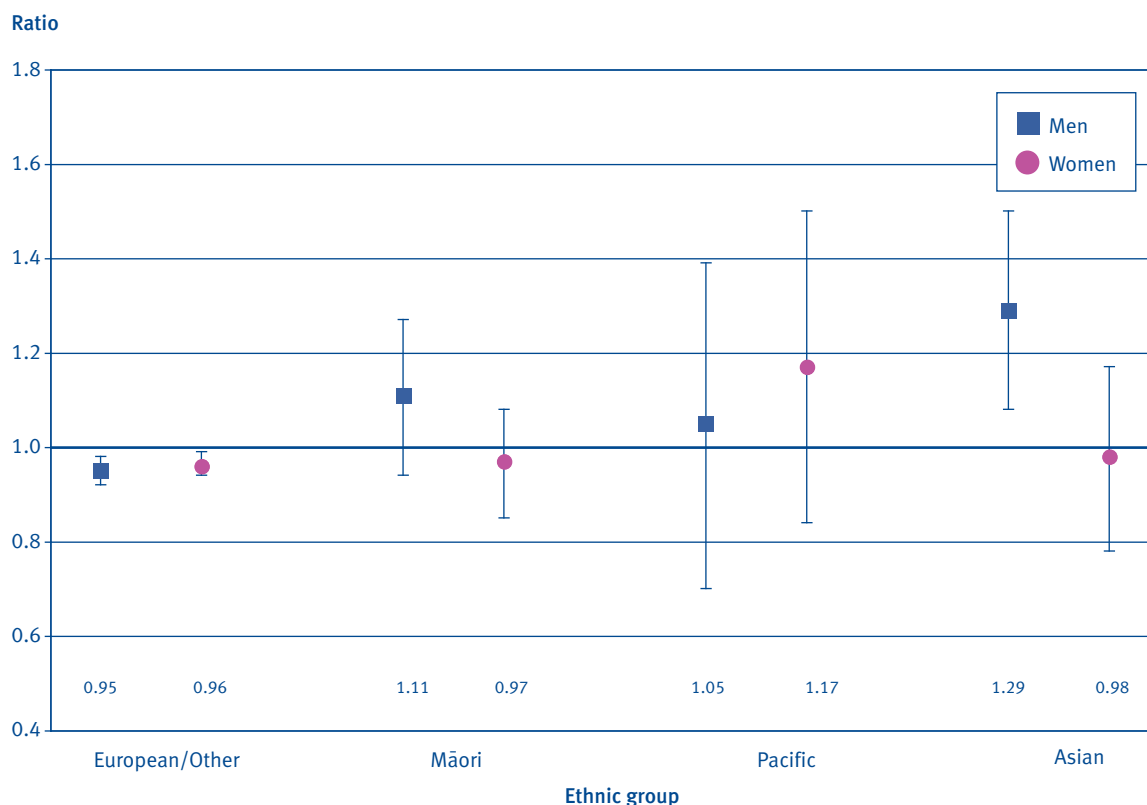


Source: 2006/07 New Zealand Health Survey

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.

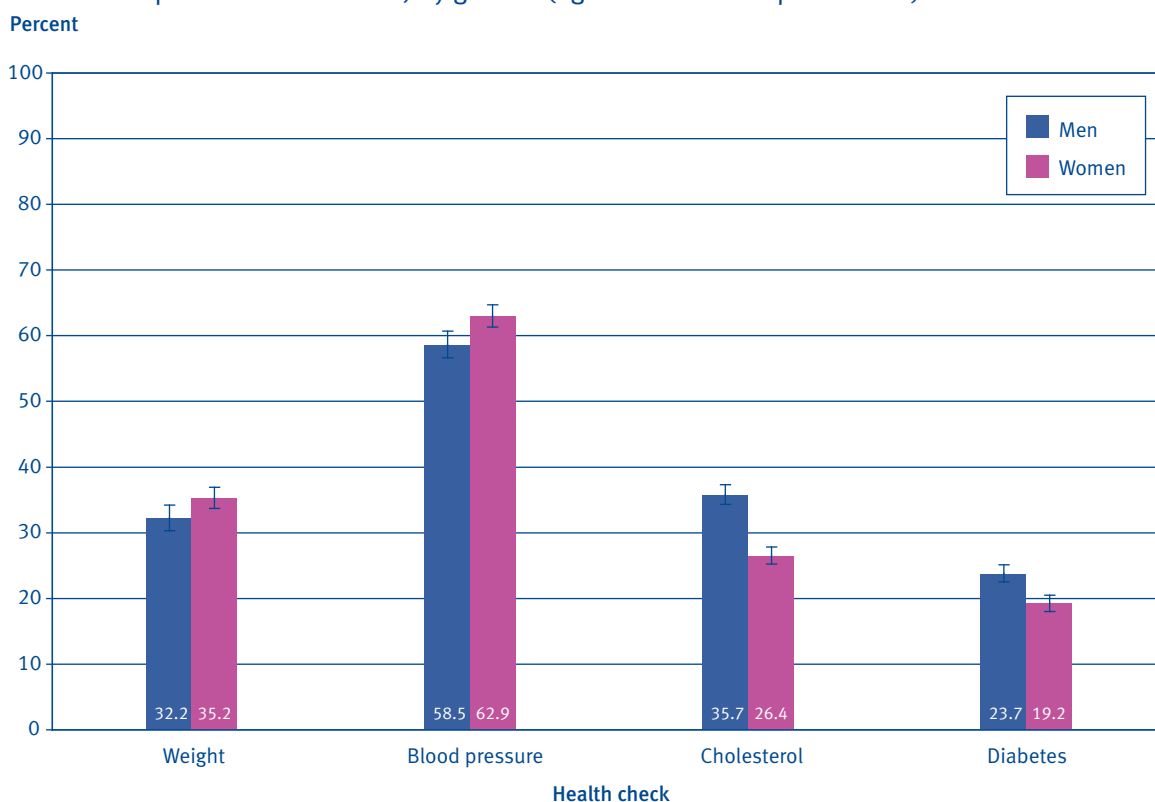
Health checks at primary health care providers

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.