

Barriers to Maori sole mothers' primary health care access

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ABSTRACT

INTRODUCTION: International research consistently shows that sole mothers experience poorer health and suboptimal health care access. New Zealand studies on sole mothers' health report similar findings. The aim of this exploratory research was to better understand the experiences of Maori sole mothers' access to health services, particularly primary health care, for personal health needs.

METHODS: This qualitative study employed a general inductive design informed by a Kaupapa Maori approach, providing guidance on appropriate cultural protocols for recruiting and engaging Maori participants. Distributing written information and snowballing techniques were used to purposively recruit seven Maori sole mothers. Data collection involved semi-structured interviews which were digitally-recorded and transcribed verbatim. Data were analysed using general inductive thematic analysis to identify commonalities and patterns in participants' experiences.

FINDINGS: The dominant themes that emerged captured and described participants' experiences in accessing health care. The major barrier to access reported was cost. Compounding cost, transport difficulties and location or scheduling of services were additional barriers to health service accessibility. Child-related issues also posed a barrier, including prioritising children's needs and childcare over personal health needs.

CONCLUSION: The findings illuminate Maori sole mothers' experiences of accessing health care and the complex socioeconomic inequalities affecting access options and uptake of services. Further investigation of barriers to access is needed. The study has implications for addressing barriers to access at policy, funding and practice levels to improve health outcomes and equitable health care access for Maori sole mothers.

KEYWORDS: Health services accessibility; Maori; primary health care; single parent; single-parent family; socioeconomic factors

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Introduction

Research interest into health disparities is growing internationally.^{1,2} Studies consistently produce evidence of social gradients of health, with income strongly associated with health status, the poor bearing a disproportionate burden of morbidity and mortality.^{3,4} Determinants of health studies show that socioeconomic status impacts on health and is inextricably linked with access to health care; thus, poor health is associated with difficult health care access.^{5,6} Sole mothers, disadvantaged by single

parenting, poverty and often ethnic minority status,⁷⁻⁹ reflect this convergence of disadvantage through poorer health and suboptimal health care access.^{3,10,11}

New Zealand research reports similar relationships among sole motherhood, poverty, stress and poor mental and physical health.^{4,12-14} Several studies have found poor mental health and high rates of substance abuse in sole mothers.¹²⁻¹⁴ Compared to partnered mothers, there is twice the likelihood of sole mothers experiencing mental health issues and increased risk of mood

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disorders, suicidal ideation and substance abuse,¹⁴ and a higher prevalence of treated hypertension, possibly related to stress.¹²

Sole mothers' poverty has been linked to a high prevalence of chronic and acute, current and recurrent health conditions as well as multiple comorbidities, including respiratory and gynaecological conditions. Compared to national data for women, sole mothers were described as having poor health status and social, physical and emotional functioning, and lives characterised by fatigue and misery,⁴ painting a dismal picture of poor health for sole mothers.

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The 2006 census reported that one-parent families constituted 39% of all families with dependent children,¹⁵ of which 81% were headed by sole mothers.¹⁶ Of those, 26% are Maori sole mothers who are disproportionately over-represented considering Maori constitute 15% of the total New Zealand population.¹⁷ Sole mothers, and Maori sole mothers in particular, are thus a significant subpopulation of women and their poor health presents a challenge to New Zealand's policy makers.^{12,18} Maori women are a marginalised and disadvantaged group, according to some research, and their poorer health needs to be better understood.^{1,19} As a significant and double-disadvantaged group in New Zealand's population, Maori sole mothers' access to health care is potentially limited and health services underutilised—an aspect needing further research.

Although Maori constitute a significant population of sole mothers, the role of Maori ethnicity in solo mothers' health has not been explored previously. This study set out to provide an in-depth understanding of Maori sole mothers' primary health care access experiences and to elucidate barriers, facilitators and issues for Maori

sole mothers in taking care of personal health. The focus of this paper is on the findings relating to primary health care access for a small group of low-income Maori sole mothers.

Methods

This exploratory, qualitative study employed a general inductive design. A Kaupapa Maori approach informed the study design, participant recruitment, and data collection procedures, to ensure appropriate cultural protocols in recruiting and engaging Maori participants. Distinct from other qualitative methodologies, a Kaupapa Maori approach is participatory and empowering, as a collectivistic practice that locates power and control within the research process, for the benefits of the research participants. Moreover, because the research is conducted from within a cultural framework, the Maori worldview, language, customs, and knowledge are legitimised in their own right.²⁰

The approach influenced recruitment and data collection by engaging community-based Maori groups; recruitment through snowballing (a relational and whanau-based method); *mihimihi* (a formal greeting) with potential participants; and self-determination given to eligible participants, through choice of interview location and whanau member support. Interviewing, participant checking of transcripts and authentication of preliminary findings supported Maori preference for narrative sharing of experiences, participatory research and dissemination of collective knowledge. Ethical approval was granted by The University of Auckland Human Participants Ethics Committee on 16 May 2011.

The study was conducted in Auckland during 2011–12. Maori sole mothers, as the group of interest, were recruited through purposive sampling,²¹ using flyers and snowballing. Sample size, proposed as from 6 to 12 participants, was determined by saturation of major themes. Inclusion criteria included self-identification as Maori; non-partnered sole mother with dependent children; aged 18 years or over; comfortable with interviewing in English; and residing in Auckland. Initial phone contact with potential participants facilitated the screening of inter-

ested individuals according to inclusion criteria. Although income was not an inclusion criterion, all participants as recipients of a Domestic Purposes Benefit (DPB) were on low incomes. After mihimihi and informed, written consent had been obtained, the interview (lasting from 40 to 67 minutes) was conducted. The semi-structured interviews, involving open-ended questions and prompts, were digitally recorded and transcribed verbatim (by the researcher), providing accurate raw data.^{22,23}

An interview guide ensured issues were systematically covered. General questions regarding participants' health and health care access were used to open the discussion, followed by questions about accessing health care, positive and negative experiences, as well as experiences of discrimination, or non-access. Participants' names were not used on the interview transcripts to ensure confidentiality; each was given a pseudonym.

Once raw information was reduced into labelled categories and subcategories, the individual accounts were re-read so facilitators and barriers as specific experiential themes could be noted, and links between subcategories revealed. A summarised table of inter-account thematic analysis was created to reveal which themes were common to several participants. As analysis progressed, themes were reworded and re-defined to better retain the meaning and context of the raw data.

Measures taken to protect authenticity of data and rigour of findings, including inviting participants to review, edit and critique their own transcript and provisional summarised findings, increased the study's 'truthfulness'.^{23,24} Six participants requested on their consent forms to receive their transcripts, but no corrections to transcripts were requested. Data collection, transcription, and analysis by one person (the researcher) provided continuity in handling and understanding of data to preserve integrity and meaningfulness, which lends rigour to findings.²⁴ The thematic analysis was subjected to secondary adjudication by the second author. Presenting findings as emergent themes and supporting themes, with evidence in the form of direct quotes also ensures findings are true to the data.²³

WHAT GAP THIS FILLS

What we already know: International research, though limited, reveals that sole motherhood is associated with low socioeconomic status, ethnic minorities, poor health status, and underutilisation of health services. International research investigating sole mothers' health has found evidence that health status and access to health care of sole mothers reflects a clear and negative social and ethnic gradient.

What this study adds: The experiences of low-income Maori sole mothers add to evidence of social gradients of health. Barriers to access are reflected in the interface of sole motherhood, Maori ethnicity and socioeconomic disadvantage, impacting on their ability to access primary health care and on their health. Findings highlight the impact of primary health care user-pays charges on Maori sole mothers and their children.

Findings

Three main barriers to Maori sole mothers' access to primary health care for personal health needs were found—cost, health service accessibility, and child-related issues. Participants' accounts revealed that access was sought mostly for curative, rather than preventative health care, mainly because cost barriers discouraged sole mothers from accessing health services until health concerns had become serious, or for emergencies.

Cost

Overwhelmingly, costs of health care were barriers to benefit-dependent participants in accessing health care for personal needs. For many, general practitioner (GP) services were too expensive to access, even when subsidised through Community Services cards. Even low-cost (under \$10) access was beyond the reach of some participants.

Those are the times when I've had to call my mother and my brother. One of them. And they've had to come from wherever, whatever they're doing to bring me, what? [Doctors fees of] \$15 or something. That sort of thing. (#1)

Ah, yeah, believe it or not the cost of \$7 [GP fees] at one point was too much, you know, it just was. (#2)

Primary health care access in weekends and evenings is well beyond the reach of most of the

participants, with after-hours fees substantially higher than routine GP visits.

Like for my daughter this weekend... \$52 for [after-hours care]. That's half of our food for the week to go to a doctor and for me it's not an option. Not an option... [I'd] probably not [go to the doctor], because of the money. I'll probably just sit there and wait until something actually happens. (#1)

Hospital emergency departments (EDs) were also reportedly utilised as 'free' primary health care by some participants in order to avoid unaffordable GP fees.

I know they know I'm only there because I can't afford the doctor. I know they know and I have to wait a long time, but they're okay. They still yeah, they don't treat me bad or anything like that, yeah... because they just take care of me. Well, they... do all the checks, you know, give me antibiotics, you know, do everything that doctors do, but they don't...[say], 'Well, it's going be a long time here!' or something like, anything that makes you [feel bad]. Well sometimes they mention, 'You should go to your GP' you know or, 'Next time you should see your GP first,' but they still are really nice, yeah. (#1)

Even when they did consult a doctor, the costs related to filling a prescription was another financial barrier. Some participants decided to find a cheaper outlet, not to fill a prescription, or to make a prescription go further by stopping a course of medicine mid-way.

With my kids, what I usually do is give the script [to the pharmacy] and say, 'Here, can you let me know how much before you put it through' and then they're like, 'Oh yeah, this one will be \$3 and that one will be \$8' and then I'm like, 'Ah no, give it [back], I'm going to go somewhere else. (#3)

When I go to the hospital and if they happen to give me antibiotics at the time that I'm there, I might only have half the course and wait until the next time I'm sick, and I'll have the other half. (#1)

Dental health was a major concern for participants because of the cost. All participants were DPB beneficiaries and familiar with Work and

Income New Zealand (WINZ) provisions to assist with dental treatment costs. Dental service access was inextricably linked to accessing WINZ advances and grants. Not being able to access limited advances or annual grants meant that some participants had to forgo dental treatment entirely, or access hospital-based dental extraction services only.

Dental care, yeah that's a big one, aye. Well, WINZ paid for my last one, otherwise if WINZ wouldn't pay for it I wouldn't even bother going. It would need to be a matter of life or death, you know. (#4)

I'd have to use up all of my grant from WINZ to get a tooth fixed from any dentist and the only other option that you have is [to go to] the hospital to pull it out and give you antibiotics...the hospital dentist. The hospital does dental work: \$40 for extraction... I've [had] four teeth removed and the first would have been when I was about 21 to 22 [years old]. (#1)

Health service accessibility

Accessibility of health services compounded cost as a barrier. Transport issues related to the impact of not owning a car, the costs to run and maintain a car, family or friends unable to assist with transport, and problems with public transport, were raised as barriers to access.

Yeah, well, I need a car and I've only just managed to get a [car]. I was three months without a car and it's impossible. Your children are sick and then if you've got no car to try and [take them to the doctor].... you can't carry them on your back to take them to the doctor and so I've now bought a \$500 car and still paying my debts off from this \$500 car and it has no warrant, no registration, the bumper's falling off. It's a piece of [rubbish], but it goes really well and it gets the kids to the doctor as well as on rainy days gets them to school. But if I didn't have a car it's impossible. (#1)

Public transport, including bus and train options, was reported as unsuitable or impossible if fares were unaffordable or where health care was needed for childbirth, serious illness, or after-hours care.

How many times do you fall sick on the right times? You know, the right time of day and those sort of things, and feeling all right to go on a bus for half an hour to get there?... [Yet] for some reason [WINZ] think it's okay to have us on [the] public service. It is [under] normal circumstances, but once the kids get sick you can't be on [the] public service and I don't have [family support]. Like I said, my family live all over Auckland. (#1)

In the light of difficulties and costs associated with transport, most participants indicated a preference or need to access 'local' health care. Some resided in Housing New Zealand properties located in high deprivation areas where low-cost primary health care services were located.

Yeah, yeah. That's true. Um, there's a lot more access out South Auckland than there is out here. I've definitely noticed that. Because there are doctors out South Auckland who will pick you up if you need. (#2)

However, as revealed in participants' accounts, while the lower-fee GPs and Maori health providers are commonly located in areas classified as high deprivation, not all sole mothers reside in those high deprivation areas. The limited availability and distribution of such primary health providers emerged as an issue that prevented access to the more affordable health care preferred and gave rise to inequities in access. While some participants preferred Maori providers, this appeared to be related to affordability.

So initially I registered with one doctor closest to me and it was something like, I don't know, \$40 to \$50, not too sure, and then I got an advertisement in the local paper for a [Maori health provider further away] and it was probably about a 15-minute drive to get there, but it advertised being free for children under 18 [years]. And so I thought, 'Well, that's the best that I could get for where I was, being free'. (#1)

Examples were given of services where cost barriers had been reduced or removed, or were free on certain days only, but still could not be accessed because the participant was unavailable on that day.

Because I was Maori it was free, you know... I think the barrier for me, why I did put it off, was that it was only free on Wednesday and I was busy on Wednesdays so, you know, I didn't go there. (#4)

Participants were more likely to access health care when barriers, such as cost, travel distance and waiting time were reduced. However, examples were given that illustrated how participants' decisions may involve balancing one barrier against another.

Cost. Yeah. And then if it's free, if someone's going to come and tell me it's free, it'll probably be on the other side of Auckland. Or [there is] a 10-hour wait to get seen. There's always those things... You can't just, you know, go to a doctor, get your checks, those sort of things. It's always everything.... It's too... it's too difficult. I would have to catch a bus all the way there and I'd probably have to miss [classes] to do it. (#1)

Child-related issues

Participants demonstrated great concern for their children's welfare and health, and prioritised children's needs at the expense of their personal health needs. This commonly reported tendency to put children's health care first, meant that participants regularly forgo access to health services.

Oh, cost is always a factor, being a sole mum and on the benefit. Cost, it's always a factor, you know, because you put your own needs aside, because you have other things or your children need other things, you know, and you need food and stuff like that. So you put your own health aside for the... children. (#4)

The low DPB income can restrict the sole mothers' ability to access health care even for the children. Several participants reported financial hardship because their children had health conditions requiring frequent visits to GPs, after-hours clinics, pharmacies, and sometimes EDs.

But it's not just [me]. Like my son, I didn't take him to the doctor a couple of weekends ago, because of the cost... because you know, the kids get quite sick and you don't want to be keeping them home,

I mean away from the doctors, because you can't afford to pay for them. (#4)

A lack of childcare was raised as a barrier to accessing health care by most participants. Sole mothers can find health emergencies or hospitalisation extremely difficult to deal with if they had no ready help with childcare:

Yeah, but I was in really bad pain, but there was no way I could ring an ambulance because I had my three-year-old son, you know. So, I had to drive all the way to [locality] in this mega-pain, track down my friend and then be driven to the hospital. (#2)

Taking children along to GP appointments or accessing after-hours care with multiple children in tow was considered stressful and sometimes unsuitable. Mothers reported disapproval from others in the waiting room regarding the children or a child missing a day at school in order for the mother to receive health care.

Sometimes you're sick and you don't want to drag your two children up to the doctors. (#2)

My daughter had to miss this day, off school, because we had to be sitting at the hospital at 5.30 in the morning and then I didn't get seen till about 12 o'clock in the afternoon... I had no choice but to take my daughter with me. (#1)

Childcare issues also interfered with services utilisation, as in these examples of maternity care and substance abuse treatment.

Yeah I don't stay there and relax [after the birth]. [The next day] I went home and cleaned the house, you know, I didn't even have time to sleep. But I cleaned the house, cleaned the mess, done the washing, cooked dinner, and then the kids came home from school. (#3)

And I couldn't do [drug treatment] because my mum had found out that she had lung cancer you know, and she couldn't look after my kids. (#4)

Discussion

All participants were DPB dependent, where providing the basic necessities of life was a daily

challenge. Cost impacted on participants' access to primary care services, with many instances of participants reporting either taking no action and the health need remaining un-met or accessing hospital ED services for 'free' primary care, with flow-on health system costs. In the United States following welfare reforms, it was reported that low-income families endured painful conditions and morbidity, when access was deferred due to cost barriers or that they used EDs for primary care treatment.¹¹ Similarly, participants reported they frequently could not afford to fill prescriptions, especially prescriptions with several items. Some participants reported having only some prescription items supplied, or taking half a course of treatment; both strategies potentially have negative impacts on health, a pattern also reported in the US.¹¹ Dental health services were consistently reported as beyond the participants' financial resources and not utilised when needed, or used in emergencies using financial aid from WINZ. Recent research reported that Maori females aged 15–44 years on low incomes were most likely to defer dental care due to cost.²

Health services accessibility compounded cost as a barrier. Transport difficulties related to the costs of running a car, not owning a car and the costs and inconvenience associated with public transport use were common experiences. In the United States, low-income families and sole mothers also reported transport difficulties and distance to services as barriers to access.^{11,25} Although participants preferred to use services located nearby, the distribution of low-cost Maori or other health providers did not always coincide with where participants' social housing was located. Inequitable distribution and utilisation of health funding, health resources, and primary health services has been highlighted previously.⁶

A third barrier to health care access was child-related issues. All participants prioritised their children's needs, some of whom suffered chronic illness, over their own. Other New Zealand research has also found that Maori women were likely to defer their own health care in order to meet the needs of others in their care; these were seen as non-financial

barriers to health care.² Childcare emerged as a significant barrier to a sole mothers' ability to access health care, as also found by Seccombe and colleagues¹¹ among low-income families on welfare in an Oregon study.

Three limitations of the current study include sample size, sample income and location. The small sample of seven participants, all living in Auckland and receiving the DPB, means that although findings are authentic to the participants, they are not generalisable to the wider New Zealand population of sole mothers. Extending the study on health care access to involve a larger and more diverse sample, representing more Maori, other ethnicities and geographical locations, would increase confidence in findings, strengthening the potential for findings to influence policy and funding decision-making.

In conclusion, sole mother populations have been shown as burdened by multiple disadvantages impacting on personal health and that create barriers to equitable access to health care. The present study provides evidence of the social gradients of health among urban, DPB-dependent Maori sole mothers. This undermines their ability to access subsidised and sometimes free primary health care, and highlights the negative impact of a user-pays primary health care system for low-income sole mothers, a barrier likely to be exacerbated with the recently implemented increase in prescription costs. Aligning with international studies, the findings elucidate the dynamic complexities inherent in ethnic minority sole mothers' circumstances and their experiences of health care provision.

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COMPETING INTERESTS

None declared.