

# Pacific Health Review

Making Education Easy

Issue 18 – 2013

## In this issue:

- *Primary Care for Pacific People: A Pacific and Health Systems Approach*
- *The Health of Pacific Adults and Children: Findings from the New Zealand Health Survey (July 2011 to June 2012)*



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**Kia orana, Fakalofa lahi atu, Talofa lava, Malo e lelei, Bula vinaka, Taloha ni, Kia ora, Greetings.**

## Welcome to issue 18 of Pacific Health Review.

The research in this issue of Pacific Health Research Review is meant to be read alongside issue 19. Both cover recently released Ministry of Health commissioned reports that discuss the health and wellbeing of Pacific peoples in New Zealand.

This issue comments upon two publications: *Primary Care for Pacific People: A Pacific and Health Systems Approach*, available online at: <http://www.health.govt.nz/publication/primary-care-pacific-people-pacific-and-health-systems-approach> and *The Health of Pacific Adults and Children: Findings from the New Zealand Health Survey (July 2011 to June 2012)*, also available online at: <http://www.health.govt.nz/publication/health-pacific-adults-and-children>.

Comments have been provided by Drs Api Talemaitoga, Kuinileti Chang Wai, Eta Raicebe, Corina Grey and Maryann Heather.

## Introduction

The lack of quality health data and analysis on Pacific people is an often cited issue in the sector. It is encouraging then that the Ministry has commissioned research to better understand the health needs of Pacific people, particularly in primary care.

While many of the health issues have remained unchanged over many years, there are challenging, complex and often interrelated factors behind them. As described below, the research on Pacific peoples' experience of primary care gives us glimpses into what needs to happen if things are to change so that the health issues can be dealt with directly.

The reports covered in this issue show that delivering effective health interventions for Pacific peoples requires major changes in the health workforce that, delivers care and health prevention and promotion programmes, as well as how these programmes are delivered.

We will always need doctors and nurses – but in my view it is the nurses, social workers, nutritionists, personal trainers and midwives that have to be the frontline deliverers of health services to Pacific people. We need to “flood” the community with an appropriate workforce, trained to deliver effective interventions. Doctors are expensive (to train and employ) and I suggest are better used as back-up to provide clinical guidance and oversight. This is very different from the GP focused model of care which has predominated in primary care in New Zealand over the past decades.

The establishment of Health Workforce New Zealand (HWNZ) in 2009 signaled a Governmental commitment to providing national leadership on the development and planning of the country's health and disability workforce. It is timely for more consideration to be given to funding the training of an ‘effective workforce’ that will deliver quality health care and effective health messages to Pacific people. HWNZ has published a report which addresses some of these. issues: *Managed Care Education: Availability, Suitability and Potential of Courses and Qualifications in Regards to Coordinated Care Workforce Skills. A Review for Health Workforce New Zealand* (Currie V, 2012). Implementation of the findings of this report will contribute to addressing the disparities in health outcomes between Pacific and other New Zealanders.

Kind regards

**Dr Api Talemaitoga, General Practitioner**

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## BE THERE FOR YOUR TEAM



## Improving primary care delivery to Pacific peoples and Pacific health outcomes

It is widely recognised that Pacific peoples in New Zealand have significantly poorer overall health across a wide variety of measures, compared with other major ethnic groups. Substantial resources have been allocated over the last 15 years to primary health care, yet preventive measures and the treatment and management of health conditions remain less effective among Pacific peoples. Pacific people appear to have gained least advantage from changes to delivery in primary care in the last decade, compared with other major ethnic groups in New Zealand.

In response to this situation, the Ministry of Health (MOH) and the Health Research Council of New Zealand (HRC) jointly funded a Request for Proposal (RFP) in 2010 – *Improving Pacific Health Outcomes: Research on the delivery of primary care to Pacific Peoples in New Zealand*. The joint initiative sought to improve knowledge about the most effective ways to improve both Pacific peoples' access to and use of primary care and, ultimately, Pacific health outcomes. The RFP called for an exploration of trends in Pacific peoples' use of primary care since the 2001/2 National Medical Care Survey (NatMedCa), a comparison of mainstream primary health care providers and Pacific providers, Pacific peoples' views of primary care, and the identification of barriers and enablers for both Pacific peoples' access to primary care and improved health outcomes.

Drs Margaret Southwick, Timothy Kenealy and Debbie Ryan collaborated on a project to compare Pacific peoples' use of mainstream providers with use of Pacific providers; consider variation by patient gender, Pacific ethnicity and deprivation level; report barriers and enablers to Pacific peoples' use of primary care; identify successful or promising practice and policy; identify measures of quality of primary care that are relevant to Pacific peoples; and seek the presence and voices of under-served, disengaged and 'informal' (non-resident and ineligible) Pacific peoples. Their report was published in June 2012. It provides evidence to support improvements in primary care delivery to Pacific peoples.

The key findings of this report are summarised below.

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**Disclaimer:** This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

### Literature Review

The literature review (reported separately in Pacific Perspectives, 2011) was organised around two domains reflecting two perspectives: domain one focused on primary health for Pacific peoples from a health systems view; domain two explored Pacific peoples' views and understandings, and how to better understand health issues from their point of view.

#### Domain One Findings

The findings highlight poor health outcomes among Pacific peoples. The report suggests that the resulting interpretation of a "Pacific problem" may prevent health providers from examining problems within their own services, cultural assumptions, and culturally framed delivery.

Data that were reviewed for the report revealed potential disconnect between primary health care providers and Pacific patients: General Practitioners (GPs) were less likely to record high levels of rapport with Pacific patients, and Pacific patients had low uptake of subsidised care, high use of Accident & Medical clinics, and lower levels of satisfaction with their experiences of primary health care.

Significantly poorer health outcomes among Pacific peoples compared with the rest of the New Zealand population include:

- higher rates of close contact infectious diseases and respiratory conditions, including asthma, among Pacific children
- high rates of avoidable Ambulatory Sensitive Hospital Admissions (ASH), including high child ASH rates for respiratory infections, asthma and skin infections
- higher rates of severe asthma symptoms, yet lower prevalence of diagnosed asthma and use of preventer medications (suggesting poor management of asthma among Pacific children)
- a higher prevalence of mental health disorders among Pacific young people, who are more likely to attempt suicide; evidence of a poor uptake of mental health services
- higher rates of chronic diseases such as diabetes, ischaemic heart disease and stroke, and greater dependence after stroke
- higher overall mortality from cancer, despite an overall lower incidence of cancers.

The top three barriers to primary health care for Pacific peoples are cost, transport and language. Others include family commitments, difficulty in meeting appointment times, difficulty in understanding the nature/necessity of an appointment, lack of access to after-hours services, communication barriers, inflexible employment, and feeling cultural discomfort when discussing health issues with non-Pacific practitioners. Long waiting times, lack of discussion time with the doctor, crowded clinics, and the bringing and minding of other children are also reported as barriers.

While these barriers have been documented in numerous reports over the past two decades, this review of the literature found that an effective health system response is yet to be demonstrated.

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## Domain Two Findings

The literature review focused on four key areas:

- demographic status: unlike the general New Zealand population, the Pacific population in New Zealand is characterised by youthfulness, rapid growth and high level of urbanisation. Key differences within the Pacific population, particularly between ethnic groups, suggest that a single approach to Pacific health is unlikely to suit everyone.
- ethnic diversity: diverse ethnic groups among Pacific peoples differ subtly in language, religion and, potentially, their health beliefs and expectations of health services. The literature highlights how Pacific identities are fluid, multiple (the proportion of Pacific peoples with more than one ethnicity is increasing) and contested. This presents challenges not only for this research, but also for health care providers who want simple remedies for complex Pacific health issues.
- socioeconomic status: Pacific peoples are over-represented among the unemployed, lower skilled and low income earners. Equity of access to health services and equity of use with regard to need are very important factors to consider.
- health literacy: the report adopted Nutbeam's (2008) concept of health literacy, which is patient-centred and problematises health providers' views. It informed the framework of this research, making it more open to the potential disconnects between health providers and Pacific patients/consumers.

## Pacific View

Pacific consumers were interviewed individually and in groups to understand Pacific worldviews on primary care and how these impact on their access to primary care. A Pacific Expert Advisory Group (PEAG) was established to ensure a high level of cultural integrity and to prevent the worldviews of participants from being 'lost in translation'. Thirty-six focus groups were held in Auckland, Hamilton, Wellington and Christchurch between 30 September and 10 October 2011. Four main themes informed the focus group discussions.

### I. Participants' views of 'health' and 'illness'

A dominant theme that emerged was that health and wellness is more than the mere absence of disease – being healthy indicated that one was leading a 'balanced life', having a state of contentment and feeling full of life. Another strong theme was the role that 'spirituality' played in the concept of health, as did relationships – positive family and family relational dynamics was an important and significant dimension in the sense of wellbeing and health.

### II. A connection between stress and poor health

Participants described stress as a result of not being able to provide the things they felt family needed such as healthy diets and adequate housing. It was also described as being due to complex family dynamics, meeting family obligations, or simply the effects felt from people having to manage very difficult life circumstances. Spirituality, a faith in God, alcohol, kava and eating were identified as ways to manage stress.

### III. Difficulties around seeking help for managing illness

Having to travel some distance to health services or lacking transportation were real barriers to seeking medical help. Other major barriers were the costs of consultation and medicines.

### IV. A Pacific perspective on the quality of the health services accessed

Experiences around consultations with health professionals included descriptions of difficulties in making appointments and the quality of the communications. The doctor's surgery might be fully booked at the only times that people are free to visit, or they see a different doctor every time they visit, which may not result in better outcomes for the patient.

## Health Services View

The research team held interviews with 50 people from Pacific and mainstream primary care providers, and with those involved in policy and/or funding and planning in Primary Health Organisations (PHOs), DHBs and the Ministry of Health. The interviews sought to understand how health services view Pacific peoples' use of primary care, how services have adapted in response to these views and what problems and solutions they see.

Appointments in primary care: The staff considered that they give better clinical care by scheduling appointments between patients and healthcare professionals, although they acknowledged that people have genuine difficulty keeping appointments. Fifteen-minute appointment slots may not be long enough to respect the family issues or their needs.

Fixed-appointment clinics see "walk-in" patients out of necessity or due to medical priority – some clinics with large Pacific populations have opted for a no-appointment system.

Some clinics operate extended hours to cater for families where both parents are working and cannot come themselves or cannot bring their children during weekdays.

Did Not Attend: Lack of transport was the most frequently cited reason for failure to attend. Lack of a phone was also mentioned. Sometimes not attending points to people choosing not to address a health issue, or reflects what several people referred to as "Pacific time". Overall, outpatient DNA rates are higher among Pacific people than non-Pacific people.

Health literacy, language and interpreters: Apparent mis-understanding in relation to health issues was interpreted as being due to limited patient understanding of their bodies, the difficulty of communication between English and a Pacific language, people choosing to ignore out of a desire to not change lifestyle or from being afraid, and having priorities higher than health issues.

Cost of primary care: Most respondents saw cost as an important problem. Some viewed it as a managed issue, taking many forms, including: undercharging; accepting non-payment or reduced payments; writing off bills; keeping downstream costs low; joining capitation or other schemes that generate higher subsidies; and seeking alternative payers such as ACC, access funding or CarePlus.

Workforce capacity: Senior people interviewed assumed the need for Pacific people in the workforce as a given. All were concerned about current low numbers of Pacific nurses and critically low numbers of Pacific doctors. In addition to not having enough nurses, doctors and other health service workers, there is a need to develop the capabilities of those already present, including primary care management staff.

Health services within a wider social context: There was universal acknowledgement that Pacific health is affected by many social and political and economic factors outside of the health system (such as low average wages, housing issues, and so on).

## Quantitative Methods

The number of general medical services claims has gone down markedly since the advent of capitation. Nevertheless, there were still about 66,000 patients in 160,000 visits in 2010. These claims are made when the patient receives no capitation subsidy and therefore pays a relatively high cost for attending primary care – currently this means attending a practice with which they are not registered, or newly registered, or attending an after-hours clinic.

The number of Emergency Department visits increased by 15% over the previous 4 financial years prior to 2010. The percentage of people who did not wait increased from 1.2% to 2.7% over the same period (i.e., about 2800 people in 2010/2011).

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## Pacific Health Review

### Independent commentary provided by:

#### Dr Kuinileti Chang Wai

Dr Kuinileti Chang Wai, (MBChB, FRACGP, FRNZCGP, MMEDSCI(Hons)) currently works as a General Practitioner in Queensland with some Pacific Island groups and lower socio-economic groups and is General Practice Teacher and Assessor for GP Registrars in Queensland.

#### Dr Eta Raicebe

Dr Eta Raicebe is Fiji-born and educated at Otago University. She has worked in Paediatrics in Fiji, New Zealand and now Australia, and is currently an advanced trainee in General and Community Paediatrics. Eta is interested most in Development Paediatrics and would like to work in the future in promoting early literacy amongst Pasifika children.

## 10 Key Recommendations

The data in this report inspired a set of evidence-based recommendations for practice and policy at the national, DHB, PHO, and practice levels:

1. Require public-funded primary care organisations to provide appropriately anonymous data for quality improvement, accountability and achievement of Better Sooner More Convenient Care (BSMC) health services for Pacific people.
2. Improve consistency in the application of capitation funding at PHO and practice level so as to achieve a population health approach, which includes targeting enrolled patients with high health needs and service delivery models based on a primary care team approach. Many practices are still operating a fee for service regime internally.
3. Improve the use of ethnicity data. Despite near universal collection of data, there is very little analysis or use of this information to improve quality of health services and to determine who is not accessing services. Mandatory reporting of service provision and outcomes by ethnicity would be one mechanism to address health equity.
4. In locating primary care provision, the availability of public and/or private transport is a key factor to enable Pacific peoples to access to primary care.
5. Require improved appointment system approaches in order to deliver Better, Sooner, More Convenient Care to Pacific peoples. This will generally mean practices actively managing a balance between consultations with and without pre-arranged appointments, and flexible length of consultation and appointment times.
6. Implement strategies that derive advantage from the clustering of Pacific peoples by area of residence and by practices they choose to attend. This clustering can facilitate delivery of local solutions within these clusters to target high needs groups requiring chronic care management.
7. Support cultural competence across the health services workforce and training for health professionals in family based approaches in health and well-being.
8. Pacific health workers make a significant contribution to Pacific health improvement, in frontline roles offering language and cultural skills and at every level of the health system, providing insights into the realities of the health system and of Pacific worldviews. Pacific workforce and provider development has been a key resource for supporting Pacific workforce participation at all levels of the health system. This support should be continued.
9. Development of policy for translation services and approaches to support effective communication between Pacific peoples and health care providers is required to address this complex topic.
10. Further investment in the development of ethnic-specific research methodologies to promote intercultural understanding and enhance the richness and knowledge of diverse populations within the New Zealand context.

**Comment (Dr Kuinileti Chang Wai):** This is a very discouraging report in the sense that after more than a decade of health funding, Pacific health care delivery and Pacific health outcomes remains poor. This is more disheartening for those Pacific health workers who are currently working in the frontline for primary care and are very dedicated to improving the health of the Pacific People within their practices.

All the findings are not new and it has validated the long held beliefs and assumptions of most health care workers who are at the coal face of both Pacific and mainstream providers.

However, despite all the negativity around Pacific people's health outcomes, a number of factors need to be considered as follows:

- 1) The effects of the Global financial Crisis of 2007. It had tremendous effects on the world economies. At a time when most major companies (i.e. manufacturing sector, finance, agriculture and insurance sectors) were facing liquidation, this clinician saw the effects of this at a primary care level in New Zealand. Many Pacific people who were the main bread winners for their families lost jobs. As a consequence, priorities for health diminished in light of other family needs such as food provision.
- 2) If after more than a decade of health provision, the desired health outcomes for Pacific people are still unattainable, then perhaps a health system overhaul is needed. Perhaps it is time to consider international community health systems where the health dollar follows the patients.
- 3) The effects of natural disasters such as the Christchurch earthquake should also be considered in light of the effects on the mental health of Pacific people within these communities. In addition, access to medical care was a significant problem, given the destruction of clinic sites.
- 4) Better sooner more convenient care cannot be achieved if affordability remains a major issue for all the reasons already alluded to in this report.
- 5) Clinicians in mainstream providers need to be adaptable in their delivery of health care to Pacific people in terms of undertaking what has been proven to be effective in lead Pacific practices where improvement in health outcomes for Pacific people has been accomplished.
- 6) Pacific people themselves need to make their health a priority and take responsibility for their health. In a study on "Samoan perspectives on adherence to blood pressure medication", (Chang Wai et al.2009), it was clear that Pacific people who have been assimilated into the New Zealand culture for at least 15 years made health a priority and therefore were more prepared to keep doctors' appointments and adhere to their medications.
- 7) Health needs for young Pacific people would be different from those needed by the older Pacific population and delivery of health would have to be adapted accordingly.
- 8) While this clinician is in agreement with most of the recommendations by the authors of this report, there are a few that could be difficult for frontline staff. For example, while appointment systems need to be flexible and be actively managed, this all depends on workforce capacity within a practice. In addition to this, some responsibility has to be on the patients themselves to make their health a priority and make every effort to attend appointments and adhere to prescribed medications.

Furthermore, ethnic-specific research methodologies may improve understanding of cultural diversity within the New Zealand context, but it does not necessarily mean that it will help improve health outcomes for Pacific people.

**Comment (Dr Eta Raicebe):** This paper once again highlights the plight of Pacific People in New Zealand. Bearing in mind our ethnic diversity, collectively we have made minimal improvement in our health outcomes, despite enormous effort and resources. Our health outcome improvements have been in our improved screening rates and immunisation rates. I was dismayed that we continue to have higher rates of close contact infectious diseases, higher rates of chronic disease and now, disturbingly, our youth have a higher rate of mental health disorders and do not seek mental health services, as well as an increase in our overall mortality from cancer.

This paper stems from our dismal health outcomes and a Health Ministry directive to understand Pacific people and their attitudes to seeking primary healthcare as well attitudes of primary healthcare workers' attitude towards their Pacific clients.

Important strengths of this review included the enormous effort to gain a collective voice for our Pasifika people. This was done so that health workers could understand us better. Pacific people know what is good for them and our view of health is a holistic approach. However, our economic disadvantage is highlighted as a root cause to our continued poor health outcomes. It would have been interesting to find out what our Pacific community thought would improve health outcomes.

Challenges in providing primary healthcare services to Pacific people include missed appointments, unscheduled presentations leading to opportunistic screening and paucity of systematic quality data. Cultural competency among health workers is invaluable as well as support for the small group that comprises the Pacific health workforce.

Publicly-funded primary health organisations has been recommended in this paper. The next challenge will be to find willing PHOs. Having PHOs collect anonymous data is a good measure of accountability and may enable researchers to publish evidence-based data concerning Pacific people and thus enable policy makers to implement strategies that could turn the tide in the bid to improve Pacific health outcomes.

## The Health of Pacific Adults and Children: Findings from the New Zealand Health Survey (July 2011 to June 2012)

Information collected by the New Zealand Health Survey (NZHS) monitors the health of the population and is an important source of supporting evidence for health and health service policy and strategy development. Historically, the NZHS consisted of individual surveys conducted once every three or four years, with a wider survey programme also including Adult and Child Nutrition Surveys, Tobacco, Alcohol and Drug Use Surveys, Te Rau Hinengaro (the New Zealand Mental Health Survey) and an Oral Health Survey (Ministry of Health 2009).

From May 2011, the NZHS and the various surveys within the wider survey programme have been integrated into a single survey that is in continuous operation, comprising a consistent core questionnaire with a flexible programme of rotating thematic/topic modules. Analyses of data from the 2011/12 NZHS have led to several publications reporting on a range of health topics, including a report released in March 2013 on the health and wellbeing of Pacific adults and children.

Key findings from the report are discussed in this article, with accompanying commentary by Dr Corina Grey and Dr Maryann Heather.

**Comment (Dr Maryann Heather):** Interesting data, the basis of which can be used to develop and promote programmes specifically to improve some of the statistics discussed in this survey.

### Health behaviours and risk factors

One in seven Pacific children is given solid food before 4 months of age

The Ministry of Health recommends exclusive breastfeeding until a baby is about 6 months old, when solid food should be introduced. One in 7 (14%) Pacific children under 5 years had been given solid food before 4 months of age. This rate exceeds that for non-Pacific children.

**Comment (Dr Maryann Heather):** Some studies have shown an increased risk in obesity and chronic diseases like diabetes, with food being introduced prior to 4 months of age.

The importance of promoting and encouraging breastfeeding in Pacific Island Mothers is a priority. At the primary care level, there continues to be a lack of support and access to lactation services for mothers.

Diet and physical activity

Pacific adults and other adults have similar levels of daily fruit intake, but Pacific adults are less likely to eat at least 3 servings of vegetables each day (46%) than the population overall (68%) and they are less likely to be physically active (46%) than the general population (54%).

Pacific children and adults have higher obesity rates

Over 1 in 5 Pacific children (23%) and 3 in 5 Pacific adults (62%) are obese. These rates are at least 2.5 times as high as the rates for non-Pacific children and adults, respectively. Obesity rates for Pacific adults and children have not changed since 2006/07.

**Comment (Dr Maryann Heather):** It is a concern that rates have remained unchanged for the last 6 years. The emphasis on health promotion, education and exercise prescription is a priority via programmes like Green Script, 12 Week Challenges, Boot Camp, Zumba, and sports groups.

One in 4 Pacific adults smoke

About 1 in 4 (26%) Pacific adults is a current smoker. This rate is 1.3-fold higher than the rate for non-Pacific adults.

**Comment (Dr Maryann Heather):** Smoking cessation programmes and screening in primary care remain a priority in reducing this statistic. The impact on families with passive smoking exposure and risk of respiratory diseases i.e. asthma, bronchiolitis, is often seen in primary care.

### Health status and conditions

Diabetes disproportionately affects Pacific adults

One in 10 Pacific adults (10%) has been diagnosed with diabetes. This rate is more than 3 times as high as the rate for non-Pacific adults, after adjusting for age and sex differences.

Moreover, the 2008/09 New Zealand Adult Nutrition Survey results suggest that about half of all Pacific adults with diabetes (diagnosed or indicated through survey blood tests) had undiagnosed diabetes. This finding suggests there is scope to improve the diagnosis and treatment of diabetes, particularly for Pacific adults.

**Comment (Dr Maryann Heather):** There is a huge amount of work needed to diagnose and manage diabetes in the Pacific Population.

It requires collaboration between all levels of the health sector from policy level down to the primary care level to implement changes.

All too often we deal with the diabetic complications of having patients with uncontrolled diabetes including diabetic sepsis, amputations, retinopathy and dialysis. The socioeconomic, financial and psychological impact on patients is enormous.

Mental distress affects 1 in 10 Pacific adults

One in 10 Pacific adults experienced psychological (mental) distress in the past 4 weeks (10%), which is a much higher rate than the national average (6%). Conversely, the rate of diagnosed common mental disorder for Pacific adults (7%) is much lower than the national average (16%).

Together, these findings suggest Pacific adults may be less likely to seek help and/or they face more barriers to accessing mental health services than other people.

**Comment (Dr Maryann Heather):** Mental distress/illness in the Pacific Community is probably unrecognised and therefore underdiagnosed. The first presentation may occur via ED at hospital or an encounter with the police, at which stage the Crisis team may be involved. One finding not mentioned is the role of drugs/alcohol with mental health in the Pacific Population.

Those working within primary care are best placed to screen for mental illness, as are school clinics, which often identify and manage at-risk youth with mental illness and may refer appropriately to secondary care. In South Auckland, services like Whirinaki and Faleola are well utilised by primary care. I believe there is a place for psychologist/counselling services to be provided, especially in those patients with mental distress and not necessarily with mental illness. The barrier to this service being available is funding, the availability of personnel, as well as accessibility.

The utilisation of screening tools and the recent introduction of e-chat (an online questionnaire that patients complete in the waiting room on the iPad) in the clinic, as well as the patient prompts for screening patients in clinic, have been very useful.

Public awareness of mental health illness has been increased by having campaigns e.g., depression. This is definitely a positive step in highlighting its presence in the community, as well as having online access to specific websites that deal with mental health.

### Access to health care

Pacific experience unmet need for health care, especially due to cost

About 31% of Pacific adults had experienced an unmet need for primary health care in the past 12 months. Cost prevented 17% of them from using GP services and 10% from using after-hours services when they had a medical problem. In addition, many Pacific adults (15%) were not able to get an appointment at their usual medical centre within 24 hours and almost 9% reported that a lack of transport prevented them from visiting a GP.

**Comment (Dr Maryann Heather):** GP clinics often have appointment systems in place as well as catering to walk-in patients and emergencies.

Issues with transport arise, as many families may only have access to a car after work and in the weekends, therefore missing booked appointments during normal clinic hours.

About 26% of Pacific children had experienced an unmet need for primary health care in the past year. This included 16% of Pacific children who were not able to get an appointment at their usual medical centre within 24 hours. Compared with adults, cost was less of a barrier for Pacific children in accessing GP services (7%) or after-hours services (8%). However, a lack of transport prevented 7% of Pacific children from accessing GP services. Pacific children were more likely than non-Pacific children to have experienced most of these types of unmet need.

A substantial proportion of Pacific adults (13%) and children (11%) did not collect 1 or more prescription items in the past 12 months due to the cost. These rates were at least 1.6 times as high as the non-Pacific rates.

### Pacific are more likely to have had teeth removed due to poor oral health

About 11% of Pacific adults and 6% of Pacific children had had a tooth removed due to poor oral health in the past 12 months. These rates exceeded those for non-Pacific adults and children.

About 73% of Pacific children aged 1–14 years had visited a dental health care worker in the past 12 months, a lower rate than the national average (78%). Only 1 in 3 (33%) Pacific adults (with natural teeth) had visited a dental health care worker in the past 12 months, which is much lower than the national average (49%). Most (78%) Pacific adults usually only visit a dental health care worker for dental problems, or they never visit.

**Comment (Dr Corina Grey):** This paper provides a summary of the health and wellbeing of Pacific adults and children, as reported in the most recent New Zealand Health Survey, conducted between July 2011 and June 2012. In total, 12,500 adults aged ≥15 years and 4500 children aged 0–14 years completed face-to-face computer-assisted interviews for this national study, which last occurred 5 years previously. Of these, 938 adults (7.5% of the adult sample) and 730 children (16% of the 0–14-year sample) were Pacific, contributing to a total of 1668 Pacific people (10% of the entire sample), slightly less than the number of Pacific people included in the 2006/07 New Zealand Health Survey (n=1831).

The results for Pacific peoples were similar in nature to that of the 2006/07 New Zealand Health Survey and other studies, which have shown significant disparities in the health and health-related behaviours of Pacific peoples compared to the non-Pacific New Zealand population. The fact that our obesity rates remain extremely high (2.5 times that of non-Pacific peoples) and are unchanged from the previous Survey suggests that more needs to be done to address obesity and its antecedents in the Pacific population. Associated with this is the worrying finding that 10% of the Pacific sample had been diagnosed with diabetes (with the suggestion that just as many again may have undetected diabetes). The Survey reported that Pacific adults are less likely than the overall population to eat 3 servings of vegetables a day and to be physically active, but interventions targeting health behaviours are unlikely to have a significant effect on their own. Energy-dense and nutrient-poor foods, such as sugary soft drinks, meat pies and takeaways are often cheaper and easier to prepare and access than fruit, vegetables and high-quality meat, making them the more obvious choice for Pacific families that are struggling financially. Interventions to improve access to better quality foods, such as removing the GST from fruit and vegetables, school-based nutrition programmes and community garden initiatives, are just some of the things that could be done to address obesity in our Pacific communities. Church-based and Pacific community programmes, such as LotuMouli (Counties Manukau DHB) and Healthy Village Action Zones (Auckland DHB), are examples of innovative and successful strategies that have been used locally to address obesity and other issues important for Pacific peoples in New Zealand.

Unmet need for healthcare is still an important issue for Pacific peoples, with 31% of adults and 26% of children indicating that they had forgone attending primary health care services when needed in the past 12 months. In adults, cost (27%), lack of appointment availability (15%) and transport (9%) were the most common reasons for unmet need. While many of the PHOs serving large numbers of Pacific peoples have substantially reduced the cost of primary care, for some Pacific peoples, even a 'small' consultation fee of \$10 may be the difference between seeking care when needed and not. Furthermore, Pacific peoples attending practices in 'wealthier' areas face fees upwards of \$50 for an adult consultation and \$15 for a child. Initiatives making under-6s free after-hours at Accident and Medical Centres in some areas has resulted in improved access to primary care out-of-hours, but adults visiting these Centres are still confronted with exorbitant fees. In addition, 13% of Pacific adults and 11% of Pacific children did not collect at least one prescribed item in the past year due to cost – 1.6 times the rate of non-Pacific peoples. This finding has major implications for the increased co-payment for prescription medications introduced at the beginning of this year, which raises the cost of subsidised medications from \$3 to \$5 each.

Oral health also remains a significant source of disparities for Pacific peoples, with both adults and children having a higher rate of tooth removal for decay in the past 12 months. The fact that almost 8 out of 10 Pacific adults stated that they only visited a dentist for dental problems or not at all underscores the need for dental care to be offered at a substantially lower cost than it is currently if we are serious about reducing disparities in oral health.

In summary, these findings reinforce what is already known about Pacific health in New Zealand. For many years, health statistics have indicated that the health of Pacific peoples is poorer than that of the total population. It is laudable that Pacific children were oversampled in the Survey to allow differences between Pacific and non-Pacific children to be explored. It is surprising that Pacific peoples comprised only 7% of the adult sample. While describing the state of health of Pacific peoples as a whole is a good first step, such a small sample size is unlikely to allow differences between Pacific groups to be studied in any detail. We may be missing important differences in health-related behaviours between Pacific groups that could be amenable to targeted interventions.

**Comment (Dr Maryann Heather):** To help mitigate the high numbers of Pacific children who are given solid food before 4 months of age, we need to support the promotion of breastfeeding and introduction of food at 6 months.

Health promotion, awareness and campaigns providing key messages around nutrition and physical activity are expected to help increase physical activity and reduce obesity. Supporting programmes like Kids In Action (identifying and working with obese children, promoting healthy eating habits and activity) is essential.

There remains a high number of undiagnosed diabetes in the Pacific Population. Health screening in the community, churches as well as in primary care surroundings is one solution, but we must also be opportunistic when patients are presenting to clinic.

In our primary care clinic, there has been great success with the CCM Diabetic team, which works on the model of being a one-stop-shop. The patient sees the GP, Diabetic Nurse or community health worker and schedules appointments on site with the podiatrist, dietitian and photoscreening. Any patients of particular concern are referred to the Multidisciplinary team or Primary Healthcare team (homevisits). This is perhaps a model of care that could be promoted in other primary care clinics.

Despite being a low-cost access clinic, cost still remains an issue for many patients. Patients frequently use after-hours care in the evenings and weekends, which incurs a greater cost for patients as well as presenting to the Emergency Department.

Failure to collect a prescription item due to cost is a frequent scenario in primary care. The recent increase in prescription costs this year has made the situation even more unaffordable for patients and more stressful financially. We often see very large families and often on limited income, the priorities and choices become restricted and are reflected in not filling scripts and presenting to clinic.

Failure to visit a dental healthcare worker is another common scenario for patients, who present to clinic with dental complaints including dental pain and abscesses. The major barrier to seeking dental care is cost. However, this would be true for most of the population in New Zealand. Health promotion, education and awareness of good oral hygiene is important to improve these statistics, in addition to having access to low-cost dental care in the future.

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## Pacific Health Review

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