

Journal Abstracts

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Do access factors affect utilisation of general practitioner services in south Auckland? Gribben B. *New Zealand Medical Journal*, 1992; 105; 453-455.

The aim of this cross sectional survey was to describe basic features of access to general practitioner services in south Auckland, and to examine the effect of different factors on utilisation of general practitioner services. Interviewing for the study was undertaken in December 1988 and January 1989.

The study examined three access components: accessibility, affordability and accommodation. In this framework 'accessibility' refers to geographic accessibility and 'accommodation' to organisational features of the providers service. These included waiting times and appointment systems. The accessibility factor was measured by mode of travel and travelling time to the doctor.

Andersen's model of health behaviour was used to identify and control for other variables known to affect utilisation of health services. "The Andersen model proposes that the likelihood of a given health behaviour depends on need (illness related), predisposing (demographic, including class) and enabling (individual and community resources) factors; the three components of access that will be investigated here are considered enabling factors in this model."

The sample was made up of a random population of residents living in Mangere Bridge, Mangere and Otahuhu. A questionnaire was administered by trained interviewers. Twenty-eight percent of the sample (compared with 31 % of the population) self reported as being of 'Pacific Polynesian' ethnicity. In addition to affordability, accessibility and accommodation components, respondents were asked to report their perceived health status, the number of visits to the general practitioner in the last three months and demographic factors, that is, age; sex; ethnicity and personal income.

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Demographic factors, or predisposing variables, were not associated with utilisation. Even though there was significant dissatisfaction with general practitioner fees, this did not decrease utilisation. Accessibility (mode of travel and travelling time) was not associated with utilisation. Increased time with current doctor was negatively associated with utilisation in that it resulted in lower utilisation. This result was unexpected. Perceived health status was strongly associated with utilisation in that people who perceived their health to be poor visited the doctor more. Waiting times were strongly associated with utilisation.

Editorial Comments: This article does not focus specifically on Pacific people in New Zealand. However, there is a large Pacific population in south Auckland.

Gribben applies the inverse care law to south Auckland and explains that it is an area with high health care needs with less health care services available. Availability of general practitioners in south Auckland have decreased and the existing general practitioners had the highest median workload at the time that this article was published. Only 28% of the sample self reported as 'Pacific Polynesian', and this demographic factor was not associated with utilisation.

This study may be viewed as rather limited in its exploration of access factors as applied to Pacific people. It addressed demographic factors, direct causes such as accessibility, and health environment factors such as affordability and accommodation. This study is a good start to understanding access issues and the utilisation of health care services by Pacific people.

Satisfaction with access to general practitioner services in south Auckland. Gribben B. *New Zealand Medical Journal*, 1993; 106; 360-362.

This study is part of the larger study outlined earlier by the same author. The same sample population were used to examine and describe satisfaction with access to general practitioner services in south Auckland. The satisfaction questionnaire included twenty six "How satisfied are you with..." questions. Satisfaction was graded using a five point Likert scale, with standard 'smiley faces' as visual cues.

The lowest score was for prices. The next group of lowest scoring items were those concerned with out-of-surgery availability of the doctor and waiting times. The main result was the low levels of satisfaction reported by young adults (18-29) and by Polynesians (sic). Polynesians were the least satisfied with prices, and showed the lowest levels of satisfaction in all subgroups analysed. There was a much greater satisfaction with doctor qualities (such as 'time with the doctor', 'words and explanations' and 'care about you as a person') in the European ethnic group.

Editorial Comments: *The results are valuable as they uncover a significant health care service problem. That is Pacific people who live in south Auckland reported the highest level of dissatisfaction with general practitioner services.*

Reasons as to why this might be are discussed in the paper. Absolute income was not associated with satisfaction levels. However the amount of disposable income may be less for younger people. Moreover, it is not mentioned that the amount of disposable income may be less for Pacific people. Family size and employment status have been identified as areas of consideration when looking at consultation and resource use.

An alienation/ assimilation hypothesis is presented as a possible explanation for the trend of decreased satisfaction "down the European/Maori/Polynesian gradient". This gradient could reflect the degree of belonging to the system that each group experiences. Language difficulties and the expectation of free medical care are also identified as possible reasons. These are all areas that could be investigated in the area of access and utilisation for Pacific people.

Other areas could be reasons for the low satisfaction with general practitioner services. These include discrimination; cultural insensitivity, and sociopolitical reasons such as the cycle of oppression (in the areas of housing, employment and education) experienced by Pacific people who have migrated to New Zealand.

The Polynesian perspective of health care delivery in general practice. Ma'ai'i S. *The Journal of General Practice*, August 1986; 45-48.

This article was written as one of a series of articles on Maori and Polynesian (sic) health care in New Zealand. The article attempts to provide a view of health and health care from a Pacific perspective in order for those involved in the delivery of primary medical care to gain a better understanding of this perspective and therefore deliver a more appropriate service to this population.

The article begins by explaining that the Polynesian (sic) patient is discriminated against in the area of health care and that they are victims of the selective inequalities in health care in the welfare state. The New Zealand health care system is based on a *palagi* (Western) framework and Western values. Therefore important health issues for Pacific people are overlooked.

The author explains that misunderstandings about the Polynesian (sic) culture lead to discrimination. Some examples are used to explain aspects of discrimination such as the practice of bringing more than one unwell person for one appointment slot. Health professionals are often judgemental

about the fact that Pacific people may sometimes present to the doctor in a state of advanced illness. It is explained that the *aiga* or extended family takes a strong role in deciding at what stage a person should consult Western primary health care. Traditional practitioners may have been consulted earlier in order to establish a cause of illness and appropriate treatments. The presumption that the Polynesian (sic) patient has an inferior education is presented as another area of discrimination.

Cultural insensitivity is identified as a reason why Pacific people may be reluctant to attend primary health care. It is stressed that the use of traditional healing practices are an important part of Samoan culture and for the doctor to dismiss these creates "a deep sense of betrayal of traditional medicine and abrogation of cultural values." The role of spirituality as part of health is explained. The fact that illness can be caused by *aitu* or *atuas*, or the gods, is identified as an aspect of health that should be understood.

The expectations of Pacific people related to health care are outlined and it is explained that these expectations are often not met. For example, longer consultation times are expected.

Editorial comments: *The article is interesting and applicable to the area of access and utilisation of primary health care services for Pacific people. Ma'ai'i examines the area in a holistic fashion including physical, emotional, spiritual and family aspects. This may well be because his own perspective of health may involve all of these aspects.*

Sociopolitical areas such as socioeconomic status and inequalities in health care are mentioned. Therefore, it becomes clear after reading this article that issues of access for the Pacific population are complex. A holistic view is necessary in order for research to uncover the many possible reasons why primary health care services may not be accessible.

The health perspectives that this reader found particularly important in the article are: the strong spiritual links with health and illness; the importance of traditional healing practices; the involvement of family in the decision making process of when to consult Western primary health care; and modesty related to the body and physical examination, especially for women.

Although this article is now ten years old the issues presented are still relevant. However, it must be acknowledged that these issues may not be applicable to young adults who may have been born in New Zealand. The author acknowledges that the word 'Polynesian' includes several different ethnic groups. He warns that there are variations between these groups.

Samoan and Cook Islander's Perspectives on Health. Laing P and Mitaera J in *Social Dimensions of Health and Disease: New Zealand Perspectives*. Spicer, J. Trlin, A. Walter, J. (editors), Dunmore Press, 1994.

This chapter draws on information from a qualitative study that involved discussions and participant observation with the Samoan and Cook Island communities. "The purpose of this project was to explore Samoan and Cook Island people's perceptions of the influence for change that migration has on family life, economic relations, cultural values, role expectations and a sense of ethnic identity. A thread that wove all these areas together was health, illness and healing."

The chapter explores three issues:

What is health? It is stressed that the extended family have a large and important role in health, illness and healing. The extended family (the Samoan *laiga potopoto* and the Cook Island *kopu tangata*) is situationally defined depending on events of social importance. The extended family are involved in the decision making process of what combination of traditional healers and Western medicine to use and when to consult Western health services. Active participation with and support within the extended family are important aspects of health and life for Samoans and Cook Islanders.

Spirituality is an essential part of life and health. The concept of health is not separated from life. However, with the influence of Western health services, the concepts of health illness and life are increasingly separated.

Migration is seen to be directly associated with ill health. The loosening of ties to the extended family and the declining commitment to traditional life style are seen to contribute to ill health. "The choice to migrate in order to maximise economic opportunity is almost always balanced against the knowledge that New Zealand is one of the sources of ill health to the family." Ill health is associated with the relationship between land, life and livelihood. The process of migration

leads to loss of land and the cycle of oppression they experience in housing, employment and education.

How is health knowledge constructed in New Zealand? The example of the medical proposition that traditional Samoan massage is responsible for a higher incidence of stillbirths from intra cranial haemorrhage is used to illustrate the power of Western medicine in the control and construction of health knowledge.

Who is accountable? The accountability of healer and medical doctor is to the family and patient. "While Western medicine monopolises the social construction of health and healing through lines of accountability to colleagues in professional associations, Samoans and Cook Islanders see their families as holding this responsibility."

Editorial Comments: *The Samoan and Cook Islander's concept of health, life and illness relates to the way in which they choose to use Western primary health care services. The authors acknowledge that further research is needed in order to investigate the phenomenon that "ill-health associated with migration is integrally connected to the relationship between land, life and livelihood..."*

The role that the traditional practitioner has in access and utilisation of health care services is important. The decision making process that the family undertakes in order to establish what combination of traditional and Western healing practices to use and at what stage one should consult a Western primary health care service is particularly interesting.

This chapter takes a holistic view in that it investigates physical, spiritual, and sociopolitical aspects of health. These aspects of health relate to access and utilisation issues.

The chapter leaves this reader with the following questions: What implications does this information have for primary health care services in New Zealand? How can this information be translated into possible practical changes within primary health care services in order for them to be appropriate for Pacific people? □

**The superior doctor prevents illness;
The mediocre doctor attends to impending sickness;
The inferior doctor treats actual sickness**

Chinese proverb

In *Medical Quotes* by John Daintith and Amanda Isaacs, 1989