A Pacific population’s access to and use of health services in Dunedin

Faafetai Sopoaga, Lianne Parkin, Andrew Gray

Abstract

**Background** Pacific peoples in New Zealand (mostly of Samoan, Tongan, or Cook Islands origin) have poor health compared to the total New Zealand population. Understanding their access to and use of health services is important in resolving this.

**Method** A survey of Pacific peoples in Dunedin obtained information about their access to and use of health services.

**Results** 372 questionnaires were analysed. Approximately one-quarter did not have a regular doctor or health service. At least 50% used hospital emergency services for non-urgent illnesses. Nearly two-thirds used a “walk-in” primary care service.

**Discussion** A significant proportion of Pacific peoples did not have a regular GP or health service in Dunedin. It was surprising students were more likely to be in this category because student health services should be more affordable. A “walk-in” primary care facility has a role in the delivery of primary care services. Pacific organisations can assist primary care providers to encourage access to and the appropriate use of health services.

Pacific peoples living in New Zealand comprise approximately 7% of the total population. The three largest ethnic groups originate from Samoa, Cook Islands and Tonga. The Pacific population is over-represented in poor health statistics compared to the total population. These inequalities can, at least in part, be attributed to differences in social, cultural and economic determinants of health.

The Ministry of Health has responded to these health disparities through efforts to improve access to primary care, and encourage the appropriate use of health services. For example, recommendations about Pacific cultural competency in the Health and Disability sectors have been developed, and Pacific health is the focus of a national health and disability plan. However, there is little published information about Pacific peoples’ use of health services in New Zealand.

Dunedin is the eighth largest city in New Zealand with an urban population of around 120,000 people. The main campus for the University of Otago is in Dunedin and students comprise approximately 20% of the total population. Pacific peoples make up 1% of the Dunedin population.

We undertook a survey of Pacific peoples in Dunedin to obtain information about their access to and use of health services.

**Methods**

Pacific peoples in Dunedin aged 15 years and over were invited to participate in this study from July 2007 to July 2008. The inclusion criteria was having Pacific heritage and aged 15 years and over. Recruitment was opportunistic, and was carried out using standardised...
instructions, by Pacific community and student leaders. Those who attended organised Pacific community and student events during the study period were invited to participate. All who were thought to be eligible were given an information sheet and invited to complete a questionnaire.

The questionnaire contained questions relating to age, sex, ethnicity, language, religion, education, income, employment, and having a community services card (a subsidy card for low income earners, which reduces medical and pharmaceutical costs). Questions were also asked about the use of primary care and hospital emergency services.

Data obtained were entered into a spread sheet and checked for possible duplication. Participants without a recorded Pacific ethnic identity were excluded from analyses. Income source was prioritised for cross tabulations with Salary, Benefit, Student allowance and Other categorised in this order.

Associations between categorical variables were explored using Chi-squared tests, with Fisher's Exact test used where expected cell counts were low (more than 20% of cells having expected cell counts below 5). All analyses were performed using Stata (version 11) software with p<0.05 considered statistically significant in all cases.

Ethical approval was granted through the University of Otago Human Ethics approval process at the departmental level.

Results

Four-hundred and ninety-three people were approached and invited to participate in this study. Although the recruiters and the information sheet clearly explained the inclusion criteria, some people completed the questionnaire but were later found to be ineligible. Fifty-five people filled in the questionnaires but were excluded because they were aged less than 15 years, had no date of birth, or did not identify with at least one Pacific ethnicity. At most, 438 people were eligible for inclusion in this study. Of these, 378 completed questionnaires. There was no evidence of data duplication. Six forms were misplaced by the community-based recruiters, resulting in 372 analysable questionnaires. The response rate was therefore 85%.

Table 1 shows the sociodemographic information of all participants, with data from the Census for the Dunedin Pacific population aged ≥15 years shown where available for comparison. Our sample had comparatively more people aged 15–29 years, receiving allowance/scholarships or with a highest qualification of either a graduate or post graduate degree. Most (87%) were able to speak well in English.

Approximately 60% earned less than NZ$15,000 and 42% had a community services card which entitled them to increased subsidies on prescriptions, some doctor visits, and some other healthcare services. One-third of all participants did not know whether they were eligible for a community services card.
### Table 1. Sociodemographic details of study participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Study participants total=372 n (%)*</th>
<th>Total Dunedin Pacific † population aged ≥15 years Total=1692 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–29</td>
<td>221 (59)</td>
<td>(51)</td>
</tr>
<tr>
<td>30–44</td>
<td>81 (22)</td>
<td>(27)</td>
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<tr>
<td>45–59</td>
<td>42 (11)</td>
<td>(15)</td>
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<tr>
<td>60+</td>
<td>28 (8)</td>
<td>(6)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>153 (41)</td>
<td>(51)</td>
</tr>
<tr>
<td>Female</td>
<td>219 (59)</td>
<td>(49)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samoan</td>
<td>155 (42)</td>
<td>(44)</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>77 (21)</td>
<td>(28)</td>
</tr>
<tr>
<td>Tongan</td>
<td>95 (25)</td>
<td>(15)</td>
</tr>
<tr>
<td>Other Pacific</td>
<td>70 (19)</td>
<td>(19)</td>
</tr>
<tr>
<td><strong>Languages spoken well</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English only</td>
<td>82 (22)</td>
<td>–</td>
</tr>
<tr>
<td>English &amp; Pacific language</td>
<td>241 (65)</td>
<td>–</td>
</tr>
<tr>
<td>Pacific language only</td>
<td>46 (12)</td>
<td>–</td>
</tr>
<tr>
<td>Missing (n=3)</td>
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<tr>
<td><strong>Income source ‡</strong></td>
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<tr>
<td>Salary</td>
<td>211 (52)</td>
<td>(68)</td>
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<tr>
<td>Benefit</td>
<td>62 (15)</td>
<td>(20)</td>
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<td>Allowance/Scholarship</td>
<td>84 (20)</td>
<td>(12)</td>
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<tr>
<td>Other</td>
<td>48 (12)</td>
<td>(22)</td>
</tr>
<tr>
<td>None</td>
<td>55 (14)</td>
<td>(11)</td>
</tr>
<tr>
<td>Missing n=5</td>
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<tr>
<td><strong>Level of income</strong></td>
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<td></td>
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<tr>
<td>&lt; $15,000</td>
<td>209 (62)</td>
<td>–</td>
</tr>
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<td>$15,000–$30,000</td>
<td>62 (18)</td>
<td>–</td>
</tr>
<tr>
<td>&gt; $30,000 – $60,000</td>
<td>58 (17)</td>
<td>–</td>
</tr>
<tr>
<td>&gt; $60,000</td>
<td>8 (2)</td>
<td>–</td>
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<tr>
<td>Missing (n=35)</td>
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<td></td>
</tr>
<tr>
<td><strong>Highest qualification</strong></td>
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<td></td>
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<tr>
<td>Secondary school</td>
<td>169 (48)</td>
<td>(51)</td>
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<tr>
<td>Graduate/Postgraduate</td>
<td>110 (31)</td>
<td>(16)</td>
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<tr>
<td>None</td>
<td>61 (17)</td>
<td>(24)</td>
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<tr>
<td>Other</td>
<td>13 (4)</td>
<td>(9)</td>
</tr>
<tr>
<td>Missing (n=19)</td>
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<td></td>
</tr>
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<td><strong>Enrolled in education</strong></td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>159 (43)</td>
<td>–</td>
</tr>
<tr>
<td>No</td>
<td>206 (56)</td>
<td>–</td>
</tr>
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<td>Missing (n=7)</td>
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<td></td>
</tr>
<tr>
<td><strong>Type of enrollment</strong></td>
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<td></td>
</tr>
<tr>
<td>Full time</td>
<td>127 (89)</td>
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<td>Part time</td>
<td>15 (11)</td>
<td>–</td>
</tr>
<tr>
<td>Missing n=17</td>
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<td></td>
</tr>
<tr>
<td><strong>Community services card</strong></td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>152 (42)</td>
<td>–</td>
</tr>
<tr>
<td>No</td>
<td>213 (58)</td>
<td>–</td>
</tr>
<tr>
<td>Missing (n=7)</td>
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<td></td>
</tr>
</tbody>
</table>

* Percentages may not add up to 100% due to rounding; **total responses, so % add to more than 100; †NZ Census 2006; ‡Participants could nominate income from more than one source

Table 2 shows the participants’ characteristics in relation to having a regular general practitioner (GP) or health service. One hundred and two (28%) of the 366 participants who answered the question reported they did not have a GP or health service they attended on a regular basis. Those who were enrolled in an education institution and in full time study were less likely to have a regular GP or health service, as were those who did not have access to a community services card.
Age, highest qualification, income source and level of income were also statistically significantly associated with whether or not a participant had a regular GP or health service.

Table 2. Participant characteristics in relation to having a regular GP or health service

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Regular GP or health service* n (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>264(72)</td>
<td>102(28)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
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<tr>
<td>15–29</td>
<td>129(59)</td>
<td>89(41)</td>
</tr>
<tr>
<td>30–44</td>
<td>67(85)</td>
<td>12(15)</td>
</tr>
<tr>
<td>45–59</td>
<td>42(100)</td>
<td>0(0)</td>
</tr>
<tr>
<td>60+</td>
<td>26(96)</td>
<td>1(4)</td>
</tr>
<tr>
<td>Languages spoken well</td>
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<td></td>
</tr>
<tr>
<td>English only</td>
<td>57(70)</td>
<td>25(30)</td>
</tr>
<tr>
<td>English &amp; Pacific language</td>
<td>168(71)</td>
<td>69(29)</td>
</tr>
<tr>
<td>Pacific language only</td>
<td>38(84)</td>
<td>7(16)</td>
</tr>
<tr>
<td>Enrolled in education</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>99(62)</td>
<td>60(38)</td>
</tr>
<tr>
<td>No</td>
<td>164(80)</td>
<td>42(20)</td>
</tr>
<tr>
<td>Type of enrolment</td>
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<td></td>
</tr>
<tr>
<td>Full time</td>
<td>71(56)</td>
<td>56(44)</td>
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<td>Part time</td>
<td>14(93)</td>
<td>1(7)</td>
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<td>Secondary school</td>
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<td>Graduate</td>
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<td>None</td>
<td>55(92)</td>
<td>6(8)</td>
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<td>Other</td>
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<td>2(15)</td>
</tr>
<tr>
<td>Income source (prioritised)</td>
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<td></td>
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<tr>
<td>Salary</td>
<td>142(78)</td>
<td>40(22)</td>
</tr>
<tr>
<td>Benefit</td>
<td>46(98)</td>
<td>1(2)</td>
</tr>
<tr>
<td>Student allowance</td>
<td>19(37)</td>
<td>33(63)</td>
</tr>
<tr>
<td>Other</td>
<td>20(69)</td>
<td>9(31)</td>
</tr>
<tr>
<td>None</td>
<td>33(65)</td>
<td>18(35)</td>
</tr>
<tr>
<td>Level of income</td>
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<td></td>
</tr>
<tr>
<td>&lt; $15 000</td>
<td>132(64)</td>
<td>74(36)</td>
</tr>
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<td>$15 000 – $30 000</td>
<td>47(77)</td>
<td>14(23)</td>
</tr>
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<td>$30 000 – $60 000</td>
<td>52(90)</td>
<td>6(10)</td>
</tr>
<tr>
<td>$60 000+</td>
<td>8(100)</td>
<td>0</td>
</tr>
<tr>
<td>Community services card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>127(85)</td>
<td>23(15)</td>
</tr>
<tr>
<td>No</td>
<td>132(63)</td>
<td>78(37)</td>
</tr>
</tbody>
</table>

* The number of respondents for each characteristic may be less than 366 due to missing data; † P-value from Chi-square test; ‡ P value from Fisher’s exact test.

Table 3 shows the participants’ characteristics in relation to the reasons for using hospital emergency services in the previous 12 months. Thirty percent (106) of all participants had used these services in this period. Of those who used hospital emergency services, 47% indicated they felt at the time their illness was an emergency. Age was the only factor which was close to being statistically significantly associated with the reason for attending hospital emergency services.
### Table 3. Participant characteristics in relation to the reasons for accessing public hospital emergency services in the previous 12 months

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Reason for using the hospital emergency services*</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Illness an emergency</td>
<td>GP unavailable</td>
</tr>
<tr>
<td></td>
<td>50(47)</td>
<td>27(25)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–29</td>
<td>23(43)</td>
<td>12(22)</td>
</tr>
<tr>
<td>20–44</td>
<td>10(38)</td>
<td>12(46)</td>
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<td>45–59</td>
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</tr>
<tr>
<td>60+</td>
<td>8(80)</td>
<td>1(10)</td>
</tr>
<tr>
<td><strong>Languages spoken well</strong></td>
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<td></td>
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<tr>
<td>English only</td>
<td>9(45)</td>
<td>5(25)</td>
</tr>
<tr>
<td>English &amp; Pacific language</td>
<td>28(42)</td>
<td>17(26)</td>
</tr>
<tr>
<td>Pacific language only</td>
<td>13(68)</td>
<td>4(21)</td>
</tr>
<tr>
<td><strong>Enrolled in education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17(45)</td>
<td>10(27)</td>
</tr>
<tr>
<td>No</td>
<td>33(45)</td>
<td>17(23)</td>
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<tr>
<td><strong>Type of enrolment</strong></td>
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<tr>
<td>Full time</td>
<td>11(48)</td>
<td>5(22)</td>
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<tr>
<td>Part time</td>
<td>3(43)</td>
<td>3(43)</td>
</tr>
<tr>
<td><strong>Highest qualification</strong></td>
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<td></td>
</tr>
<tr>
<td>Secondary school</td>
<td>20(47)</td>
<td>9(21)</td>
</tr>
<tr>
<td>Graduate</td>
<td>14(54)</td>
<td>8(31)</td>
</tr>
<tr>
<td>None</td>
<td>12(48)</td>
<td>8(32)</td>
</tr>
<tr>
<td>Other</td>
<td>3(43)</td>
<td>3(43)</td>
</tr>
<tr>
<td><strong>Income source (prioritised)</strong></td>
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<td></td>
</tr>
<tr>
<td>Salary</td>
<td>20(40)</td>
<td>16(32)</td>
</tr>
<tr>
<td>Benefit</td>
<td>14(61)</td>
<td>3(13)</td>
</tr>
<tr>
<td>Student allowance</td>
<td>7(70)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Other</td>
<td>2(29)</td>
<td>3(43)</td>
</tr>
<tr>
<td>None</td>
<td>4(33)</td>
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<td><strong>Level of income</strong></td>
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<td>&lt;$15000</td>
<td>26(45)</td>
<td>15(26)</td>
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<td>6(33)</td>
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<td>$60,000+</td>
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<td>2(50)</td>
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<td><strong>Community services card</strong></td>
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<td>15(26)</td>
</tr>
<tr>
<td>No</td>
<td>21(47)</td>
<td>10(22)</td>
</tr>
</tbody>
</table>

*a The number of respondents for each characteristic may be less than 106 due to missing data; ‡ P-value from Fisher’s exact test.

Table 4 shows the participants’ characteristics in relation to the reasons for using the Urgent Doctors (“walk-in service”) in the previous 12 months. Approximately 40% (146) had used this service in this period. The unavailability of their GP was the main reason most people (65%) attended the Urgent Doctors, and one fifth did so because it was convenient. Age, highest qualification, income source and level of income were statistically significantly associated with the reason for accessing the Urgent Doctors.
Table 4. Participant characteristics in relation to the reasons for accessing the “Urgent Doctors” in the previous 12 months.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Reason for using the “Urgent Doctors”</th>
<th>n (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GP unavailable</td>
<td>Convenient</td>
<td>Other</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–29</td>
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<td>15(21)</td>
<td>14(20)</td>
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<tr>
<td>30–44</td>
<td>38(85)</td>
<td>4(9)</td>
<td>4(9)</td>
</tr>
<tr>
<td>45–59</td>
<td>11(65)</td>
<td>4(24)</td>
<td>2(12)</td>
</tr>
<tr>
<td>60+</td>
<td>5(38)</td>
<td>8(62)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Languages spoken well</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English only</td>
<td>22(71)</td>
<td>4(12)</td>
<td>5(16)</td>
</tr>
<tr>
<td>English &amp; PI language</td>
<td>64(67)</td>
<td>18(18)</td>
<td>14(15)</td>
</tr>
<tr>
<td>PI language only</td>
<td>9(50)</td>
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<td>34(60)</td>
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<td>12(21)</td>
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<td>No</td>
<td>60(69)</td>
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<td>Type of enrolment</td>
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<tr>
<td>Full time</td>
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<td>9(23)</td>
</tr>
<tr>
<td>Part time</td>
<td>8(73)</td>
<td>1(9)</td>
<td>2(18)</td>
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<tr>
<td>Highest qualification</td>
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<tr>
<td>Secondary school</td>
<td>30(59)</td>
<td>10(20)</td>
<td>11(22)</td>
</tr>
<tr>
<td>Graduate</td>
<td>39(76)</td>
<td>5(10)</td>
<td>7(14)</td>
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<tr>
<td>None</td>
<td>19(61)</td>
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<tr>
<td>Other</td>
<td>1(25)</td>
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</tr>
<tr>
<td>Income source (prioritised)</td>
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</tr>
<tr>
<td>Salary</td>
<td>61(79)</td>
<td>7(9)</td>
<td>9(12)</td>
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<tr>
<td>Benefit</td>
<td>10(53)</td>
<td>9(47)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Student allowance</td>
<td>8(53)</td>
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<td>4(27)</td>
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<td>3(21)</td>
<td>6(43)</td>
<td>5(36)</td>
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<td>None</td>
<td>10(59)</td>
<td>5(29)</td>
<td>2(12)</td>
</tr>
<tr>
<td>Level of income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$15000</td>
<td>40(53)</td>
<td>24(32)</td>
<td>11(15)</td>
</tr>
<tr>
<td>$15,000≤&lt;$30,000</td>
<td>21(84)</td>
<td>2(8)</td>
<td>2(8)</td>
</tr>
<tr>
<td>$30,000≤&lt;$60,000</td>
<td>23(77)</td>
<td>2(7)</td>
<td>5(17)</td>
</tr>
<tr>
<td>$60,000+</td>
<td>4(100)</td>
<td>0(0)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Community services card</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>43(67)</td>
<td>16(25)</td>
<td>5(8)</td>
</tr>
<tr>
<td>No</td>
<td>49(63)</td>
<td>14(18)</td>
<td>15(19)</td>
</tr>
</tbody>
</table>

* The number of respondents for each characteristic may be less than 146 due to missing data; P-value from Fisher’s exact test.

Discussion

This study describes the use of health services by Pacific peoples who attended Pacific community and student events during the study period in Dunedin. It is not a randomly selected sample of the local community. Our sample was approximately one quarter of the total Dunedin Pacific population aged 15 years and over. The results from this study provide useful information about Pacific peoples access to health services in New Zealand, in particular those attending education institutions.

A large proportion of participants in our study did not have a doctor or health service they attended on a regular basis. Those who were younger, enrolled in education, had high school as their highest qualification, were on a student allowance or on a low income were less likely to have a regular GP or health service. The 2004 Pacific Health Chart book reported 97% of all Pacific peoples in New Zealand had a usual carer.
Most Pacific peoples (67%) in New Zealand live in the Auckland area, where Pacific-led health services are well developed. In areas whether there are fewer Pacific peoples such as Dunedin, there is a risk of increasing existing disparities because it is either not cost-effective to have Pacific-led health services or mainstream services do not address the needs of minority communities. It was surprising Pacific students were not accessing student health services, because costs were minimal. Previous research however indicated even minimal costs could still be a barrier to accessing health services.

Medical costs are subsidised in New Zealand for those who are eligible for a community services card. Most participants had an income less than $15,000 and were therefore eligible for this subsidy card. Approximately 15% of participants eligible for a community services card did not have one. Enabling those who are eligible to obtain a subsidy card may assist access. Education through local Pacific networks can ensure all who are eligible access available support services.

Recent changes in health services delivery with the establishment of Primary Health Organisations (PHOs) required patients to enrol with one health provider. Enrolling with a PHO entitles patients to a universal subsidy. Although there are no Pacific-led health services in Dunedin, there are specific targeted health initiatives for Pacific patients through mainstream services. Patients not enrolled with a PHO cannot access any of these services.

The overcrowding of ED services is a world-wide concern. The high use of emergency services by Pacific peoples in New Zealand has previously been reported. Patients with non urgent conditions in emergency departments are unlikely to see a health professional immediately. Health professionals and Pacific organisations can work together to improve health and the appropriate use of services through better community engagement and dissemination of information.

Participants’ age, qualifications, income source and level of income were associated with accessing the Urgent Doctors (UD) service. Those who were aged 30–44 years were more likely to attend the UD because their GP was unavailable. This may be due to their inability to access their GP during normal working hours because of work commitments. The older age group and those on a benefit were more likely to report they attended the UD because it was more convenient. The Urgent Doctors is a “walk-in” primary care service and patients usually present with acute illnesses. It is open during normal working hours, and also provides After Hours care. There have been discussions over the years whether this service was needed.

Patients are normally encouraged to see their own GPs first because costs associated with consultations are less. GPs however were not always available to see their patients when needed. A “walk-in” primary care facility provides a useful service when patients’ GPs are either fully booked or unavailable for other reasons.

There are systemic and structural issues minority groups (such as Pacific peoples) often struggle with, within the health and education sectors in New Zealand. These have contributed to poor health and education outcomes. Pacific peoples migrated to New Zealand.
Zealand in the hope of a better future for their families, but this has not been a reality for many.\textsuperscript{1, 27}

The government has responded to these needs by outlining plans and strategies to address the challenges.\textsuperscript{10, 28} There are efforts within health and tertiary organisations to contribute to improving outcomes for Pacific peoples.\textsuperscript{11, 29-31} Some Pacific peoples have indicated they wished to be seen by a Pacific health professional when seeking healthcare.\textsuperscript{32} The challenge for health providers and education institutions in New Zealand is to ensure the services they provide cater for the needs of all New Zealanders including disadvantaged minority communities within society.

The motivation for this study was to learn more about access to, and the use of, health services by a particular group of Pacific peoples in Dunedin—those with links to Pacific networks and activities. Therefore participants were recruited at community events and through churches by members of the relevant communities. Community members who undertook the recruitment were instructed to invite all (rather than sample) Pacific peoples aged >15 years who attended particular events to complete the questionnaire.

The strength of this study was the participation of community members as researchers and facilitators of the research process. This resulted in a very good response rate of 85%. It also established good partnerships and pathways for future work and research. However the method of recruitment means that our results may not be generalisable to all Pacific peoples in Dunedin.

Although face-to-face recruitment at community events was an effective means to get a high response rate among those who attended those events, it meant the experiences of people without ties to Pacific networks were inevitably not captured. The needs of these people may be different and further research using different recruitment methods is required to explore their use of health services.

\textbf{Conclusions}

There is a significant proportion of Pacific peoples not enrolled with a primary care service provider in some areas of New Zealand. This can contribute to increasing disparities particularly in small settlement areas. A “walk-in” health facility plays an important role in the delivery of primary healthcare. Pacific community organisations can work together with primary care providers to encourage Pacific peoples’ access to, and the appropriate use of health services in New Zealand.

\textbf{Competing interests:} None known.

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References:


