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 practise one's culture without fear, as a framework for primary care service provision, is essential for improved health service in a multicultural society such as 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 discrimination or malice from those of other ethnicities. In New Zealand, the scientific health services to improve the health of a multicultural society are available but there is a need to improve access and utilisation by hard to reach New Zealanders.

This paper discusses cultural democracy and provides examples of how successful health ventures that have embraced cultural democracy were implemented. It suggests that cultural democracy will provide the intellectual impetus and a robust philosophy for moving from equality to equity in health service access and utilisation. This paper provides a way forward to improve primary care utilisation, efficiency, effectiveness and equitable access, especially for the hard to reach populations. It uses 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 cognisance of 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.

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Introduction

The access to and utilisation 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 some time that whichever way New Zealand society is categorised, the 'inverse care law' is the norm rather than the exception.[4,5] That is, regardless of the categorisation, New Zealanders who need care the most have the least access to the health care services they need to address their health wants, needs and demands. This limited access is due to disparities in health care service availability, acceptability, and affordability.[4]

For many years the notion of equality has underpinned health service provision.[5,6,7] Therefore the emphasis in health service development has 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-six-year-old health funding provision has mostly increased health service utilisation among the easy to reach New Zealanders while those who need the care most still use the services least. Therefore, equal availability to all, though the politically correct equality notion still does not adequately address the reign of the 'inverse care law'.[7,8,9]

In New Zealand, the scientific health services required to improve the health of a multicultural society are available, but there is a need to improve access and utilisation 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 utilisation. Political democracy has been well expressed and practised in New Zealand in its various forms but political participation and utilisation of the system by minority groups has been low and ineffective. Political democracy needs cultural democracy as the over arching 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 benefit, is at least questionable.[11] It is accepted that the ideal of political democracy does not work quite that simply in practice. In fact, some political commentators have stated that the media and wealth have more control over the democratic political process than individual or community choice.[11,12]

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 cognisance of and use cultural democracy and equity as the basis for the design and practice of primary health care for hard to reach New Zealanders, usually minority groups with minimal political power living at the margin of New Zealand mainstream, regardless of ethnicity, social class, socioeconomic status and geographical location.

Cultural democracy will provide the intellectual impetus and robust philosophy for moving from equality to equity in health service access and utilisation

Terms and concepts

The discussion of primary care has been hampered by the dominant use of doctors' clinical professional language.[13,14] Given that language is also a medium for thinking, conceptualisation and communication in primary care, provision has been curtailed by lingual gymnastics and the boundaries of providers. For example the communication of health risks has 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]

Cultural democracy is the ability of the people to practise their culture and language with relative freedom without discrimination

These frameworks are addressed through cultural democracy.[15] This is a philosophical precept that recognises that the way a person communicates, relates to others, seeks support, thinks and learns (cognition) are products of the value system of his/her community.[16] Furthermore, a policy that does not recognise individuals' and communities' rights to remain identified with the 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 practise 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. Therefore indigenous Pacific cultures must be viewed in New Zealand in the context of their cultural histories. Pacificans must be given the rights and opportunities to study, learn and practise important elements of their culture, including health, health risks, and health service provision in New Zealand educational institutions and be socialised to a cultural process whereby Pacificans of all ages learn to be members of their respective societies and communities, sharing with other cultures through their ability to read the cues of each other's culture through competences in cultural and social literacy.[17,18] This has been the basis for 'unity in diversity' among the Pacific nations.[12,19]

Cultural democracy enables 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 programmes 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 populations of New Zealand, e.g. Pacific communities and other minority groups, are characterised by low health service utilisation rates and lower health status[1,5,6] with more linguistic disadvantages than the mainstream New Zealand of predominantly Pakeha origin. Cultural differences, language, and poor education contribute to their 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 the New Zealand Health Primary Health Care Strategy launched in 2001.[20] This strategy has the following:

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

- Ensuring accessible and appropriate services for people from lower socio-economic groups
- Ensuring accessible and appropriate services for Maori
- Ensuring 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 include:
- 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 include:
- Reducing smoking
- Improving nutrition
- Increasing the level of physical activity
- Reducing the rates of suicide and suicide attempts
- Minimising harm caused by alcohol, illicit and other drug use to both individuals and the community
- Reducing the incidence and impact of cancer
- Reducing the incidence and impact of cardiovascular disease
- Reducing the incidence and impact of diabetes
- Improving oral health
- Reducing violence in interpersonal relationships, families, schools and communities
- Improving the health status of people with severe mental illness
- Ensuring access to appropriate child health care services including well child and family health care, and immunisation.

These have been the basis for health reform in New Zealand.[20,21] The continued reforms over the last decade have intended to underpin the implementation of the strategy and the work of Primary Health Organisations (PHOs) and Independent Practitioners Associations (IPAs) to deliver primary care.[21] The intentions of the reforms 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 from a variety of nationalities. Pacificans are disadvantaged economically with poor health status and indicators, with higher morbidity, mortality and health risk but low health service utilisation (the 'inverse care law'). Pacificans have become an 'entrenched under class' in New Zealand with increased marginalisation, discrimination, both socially and economically.[23] (Table 1. A table detailing the differences in health status, health outcomes, health service utilisation and socioeconomic status between Pacificans and other New Zealanders is available from the author). The Pacific population has been characterised with a trend of worsening socioeconomic status, increasing powerlessness and poor health status and lower health service utilisation since the beginning of mass migrations in the 1940s.[24,25] Similarly, the solution has been evident, however the discourses and responses have been framed in assimilation and a culturally undemocratic approach. Various reports from 1940 to now have articulated the plights of Pacificans in New Zealand but there has been a lack of political will and actions beyond the rhetoric to address the 'inverse care law' and thus the marginal populations.[24] Even when health and socioeconomic disparity was evident in the early 1990s,[1] there was no consensual political will to use cultural democracy as a basis for equitable resource allocation and the mainstream populations erroneously insisted that all New Zealanders are equal in needs, wants and demands and that all are on a level playing field and therefore should be given equal allocation of the national treasures.

Table 1. Summary of the health situation of the hard to reach New Zealanders

Health Items	Hard to Reach New Zealanders	Average New Zealanders
Risk Factors	Higher	Lower
Morbidity	Higher	Lower
Mortality	Higher	Lower
Health Service Utilisation/Access	Lower	Higher

It must be emphasised that the existing health and socioeconomic disparities are a consequence 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 sanitised so that their plight has been seen as being a consequence of Pacific lifestyle, culture, including obligatory customary reciprocation, remittance to the Pacific island, and church and religious donations.[26] This has meant that all manner of social investment and building of social capital[27] was arrogantly deemed to be detrimental and contributory to the Pacificans' demise in New Zealand, a very culturally undemocratic view.

There has been negligible 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 being the fundamental reasons for the state of Pacificans and other minority groups. A recent publication on Maori health[28] suggests that the tangatawhenua share similar issues with Pacificans for similar reasons even though the Treaty of Waitangi is supposed to be used as a document to guide Maori health and development. This publication claims that the current state of Maori health and health services is a product of three 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, type 2 diabetes, chronic obstructive pulmonary disease (emphysema) and stroke. These causes of mortality account for 44% of Maori deaths in 2000. The authors ask, *'Why does the Crown require Maori to do it in this particular way and deny them access to other ways they would prefer?'* They state that, *'For Maori there are many examples of racism in the health system. Some are nasty examples at an individual level.'*

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

- *'The Maori workforce is dominated by house niggers.'* The authors claim that a *'house nigger can be recognized by the way she or he has been institutionalized as a Pakeha.'* They state that the *'house niggers have qualifications. They have competencies. Yet they choose to feather 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 while hoping to help Pacificans when they eventually become the ultimate bosses. This they call working smart rather than working hard. This phenomenon has been called the 'Pone Syndrome',[29] derived from the 'fag system' of the old English boarding schools in which senior students adopt junior students, who help them with menial tasks in exchange for the senior students' mentorship and protection. This phenomenon 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 its 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 advice of 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 and later a similar service was funded to a different Pacific provider related to the Crown employees involved. Fortu-

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 wellbeing	• 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

nately this has 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 a notion is a racist approach, to which I quickly retorted, *'For more than 150 years Pakeha 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]

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 a 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, emphasising the establishment of a network of Pacific health services, especially in Auckland and recognising 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 this was driven by Pacificans impatient with the sluggishness of the bureaucracy[31] and wanting to take 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 remarkable results. Examples include 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 categorised into the following efforts:

- Ethnic specific health services developments.[31] These have been Pacifican controlled community-based services employing Pacific health professionals and incorporating Pacific values (see Table 1) and ways of doing things.
- Human Resources and capacity development. Pacificans took control of policy development[35] and training of health professionals from community health workers[37] and SIDS community educators[38] to clinicians, health administrators and managers.
- Building 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 for the impact of the Pacific responses to be evaluated. The process indicators, e.g. utilisation, service acceptability and affordability have been profound. However, the effect on outcomes of health, powerlessness, productivity and socioeconomic status, are still forthcoming.

Discussion

This discourse on Pacific health has used cultural democracy as the framework for analysis. Although the link to cultural democracy has been a hindsight, the precepts of community-based services dealing with the particular needs and values of Pacificans, has 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 focus on ethnic specific needs as being more efficient than looking for one model to fit all and also considers the achievement of economy of scale.

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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 maintaining discrimination, it will show that empowerment contributes significantly to health, productivity and socioeconomic status. This, and the many schools of thought concerning poverty and powerlessness, has been discussed in relation to Pacific children.[41]

There is a complex interaction involving political traditions, policies and systematic patterns in population health over time. A recent study supports the hypothesis that the political ideologies of government affect indicators 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 and cultural democracy 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 programmes plus a demonstrable respect for each other will address the needs of the poor and maintain the health and harmony of New Zealand.

Competing interests

None declared.

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Restless legs syndrome

'RLS is a common disorder thought to involve abnormal iron metabolism and dopaminergic systems. Nonpharmacologic therapy should be suggested for all patients with RLS, but pharmacologic therapy may be required, and evidence is strongest for levodopa and dopamine agonists.'

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