

Takeaways from workshop 1: Inequities in access and outcomes

Guests attending workshop:

- Rachel Brown, National Hauora Coalition
- Amy Chan, University of Auckland
- Pauline Norris, University of Otago
- Faafetai (Tai) Sopoaga, University of Otago
- Garry Nixon, University of Otago

The big challenge is that people need to access antimicrobials when necessary, especially for strep A infection to prevent rheumatic fever, but overall use of antimicrobials needs to be judicious to reduce AMR because all use contributes to this issue.

Addressing this challenge requires a multifaceted approach to improve health literacy, reduce structural barriers to medicine access, and use data to make better-informed decisions.

Enhancing health literacy

- Improved health literacy could support health-seeking behaviours while reducing patient expectations of receiving antibiotics
 - We could capitalise on the willingness for collective action to prevent COVID-19 to explain the similar challenge of balancing individual safety vs community safety for AMR
 - Understanding what is meant by 'resistance' is key – i.e. that it's the microbe not the person
 - This could support people understanding why there is mixed messaging for RF and AMR
 - Any public-facing communications need to be clear and accessible and come in a range of languages
 - There is demonstrated evidence of the efficacy of using behavioural science to inform communications to shift public beliefs and behaviours.
- Patients will be more receptive to not receiving antibiotics if they are given an explanation
 - There is [evidence](#) that point of care testing, when combined with enhanced education, can help to reduce unnecessary antibiotic prescribing
 - The new camera/image processor being developed to diagnose strep throat rapidly could work in the same way by providing evidence that can be shared with the patient. However, a drawback might be the loss of clinical isolates for further investigation, and it might not be able to distinguish between different types of strep.
 - Guidelines are helpful to justify clinical decisions (ideally there would be national guidelines layered with local context combined with a clear path to action. Effective guideline implementation is key - local context needs to be considered to make 'doing the right thing' the easy and default option employing behavioural theories of nudge and behavioural economics.

Even when whānau have a good understanding of the importance of getting infectious diseases checked they can be limited in their actions because of other structural barriers – such as cost and transport and access to primary care.

Reducing structural barriers

Barriers to accessing primary care include:

- Distance i.e. living in rural or remote communities (38% of people living in the 'most remote' category are Māori)
- Prohibitive costs of GP appointments, travel and prescriptions
- Inability to get time off work during standard GP clinic times
- Not having access to transport to get to appointments
- Lack of continuity with GP so not forming a relationship

- Institutional racism (hidden and visible) in healthcare sector

These could be addressed by

- Rethinking primary care
 - Bringing the primary healthcare system (including GPs, community pharmacists and dental) into the national health system to ensure access and continuity in all locations and remove cost barriers
 - Expanding the settings where patients can receive primary care
 - Provide choices and diversity – no one setting is better than others [new report provides evidence of this?]
 - School-based clinics have been effective because they are free, family-based and follow-up with patients
 - Community pharmacist prescribing gives an option for easily accessible prescriptions that do not require consultation fees/appointments (there's [evidence](#) this supports AMS)
 - Listening to the needs and experiences of the communities served
 - E.g. a [study](#) from 2012 shows Pacific perspectives on primary care, which can inform decisions
 - Coordinating efforts around NZ
 - The national lab network could be better coordinated (public/private challenges)
 - Generalist doctors around the country need access to advice from infectious disease and microbiologist specialists so that people in regions without these specialists don't miss out
- Recognising and addressing racism in our healthcare system
 - Culture change in medicine required (this is already happening with younger doctors)
 - Encouraging diversity within our healthcare professionals helps, and efforts to improve this need to be broad, e.g. include refugees
 - Focus on togetherness and safety
- Coming up with new systems so patients don't have to have a follow-up appointment
 - POC testing is a priority (and there's [evidence](#) it can reduce prescription rates)
 - Delayed scripts, so a prescription is only dispensed once test confirmed – there's [evidence](#) this is safe and effective, and reduces re-consultation, but it hasn't been trialled in NZ
 - School-based clinics have been effective at following up siblings for infection and reaching out to whānau for check ins – this practice could be expanded beyond these clinics [note: there isn't evidence on whether swabbing all household members makes a difference to RF rates but Rachel Webb is looking at this through a sibling study]
 - Developing a register for RF + GAS that collects comprehensive information could support patient check ins and targeted information sharing
- Reducing the costs associated with appointments and prescriptions
 - Removing \$5 co-pay would make a huge difference – especially for the most vulnerable high risk communities. The current 'high use health care' card etc needs to be rethought as that relies on number of healthcare visits/ number of prescriptions to access the subsidy benefits - however for those who are in financial difficulties, even getting to the required number of visits/scripts is difficult.
 - Funding community care differently (see 'rethinking primary care')

Improving data to make better decisions

- The pharmaceutical dispensing database is a great start but has limitations as this database captures only claims data (i.e. subsidised medicines) and was not designed to be a data capture system.
 - Practitioner supply orders are not captured, and these are used for important groups such as school-based sore throat clinics and marae clinics, which skews the data

- Medicines with a cost below the \$5 co-pay are not captured, nor are medicines that are not subsidised.
- Indication is not included
- We could build on this database to capture more comprehensive dispensing information
- Looking at individual pharmacy dispensing data would be more reliable.
- Regional electronic systems such as testsafe exist however are limited to only certain regions and are not easily accessible. A national system collecting primary care data, pharmaceutical dispensing, laboratory data is needed.
- Any added data capture needs to minimise added burden for the front-line workforce
- In a dream world, comprehensive data would be pulled off primary care PMS and pharmacy dispensing databases and be sent to a centralised national registry to inform decisions. Providing that data was kept in NZ and there was Māori governance this should not cause data sovereignty issues.
- Data can be used to provide individualised and peer comparison feedback to prescribers as part of a behavioural science-informed intervention
 - Regular feedback to prescribers has shown to be effective [overseas](#)
 - This has been [replicated in NZ](#) though effectiveness did not reach statistical significance (possibly due to smaller or more limited data)
 - Such feedback should be localised or compare rural/urban separately due to inherent differences – better to compare urban vs rural than DHB vs DHB
 - Important to consider factors that might change prescribing practices or make data less reliable for comparison e.g. changes to diagnostic criteria, COVID-19 lockdowns affecting ability to swab throats

Any approach to address these challenges needs to:

- Recognise the unique needs of Māori, Pacific peoples, and regional and remote communities
- Have Māori and Pacific governance
- Focus on prevention by addressing inequities in the wider determinants of health, such as poverty, housing and social crowding
- Be informed by accurate data and by behavioural science (key to any effective sustained change)