Cultural Democracy: The way forward for primary care of hard to reach New Zealanders*

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Abstract

The use of cultural democracy, the freedom to practice one's culture without fear, as a framework for primary care service provision is essential for improved health service in a multi cultural society like New Zealand. It is an effective approach to attaining health equity for all. Many successful health ventures are ethnic specific and have gone past cultural competency to the practice of cultural democracy. That is, the services are freely taking on the realities of clients without and malice from those of other ethnicities. In New Zealand the scientific health service to improve the health of a multi cultural society are available but there is a need to improve access and utilization by hard to reach New Zealanders.

This paper discusses cultural democracy and provide example of how successful health ventures that had embraced cultural democracy were implemented. It suggests that cultural democracy will provide the intellectual impetus and robust philosophy for moving from equality to equity in health service access and utilization. This paper would provide a way forward to improved primary care utilization, efficiency, effectiveness and equitable access especially for the hard to reach populations. use the realities of Pacificans in New Zealand illustrate the use of cultural democracy, and thus equity to address the "inverse care law" of New Zealand. The desire is for primary care providers to take cognizance and use cultural democracy and equity as the basis for the design and practice of primary health care for the hard to reach New Zealanders

Introduction

The access to and utilization of primary health care services is the most common denominator reflecting health disparity in New Zealand[1]. The basis may be ethnicity, socioeconomic status, social class and/or geographical distribution[2,3]. However it has been apparent for sometimes that which ever way New Zealand society is categorized, the "inverse care law" is the norm rather than the exception[4,5]. That is, regardless of the categorization, the New Zealanders who needs care most have the least access to the health care service they need to address their health wants, needs and demands. The least access is due to health care service availability, acceptability, and affordability[4].

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For many years the notion of equality have underpinned health service provision[5,6,7]. Therefore the emphasis in health service development have almost exclusively focused on availability to the detriment of equitability and thus the resolution of the "inverse care law" in New Zealand[2,4,5]. For example the advent of the politically correct under 5 year old health provision have mostly increased the health service utilization among the easy to reach New Zealanders and those who needs the care most still use the services least. Therefore equal availability to all, though the politically correct equality notion, still did not adequately address the reign of the "inverse care law"[7,8,9].

In New Zealand the scientific health service to improve the health of a multi cultural society are available but there is a need to improve access and utilization by hard to reach New Zealanders[7,10] in order to resolve the shameful national health statistics. However, there is a conceptual impasse in providing a robust framework with the essential associated theoretical, contextual and intellectual support for replacing equality with the notion of equity as the matrix for health services provision in New Zealand.

This paper suggests that cultural democracy will provide the intellectual impetus and robust philosophy for moving from equality to equity in health service access and utilization.

Political democracy has been well expressed and practiced in New Zealand in its various forms but political participation and utilization of the system by minority groups have been low and ineffective. Political democracy needs cultural democracy as the over aching philosophy.

Furthermore, the government "of the people by the people for the people", assuming equality in the abilities of communities and individuals to access its mechanisms and make these work on their behalf and for their benefits, is at least questionable[11]. It is accepted that the ideal political democracy does not work quite that simply. In fact, some political commentors have stated that the media and wealth has more control over the democratic political process rather than individual or community choice[11,12].

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This paper will use the realities of Pacificans in New Zealand to illustrate the use of cultural democracy, and thus equity to address the "inverse care law" of New Zealand. The desire is for primary care providers to take cognizance and use cultural democracy and equity as the basis for the design and practice of primary health care for the hard to reach New Zealanders, usually minority groups with minimal political power living at the margin of New Zealand main stream, regardless of ethnic`ity, social class, socio economic status and geographical location.

Terms and Concepts

The discussion of primary care have been hampered by the dominant use of doctors' clinical professional language[13,14]. Given that language is also a medium for thinking, the conceptualization and communication in primary care provision have been curtailed by the lingual gymnastic and boundaries of the providers. For example the communication of health risks have often been viewed as neutral, value free and strictly scientific. However, from a socio-cultural perspective, health risks are not just objective realities but a construction mediated through social and cultural assumptions and frameworks[14].

These frameworks are addressed through cultural democracy[15]. This is a philosophical precept which recognizes that the way a person communicate, relate to others, seek support, think and learns (cognition) are a products of the value system of his/her community[16]. Further more a policy that does not recognize the individuals' and communities' rights to remain identified with culture and language of his or her group is said to be culturally undemocratic[15]. Therefore cultural democracy is the ability of the people to practice their culture and language with relative freedom without discrimination[15,16]. Cultural democracy is an alternative ideology to acculturation. It is now identified with pluralism and multiculturalism.

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Therefore indigenous Pacific cultures must be viewed in New Zealand in the context of their cultural histories and Pacificans be given the rights and opportunities to study, learn and practice important elements of their culture, including health, health risks, and health service provision in New Zealand educational institutions and be socialized to a cultural process whereby Pacificans of all ages learn to be a member of their respective societies and communities, sharing with other culture through the ability to read the cues of each other's culture through competences in cultural and social literacy[17,18]. These has been the basis for "unity in diversity" among the Pacific nations[12,19].

Cultural democracy enable the development and acceptance of the processes for equity. The latter is the ability to allocate resources according to want, need and demands of groupings based on culture, class, socioeconomic status and location. The basis for such groupings usually reflects degrees of poverty and powerlessness. Equity purports to allocate resources to achieve a level playing field for community development and political processes. These justify the use of affirmative programs to address: population deficits leading to poverty and powerlessness; and subsequently the "inverse care law" in New Zealand. On the other hand, equality tries to address individuals and communities as if they have equal access to wealth and power. This fallacy gives rise to the uneven playing field. The hard to reach population of New Zealand, e.g. Pacific communities and other minority groups are characterized with low health service utilization rates and lower health status[1,5,6] with more linguistic disadvantages than the main stream New Zealand of predominantly Pakeha origin. Cultural differences, language, and poor education contribute to the inability to negotiate the New Zealand primary health care system and their marginal access to political power.

The philosophy of cultural democracy is consistent with New Zealand Health Primary Health Care Strategy launched in 200120, This strategy: has the following:

1. **It explicitly states that: the priority objectives to reduce inequalities includes:**

- Ensure accessible and appropriate services for people from lower socio-economic groups
- Ensure accessible and appropriate services for Maori
- Ensure accessible and appropriate services for Pacific Peoples;

2. **Its service delivery priority Areas are as follows:**

- Public health
- Primary health care
- Reducing waiting times for public hospital elective services
- Improving responsiveness of mental health services
- Accessible and appropriate services for people living in rural areas

3. **Its principles includes:**

- Acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi
- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- A high performing system in which people have confidence
- Active involvement of consumers and communities at all levels.

4. The population health objectives includes:

- Reduce smoking
- Improve nutrition
- Increase the level of physical activity
- Reduce the rates of suicide and suicide attempts
- Minimize harm caused by alcohol, illicit and other drug use to both individuals and the community
- Reduce the incidence and impact of cancer
- Reduce the incidence and impact of cardiovascular disease
- Reduce the incidence and impact of diabetes
- Improve oral health
- Reduce violence in interpersonal relationships, families, schools and communities
- Improve the health status of people with severe mental illness
- Ensure access to appropriate child health care services including well child and family health care, and immunization

These have been the basis for Health reform in New Zealand[20,21]. the continued reforms over the last decade have been intended to underpin the implementation of the Strategy and the work of Primary Health Organizations (PHOs) and Independent Practitioners association (IPAs) to deliver primary care[21]. The intentions of the reform were to:

- Increase choice and access for all New Zealanders in a health care system that was effective, fair and affordable
- Encourage efficiency, flexibility and innovation in health care delivery
- Increase accountability to purchasers
- Reduce hospital waiting times
- Enhance the working environment for health professionals.

The Pacificans of New Zealand

The Pacific communities in New Zealand have all the characteristics of a hard to reach population[22]. They are scattered throughout the electorates of New Zealand in small ethnic-based and heterogeneous communities with at least 20 languages and from a variety of nationalities. Pacificans are disadvantaged economically with poor health status and indicator with higher morbidity, mortality and health risk but low health service utilization (the "inverse care law"). Pacificans have become an "entrenched under class" in New Zealand with increased marginalization, discrimination, both socially and economically[23]. (See Table 1 for determinants of health, health outcomes, health service utilization and socioeconomic status). The Pacific population have been characterized with a trend of worsening socio economic status, increasing powerlessness and poor health status and lower health service utilization since the beginning of mass migrations in the 1940s[24,25]. Similarly the solution has been evident however the discourses and response have been framed in an assimilation and culturally undemocratic approach. Various reports since 1940 to the modern days have articulated the plights of Pacificians in New Zealand but there has been a sparcity of political will and actions beyond the rhetoric to address the "inverse care law" and thus the marginal populations[24]. Even when health and socio economic disparity were evident in the early 1990s1, there was no: consensual political will to use cultural democracy as a basis for equitable resource allocation; and the main stream populations erroneously by insisteted that all New Zealanders are equal in needs, wants and demands and all are on a level playing field; and therefore should be given equal allocations of the national treasures.

The Pacificans have similar experiences and may well ask the same questions about the way of: delivering cervical screening; and access to medication, primary secondary, and tertiary care.

It must be emphasized that the existing health and socio economic disparities is a product of how New Zealand policies and ways of doing things (the national psyche) to date have failed to address the uneven playing field and the "inverse care law" due to inequity. Many of the reports on Pacificans have been sanitized so that their plight has been seen as a consequence of Pacific lifestyle, culture, including obligatory customary reciprocation, remittance to the Pacific island, and church and religious donations[26]. This means that all manners of social investment and building of social capital[27] were arrogantly deemed to be detrimental and contributory to the Pacificans' demise in New Zealand, a very culturally undemocratic view.

There has been negliable discourse on the context of power equality; institutional discrimination; (racism)[28,29] and culturally undemocratic ways of thinking and doing business in New Zealand as the fundamental reasons for the state of Pacificans and other minority groups. A recent publication on Maori health[28] suggests that the tangata when a shares similar issues with Pacificans for the similar reasons even though the Treaty of Waitangi is supposed to be used as a guide document for Maori health and development. This publication claims that the current state of Maori health and health services is a product of 3 important reasons. They are, in no particular order:

- "The New Zealand health systems are racist": This claim stems from the assumption that the major causes of death and low life expectancy are because Maori "choose to smoke, they choose to be fat and they are lazy". However, there is more than one way to view and reduce premature mortality from heart attacks, lung cancer, and type 2 diabetes, chronic obstructive pulmonary disease (emphysema), and stroke. These causes of mortality account for 44% of Maori deaths in 2000. "Why does the Crown require Maori to do it in this particular way and deny them access to other ways they

would prefer"? "For Maori there are many examples of racism in the health system. Some are nasty example at an individual level".

The Pacificans have similar experiences and may well ask the same questions about the way of: delivering cervical screening; and access to medication, primary secondary, and tertiary care.

- "The Maori workforce is dominated by house niggers". This claims that a house nigger" can be recognized by the way she or he has been institutionalized as a Pakeha". The house niggers "have qualifications. They have competencies. Yet they choose to further their own nests and those of friends and families, while remaining in favour with the white master".

Among Pacificans are similar individuals especially the young, building a career through greasing their way up the system and hope to help Pacificans when they become the ultimate boss. This they call working smart rather then working hard. This phenomenon have been called the "Pone Syndrome"[29]. This has been derived from the "fag system" of the old English boarding schools where senior students adopt junior students, who helps them with menial tasks in exchange for the senior students' mentorship and protection. This phenomena of Pacific gate keeping was espoused and discussed without resolution in a 1997 Pacific Health Conference[30].

- "The Providerism of the Crown" "The effect of providerism is that established Maori providers never have incentives to become competent providers … a huge advantage to the Crown of its providerism is it effectiveness as a 'divide and rule' tool".

The Crown obviously "favours certain Maori providers because they are kiwi-based or because they are friendly with the Crown".

Similar situations have been observed among Pacificans. As the Chief Executive Officer of the Tongan Health Society, we on the advise of the Pacificans from the Health Funding Authority, submitted a proposal for a church-based parish nurse primary health care service. After submission there was minimal dialogue to no communication and later a similar service was funded to a different Pacific provider related to the Crown employees involved. Fortunately this have not generated the usual animated debates which can be very divisive and detrimental to the collective Pacific efforts.

In the early days of establishing the Tongan Health Society as an ethnic specific health provider I was told that such is a notion is a racist approach to which I quickly retorted, "For more than 150 years Pakeha only have exclusively provided primary medical care to Pacificans, and now Tongans providing medical care to all New Zealanders is racist?" Again, fortunately negotiations proceeded and now the Tongan Health Society is a symbol of ethnic specific self determination in New Zealand and an example of cultural democracy in action 31

Table 1. Summary of Indicators for Pacificans in New Zealand

'Key' indicators have been highlighted in the summary table. The criteria used to select these indicators were:

- High impact
- Modifiable
- High inequality
- Good data quality

(Note: ASR = rate standardized for age by the direct method, using the WHO world population as the standard).

Source: Pacific Health Chart Book-2004[25]

Indicator	Pacificans	Total NZ Population
	Persons	Persons
Health Outcomes		
Whole of Life		
Health expectancy (ILE), 2000-2002, years	62.5	66.1
Life expectancy at birth, 2001, years	74.1	78.7
Avoidable mortality, 1996-2000, ASR per 100,000	604(581-628)	397(394-399)
Ambulatory sensitive hospitalizations, 1998-2002, ASR per 100,000	4655 (4608-4704)	2856 (2848-2864)
SF-36 Mental health scale mean scores, 2002/03	81.9 (80.3-83.4)	82.9 (82.5-83.4)
Injury mortality, 1996-2000, ASR per 100,000	24 (21-29)	26 (25-27)
Injury hospitalization, 1996-2000, ASR per 100,000	2744 (2706-2782)	2393 (2386-2400)
Causes of infant mortality, rate per 1000 live births		
• Prematurity complications	1.3 (0.9-1.7)	0.8 (0.7-0.9)
• Birth complications	0.3 (0.1-0.5)	0.4 (0.4-0.5)
• SIDS	0.7 (0.4-1.0)	0.9 (0.8-1.1)
• Birth defects	0.6 (0.4-0.9)	0.4 (0.4-0.5)
Hearing failure at school entry, 2001/02, percent	18.1 (16.7-19.5)	8.4 (8.1-8.7)
Asthma hospitalizations, ASR per 100,000 children	748 (719-777)	491 (485-498)

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Indicator	Pacificans	Total NZ Population
	Persons	Persons
Health Outcomes		
Causes of infant mortality, rate per 1000 live births		
Meningococcal disease notifications, ASR per 100,000 children	21.8	8.6
0-14 years – infants and children		
Infant mortality, 1997-2001, rate per 1000 live births	7.1 (6.2-8.0)	5.1 (4.8-5.3)
Rheumatic fever notifications, ASR per 100,000 children	7.0	1.4
Tuberculosis notifications, ASR per 100,000 children	6.1	1.0
15-24 years – young people		
Lower respiratory tract infection hospitalizations, ASR per 100,000 children	1523 (1483-1564)	590 (583-598)
Pregnancies 2002, rate per 1000 females (10-19 years)	65	37
Births 2002, rate per 1000 females (10-19 years)	41	19
Sexually transmitted infections, all types, 1999-2002, rate per 100 young people attending sexual health clinics	23.7	14.8
15-24 years – young people		
Suicide mortality, 1996-2000, rate per 100,000 young people	21 (15-29)	24 (22-26)
Road traffic injury hospitalization, 1998-2002, rate per 100,000 young people	260 (236-285)	407 (399-415)
Cardiovascular disease mortality, 45-64 years, 1996-2000, per 100,000 middle-aged adults	390 (353-428)	176 (172-180)
Cardiovascular disease mortality, 65+ years, 1996-2000, rate per 100,000 older people	2617	1980 (1962-1998)
Ischaemic heart disease mortality, 45-64 years, 1996-2000, rate per 100,000 middle-aged adults	217 (190-246)	115 (112-119)
Ischaemic heart disease mortality, 1996-2000 65+ years, , rate per 100,000 older people	1165 (1041-1301)	1103 (1089-1116)
Stroke mortality, 45-64 years, 1996-2000, rate per 100,000 middle-aged adults	71 (56-89)	26 (25-28)
Stroke mortality, 65+ years, 1996-2000, rate per 100,000 older people	783 (680-899)	477 (469-486)
Self-reported diabetes, 15+ years, 2002/03, ASR per 100 persons (15+ years)	10.1 (7.0-13.2)	4.1 (3.6-4.6)
Vitrectomy in adults, 25+ years, ASR per 100,000	54 (46-61)	9 (8-9)
Lower limb amputation in adults, 25+ years, ASR per 100,000	44 (37-50)	17 (17-18)
Renal failure in adults, 25+ years, ASR per 100,000	60 (52-68)	13 (13-14)
25+ years – adults		
Lung cancer mortality, 1996-2000, 65+ years, rate per 100,000 older people	725	488
Colorectal cancer registrations, 1996-2000, 65+ years, rate per 100,000 older people	279	746
Breast cancer mortality, 1996-2000, 65+ years, rate per 100,000 older women	136	123
Prostate cancer registrations, 1996-2000, 65+ years, rate per 100,000 older men	1272	1603
Prostate cancer mortality, 1996-2000, 65+ years, rate per 100,000 older men	463	267
Chronic obstructive pulmonary disease (COPD) mortality, 1996-2000, rate per 100,000 adults	82 (70-96)	50 (48-51)
Chronic obstructive pulmonary disease (COPD) hospitalization, 1998-2002, ASR per 100,000 adults	629 (599-661)	269 (266-272)

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Indicator	Pacificans	Total NZ Population
	Persons	Persons
Health Service Utilization		
Primary care services		
Have usual carer, 2002/03, ASR per 100 adults	95.2 (93.1-97.3)	93.0 (92.1-93.9)
Saw doctor last year, 2002/03, ASR per 100 adults	79.6 (75.3-84.0)	80.8 (79.7-81.9)
GP visits, 2002/03, number, age-standardized mean per adult	3.6 (3.1-4.1)	3.2 (3.1-3.3)
Saw dentist last year, 2002/03, ASR per 100 adults	20.6 (16.3-24.9)	41.0 (39.5-42.4)
Saw Pacific worker in the past year, 2002/03, ASR per 100 adults	9.7 (6.3-13.2)	0.5 (0.4-0.7)
Attended private A&E or after hours clinic, 2002/03, ASR per 100 adults	10.7 (7.6-13.9)	13.9 (12.8-25.2)
Saw complementary provider in the past year, 2002/03, ASR per 100 adult	12.0 (8.6-15.5)	24.0 (22.8-25.2)
Saw Pacific healer in the past year, 2002/03 ASR per 100 adults	3.2 (1.2-5.2)	0.3 (0-0.3)
Reasons for most recent primary care visit, 2002/03, ASR per adults:		
• Chronic disease or disability	18.3 (13.3-23.2)	19.3 (18.1-20.4)
• Short-term illness	40.5 (34.8-46.1)	35.3 (34.2-36.7)
• Clinical preventive service use	7.5 (4.6-10.3)	12.7 (11.7-13.8)
Uptake of cervical screening, 2002, percent	49	73
Uptake of breast screening, 2002, percent	42	63
Opportunistic screening in primary health care setting, 2002/03, ASR per 100 adults		
• Blood pressure test	56.1 (19.8-62.4)	50.0 (48.6-51.5)
• Diabetes test	30.4 (24.4-36.3)	16.8 (15.7-17.9)
• Discussed smoking	3.6 (2.1-5.2)	8.1 (7.4-8.8)
Needed to but did not see GP, 2002/03, ASR per 100 adults	17.9 (13.6-22.2)	12.7 (11.5-13.9)
Reasons for not seeing GP despite perceived need, 2002/03, ASR per 100 adults		
• High cost	54.2 (40.6-67.9)	49.3 (44.6-54.1)
Reasons for not collecting prescription, 2002/03, ASR per 100 adults		
• Cost too much	50.5 (36.1-64.9)	27.0 (23.7-30.2)
Acc claims		
Visits that were ACC related, 2002/03, ASR per 100 adults	6.7 (3.8-9.5)	9.6 (8.6-10.5)
ACC claims, 2003, rate per 100,000	300	660
Ongoing serious injury ACC claims, 2003, rate per 100,000	44	70
Secondary care services		
Saw medical specialist, 2002/03, ASR per 100 adults	20.2 (16.5-24.0)	30.4 (29.3-31.5)
Proportion of people who saw medical specialist in private rooms, 2002/03, ASR per 100 adults	46.3 (32.7-59.9)	44.9 (42.3-47.6
Attended hospital emergency department 2002/03, ASR per 100 adults	4.9 (3.1-6.8)	7.8 (7.0-8.6)
Attended hospital outpatients, 2002/03, ASR per 100 adults	5.9 (4.0-7.9)	10.7 (9.8-11.7)
Attended hospital inpatients (including day patients) 2002/03, ASR per 100 adults	14.9 (11.2-26.4)	11.3 (10.5-12.1)
Pacific medical admissions, 2002/03, percent of expected (standard discharge ratio)	116	100
Pacific surgical admissions, 2002/03, percent of expected (standard discharge ratio)	90	100
• Community outpatient care	141	290
• Forensic	8	5

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Indicator	Pacificans	Total NZ Population
	Persons	Persons
Risk Factors		
Physical activity		
Physically active children (5-17 years), 1997-2000, percent	52 (43-61)	68 (66-70)
Physically active adults (18+ years), 1997-2000 percent	63 (57-69)	68 (67-69
Consumption of at least three servings of vegetables per day, children (5-14 years), 2002, rate per 100 children	61	57
Consumption of at least two servings of fruit per day children (5-14 years), 2002 rate per 100 children	50	43
Physical activity		
Consumption of at least three servings of vegetables per day, adults (15+ years), 2002/03, ASR per 100 adults	41.1 (35.1-47.0	67.3 (65.6-69.1)
Consumption of at least two servings of fruit per day, adults (15+ years), 2002/03, ASR per 100 adults	55.6 (50.2-61.0)	53.9 (52.4-55.3)
• Only sometimes	47.9	20.1
Full breastfeeding at 3 months, percent, 2002/03	50.1	55.2
Overweight children (5-14 years), 2002, rate per 100 children	33	
Obese children (5-14 years), 2002, rate per 100 children	24	10
Overweight adults (15+ years), 2002/03, ASR per 100 adults	39.2 (34.3-44.1)	34.0 (32.6-35.3)
Obese adults (15+ years), 2002/03, ASR per 100 children	43.0 (37.7-48.3)	20.1 (19.0-21.2)
Tobacco smoking (15+ years), 2002, rate per 100	31.9	25.8
Hazardous drinking, adults (15+ years), 2002/03, ASR per 100	18.6 (13.7-23.5)	18.9 (17.6-20.3)
Socioeconomic determinants of Health		
Neightbourhood deprivation		
Proportion of population living in10% of most deprived areas (NZ Dept 01 Decile 10), 2001 , percent	42	10
Education		
Participation in early childhood education, 0-4 years, 2001, percent	33	63
Participation in tertiary education, 18-24 years, 2001, percent	15	32
Proportion of adults (18+ years) with no formal qualification, 2001, percent	36	28
Employment		
Labour force participation, 2004, percent	62	67
Unemployment 2004, percent	7.9	4.6
Occupation and industry		
Proportion of labour force by occupation and industry, 2001, percent of labour force		
• Legislators, administrators and managers	5.4	13.3
• Professionals	7.9	14.7
• Technicians and associate professionals	9.1	11.7
• Clerks	16.4	13.3
• Agriculture and fisheries workers	3.3	8.4
• Trades workers	8.5	8.9
• Plant and machine operators and assemblers	18.9	8.8
• Elementary occupations	13.9	6.2
Income		
Real median annual income (15+years), 2001, dollars	$14,600	$18,600

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Indicator	Pacificans	Total NZ Population
	Persons	Persons
Socioeconomic determinants of Health		
Housing		
Proportion of people owning (with or without mortgage the dwelling in which they usually live, 2001, percent	26	55
Proportion of people renting the dwelling in which they usually live, 2001, percent	59	29
Proportion of people living in dwellings with more than two occupants per bedroom, 2001, percent	20.9	3.3
Family structure		
Proportion of people living in extended families, 2001, percent	29.4	8.3
Proportion of parents with dependent children who were sole parents, 2001, percent	21.9	17.3
Acculturation and discrimination		
Proportion of Pacific people born in NZ able to speak languages, 2001 percent:		
• Pacific language(s)	28	?
Proportion of Pacific people born overseas able to speak languages, 2001 percent:		
• English	81	98
Proportion of people acknowledging belonging to a religion, 2001, percent	80	60

The Pacific response to the "Inverse Care Law"

In the late 1980s the growing concern over the status of Pacificans in New Zealand provided the impetus for major policy initiative and radical change of the infrastructure of the health system[31]. This gave rise to Pacific ethnic specific health services and PHOs, emphasizing the establishment of a network of Pacific health services, especially in Auckland, recognizing the different needs of Pacificans[31] and thus the importance of cultural democracy using Pacific specific approaches to thinking and doing business. Pacific advisory groups emerged at all levels of government and the Ministry of Pacific Island Affairs was established and strengthened. Much of these developments were driven by Pacificans impatient with the sluggishness of the bureaucracy[31] and taking charge of their own destinies through self determination[26] and self-help community development models[31].

Cultural democracy pervades the provision of Pacific primary health services with very remarkable results. The examples includes the prominent participation in the hepatitis B Screening programme[33]; meningococcal B meningitis vaccine trial[35], control of Pacific cot death[36]; establishment of Pacific ethnic specific services[31], and the establishment of translation and Pacific social support services[26].

The Pacifican response may be categorized into the following efforts:

- Ethnic specific health services development[31]. These have been Pacifican controlled community-based services employing Pacific health professionals and incorporating the Pacific values (see Table 2) and ways of doing things;
- Human Resources and capacity development. Pacificans took control of the policy development[35], training of health professional from community health workers[37], SIDS community educators[38], to clinicians and health administrators and managers; and
- Building of a Pacific body of knowledge through increased capacity and participation in health research and efforts to improve professional writing publication[40], and research translation[39].

It is time that the impact of the Pacific responses be evaluated. The process indicators e.g. utilization, service acceptability and affordability have been profound. However, the effect on outcomes of health, powerlessness, productivity and socioeconomic status, are still forthcoming.

Discussions

The discourses on Pacific health have used cultural democracy as the framework for analysis. Although the linking to cultural democracy have been a hindsight, the precepts of community-based services dealing with the particular needs and values of Pacificans have been the focus from inception. These of course are fundamental components of cultural democracy which favours particularism over universalism (one model fits all)[42]. Particularism addresses the need to address ethnic specific needs as more efficient than the looking for one model to fit all and the achievement of the economy of scale.

What is needed to use cultural democracy is the will for equity. This is more crucial than the often widely held view that lack of resources makes particularism, and thus cultural democracy, untenable. If a power structure perspective is used to examine and explore the underlying causes of poverty and insecurity that is keeping the system discriminatory, it

will show that empowerment will contribute significantly to health, productivity and socioeconomic status. This and the many schools of thoughts concerning poverty and powerlessness have been discussed in relation to the Pacific children[41].

There is a complex interaction between political traditions, policies and systematic patterns in population health over time. A recent study supports the hypothesis the political ideologies of government affect indicator of population health[43]. The policies aimed at reducing social inequalities seem to have a salutary effect on selected health indicators, infant mortality, and life expectancy at birth.

There is a need for affirmative action to address inequity; cultural democracy; and to achieve a level playing field for all New Zealanders. This process should not be seen as deprivation of some for the benefit of others less deserving. It is essential to understand that poverty and unequal power distribution will ultimately threaten the security of New Zealand. Therefore, the use of equity and affirmative programs plus a demonstrable respect for each other will address the needs of the poor and maintain the health and harmony of New Zealand.

Table 2. Comparison of Pacific and Pakeha core values

Pakeha	Pacific
• Individual rights and freedom	• Cooperation
• Independence	• Consensus
• Justice – equality and access	• Respect
• Privacy	• Generosity
• Competition	• Loyalty
• Consumerism	• Sharing
• Scientific-rational	• Humility
• Emphasis on individual well-being	• Reconciliation
	• Fulfillment of mutual obligations
	• Reciprocity
	• Emphasis on relationships

Source: A Taufehulungaki (2004) Rising Pacific waves: approaches to inform change. Presentation at Pasifika Spirit Conference 2004, ALAC, New Zealand.

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