The long road to good care

Jason K Gurney

I grew up in Te Tai Tokerau, the Winterless North. My tūrangawaewae—the place where I feel I stand and belong—is in a little seaside village called Whananāki, on the east coast of Te Tai Tokerau. It’s the place where I spent every long summer when I was growing up, and where nearly all my childhood memories were made. I learned how to surf there, how to fish, and how to make a bonfire. I now find great joy in taking my own children to that same place, and in teaching them the same things.

The road from Whananāki into the nearest city—Whangārei—is a winding one, and access to healthcare for the Whananāki locals is not straightforward. The nearest hospital is around an hour away, and the rurality of the setting means that unless the Northland Rescue Helicopter is handy, any hope of an ambulance arriving in time to assist in an acute critical event is foolish (trust me). The locals get around this problem by having a First Response team, made up of an indefatigable group of trained volunteers who respond to 111 calls from wherever they are—usually down on the farm—to deliver first-response care as best as they can. Of course, acute care is only part of the picture: the remoteness of the coastal town makes the management of chronic health problems challenging too. Some surgeries can be safely performed at Whangārei Hospital, but the more complex stuff is referred down to Auckland, as is all radiation therapy for cancers diagnosed throughout Te Tai Tokerau.

Whananāki is by no means unusual in terms of its remoteness to care: I suspect the above situation is repeated in countless towns and villages across the motu. In terms of area, we’re similar in size to the United Kingdom (UK) but with a much smaller population (around 5 million vs 69 million in the UK)—which means that we’re relatively dispersed across a large area, broadly peppered around our coastline and along our rivers, with a few concentrated clumps in our main centres.

All of this leads to a vexing problem in terms of the delivery of safe, consistent and equitable healthcare in this country. When it comes to the provision of cancer care, the vast majority of our surgery and systemic therapy—and all of our radiation therapy—are provided within just six regional cancer centres (Auckland, Hamilton, Palmerston North, Wellington, Christchurch, Dunedin) and not all of these will provide all of the care required for a given cancer. This, combined with the relative dispersion of our population, means that New Zealanders tend to need to travel—sometimes far—to access the care that they need.

This travel issue impacts our Indigenous Māori population to a much greater extent than it impacts our non-Māori population. Around 25% of Māori live in rural areas, compared to 20% of NZ Europeans, 7% Pasifika and 5% Asian—and nearly a third (32%) of those who live in the most remote areas of Aotearoa are Māori. This has significant consequences for care access: in our recent study of liver cancer care, we measured how far Māori and non-Māori had to travel to access their first surgical treatment. We found that Māori, on average, had to travel 120km (or over two hours) to access their first surgery, compared to around 60km (or less than one hour) for non-Māori. Māori were also 50% more likely to have to travel more than 200km to access their first surgery (adj. OR 1.48, 95% CI 1.09–2.01).

In this issue of the New Zealand Medical Journal (NZMJ), Cormack and colleagues reinforce the importance of this travel issue for Māori. Examining national level hospitalisation data across six years (2009–2014), the authors found that around 10% of all Māori hospital admissions—and more than 25% of all Māori hospital transfers—took place outside of the District Health Board (DHB) where the person lived. In other words, one in ten Māori hospitalisations (and a quarter of all transfers between hospitals) required Māori to travel to a hospital that was outside their home region. With more than a million hospitalisations among Māori over the six-year study period, the cumulative demand placed on individuals and their whānau—the transport costs, the accommodation for supporting whānau, the organisation of childcare or elderly care for those left back at home—is difficult to fathom.

In another study published in this issue of the NZMJ, Loring and colleagues remind us of
the profound disparity between Māori and our majority NZ European population in terms of socio-economic deprivation. The authors observed that over 40% of the Māori population have been living in the two most deprived deciles for the past several decades, compared to less than 15% of NZ Europeans. So, Māori are not only more likely to need to travel further to access healthcare in Aotearoa, but also less likely to be able to cover the costs of that travel. This paradox is why schemes like the National Travel Assistance (NTA) programme are critical to the achievement of equitable health outcomes between our Māori and non-Māori populations. This paradox also makes the way in which we currently provide financial support—through reimbursement schemes, where already impoverished whānau are required to cover the costs of their travel up-front—relatively maddening.

Bringing care closer to home is an obvious solution, but one that is unlikely to be straightforward in its implementation. In the context of cancer, the delivery of systemic therapy within marae remains under-examined and could conceivably work—with considerable ramifications when we think of the repeated travel required to access this care from remote communities like Whanāki. However, it's unlikely that we will be able to de-centralise treatment like complex surgery or radiation therapy in the short- to medium-term.

In our aforementioned liver cancer study, we made three recommendations for forward-movement in terms of addressing inequities in travel burden in those cases where care cannot feasibly be decentralised. These recommendations bear repeating in abridged form:

1. Firstly, schemes such as the NTA should provide patients and/or their whānau with up-front funding, rather than relying on reimbursement. These schemes need to recognise both the direct and indirect costs associated with travelling for care, and also ensure that whānau are aware of what funding is available and make access to that funding as straightforward as possible.

2. Secondly, where possible, clinics that require in-person attendance should be held closer to where our Māori whānau live. That means more clinics in remote regions, particularly (but not limited to) Te Tai Tokerau, Tairāwhiti and the Waikato. We need more opportunities for clinical staff to move between hospitals, shifting care to regions that are underserved. In addition, we need to better support and facilitate regional collaboration, including pan-region multidisciplinary team meetings (MDMs).

3. Thirdly, we should recognise that there is a need for more Māori health support workers (such as Māori cancer care navigators) to help Māori navigate the complexity of their various appointments, including helping to understand care options and demystify clinical information. We might not always be able to reduce the travel required by Māori to access best practice care, but we can certainly make their care pathway as bright and clearly marked as possible.

For too long, we have conceptualised travel to access care as a patient-level problem. Our collective attitude has been something like this: the care is here, and it’s up to you to get to it. This view is archaic, and fundamentally underestimates both the impact of geography as a determinant of access to good health, as well as the pervasive way in which this factor contributes to inequities in health outcomes for Māori. The urgency for change in this area cannot be overstated.
COMPETING INTERESTS
Nil.

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REFERENCES