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An Empirical Examination of Ethnic Differences in the Use and Experience of Child Healthcare Services in New Zealand

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Abstract : This paper focused on two main research aims using data from the Growing Up in New Zealand (GUINZ) birth cohort: 1. To examine ethnic differences in life-course trajectories in the use and experience of healthcare services in early childhood years (namely immunisation, dental checks and use of General Practitioners (GPs)) 2. To quantify the contribution of relevant explanatory factors to ethnic differences. Current policy in New Zealand indicates there should be, in terms of associated direct costs, equitable access by ethnicity for healthcare services. However, empirical evidence points to persistent ethnic gaps in several domains. For example, the data highlighted that Māori have the lowest immunisation rates, across a number of time points in early childhood – despite having a higher antenatal intention to immunise relative to NZ European. Further to that, NZ European are much more likely to have their first-choice lead maternity caregiver (LMC) and use child dental services compared to all ethnicities. Method: This research explored the underlying mechanisms behind ethnic differences in the use and experience of child healthcare services. First, a multivariate regression analysis was used to adjust raw ethnic gaps in child health care utilisation by relevant covariates. This included a range of factors, encompassing mobility, socio-economic status, mother and child characteristics, household characteristics and other social aspects. Second, a decomposition analysis was used to assess the proportion of each ethnic gap that can be explained, as well as the main drivers behind the explained component. The analysis for both econometric approaches was repeated for each data time point available, which included antenatal, 9 months, 2 years and 4 years post-birth. Results: The following findings emerged: There is consistent evidence that Asian and Pacific peoples have a higher likelihood of child immunisation relative to NZ Europeans and Māori. This was evident at all time points except one. Pacific peoples had a lower rate relative to NZ European for receiving all first-year immunisations on time. For a number of potential individual and household predictors of healthcare service utilisation, the association is time-variant across early childhood. For example, socio-economic status appears highly relevant for timely immunisations in a child's first year, but is then insignificant for the 15 month immunisations and those at age 4. Social factors play a key role. This included discouragement or encouragement regarding child immunisation. When broken down by source, discouragement by family has the largest marginal effect, followed by health professionals; whereas for encouragement, medical professionals have the largest positive influence. Perceived ethnically motivated discrimination by a health professional was significant with respect to both reducing the likelihood of achieving first choice LMC, and also satisfaction levels with child's GP. Some ethnic gaps were largely unexplained, despite the wealth of factors employed as independent variables in our analysis. This included understanding why Pacific mothers are much less likely to achieve their first choice LMC compared to NZ Europeans; and also the ethnic gaps for both Māori and Pacific peoples relative to NZ Europeans concerning dental service use.

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