

Pacificans' access to primary health care in New Zealand: a review

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Abstract

Primary health care services in New Zealand are not accessible to many Pacific people for many different reasons. This may lead to the higher incidence of some diseases and higher hospitalisation rates experienced by Pacificans. This review explores the many components of access and the utilisation of health care services by Pacificans.

'Cost' and 'ethnicity' as components of access are discussed. It is suggested that the ethnocentricity and the resulting institutional racism of the New Zealand health system is a barrier to health care services for Pacific people.

A better understanding of Pacific people's concept of health and an acceptance of traditional medicine as part of primary health care is needed in order to improve and maintain the health standards of Pacific people in New Zealand. Along with this is the need for a commitment by the government, specific agencies, health care workers, and Pacific people to develop joint policies in the area of health care services for Pacific people.

Introduction

Primary health care services in New Zealand are not accessible to many Pacific people for many different reasons. This may lead to the higher incidence of some diseases and higher hospitalisation rates experienced by Pacificans. Access to health care services is a complex phenomenon involving

many variables. Vertical reasoning was used in this review in order to cope with the multicausality of access to health care¹. Access effects utilisation of health services and therefore impacts on the health status of individuals².

It has been reported that Pacific people in New Zealand have lower utilisation rates of primary health care services, a higher incidence of some diseases and higher hospitalisation rates than non Pacific New Zealanders^{3,4,5,8}. This review explores the many components of access and the utilisation of health care services by Pacific people. 'Cost' and 'ethnicity' as components of access are discussed. The literature was obtained from a variety of sources and attempts were made to include literature that contributes to the definition of access; the description of the current issues of access; and suggested strategies for improving access for Pacific people in New Zealand.

Primary health care

The Declaration of Alma Ata describes primary health care as; 1) scientifically based; 2) addresses the main health

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problems of the community; 3) includes: health education, food supply and nutrition, safe water and sanitation, maternal and child care, immunisation and prevention of infectious diseases, appropriate treatment and provision of essential drugs; 4) involves

intersectorial collaboration; 5) requires community participation; 6) works towards comprehensive health care for all and gives priority to those most in need; and 7) relies on health professionals, community workers and traditional practitioners to work as a team^{6,7}.

In New Zealand health professionals use the term 'primary health care' in a more limited sense. That is, when referring to medical and personal services provided by general practitioners, practice nurses and public health nurses, Plunket nurses, midwives, pharmacists and dentists. These activities may be better described as primary medical services⁸.

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Pacific people in New Zealand

The Pacific population living in New Zealand is heterogeneous. It is comprised of people originating from Polynesia, Micronesia and Melanesia. Within the Pacific population in New Zealand there are many distinct languages and cultural groups³. The Pacific population is disproportionately situated in the lower socio-economic groups in New Zealand. There are high levels of unemployment. Nearly 80% of Pacifican income earners earn less than \$20,000 per annum compared with 64% of income earners in the total population. However, Pacific people have strong social and family ties and belong to many rich and vibrant cultures³.

Access

Access to health care is an important concept in health policy and health services delivery. Equitable access to primary health care services is a policy goal and is recognised as a basic human right^{6,9,10}. However, the concept of access is difficult to define because it involves many different interrelated components. The terms 'access' and 'accessibility', when related to health services, are used in different ways by different authors.

The Declaration of Alma Ata identifies four components of access. These are geographic, financial, cultural and functional. Functional accessibility is described as "care that is available on a continuing basis to those who need it, whenever they need it, and that it is provided by the health team required for its proper delivery."¹¹.

The concept of access can be regarded as something that belongs to the individual in which case it is the responsibility of the individual. This is a libertarian view. Alternatively, it can be regarded as a feature of the system. Access is described as having five components that represent the degree of 'fit' between the client/patient and the health care system². The five components are availability; accessibility; accommodation; affordability and acceptability.

Availability refers to the adequacy of supply of the appropriate type of providers in relation to the volume of clients and their types of needs. There is evidence that health care resources are not evenly distributed across all social groups. Those most in need of health services receive a lower proportion of resources. This is known as the 'inverse care law'¹².

Accessibility refers to geographic accessibility including client transportation resources, travel time and distance.

Accommodation refers to the organisational features of the provider's service such as waiting times and appointment systems.

Affordability refers to the relationship between the cost of the service and the client's ability to pay.

Acceptability refers to the clients attitudes about the personal and practice characteristics of the provider and the provider's attitudes about the characteristics of the client. "In the literature, the term appears to be used most often to refer to specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, neighbourhood of facility, or religious affiliation of facility of provider"². On the other hand providers may be unwilling to serve certain clients (for example those with less money) or, through accommodation make themselves more or less available.

These components of access are not easily separated. For example, in some areas accessibility may be closely related to availability. However, when examining where people actually go for care, the more important component is often acceptability².

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Problems with access to health services are thought to influence clients and the system in three measurable ways. 1) Utilisation of services can be affected. For example, decreased utilisation of primary care services and perhaps, in turn, increased utilisation of secondary services. 2) The client's satisfaction with the services can be influenced. 3) Provider practice patterns can also be effected such as

the curtailing of preventative services when resources are scarce².

Much of the literature that aims to define the components of access includes a description of Anderson's theory of health service utilisation: the Health Behaviour Model. Health service utilisation is thought to be influenced by problems with access. Therefore, it is only logical that this model is explored by those interested in the components of access^{2,11,13,14}. The model proposes that use of health services is the consequence of three sets of factors: predisposing factors (that is, demographics such as age, sex and ethnicity); enabling factors (such as socioeconomic positioning and resources available); and need factors, or health status¹⁴.

Geographical and financial components are obvious barriers to access. Much of the New Zealand literature focuses on these two components^{15,16}. However, many authors have recently focused on the non-financial components of access. Rosenberg and Hanlon, 1996, identified 'non-income based barriers' to explain differences in utilisation of health services within and between income groups especially in health care systems such as Canada where provincially administered health insurance eliminates cost as a barrier to utilisation.

Non-income based barriers are identified as those that define the type of *health service environment* such as whether people live in rural or urban areas, population density, the availability of health care providers and the types of services offered. Their study of health service utilisation in Canada, found that health service environments do affect utilisation, as well as age, gender, and income. There was a higher utilisation of secondary and specialist services in rural areas with a low population because of the decreased availability of primary health care services compared to urban areas¹³.

However, these non-financial barriers include only two of Penchansky and Thomas's five components of access: *accessibility* and *availability*. Rosenberg and Hanlon acknowledge that other non-income based barriers include discrimination on the basis of race, religion, ethnicity, gender or sexual orientation. They conclude by acknowledging the challenge of investigating these more complex non-income based barriers¹³.

Margolis et. al. propose that many of the problems with the provision of health services are not directly related to financial issues. These non-financial barriers are applied to the socially and economically disadvantaged. Non-financial barriers are identified as 'structural' and 'personal'¹⁷.

Structural barriers include availability of services; organisational features of the provider and transportation. (In Penchansky and Thomas's words: *availability, accommodation* and *accessibility*). Personal barriers include *acceptability* of the service; cultural aspects; language; attitudes; education; and income. Income is included in personal barriers because it is seen to belong to the person. Financial barriers are described as: insurance coverage; reimbursement levels and public support which all belong to the service and the socio-political environment, rather than to the person¹⁷.

Personal barriers or acceptability appear to be the most vaguely defined component of access in the literature. Margolis et. al. provide further definitions of personal barriers. Families' lack of knowledge about the reasons for preventative care

and poor training in the skills necessary for obtaining health care for their children. Language barriers and social distance between patients and providers are also included. These issues are often not addressed by changes in health care financing¹⁷.

Utilisation of health services by Pacificans in New Zealand

The 1992/93 New Zealand Health Survey provides valuable information about New Zealander's use of health services. The study found that health status was most strongly associated with health service use. Poor health status and higher use of health services were more common in older people; people with a disability or a long-term illness; people in lower income brackets or on benefits; Maori; individuals from single parent families and those who practised risk behaviours such as smoking. Women aged 15-34 years and children are high users of health services, not because of poor health status, but because they have a high use of well-health services⁸.

Only a limited amount of information about the Pacific

population is provided in this Ministry of Health study. Ethnicity is often simply by Maori and non-Maori. However, Pacific people were reported as the least likely to consult a specialist (Europeans/European 25%, Maori 17%, Pacific 16%) and the most likely to consult a nurse (Europeans/European 9%, Maori 11%,

Pacific 14%). This may be because nurses are cheaper to consult, and also because of the high percentage of Pacific children under five. Children under five are more likely to be checked by a Plunket or Public Health Nurse than by a doctor or a specialist. Pacific people were more likely to describe their health as 'not so good' or 'poor' (Pacific 19%, Maori 14.6%, European 7.7%). These figures are adjusted for differences in age and sex. Lower utilisation rates of primary health care services and higher hospitalisation rates are reported^{3,8}.

The five year hospitalisation rates for Pacific people between 1987 and 1991 were higher than the national rates. The greater use of obstetric services by Pacific women because of higher fertility would contribute to this. Under-reporting of the number of Pacific people hospitalised does occur because of inaccuracies in the recording of ethnicity³.

Data from the National Health Statistics Centre show a lower mortality rate, for coronary heart disease, for Pacific people than for Maori and European people³. However, two studies examining the incidence of coronary heart disease found higher fatal coronary heart disease rates among Maori

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and Pacific people and confirmed lower mortality rates for European New Zealanders^{5,18}. These rates are from the Auckland Region Coronary or Stroke Study (ARCOS) database. It is thought the ARCOS database is more accurate in the recording of ethnicity.

The authors of both studies agree that the most likely explanation for high mortality and increasing morbidity rates from coronary heart disease are the difficulties faced by Pacific people in getting access to health care services. They often present for treatment later and in a more seriously ill condition than other ethnic groups. Cost, language difficulties, perceived loss of dignity, and intimidation by health care facilities are identified as contributing factors^{5,18}.

Studies in Auckland have shown that Polynesian children (Maori and Pacific children) have higher hospitalisation rates for asthma than European children^{19, 20}. In a randomised controlled study of children admitted to Auckland hospital for asthma, Mitchell and Quedsted found that Polynesian children were less likely to be referred to hospital by a general practitioner, and were less likely to have received asthma medication prior to admission than European children. This was after controlling for socioeconomic factors and despite similar prevalence rates and severity between Polynesian (sic) and European children²¹.

The authors conclude that differing medical management practices could explain these findings. Another possible explanation presented is that Polynesian (sic) children may have less frequent contact with primary medical services and therefore are not prescribed appropriate treatment. A limitation of this study is that information about Pacific children cannot be separated from those about Maori children because they are grouped together into one 'ethnic group'.

Similar findings are documented in a south Auckland study that investigates whether racial differences in the severity of asthma account for the higher accident and emergency department (A&E) use by Pacific people and Maori²². A slightly different methodology was used to compare rates of attendance to Middlemore Hospital A&E with rates of attendance to urgent medical services in the same area for Maori, Pacificans and European asthmatics. A cross sectional survey was used to investigate the characteristics of asthma, and medical care, of A&E attenders. Charts of those attending the urgent medical services were retrospectively reviewed. Severity of asthma was not found to be a reason for disproportionate use of the A&E by Pacific people. However,

Pacific people were less likely than European people to have a regular general practitioner; were less likely to be referred to A&E by a general practitioner; and were less likely to be on prophylactic medication²².

A possible explanation offered by the authors is that Maori and Pacific people are situated in the lower socio-economic groups and therefore financial barriers to primary health care have a greater impact on these groups. Again the authors suggest that lower utilisation of primary health care leads to decreased preventative measures including education, an increased morbidity, and therefore an increased need to use the A&E department²².

Gribben investigated the affects of three access components

(accessibility, affordability and accommodation) on the utilisation of general practitioner services in south Auckland. He applied Penchansky and Thomas's theory that the components of access affect the utilisation of health services. Twenty-eight percent of the sample self reported as being of 'Pacific Polynesian' ethnicity. Demographic factors were not associated with

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utilisation²³.

However, a study published subsequently, using the same sample population examined satisfaction with access to general practitioner services in south Auckland. Pacific people were the least satisfied with prices, and showed the lowest levels of satisfaction in all areas to do with accessibility and accommodation²⁴.

Again, language barriers and a lack of disposable income are offered as possible explanations. 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 experiences²⁴. The concept of 'belonging to the system' can be seen as similar to the personal barrier described above as 'social distance between patients and providers'¹⁷.

The access component of cost or affordability

Research has consistently highlighted that those people in the lower socioeconomic groups have lower standards of health as shown by higher mortality and morbidity rates than those in the higher socioeconomic groups^{12,25}. Those in the lower socioeconomic groups have consistently been shown to have high utilisation of secondary health services such as

emergency departments^{14,22}. Cost has been identified as an important barrier to primary health care services and several New Zealand studies have investigated the effect of cost on the utilisation of primary health care services^{26,27,28}.

In 1992 a new subsidy and charging regime in general practice was introduced. This was a system of user charges where subsidies were targeted more directly to those in financial need. A study of the impact of this new subsidy regime found that utilisation of general practitioners fell by 15% indiscriminately for all groups²⁶.

A study of eight health centres serving predominantly Maori and other low income groups found that rates of utilisation in all centres studied were substantially lower than national utilisation rates. After adjusting for age and Community Services Card status total expenditure (on GMS, ACC, laboratory and pharmaceutical services) was only approximately 40% of the national average. The author offers the explanation that Maori and other low income groups experience financial and other barriers in accessing general practitioners. General practitioners servicing poorer populations are unable to subsidise them from the rest of their patient population because they have less patients who are better off²⁷. The results of this study can be applied to Pacific people in New Zealand because they tend to be situated in the lower socio-economic groups³.

However, it has also been found that New Zealanders in lower socio-economic groups have higher utilisation rates of all health services including hospitals and general practitioners. These authors acknowledge that given the relationship between poor health and low socio-economic status, it can be expected that low socio-economic status would result in greater use of health care services^{8,28}.

The above studies show that cost is an important barrier to health care services in New Zealand. The studies could be applied to Pacific people because it is known that they are disproportionately situated in the lower socio-economic groups³. However, no reliable and specific information is available on the impact that cost has on access to primary care services by Pacific people.

Ethnicity and the use of health services

Anderson's theory of health service utilisation describes ethnicity as a variable that effects the use of health services². Factors influencing the lower health status of ethnic minority groups (such as cost barriers, transportation and location of medical services) overlap with those influencing people in

lower socio-economic groups. This is because ethnic minorities are often represented disproportionately in the lower socio-economic groups. Therefore those factors effecting lower socio-economic groups will effect ethnic minorities. However, over the last twenty years there has been increasing concern about discrimination and institutional racism leading to ethnic minorities receiving a lower quality health care than those in the ethnic majority²⁹. It is well documented in the literature that the ethnocentricity of New Zealand's health system leads to cultural inappropriateness by the health service and its workers^{30,38}.

A possible explanation for the higher use of secondary health care services by Pacific people is that they are situated in the lower socio-economic groups^{3,22}. However, an Auckland study that controlled for socio-economic status and severity of illness still found higher hospitalisation rates in Pacific children with asthma²². Overseas studies have found higher utilisation rates of A&E in some ethnic groups after controlling for health insurance status and socioeconomic status^{14,31}.

“ ... Maori and other low income groups experience financial and other barriers in accessing general practitioners. ”

A growing amount of overseas literature indicates that being a member of a minority group, with no influence from other variables, constitutes a barrier to access. Great disparities in the amount and type of health care given to

Latino and African American people compared to white people in the United States (after controlling for insurance status) have been reported³². Very little literature examines the ethnocentricity of the New Zealand health system and how this impacts on access for Pacific people. However, a small amount of literature investigates aspects of Pacific people's lives and culture that may impact on access to health services in New Zealand.

Ma'ai'i provides a personal view on the Polynesian (sic) perspective of health care delivery in general practice. He explained that within the Western health care system in New Zealand important health issues for Pacific people are overlooked. Misunderstandings about the Polynesian culture lead to discrimination. These issues include the importance of the extended family. A large family presence is often looked upon unfavourably in the Western health care setting. The fact that illness can be caused by *aitu* or *atuas*, or the gods, is identified as an aspect of health that should be understood³³. This article identifies several barriers that Pacific people experience in the general practice setting. Although this information is a personal view it is well supported by subsequent research³⁴.

Laing and Miteara showed that the Samoan and Cook Islander's concept of health, life and illness strongly relates to

the way in which they choose to use Western health care services. This qualitative study involved discussions and participant observation with Samoan and Cook Island communities in New Zealand, Samoa and the Cook Islands. The extended family are heavily involved in the decision making process of what combination of traditional healers and Western medicine to use and when to consult Western health services. The accountability of the healer or health worker is to the extended family and not to the health worker. Migration is seen to be directly associated with ill health, as the process of migration leads to loss of land, livelihood and family ties³⁴. Further research is needed in the area of how these findings impact on access to health care services for Pacific people in New Zealand.

Information relating to access was obtained when the Public Health Commission held nine meetings with representatives of the Pacific communities in eight city centres throughout New Zealand. Barriers to use of primary care services identified by the participants were: language; cultural, that is, feeling 'scared' or 'shy'; lack of information; cost; health is a low priority; preference of traditional medicines; and the preference to care for the elderly and disabled at home instead of bringing them to health services³.

Traditional medicine is sometimes regarded by New Zealand health workers as detrimental and a barrier to access to Western health care services. However, several authors stress the importance of traditional healing practices. Traditional and Western medicine cater for different health needs. It has been suggested that there is a need for both and an aim is the "mutually beneficial coexistence" of the two^{4,33,35}.

Among Vietnamese people in the United States, a number of traditional health beliefs and practices have been identified to pose barriers to Western medical care. However, a study in California found that although Vietnamese people possess traditional health beliefs and practices, which differ from those of the general population, the data did not support the hypothesis that these traditional beliefs and practices act as barriers to access to Western medical care or to utilisation of preventative services³⁶. Studies like this help to decrease the suspicion and discrimination that occurs in Western health services toward people in ethnic minorities.

There is a need for research investigating the role of traditional medicine in the lives of Pacific people in order to promote a pluralistic health care system in New Zealand that

better reflects Pacifican's health care needs⁴. A strategy that may help the health care system better reflects this need is the funding of services organised and managed by Pacific people. A Wellington survey of Pacific people with noninsulin dependant diabetes found that 89% favoured a specific service for Pacific people with education being the major emphasis. "More than a third preferred the service to be near home and run by Pacific health professionals."³⁷.

It is argued that the lower utilisation of primary health care services by ethnic minorities can be explained by financial barriers to health care. However, in order to explain the relationship between ethnicity and access to health care, an increasing amount of literature is drawing our attention to the areas of access that fall under the component of *acceptability*. For Pacific people these areas include the role of the family, the use of traditional medicine, the ethnocentricity of the health care system, and the social distance between the patient and the provider^{4,17,24,33,34}.

Conclusion

From this review it is evident that issues of access for Pacific people are complex. Obvious barriers to health care are geographical and financial. These components of access are accessibility, affordability, and availability.

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Non financial barriers to health care have more recently been identified as important components of access. These include organisational features the system (accommodation) and acceptability of the service. Research in this area related to Pacific people in New Zealand is very scarce.

It is suggested that the European ethnocentricity and the resulting institutional racism of the New Zealand health system is a barrier to health services for Pacific people. Institutional racism can be described as falling under the *acceptability* component of access. A better understanding of Pacific peoples' concept of health and an acceptance of traditional medicine as part of primary health care is needed in order to improve and maintain the health standards of Pacific people in New Zealand. Along with this is the need for a commitment by the government, specific agencies, health care workers, and Pacific people to develop joint policies in the area of health care services for Pacific people⁴.

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