

# IMPROVING QUALITY OF CARE FOR PACIFIC PEOPLES

A paper for the  
PACIFIC HEALTH AND DISABILITY ACTION PLAN REVIEW



2008



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## Acknowledgements

The Ministry of Health would like to thank Fuimaono Karl Pulotu-Endemann for peer review, and Dr Colin Tukuitonga, Professor Peter Crampton and Dr Juliet Walker for guidance and expertise in the development of the paper.

Within the Ministry of Health, the development of this paper was led by Dr Debbie Ryan and Julie Hynes (Pacific Innovations and Capability) and Marisa Maepu (Pacific Policy and Strategy team) with advice from Gillian Bohm (Quality, Improvement and Innovation) and the Primary Care Policy team.

Left and right photos on cover are courtesy of Hoe Mua Designs Limited.

Citation: Ministry of Health. 2008. *Improving Quality of Care for Pacific Peoples*.  
Wellington: Ministry of Health.

Published in February 2008  
by the Ministry of Health  
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-31704-6 (Print)  
ISBN 978-0-478-31705-3 (Online)  
HP4543

This document is available on the Ministry of Health's website:  
<http://www.moh.govt.nz>



MANATŪ HAUORA

# Foreword

*Talofa lava, Malo e lelei, Kia Orana, Taloha Ni, Fakalofa Lahi Atu, Ni Sa Bula Vinaka, Talofa, Kia Ora, Greetings*

In 2003 the Minister of Health launched the Improving Quality (IQ): A systems approach for the New Zealand health and disability sector document. It endorsed a systems-wide approach, which recognises that quality is the result of the complex interaction of people, individuals, teams, organisations and systems. The IQ systems approach also puts people at the heart of improving quality.

This document *Improving Quality of Care for Pacific Peoples* supports the IQ systems approach as an opportunity for improving quality for Pacific peoples.

The inequalities between the health status of Pacific and non-Pacific peoples are a quality issue when the inequalities result from poor access to services and/or inappropriate service delivery. Recent Ministry sponsored research about the contribution of health care to health gains is showing that, in contrast to other population groups, Pacific peoples have benefited least. This clearly warrants further investigation and suggests that concerns about inequalities in access and exposure to health services (including health promotion and disease prevention programmes) are well founded.

The Primary Health Care Strategy's population based approach to health care, Pacific models of health care and Pacific cultural competence are positive steps, and many organisations are already undertaking quality improvement initiatives. Quality, however, can always be improved on.

This document builds on existing quality improvement literature by giving a specific focus to the importance of quality for Pacific peoples in New Zealand. It also attempts to describe some of the many complex and interrelated factors impacting on quality of care for Pacific peoples.



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# Contents

<b>Acknowledgement .....</b>	<b>ii</b>
<b>Foreword .....</b>	<b>iii</b>
<b>Executive Summary.....</b>	<b>vii</b>
<b>1. Introduction.....</b>	<b>1</b>
Background .....	1
Scope .....	2
Health indicators.....	2
Quality of care.....	5
<b>2. Pacific Peoples in New Zealand.....</b>	<b>6</b>
Demography .....	6
Socioeconomic determinants.....	13
Pacific views, beliefs and approaches to health.....	17
Use and expectations of the health system in New Zealand .....	22
Pacific health providers.....	24
Issues and concerns.....	26
Discussion .....	29
<b>3. Quality of Care Initiatives across the Health Sector.....</b>	<b>31</b>
Health targets .....	31
The Primary Health Care Strategy (PHCS) .....	32
Leading for Outcomes .....	33
Pacific provider and workforce development .....	34
National Pacific Diabetes Initiative .....	36
Health Innovation Awards .....	36
Inequalities: evidence and tools.....	37
Ethical guidelines .....	37
Quality improvement.....	38
The Health and Disability Commissioner.....	39
The Health and Disability Services (Safety) Act 2001 .....	39
The Health Practitioners Competence Assurance Act 2004.....	40
Discussion .....	40
<b>4. Opportunities for Improving Quality of Care for Pacific Peoples .....</b>	<b>42</b>
Improving Quality (IQ): A systems approach for the New Zealand health and disability sector	42
Cultural competence .....	47
Improving information.....	48
The Improving Quality Action Plan .....	49
Discussion .....	50
<b>5. Conclusion.....</b>	<b>51</b>
<b>6. Options for future work .....</b>	<b>52</b>
<b>References and Bibliography .....</b>	<b>53</b>

## Tables

Table 1: Life expectancy at birth, by ethnicity, sex and year 2000–02 .....	2
Table 2: Size of main Pacific ethnic groups, total counts, 1996 to 2006 .....	8
Table 3: Percentage of each Pacific group born in New Zealand, total counts, 2006.....	10
Table 4: Percentage of Pacific peoples resident in New Zealand speaking their own language, 2006 .....	12
Table 5: Incidence and mortality rates (per 100,000 women) for cervical cancer in New Zealand 2006, by ethnicity.....	23
Table 6: Enrolment in Pacific-specific PHOs (Quarter 1, 2007).....	34
Table 7: Pacific enrolment in three mainstream DHBs (Quarter 1, 2007) .....	34

## Figures

Figure 1: Avoidable mortality for Pacific peoples and total New Zealand population, by sex, 1996–2000 .....	3
Figure 2: Ambulatory-sensitive hospital admissions for people aged 0–74 years, age- standardised rate per 100,000, by ethnicity and sex, 2000/01–2005/06 .....	4
Figure 3: Age distribution of the New Zealand-born and overseas-born New Zealand Pacific population, 2006.....	11
Figure 4: Labour-force participation rates for Pacific and total populations, 1987–2001 .....	14
Figure 5: Occupation for Pacific and total males, 2001 .....	14
Figure 6: Occupation for Pacific and total females, 2001 .....	15
Figure 7: The Fonofale model of health .....	25
Figure 8: Quality dimensions for the New Zealand health and disability system .....	43

# Executive Summary

Although Pacific people are well linked into the primary care system, health indicators for life expectancy, avoidable mortality and ambulatory-sensitive hospitalisations suggest that health and disability services are not fully meeting the health needs of Pacific people. Socioeconomic determinants exert a strong influence on Pacific health status but cannot fully explain different outcomes from health care services. Pacific people were severely impoverished by the economic conditions and reforms of the 1980s and 1990s and the legacy is apparent in ongoing health inequalities at a time when most Pacific people and other New Zealanders are experiencing improved economic and social circumstances.

This paper identifies and considers a range of factors thought to influence Pacific health status including Pacific culture and identity in New Zealand, demography and community and family networks. An explanation is provided of how research findings show that cultural views, language, and history significantly influence the way in which Pacific people perceive, access and continue to use health services in New Zealand. There is a discussion of Pacific peoples' use and expectations of the health system in New Zealand including the significance of same-ethnicity providers and the developing role of Pacific health providers. Pacific health providers have demonstrated capacity to attract and upskill Pacific health workers, as well as developing and implementing innovative responses to Pacific health need.

The efforts and investment of the health and disability sector in seeking to improve quality of care is acknowledged and the key strategies and tools described. The critical importance of needs-based population health approaches and the Primary Health Care Strategy (PHCS) is highlighted. Early evidence about the impact of the PHCS for Pacific people has been positive but the challenge now is to ensure that the needs of Pacific people and other high needs groups receive the profile and priority that will ensure high quality care at all levels and improved health status. Improving cultural competence across the health and disability workforce and at a systems level is identified as having considerable potential for bridging the quality of care gap.

The analysis suggests that the Improving Quality (IQ) systems approach has the potential to provide overall sector leadership and guidance to the diverse elements required for improved quality of care. Real achievement is unlikely unless there is more direction and accountability for effecting improvement in quality of care and progressing health gain.

The conclusion is that the health system is not currently meeting Pacific peoples' health needs and that action is required to improve responsiveness and quality of care. This can be accomplished within existing structures and mechanisms if expectations are set, commitments made and performance targets agreed. Suggestions for improving quality of care include improving health sector collaboration and tools, implementing Pacific cultural competence, collecting and analysing ethnicity data and researching Pacific peoples' perspectives. Health system improvement must be supported by broader intersectoral actions to improve the determinants of Pacific peoples' health.



# 1. Introduction

This paper stands alone, but also forms part of a series of papers prepared for the review of the Pacific Health and Disability Action Plan (PHDAP) 2002. Other papers in the series are:

- *Pacific Child Health* (Ministry of Health 2008a)
- *Pacific Youth Health* (Ministry of Health 2008b)
- *Promoting Healthy Lifestyles and Preventing Chronic Disease Among Pacific Peoples* (Ministry of Health 2008c)
- *Pacific Peoples and Health Services* (Ministry of Health 2008d)
- *Pacific Peoples' Experience of Disability* (Ministry of Health 2008e)
- *Pacific Peoples and Mental Health* (Ministry of Health 2008f).

## Background

The PHDAP highlighted primary care as one of the six priority areas where improvements can be made to health and disability support services for Pacific peoples. This reflected concern about low rates of access by Pacific people to effective primary care and other health services. The PHDAP supported the six key directions of the Primary Health Care Strategy (PHCS) to:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- co-ordinate care across service areas
- continuously improve quality, using good information
- integrate access to public health and primary health care services.

The foundations for the PHCS are now largely in place, with primary health organisations (PHOs), patient registers and new funding arrangements all established. There are also some significant indicators of progress, such as high Pacific PHO enrolment numbers. It may, however, be some time before evidence is available about the extent to which the PHCS has contributed to reduced inequalities and improved health outcomes for Pacific people.

Evidence gathered as part of the PHDAP review suggests that Pacific peoples, when compared with the total New Zealand population, continue to experience poorer health outcomes, and that the role of health and disability services in improving health outcomes is less effective for Pacific peoples compared to other population groups.

## Scope

This paper is concerned with quality of care and the implications for Pacific peoples.

Although this paper focuses mainly on primary health care, the issues it covers are relevant across the health care continuum eg primary, secondary and tertiary health care.

The themes are relevant to all of the PHDAP papers. However this paper has a specific link to the PHDAP paper *Pacific Peoples and Health Services* (Ministry of Health 2008d) and the report *Pacific Cultural Competencies: A literature review* (Tiatia 2008). As will be discussed later, an important part of improving the quality of care for Pacific peoples includes a culturally competent health workforce.

There are three main sections. Following this introduction, section 2 describes Pacific peoples' demographics, socioeconomic determinants, values and approaches to health, and Pacific peoples' use and expectations of the health system. The relationship between Western medical culture and Pacific culture and beliefs is also considered. This section attempts to explain how the difference in quality of health care experienced by Pacific peoples arises.

Section 3 acknowledges the efforts being made to implement sector-wide and system-wide improvements in quality of care. It recognises that the health sector is investing in improving quality of care and that this potentially benefits Pacific peoples, but that the evidence of substantial achievement in terms of Pacific peoples' quality of care is yet to materialise. It describes the PHCS and other initiatives, which are directly and indirectly helping to improve the quality of care for Pacific peoples.

Section 4 considers some specific tools, including the *Improving Quality* (IQ) framework, and the possibilities these offer for effecting improvements in quality of care for Pacific peoples. The paper finishes with a short conclusions section and recommendations.

## Health indicators

Although Pacific people seem to be well linked into the primary care system, as high PHO enrolment rates demonstrate, the health indicators of life expectancy, avoidable and amenable mortality and ambulatory-sensitive hospitalisations suggest that health and disability services are not fully meeting the health needs of Pacific people. It seems that not all Pacific people are receiving the necessary high-quality care that their health needs indicate.

### Life expectancy

Life expectancy at birth refers to the average estimated number of years that people born now can expect to live if current mortality rates persist for the whole of their lives. As shown in Table 1, Pacific people's life expectancy was 4.8 years lower than the New Zealand average for males, and 4.4 years lower than the average for females in 2000–2002.<sup>1</sup>

Table 1: Life expectancy at birth, by ethnicity, sex and years, 2000–02

	Pacific	Māori	Total NZ population
Females	76.7	73.2	81.1
Males	71.5	69.0	76.3

Source: Statistics New Zealand 2002

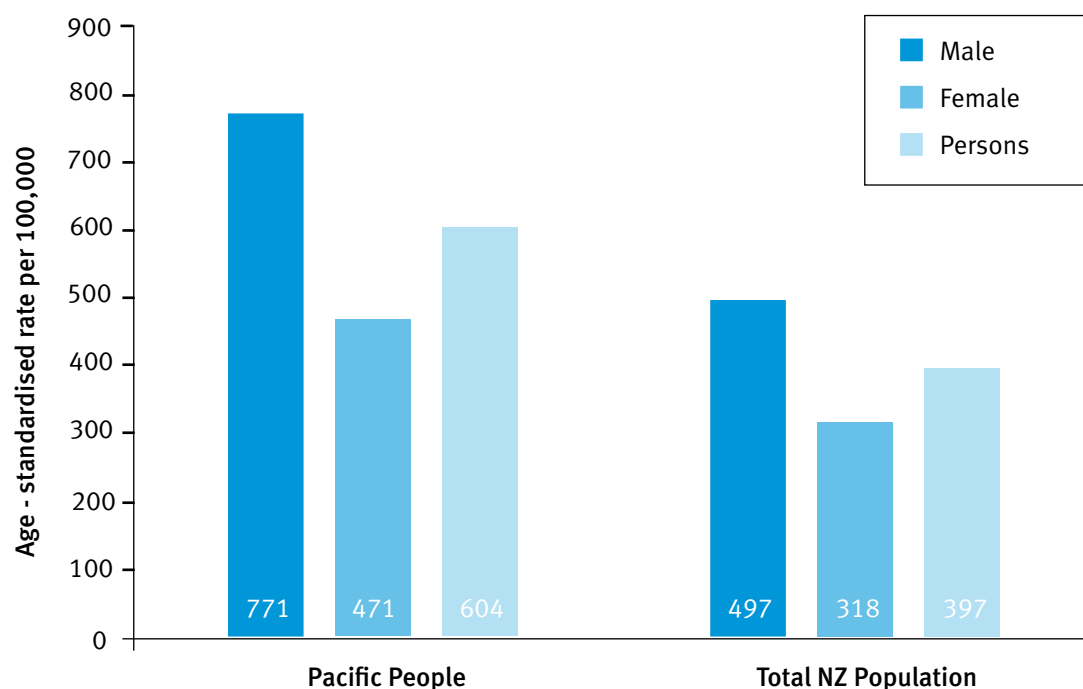
### Avoidable mortality

Pacific peoples' relatively high rate of avoidable mortality is a key contributor to health inequalities. Avoidable mortality is defined as deaths occurring under age 75 years<sup>2</sup> that could theoretically have been avoided, given the current understanding of causation and potentially available prevention and health care technologies (Ministry of Health and Ministry of Pacific Island Affairs 2004). It should be noted that avoidable mortality reflects influences, such as determinants, that are external to the health care system.

1 The next set of life tables for 2005–07 will be produced by Statistics New Zealand in 2008.

2 An age threshold of 75 years is applied because of the high prevalence of co-morbidity at advanced ages (Ministry of Health and Ministry of Pacific Island Affairs 2004).

Figure 1: Avoidable mortality for Pacific peoples and total New Zealand population, age standardised, by sex, 1996–2000



Source: Ministry of Health and Ministry of Pacific Island Affairs 2004

As shown in Figure 1, Pacific males and females have higher rates of avoidable mortality than the ‘all New Zealand’ benchmark – approximately a 50 percent excess risk. Pacific males have avoidable mortality rates about 1.5 times those of their female counterparts.

## Amenable mortality

Amenable mortality is a subset of avoidable mortality and is an indicator of mortality that should not occur given availability (and utilisation) of high quality health care. It is based on the premise that the effectiveness of health care can be evaluated from mortality due to certain conditions which are wholly or substantially avoidable by timely and appropriate medical care interventions.

Recent research findings that amenable causes contributed

- little (if at all) to the relatively small decline in all-cause mortality (1-74 years) over a 23 year observation period for Pacific peoples

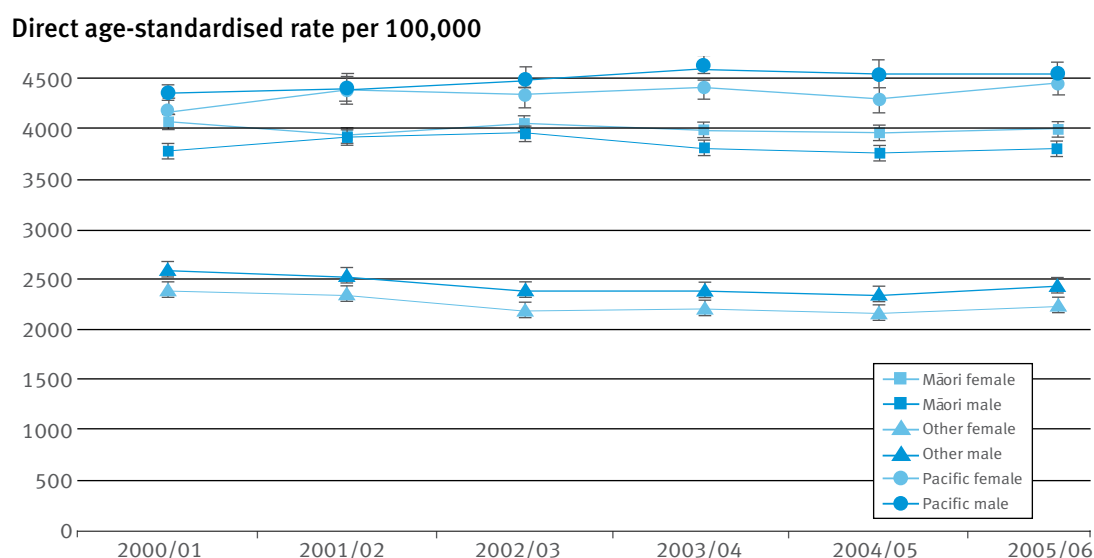
was a marked contrast to the

- one-third of mortality reduction attributed to amenable causes for the total New Zealand population (1-74 years) (Tobias et al 2008 unpublished).

## Ambulatory-sensitive hospitalisations

Ambulatory-sensitive hospitalisation is the hospitalisation of people aged less than 75 years that results from diseases and conditions sensitive to interventions delivered through primary health care (eg, immunisation-preventable conditions), and which could therefore potentially be avoided. This indicator partly reflects effectiveness and access to health care. As seen in Figure 2, between 2000/01 to 2005/06 ambulatory-sensitive hospital admission rates have declined for non-Māori non-Pacific (ie, ‘Other’) people. However, rates for Māori and Pacific people have remained the same or increased slightly during this period. The ambulatory-sensitive hospital admission rate for Pacific people is 1.9 times and for Māori 1.67 times that for Others.

Figure 2: Ambulatory Sensitive Hospital admissions for people 0-74 years, age standardised rate per 100,000, by ethnicity and sex, 2000/01 – 2005/06



Source: Ministry of Health and Minister of Health 2007.

Further details of Pacific peoples' ambulatory-sensitive hospitalisation rates are provided in the papers on child health (Ministry of Health 2008a) and health services (Ministry of Health 2008d).

## Quality of care

### What is quality of care?

There are differing views on what quality health care means. For instance, patients will have a different definition depending on whether they are awaiting elective surgery (where access and timeliness might be the main indicators of quality), or whether they have a chronic disease (where co-ordination of care might be more important) (Seddon 2006).

One of the most-often quoted definitions of health care quality is the American Institute of Medicine definition, which defines quality health care as:

the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Lohr 1990).

Quality may also include the degree to which services increase the participation and independence of people with a disability (Lohr 1990).

## Quality of health care: why it is important for Pacific peoples

Early in the analytical and discussion part of the PHDAP review process, quality of care emerged as a possible explanation for the extent of disparities in health outcomes of Pacific peoples. As evidence gathered from a range of sources was reviewed, it became apparent that Pacific peoples' experience of poor health is not mitigated by health and disability services to the extent expected by comparing Pacific peoples with European and other groups across a range of indicators. Some exceptions, such as the Meningococcal B campaign for Pacific children and youth, were characterised by adopting population-appropriate approaches to service delivery and care.

The implementation of the PHCS and the associated environment of dynamic change in the health sector – which includes District Health Board (DHB) and PHO-led initiatives to improve access and use – lent support to identifying the issues and options for improving quality of care for Pacific peoples. It is important that actions and initiatives with this aim are monitored, profiled and contribute to system improvement.

## 2. Pacific Peoples in New Zealand

### Demography

#### Pacific peoples

‘Pacific peoples’ is a collective term used to describe the diverse cultures of peoples from Polynesia, Melanesia and Micronesia. The term ‘Pacific peoples’, like the term ‘Asian people’, includes groups with a range of ethnic affiliations (Bedford and Didham 2001). In New Zealand the term is usually applied to people of Samoan, Tongan, Cook Islands, Fijian, Niuean, Tokelauan and Tuvaluan descent. However, there are significant populations of migrants in New Zealand from other Pacific nations, including French Polynesia, Kiribati, Papua New Guinea and the Solomon Islands. It should also be remembered that ‘Pacific peoples’ could also include people with more than one ethnicity (Bedford and Didham 2001). In New Zealand, ‘Pacific peoples’ has been used synonymously with ‘Pacific Nations people’, ‘tangata pasifika’, ‘tagata pasefika’, ‘Pasifika peoples’ and ‘Pacific Islanders’ or ‘PIs’ (Teaiwa and Mallon 2005).

Although ‘Pacific peoples’ is the term used by the New Zealand Government to describe people who identify with a Pacific ethnic group, it has been noted that the term disguises diversity and can generate a misleading impression of homogeneity within Pacific communities. When considering or using the term ‘Pacific peoples’, it is therefore important to be mindful of the ethnic and national diversity covered by the term (Bedford and Didham 2001). The rich diversity of Pacific peoples is discussed in more detail throughout this paper.

‘Pasifika is pan-Pacific ... and the reason I say that is that the idea of being a Pacific islander – rather than a Samoan – is one that’s evolved here [in New Zealand] as well. Despite the ructions between different Pacific groups in the early days, most second- or third-generation PIs have more in common with each other than they do with their own ethnic group in the islands. What connects us as PIs are the common experiences of being PI in New Zealand,’ Tapu Misa (in Perrott 2007).

#### Migration and settlement history

New Zealand and Pacific Island relations date back to the 1840s<sup>3</sup> with the activities of the missionaries, trade, and the colonial aspirations of the British Empire (Fairbairn-Dunlop and Makisi 2003). Pacific peoples have been in New Zealand for more than a century. Migration from the Pacific to New Zealand started in a small way in the early 1900s, and by 1945 it had risen to 2159 (Fairbairn Dunlop and Makisi 2003). From the 1950s to the 1970s large-scale migration of Pacific people to New Zealand took place, reflecting the prosperous economic times of this period. In 1999 the population of Pacific peoples in New Zealand had reached 6 percent of the New Zealand total. By 2006 265,974 people identified with the Pacific peoples ethnic group in the census, representing almost seven percent of the total New Zealand population (Statistics New Zealand 2007a).

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3 Some historians have noted Polynesian and New Zealand links earlier than the 1840s.

## Diversity

There is no generic ‘Pacific community’ in New Zealand (Anae et al 2001). Instead, Pacific people in New Zealand occupy different social locations and encompass a range of backgrounds and experiences, depending on whether they are Pacific Island born, New Zealand born, multi-ethnic, disabled, religious, and so on (Macpherson 2001). The diversity within Pacific communities in New Zealand is vast. There are more than 22 different Pacific communities, each with its own distinctive culture, language, history and health status (Finau and Tukuitonga 2000).

Further adding to this diversity, of those Pacific children born between 2002 and 2004, over half (54 percent) had more than one ethnicity and almost a quarter (23 percent) had more than one Pacific ethnicity (Callister and Didham 2007). Seven percent of Māori also identified with Pacific ancestry in the 2006 census (Statistics New Zealand 2007b).

As Tiatia and Foliaki (2005) point out, the term ‘Pacific’ encompasses a diversity which reflects the fact that:

- each Pacific group has its own language, etiquette and protocols
- ethnic-specific identities and accountabilities exist within families and ethnic-specific communities
- there are both similar and different historical and political relationships with New Zealand
- there are multiple world views and diverse perceptions of illness, treatment and prevention
- there are diverse belief systems, including cultural and religious factors, which influence behaviours and attitudes towards wellbeing.

There are also some commonalities across Pacific groups, including:

- belief in Christianity
- mythology
- communal land ownership
- genealogically based identity
- extended family accountability
- beliefs that wellbeing and illness are linked to obligations to extended family being met or not being met (Tiatia and Foliaki 2005).

While acknowledging the similarities and commonalities that Pacific peoples share, it is important to remember the many differences among Pacific groups.

‘One thing you have to understand about the Pacific is they are not one people. But often they plan as though they speak one language. The truth is they see the world differently yes, we have a common heritage ... but we have to address the uniqueness, respect the diversity,’ Olo Elise Puni, on the MeNZBTM campaign for Pacific communities (in Ministry of Health 2006f).

## Pacific ethnic groups

As shown in Table 2, the six largest Pacific groups in New Zealand are Samoan, Cook Island, Tongan, Niuean, Fijian and Tokelauan.

Table 2: Size of main Pacific ethnic groups, total counts, 1996 to 2006

Ethnic Group	1996	2001	2006	2001-06 Change No.	%
Samoan	101,754	115,026	131,103	16,077	13.97
Cook Island	47,019	51,486	58,008	6,522	12.66
Tongan	31,392	40,716	50,481	9,765	23.98
Niuean	18,477	20,154	22,476	2,322	11.52
Fijian	7,695	7,041	9,861	2,820	40.05
Tokelauan	4,917	6,198	6,822	624	10.06

Source: Statistics New Zealand 2007

One crucial point of difference between these Pacific groups are the histories and constitutional relationships between them and New Zealand (Teaiwa and Mallon 2005). Unless otherwise indicated, the following discussion is based on Ministry of Foreign Affairs and Trade (2007).

In 1965, following an act of self-determination under United Nations auspices, the people of the Cook Islands adopted a constitution for full self-government in free association with New Zealand. Free association is a status distinct from full independence in that it allows the Cook Island people to maintain New Zealand citizenship. Similarly, Niue became self-governing in free association with New Zealand under the Niue Constitution Act in 1974.

Tokelau has been a non-self-governing territory of New Zealand since 1926. In February 2006 and November 2007 Tokelau held referendums on whether to move to self-government in free association with New Zealand. In both referendums, the required two-thirds majority support for a change was not reached. The citizens of the Cook Islands, Niue and Tokelau hold New Zealand citizenship, travel on New Zealand passports and have automatic right of entry into New Zealand. An important consequence of this is that people of Cook Island, Niuean and Tokelauan descent (as New Zealand citizens) are entitled to the same health care as other New Zealanders if they are resident in New Zealand.

Samoa was a German colony until New Zealand assumed control following the outbreak of the First World War. Samoa then became a territory of New Zealand under a League of Nations mandate. After the Second World War Samoa was administered by New Zealand as a United Nations trust territory, and measures were gradually introduced to prepare for self-government. In 1962 Samoa became the first Pacific Island country to gain independence.

New Zealand and Samoa share a bilateral relationship, of which an important element is the 1962 Treaty of Friendship, concluded shortly after Samoa achieved independence. In this treaty New Zealand agreed to 'consider sympathetically' requests from Samoa for 'technical, administrative and other assistance', and both governments agreed to consult as appropriate on 'matters of mutual interest and concern'.

The independent nation of Tonga is a constitutional monarchy. Remittances to the Kingdom from the Tongan community in New Zealand are an important source of foreign exchange and income.

Tongans and Fijians are the largest populations of Pacific people not to share a formal colonial history with New Zealand (Teaiwa and Mallon 2005). Tongans (like Samoans) can enter New Zealand through a range of provisions, including quota schemes.

## Ethnic intermarriage

Intermarriage is increasing for Pacific men and women in New Zealand (Callister and Didham 2007). A number of interconnected factors influence the marriage choices of Pacific people in New Zealand, including levels of education (with better-educated people more likely to marry outside their group, but more likely to marry within their educational group), attitudes, time in a country, level of residential segregation, relative sizes of ethnic groups, and whether there is an imbalance between the number of men and women in the main couple-forming age groups (Callister and Didham 2007).

## Culture and identity

Culture can be defined as a way in which ‘human groups create and share explanatory systems about the world in which they live and the ways in which they act according to their shared understandings’ (MacDonald 1999). Teaiwa and Mallon (2005) note that Pacific peoples in New Zealand inhabit a social and cultural place in between the tangata whenua and Pākehā and other migrant groups, and that Pacific people have negotiated a complex and shifting set of relationships with these other groups.

The following quotes illustrate this idea. The quotes also show that having a multiplicity of identities may be becoming more common for many Pacific people, as many Pacific people now identify with more than one ethnicity and ‘culture’, and the majority of Pacific people are now New Zealand-born:

‘I get asked the question myself and say I’m Samoan-Chinese and English. Then I get the ‘Well, where were you born?’ question. I say here [New Zealand] and they say, then, you’re a Kiwi ... But I think it’s quite funny because wherever I go in the world, where my passport says I was born and who I am will always be different things,’ Fereti Strickland-Pua (in Perrott 2007).

‘Life in Aotearoa has provided many opportunities to challenge and change my thinking and perceptions of education, children, Pacific peoples and my Tongan values,’ Ana Koloto (in Koloto 2003).

‘I am the sum of all my diverse experiences,’ Pefi Kingi (in Kingi 2003).

‘Being in two minds has become the dilemma for a growing number of Pacific youth: neither the traditional customs, nor the contemporary New Zealand context offer adequate expressions in themselves – their experience lies in the tension between these two points,’ Tagaloa Peggy Fairbairn-Dunlop (in Fairbairn-Dunlop and Makisi 2003).

‘What do I call myself? When it comes to this question, I just thank God for the little box called ‘other’ on the census forms. I either put Melanesian/English or Melanesian/English/Kiwi. I put Melanesian for my mum who is a Solomon Islander, English for my Dad, and Kiwi for me, because I was born here in New Zealand and lived in Christchurch for most of my life,’ Mali-Ann Jane Cole (in Cole 2003).

What it means to be a Pacific person in New Zealand today can be different and often more complex than just biological make-up or place of birth. Culture is dynamic (Blakely and Dew 2004), and for the New Zealand-born Pacific population in particular, cultural identities are constantly being examined, deconstructed and redefined (Counties Manukau DHB 2006).

## New Zealand-born

Since the early 1980s it has become increasingly more common for Pacific peoples to be divided into two groups: those born overseas (mainly in the Pacific Islands) and those born in New Zealand (Bedford and Lloyd 1982; Bedford 1985). The term 'New Zealand-born Pacific peoples' recognises local (New Zealand) upbringing but also Pacific descent (Macpherson 2001).

The proportion of the New Zealand-born Pacific population has been steadily increasing. In 1976 38 percent were born in New Zealand, but by 1991 this had reached 50 percent. The 2006 census found that 60 percent of Pacific people were born in New Zealand. Table 3 shows that the proportion of New Zealand-born varies between ethnic groups.

Table 3: Percentage of each Pacific group born in New Zealand, total counts, 2006

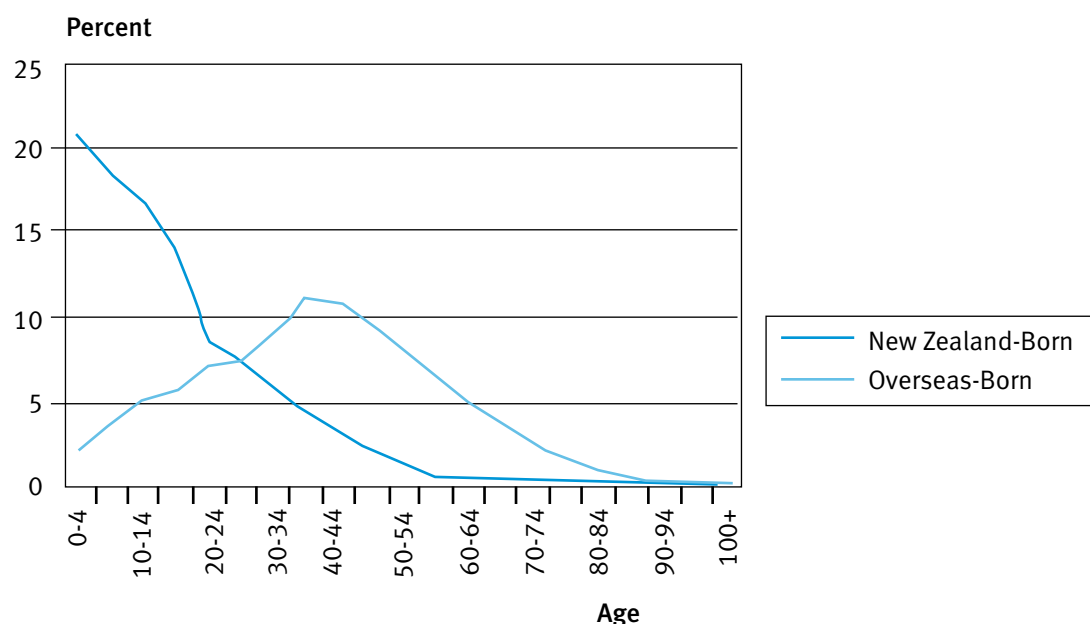
Ethnic Group	New Zealand-born %
Niuean	74.1
Cook Island Maori	73.4
Tokelauan	68.9
Samoaan	59.7
Tongan	56.0
Fijian	43.6
Tuvaluan	37.0
<b>Total</b>	<b>60.0</b>

Source: Statistics New Zealand 2007c

Niueans, Cook Island Maori and Tokelauans had the highest proportions of people born in New Zealand. This may be in part a reflection of the special status of the citizens of these nations, who hold New Zealand citizenship and have unrestricted right of entry to and settlement in New Zealand. The Fijian ethnic group and Tuvaluan ethnic groups had the lowest proportion of people born in New Zealand at 43.6 percent and 37 percent respectively.

Figure 3 shows the marked differences in age structures between those Pacific people born in New Zealand and those born outside New Zealand. Of Pacific people aged under 20 years, just under 70 percent are New Zealand-born and only 17 percent were born overseas. However, it is worth noting that these are not separate populations: in many households there will be parents or grandparents who were born overseas and children or grandchildren born in New Zealand (Callister and Didham 2007).

Figure 3: Age distribution of the New Zealand-born and overseas-born New Zealand Pacific population, 2006



Source: Statistics New Zealand 2007

It has been noted that New Zealand-born generations have grown up in very different social and economic circumstances from Pacific Island-born people. These circumstances have allowed and indeed encouraged New Zealand-born Pacific people to question the cultures and identities that served their parents' and grandparents' generations (Macpherson 2001).

'... New Zealand-born Pacific people ... their attitude, expectation and culture are different,' Dr Leopino Foliaki (in Ministry of Health 2003b).

'... our parents wouldn't understand, it's a different life here in New Zealand than in Samoa, our needs are different for New Zealand-born,' Youth participant in Waitemata District Health Board Pacific Youth Health Project (in Leger 2005).

## Acculturation

Acculturation can be defined as the changes that take place as a result of continuous first-hand contact between individuals of different cultures. It usually refers to the experiences of adults. The majority (60 percent) of Pacific people are born in New Zealand. This means that the majority of Pacific people will have been more exposed to New Zealand systems and ways (ie, will have been more acculturated by the time they are adults).

One important indicator of acculturation is language competence. According to the 2006 census, Pacific language retention varies among Pacific ethnic groups. As seen in Table 4, Samoans, Tongans and Tuvaluans have the highest proportions of people able to speak their own Pacific languages. Cook Island Maori had the lowest, with 16 percent able to speak Cook Islands Maori, while about a quarter of Niueans and Fijians are able to speak their own languages (Statistics New Zealand 2007a). As would be expected, Pacific people born overseas have higher rates of being able to speak their language compared with those born in New Zealand.

Table 4: Percentage of Pacific people resident in New Zealand speaking their own language, 2006

	Tuvaluans speaking Tuvaluan	Samoans speaking Samoan	Tongans speaking Tongan	Tokelauans speaking Tokelauan	Fijians speaking Fijian	Niueans speaking Niuean	Cook Islanders speaking Cook Islands
NZ born	55	44	44	24	6	11	5
Overseas born	78	90	82	73	45	63	48
Total population	71	63	61	40	29	25	16

Source: Statistics New Zealand 2007c

For Pacific people born in the Pacific Islands who have migrated to New Zealand at different times, some level of acculturation is inevitable. To some extent community settings such as Pacific churches have acted as preservers of culture, traditions and language in New Zealand and have played a role in providing information and services and generally mediating between the community and wider society (Ministry of Health and Ministry of Pacific Island Affairs 2004).

‘A major dilemma New Zealand-born Pacific Islanders face is the playing out of their dual role. This role demands an appropriate display of certain behaviour and conduct, and the internalisation of what is ‘validated’ knowledge, and an understanding of the values of both the Pacific Island and European cultures ... The challenge for us New Zealand-born Pacific peoples is to theorise our own experiences as we understand them...’ Dr Jemaima Tiatia (in Tiatia 1998).

‘It’s somehow assumed that we New Zealand-born have become part of the mainstream.’ Dr Melanie Anae (in Perrott 2007).

## Metropolitan population

Pacific peoples are highly urbanised. In 2006 over 93.4 percent of Pacific people lived in the North Island, with two-thirds (66.9 percent) in the Auckland region. The Auckland region also had the highest proportion of usual residents born in the Pacific Islands (8.1 percent), and of the cities and districts, Manukau City had the highest proportion of usual residents born in the Pacific Islands (16.0 percent) (Statistics New Zealand 2007c).

## Youthful population

The Pacific population is significantly younger than the total population. In 2006 the Pacific median age was 21 years, compared with that for all New Zealand of 36 years. Pacific peoples have the highest proportion of children (0 to 14 years) at 37.7 percent of all the major ethnic groups (Statistics New Zealand 2007c)

## Population projections

The current Pacific population of 6.9 percent is expected to grow to around 373,000 people, or 8.3 percent of the population, by 2021, and to around 599,000 people, or 12.1 percent of the New Zealand population, by 2051 (Statistics New Zealand 2002).

Although the current Pacific population is young, the number of older Pacific people (aged 65 years and older) is projected to increase rapidly over the next two decades. Older Pacific people accounted for 3 percent of the total Pacific peoples population in 2001, but this proportion will increase to 4 percent by 2011 and to 8 percent by 2031. They have a similar age structure to that of older Māori, with 71 percent aged 65–74, 25 percent aged 75–84 and 4 percent aged 85 plus. The vast majority of older Pacific people migrated to New Zealand; at the 2006 Census less than 1 percent were New Zealand-born (see Figure 3).

## Community

Many Pacific people draw their sense of health and wellbeing from the quality of their relationships within their collective contexts, including extended family and community networks such as church (Counties Manukau DHB 2006). The church is an integral part of most of New Zealand's Pacific communities (Jansen and Sorenson 2002), directly impacting on wellbeing and that of families (National Health Committee 2007). According to the 2006 census, just over 8 in 10 Pacific people (199,983 people) who answered the religious affiliation question identified with Christian religions.

As already noted, the church provides a social institution for ethnic minorities such as Pacific peoples to maintain and retain their language, cultural beliefs and practices. With large populations of Pacific people belonging to churches, the churches have increasingly been identified as enablers for empowering communities to improve their health.

Some have noted that there has been a declining rate of Pacific Island church attendance and membership by New Zealand-born youth. This has been attributed in part to conflicting cultural values of Pacific Island-born and New Zealand-born Pacific people (Tiatia 1998).

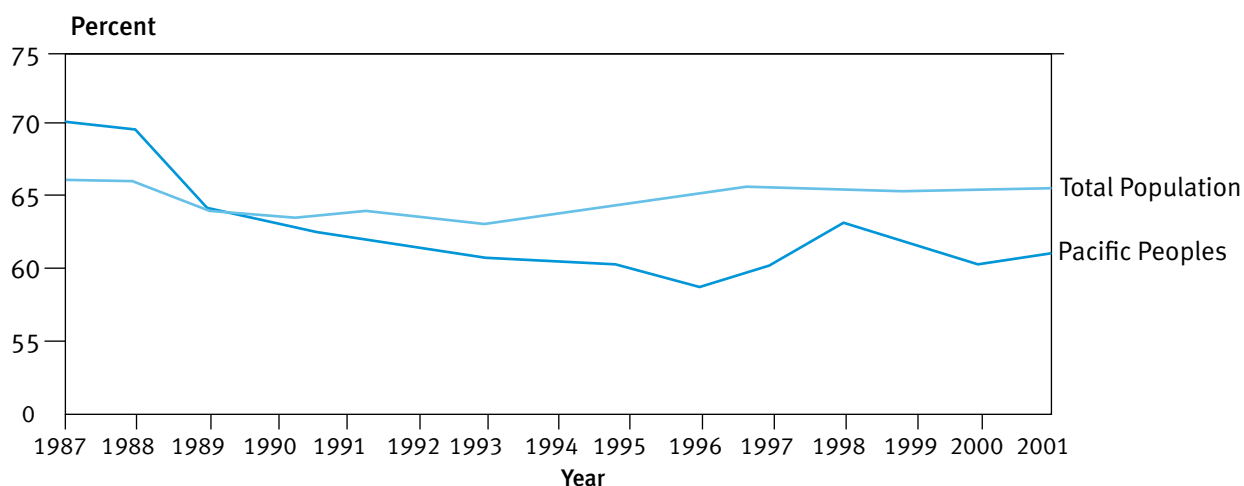
## Socioeconomic determinants

### Economic history

During the large-scale migration of Pacific peoples to New Zealand from the 1950s to the 1970s Pacific people enjoyed average incomes, high employment and high participation rates in the labour market. Economic changes arising from the oil-related recessions in the 1970s and subsequent economic reforms in the 1980s had a significant impact on Pacific people with high rates of unemployment experience, and Benefit reform in the early 1990s further contributed to the low socioeconomic circumstances of many Pacific people. The legacy of these social and economic impacts on Pacific people persists today (Counties Manukau DHB 2006).

Figure 4 shows the labour-force participation rates of Pacific peoples in comparison to the total population from 1987 to 2001. It helps to illustrate how labour-force participation changed in response to changing economic circumstances.

Figure 4: Labour-force participation rates for Pacific and total populations, 1987–2001



Source: Statistics New Zealand 2002

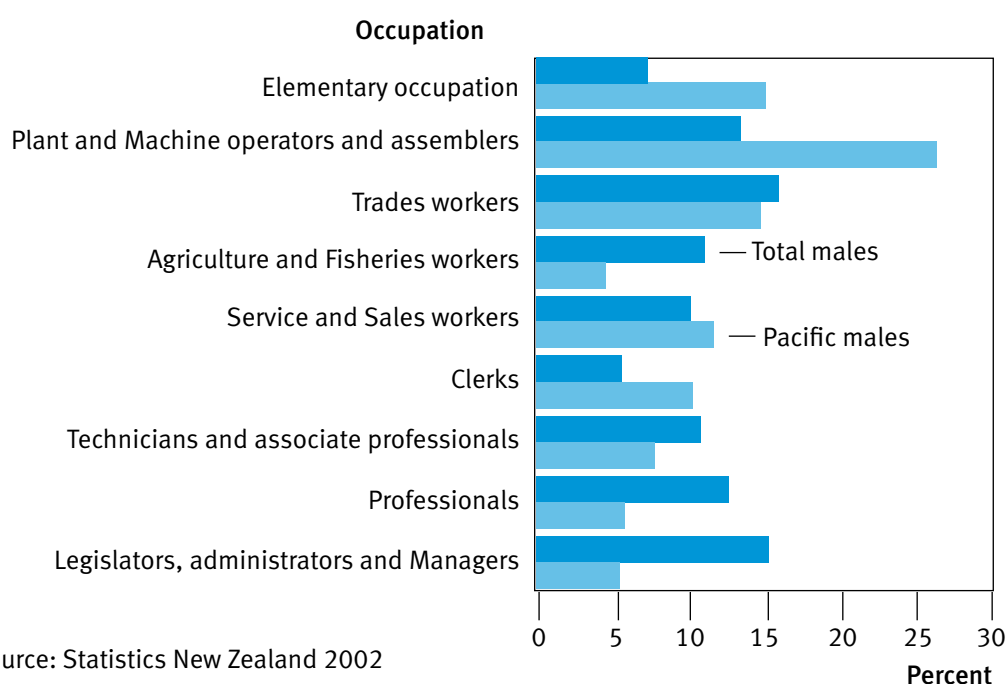
## Employment

In recent years Pacific peoples have benefited from improving labour market conditions. The labour force participation rate was 65 percent for Pacific peoples compared to the total New Zealand rate of 69 percent in 2006. Fifty-eight percent of Pacific peoples were employed compared to 65 percent of the total New Zealand population (Statistics New Zealand 2007).

## Occupations

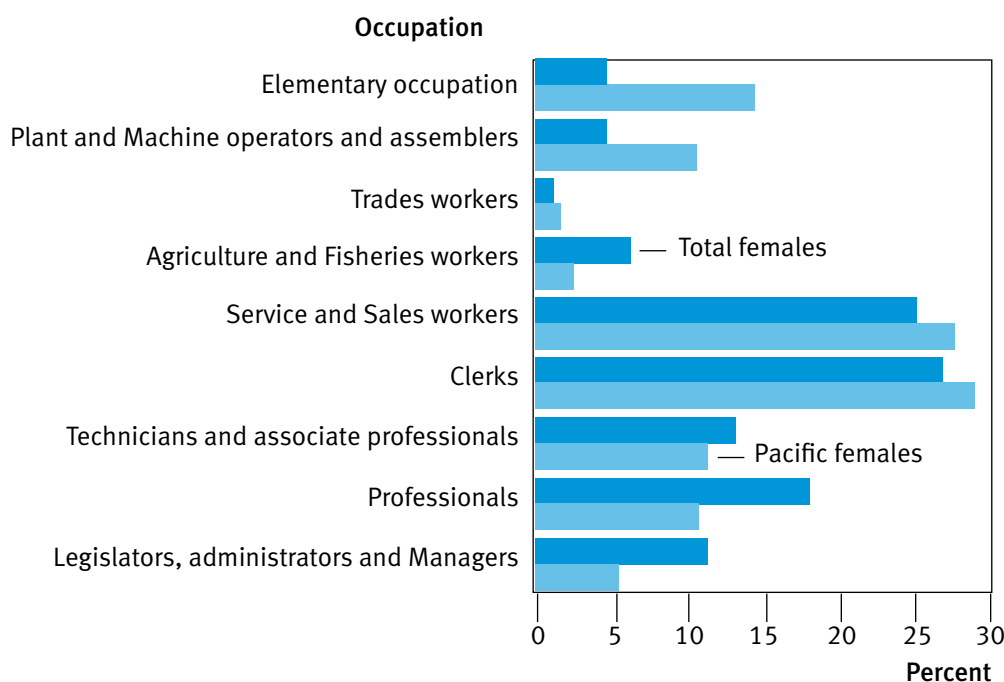
As shown in Figures 5 and 6, the Pacific workforce is predominantly located in lower-skilled and lower-status occupations. Pacific people are less likely to be in skilled white-collar occupations than is the case nationally (Statistics New Zealand 2002). This is changing, however, as younger Pacific people acquire more qualifications and skills.

Figure 5: Occupation for Pacific and total males, 2001



Source: Statistics New Zealand 2002

Figure 6: Occupation for Pacific and total females, 2001



Source: Statistics New Zealand 2002

## Income

Pacific people are more likely than those in the total population to be in the lower income bands and less likely to be in the higher income bands (Statistics New Zealand 2002). In 2006 median income for Pacific people was lower than for the total New Zealand population, at \$20,500 versus \$24,500 respectively (Statistics New Zealand 2007c). A higher proportion of Pacific people than the total New Zealand population received some kind of income support (28 percent versus 18 percent, respectively) (Statistics New Zealand 2007c).

## Education

Pacific people are participating in education and gaining qualifications at higher rates than before, but attainment lags behind that of European New Zealanders. The majority of Pacific students attend low-decile schools that are associated with lower rates of attainment. For more information see the papers on child health (Ministry of Health 2008a) and youth health (Ministry of Health 2008b).

## Neighbourhood deprivation

Low socioeconomic status and high deprivation are linked to negative health outcomes. For example, people from more deprived areas experience lower life expectancies than people from less deprived areas. The 2001 Census showed that almost 60 percent of Pacific people lived in the most deprived areas in New Zealand.

The other papers in this series also include some discussion on the influence of deprivation and other socioeconomic determinants on Pacific people's health.

## Inverse care law

First introduced in 1971 by United Kingdom Professor Julian Tudor Hart, the inverse care law is the concept that the availability of good medical care tends to vary inversely with the need of the population served. In areas with the worst health, GPs have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation than in the healthiest areas; and hospital doctors shoulder heavier case loads with fewer staff, less equipment and more obsolete buildings, and suffer recurrent crises in the availability of staff (Hart 1971). Although Hart proposed this idea to describe the situation in Great Britain, the inverse care law is widely recognised as applying to other parts of the world as well. In New Zealand it has been applied to Māori and Pacific peoples (Finau and Finau 2006).

‘In New Zealand, as elsewhere, inequalities in health exist between ethnic groups and social classes. The inequalities are not random: in all countries, socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards and less access to high-quality health services than their more privileged counterparts,’ Minister of Health.<sup>4</sup>

## Housing and family structure

Koloto’s report on Pacific housing (2007) found that Pacific households are larger than average and many include extended family members. The pressure for household space is compounded by cultural traditions of hospitality, regular family meetings and rituals, and the expectation to provide accommodation for extended family and new arrivals.

Pacific people largely live in industrialised urban areas (such as Auckland and Wellington), which have become higher-cost housing areas. In 2006 people identifying with Pacific ethnic groups were least likely to own the dwelling they lived in, at 21.8 percent, compared with the other major ethnic groups (Koloto 2007). This is partly due to the younger age structure of Pacific ethnic groups.

In 2006 just over 35,000 (67 percent) of Pacific households were renting, of which 43 percent had private sector landlords and 37 percent rented through Housing New Zealand. Also in 2006, the proportion of renting Pacific households paying less than \$125 per week was much higher than for non-Pacific households, reflecting the proportion on income-related rents.

It is important to understand Pacific people as members of an extended family and community (eg, church), because the extended group is often involved in decisions on health care plans and management, and assists in the care-giving (Counties Manukau DHB 2001). The 2001 census showed that Pacific people were much more likely than the total New Zealand population to be living as part of an extended family, with 29 percent in this situation compared with 8 percent of the national population. Aged care (caring for the elderly) is an important part of the role of the extended family among Pacific people (Statistics New Zealand 2002).

## Social connectedness

Social connectedness refers to the relationships people have with others (Ministry of Social Development 2007).

The 2007 Social Report (Ministry of Social Development 2007) showed that people living in Pacific economic families (defined as those with any Pacific member) had the lowest level of internet access in the home (39 percent) compared with European, Māori and other ethnic groups in 2004.

<sup>4</sup> Hon Pete Hodgson’s speech at the launch of *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981–2004* (Blakely et al 2007).

However, Pacific economic families had strong growth in access between 2000 (when only 11 percent had internet access) and 2004.

Telephone access rates in 2004 for Pacific economic families were 89 percent compared with Māori economic families (84 percent) and highest in European economic families (97 percent).

According to the 2004 New Zealand Living Standards Survey, Pacific families had average levels (70 percent) of having friends or family over for a meal at least once a month. This is compared with Māori (73 percent), European families (66 percent) and Other economic families (78 percent).

Almost a quarter of Pacific peoples (23 percent) reported they were sometimes, most of the time or always lonely. This was compared with Europeans (16 percent), Māori (18 percent), Other (excluding Asian) (22 percent) and Asian people (27 percent) who reported the highest rates of loneliness.

The loneliness findings for Pacific people is quite surprising given the high priority Pacific people place on social institutions such as churches and extended family. However the findings may reflect complex and changing social situations for Pacific people in contemporary New Zealand.

For an increasing number of Pacific adults and youth, social connectedness is being achieved more commonly through mobile phone use and social networking websites such as BEBO and Face Book.

## Pacific views, beliefs and approaches to health

While acknowledging the diversity of Pacific peoples, research studies confirm that cultural views, language and history significantly influence the way in which Pacific people perceive, access and continue to use health services in New Zealand (Foliaki 2002), and can also influence the outcomes of interventions for Pacific people (Barwick 2000). Therefore, understanding Pacific people's personal perceptions and cultural beliefs about their health is crucial to understanding individuals', families' and communities' use of health services and expectations of quality of care.

This paper does not attempt to present a comprehensive set of Pacific cultural beliefs. Instead, it attempts to highlight some of the Pacific beliefs and views that have been noted in the available literature as having an influence on Pacific health issues, and which may contribute to the rationale (evidence base) for improving quality of care for Pacific people.

## Traditional beliefs, values and practices

### Beliefs and perceptions about health

In general, Pacific culture and beliefs about health and illness are different from those of the mainstream New Zealand culture (Tukuitonga 1999).

There are two well-documented health fundamentals that Pacific people share: a holistic notion of health (Bathgate 1994) and health as a family concern rather than an individual matter (Laing and Mitaera 1994; Tukuitonga 1990).

Furthermore, understanding Pacific people both as New Zealand-born and as migrant people is important because of the contact and interaction between the two groups, with each contributing to the life and health of the other (Finau and Tukuitonga 2000). As already noted in this paper, views may vary widely between these two broad Pacific groups.

‘Living life to the full is about physical as well as spiritual health – body, mind and spirit. We can’t just concentrate on the spirit when the spirit lives within a body. We must care for the whole person,’ Reverend Setaita Veikune (in Ministry of Health 2007a).

Within Pacific communities themselves there are diverse perceptions of health and illness and how they come about (Pande et al 2003). Some Pacific people may link illness to beliefs about God and punishment, while some perceptions are linked to beliefs about a much wider range of misfortunes (including accidents, interpersonal conflicts, natural disasters and supernatural insult), of which ill health may be a manifestation (Huakau and Bray 2000). Although crediting Pacific illness to supernatural phenomena is seen by some as an ancient belief and the number of illnesses attributed to this has reduced significantly (Whistler 1992; Macpherson and Macpherson 1990) it is still regarded as a valid cause by some Pacific people (Ng Shiu 2006).

Some studies have noted that certain cultural worldviews are not always conducive to healthy behaviours. For example, in the Pacific Islands purchasing imported food goods (which may have less nutritional value) has become a sign of social status in some communities, and traditional foods have decreased in importance (Clarke 2006). More recently, some examples of unsafe practice in relation to traditional tattooing and kava use have been highlighted in the New Zealand media.

Overweight and obesity were uncommon in traditional Pacific communities and up until the 1960s were rarely noted. However, it has also been acknowledged that some Pacific peoples have a different model of beauty and body size to Europeans. For example, the Tongan men in a study of body size perceptions and preferences in Tonga consistently chose the larger body sizes for both males and females as being more attractive. The ‘attractive’ body size for men was approximately BMI 30 kg/m<sup>2</sup>, the World Health Organization cut-off signalling obese weight (Coyne 2000).

On the whole, Pacific perceptions of body size and beauty are changing, but the preference for larger body sizes still has continuing relevance for health professionals, as do other views relating to Pacific peoples’ health and wellbeing.

A study of Tongans and Europeans with diabetes in New Zealand found that there are different perceptions of diabetes, and that the perceptions that characterise Tongan patients tend to be associated with lower adherence to dietary and medication recommendations. Tongan patients believed their diabetes to be a more cyclical, acute illness, whereas European patients tended to view their illness as chronic (Barnes et al 2004). Tongan patients were also more likely to attribute their illness to external factors, including beliefs that poor medical care in the past, environmental pollution or God’s will caused their diabetes. They were more emotionally distressed by their diabetes and had less confidence in the ability of their treatment to control their illness. Finally, Tongan patients saw less necessity for diabetes medication than European patients did (Barnes et al 2004).

Of particular significance was the finding that one-third (33 percent) of the Tongan patients had exceptionally poor control over their diabetes compared with only 6 percent of European patients. Tongan patients were also more likely to be hospitalised for their diabetes, to adhere less to dietary and medication regimens, and to be unemployed because of their condition. The findings of this study highlight the importance of effective clinical interventions for these patients. Another study looking at Pacific peoples’ use of primary health care services found that many of the Samoan people in the study divided illness into Samoan illness and Palagi (European) illness. If sick with a ‘Samoan illness’, Samoan patients would visit a traditional healer, but if sick with a ‘Palagi illness’ they would go to a Western-trained doctor (Pacific Health Research Centre 2003). Another finding, that Samoan illness could also be attributed to stress, points to a holistic view

of health, including mental health. Furthermore, the understanding of health was largely related to family, both living and dead. The same study reported that for Cook Islanders the predominant perception of health was that it was an individual responsibility.

In the Pacific Health Research (2003) study most of the Niuean people defined good health in terms of looking after themselves by eating a healthy balanced diet and having plenty of exercise. All four ethnic groups (Samoan, Tongan, Cook Islands and Niuean) in the study used traditional healing, particularly the older and/or Pacific-born participants (Pacific Health Research Centre 2003).

Cultural beliefs may also partially explain (for example) some Pacific people's dislike of drugs and therefore why they may fail to complete a course of prescribed medication (Ministry of Health and Ministry of Pacific Islands Affairs 2004), or why some Pacific people choose to migrate back to the islands to die (Tukuitonga 1999).

Some cultural beliefs about disability and mental disorders are outlined in the papers on Pacific peoples and disability and Pacific peoples' mental health.

Another important consideration is how Pacific people in New Zealand perceive their own health. In the New Zealand Health Survey 2002/03, Pacific people rated their health as better than Māori, the same or higher than the European /Other group but lower than Asian people.

## Pacific Islands-based approaches to primary health care

Pacific people may be accustomed to particular models of health care in the Pacific Islands, which may influence their attitudes, behaviour and use of primary health care in New Zealand. Some of these attitudes and behaviours may be passed on (albeit somewhat modified) to successive generations. An example of this is the differing views on traditional healing and medicine held by Pacific people born in New Zealand and those born in the Pacific Islands.

The youth participants in the Waitemata DHB Pacific Youth Health Project (see Leger 2005) accepted traditional healing and medicine because it is what their families had traditionally used in the Pacific Islands. They believed traditional medicine was used in New Zealand because their parents believe in its effectiveness. The majority of participants did not see the primary use of traditional medicine as being effective as a complete management of health problems, but felt that it has a place when used in conjunction with Western medicine (Leger 2005).

'I think that traditional medicine can make it worse, like for broken bones.'

'If parents use it then we have to but I don't know if it can really help.'

'The massage is really good and does help.'

'Using both kinds of medicines works better.'

Participants in Waitemata District Health Board Pacific Youth Health Project (in Leger 2005).

For many years the health services of most Pacific nations had only two tiers: peripheral village-based health providers and central health boards (Newell 1983). Furthermore, the health providers of the Pacific Islands have largely focused on diseases. This has been reflected in the disproportionate allocation of at least 80 percent of the national health resources to personal disease services (Pande et al 2003). There is now an acknowledgement in the Pacific that these kinds of systems have not been the most effective, and there have been moves towards a greater

focus on primary health care services (Pande et al 2003). However, even where primary health care services exist in Pacific Island countries, bypassing them to access hospitals and doctors directly is an undesirable but common feature of modern Pacific health service usage (Finau et al 2001).

In the Pacific Islands, the approaches to health care appear to be a combination of traditional methods first, and then later seeking Western services at a 'central' health facility, where people may have to wait for some time to be seen (Finau and Tukuitonga 2000). The likely consequence of this pattern is that diseases will be more advanced by the time patients present for treatment, and that significant pressures will be placed on central outpatient departments, not just due to the numbers of late presentations but also to the severity of presenting illnesses.

For some Pacific people the hospital is also the traditional focus of health care in New Zealand (Ministry of Health and Ministry of Pacific Islands Affairs 2004), while for others traditional healers may be the first point of health care contact (Finau and Tukuitonga 2000). Understanding Pacific people's preferences in health care models can help to explain certain patterns. For example, it has been noted that Pacific people in New Zealand have high rates of use of emergency departments of hospitals for conditions that would be better treated in a primary health care setting (Ministry of Health and Ministry of Pacific Island Affairs 2004).

'For Pacific people, the hospital is traditionally the focus for health care, yet that's only 20 percent of where the health care actually happens. Most of our patients need a lot of extra work – they will wait until they have many problems. They have to be encouraged to participate more in their care, to be less passive, less reactive. They will bring extra people with them to the consultation (which means bigger surgeries and waiting rooms), they find it hard to meet transport and medication costs. There will be wider health issues – housing, education,' Dr Siro Fuatai, TaPasefika PHO (in Ministry of Health and Ministry of Pacific Island Affairs 2004).

## Traditional medicine

Traditional medicine and healing is defined as a health system that evolves from within the community to address personal ailments and community problems within its socio-cultural world view and experiences (Finau et al 2004). The use of traditional medicine is widespread throughout the Pacific region.

In New Zealand, traditional medicine remains important for many Pacific people. Although the New Zealand Health Survey 2002/03 reported that only around 3 percent of Pacific adults reported used a traditional Pacific healer in 2002/03, some have argued that this figure is an underestimate (Ng Shiu 2006). Other studies (including Finau et al 2004; Van der Oest et al 2005; Tukuitonga 1990) have noted that large proportions of Pacific people use traditional medicine in New Zealand. Most Pacific health professionals are aware that Pacific people use traditional remedies in New Zealand, and traditional healers or remedies are sometimes brought from the Pacific Islands to New Zealand for this purpose (Tukuitonga 1999).

Pacific people use traditional healers for a number of reasons, most of which are linked to cultural beliefs about illnesses. Traditional medicine and healing may appeal to Pacific people because of the focus on physical healing (for instance, with traditional masseurs), the inclusion of spiritual elements of healing, and/or the use of natural and herbal remedies. Traditional healing also fits in with the holistic view of health that Pacific people hold, whereby physical and spiritual health is linked. Finau et al (2004) argues further that even in areas with free GP services, Pacific people may still choose to pay for traditional healing because of long waiting times at the GPs, language barriers, perceived complicated treatments, and the view that there is more to illness than the New Zealand system deals with.

It is important to note that there are different worldviews about traditional healing between Pacific groups. There is also a perception that there are ethnic-specific illnesses that can be treated only by healers from that ethnicity; for instance, Tongan healers to treat Tongan illnesses (Pacific Health Research Centre 2003).

As noted earlier, Pacific Island-born and New Zealand-born Pacific people have different views and usage of traditional healing. It is generally acknowledged that older Pacific people or those born in the Pacific Islands are more likely to be familiar with concepts of traditional medicine and to seek out traditional healing when ill. In contrast, New Zealand-born Pacific people are more familiar with Western medicine and so are sometimes wary and distrustful of traditional medicine (Pacific Health Research Centre 2003). Many of those New Zealand-born Pacific people who use traditional healing would do so because of the influence of older and/or Pacific Island-born relatives.

## Changing dynamics

As discussed earlier in this paper, a number of important social and demographic changes are taking place within Pacific communities in New Zealand (Callister and Didham 2007). Understanding these factors and having awareness of them is important for understanding Pacific patterns of service use.

## Complementary health services

In the 2002/03 New Zealand Health Survey 12 percent of Pacific people, compared with 24 percent of the general population, reported that they had visited a complementary health worker (eg, massage therapist, chiropractor, homoeopath, naturopath or osteopath).

Pacific people in New Zealand use traditional Chinese remedies and medicines, although the extent of usage is unknown (Pacific Health Research Centre 2003). Finau et al (2004) have suggested that the existence of Chinese and other health shops in New Zealand (and particularly in areas with large Pacific populations such as Otara and Mangere in Auckland) is an indication of the importance of traditional healers to Pacific peoples in New Zealand.

Despite many of the medicines and services in Chinese clinics being more expensive than mainstream GP services (Finau et al 2004; Tukuitonga 1999) and the effectiveness of these services on the health of Pacific peoples being largely unknown (Finau et al 2004), some Pacific people continue to use them. It may be the length of time spent on consultations, the focus on physical examinations and the use of herbal or natural remedies at Chinese clinics that appeal to Pacific people (Pacific Health Research Centre 2003). As we have seen, some Pacific people may prefer to use traditional healing or complementary healing (such as Chinese medicine) as a preferred option of health care, and may present to a Western health service only if perceived health outcomes have not improved.

‘They actually do physical stuff on you, they actually wrench your whole arm up and they really examine you.’

‘The paradigm of Tongan medicine is the same as of the Chinese. Tongan people find Chinese medicine more compatible with Tongan medicine.’

Participants in the Pacific Island Primary Health Care Utilisation Study (in Pacific Health Research Centre 2003).

## Development of church, community and family in New Zealand

In New Zealand the Pacific church setting has replaced the village setting of the islands, and Pacific churches act as the social centres of many Pacific communities. As already noted, Pacific churches in New Zealand fulfil a wider function beyond meeting the spiritual needs of Pacific people, and are also important as places where Pacific languages and elements of traditional culture are maintained and practised.

Although the 2006 census showed that over 80 percent of Pacific people identified with Christian religions, this is not always linked to Pacific church attendance. Today, many younger Pacific people, often New Zealand-born, are exploring different social and spiritual identities outside of the Pacific churches. Pacific church attendance has been declining for these groups (Tiatia 1988) with younger Pacific people attending non-Pacific speaking (palagi) churches or not at all.

## Financial priorities

Even low fees cannot help some people – especially the very poor – accessing primary health care. For these groups, transport difficulties are a key barrier for Pacific people to both primary and secondary health care services (CBG Health Research Ltd 2006).

Also, when compared with other financial priorities, health care may be a lower priority for Pacific people. For example, a 2005 study found that Pacific women considered their medical care to be a lower priority when compared with the payment of bills, family needs and projects, mortgage or rent, children's needs, school expenses, and food and clothing (Ministry of Women's Affairs 2005). Pacific people can often have heavy family commitments, and these may take precedence over the need for health care.

The Pacific Island Families Study is a longitudinal study with a cohort of 1376 mothers of Pacific children. It found that when asked about their traditional gift-giving commitments, 62 percent of the women reported that they or their partner usually gave to the family or church, with 66.5 percent of this group giving to family in New Zealand, 58 percent to family in the Pacific islands and 75.9 percent to their church; 59 percent of these mothers reported that this gift commitment made their household financial situation more difficult (Cowley et al 2004).

## Use and expectations of the health system in New Zealand

### Health services use

Improving the quality of care for Pacific peoples will involve making services more acceptable to both individuals and families. Pacific people are more likely than other New Zealanders not to have seen a doctor even though they perceived a need to (Ministry of Health 2004a).

The paper on *Pacific Peoples and Health Services* (Ministry of Health 2008d) has more detail about Pacific peoples' health service use and experience. The following examples illustrate the disparity between enrolment and subsequent uptake, engagement and participation by Pacific peoples and lead to questions about approaches to and provision of quality of care.

### Get Checked

The national diabetes Get Checked programme was established to ensure that people with diagnosed diabetes have an opportunity to check with their GP or nurse each year. The free check aims to help people manage their own diabetes and to educate them about what they need to do to protect their own health, such as healthy eating, regular physical activity to maintain a healthy weight, regular foot checks and regular eye screening.

Get Checked has three main national indicators, which are collected in the primary care setting:

- the proportion of people estimated to have diagnosed diabetes and who are enrolled in a free annual check – this is thought to represent the best indicator of access to good-quality care
- the proportion of people with satisfactory or better diabetes control (defined as an HbA1c of 8 or less) among those who have had a free annual check each year
- the proportion of people who have had a free annual check each year and who have had their eyes screened within the preceding two years.

Pacific peoples' enrolment in Get Checked is encouraging. In 2004 they were more likely than any other group to have enrolled in the programme, with 92 percent of all known Pacific people with diabetes enrolled, compared to 27 percent of Māori and 63 percent of Europeans/Others. However, the percentage of Pacific people enrolled in Get Checked with satisfactory diabetes control was much lower than for the rest of the population: 50 percent of Pacific people were reported to have satisfactory diabetes control, compared to just over 70 percent of the total population (Ministry of Health 2006e). Also, Pacific people are the least likely of all population groups to have received retinal screening. In 2005 50 percent of Pacific people with diabetes had received retinal screening, compared to 65 percent of the total population (Ministry of Health 2006e).

Although the levels of entry and enrolment of Pacific people into Get Checked are positive, subsequent indicators of diabetes control and retinal screening are not. This may suggest that barriers to care could be emerging in the context of the patient–provider interaction. For example, some Pacific people with diabetes may, for various reasons, not understand the importance of diabetes management. Other factors such as Pacific beliefs and values in relation to health and illness, as highlighted earlier in the study (see Barnes et al 2004), may come into play.

## Breast and cervical cancer screening

Breast cancer is the most common cancer for Pacific women and has a relatively high mortality rate (Ministry of Health and Ministry of Pacific Islands Affairs 2004). BreastScreen Aotearoa reported in June 2006<sup>5</sup> breast-screening coverage for Pacific women was 41.2 percent compared with 61.7 percent for all eligible women.

Barriers to breast screening for Pacific women include fear, procrastination and pain, whereas a GP's recommendation was reported to be a major motivator to get a mammogram done (Kahui Tautoko Ltd 2004).

Pacific women have a higher incidence and mortality from cervical cancer compared with non-Māori, non-Pacific women, as shown in Table 5.

Table 5: Incidence and mortality rates (per 100,000 women) for cervical cancer in New Zealand, by ethnicity, 2006<sup>6</sup>

	Pacific	Māori	Non-Māori non-Pacific
Incidence of cervical cancer	10.05	16.19	8.22
Mortality from cervical cancer	4.44	8.06	1.99

Source: Ministry of Health 2007 unpublished

<sup>5</sup> Data from National Cervical Screening Programme register, December 2006. Hysterectomy-adjusted 3-year coverage for Pacific women and all women.

<sup>6</sup> Ibid

Despite this, Pacific women's cervical screening coverage is significantly lower than average, at 44 percent compared with 70 percent for the total population in 2006<sup>7</sup>. Barriers to cervical cancer screening for Pacific women may include not only practical difficulties (such as cost), but cultural misconceptions, such as the view that the test is a test for cancer (not a preventive measure), associating the test with promiscuity and sexually transmitted diseases, and the sacredness of women's genital areas, particularly with respect to exposure to male doctors (Women's Health Action Trust 2000).

## Pacific health providers

### Development and community support

The health needs of Pacific peoples appear to be best met through services that are provided parallel to mainstream services. The concept of 'by Pacific for Pacific' is integral to this. (Ministry of Health 2003b).

The Government has supported the development of 'by Pacific for Pacific' services as a positive response to the health needs and inequalities experienced by Pacific peoples. Provider diversity recognises that the potential for improvement and innovation, which is often best fostered in dedicated services, also has the capacity to contribute to improvements in the wider health system and services.

A number of studies have indicated that for minority groups, ethnic-specific provider services tend to be more effective than mainstream providers, and same-ethnicity workers contribute to better outcomes (Barwick 2000). This is especially true when language or cultural barriers are an issue for Pacific patients. Younger and/or New Zealand-born Pacific peoples may have different service needs and expectations (see 'Cultural discomfort').

'It is impossible to look at the development of health services to Pacific peoples without considering the critical role played by the community itself for many decades. In fact the strength of Pacific communities in New Zealand has been the cornerstone of much of the work today,' Audrey Aumua (in Ministry of Health 2003b).

### Evolution of Pacific providers

Many provider groups for Pacific peoples can be traced back to the early 1950s (Ministry of Health 2003b). The 1950s was a time when there was a strong sense of community among Pacific peoples as well as high Pacific migration into New Zealand. Just as they are today, Pacific churches were community focal points.

In 1976, PACIFICA Inc - a national organisation for Pacific women - was established. One of PACIFICA's objectives was to initiate and support programmes promoting the education, welfare, health and social development of Pacific families. PACIFICA Inc was also instrumental in the establishment of early childhood aoga amata (Samoan language pre-schools) in the 1970s –1980s.

In 1978 the Pacific Island Health and Welfare Society was set up by Dr Leopino Foliaki and Dr Papali'i Semisi Maia'i (Ministry of Health 2003b).

In 1989, West Auckland Pasifika Healthcare was established. Through the 1990s – 2000s other Pacific providers were established across the country. The first Pacific PHO, Ta Pasefika, was established in July 2002 and was one of the first of two PHOs to be formed in the country. Today there are around 40 Pacific health providers throughout New Zealand.

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<sup>7</sup> Ibid

‘Sometimes the initiatives started before there was a policy. This usually happened with support of some Pacific people and Māori people who were able to see the need for Pacific Island involvement in the health initiatives,’ Fuimaono Karl Pulotu-Endemann (in Ministry of Health 2003b).

‘The Tongan community played a huge role in contributing to the service’s success, through monetary donations, providing voluntary services and equipment such as furniture, as well as strong church support,’ Dr Sitaleki Finau on the establishment of Langimalie Health Centre (in Ministry of Health 2003b).

## Pacific models of health

Pacific models of health care have been developed which recognise Pacific worldviews and beliefs about health.

One example is the Fonofale model created by Fuimaono Karl Pulotu-Endemann, for use in the New Zealand context. According to Pulotu-Endemann, the Fonofale model incorporates the values and beliefs that many Samoans, Cook Islanders, Tongans, Niueans, Tokelauans and Fijians had conveyed to him during workshops relating to HIV/AIDS, sexuality and mental health in the early 1970s through to 1995. In particular, these Pacific groups all stated that the most important things for them were family, culture and spirituality. The concept of the Samoan fale (house) was a way to incorporate what they considered important components of Pacific people’s health. The metaphor of the fale with the foundation or the floor, posts and roof, encapsulated in a circle, promotes the philosophy of holism and continuity.

Figure 7: The Fonofale model of health



## Issues and concerns

### Cultural discomfort

Unfamiliarity or discomfort may be a barrier to Pacific people's access to certain health services (Pacific Health Research Centre 2003). Other studies have described Pacific people's perceptions of social or cultural isolation as key barriers to the use of services (Ministry of Health 2004c).

There are also some aspects of Pacific cultures that may prevent some Pacific people from discussing their personal and health problems with a health provider from a different ethnic group (Tukuitonga 1999).

Conversely, there are certain health or social issues that Pacific peoples find difficult to discuss with other Pacific people. For example, Dr Papali'i Semisi Maia'i (Ministry of Health 2003b) notes how the topic of sex is a tapu (taboo) topic for some Pacific people:

'... there is a notion that Pacific Islanders are not interested in sex. Therefore in the family there is a tapu about everything concerning sex, especially in the home. This means that young people go and try sex and this creates a disastrous effect.'

This issue may reflect some concerns that younger Pacific people have. For example, some younger Pacific people avoid using Pacific providers or Pacific staff in services for fear that their confidences will be breached due to the close-knit nature of the Pacific community (CBG Health Research Ltd 2006). The paper on youth health (Ministry of Health 2008b) describes the concerns youth have about confidentiality.

'When I go to [the Pacific health] service, I feel comfortable and happy, although we talk about serious things, we always end up laughing, I always feel better when I have been,' Pacific participant in case study (National Health Committee 2007).

'It's important that Pacific people work with Pacific people because our sensitivities can be very different. If you just tell Pacific people to stop doing something, it won't work. The message won't get through,' Tule Misa, Community Dentist, Canterbury DHB (in Ministry of Health 2007a).

### Language

Language or communication barriers can affect Pacific people's access to and use of health care services (Pacific Health Research Centre 2003; Women's Health Action Trust 2000). Language may be a barrier especially for Pacific-born individuals for whom English is a second language (Tukuitonga 1999; CBG Health Research Ltd 2006; National Health Committee 2007). Younger New Zealand-born Pacific people generally prefer English as their first language, and many are unable to speak a Pacific language (Tukuitonga 1999).

Furthermore, communication barriers can significantly affect the quality of care for the patient. For instance, if there is misunderstanding about a patient's illness, this may affect diagnosis, or the patient may not understand instructions about the use of medicines. (This issue is discussed in more detail under Safety in section 4.1).

'Communication was a big problem. Even if they didn't understand what the doctor was saying, our people would just say yes. That meant prescriptions weren't always relevant,' Paul Lavulo, CEO Langimalie (in Ministry of Health 2007b).

## Information for Pacific people

Pacific people are often unaware of the support and services available to them from government agencies (Koloto 2007), as well as from health professionals and services (Pacific Health Research Centre 2003; Paterson et al 2004). It has also been noted that advertising campaigns promoting messages such as healthy eating are not effectively reaching Pacific people (Johnston 2007). This suggests that methods of information delivery or promotion are not always useful for Pacific people, and that part of this is because of the diversity of Pacific people's worldviews and priorities.

## Did not attend (DNA)

Did not attend (DNA) refers to the non-attendance of patients at appointments that have been made. The reasons for high Pacific DNA rates and low uptake of certain health services such as screening can be complex. For instance, the 2005 evaluation report on the Reducing Inequalities Contingency Fund found that Pacific patients who did not attend secondary care appointments felt misunderstood and intimidated, and that their needs had not been addressed. They also had problems with appointment times, getting to the venue, and understanding the nature and necessity of the appointment (CBG Health Research Ltd 2006).

The report noted reasons that Tongan patients gave for failure to attend secondary care appointments (eg, they had not received communications, or had not understood the communications they did receive). Some patients felt intimidated if they did not understand the communications. The process of making an appointment assumed that the appointment time was convenient to the patient and that they would be able to get to the venue. The report also found that when it is not convenient or the patient cannot get to the venue, the chances are the patient will simply not turn up at the scheduled time.

## Expectations and perceptions of service

To provide quality health services, it is important that the provider understands Pacific people's perceptions of their illness and treatment. According to Blakely and Dew (2004), the implicit message to health care professionals is that asking about Pacific people's beliefs regarding their disease is important, not just their knowledge or understanding of the disease.

The Pacific Island primary health care utilisation study noted that Pacific patients in the study were interested in building long-term and positive relationships with GPs where the GP knows their patient history. The study also noted that some Pacific patients felt that if they were not physically examined or if they perceived their consultation was hurried, then the GP was not interested in them or was failing in their duty as a doctor (Pacific Health Research Centre 2003).

'The Pacific touch: It [has] struck me that there is an incredible amount of work, dedication and commitment in our Pacific community that largely goes unacknowledged ... They are the Pacific Island cultural support workers making themselves available 24 hours a day in our hospital; the community worker filling out WINZ forms for a family; the nurse who ensures that a family has money to buy food.'

'A Samoan nurse once explained to me about "the Pacific touch". What is the Pacific touch? It is taking the time to stop and pray with a family. It is taking the time to teach a young mother how to cook. It is being committed and dedicated and passionate about our people. The Pacific touch is that quality that sets a special few of our nurses and health workers apart,' Dr Teuila Percival (in Ministry of Health 2003b).

## Provider attitudes / clinical behaviour

The National Primary Medical Care (NatMedCa) Survey 2001/02 was undertaken to describe primary health care in New Zealand, including the characteristics of providers and their practices, the patients they see, the problems presented and the management offered. The study covered private general practices, community-governed organisations, accident and medical clinics, and emergency departments. It was intended to compare data across practice types as well as over time.

The NatMedCa report on Pacific patterns in primary health care provides a description of the weekday, daytime experience of visits to primary health care doctors by patients of Pacific origin. The report notes that the GPs surveyed were less likely to say that they had high rapport with their Pacific patients (54.8 percent<sup>8</sup> compared with 68.7 percent for patients drawn from the entire sample) (Davis et al 2005). The survey also found that fewer tests and investigations were conducted for the Pacific clients (17.8 percent for Pacific compared with 24.9 percent for the whole sample). Pacific patients had a lower rate of referral to specialists than the total surveyed (10.2 percent versus 15.8 percent), although the distribution of referrals differed little between the Pacific group and the total. About half of all referrals were to medical/surgical specialists, about one-third were non-medical, and the remainder were either emergency or unspecified.

The specific destinations however, did differ. Just over 20 percent of all referrals for Pacific patients were to physiotherapy (the predominant non-medical destination) and 8.3 percent were to obstetrics (the predominant medical destination). This concentration was not as great for the total sample (physiotherapy 11.5 percent and obstetrics 1.2 percent); the difference was in the higher rate of referral to non-medical and medical/surgical specialties for the total sample. Considered as a rate per 100 visits, the levels of referral were higher for the total sample, but otherwise rates were too low to discern any further pattern. If Pacific peoples' higher health need was not factored into this comparison, it is likely that a different pattern might emerge, which lends support to the case for a closer examination of referral patterns.

The study also found that overall referral rates were higher for patients attending community-governed practices. Indeed, in the case of medical/surgical specialists, these rates were strikingly high. In most cases referral rates were higher for females, but no consistent age pattern was evident, in part because of the small numbers. On average the length of visits for Pacific patients was also shorter at 11.9 minutes, against an overall sample average of 14.9.<sup>9</sup> Pacific patients were less likely to receive a script or a non-drug treatment, and were less likely to be referred, but they had a higher rate of follow-up.

The NatMedCa survey shows differences in the patterns between Pacific and non-Pacific patients for certain aspects of visits, from the GP's perspective, but there is little qualitative data or analysis on the reasons for the patterns.

## Self-reported discrimination

There has been an increasing awareness internationally of the impact of racism on ethnic inequalities in health, with growing recognition of the need to examine racial discrimination as a social determinant and fundamental driver of such inequalities (Harris et al 2006).

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8 Rapport scores may reflect lack of rapport with caregivers attending the visit: it is not clear whether the rapport scores include rapport with caregivers or not. With over half of all Pacific patients being predominantly children and some older people, the likelihood of a caregiver attending the visit is high. Hence, differences in rapport scores may well reflect difficulties associated with working through a third person.

9 The patterns of problems and their treatments presented here could also be characteristic of the relatively young Pacific patient group involved in the survey ie, these times are not age standardised.

The issue of racism in health is complex. There are many different types, levels and expressions of racism, and there are multiple theories explaining how racism may affect health. The 2002/2003 New Zealand Health Survey for the first time included a series of questions on people's experiences of racial discrimination. A study by Harris et al (2006) used data from the survey to examine the relationship between experience of racial discrimination and health using a range of health indicators.

Two percent of Pacific people reported unfair treatment by a health professional because of their ethnicity, compared with 2 percent of Māori, 1.3 percent of Asian and 0.6 percent of European/others. Self-reported experience of racial discrimination is strongly associated with a range of negative health outcomes and with tobacco use among New Zealand adults. Smoking was tested to see whether it acted as a mediator of discrimination on negative health outcomes.

The survey found that measures of discrimination remained strongly associated with poor/fair self-rated health, lower physical functioning, lower mental health and cardiovascular disease.

The study also stated that while racism is recognised as a determinant of health, contributing to ethnic inequalities in New Zealand, there is no empirical evidence directly examining the relationship between personal experience of racial discrimination and health in New Zealand.

## Discussion

Pacific peoples in New Zealand are immensely diverse - culturally and socially. Despite this diversity, however, the vast majority of Pacific people (regardless of gender, or place of birth, for example) experience more ill health than average, and are more likely to engage in behaviours and lifestyles that are consistent with poorer health.

Pacific peoples are one of the most socioeconomically disadvantaged groups in New Zealand, and although this has obvious implications for health status, ethnic differences in health are due to more than just socioeconomic position (Blakely and Dew 2004). For example, even when Pacific and other high-needs groups do live close to services and have access to low or no fees, they can still under-use appropriate services (CBG Health Research Ltd 2006). This suggests that there are other factors at play to explain low use of services, which may include cultural worldviews.

Pacific people's cultural identification and needs are also diverse and dynamic, and this may have become even more so with acculturation. Therefore, improving quality of care for Pacific people cannot be addressed with a 'one size fits all' approach. Attention to many different factors (such as socioeconomic determinants and Pacific views of health) and multiple approaches (such as ethnic-specific family approaches or specific youth services) are more constructive. Removing the barriers will need to include intensive and comprehensive involvement from all health professionals, the Pacific health sector and Pacific communities.

Overall, the reasons behind barriers to quality of care for Pacific peoples are complicated and relatively unexplored. This is an area that will require further investigation.

Similarly, culture is examined all too often in deficit terms in attempts to explain ethnic differences in health (Blakely and Dew 2004). However, there may be opportunities for health care practitioners to reduce inequalities by better research and understanding of the beneficial effects of culture in health care delivery.

The evidence is clear that unless health providers are empathetic to Pacific worldviews, health care interventions can become ineffective (Tukuitonga 1999). Counties Manukau DHB has identified the following risks arising from a lack of understanding and empathy of Pacific worldviews related to health, and how that can further contribute to health inequalities.

- patients may choose not to access services they need for fear of being misunderstood or not respected
- providers may miss opportunities for screening or assessment because they are not familiar with the prevalence of conditions among Pacific peoples
- providers may fail to take into account differing responses to medication, treatment or care options
- providers may lack knowledge about traditional remedies, leading to harmful drug interactions or incomplete care planning to take account of other therapies or services being used
- providers may make diagnostic errors resulting from miscommunication
- patients may not adhere to medical advice because they do not understand or don't trust the provider.

Encouragingly, some organisations – particularly Pacific providers – are already delivering services that reflect or consider Pacific cultural practices and settings. Section 3 describes some of these services, initiatives and approaches as well as a range of initiatives to improve quality of care.

‘Improving health status among Pacific people requires health professionals to understand that poor health status is a ‘product, not the sum of a complex interaction between genes, behaviours and environment,’ Daniel et al 1999 (in Counties Manukau DHB 2006).

### 3. Quality of Care Initiatives across the Health Sector

The Ministry of Health, DHBs and the wider health and disability sector recognise the importance of improving the quality of care for people with the highest health need, including Pacific peoples. This section looks at some activities that are improving or have the potential to improve quality of care outcomes for Pacific peoples. Although much activity overlaps across these three areas, these activities can be broadly grouped into:

- central government (the Minister and Ministry of Health)
- District Health Boards
- providers

Considerable activity has been undertaken and is currently under way in the health and disability sector, which is helping to reduce inequalities and improve quality of care. The following activities and initiatives are only a small selection of this work.

There is also a wide range of legislation and associated regulations that apply to the health and disability system. These can be considered as defining the scope of quality assurance mechanisms in the system. The health and disability sector is also bound by a range of generic legislation, including the Injury Prevention, Rehabilitation, and Compensation Act 2001, the Privacy Act 1993 and the Health and Safety in Employment Act 1992 (Minister of Health 2003).

#### Health targets

On 1 July 2007 the Ministry of Health introduced 10 health targets aligned with its strategic priorities. The targets form part of DHBs' district annual plans, and they also bind the Ministry of Health, which is charged with assisting in their achievement.

The health targets give the health sector a focus for more concerted action, and measurement of the targets enables an assessment of their impact to see what difference is being made. It is generally accepted that carefully chosen targets with appropriate and proportionate sanctions and rewards are associated with improvements in performance (Mays 2006).

The 10 health targets are:

1. improving immunisation coverage
2. improving oral health
3. improving elective services
4. reducing cancer waiting times
5. reducing avoidable admissions
6. improving diabetes services
7. improving mental health services
8. improving nutrition, increasing physical activity and reducing obesity
9. reducing the harm caused by tobacco
10. reducing the percentage of the health budget spent on the Ministry of Health.

A key guiding principle underpinning all the health targets is the reduction of inequalities for those groups who currently have worse health status than other New Zealanders, particularly Māori, Pacific peoples and those who are most deprived. The 2007/08 health targets for improving diabetes and reducing avoidable hospital admissions have been set by ethnicity. In future years as data quality improves, performance in all target areas will be measured by ethnicity and deprivation.

For more information on the health targets, see: [www.moh.govt.nz/healthtargets](http://www.moh.govt.nz/healthtargets)

## The Primary Health Care Strategy (PHCS)

The Government has invested significantly in improving access to primary health care services. So far implementation of the Primary Health Care Strategy (PHCS) has focused on reducing costs for primary health care and continuing the shift towards a population approach. Primary health organisations (PHOs) have continued to focus on these two areas, as well as prevention, early detection and broadening the range of health professionals involved in managing and co-ordinating the continuum of a person's care. These areas will be key to addressing quality of care issues for Pacific peoples.

The Ministry of Health has continued to work on the strategic direction and policy development for primary health care, as well as systems for monitoring DHB performance. DHBs are responsible for implementing decisions and local arrangements, and PHOs are responsible for the changes needed at the local level.

## PHCS Implementation Work Programme

The joint Ministry of Health and DHB work programme for implementing the PHCS is set out in the *Primary Health Care Strategy Implementation Work Programme 2006–2010* (Ministry of Health 2006a). The document explains what needs to be achieved, and outlines the developments that will occur in the primary health care sector from 2006 to 2011. The aim of working in this way is to fully engage the wider sector at all levels in developing and implementing the PHCS, and to clarify accountabilities for the agreed programme and project outcomes. PHOs, providers, health professionals and communities are explicitly linked into the work programme.

For more information on the PHCS Implementation work programme, see: [www.moh.govt.nz/moh.nsf/indexmh/phcs-iwp](http://www.moh.govt.nz/moh.nsf/indexmh/phcs-iwp)

## Involvement of consumers and communities in DHBs and PHOs

Eighty-two PHOs have been established across New Zealand. One principle of the PHCS is for PHOs to work with local communities and enrolled populations. Each PHO must demonstrate that its community and consumers are involved in its governing process, and that it is responsive to its community.

For PHOs with significant Pacific enrolments, this means appropriate Pacific representation, and engagement and interaction at appropriate levels such as governance, service design, delivery and monitoring.

DHBs are also required to involve communities in planning and decision-making so that they develop services that best meet their communities' needs. Consumers and communities can have a direct involvement in DHB governance by voting and/or by standing as a candidate in DHB elections. Non-board members are also often involved in DHB committees, such as the public health advisory committee, hospital advisory committee, and disability support advisory committees.

## PHO Community Council

Each PHO includes community representatives on its governing body. In 2005 the Ministry of Health established the PHO Community Council, comprising members selected from the community representatives on PHO boards and a DHB representative. The Community Council meets quarterly to provide strategic advice to the Ministry of Health on how to strengthen community involvement in implementing the PHCS and developing PHOs, and how to develop the capacity of PHO board members.

The chair of the PHO Community Council represents the council on the PHCS implementation group. This enables the PHO Community Council to influence, at the highest level, the PHCS Implementation Work Programme. Using community representation in the project teams allows communities to be represented and engaged at a range of levels.

## PHO Performance Management Programme

Launched in January 2006, the PHO Performance Management Programme has been designed by the Ministry of Health, primary health care representatives and DHBs to improve the health of enrolled populations and reduce inequalities in health outcomes. It seeks to achieve these goals by supporting clinical governance and rewarding quality improvement within PHOs. When PHOs improve their performance against a range of nationally consistent indicators, they receive incentive payments. As at July 2007, 81 of the 82 PHOs had joined the programme.

For more information on the PHO Performance Manager Programme, see: [www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-phoperformance](http://www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-phoperformance)

## Services to Improve Access

There are a number of specific programmes within the PHCS that focus on reducing inequalities, one of which is Services to Improve Access funding. This funding enables PHOs to introduce innovative approaches to reach people with high health needs who may not have access to the services they need.

Successful initiatives developed with Services to Improve Access funding have included:

- providing nursing outreach services to manage diabetes or cardiovascular disease in such varied settings as 'walk-in' clinics and a health bus taking services to rural areas
- employing community health workers to help break down language barriers and social isolation among hard-to-reach groups.

## Leading for Outcomes

Leading for Outcomes is a response to the requirement that all government departments manage their business with reference to outcomes. Leading for Outcomes seeks to provide a systematic pathway to reducing inequalities and improving health. To do this it focuses on populations at greatest risk of ill health. This mainly involves primary health care and community settings. The agencies primarily responsible for this activity are DHBs acting with and through PHOs to evolve the delivery of health care in community settings to better meet the needs of people at risk of or suffering from long-term conditions. Public health and personal services, previously separate spheres of activity, now have an opportunity to work in close collaboration at the local or PHO level.

A key plank of Leading for Outcomes is population health approaches, which include using evidence-based guidelines and a knowledge environment that supports the collection of meaningful data and shared learning. Participation by communities in health care decision-making

and by consumers in their treatment plans and ongoing care are two important changes sought in the primary health care environment. Continuity of care, and support for self-management are essential when addressing long-term conditions (Minister of Health 2006).

‘While New Zealand has been internationally recognised as having one of the best primary health care systems in the world, we must not forget the need to continuously improve quality so we can deliver improved health outcomes for all New Zealanders,’ Minister of Health 2007.<sup>10</sup>

## Pacific provider and workforce development

The Ministry of Health’s \$5.0 million Pacific Provider Development Fund (PPDF) contributes to improved health services for Pacific peoples by assisting the development of Pacific health providers and the Pacific health workforce (Ministry of Health 2005).

### Pacific health providers

There are currently around 40 Pacific health providers in New Zealand, including three Pacific PHOs. Table 6 shows the three Pacific PHOs and their enrolments.

Table 6: Enrolment in Pacific-specific PHOs (Quarter 4, 2007)

PHO	Pacific enrolments	Total enrolments	Proportion Pacific %
AuckPAC	12,911	37,792	34
TaPasefika	14,676	19,939	73
Langimalie	4,858	5,000	97
Total	32,445	62,731	52

Source: Enriched CBF Register, HealthPAC, Ministry of Health 2007.

Although around two-thirds of New Zealand’s Pacific population are concentrated in the Auckland DHB regions, Pacific people live all over New Zealand. Table 7 shows a sample of Pacific enrolments in mainstream PHOs outside the Auckland region.

Table 7: Pacific enrolment in three mainstream PHOs (Quarter 4, 2007)

PHO	DHB region	Pacific enrolments	Total enrolments	Proportion Pacific %
Partnership Health (Canterbury)	Canterbury	7,204	345,795	2
Porirua Health Plus Limited	Capital and Coast	2,784	4,551	61
Pinnacle	Waikato	6,003	303,516	2

Source: Enriched CBF Register, HealthPAC, Ministry of Health 2007.

The PHCS recognises that most Pacific people will continue to be cared for by mainstream providers. Around 88 percent (233,521) of the PHO-enrolled Pacific population are enrolled in a mainstream PHO (Ministry of Health 2006b). Improving the quality of care for Pacific peoples

10 Hon. Pete Hodgson. News release 23 /05/2007. <http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=29492>. Accessed 19/07/07.

will therefore involve mainstream providers organising and delivering services in ways that are increasingly culturally competent and effective.

‘Mainstream PHOs that have significant numbers of Māori or Pacific peoples among their enrolled population should consider establishing specific services for these people,’  
Minister of Health (in Minister of Health 2001).

## Pacific workforce development

The Ministry of Health’s *Pacific Health and Disability Workforce Development Plan* (2004) has three goals:

- to increase the capacity and capability of the Pacific health and disability workforce
- to promote Pacific models of care and cultural competence
- to advance opportunities and improve information for the Pacific health and disability workforce.

The following national Pacific Provider Development Fund (PPDF) initiatives and projects have been undertaken in support of these goals.

## Pacific health workforce awards

These awards support Pacific students to undertake health-related courses of study in medicine, health sciences, nursing, public health, health management and midwifery.

## Pacific research capability and capacity development

This programme supports the development of emerging Pacific health researchers. It provides them with research experience through working with senior Pacific and non-Pacific researchers in a university setting, while producing Pacific health-related research products.

## Support for Pacific professional organisations

The Samoan Nurses Association, the Cook Islands Health Network Association, the Tongan Nurses Association and the Pasifika Medical Association are supported to develop their workforce, member activities and workforce development projects. The activities include developing membership and membership databases, identifying workforce development opportunities, and recruiting, mentoring and supporting Pacific students.

## The Pacific Health Leadership Development Programme

This programme aims to develop the leadership capability of Pacific people working in the health sector. Thirty participants from a mix of clinical and management roles in health and community organisations completed the programme in 2006. Twelve Pacific people completed the leadership programme held in 2002 and 15 in 2003. The programme will be run again in 2008. An alumni programme was established in 2007.

## Pacific cultural competence

Under the *Pacific Health and Disability Workforce Development Plan* (2004) objective to define and develop cultural competence, the Ministry of Health commissioned the report *Pacific Cultural Competencies: A literature review* (Tiatia 2008).

In 2006 the Ministry of Health undertook a stocktake of Pacific cultural competence activity in the health sector. Other organisations such as the Waitemata DHB and the Medical Council of New Zealand also have work under way looking at Pacific cultural competence.

‘The Pacific model of care is about the ability of the system to work across cultures’,  
Lita Foliaki, Waitemata District Health Board (in Ministry of Health 2006f).

‘Culture does matter if you want to provide a great service. There are many culturally distinct ways of reaching the same goal,’ Dr Ellis Situe (in Ministry of Health 2006f).

## National Pacific Diabetes Initiative

The joint Ministry of Health and Counties Manukau DHB National Diabetes Initiative work includes:

- the Pacific Diabetes Framework, linking clinical interventions, lifestyle interventions and service integration, best practice methods and identifying workforce gaps and issues
- a literature review
- toolkits for nutrition, physical activity and smoking cessation for use by Pacific service providers and mainstream providers
- a ‘Diabetes Directory’ of services, including Pacific and mainstream services.

## Health Innovation Awards

The fifth New Zealand Health Innovation Awards<sup>11</sup> were presented in October 2007. The awards celebrate excellence, help share good ideas, and aim to promote innovation and improvement throughout the health, disability and rehabilitation sector. They recognise individuals and organisations that have developed new and innovative approaches to delivering better health services. Overall, they provide an opportunity to showcase some of the cutting-edge developments and improvements within the health service.

In 2007 the Supreme Award at the New Zealand Health Innovation Awards went to the Mangere Healthy Kai programme. The programme is aimed at tackling obesity in Auckland’s Mangere town centre. Since the Mangere Healthy Kai programme began in 2003, retailers have been selling more nutritious food such as filled rolls, sandwiches and grilled fish – at the expense of high-fat food. The programme has been changing eating habits in Auckland’s Mangere town centre to help combat obesity, type 2 diabetes and cardiovascular disease.

The Healthy Kai programme, from Auckland Regional Public Health Service, is supported by Auckland DHB, Mangere Community Health Trust, National Heart Foundation of New Zealand, Bader Drive Healthcare, Te Kupenga o Hoturoa, Procure Network Manukau, Manukau City Council and Otara Health Incorporated.

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<sup>11</sup> The awards are a joint initiative by the Ministry of Health and Accident Compensation Corporation, and are administered by the New Zealand Business Excellence Foundation.

## Inequalities: evidence and tools

The growing body of knowledge that informs activities undertaken by the health and disability sector to tackle health inequalities includes the following Ministry of Health documents and tools.

### Reducing Inequalities in Health

Reducing Inequalities in Health (Ministry of Health 2002a) describes the Reducing Inequalities Intervention Framework. The proposed framework for intervention involves developing and implementing comprehensive strategies at four levels:

1. structural – tackling the root causes of health inequalities; that is, the social, economic, cultural and historical factors that fundamentally determine health
2. intermediary pathways – targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health
3. health and disability services – undertaking specific actions within health and disability services
4. impact – minimising the impact of disability and illness on socioeconomic position.

Intervention at these four levels should be undertaken nationally, regionally and locally by policy-makers, funders and providers. The framework can be used to review current practice and ensure that actions contribute to improving the health of individuals and populations, and to reducing inequalities in health.

### Health Equity Assessment Tool

The Health Equity Assessment Tool is a set of questions that has been developed to assist in the consideration of how particular inequalities in health have come about, and where the effective intervention points are to tackle them. The tool should be used in conjunction with the Ministry of Health's Reducing Inequalities Intervention Framework.

### Decades of Disparity reports

The Decades of Disparity series of reports utilise linked census and mortality records (the New Zealand Census – Mortality Study) to monitor trends in ethnic and socioeconomic inequalities in mortality. In 2007 the Ministry of Health released *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981–2004* (Blakely et al 2007). The report is the fourth in the Decades of Disparity series. It updates the earlier reports by providing estimates of ethnic inequalities and income gradients in mortality (all-cause and by-cause) for 2001–04.

### Pacific Health Chart Book

The *Tupu Ola Moui: Pacific Health Chart Book*, developed jointly by the Ministry of Health and Ministry of Pacific Island Affairs, was published in 2004. The report provided a comprehensive review of Pacific health, and used an indicator approach to focus attention on specific health issues.

### Ethical guidelines

The National Ethics Advisory Committee (an independent advisor to the Minister of Health) has prepared new ethical guidelines for researchers doing observational studies, which will improve safety and quality in the health system.

The guidelines are designed for investigators working out how best to conduct a study. They also state whether the different kinds of observational studies need to be reviewed by an ethics

committee. The guidelines are intended to facilitate high-quality studies, protect the interests of participants, and underpin public assurance of good study conduct (National Ethics Advisory Committee 2006).

## Quality improvement

### The Quality Improvement Committee

The Quality Improvement Committee (formerly Epiqual – the National Health Epidemiology and Quality Assurance Advisory Committee) provides advice to the Minister of Health on health epidemiology and quality assurance matters.

The Committee has a revised terms of reference, which will focus more on developing a shared learning environment in the health sector so that innovations that improve the quality of health care can be more quickly adopted throughout the system.

For more information on the Quality Improvement Committee see: [www.qic.health.govt.nz](http://www.qic.health.govt.nz)

### District Health Board and provider quality improvement initiatives

DHBs are undertaking a range of work to improve the quality of care for New Zealanders. Following are some examples.

#### Canterbury DHB's Improving the Patient Journey

This initiative is a single uniting banner for quality and performance improvement within the clinical and patient processes of hospital and specialist services in the Canterbury district. One example is the emergency department review. By improving systems to manage the flow of patients through the hospital, Canterbury DHB has reduced incidents of emergency department overcrowding by 50 percent. Improving bed management and rosters has saved an estimated \$2 million in nursing costs over 18 months. Staff and patient safety are improved as less overcrowding allows for more consistent staffing levels.

#### Counties Manukau DHB's Chronic Care Management Programme

Counties Manukau DHB uses a chronic care model to provide the framework for a number of chronic conditions programmes or initiatives spanning a person's life course, from prevention to palliative care. The model and associated programmes were developed to consistently deliver seamless care to targeted patients with specific chronic diseases and varying levels of need (ranging from low to very high). Underlying the model are key approaches and principles of all chronic care models, including: population health approaches; person-centred care; involvement of family/whānau; multidisciplinary teamwork; effective communication; and information-sharing.

A significant initiative set within the framework is the Chronic Care Management programme (CCM). The CCM is the first structured chronic care management programme to be developed and evaluated in New Zealand. Key components of the CCM reflect a chronic care model, addressing system design, decision support, information systems and system organisation. The programme focuses on people with chronic conditions who have very high and complex needs. In addition to the CCM, the DHB has worked collaboratively with the community to develop Let's Beat Diabetes, a whole-district initiative with considerable community participation (National Health Committee 2007).

## Accreditation and Certification

Two key quality improvement tools in use in the New Zealand health and disability system are accreditation and certification.

Accreditation is the process by which organisations demonstrate adherence to specific levels of practice defined by an accreditation agency, often expressed as standards, with the subsequent right to associate themselves with the agency. The practices may cover quality assurance and/or improvement activities. The requirements may include minimum requirements (quality assurance) as well as setting goals for ongoing improvement (quality improvement). Different agencies have a different mix of assurance and improvement in their requirements. Over time, as improvements are made, the accreditation agencies may update their requirements to support further improvements.

Certification is a legislative requirement and is the process by which organisations meet the standards of the Health and Disability Services (Safety) Act 2001. Many health and disability service providers are continually improving the quality of their services with certification and accreditation processes.

## The Health and Disability Commissioner

The complaint mechanisms under the Health and Disability Commissioner Act 1994 have become the primary vehicle for dealing with complaints about the quality of health care and disability services in New Zealand. The Health and Disability Commissioner Act created the Office of the Commissioner, whose role includes promoting and protecting the rights of health and disability consumers, and facilitating the fair, simple, speedy and efficient resolution of complaints (Health and Disability Commissioner 2007).

## The Health and Disability Services (Safety) Act 2001

The passing of the Health and Disability Services (Safety) Act 2001 (the Safety Act) introduced a framework for improved safety standards in hospitals, rest homes and in residential homes for people with disabilities (Minister of Health 2003). The objectives of the Safety Act are to:

- promote safe health and disability services
- establish consistent and reasonable standards for health and disability services
- encourage health and disability providers to take responsibility for safely providing services
- encourage health and disability providers to continuously improve service quality.

The Safety Act provides for consistently safe, high-quality services for consumers from health and disability service providers. Medical, surgical, paediatric, maternity, age-related, mental health, and intellectual and disability services (including residential mental health homes and homes for people with disabilities) are all covered by the Safety Act (Minister of Health 2003).

## The Health Practitioners Competence Assurance Act 2004

Effective from September 2004, the New Zealand Health Practitioners Competence Assurance (HPCA) Act covers all health professionals in New Zealand. The function of the Act is to protect the health and safety of New Zealanders by providing mechanisms to ensure health professionals are competent, registered and subject to regulation. The Act requires that professional registration bodies<sup>12</sup> set standards of clinical competence, cultural competence and ethical conduct, and ensure that these are observed by health practitioners of their profession.

In achieving the goal for all health professionals to be familiar with the concept of cultural competence, it is also critical that they be able to demonstrate it. Other relevant legislation and regulations not covered here that contribute to people's rights and safety are outlined in *Improving Quality: A systems approach for the New Zealand health and disability sector* (Minister of Health 2003).

## Discussion

There has been a considerable investment across the health sector in improving understanding of health care issues and implementing better quality of care.

The role of the Primary Health Care Strategy (PHCS) in improving quality of care for Pacific peoples is critical. There is some evidence that recent primary health care reforms (such as PHOs and fee reductions) have contributed to improved low-cost access to services for Pacific peoples and other vulnerable groups (Hefford et al 2005). The paper on *Pacific Peoples and Health Care Services* (Ministry of Health 2008d) in this series finds that the introduction of low-cost fees and pharmaceuticals is helping to address two frequently cited barriers to health services for Pacific peoples.

The evidence and information contained in this series of papers makes a case for PHCS work to carefully and appropriately consider the uniqueness of Pacific peoples' needs, and how improving quality might best be achieved. PHCS and PHOs' focus on population health is one of the most significant enablers for doing this.

As the majority of Pacific people engage with non-Pacific providers for most of their health and disability needs the importance of primary health care providers being culturally competent in delivering services cannot be overstated. Pacific cultural competence is fundamental to the delivery of quality health and disability services to Pacific people by both Pacific and mainstream providers. It is timely for all providers to consider what cultural competence means for them and their practice, what it should mean, and how they intend to bridge the gap. Pacific cultural competence is also required at an organisational and wider systems level.

Tiati's 2008 report on Pacific cultural competencies recommended that:

'Pacific cultural competencies should be considered integral to the definition of quality of care to move towards quality outcomes. This could best be included in accreditation tools, regulatory criteria and national surveys. Quality indicators are required to identify, define, track, evaluate and improve culturally competent practices and services'.

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12 Authorities appointed under the Act include the: Chiropractic Board, Dental Council of New Zealand, Dietitians Board, Medical Council of New Zealand, Medical Laboratory Science Board, Medical Radiation Technologists Board, Midwifery Council, Nursing Council of New Zealand, Occupational Therapy Board, Optometrists and Dispensing Opticians Board, Osteopathic Council, Pharmacy Council, Podiatrists Board, Physiotherapy Board of New Zealand, and Psychologists Board.

The report also suggested that evaluative research on the feasibility and efficacy of Pacific cultural competencies in practice would also be useful (Tiatia 2008).

The development of Pacific health providers and the Pacific health workforce is progressing. Pacific health providers have been instrumental in developing models of care and approaches to service delivery that reflect and respond to Pacific culture and values. The recent evaluation of the Pacific Provider Development Fund (PPDF) confirms the significant role of the fund in supporting Pacific health provider development and innovative Pacific led responses to Pacific health issues. This includes the set up of outreach clinics, establishment of exercise and nutrition centres and groups, and the involvement of church groups in health promotion projects. The evaluation reports that Pacific led providers have increased use of Pacific protocols and models of care and improved Pacific peoples' involvement with the service. As autonomous entities providers are better able to adapt and present services to suit Pacific people.

The PPDF also has an important role in supporting Pacific workforce development that has enabled Pacific providers to successfully deliver a wide spectrum of services to Pacific people. The PPDF evaluation reports that most service contracts do not provide for the capacity and capability building required to fulfil the service specification and provide a 'by Pacific for Pacific' service. An added complication is that service contracts do not recognise training and retention challenges faced by Pacific providers. Workforce development is not lost as many Pacific providers attract and train Pacific health workers for the wider health sector.

Quality frameworks, such as the Improving Quality (IQ) framework and associated work, can also help in designing a systematic approach to implementing Pacific cultural competence and improving quality of care for Pacific peoples. Section 4 will explore this opportunity in more detail.

Developing and setting measures of improvement for Pacific peoples (and other population groups) would be a good test of the efficacy of the range of initiatives dedicated to the improvement of quality of service and quality of care. It will also increase focus on measuring and achieving the objectives of these initiatives and encourage the development of evaluation and accountability tools. This approach is also consistent with the health targets approach.

## 4. Opportunities for Improving Quality of Care for Pacific Peoples

### Improving Quality (IQ): A systems approach for the New Zealand health and disability sector

In September 2003 the Minister of Health released *Improving quality (IQ): A systems approach for the New Zealand Health and Disability Sector* and launched the *IQ Action Plan: Supporting the improving quality approach* (Minister of Health 2003). The vision of the IQ document is:

Improvements in quality are necessary to support a vision of people in the New Zealand health and disability system receiving people-centred, safe and high-quality services that continually improve and that are culturally competent.

The direct acknowledgement of cultural competence in the vision statement is significant, and suggests that the IQ strategy is potentially a very useful tool to guide improvements in the quality of care for Pacific peoples. Its relationship to quality for Pacific people will be explored in more detail later.

Importantly, the IQ document supports a greater systems approach to quality improvement and improved co-ordination of quality improvement. A systems approach is necessary because the health and disability system is complex, with decision-making and actions happening across a variety of people, organisations and subsystems. A systems approach is not an end in itself but a means to enhance services for the benefit of people, including consumers and their families (Minister of Health 2003).

‘A systems approach recognises that quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems,’ Minister of Health (in Ministry of Health 2003).

Quality improvement needs to encapsulate all levels of the system and the interactions between them. The levels are shown diagrammatically in Figure 8. The levels range from the overall system, through the organisations and teams and individuals within those organisations, to the people receiving and affected by the services delivered in the system.

The health and disability sector exists within, and interacts with, wider systems and other sectors. For simplicity this wider environment has not been shown diagrammatically. It is nevertheless very important given the contribution of other sectors to improved health outcomes, and the participation and independence of people with a disability (Minister of Health 2003). For Pacific people the wider environment (which includes many of the areas described in section 2 of this paper) is a particularly pertinent consideration.

Figure 8: Quality dimensions for the New Zealand health and disability system



From Figure 8, the four general dimensions required to achieve quality are:

- access and equity
- safety
- effectiveness
- efficiency.

People and whānau or family are at the ‘heart’ of quality in the New Zealand health and disability system. ‘People’ also encompasses both individuals and population groups receiving services.

### Access and equity

Access and equity cover the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment, and the extent to which this is a barrier to accessing health and disability support services. Being able to physically access health and disability support service facilities can be a significant issue for people with disabilities (Minister of Health 2003).

Access to health care is a multi-dimensional concept that continues to evolve. In New Zealand, measuring access is a challenge given the continuing changes in the health care system (Berk and Schur 1998), and it can be even more of a challenge with the currently evolving face of primary care delivery. Access is more than merely entering the system, and measuring it needs to include measuring whether individuals have real access to effective and appropriate health care (Barwick 2000).

In a paper on Pacific peoples’ access to health services in New Zealand, Young (1997) described five dimensions<sup>13</sup> that are useful to understanding barriers to access faced by under-served groups in general, and Pacific peoples in particular. They are:

- availability – the adequacy of supply in relation to the volume and types of needs
- accessibility – geographical access, distance, transport options and travel time

<sup>13</sup> These five dimensions of access were first proposed by Pechancky and Thomas in 1981.

- accommodation – the organisational features of a provider’s services, such as appointment systems and waiting times
- affordability – the relationship between the cost of service and the client’s ability to pay
- acceptability – the client’s attitudes about the personal and practice characteristics of the provider and the provider’s attitude about the characteristics of the client (Young 1997).

Furthermore, access and equity are the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment and the extent to which this is a barrier to accessing health and disability support services. Improving access at a practical level may, for instance, mean having bigger surgeries and waiting rooms in clinics, because Pacific people sometimes bring extra people to a consultation (Ministry of Health and Ministry of Pacific Island Affairs 2004).

The equity and access dimensions most directly relate to inequalities, and are therefore important for Pacific people. An accessible and equitable health care system for Pacific people is one where health services are financially and culturally accessible, and access to the right health services is proportionate to need.

At a systems level, Pacific cultural competence sits best under the access and equity component of the IQ strategy. But cultural competence is important beyond just medical care. It applies to all levels of the health system, and includes individuals, teams, organisations and the overall health system. Cultural competence is not just the responsibility of those directly involved in the delivery of health and disability support services (Minister of Health 2003).

Pacific cultural competencies are crucial to better health outcomes for Pacific peoples (Tiatia 2008). The provision of culturally competent health care is one of the strategies advocated for reducing or eliminating racial and ethnic health disparities (Ngo-Metzger et al 2006). Culturally appropriate provider services may include:

- targeted health promotion activities
- formal partnerships and consultations with organisations or groups representing ethnic minorities
- the availability of a multi-lingual health workforce
- provision of information in a variety of media and languages
- provision of services in locations that are readily accessed by people from different communities, such as churches, community centres, schools or shopping centres
- provision of services and facilities that welcome the participation and support of families (National Health Committee 2007).

## Safety

According to the IQ document, safety is the extent to which harm is kept to a minimum (Minister of Health 2003). Pacific people have a strong need to feel safe, and to have a sense of trust in their health professional (Kiro et al 2004).

In New Zealand, and across the developed world, there has been an increased awareness of iatrogenic harm. Iatrogenic harm is harm resulting from the process of care. A study of New Zealand hospital admissions in 1998 estimated that 12.9 percent of admissions – around 14,000 patients – were associated with an adverse event, and that a third of these were preventable (Merry and Seddon 2006).

Serious safety concerns are possible for Pacific people who experience communication barriers with their health providers, and the risk of iatrogenic harm may be increased for these Pacific people. Effective communication between the patient and provider is critical to the delivery of safe, high-quality care, and any language barrier can hinder this (Cohen et al 2005). It limits patient access to health services, undermines trust in the quality of care received and decreases the likelihood that patients will receive appropriate follow-up (Flores et al 2002). Furthermore language barriers can result in misunderstandings, problems with informed consent, inadequate comprehension of diagnoses and treatment, dissatisfaction with care, preventable morbidity and mortality, disparities in prescriptions, test ordering and diagnostic evaluations (Flores et al 2002).

An American study looking at language proficiency and adverse events in United States hospitals found that language barriers add to the risks to patient safety (Divi et al 2007). The study recommended that patients with English language barriers have ready access to competent language services. Providers need to collect not only reliable ethnicity data but also information on the first language of the patient.

These findings are relevant to the New Zealand context where like the United States there is a multi-cultural and multi-lingual population, which includes Pacific people.

A safe health care system for Pacific peoples would include health services that are not only clinically safe but also culturally safe. Culturally safe practice involves recognising negative attitudes and stereotyping of individuals due to their ethnicity (Tiatia 2008).

## Efficiency

Efficiency is the extent to which a service gives the greatest possible benefit for the resources used (Minister of Health 2003). Efficiency and value for money are a high priority across the health sector, because the sector is charged with achieving the greatest health gain within the limited resources available. A range of approaches is used to obtain value for money from health expenditure, including:

- supporting evidence-based policy and clinical practice
- developing information systems that support performance measurement
- reviewing new investments
- periodically reviewing major service areas to ensure best practice and identify areas where services could be delivered more effectively
- managing demand through needs-based resource allocation
- controlling price and supply through contracting strategies
- making optimal use of the available health workforce.

Linked to this concept of efficiency, one of the Ministry of Health's 10 health targets is to reduce the percentage of the health budget spent on the Ministry.

All of these approaches can potentially improve Pacific peoples' health care if:

- information systems are designed to collect and report ethnicity data
- review processes are based on a population health perspective that includes Pacific peoples' health needs
- monitoring and evaluation are timely and include ethnicity information
- Pacific peoples' contribution to the health workforce is recognised and promoted.

For Pacific peoples, like most New Zealanders, optimum efficiency in health care occurs when staff and equipment are available and communication and relationships meet health needs effectively and in a timely way. For Pacific peoples in particular, the importance of establishing satisfactory relationships and communications is the basis of an efficient relationship. This may initially appear to conflict with some Western notions of efficient business management and the way time is allocated and costed in medical practices. For example, the National Primary Medical Care Survey reported that Pacific people had on average shorter consultation times with GPs than others (Davis et al 2005). The Pacific cultural competence of providers is a key mechanism to improve useful communication and relationships between Pacific patients and health service providers.

## Effectiveness

The ‘effectiveness’ dimension of the IQ framework has been defined as the extent to which a service achieves an expected and measurable benefit (Minister of Health 2003). Effectiveness also involves making appropriate decisions based on the best available evidence, avoiding ‘overuse’ (providing care of no proven benefit or in a situation where the benefits are outweighed by the risks), and ‘underuse’ (failing to provide care of proven benefit) (Seddon 2006).

There are two facets to providing effective care. The first involves using research to determine the best evidence for therapeutic decisions, which drug regimen is superior, and which test will provide the closest approximation of the truth with the fewest false positives. The second facet of effective care is ensuring that the best evidence, as determined by research, is applied to everyday practice (Seddon and Buchanan 2006). The involvement of clinicians in the measurement and management of quality is vital to address the gap between best practice and current practice, and it is essential that clinicians take a lead in quality improvement (Seddon and Buchanan 2006). For Pacific people, effective health care also needs to include effective communication where the patient is understood and supported to access and use the best health care interventions they need.

## People- and family-centredness

‘People-centred’ or ‘patient-centred’ means involving people and being receptive and responsive to their needs and values. It includes both individuals and population groups receiving services. People- and family-centred health care is arguably the most important of the dimensions of quality, because it is likely that a health care system that is people-centred will also perform well against the other dimensions (Robb and Seddon 2006).

The common themes in patient-centred health include:

- informing and involving patients
- eliciting and respecting patient preferences
- engaging patients in the health process
- treating patients with dignity
- designing care processes to suit the needs of the patient, not the providers
- ready access to health information
- continuity of care (Robb and Seddon 2006).

People-centred health care also includes integrating secondary and primary care systems to improve the management of disease, avoid unnecessary care, and reduce costs per person. Pacific people with chronic disease are likely to benefit from approaches that manage people across a continuum of services, or co-ordinate delivery in a range of settings.

People-centred health care requires greater PHO and GP accountability for the care of enrolees inside and outside the PHO, and for referrals made or not made by GPs. However, some overseas studies have noted some barriers to achieving patient-centred care in relation to ethnic minority groups; for instance, some ethnic groups do not value autonomy and may be reluctant to engage in shared decision-making (Ngo-Metzger et al 2006). This risk could be mitigated with effective cultural competence training for health professionals.

Many themes of the patient-centred and family-focused approaches could be beneficial to improving quality of care for Pacific peoples. For instance, family approach interventions to health care have been shown to be effective for Pacific peoples (Simmons and Voyle, 1996). The National Health Committee's report *Meeting the Needs of People with Chronic Conditions* (2007) included case studies of interviews with Pacific people. The participants were clear that a willing and organised family was more important for them than any specific services. The participants also conveyed a general feeling about the lack of respect (from health professionals) for the views and knowledge of family caregivers. However, participants felt that family caregivers were best placed to explain how a family member was feeling or to answer questions on behalf of their family members.

One aim of the IQ document is to set a high-level direction through goals that can enable locally appropriate quality improvement practices to evolve and improve on a continual basis. There are 11 goals in the IQ document. The most relevant goals for improving quality of care for Pacific peoples are:

- leadership: a shared vision of safe and quality care is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality
- people involvement: people are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes
- quality improvement culture: a widespread awareness, understanding and commitment to a quality improvement culture are evident at all levels of the health and disability sector
- communication, co-ordination and integration: effective and open communication, co-ordination and the integration of service activities recognise the value of teamwork
- supporting the workforce to undertake quality improvement activities: a supportive and motivating environment provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in the planning, delivery and assessment of health and disability services
- knowledge and information infrastructure: useful knowledge and information.

It would be beneficial if some goals such as 'knowledge and information infrastructure' could make provision for Pacific people's knowledge and information needs.

## Cultural competence

Improving the quality of care for Pacific peoples will involve making services more acceptable to both individuals and families. This is where Pacific cultural competence has a link to quality of care for Pacific people.

As noted earlier, the IQ document makes explicit reference to cultural competence in its vision statement:

'Improvements in quality are necessary to support a vision of people in the New Zealand health and disability system receiving people-centred, safe and high-quality services that continually improve and that are culturally competent.'

Cultural competence contributes to improving quality of care. Pacific cultural competence may include:

- understanding the diversity of Pacific peoples and
- the varied and complex factors /influences on Pacific peoples and their decision making.

Pacific cultural competence is about the ability of health and disability care providers to understand and appropriately apply cultural values and practices that underpin Pacific peoples' diverse world views and perspectives on health (Tiatia and Foliaki 2005). It also involves acknowledgement of the various facets of culture, particularly in terms of understanding cultural differences between Pacific clients and their families (Suaalii-Sauni and Samu 2005), the varied and complex factors and influences on Pacific peoples, and their decision making.

Pacific cultural competence has also been defined as the ability to integrate Pacific values, principles, structures, attitudes and practices in the care and delivery of service to Pacific clients, their families and communities (Counties Manukau District Health Board 2001).

The National Health Committee recommended that care for people with chronic conditions proactively support people in a community setting (which emphasises the central role of primary health care), and be delivered as a continuum of care across hospital and community-based services. It believes this approach is key to reducing inequalities (National Health Committee 2007).

The National Health Committee endorses the Counties Manukau Chronic Care Management programme, which includes cultural competence as a core component of provider systems (National Health Committee 2007). The outcomes sought from the provision of culturally appropriate services are:

- increased access to quality care
- reduced inequities of service provision and reduced health inequalities in outcomes
- improved health and wellbeing.

## Improving information

Comprehensive high-quality ethnicity data is essential for: mapping health trends by ethnicity; developing effective policies and strategies; and measuring, monitoring and eliminating ethnic disparities in New Zealand (Health Utilisation Research Alliance 2006). A fundamental principle of the PHCS is to continually improve quality by using good information. Capitated funding and a population health approach are both relevant to quality because they rely on high-quality joined-up information.

The correct recording of an individual's National Health Index (NHI) number is the first step towards a comprehensive information system that enables more sophisticated monitoring of quality indicators. The NHI number is the unique identifier used in the health system. When used consistently across health information systems, health events for individuals can be organised in such a way that they reveal patterns of health care use and health status. For example, if the NHI was used uniformly across primary and secondary health transactions and PHO enrolment, planners and researchers could describe the full cost of care for groups of individuals based on their personal characteristics or residence (Ministry of Health 2006e).

Given that health interventions are most effective at the level of the lowest unit of interaction, ethnic-specific information on individuals and families is essential for improving, monitoring and evaluating the health of Pacific people and the services provided for them. The health effects of

social policies on minority groups have to be assessed with ethnic-specific information (Tukuītonga 1999). Furthermore, the recording of a Pacific patient's first language (if not English) may help providers plan for the delivery of more appropriate services.

At present, however, it appears that there are some problems with the accuracy of ethnicity data collection at the primary care level. There is also large variance in the level of ethnicity data coverage that practices achieve. However, a recent study found that collecting quality ethnicity data in general practices is possible, and that combining practice-collected ethnicity data with NHI ethnicity data increases coverage. The findings also supported the need for standardised, consistent approaches to ethnicity data collection and analysis, as well as systems and policies that make it easier to collect high-quality health data (Health Utilisation Research Alliance 2006).

## The Improving Quality Action Plan

An IQ Action Plan for 2007–2010 is to be developed, which will build on the IQ Action Plan 2003. Key features of the updated IQ action plan will include:

- building on the systems approach in the IQ strategy
- incorporating the frameworks and concepts identified through building on the systems approach
- working on both technical and adaptive problems within high-priority areas, such as medication safety and health care acquired infection
- strengthening strategic partnerships
- working with the sector on real, complex problems to inform learning about the resources needed for improvement.

Leaders in quality and safety in the health sector met in 2006 to identify a small number of national quality improvement activities that will form the basis of the new IQ action plan. They identified six priorities for action.

1. Develop and implement a nationally consistent approach to the management of health care incidents – this should include a major focus on 'open disclosure' of adverse events.
2. Implement a national medicine strategy for the improved management of medications across all health and disability sectors – the strategy should focus on medication reconciliation and high-risk medication management.
3. Develop and implement a national programme that is designed to improve patient-centredness and the flow of patients across the continuum of care, from the primary or community sector.
4. Improve infection prevention and control throughout the sector.
5. Provide undergraduate training for all health professional teams in quality improvement methods (eg, clinical audit).
6. Implement a strategy for improving consumer participation in health care.

Priority action areas 3, 4 and 5 are particularly pertinent for Pacific peoples' health. Priority area 5 could include Pacific cultural competence training.

## Discussion

The rich diversity of Pacific peoples' ethnic and cultural backgrounds, social and economic situations, histories, beliefs and values means that approaches to health care need to be flexible to meet the different needs and expectations of Pacific peoples. For example, for some Pacific people language barriers can be a significant safety and quality issue. For other Pacific people, cost of health services might be a difficulty.

The continued implementation of the PHCS can help to improve the quality of health care for Pacific peoples. Although financial issues continue to be a key barrier for some Pacific groups to access primary care, non-financial barriers to care now also need to be brought into focus. The PHCS's population health approach is a key driver for improving quality of care for Pacific peoples. Evidence suggests that Pacific cultural competence is a tool for removing barriers between Pacific people and the health care system. Just as the IQ strategy acknowledges the importance of cultural competence in improving quality outcomes, so the development of the second IQ action plan may be a platform for developing Pacific cultural competence across the workforce. The work under way by the Ministry of Health, DHBs and professional bodies on Pacific cultural competence is (and will be) available to inform this work. PHOs and DHBs should begin to report on their IQ actions for Pacific peoples and how all IQ actions affect high-needs populations.

Improving the quality of health care for Pacific peoples depends on making improvements throughout the system. The existing IQ approach has been in place for some time and appears to have the potential to bring a more systematic and focussed direction to improving quality of care for Pacific peoples. Currently it appears to offer the best umbrella or shelter for this important work that extends across (and beyond) the health sector. The challenge is to find a driver that can direct, encourage and disseminate good practice, and as necessary manage for accountability the range of initiatives already in place.

## 5. Conclusion

Evidence shows that high-needs populations such as Pacific peoples, although entering the health system (as seen by high PHO enrolments), are often not getting the appropriate and quality care they need. High Pacific ambulatory-sensitive hospitalisation rates and other indicators suggest that specific approaches for addressing Pacific quality of care may be necessary.

Some of the key messages to come out of this discussion document are that:

- continued and concerted efforts across agencies are needed to improve the underlying socioeconomic determinants of health for Pacific peoples
- improving health system responsiveness through improvements in quality of care is the way to achieve better health outcomes for Pacific peoples
- Pacific peoples' belief systems have an impact on their use of health care services, as do the acceptability and flexibility of services and clinical behaviours
- an important safety and quality issue for Pacific people is the provision of effective communication by providers, including the use of Pacific languages
- Pacific cultural competence is a crucial tool for improving quality of care for Pacific people
- Pacific cultural competencies should be considered integral to the definition of quality of care to move towards quality outcomes. This could best be included in accreditation tools, regulatory criteria and national surveys. Quality indicators are required to identify, define, track, evaluate and improve culturally competent practices and services
- Pacific providers offer a choice of service provision for Pacific people, but most Pacific people are cared for by mainstream providers. Mainstream providers must therefore be responsive to the diverse needs of Pacific people
- the quality and safety of services in the health sector must be continually monitored and improved to ensure that agreed standards are met
- the involvement of clinicians in the measurement and management of quality is essential to improve the quality of care delivered
- reducing financial barriers such as fees and pharmaceutical costs has been a key focus of the Government and is a significant step towards reducing barriers to care for Pacific peoples
- non-financial barriers to care now need to be the focus of the Primary Health Care Strategy (PHCS), and the PHCS's population health approach is a key driver for improving quality of care for Pacific peoples
- the IQ framework and action plan has the potential to assume a greater role in driving further improvement in quality of care. Specific actions may be needed to ensure optimal focus on improving quality of care for Pacific peoples.

## 6. Options for Future Work

The conclusion of this paper leads to the following suggestions for improving quality of care for Pacific peoples.

### Sector collaboration and tools

1. Include a section for Pacific people in the IQ Action Plan 2007-2010, which describes the need and methods of improving the provision of services to Pacific people, and the ways in which this information is disseminated.
2. Explore more concentrated and effective mechanisms for intersectoral relationships to improve the socioeconomic determinants of health of Pacific peoples.
3. Initiate the development and setting of targets to measure progress towards improving quality of care for Pacific peoples.

### Pacific cultural competence

4. More actively implement goals and actions for the provision of culturally competent health care, in recognition of the strategic importance of cultural competence for reducing or eliminating racial and ethnic health disparities.
5. Undertake the development of appropriate Pacific cultural competence tools (for organisations and individuals), and evaluate the efficacy of existing Pacific cultural competence tools and models.
6. Introduce and incorporate these tools into the training and development of health care workers. Specifically, we recommend the inclusion of Pacific cultural competence training under Priority 5 of the 2007–2010 Action Plan, to: ‘Provide undergraduate training for all health professional teams in quality improvement methods’.
7. Require, encourage and as necessary assist all health providers to organise and deliver services in ways that are culturally competent and effective.
8. Develop appropriate and effective social marketing tools for targeting Pacific communities.

### Improving information

9. Promote standardised, consistent approaches to the collection and analysis of ethnicity data (including a Pacific persons first language), and to the design of systems and policies that facilitate the collection of high-quality health data.
10. Introduce incentives to encourage the correct recording of each patient’s National Health Index number as the first step towards a comprehensive information system that enables more sophisticated monitoring of quality indicators.
11. Undertake further investigation to clearly identify and understand the Pacific barriers to quality health care, especially from the patient’s perspective.

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