Primary care experience in people with mental health conditions: results from a national patient experience survey

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ABSTRACT

AIM: The study explored whether the reported experience of primary healthcare differs for survey respondents in Aotearoa New Zealand who self-report having a mental health (MH) condition in comparison with those who do not.

METHOD: Responses to the New Zealand Health Quality & Safety Commission's adult primary care patient experience survey received from August 2020 to May 2022 were analysed. Comparative analysis of patient-reported experience measures were completed to contrast experiences reported by those with and without a MH condition, with results stratified by ethnicity (Māori/non-Māori), age group and gender. Age/gender-standardised estimates for proportions of positive responses to each question were developed for each group alongside standardised risk differences.

RESULTS: Our sample comprised 201,650 responses, with 21% reporting a current diagnosed MH condition. While most respondents reported positive experiences of primary healthcare, we found a consistent pattern of fewer positive experiences for those with MH conditions across dimensions of care quality**,** age and gender groups. When responses were separated by ethnicity, this difference was amplified among Māori.

CONCLUSION: This analysis adds to the increasing body of evidence that experience of MH conditions is associated with worse healthcare experiences. It demonstrates that data are available in Aotearoa New Zealand to routinely monitor and report on primary care experiences for this group. Interventions to improve healthcare should focus on care for Māori with MH conditions as a priority.

Mental health (MH) impacts physical health. In comparison with the general population, people with MH and substance use conditions have a greater level of exposure to risk factors that contribute to a range of chronic physical health conditions, leading to higher mortality and lower life expectancy.[1–3] This relationship between mental and physical health represents a significant element of the personal, social and economic impact of MH conditions for people throughout their lives.[4]

International evidence has shown that a more positive patient experience of healthcare can improve health, clinical, financial, service and satisfaction outcomes.[5] For people with MH and substance use conditions, several aspects of quality of care may contribute to inequitable outcomes. These include structural and financial barriers to accessing services, and prejudice and discrimination from health professionals (whether implicit or overt) that can lead to overlooked or misattributed physical symptoms, missed or late diagnoses and limited access to the best treatment options.[6] High-quality primary care has been shown to improve health outcomes and wellbeing of people with MH conditions;[7] however, studies conducted overseas show that people with MH conditions often report low levels of satisfaction with their primary healthcare experience.[8–10]

Te Tāhū Hauora (the New Zealand Health Quality & Safety Commission [HQSC]) has been running patient experience surveys for nearly a decade in Aotearoa New Zealand. The survey programme provides tools and data to support national and local monitoring and quality improvement initiatives. The adult primary care patient experience survey (PCPES) was the source of data for this study,[11] which samples people who have had a recent visit to a general practice.

The objective of this study was to compare the primary healthcare experiences of adult patients with and without long-term MH conditions (those lasting or expected to last for more than 6 months), using data from the PCPES. The main research

question was: "*Does the reported experience of primary health care differ in survey respondents with a self-reported MH condition compared to those without?*" It was not possible to separately assess patient experience for people with substance use conditions due to the absence of relevant survey questions. Information on clinician-reported MH diagnoses was also not available.

Methods

Data sources/measurement

The HQSC PCPES data are collected on a quarterly basis. Every 3 months, a sample of adults aged 15 years and over who are enrolled with and have been seen by a general practice within Aotearoa New Zealand is invited to complete an online survey. Each participating practice prepares a list of all eligible patients who have had a consultation with the practice over a designated 1–2-week period. Eligible patients with contact details are invited by email to complete an online survey. Extra efforts are made to reach Māori and Pacific patients by sending an SMS reminder 2 days after the initial email invitation. The overall response rate is 16–17%.[11]

Study sample

We analysed PCPES responses in the 2-year period from quarter 3 of 2020 to quarter 2 of 2022 (August 2020 to May 2022). The survey asked respondents about experiences at the most recent interaction with a healthcare professional in primary care.

The survey question "*Which, if any, of the following long-term health conditions have you been diagnosed with and currently have?*" was used to classify respondents into those with and without MH conditions. A long-term health condition was defined in the survey as "*a physical or mental illness or condition that has lasted, or is expected to last, for more than six months. The symptoms may come and go or be present all the time*." Where this question had not been answered, responses were excluded from analysis.

The "with MH condition(s)" group comprised responses from people reporting a diagnosis of at least one of "Anxiety", "Depression" or "Other MH conditions", and the "without MH condition(s)" group captured all remaining responses, including those who reported not currently having any long-term health conditions.

Key variables

Characteristics of each of the two groups were compared, stratified as follows:

- **Ethnicity:** European; Māori; Asian; Pacific peoples; and Other ethnicity, including Middle Eastern/Latin American/African (the survey allows selection of multiple ethnicities but was provided as prioritised ethnicity in the order: Māori, Pacific, Asian, Other, European), further stratified into Māori and non-Māori.
- **Age group**: 15–24 years; 25–64-years; and 65 years or over.
- **Gender:** Male; female; and another gender.
- **Long-term condition(s):** In addition to the responses indicating a MH condition, other potential responses were: arthritis (including gout); asthma; cancer (diagnosis or treatment in the last 5 years); chronic obstructive pulmonary disease; diabetes; heart disease; high blood pressure; long-term pain; stroke; other; and "*I do not currently have any long-term health conditions*."
- **Main type of healthcare professional (HCP) seen at the most recent appointment:** Doctor; nurse; MH professional; or another healthcare professional.

Seven experience of care questions were grouped into three dimensions of care outlined below:

Relationships:

- **Listened to:** Did the (HCP seen at most recent appointment) listen to you?
- **Involved in decisions:** Did the (HCP seen at most recent appointment) involve you as much as you wanted to be in making decisions about your treatment and care?
- **Treated with respect:** Did the (HCP seen at most recent appointment) treat you with respect?

Barriers to care:

- **Given enough time:** Did the (HCP seen at most recent appointment) spend enough time with you?
- **Unable to get an appointment:** In the last 12 months, was there ever a time when you

wanted healthcare from a GP or nurse, but you couldn't get it?

Meeting needs:

- **Individual needs were met:** Did you feel your individual needs were met? (For the first two survey quarters [August 2020 and Nov 2020], the question was "*Did you feel your individual and/or cultural needs were met*?" For the remaining six survey quarters, the question was "*Did you feel your individual needs were met*?")
- **MH needs were met:** Did you feel that the (HCP seen at most recent appointment) recognised and/or understood any MH needs that you might have had?

Analysis

Demographic and other descriptive characteristics are presented for the two groups using frequency counts and proportions. The number of other long-term health conditions reported by respondents was determined and frequency counts were reported for any conditions that represented over 10% of all responses for either group.

For experience of care measures, we reported the count and proportion of responses within each group that reported "yes definitely", "somewhat" and "no" to each question. Respondents that did not include an answer to a specific question were excluded from analysis relating to that question. Eight of the nine questions were framed so that a positive report of experience was indicated by "yes definitely", except for the question "*Were you unable to get an appointment with a GP/nurse sometime in past year*?", where a positive experience was indicated by "no". Response options for this question were limited to "yes" and "no". Comparisons focussed on the most positive responses ("yes definitely" and "no" respectively) in order to focus on the group reporting the best care experiences (as the aim of health services). However, all three levels of response are reported.

Comparative analysis of the experience of care measures was completed to contrast experiences reported by those with and without a MH condition. Results were further stratified by ethnicity (Māori/non-Māori), age group and gender.

Age/gender-standardised estimates of the proportions of responses to each question were developed for the groups with and without MH conditions, with 95% confidence intervals, following principles for age-standardisation of complex survey estimates.[12] Firstly, estimates of responses for each question were produced accounting for survey weights for each group (those with/without MH conditions), further stratified by age and gender. The age–gender standardisation step then involved creating reference weights reflecting the relative distribution of age and gender among PCPES respondents with MH conditions: these weights were then applied to the sample-weighted estimates stratified by group and age/gender to produce standardised estimates by group. Similarly, to compare experiences reported by Māori and non-Māori with and without MH conditions, age/gender-standardised estimates were developed that matched the age/gender structure of the MH conditions group. That is, to consider differences between groups without confounding by age or gender, the group with MH conditions was used as the standard population for standardisation.

For each analysis, risk differences were calculated from the standardised estimates to compare the proportions of the most positive responses from each group of survey questions. The risk difference (also called the absolute risk reduction) measures the difference observed for the outcome of interest between two groups, when accounting for a differential age/gender profile by group, providing an estimated difference in experiencing an event.[13]

Results

Participants

During the study period, there were 229,083 survey responses. Of these, 27,433 had not answered the long-term conditions question, leaving a total sample of 201,650 eligible responses.

Sample characteristics

About one in five (21%) of eligible survey respondents reported a current diagnosed MH condition, with the majority reporting anxiety (67%) and/or depression (59%) (Table 1). Survey respondents who reported not having a MH condition were more likely to be older, male and non-Māori than those with a MH condition.

Both groups presented with a substantial burden of chronic disease, reflecting a population of people attending primary care. Two-thirds of all respondents indicated they had at least one long-term physical health condition (not including MH

Table 1: Demographic characteristics of survey respondents without and with mental health conditions.

Characteristic[a]	Without mental health condition(s)		With mental health condition(s)	
	N=159,875		N=41,775	
	n	%	n	%
Ethnicity[b]				
European	99,286	67.5%	26,001	67.2%
Māori	20,770	14.1%	7,010	18.1%
Asian	9,583	6.5%	1,125	2.9%
Pacific peoples	6,631	4.5%	1,190	3.1%
MELAA/Other ethnicity	10,914	7.4%	3,340	8.6%
Missing values	12,691		3,109	
Age				
15–24 years	3,175	2.1%	2,439	6.3%
25–64 years	71,348	48.2%	25,566	65.7%
65 years or over	73,599	49.7%	10,890	28.0%
Missing values	11,753		2,880	
Gender				
Male	56,569	38.5%	10,108	26.2%
Female	89,845	61.2%	27,990	72.6%
Another gender	340	0.2%	451	1.2%
Missing values	13,121		3,226	
Long-term conditions				
Mental health conditions				
Anxiety			27,973	67%
Depression			24,659	59%
Other mental health condition			10,119	24%
Non-mental health long-term conditions				
No other conditions	58,760	36.8%	15,749	37.7%
1 other condition	53,179	33.3%	12,662	30.3%
2 other conditions	29,290	18.3%	7,198	17.2%
3 other conditions	12,618	7.9%	3,682	8.8%
4 or more other conditions	6,028	3.8%	2,484	5.9%

Table 1 (continued): Demographic characteristics of survey respondents without and with mental health conditions.

Most common non-mental health long-term conditions[c]				
High blood pressure	56,219	32.0%	12,177	24.7%
Arthritis	30,276	17.2%	8,156	16.6%
Asthma	18,522	10.5%	8,136	16.5%
Diabetes	18,019	10.3%	4,414	9.0%
Coronary health disease	17,295	9.8%	3,252	6.6%
Long-term pain	16,405	9.3%	8,566	17.4%

[a] Proportion calculations exclude "No response", "NA" or "Prefer not to answer". As percentages reported are unweighted, the table indicates differences in who is included in the study, rather than making inferential statements about these groups.
[b] The survey uses the prioritised ethnicity classification method. MELAA is Middle Eastern/Latin American/African.
[c] Percentages show proportions of all long-term condition responses within each group.

Figure 1: Age/gender-standardised proportions of positive responses to quality of primary healthcare questions for respondents with and without mental health conditions (95% confidence intervals).

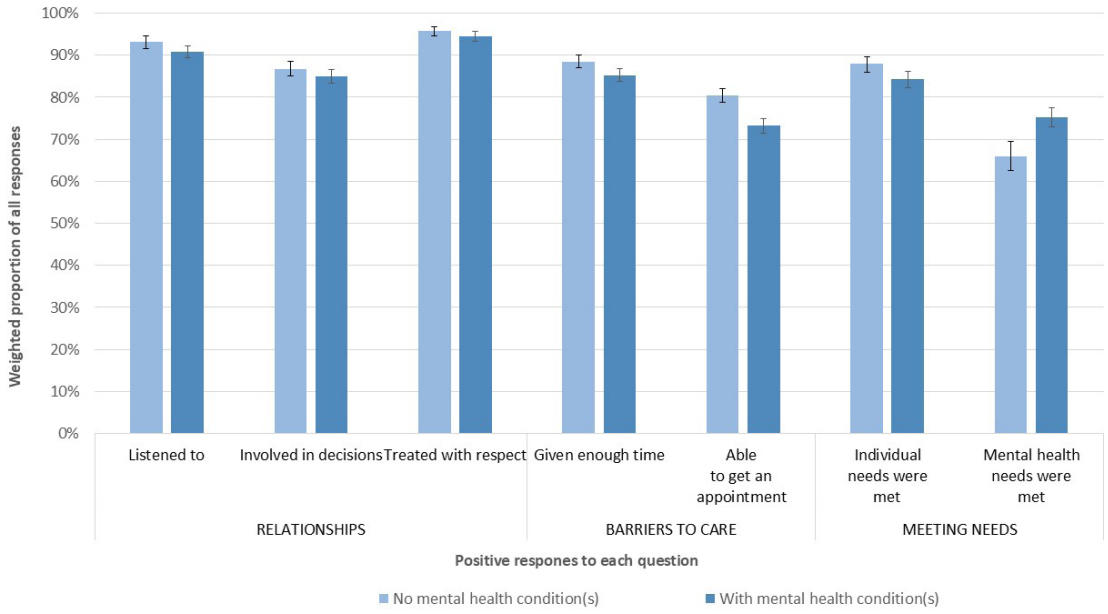

Table 2: Age/gender-standardised analysis of responses to quality of primary healthcare questions for respondents with and without mental health conditions.

Dimension of care/response to question	No MH condition(s)		With MH condition(s)		Risk difference—"with MH condition(s)" compared with "no MH conditions" (95% CI)
	N=159,875		N=41,775		
	n Crude responses[a]	% Standardised proportions	n Crude responses	% Standardised proportions	
Relationships					
Listened to					
Yes, definitely	115,548	93.1%	30,623	90.9%	-2.2 (-4.2–0.2)*
Somewhat	5,574	6.2%	2,300	7.8%	
No	597	0.7%	377	1.4%	
Involved in decisions					
Yes, definitely	110,075	86.8%	28,931	84.9%	-1.9 (-4.3–0.4)
Somewhat	10,423	10.2%	3,488	11.2%	
No	2,406	2.9%	1,121	3.9%	
Treated with respect					
Yes, definitely	117,290	95.8%	31,546	94.5%	-1.3 (-2.8–0.2)
Somewhat	2,974	3.4%	1,249	4.1%	
No	645	0.8%	368	1.4%	
Barriers to care					
Given enough time					
Yes, definitely	110,246	88.5%	28,812	85.3%	-3.2 (-5.4–1.0)*
Somewhat	8,536	8.7%	3,264	10.8%	
No	2,243	2.7%	1,115	3.9%	
Unable to get an appointment sometime in past year[b]					
Yes, definitely	22,883	19.6%	9,724	26.8%	
No	120,769	80.4%	28,226	73.2%	-7.1 (-9.5–-4.8)*
Meeting needs					
Individual needs were met					
Yes, definitely	80,428	87.9%	21,098	84.3%	-3.6 (-6.3–-0.9)*
Somewhat	6,562	9.1%	2,580	11.3%	
No	1,851	3.1%	935	4.4%	

Table 2 (continued): Age/gender-standardised analysis of responses to quality of primary healthcare questions for respondents with and without mental health conditions.

Mental health needs were met					
Yes, definitely	13,471	66.0%	16,560	75.2%	9.2 (5.2–13.2)*
Somewhat	3,277	18.8%	3,472	16.7%	
No	2,793	15.2%	1,686	8.1%	

[a] For age/gender-standardised analyses, n counts only include responses that report age and a valid gender (male, female or other). Denominators exclude "No response", "NA" or "Prefer not to answer", "Can't remember" and "I did not have any" responses to questions.
[b] Note that a "No" response indicates a positive experience for this question.
* Statistically significant difference.
MH = mental health; 95% CI = 95% confidence interval.

conditions). For respondents with one or more MH condition, 14.7% reported having three or more long-term physical health conditions, compared with 11.7% of those with no MH conditions. People with MH conditions were less likely to report high blood pressure and more likely to report long-term pain conditions and asthma than those without MH conditions, in keeping with the age and gender distribution of people with MH conditions in our sample.

Most respondents in both groups had seen a doctor at their recent visit—82% of respondents without MH conditions and 85% of those with MH conditions. Smaller proportions reported having seen a nurse—17% without MH conditions and 13% with MH conditions, respectively. Only 1% of respondents with MH conditions indicated they had seen a MH professional at their most recent primary care visit.

Primary care experience

While most respondents reported positive experiences of primary healthcare, we found a pattern of worse experiences for those with MH conditions reflected consistently across dimensions of care experience.

Those without MH conditions reported more positive experiences than those with MH conditions (Figure 1) across all but one experience of care measure (whether MH needs were met) after adjusting for age and gender differences between groups.

Standardised comparisons and risk differences are provided in Table 2. Within the "relationships" dimension of care, being treated with respect received the highest proportions of positive responses for both groups (95.8% without and 94.5% with MH conditions), with no significant difference between the groups. This was closely followed by being listened to (93.1% and 90.9% respectively), which also showed the widest difference between groups (risk difference [RD] = -2.2%) and the only significant difference between groups within this dimension of care.

Differences between groups were more marked across measures in the "barriers to care" dimension, particularly regarding the ability of respondents to access primary care consultations. Respondents with MH conditions were more likely to report problems with obtaining an appointment with a general practitioner (GP) or nurse during the past year than those without MH conditions (RD=7.1%). Respondents with MH conditions were also less likely to report that primary care providers spend enough time with them (RD=-3.2%).

Within the "meeting needs" dimension of care, respondents with MH conditions were less likely to report that their individual needs had been met (RD=-3.6%). Respondents with MH conditions were much more likely to report having their MH needs met at the most recent appointment (RD=9.2%). However, this question was not applicable to the majority of those without MH conditions, where only around one in 10 of this group (n=19,541) indicated that they had MH needs at the last appointment. Moreover, this dimension of care was the lowest scoring, with over one-quarter of people with MH needs at their primary care appointment not having those needs met.

When responses were separated by ethnicity, the differences in care experiences associated with MH conditions were amplified for Māori

Table 3: Age/gender-standardised analysis of responses to primary healthcare quality of care questions by group with or without mental health conditions, by ethnicity.

	Non-Māori					Māori				
	N=158,070					N=27,780				
	No MH condition(s)		With MH condition(s)		Risk difference[b]: "with" compared with "no" MH condition(s) (95% CI)	No MH condition(s)		With MH condition(s)		Risk difference: "with" compared with "no" MH condition(s) (95% CI)
Dimension of care	N=126,414		N=31,656			N=20,770		N=7,010		
Response to question[a]	n Crude responses	% Standardised proportions	n Crude responses	% Standardised proportions		n Crude responses	% Standardised proportions	n Crude responses	% Standardised proportions	
Relationships										
Listened to										
Yes, definitely	99,725	93.2%	25,223	91.0%		15,682	92.7%	5,375	90.0%	
Somewhat	4,665	6.2%	1,816	7.7%	-2.2 (-4.3–0.03)	904	6.40%	483	8.5%	-2.8 (-8.3–2.8)
No	479	0.7%	287	1.3%		118	0.90%	89	1.6%	
Involved in decisions										
Yes, definitely	94,948	86.9%	23,797	85.1%		14,987	86.6%	5,108	84.0%	
Somewhat	8,861	10.3%	2,817	11.1%	-1.8 (-4.3–0.8)	1,554	9.9%	669	11.8%	-2.6 (-9.3–4.2)
No	1,958	2.9%	878	3.8%		444	3.5%	242	4.2%	
Treated with respect										
Yes, definitely	101,163	95.8%	25,939	94.6%		15,993	95.4%	5,581	93.8%	
Somewhat	2,470	3.4%	985	4.1%	-1.2 (-2.8–0.4)	499	3.7%	264	4.6%	-1.5 (-6.8–3.7)
No	516	0.8%	281	1.3%		128	1.0%	86	1.6%	

Table 3 (continued): Age/gender-standardised analysis of responses to primary healthcare quality of care questions by group with or without mental health conditions, by ethnicity.

Barriers to care										
Given enough time										
Yes, definitely	95,056	88.5%	23,693	85.4%	-3.1 (-5.4–0.7)	15,060	88.7%	5,098	84.8%	-3.9 (-10.1–2.3)
Somewhat	7,317	8.7%	2,643	10.7%		1,209	8.5%	618	11.1%	
No	1,890	2.7%	890	3.9%		352	2.8%	224	4.1%	
Unable to get an appointment with GP/nurse sometime in past year[c]										
Yes, definitely	18,418	19.2%	7,545	26.2%	-7.0 (-9.6–4.4)	4,437	23.0%	2,171	30.7%	-7.7 (-13.9–1.5)
No	104,935	80.8%	23,536	73.8%		15,666	77.0%	4,665	69.3%	
Meeting needs										
Individual needs were met										
Yes, definitely	68,777	88.0%	17,148	84.4%	-3.6 (-6.5–0.6)	11,567	87.3%	3,934	83.5%	-3.8 (-10.4–2.8)
Somewhat	5,499	9.1%	2,074	11.4%		1,056	9.1%	505	11.2%	
No	1,481	3.0%	713	4.2%		367	3.6%	222	5.3%	
Mental health needs were met										
Yes, definitely	11,064	65.7%	13,458	75.4%	9.7 (5.3–14.2)	2,389	68.1%	3,086	74.2%	6.0 (-3.3–15.4)
Somewhat	2,729	19.3%	2,822	16.7%		545	15.9%	650	16.7%	
No	2,300	15.0%	1,299	7.9%		489	16.0%	386	9.1%	

[a] For age/gender-standardised analyses, n counts only include responses that report age and a valid gender (male, female or other). Denominators exclude "No response", "NA" or "Prefer not to answer", "Can't remember" and "I did not have any" responses to questions.
[b] Risk differences are presented for most positive responses only.
[c] Note that a "No" response indicates a positive experience for this question.
MH = mental health; 95% CI = 95% confidence interval; GP = general practitioner.

(Table 3). The pattern of worse experiences of care among Māori and non-Māori with MH conditions compared with those without held across all measures (with the exception of meeting MH needs). Risk differences between those with and without MH conditions were consistently smaller for non-Māori than for Māori. For age and gender, there was a similar overall pattern of respondents with MH conditions reporting more negative experiences of primary care within all gender and age strata (Appendix Tables 1 and 2).

Discussion

A high proportion of all survey respondents reported that they felt listened to, treated with respect and involved in decisions (e.g., >90% reported definitely being treated with respect). People with self-reported MH conditions attending general practice in Aotearoa New Zealand report predominantly positive experiences in primary healthcare, and three-quarters report having their MH needs "definitely" met. However, a clear and consistent pattern of worse experiences of primary healthcare compared with those without MH conditions is evident. This same pattern holds across breakdowns by gender and age group, and across all dimensions of experience for Māori and non-Māori respondents.

Comparison with previous research

Other recent research on the healthcare experiences of people in Aotearoa New Zealand with MH and substance use conditions was conducted in 2022 using a web-based survey of adults.[6] Participants were recruited nationally through MH, addiction and lived experience networks and social media. In a subset of respondents who had accessed primary care services (n=335), the majority reported positive experiences; for example, always or most of the time being treated with respect (81%) and being listened to (79%). However, non-Māori had better experiences than Māori for both of these measures. The lower proportion of positive responses in that study compared with the PCPES reported here may relate to the survey sample. This was self-selected, which could introduce bias if people responded more to the survey if they had negative experiences to report and included a high proportion (more than 20%) of people with schizophrenia or bipolar disorder diagnoses, who experience more discrimination than people with other MH conditions. In addition, the majority (70%) were under 45 years of age and younger age in general is associated with responses that are not as positive as those from older people. The differences may also relate to respondents being asked about experiences over the last 5 years, and from all primary care staff. In comparison, the PCPES asks about reception or administrative staff separately and the results presented here concentrate on experiences of clinical interactions at the most recent visit. Another survey of people in Auckland who were engaged with MH services[14] found that people with MH conditions were much more likely to be unable to access a GP within 24 hours, compared with the general population.

Similar findings have also been found in research from Australia into physical healthcare service access for people with MH conditions.[15] This Australian study found that people with MH conditions, compared with those without MH conditions, reported lower levels of being treated with respect, higher levels of waiting for an appointment, not having a response from a GP clinic, not being involved in decisions and the GP not spending enough time.

Implications for clinical practice and research

The importance of strong therapeutic relationships with primary healthcare practitioners for people with MH conditions has long been acknowledged.[16] Positive relationships (characterised as empathetic, non-judgmental and person centred) facilitate access to services, while experiences of stigma or a lack of knowledge from providers act as a barrier.[17] Patient-centred approaches to care and a focus on empathy in communication styles have been central to primary care clinician training and practice for many years, and no doubt are contributing to the high levels of positive patient experiences reported.[18] However, stigmatised attitudes towards people with MH conditions are common in primary care providers, even more than in the general population.[19,20] Discrimination from health professionals also contributes to diagnostic overshadowing, where physical conditions in people with MH conditions are missed or undertreated.[21] People who experience stigma and discrimination are more likely to report unmet health needs, poor communication from providers and difficulties in accessing healthcare.[22] Healthcare experience is a modifiable factor that can improve health outcomes for people experiencing MH conditions. The results presented in this analysis,

consistent with research conducted previously, emphasise the need to ensure that all primary health practitioners are skilled and comfortable with supporting people with MH conditions. A patient-centred approach, with a focus on empathy in communicating with patients, has the potential to both improve clinical outcomes and patient satisfaction with services.[23,24] Programmes to address stigma and discrimination in health professionals need to take a tailored and multifaceted approach, recognising that the origins and impacts of stigma and discrimination can differ across organisations and individuals.[25] The potential to reduce stigma and discrimination towards people with MH conditions goes hand-in-hand with improving both experiences of care and health outcomes.[26]

Relatively little research has been done on the intersection of MH discrimination and racism, but these factors can compound to cause negative impacts on patient–doctor relationships and quality of care,[8,27] and there is plenty of evidence that racism is a determinant of health in Aotearoa New Zealand.[28,29] Interventions tailored to the Aotearoa New Zealand context and workforce that address this intersection are urgently required, as well as equity targets to ensure that progress in addressing systemic racism is monitored and change is achieved.

Strengths and limitations

This study used a large sample of people accessing primary care in Aotearoa New Zealand, where self-reported information on MH conditions was available for almost every participant. The PCPES is one of the main measures of patient experience of care in Aotearoa New Zealand and uses validated measures on patient care experiences. Although the response rate is relatively low, this is comparable to similar surveys and a strong survey methodology and representative sampling mean that the risk of non-response bias is low.[30] However, it only captures people who have accessed primary care, and people with MH conditions may not seek healthcare due to fear or past experiences of discrimination.[20,31] The data collection period occurred during the COVID-19 pandemic, which could have affected patient experiences. However, it is notable that predominantly positive experiences were reported.

The focus of this study was on comparing those with and without MH conditions within the responding sample, and so while survey weights were used in the calculations (typically serving to weight responses to be representative of the population accessing primary care), the presented results as proportions and risk differences have been age/gender-standardised to the profile of the group with a history of MH conditions in order to adjust for confounding by these factors. This maximises internal validity for comparing these groups, but means that the proportions of responses are not directly comparable to other survey analyses using weighted data.

The data available allowed us to identify people with MH conditions. However, it was not possible to explore history of MH conditions in more detail than the diagnoses of anxiety and depression and an "other" category. It was therefore not possible to explore whether there were different impacts on care experiences for people diagnosed with different types of condition; for example, psychosis versus mood disorders. Previous research has indicated that people with substance use conditions experience stigma impacting on quality of care provided.[32,33] In this survey, data on substance use conditions were not collected and so it was also not possible to explore the impact of substance use conditions on care experiences. The group identified as having MH conditions lasting longer than 6 months will include those with conditions having a higher impact, who are likely to be accessing specialist MH services, as well as those whose conditions are managed in primary care.

We have focussed on comparing the reported experiences of Māori as the Indigenous population compared with non-Māori. However, we recognise that the non-Māori group will include other ethnic groups that experience discrimination and marginalisation, including Pacific peoples. This will mean that the true of extent of inequities between Māori and NZ European, as the most privileged group, may be masked in this comparison.

From a public health and equity perspective, our findings demonstrate the importance of thinking carefully about the populations we compare when monitoring patient experience and outcomes. Adopting an approach that considers healthcare equity for people with MH conditions will support improved understanding of how experience of care may impact on outcomes for people experiencing long-term mental distress and contribute to improving experiences of care.

Within this, inequalities in the receipt of quality physical healthcare may be intensified

among those who experience MH conditions and are also members of other minoritised or marginalised groups. Our results demonstrate that for Māori, poor experiences of healthcare are compounded among people with MH conditions.

Conclusion

This analysis adds to the increasing body of evidence that experience of MH conditions is associated with adverse healthcare experiences. It demonstrates that data are available in Aotearoa New Zealand to routinely monitor and report on care experiences for this group. Interventions to improve healthcare to provide equitable care for Māori with MH conditions are required as a priority. Further research should focus on developing and evaluating the effectiveness of interventions in the Aotearoa New Zealand context.

COMPETING INTERESTS
Nil.

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Appendix

Appendix Table 1: Primary healthcare quality of care responses for respondents without or with mental health conditions, by gender (unweighted and unstandardised data).

	Male				Female				Other gender			
	N=83,043				N=118,198				N=1,052			
Dimension of care	**No MH condition(s)**		**With MH condition(s)**		**No MH condition(s)**		**With MH condition(s)**		**No MH condition(s)**		**With MH condition(s)**	
Response to question[a]	**N=67,943**		**N=15,100**		**N=88,233**		**N=29,965**		**N=402**		**N=650**	
Relationships												
Listened to												
Yes, definitely	45,266	96.1%	8,117	93.6%	71,550	94.2%	22,433	91.5%	248	87.9%	340	84.2%
Somewhat	1,679	3.6%	467	5.4%	3,957	5.2%	1,814	7.4%	33	11.7%	46	11.4%
No	171	0.4%	85	1.0%	437	0.6%	279	1.1%	1	0.4%	18	4.5%
Involved in decisions												
Yes, definitely	43,159	90.4%	7,589	86.7%	68,217	89.0%	21,296	86.2%	216	78.0%	306	76.5%
Somewhat	3,805	8.0%	907	10.4%	6,736	8.8%	2,549	10.3%	51	18.4%	71	17.8%
No	771	1.6%	257	2.9%	1,670	2.2%	852	3.4%	10	3.6%	23	5.8%
Treated with respect												
Yes, definitely	45,672	97.6%	8,287	96.0%	72,882	96.6%	23,179	94.9%	256	92.4%	351	87.3%
Somewhat	934	2.0%	253	3.1%	2,070	2.8%	973	4.2%	17	6.6%	38	10.8%
No	173	0.4%	88	1.1%	481	0.7%	271	1.2%	4	1.6%	13	3.7%

Appendix Table 1 (continued): Primary healthcare quality of care responses for respondents without or with mental health conditions, by gender (unweighted and unstandardised data).

Barriers to care												
Given enough time												
Yes, definitely	36,511	95.7%	6,268	91.1%	56,792	93.1%	17,001	88.5%	191	85.7%	248	76.8%
Somewhat	1,279	3.4%	458	6.7%	3,341	5.5%	1,695	8.8%	24	10.8%	55	17.0%
No	354	0.9%	154	2.2%	890	1.5%	521	2.7%	8	3.6%	20	6.2%
Unable to get an appointment with GP/nurse sometime in past year[b]												
Yes, definitely	6,561	11.7%	1,847	18.4%	16,587	18.6%	7,809	28.0%	85	25.1%	178	39.6%
No	49,678	88.3%	8,187	81.6%	72,615	81.4%	20,040	72.0%	253	74.9%	272	60.4%
Meeting needs												
Individual needs were met												
Yes, definitely	31,083	92.1%	5,540	87.4%	50,227	89.6%	15,513	85.3%	153	75.0%	228	75.2%
Somewhat	2,119	6.3%	587	9.3%	4,490	8.0%	1,962	10.8%	42	20.6%	55	18.2%
No	546	1.6%	213	3.4%	1,336	2.4%	714	3.9%	9	4.4%	20	6.6%
Mental health needs were met												
Yes, definitely	4,698	70.3%	4,321	78.4%	8,885	68.2%	12,170	75.7%	57	62.0%	205	60.7%
Somewhat	1,009	15.1%	835	15.1%	2,283	17.5%	2,590	16.1%	22	23.9%	73	21.6%
No	979	14.6%	358	6.5%	1,854	14.2%	1,310	8.2%	13	14.1%	60	17.6%

[a] All proportion calculations exclude "No response", "NA" or "Prefer not to answer", "Can't remember" or "I did not have any" responses from denominators.
[b] Note that a "No" response indicates a positive experience for this question.
MH = mental health; GP = general practitioner.

Appendix Table 2: Primary healthcare quality of care responses for respondents without or with mental health conditions, by age group (unweighted and unstandardised data).

	15–24 years				25–64 years				65 years or over			
	N=5,614				N=96,914				N=84,489			
Dimension of care	**No MH condition(s)**		**With MH condition(s)**		**No MH condition(s)**		**With MH condition(s)**		**No MH condition(s)**		**With MH condition(s)**	
Response to question[a]	**N=3,175**		**N=2,439**		**N=71,348**		**N=25,566**		**N=73,599**		**N=10,890**	
Relationships												
Listened to												
Yes, definitely	2,450	88.1%	1,887	84.8%	56,471	93.6%	20,521	91.4%	59,343	96.6%	8,762	95.1%
Somewhat	295	10.6%	279	12.5%	3,458	5.7%	1,654	7.4%	1,945	3.2%	415	4.5%
No	35	1.3%	60	2.7%	429	0.7%	286	1.3%	144	0.2%	37	0.4%
Involved in decisions												
Yes, definitely	2,193	80.2%	1,732	78.9%	52,727	87.7%	19,300	85.8%	57,759	91.8%	8,434	89.1%
Somewhat	404	14.8%	318	14.5%	5,771	9.6%	2,378	10.6%	4,518	7.2%	863	9.1%
No	136	5.0%	145	6.6%	1,657	2.8%	823	3.7%	668	1.1%	169	1.8%
Treated with respect												
Yes, definitely	2,558	92.4%	2,013	91.1%	57,646	96.0%	21,179	94.6%	59,828	98.2%	8,928	97.4%
Somewhat	169	6.1%	146	6.6%	1,915	3.2%	924	4.1%	962	1.6%	198	2.2%
No	42	1.5%	51	2.3%	466	0.8%	81	1.3%	151	0.2%	42	0.5%
Barriers to care												
Given enough time												
Yes, definitely	2,257	81.1%	1,722	77.6%	53,805	89.4%	19,367	86.4%	56,744	93.2%	8,246	90.2%

Appendix Table 2 (continued): Primary healthcare quality of care responses for respondents without or with mental health conditions, by age group (unweighted and unstandardised data).

Somewhat	396	14.2%	347	15.6%	4,875	8.1%	2,242	10.0%	3,476	5.7%	726	7.9%
No	130	4.7%	149	6.8%	1,510	2.5%	818	3.6%	651	1.1%	171	1.9%
Unable to get an appointment with GP/nurse sometime in past year[b]												
Yes, definitely	747	23.6%	854	35.1%	15,148	21.3%	7,413	29.1%	7,547	10.4%	1,647	15.3%
No	2,418	76.4%	1,579	64.9%	55,896	78.7%	18,042	70.9%	65,340	89.6%	9,135	84.7%
Meeting needs												
Individual needs were met												
Yes, definitely	1,524	81.8%	1,177	76.4%	38,233	88.3%	14,058	85.1%	42,618	93.0%	6,275	89.2%
Somewhat	249	13.4%	255	16.6%	3,763	8.7%	1,757	10.6%	2,718	5.9%	614	8.7%
No	91	4.9%	108	7.0%	1,324	3.1%	699	4.2%	496	1.1%	143	2.0%
Mental health needs were met												
Yes, definitely	451	53.4%	1,164	66.1%	8,650	68.4%	11,961	76.3%	4,700	72.0%	3,709	79.8%
Somewhat	233	27.6%	378	21.5%	2,199	17.4%	2,463	15.7%	909	13.9%	688	14.8%
No	160	19.0%	219	12.4%	1,790	14.2%	1,247	8.0%	915	14.0%	251	5.4%

[a] Response data exclude "NA" or "No response" for all quality and access measures.
[b] Note that a "No" response indicates a positive experience for this question.
MH = mental health; GP = general practitioner.