

Primary healthcare for Pacific People in New Zealand

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1.0 Executive Summary

Pacific people in New Zealand consists of several distinct language and cultural groups. They are among the fastest growing ethnic groups in the country. Pacific people are over-represented at the lower end of the socioeconomic spectrum and their health needs are greater than other New Zealanders. There is good evidence to suggest that they are not getting access to adequate primary health care services.

Per capita primary and preventive health care utilisation rates among Pacific people are lower than other New Zealanders. They are over-represented in selected hospital discharge statistics for conditions which are preventable. The reasons for the differences are unclear but there are significant barriers to primary care for Pacific people. These include financial, language, cultural reasons, and inadequate availability and inappropriate delivery of primary health care services. Per capita expenditure on diagnostic support and pharmaceuticals is lower in areas where Pacific people live.

The primary health care system in New Zealand is dictated by the open market which works against early access for Pacific people. Existing funding arrangements favour established providers even though the evidence suggests that conventional general practice does not adequately meet the needs of Pacific people. The main areas of concern for Pacific people are barriers created by co-payments and limited access by Pacific individuals and organisations to capital required to enter the primary care market in a meaningful way. Existing Pacific providers are concerned at the 'standard' state subsidies when there is good evidence of higher health needs among Pacific people.

In response to opportunities provided by the health reforms, a number of 'for-Pacific-by-Pacific' initiatives in primary care have been established throughout New Zealand. The full impact of these developments are yet to be determined but process indicators suggest that utilisation by Pacific people is better and selected outcomes improved e.g immunisation coverage are better than conventional delivery models. However, these initiatives suffer from lack of capital and shortage of Pacific people with clinical and health management skills. Moreover, they are small and susceptible to external factors beyond their control.

Pacific-owned models of care provide excellent opportunities for population health interventions and for enabling greater community involvement in health care planning, delivery and evaluation. While the approach presents significant financial, managerial and clinical risks, the opportunity presents the best prospects for improving health outcomes for Pacific people in New Zealand. Creative funding and technical support from state agencies is required if these developments are to be sustained. Action must also be taken outside the health sector before health improvements can be achieved. Strategies which could improve health outcomes for Pacific people include the following;

- In areas where there is a high concentration of Pacific people, every effort should be made to support the development of primary health care services owned and managed by Pacific people. These developments should encourage community involvement in the planning, management and delivery of services to meet local needs. Consideration should be given to the development of fewer bigger provider groups to improve

efficiencies and financial viability and to enhance their ability to participate effectively in the sector. The development of a 'Pacific Health Management Organisation' or IPA-type organisation needs further consideration.

- Contracts for service provision should move towards better definitions of health outcomes for Pacific people rather than focusing on process measures. There is an urgent need to develop reliable and meaningful health outcome indicators for Pacific people. Where outcomes are known to be inadequate, providers should be required to achieve reasonable and/or desirable levels linked to their contracts.
- Where the number of Pacific people do not justify the establishment of Pacific-owned services, mainstream providers should be encouraged and supported to provide 'Pacific-friendly' services. Guidelines could be developed for use by mainstream service providers to enhance the effectiveness of their services.
- Patient co-payments should be kept to a minimum and funding arrangements between providers and the funder should reflect this. Capitation payments could be a suitable method provided the funding formula reflect the poor socioeconomic circumstances and high health needs of Pacific people. Providers should not be allowed to exclude certain clients and accountability arrangements should ensure that providers actually provide care for the money received.
- A strategy for training Pacific providers and individuals in policy, governance, management and clinical disciplines is required if Pacific-owned initiatives are to survive. The Clinical Training Agency should consider supporting training programmes for Pacific clinicians and health managers.
- Research and development of suitable health outcomes for Pacific people needs further consideration. Improvements in health status would be assisted by the development of clearer goals and indicators for measuring progress.

Providers should be encouraged to improve delivery of care and to overcome known barriers to care for Pacific people. Services should include as many preventive and curative services as possible in the same contract. Service providers should support the training and recruitment of appropriately qualified staff.

2.0 Background

The National Health Committee (NHC) is currently reviewing the provision of primary health care services in New Zealand. The review provides the basis for improving the provision and quality of primary care particularly for 'hard-to-reach groups' in New Zealand by identifying ways of improving access to care. A full description of the project and Terms of Reference is attached as Appendix 1.

This is a discussion paper on primary health care services for Pacific people in New Zealand developed as part of a series of discussion papers produced for the NHC.

Part I describes the demographic profile, socioeconomic circumstances, morbidity and mortality patterns and health service utilization by Pacific people. Part II describes primary health care delivery and funding arrangements in New Zealand. Part III examines primary health care delivery and new models of primary health care delivery for Pacific people in New Zealand. Part IV discusses population-based approaches in primary care including Community Orientated Primary care (COPC). Suggestions for improving funding, delivery and quality of primary care for Pacific people are presented throughout the report.

3.0 Introduction

People from the Pacific have been in New Zealand for over 100 years. In 1945, people of Pacific origin made up just 0.1% of the total New Zealand population, but in 1991 the number totaled more than 167,000 (4.9%) and more than 200,000 (5.9%) in 1996. Statistics New Zealand estimates that this population will make up 7% of the New Zealand population by the year 2031. People of Pacific origin have contributed in a significant way to the political, social, cultural and sporting profile of New Zealand society. Adverse socio-economic circumstances, changing epidemiological and demographic characteristics of this population suggest that the poor health of Pacific peoples will affect the overall health status of the New Zealand population in the future.

3.1 Demographic Characteristics

The Pacific population is under-enumerated during the census of New Zealand population, sometimes by up 32% (1). Data relating to specific health events also underestimate actual incidence. Selective migration from the Pacific for treatment, changes in the definition of ethnicity used in the census and data collection sources and differences in definition of ethnicity used in the numerator and denominator populations seriously undermine the accuracy of morbidity and mortality information. A small review of cases of cervical cancer in the Wellington region showed that the rate in Pacific women was comparable with other ethnic groups despite reported figures which showed a higher rate of cervical cancer among Pacific women.

The Pacific population in New Zealand is characterised by a high birth rate and low death rate making it among the fastest growing ethnic groups in the country. Children and young people less than 14 years of age comprised 34% of the population compared with 19% of the New Zealand population. Total fertility rate is 3-4 times the rate in the general population with only a small reduction in total fertility between 1981 and 1991. High population growth rates are attributed to low utilisation of family planning methods and a strong cultural desire for large families. Therapeutic termination rates are highest among Pacific women in New Zealand but the reasons for this are uncertain. Immigration policy changes in the early 1990s have significantly reduced the number of people emigrating from the Pacific Islands.

Only 3% of the Pacific population are aged 65 years and over compared with 15% of the national population.

The 'Pacific People' community consists of several distinct language and cultural groups. The Samoan community is the largest of the ethnic groups (51%), followed by the Cook Islands community (22%), Tongan (14%), Niuean (9%), Fijian and Tokelauan communities. The Pacific population is heavily concentrated in urban centres of Auckland (66.6%) and Wellington (15.6%). Dispersion to provincial centres has been increasing in recent years. While migration was an important contributor to population growth in early years, 50-60% of all Pacific people living in New Zealand in 1996 was born here. The majority of the children and young people are born in New Zealand and many do not affiliate with the traditional social and cultural values of their parents. Inter-marriage and cultural assimilation has produced a sub-culture of importance needing specific consideration for healthcare provision (2).

3.2 Socioeconomic circumstances

Pacific people are over-represented at the lower end of the socio-economic spectrum compared with other New Zealanders. Socio-economic disadvantage has been closely linked with poor health status. Unemployment among Pacific people is high. In 1997, 17% of Pacific people were unemployed compared with 9.5% of European new Zealanders and half of all unemployed Pacific people were aged between 15 and 34 years. In 1991, 80% of Pacific people earned less than \$20,000 per annum compared with 64% of other New Zealanders. This situation has not changed significantly in recent years. Traditional commitments to family and society, and remittances to family members remaining in the islands of the Pacific have perpetuated a 'hand to mouth' existence for many Pacific families in New Zealand. A survey by the Manukau City Council in 1993 showed that Pacific families were financially and socially worse off than any other ethnic groups in that city.

Overcrowding and poor quality housing is one of the major public health problems for Pacific families. In 1996, the average number of people per Pacific household was 4.2 compared with the national average of 2.8. More than 26% of Pacific households had more than seven people living in it compared with national rate of 4.6%. Over-crowding among Pacific households is more likely to be due to economic hardship rather than cultural preference. Pacific peoples depend more than other groups on renting their dwelling but there is also anecdotal evidence of continuing discrimination against Pacific people in the rental housing market in Auckland. Much of the excess in childhood morbidity among Pacific children in New Zealand could be attributed to poor housing. There is as yet no serious attempt to address housing problems among minority and disadvantaged groups as a cause of poor health in New Zealand.

3.3 Morbidity and Risk Factors

The 1992-93 Household Health Survey showed that Pacific people were the largest group who rated their overall health as poor/not so good (6). They were also the least likely to exercise regularly and while there is debate about the accuracy of the Body Mass Index (BMI) as a measure of obesity in Polynesians, 75% were overweight. Obesity is more prevalent among Pacific people in New Zealand compared with Pacific people living in the

islands of origin. Obesity is the major cause of morbidity for adult Pacific people. It is also a growing problem among Pacific children and young people in New Zealand.

Pacific children have poorer health status than other New Zealand children. Hospitalisation rates for respiratory conditions, infectious and parasitic diseases, burns and unintentional injuries exceed national rates. Age-specific annual notification rates for rheumatic fever between 1990-1995 for children aged 10-14 years was 77.7 per 100,000 for Pacific children, 30.4 per 100,000 for Maori children and 1 per 100,000 for European children. The current epidemic of meningococcal meningitis is a particular problem for Pacific children with incidence rates of 32.9/100,000 for Pacific peoples, 13.7/100,000 for Maori children and 7.9/100,000 for European children. These childhood problems are consequences of poverty and substandard housing (3).

While breast feeding rates continue to be high among Pacific mothers, other health promotion and disease prevention strategies are problematic. Immunisation coverage continues to be a major concern with Pacific children being least likely to have received full immunisation by age two years. A survey of immunisation coverage in the Northern Regional Health Authority region in 1996, showed that 53% of Pacific children were fully immunised at 2 years compared with 45% of Maori children and 72% of European children. Pacific children were more likely to fail their hearing test at new entrant level despite reported lower rates of admission for otitis media.

Estimated iron deficiency among Pacific children at 36 months is 30% compared with 7% among European children. A recent school based survey showed that iron deficiency could be higher in adolescent Pacific girls.

Young Pacific people generally show morbidity patterns similar to that of other young New Zealanders. A needs assessment process carried out by Pacific young people in the North Health region showed that identity crisis, poor self esteem and lack of confidence could be important underlying contributors to the observed problems of suicide, unwanted teenage pregnancy, alcohol misuse and sexually transmitted diseases.

Much of the burden of ill health among Pacific adults could be attributed to poor nutrition and a sedentary lifestyle. However, there is no recent reliable information on diet and nutritional habits of Pacific peoples in New Zealand although it is generally known that their dietary patterns have changed markedly and are more closely aligned those of other New Zealanders. Specific dietary changes include increases in energy intake, saturated fat and dietary cholesterol, refined sugars and sodium and a decrease in dietary fibre. Dietary patterns of Pacific people are influenced by place of residence and if one parent is of non-Pacific origin. The high cost of imported food items from the islands in comparison to local food items appears to be the primary reason for the dietary change. A study of Tongan and Tokelauan children aged 10-13 years showed that they had no preference for traditional food items, had a high intake of meat, bakery products, fast foods with a virtual absence of vegetables and fruit. It is clear that much of the prevalent adult health problems are related to dietary change, which is apparent at an early age.

Pacific people consume alcohol less often than Maori and European, but they consume more alcohol at the last occasion than other New Zealanders. 57% of Pacific people do not consume alcohol compared with 12% of the general population. Information on smoking prevalence is sparse but the indications are that smoking rates are midway between Maori and European rates. In 1981, 32% of Pacific peoples aged 15 years and over smoked compared with 13% of the general population. Pacific women had the lowest smoking rates compared with Maori and European women. In 1996, 28% of Pacific men and women smoked cigarettes.

Non-communicable diseases are the leading causes of morbidity in the adult Pacific population. The prevalence of Non-insulin Dependent Diabetes Mellitus (NIDDM) is 3-4 times the rate of European New Zealanders and complications are common. NIDDM is the leading cause of end stage renal failure presenting for dialysis at Auckland hospitals. Pacific people with NIDDM have the poorest knowledge about NIDDM and are least likely to be receiving optimum treatment. Reported morbidity from coronary heart disease is lower but mortality rates are higher compared with European rates. The difference is more likely to reflect poor access to health information and care rather than an inherently more severe disease among Pacific people. The prevalence of hypertension is higher among Pacific people compared with other New Zealanders but they are less likely to be on treatment. Pacific men have a higher predisposition to hyperuricaemia and gout. Pacific women have lower blood levels of cholesterol and triglycerides than European women and Pacific men have lower cholesterol but higher triglycerides levels than European men.

While the major cause of morbidity among Pacific people is due to non-communicable diseases, they also suffer from the highest rates of tuberculosis and other infectious diseases reported in New Zealand.

Unintentional injuries were the leading causes of admission to hospital followed by asthma, stroke and coronary heart disease in 1993-94. In spite of a similar coronary heart disease hospitalisation rates, Europeans have a three times higher coronary bypass graft and seven times more angioplasty rate than Pacific peoples.

Admission rates for Pacific people exceeded the rates in Maori and others in all age groups except for young people aged 15-24 years in 1994. Hospitalisation of Pacific children and young people were particularly high. The frequency of hospital use among 65+ year olds is five times higher among Europeans. Pacific people in the young age groups are the main hospital users.

There is no accurate information on the prevalence of disabilities among Pacific people in New Zealand. Better information on the prevalence and types of disabilities among Pacific people is an urgent research priority. Similarly, reliable community based information on the prevalence of mental health problems of Pacific people is not readily available. One study showed that Pacific people were under-represented in total psychiatric admissions but were over-represented in committed patients. This finding has been supported by a recent analysis of institutional mental health statistics which showed that 25% of first admissions for Pacific people were through law enforcement agencies compared with 9% of European cases. The

author concluded that “while Pacific people appear to have low rates of psychiatric illness, the way they come into hospital services and the pattern of utilisation of services suggests that services are not well adapted to better meet the needs of Pacific people”. The most common reasons for first admissions to mental health institutions for Pacific males were alcohol and drug abuse followed schizophrenia. For Pacific woman, affective psychoses, paranoid states and other psychoses were the leading causes of first admissions (4).

3.4 Mortality patterns

Standardised all cause mortality rate for Pacific people is reported to be lower than national rates. However, previous studies have shown that the recording process used and changes in the definition of ethnicity under –estimate the true mortality rate for Pacific people. This is compounded by Pacific people who return to the islands to die.

The leading cause of death for Pacific people between 1988 and 1992 were cancer and coronary heart disease. The rates among Pacific people are generally lower than those of Maori and others. This does not reflect the high hospitalisation rate and the notion that Pacific peoples present with late and more serious disease state.

While the infant mortality rate is similar to the general population, the perinatal mortality rate is 34% higher than the national rate. Many of the infant deaths were due to unexplained intra-cranial haemorrhage thought to be due to abdominal massage during pregnancy. This theory has been refuted by Pacific health workers because of the failure of the authors to appreciate traditional Pacific therapies and the lack of supportive evidence for the hypothesis. Sudden infant death syndrome(SIDS) or cot death among Pacific families was previously reported as low. However a recent review of cases in Auckland showed that SIDS rate increased fourfold between 1994 and 1995. The trend was significant because of the declining SIDS rate among European infants and to lesser extent, Maori infants.

Mortality among Pacific people are similar to the pattern seen among European and Maori young people with suicide and motor vehicle accidents being the leading causes of death.

Coronary heart disease is the leading cause of death for both men and woman with mortality rates midway between rates in Maori and European. One of these studies showed that deaths due to coronary heart disease among Pacific people has not declined in line with national and international trends. The leading sites for cancer in males are lung and prostate, and breast and cervical cancer in woman. Large bowel cancer is rare in Pacific people but liver cancer incidence is four times and stomach cancer is twice the national rate.

3.5 Use of health services

Five-year hospitalisation rates for Pacific people are above the national rates. Admission rates for preventable conditions such as asthma and diabetes are two to three times the national rates. Pacific people with asthma were seen more often in hospital emergency departments and were less likely to be on preventative therapy. Similarly, Pacific people with diabetes develop more complications as a result of their disease. Children of Pacific

origins are six times more likely to be admitted with pneumonia than children of other New Zealanders. These outcomes are likely to be delay in seeking care compounded by traditional beliefs about health and illness, poor access to primary care providers and preference for hospital services.

While mortality and morbidity from coronary heart disease is higher among Pacific people than European New Zealanders, an analysis of coronary artery bypass grafts and coronary artery angioplasty operation rates in Auckland showed that Pacific people had the lowest intervention rates. There is no evidence to suggest that primary care practitioners are not referring Pacific people for assessment and no evidence of more severe coronary heart disease in this population. It is possible that Pacific people are not being offered these cardiac procedures.

Over-representation of Pacific people in hospital discharge statistics could be attributed to lower primary care utilisation. Availability of primary care practitioners is generally lower in areas with a high Pacific and Maori population densities. Also efforts to improve access to primary medical care services do not appear to be effective. One study has shown that Pacific people were more likely not to visit a health professional or to delay seeking care than other New Zealanders. Primary care consultation rates are lower than other New Zealanders. One study showed that general practitioners rated their rapport with Pacific people as the lowest and another study in South Auckland showed that Pacific people were least satisfied with doctors fees. Financial, social language and cultural factors are likely to be important barriers but objective information on their relative importance of these factors is not available. Most Pacific health professional are aware that Pacific peoples are using traditional remedies in New Zealand and traditional healers and/or remedies are often brought from the islands for this purpose.

3.6 Barriers to Care

It is generally accepted that there are significant barriers for Pacific peoples accessing primary health care services in New Zealand. However, there is no hard evidence to support these claims and most of the information has been derived from experiences of health professionals and opinion leaders of Pacific origin. In 1994, as part of the preparation of a report on health status of Pacific peoples in New Zealand, the Public Health Commission identified the following barriers (4);

- Language – especially for older Pacific-born individuals for who English is a second language. Young New Zealand born Pacific people generally prefer English as their first language and indeed many of them are unable to speak a Pacific language.
- Cultural – certain aspects of Pacific cultures prevent people from discussing their personal and health problems with a health provider from a different ethnic group. In many Pacific cultures, beliefs about health and illness are different from mainstream culture. Sexual and reproductive health concerns are not likely to be openly discussed and sensitivities surround people with mental illness. Unless, providers are empathic with their worldview, healthcare interventions can become ineffective.

- Lack of Information – in many cases, Pacific people has been unable to access health services appropriately because they are unaware of the services that are available. Traditional printed methods of information delivery have been shown to be less effective for these communities who have a preference for oral dissemination of information. An evaluation of the National Heart Foundation Pacific Heartbeat programme showed that people who attended face to face information sessions were generally better informed than those who relied on traditional means of obtaining information.
- Cost – anecdotal evidence supported by several studies show that the overall cost of primary care is a major barrier for Pacific families. In 1994, a survey of households in Manukau city showed that two thirds of Pacific families postponed their visit to the doctor because they could not afford it compared with one third of European residents. Economic barriers are influenced by other considerations such as community commitments, budgeting skills, and relative importance of the medical problem and confidence with health providers. One survey in Auckland in 1985 showed that the average Samoan contributed \$1,500 during the previous year to community and kinship obligations compared with \$500 by Cook Islanders and \$250 by Europeans. Similarly, many Pacific health providers are aware of Pacific peoples paying for alternative Chinese remedies which can often cost more than conventional primary care services.

Government attempts to improve access to primary health care services in New Zealand through the provision of subsidised health care by way of community services cards have been only partially successful. Approximately half of eligible people possess Community Services Cards. “Hidden” costs associated with seeking health care could be significant e.g transport and child care arrangements.

- Health is low priority – Educational levels, socio-economic circumstances, family, cultural and traditional commitments has created a type of existence which focus on immediate needs such as food, housing, church and kinship obligations.
- Traditional remedies – All Pacific communities have their own traditional practices and practitioners which Pacific peoples use alongside conventional primary care. However, there are no authoritative studies on the extent and types of traditional practices being used in Auckland. One small study in Wellington showed that 30% of children admitted to the children’s ward had received traditional remedies before admission.
- Appropriateness of Care – Pacific people are more likely to use services where they feel welcomed and able to communicate with their caregivers. The philosophy of the service and delivery staff could either enhance or discourage attendance. Pacific people are perceptive and staffing arrangements, behaviour and service style which could be interpreted as unfriendly would turn people away. Confidence and trust in their care givers is an important requirement.

4.0 Primary Health Care Delivery and Funding In New Zealand

Primary health care service delivery in New Zealand is dominated by primary medical care providers. Funding arrangements reinforce the central role of general practice and practitioners and very few alternative models of care are available. The health reform has provided limited opportunities for other models of care to be established but these are not likely to change the style of delivery by mainstream service delivery in the short term. Health Funding Authority attempts to change the provision of primary care have been successfully resisted by established providers. The funder has focused on audit of claims and administrative changes within the sector rather than outcome or effectiveness measures (5).

4.1 Independent Practice Associations

Primary medical care services are predominantly provided by general practitioners (GP) as private enterprises. These services are funded by government subsidies and benefits with variable levels of patient co-payments depending on the fees set by the GP. Existing GP services are generally well regarded by the general public. In response to the health reforms, GPs have formed groups called Independent Practice Associations (IPA) primarily to protect their political and clinical freedom and resist government intervention. A number of positive developments have taken place especially in continuing education for GPs and quality of care issues but better coordination of services remain problematic. IPAs are regarded by non-GP groups as better serving the interests of GPs rather than the patient.

CareNet is a non-IPA group of GPs which oppose the IPA philosophy, funding arrangements, health care delivery and promote professional values ahead of financial incentives. The group proposes the retention of Section 51 as an alternative funding arrangement to the national IPA contract.

4.2 Third Sector' Approaches

Healthcare Aotearoa is an umbrella organisation which represents the interests of smaller community-owned organisations such as the Union Health Centres, iwi-based Maori services and other groups. It provides management and contract negotiation services as well as protocol development and quality assurance. Members continue to have direct contracts with the funder but share the benefits negotiated by the group. Pacific providers identify with the philosophy of Healthcare Aotearoa but few Pacific groups have joined the organisation.

4.3 Funding for Primary Health Care Services

Funding arrangements can enhance or hinder early access to primary care. It is clear that existing fee-for-service funding arrangements based on the Community Services Cards do not encourage early access to primary medical care for Pacific people. The situation is complicated by the public and private mix in the funding and provision of primary health care services in New Zealand.

The main areas of concern for Pacific people are barriers created by co-payments and limited access by Pacific individuals and organisations to capital required to enter the primary care market in a meaningful way. Existing Pacific providers are concerned at the 'standard' state subsidies when there is good evidence of higher health needs among Pacific people.

4.3.1 Fee-for-Service

Fee-for-service funding involves the payment of an agreed fee in return for services provided. This is basis of funding for primary care services in New Zealand for several decades. While it is regarded as contributing to over-servicing by providers, this is not the case for Pacific people. Fee-for-service payments for immunisation services has been equally unsuccessful for Pacific families. There is good evidence that per capita consultation rates for Pacific people at the primary care are significantly lower than other New Zealanders. Similarly, only half of all children aged two years have completed the recommended immunisation schedule. Moreover, only half of eligible people actually have the Community Services Card, which suggests that targeting regimes have been only partially successful.

4.3.2 Capitation

Capitation funding allocates an amount of money per head of population registered with a particular provider. In exchange, the provider is expected to manage all of the health care needs of all registered clients/patients during the contract period. Services provided are agreed between the provider and the funder and in most cases, these are limited to primary care services provided directly by the provider. In some cases where the provider has a large client base and he/she can afford to accept some financial risk, referred services may be included in the agreement.

The benefits of capitation have been adequately promoted but the consequences of capitation funding for low socio-economic groups in New Zealand have not been adequately debated. Pacific people are particularly vulnerable. The main problems associated with capitation relate to the way in which formula which is used to calculate the capitation amount, limits the user's freedom to choose his/her provider, high mobility, under-counting and mis-classification of Pacific people. Provider behaviour is another concern because in a capitation environment, there are no incentives for providers to see people because money is paid out regardless of attendance. Providers can also exclude undesirable users if there are regulations in place.

Capitation was developed and promoted by funders as a way of limiting their exposure to budget blow-outs in a demand –driven environment such as fee-for-service funding arrangement. Age, gender, socio-economic circumstance and ethnicity (only Maori have been considered for inclusion so far) have been used as the main factors, which determine the quantum of money to be allocated per registered patient/client. Sickness/illness status remains problematic both in terms of an acceptable measurement unit and the overall

influence it has on the capitation formula. Possession of the community services card is likely to be the proxy for socio-economic status. The formula should make appropriate adjustments to the provider payment in recognition of this problem.

Misclassification, undercounting and high mobility of Pacific people is likely to present significant financial and administrative problems for the funder and providers. An accurate patient/client register is an essential feature of any capitation arrangement. Problems associated with registration and enrolment present particular problems for Pacific people because of high mobility.

Misclassification and undercounting of Pacific people will seriously undermine the actual quantum of money due to a provider. Unless providers negotiate realistic budgets at the commencement of the contract or acceptable review clauses during the contract term, they could end up managing patients for which they have not been paid. Estimates of undercounting and misclassification could be as high as 40% based on community based surveys in Auckland. Low income families are likely to receive the highest capitation sum payable and the shortfall to some providers could be substantial.

High mobility among Pacific people will present major administrative problems as Pacific patients are known to 'doctor shop' more than other New Zealanders. Therefore, the funder will require a system whereby providers who have received the capitation sum for the patient may be required to reimburse the provider who actually provided the service. It is likely that providers and the funder could punish the patient by making patients pay for the service and claiming the money back from the funder or 'registered' provider.

Capitation will limit the user's freedom to choose his/her provider. Part of the reason for the high mobility among Pacific people relates to poor user satisfaction with the service provided. Limitations on the freedom to choose the provider has been shown to have adverse effects on the health status of low income groups enrolled with capitation funded providers in the United States of America.

The most serious risk for Pacific people from capitation funding of primary care is the fact that historically, Pacific people have been low users of primary and preventive services. This pattern of health care utilisation suggests that in a capitation arrangement, utilisation could be further reduced as providers no longer need to see the patient to receive payment. It is highly likely that Pacific people will continue to miss out at the primary care level. It is equally likely that providers will not seek out Pacific people for care because they will have already received the money. Providers may be discouraged from accepting Pacific people because they are 'sicker' and need more care and resources.

In order to avoid reduced care provided to Pacific people, the funder must insist on better transaction data to ensure that people are seen for preventive and anticipatory care. The requirement for more transaction data to be provided to the funder will further increase administrative costs. High administrative costs reduce the quantum of resources available for clinical care. An alternative would be to develop better outcome measures in contracts

between the funder and the providers. Good or bad outcomes could not be totally attributed to health service provider interventions.

The funder must also ensure that providers do not exclude 'high risk' groups such as Pacific people from their registers because of their socio-economic characteristics, morbidity profile and health services utilisation pattern. The health status of Pacific people is poor and their needs are greater. Requirement for providers to take all patients/clients must be implemented to ensure that high need population groups get good care.

Capitation is an attractive option for the funder because it can set a budget with certainty and offload some of its financial risk to the provider. However, unless adequate provisions are made in setting the capitation formula and contractual arrangements are made to ensure appropriate utilisation of primary care services, capitation could further compromise access to primary health care services by Pacific people (6).

4.3.3 'Bulk' (Block) Funding

The HFA is 'bulk' (block) funding certain services and certain providers. This method involves a global fee in exchange for a range of services to be delivered by the provider. Services usually involve personal and public (population) health programmes for a defined geographical area or group. An extension of this funding method involves budget-holding where the provider purchases services from other providers on behalf of enrolled users. Funding levels are usually set on historical spends which has its own risks.

This method of funding is potentially more useful for Pacific people because determinants of poor health spread across many disciplines. More importantly, improvements in health status would come about by improvements outside the health sector. Pacific providers have tended to develop in this way and often involving community development principles. This method of funding could assist the development of 'One Stop Shops' which Pacific people prefer.

4.3.4 Patient Co-payments

Patient co-payments may contribute to the low utilisation of primary care services. Studies in South Auckland have shown that Pacific people are more likely to be dissatisfied with fees and this affected their relationship with providers. This is not surprising because four out of every five Pacific families earn less than \$20,000 per annum. Another study in South Auckland, showed that as many as two thirds of the families studied had postponed a visit to the doctor because of fees. This included fees for medication and opportunity costs.

There are no good studies on the effects of co-payments on service utilisation by Pacific people. However, the RAND Health Insurance Experiment in the USA showed that as the size of the co-payment increased, the number of patient initiated visits declined and there was a greater reduction in service use by the poor and sick. Similar findings have been demonstrated in the United Kingdom where introduction of free medical care showed greater increase in service utilisation by the poor. It is difficult to extrapolate these findings to the New Zealand situation. However, Pacific-owned clinics in Auckland which have low patient co-payments generally have higher utilisation than services which charge standard fees.

Equally, there is concern over free services where providers do not charge patient co-payments. The potential for 'abuse' is greater and there are risks associated with continuation of 'dependence' on providers and the health care system. Ultimately, short-term assistance may limit the prospects for greater self care and independence.

4.3.4 Flow-on Effects

Pacific people are 'over-represented' in selected hospital discharge statistics such as asthma and complications from Type 2 diabetes. Many of these problems are preventable at least in part by better primary care services and patient involvement. There is a lack of good information on how Pacific people access health services and studies are required in this area. However, early and effective primary care interventions could achieve measurable changes in the affected population. The net effect of 'free' primary care on secondary care costs is difficult to measure.

4.3.5 Future Funding

It is essential that funding for primary care is structured to encourage early and appropriate care for Pacific people. Funding for personal health care services should also make provision for public health interventions which prevent similar health problems from recurring. These interventions require action at various levels and funding arrangements should enable communities and organisations to take the necessary actions at the local level. Some potential models are already in place among Pacific providers in Auckland.

Future funding arrangements should also make provision for service development, infrastructural support and on-going training for Pacific providers and individuals.

5.0 Primary Health Care Services for Pacific People

It is clear that conventional methods of funding and providing primary health care services to Pacific people in New Zealand could be improved. One of the unexpected benefits of the health reforms has been the opportunity for disadvantaged groups to participate in the development of other models of providing primary and preventive care. Maori communities and to a lesser extent Pacific communities have established other models of primary and community health care which are potentially better suited to the communities. Most of these developments have only just begun and their full impact is yet to be determined and many remain at risk because of inadequate management and clinical support.

The following examples are illustrations of some of the Pacific-owned models describing the philosophy and delivery styles, governance and ownership mechanisms, funding arrangements, staffing arrangements, short-comings and impact on health outputs/outcomes. These models could be best described as 'by Pacific for Pacific' models of care to distinguish these from other models developed by existing institutions with nominal Pacific involvement. It is important to note that the majority of Pacific people are served by non-Pacific providers at the present time.

5.1 Pasifika Healthcare

The West Auckland Pacific Islands Health Fono Inc. in West Auckland (Pasifika Healthcare) is the first of these developments in primary care specifically designed, owned, managed and provided by and for Pacific peoples in New Zealand. The service was initiated by Pacific health professionals and community leaders in response to community concerns about availability of culturally appropriate health care services for Pacific people.

Pasifika Healthcare now provides general practice, practice nursing, community health for residents of West Auckland and cervical screening services for Pacific women in the Auckland region. It also provides “Family Start” services for high-risk families through a company jointly owned by Pasifika Healthcare and Te Whanau o Waipareira Trust. Pasifika Healthcare also provides the one-stop shop youth service for young people in association with Waitemata Health and Te Whanau o Waipareira Trust. Approximately 20% of Pasifika clients come from outside the district.

Pasifika Healthcare is a community owned not-for-profit organisation governed by a board elected by the community. Each Pacific language group elects their respective representative and in addition, all society members elect four office holders at the annual general meeting of the society. Good governance has been hindered by lack of sector knowledge and confusion about the role of trustees. It has been a time consuming process to ensure that all trustees contribute meaningfully to the activities of the organisation. Despite these drawbacks, community involvement has provided a medium for input into service delivery and information dissemination to Pacific communities.

Primary care services are available seven days per week and thirteen hours per day. All staff including doctors are employed on salary. Pasifika employs qualified staff who are able to speak at least one Pacific language because older Pacific-born people prefer to speak to staff in their first language. It has become normal practice for people from different Pacific ethnic groups to attend when the doctor of the same ethnic group is consulting. Shortage of qualified Pacific clinical staff has hampered the implementation of services for all Pacific language groups.

Pasifika Healthcare has adopted a philosophy of providing affordable care, hence patient co-payments are minimal with no fee for children and young people under sixteen years of age. Affordable co-payments have contributed to a substantial increase in the number of people registered with using Pasifika Healthcare services. The recently introduced free under-six programme has not affected utilisation at Pasifika Healthcare because no adjustment was made to Pasifika’s funding levels after its introduction. Pasifika Healthcare is ‘bulk funded’ (block) calculated on the basis of staffing numbers, mix and applicable professional awards.

The impact of this model of health care delivery on the community it serves is yet to be formally evaluated. It has 7,500 people registered as clients with high attendance by its target audience. Completed immunisation rates exceed national rates and cervical screening uptake by Pacific women is high. Feedback from Pacific communities has been positive. It

is yet to provide the full range of services to all of its constituent population groups because of a shortage of funds and appropriate clinical staff.

The major drawbacks are shortage of qualified Pacific clinical staff and lack of suitable governance and management skills. Meeting the cultural needs of several Pacific language groups within limited resources presents problems with continuity of care.

5.2 Southseas Healthcare

South Seas Healthcare is a recent primary health care development based in Otarā in South Auckland. The service is owned and managed by a group of Samoan doctors through a Limited Liability Company. It provides general practice, practice nursing and well child services for all Pacific language groups. The organisation does not have a formal mechanism for community involvement. All staff employed by South Seas Healthcare are Pacific people who are able to speak a Pacific language. Clinicians from different Pacific ethnic groups provide care similar to services provided by Pasifika Healthcare. The organisation also suffers from lack of management skills and shortage of Pacific people who are qualified in a clinical discipline.

Patient co-payments are similar to rates set by other general practitioners in the area. Primary health care services are funded by the existing funding arrangements for all GPs in New Zealand. Well child services are funded by a block contract.

A significant growth in patient throughput has taken place in the short time the service has been available.

5.3 Langimalie

Lagimalie is a primary care and community health service developed and managed by the Tonga Health Society Inc. on behalf of the Tongan community in Auckland. The service was established with a grant from the Health Funding Authority but the services are funded as part of the existing fee-for-service arrangement for all general practitioners. Selected projects and programmes are funded separately e.g well child services are funded by a block fee. The service is governed by a board elected by members of the Tongan community in Auckland. Management is provided by clinicians who also work at the clinic. The organisation is not-for-profit and surpluses are returned to the service.

The service is available to people of all ethnic groups but most of the clientele at Langimalie are Tongan. Early indications are that this service is well accepted by the Tongan community and throughput is high. Langimalie is positioning itself to provide other services in public health and primary care area.

At this stage, Langimalie does not employ staff from other Pacific ethnic groups. Funding arrangements have caused problems for the service because patient co-payments and revenue streams have not provided sufficient funds to meet service costs. Primary care

services are funded through existing fee for service arrangements. The clinic was recently forced to reduce operating hours to remain viable.

5.4 Health Star Pacific

Health Star Pacific is a limited liability company owned by Samoan people which provide child and women's health, pregnancy support, immunisation, well child and support services for high risk Pacific families in the Glen Innes area in Auckland. Services are provided by registered nurses and community health workers and medical support is provided by the family's general practitioner. Health Star Pacific does not employ general practitioners of its own.

No formal evaluation of these services has been done except for the pregnancy support services. Pregnancy support services for Pacific women was found to be well-received by Pacific women but no information was provided on pregnancy outcomes. Health Star Pacific is a model which could be described as a support organisation providing information and support for clients who remain registered with other primary care providers.

5.5 Porirua

Pacific communities in Porirua recently responded to a request for proposal by the HFA to establish a primary and community health service for Pacific people living in Porirua and surrounding areas. The details of this service is still being negotiated with the HFA.

Governance consists of six trustees, one each appointed by three participating churches on behalf of their respective communities and three additional trustees selected on the basis of essential skills needed by the organisation. These trustees provide expertise in accounting, medicine and the law. The organisation is a non-profit charitable trust. Management is provided by clinicians employed by the trust.

5.6 Christchurch

A similar initiative to the Porirua was recently established by Pacific health professionals and community leaders in Christchurch. The service is governed by a not-for-profit community-owned trust. Trustees consist of Pacific health professionals, business and community representatives. It provides community, child and mental health services for Pacific people living in the region.

A number of other initiatives in primary care are being developed in several centres throughout New Zealand. The scope of services, governance and management arrangements, target audience and funding arrangements vary from centre to centre.

6.0 Population-based Approaches to Primary Care

The Alma Ata Declaration on Primary Care highlighted a number of important criteria and principles for providing sustainable primary health care. The principles are as relevant now as they were in 1978 (7). Unfortunately, the implementation of the declaration and associated policies has not been effective in New Zealand.

The nature of the health problems among Pacific people require interventions at various levels both within the health sector and between sectors. Population-based approaches in primary care provides the best strategy for achieving health improvements among Pacific people in New Zealand. While there are diverse language groups within the Pacific community, there are sufficient similarities for population-based approaches to work. A model of health care provision based on free market principles is difficult for a population group with limited economic means, health knowledge and delivery capacity.

Essential elements for an effective population-based approach in primary care include;

- i. effective and comprehensive primary health care services for the individual and his/her family. This includes educational, preventive, screening, treatment, rehabilitation and follow up services.
- ii. a system of keeping track of patients for regular preventive care and education
- iii. a community that can work together
- iv. method(s) for identifying priority community health needs and actions needed which take account of quantitative and qualitative information
- v. mechanism(s) for enabling and supporting community action which target prevalent priority health problems demonstrated by personal health care needs and demands
- vi. funding and technical support for community action

Population-based approaches will not reduce health inequalities unless there is action in other sectors which affect health. Traditionally, these are education, employment, housing, social welfare and business. It could be argued that much of the burden of illness among Pacific people have their origins in their adverse socioeconomic circumstances. Therefore, unless there is significant improvement in their socioeconomic situation, their health status is not likely to improve significantly in the foreseeable future.

Effective population-based approaches demand effective intersectoral collaboration. A major limitation in intersectoral work in New Zealand is due to the absence of an effective method of working collaboratively with affected communities. Bureaucracies are often unable or unwilling to compromise on accountability or boundary concerns and these could deter community enthusiasm. Better collaboration between state agencies is needed and creative ways of assisting are needed. It is possible to ensure public sector accountabilities and enable communities to take action on health and social problems which affect them.

The risks associated with population-based approaches to primary care for Pacific people are;

- i. lack of a policy direction for population-based approaches,
- ii. financial risks and shortage of capital for investment,

- iii. political risks and tension between 'ethnic-specific' services versus 'pan-pacific' service provision and uncertainty about what constitutes 'community'
- iv. confidence in the Pacific community - lack of suitable leadership including health governance, business, management and clinical skills
- v. low levels of health knowledge and lack of sophistication as advocates among Pacific people. This is often related to the low priority accorded to health concerns.
- vi. democracy and collaboration takes time which leads to significant delays in project implementation

6.1 Community Orientated Primary Care (COPC)

Community-orientated primary care (COPC) brings together the health of the individual and the health of the community in a single integrated practice. COPC has been implemented in different forms under different names in different countries. COPC requires high quality clinical care, a comprehensive approach to health and health care, a multidisciplinary health team, community involvement and cooperation with other services and agencies. International experience has shown that significant improvements can be made in a number of individual and community health outcomes.

COPC provides one way of achieving improvements in health outcomes through population based approaches. COPC provides a model for responding to the failure of conventional care systems and rising costs of health care. It represents a shift away from individual to community, from centralised biomedical and technologic care to a more decentralised, ecological system of care. It enables policy makers to address issues of system design and coverage, financing of healthcare, individual action and community participation. There is growing awareness of its potential for improving the health of the population.

Primary care organisations practising COPC accept responsibility for the health of the population they serve, involve local communities in defining needs and developing solutions and utilise a multi-disciplinary primary health care team as the main strategy for delivering health care (8).

7.0 Conclusions

Information that is available on the health status of Pacific people is of variable quality and must be used with care. However the magnitude of the difference of some conditions confirm existing anecdotal evidence about certain events which are particular problems among Pacific people. Pacific people will influence the demographic pattern, socio-cultural characteristics and overall health status of New Zealand in future as the population increases and age. Non-communicable disease will continue to be the major cause of morbidity and mortality for Pacific people. Effective and efficient management of these diseases and their complications will be a priority. The effective management of NIDDM and cardiovascular disease clearly stand out. However, control of communicable diseases e.g. tuberculosis and rheumatic fever will remain important activities in the short to medium term.

The need for ethnic specific information is paramount. Accepting that health and interventions are most effective at the level of the lowest unit of interaction, ethnic specific information on individuals and families are essential for improving, monitoring and evaluation of the health and services for Pacific people. The health effects of social policies on minority groups have to be assessed with ethnic specific information. In order to achieve this, accurate and standardised ethnic specific databases need to be established and Pacificentric analysis be initiated. The present situation is that of a Pacific population that needs to be liberated from poverty and poor health characteristics, similar to those of developing countries. The bases for the new approach is ethnic specific information.

The discrepancy between high hospital utilisation and mortality rates needs to be understood. The misclassification of ethnicity at death have been suggested. However, this discrepancy is especially curious with the accepted notion that Pacific people present late with more serious disease. If this is so, then the mortality rate should be higher unless hospital services for Pacific people are much better than to the rest of New Zealand. The use of angioplasty and coronary bypass graft suggest otherwise. Therefore the rate of coronary heart disease mortality should reflect this (unless these two procedures do not make any difference to coronary heart disease mortality rates). Other alternative explanations for the discrepancy may include: migrating back to the Pacific country of origin to die e.g. cancers; services provided by the hospitals to Pacific people prevent mortality more than the primary care providers; the hospitals over enumerate Pacific people; and the personal hardiness of Pacific people allows them to survive the adverse life conditions in New Zealand.

Reducing reliance on hospital care and improving primary care utilisation will pose the biggest challenge for health agencies if the current pattern of healthcare is to be changed. Existing health service provision systems need to be adapted and Pacific communities encouraged and supported to develop more effective and innovative models of health care delivery. Several community owned initiatives have been developed with promising results. Training of a suitable workforce including a credible research capability are important additional requirements. A national agenda on improving the health status of Pacific people is needed, supported by political commitment, resources and empowering policies.

Pacific people have low utilisation of conventional primary care and preventive health services despite having greater health needs. This situation has arisen as a result of the high incidence of certain health conditions and a young population. High health needs also reflect their adverse socio-economic circumstances. Low utilisation of primary care services contributes to high utilisation of secondary services for selected disciplines by Pacific people. Much of the hospital admissions among Pacific people are avoidable.

Provision of primary and preventive care in New Zealand is predominantly dictated by the market. Funding and delivery style reflect established conventional practices and practitioner preference. Therefore, availability of primary health care services is better in more affluent areas of the country whether this is measured by practitioner:population ratios or dollars spent per capita. State funded per capita expenditure on diagnostic support services and pharmaceuticals is higher in these areas compared with areas where there is a higher Pacific population density.

Recent developments in primary health care for Pacific people by Pacific people have been in response to the failure of existing services to meet the needs and expectations of Pacific people. These new initiatives have been community driven and owned to take advantage of state contribution to establishment costs and tax advantages. While community ownership and involvement is desirable, these organisations are small, isolated, inefficient and susceptible to external factors. Good governance is hampered by lack of knowledge and skills and confusion about the roles of members. Under-funding puts pressure on these organisations to compromise on good systems and management structures and many are at risk of failing to comply with relevant legislation. There is an extreme shortage of suitable clinical skills despite opening longer hours and flourishing opportunities. The impact of these models of clinical outcomes remains unknown but process indicators suggest that utilisation is better than conventional models.

Pacific providers, professionals and communities lack capital needed for investment in healthcare. Market driven health care delivery is not likely to meet the needs of Pacific people unless there is intelligent state intervention. These services must take account of the needs and expectations of Pacific communities whereby each ethnic group require ethnic-specific services despite low volumes overall.

Pacific communities are also aware that services provided by Pacific people for Pacific people cannot meet the needs of the whole community. Therefore, mainstream providers need to be supported and encouraged to provide their services in a Pacific-friendly manner.

8.0 A Way Forward

A reduction in the health inequalities between Pacific peoples and other New Zealanders must include action at various levels. Pacific people must take ownership of most of the actions required and government should assist by facilitating appropriate responses by responsible agencies. The critical issues for improving primary health care for Pacific people include;

- political commitment followed by adequate resources and policy direction to implementing government's goals and targets for Pacific people included in the medium term statement to the sector
- appropriate subsidy levels and funding arrangement for primary care
- commitment and support for Pacific communities to provide more 'for-Pacific-by-Pacific' primary health care services
- assisting Pacific providers in establishing new models of care in strategic locations
- consolidating and supporting more robust Pacific providers
- supporting the training of a more robust Pacific health workforce
- research and information on interventions which work
- developing suitable health outcomes for Pacific people

Political commitment to improving the health status of Pacific people is demonstrated in the government's medium statement for the health sector. These intentions should be implemented and adequate resources provided to ensure that expressed goals and targets are achieved. A clear implementation plan is required.

Funding arrangements for primary care should be structured to enhance access by disadvantaged groups. This may require enhanced differentials in state subsidies to take account of greater health needs among Pacific people. Consideration should be given to setting state subsidies at levels which eliminate patient co-payments. Funding for personal health care services should be linked to population-based approaches in primary health care. Programme-based funding should target prevalent health problems and a requirement to work collaboratively with other sectors. In areas where there are no existing providers, 'establishment' costs associated with new provider development should be provided for.

It is highly likely that a form of capitation funding will be used to fund primary health care in New Zealand. It is important that the formula takes account of greater health needs among Pacific people, higher costs associated with registration and administrative problems for providers who care for Pacific people.

While it is too early to assess the impact of Pacific-owned providers on the health status of Pacific people, early indications suggest that these services are better utilised by Pacific people. Throughput statistics confirm higher rates of consultation and selected outputs/outcomes are better than conventional service provision. Formal evaluation of one or more Pacific-owned providers may provide further information on the benefits and costs of such initiatives.

Existing Pacific-owned providers need support to consolidate their positions in the market. Suitable governance arrangements require further investigation and training provided for those involved. Considerable investment in health management and clinical training for Pacific people is required. Providers need to be encouraged to form fewer more robust organisations to enable them to provide a broader range of services and share risk. Existing Pacific providers are too small and none are capable of managing a greater level of

responsibility. Consideration should be given to developing a Pacific Integrated Care Organisation capable of taking responsibility for a larger population base.

- In areas where there is a high concentration of Pacific people, every effort should be made to support the development of primary health care services owned and managed by Pacific people. The level and mix of services would depend on actual population size. These developments should encourage community involvement in the planning, management and delivery of services to meet local needs. Consideration should be given to the development of fewer bigger provider groups to improve efficiencies and financial viability and to enhance their ability to participate effectively in the sector. The development of a 'Pacific Health Management Organisation' or IPA- type organisation needs urgent consideration.
- Contracts for service provision should move towards better definitions of health outcomes for Pacific people rather than focusing on process measures. There is an urgent need to develop reliable and meaningful health outcomes for Pacific people. Where outcomes are known to be inadequate, providers should be required to achieve reasonable and/or desirable levels.
- Where the number of Pacific people do not justify the establishment of these types of services, mainstream providers should be encouraged and supported to provide 'Pacific-friendly' services. Guidelines could be developed for use by mainstream service providers to enhance the effectiveness of their services.
- Patient co-payments should be kept to a minimum and funding arrangements between providers and the funder should reflect this. Capitation payments could be a suitable method provided the funding formula reflect the poor socioeconomic circumstances and high health needs of Pacific people. Providers should not be allowed to exclude certain clients and accountability arrangements should ensure that providers actually provide care for the money received.
- Providers should be encouraged to improve delivery of care and to overcome known barriers to care. For example, clients should be able to speak to clinicians in their first language and consideration should be given to extending the hours of service availability. Services should include as many preventive and curative services as possible in the same contract. Service providers should support the training and recruitment of appropriately qualified staff.
- A strategy for training of Pacific providers and individuals in policy, governance, management and clinical disciplines is required if Pacific-owned initiatives are to survive. The Clinical Training Agency should consider supporting training programmes for Pacific clinicians and health managers.
- Research and development of suitable health outcomes for Pacific people needs further consideration. Improvements in health status would be assisted by the development of clearer goals and indicators for measuring progress.

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