# CHAPTER 6

**Pacific people in New Zealand**

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Introduction

This chapter describes the health status of Pacific people in New Zealand, health service availability and usage and factors that may affect the interactions between health professionals and patients. Guidance is provided on additional sources of information, advice and support for health practitioners, their patients and their families.

Background

There are more than 300,000 Pacific people in New Zealand (NZ). The population grew rapidly during the 1950s through to the 1970s as a result of work related migration. The Pacific population is currently among the fastest growing groups in NZ, but most of the recent growth is due mainly to births in NZ. Two thirds of the population are now born in NZ and approximately one quarter of all births in Auckland claims a Pacific heritage. The Pacific population is projected to make up approximately 10 percent of the NZ population in 2026. Pacific people will form an increasing share of the consumer and voter base, school age population as well as an increasing share of an ageing and shrinking NZ workforce. Pacific people form a significant share of the patient/client base in selected urban neighbourhoods in NZ.

In NZ, the term “Pacific” or “Pasifika” usually refers to people who have a Pacific heritage. Samoan people make up half of the total Pacific population, Cook Island Maori one quarter, Tongans about one fifth, Niueans one tenth and smaller numbers from other island groups. Successive census has shown that an increasing proportion of Pacific people who claim origins from more than one ethnic group with unique sociocultural characteristics combining elements from their heritage cultures with significant Maori and palagi/pakeha (European) influences. Approximately, one in five individuals claim both Pacific and Maori heritage.

There is very little reliable literature on the health needs of the young, NZ born, urban Pacific people. This is an important and urgent area for research in order to improve policy development and service delivery. Much of the literature about health and illness among Pacific populations refer to older adults who were born in the islands.

The Pacific population is very young with 38 percent under 15 years of age compared with 22 percent of the total population. The mean age of the Pacific population at the 2006 Census was 21 years compared with 36 years in the total NZ population. Less than 5 percent of the Pacific population are over 65 years of age but the cultural importance of the elderly in most Pacific societies often means that the needs of the elderly take precedent over the needs of younger people.

Respect for the elderly is an important aspect of all Pacific societies in NZ, and this fact has a major influence on how Pacific families live.
Two thirds of the Pacific population live in Auckland, mostly in South and Central Auckland. Significant pockets of Pacific people live in Wellington, Porirua, Hutt Valley, Waikato and Canterbury. Studies have shown that nine out of ten Pacific persons live in low decile areas with significant social and economic disadvantage. Socioeconomic disadvantage is closely correlated with poor health and access to health services. It is also important to note that increasing numbers of Pacific people are not connected to their extended family and many need support from outside the family. Further, while most Pacific adults are regular church attendees, an increasing proportion of young people are less religious in their outlook compared with their parents. For most Pacific people, the church remains a significant influence on their lives, attitudes to health, illness, death and dying.

Health Status and Influences

Pacific people have some of the worst health and social indicators in NZ and there is considerable unmet health needs in these communities. Several reports show little improvement in the socioeconomic circumstances of Pacific people and little change in their overall health status. Prevailing disease patterns largely reflect the socioeconomic conditions under which they live and poverty is a major contributor of ill health among Pacific families. It appears that the most important factors that adversely affect their health are low educational achievement and health literacy, high unemployment rates, crowded, cold and damp houses and inequities in access to and quality of health care provided. While socioeconomic factors are the main underlying factors that contribute to poor health in Pacific people, not all of the ethnic disparities in health are attributable to socioeconomic factors.

However, Pacific cultures and practices rarely ever contribute to poor health, although attitudes to health and illness can influence health outcome mainly as result of the delay in seeking health care. Traditional tattooing using traditional methods has on occasion caused serious infections and even death.

Older Pacific people who were born in the islands have a socioecological approach to health with strong spiritual dimensions to their beliefs about illness, healing, death and dying. Death, disease and disability are often attributed to the will of God and/or superior being. Mental disorders in particular are often regarded as possession by evil spirits or deceased relatives as retribution for wrong doing by the affected individual or members of his/her family. As a result, health care practitioners often have difficulty understanding the apparent fatalism that can be seen in some Pacific patients. These beliefs can lead to much “shopping around” with different health care practitioners, including traditional healers. There is anecdotal evidence that older members of Pacific families commonly use traditional healers and complimentary therapies in addition to or in place of conventional remedies.

Attitudes to health and illness among younger members of the Pacific communities are less clear. It is likely that young people are less likely to hold traditional attitudes and views about health and illness.
Morbidity and Mortality

Pacific people experience significant premature mortality and preventable morbidity mainly due to chronic noncommunicable diseases (NCDs), such as diabetes and heart disease. In the adult population, cardiovascular diseases are the leading cause of death and disability. Coronary artery disease mortality rates have declined in line with the decline in CVD mortality in the total NZ population but the decline has been less rapid among Pacific people. However, stroke incidence and mortality has not declined in line with other New Zealanders and stroke tends to affect younger adults in their most productive years in Pacific people. Ethnic differences in CVD mortality and morbidity are attributable to differences in risk factor prevalence and access to health care services.2, 3

The prevalence of smoking has declined in the Pacific population but still remains higher than the smoking rate in other New Zealanders. Youth smoking rates, especially among Pacific girls, remain much higher than their peers. An additional challenge is the low uptake of smoking cessation services that have been proven highly effective in other groups in NZ. Preventing uptake of smoking and increasing uptake of smoking cessation programmes are important priorities for health care practitioners, especially in primary health care settings in NZ. Smoking remains one of the most important and preventable causes of morbidity and premature mortality among Pacific people in NZ.

Type 2 Diabetes is more prevalent among Pacific people in NZ due in part to the higher prevalence of overweight and obesity among them. The prevalence of diabetes is 2—3 times higher in Pacific people compared with the total NZ population. Several surveys have shown that approximately 90 percent of the adult Pacific population were overweight or obese compared with 60 percent of the total NZ population. Furthermore, the prevalence of obesity in young Pacific boys and girls was 55 percent compared with 29 percent other young New Zealanders respectively. High prevalence of obesity in Pacific people is attributable to the “obesogenic environment” that exists in urban areas in New Zealand. Consumption of highly processed food items and reduced physical activity levels are the most direct influences on obesity but there is a complex web of interrelated factors that lead to the unhealthy diets and low physical activity levels. Studies have shown that Pacific people are more likely to consume diets high in fats, sugar and salt, more likely to have takeaway meals and less likely to cook at home.

Young Pacific boys consume sugar sweetened soft drinks (SSSD) more often than their peers. Excessive consumption of SSSDs is closely associated with increased prevalence of obesity. Preventing and managing obesity in Pacific people is the most urgent priority for the NZ health system. Demand for services such as renal dialysis as a result of renal failure due to diabetes is already reaching a point where health services are struggling to meet demands.
Pacific children experience significant preventable morbidity. The most prevalent conditions largely reflect the socioeconomic circumstances of their families, including overcrowded, damp and cold housing, unhealthy diets and difficulties accessing health care services. The Children’s Commission estimated that 22 percent of NZ children were living below the poverty line, and Pacific children were more likely to be below the poverty line. Several studies have shown that respiratory disorders and skin infections are very common and hospital admissions are higher than other NZ children. Acute Rheumatic Fever and Rheumatic Heart Disease (ARF/RHD) are three times more common among Pacific children and young people compared with other NZ children and young people. ARF/RHS is widely regarded as a disease of poverty and a good indicator of the socioeconomic conditions under which children live. Increased government funding recently allocated to the prevention and management of ARF/RHD in priority groups is a promising development although action on the wider determinants of health is equally important. Unless effective action is taken to address poverty, interventions directed as specific diseases are unlikely to be sustainable.

The 2006 NZ Mental Health Survey (Te Rau Hinengaro) showed that the prevalence of mental disorders among Pacific people in NZ is similar to Maori and other New Zealand populations except psychotic disorders where the prevalence of schizophrenia is higher among young Pacific men. The study showed similar prevalence of suicide across all population groups in NZ but much higher prevalence of suicide ideation among Pacific people. Survey findings showed that only one quarter of Pacific people with severe mental disorders were receiving recommended care.

**Access to and quality of health care**

Pacific people are known to have low uptake of preventive and primary health care services for example, low uptake of cervical and breast cancer screening and low immunisation coverage rates. These observations are supported by high rates of Ambulatory Sensitive Admission (ASH) among Pacific people. ASH admission rates are generally accepted as a reasonable indicator of the quality and effectiveness of primary health care services. A recent review of the primary health care for Pacific people in NZ showed a potential disconnect between PHC providers and Pacific patients. General practitioners were less likely to record high levels of rapport with Pacific patients, and Pacific patients had low uptake of subsidised care, high use of Accident and Medical (A&M) clinics, and lower levels of satisfaction with their experiences of PHC. The report also concluded that the top three barriers to primary health care for Pacific people were cost, transport and language.

Reforms of the health sector and changes to the funding and delivery of PHC in NZ as part of the NZ Primary Health Care Strategy and the Pacific Health Strategy has resulted in some improvements for Pacific people. Information from Primary Health organisations (PHOs) has shown high enrolment rates for Pacific people. Furthermore, the NZ Health Surveys have shown that the per capita general practitioner consultation rates for Pacific people is comparable to other New Zealanders, although the level of consultation may not be appropriate for the level of health needs in these communities. Immunisation coverage rates among Pacific children are now among the best in the country.
Despite these improvements, it is clear that Pacific people continue to receive variable quality of health care. Studies of almost all health conditions have shown that Pacific people continue to receive lower levels of care, especially at the primary health care level. Health practitioners who work in health settings in communities need to ensure that best practice is normal practice at all times. Additional support, education and information for patients and their families will assist in improving the consistency and impact of primary health care for Pacific people. Improvements in the quality of primary health care will reduce attendance rates at emergency departments and avoidable hospital admissions among Pacific people. It is also worth noting that “free” health care in hospitals will continue to be a factor influencing Pacific people’s decisions about where to seek health care services.

Community controlled PHC

The emergence of Pacific owned community health services in NZ has contributed to the overall improvements in access to and quality of health care provided to Pacific patients and their families. However, it is estimated that 90 percent of Pacific patients continue to receive health care from mainstream providers and this situation is likely to continue. Many Pacific patients and their families also receive care from Maori service providers, especially in Auckland in view of the similarities in service delivery ethos of Maori providers to Pacific providers. Most Pacific community owned services are located in areas with high Pacific population in urban centres. Informal feedback confirm that Pacific patients report positive interactions with Pacific owned providers although there has been no independent evaluation of these services. In general, Pacific owned clinics have distinct advantages over conventional care models, such as lower fees, clinical staff who speak a Pacific language and good community support for patients and their families.

Getting assistance

The Ministry of Health (MOH) has a well developed strategy for improving the health of Pacific people and funds service delivery by selected District Health Boards (DHBs) which serve large numbers of Pacific people. The key MOH strategy is the Ala Moui Pathways to Pacific Health and Wellbeing 2010—2014, which outlines government priorities, programmes and major contributors to health. Much of the actual service delivery and support for health care providers is funded and coordinated by selected DHBs, mainly in urban centres. Pacific teams in DHBs are well placed to provide an overview of service delivery in their districts and advise on how best to support health care professionals. In addition, there are several Pacific owned health care providers in most urban centres throughout NZ. These providers have well developed networks that can assist with advice and support. Le Va is a national coordination service and workforce development programme for Pacific mental health, addictions, disabilities and general health (www.leva.co.nz).
The Pasifika Medical Association (www.pacifichealth.org) is the leading Pacific organisation dedicated to improving the health status of Pacific people, both in NZ and the Pacific region. Membership includes doctors, nurses, other health workers and community leaders. PMA provides professional support to its members, delivers health workforce development in schools and advocates for better policies and services for Pacific people. Most of the senior and experienced clinicians of Pacific descent in NZ are members of PMA. Most Pacific nations also have associations and community groups with an interest in health such as the Tongan, Samoan Nurses Association, the Cook Islands Health Network.

The Medical Council has produced an excellent resource for clinicians working with Pacific patients with an emphasis on supporting the best outcomes for patients. The resource includes information on key concepts in Pacific societies that impact on health and health care provision and specific advice on how best to manage Pacific patients. Pacific Heartbeat at the National Heart Foundation has been providing information and training for health and community workers for several years. Their focus is on improving nutrition and physical activity as well smoking prevention and cessation information service. The NZ Stroke Foundation has recently established a service dedicated to preventing stroke in Pacific communities.

Resources
1. MPIA/Stats NZ Pacific Population Report 2010
2. MOH Tupu Ola Moui Pacific Health Chartbook 2012
3. MPIA/Stats NZ Pacific Report Health 2010
4. Pacific Perspectives Primary Care for Pacific People 2011
5. MSD Social Report 2010
6. A Fair Go for All Children — Children’s Commission 2008
8. The NZ Mental Health Survey 2006 (Te Rau Hinengaro)
9. MOH The NZ Health Survey
10. MOH Ala Moui Pathways to Pacific Health and Wellbeing 2010—2014