Non-financial barriers to primary health care services for Maori

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In the June edition of the *Journal of Primary Health Care*, Jim Vause identified ways to address cost barriers for Maori.[1] Other barriers to care identified in qualitative research[2] include communication; structural barriers; and cultural fit. In this column the focus is on identifying the remaining (non-financial) barriers, while the next column (*Pounamu*, December 2009) will provide examples of successful initiatives in New Zealand that have overcome these barriers, leading to equitable provision of primary care services.

Barriers to care exist between the predominantly non-Maori health professionals and Maori patients. These barriers can inhibit effective care.

Communication barriers include differences in educational attainment leading to differences in health literacy, and knowledge of how services are organised or accessed. In addition, prior experience of unfavourable attitudes to Maori in health care or other settings can create a barrier to communication.

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Structural barriers include the distance to travel for rural Maori, the availability of suitable appointment times, the need to take time off work, and clinic waiting times. Lastly, physical barriers impact more on Maori than Europeans because of a greater prevalence of physical or sensory disabilities.

Cultural fit refers to the alignment of health provider and patient perceptions, attitudes, and beliefs. The 'fit' between non-Maori provider and Maori patient influences the acceptability of services and adherence to treatment recommendations. Barriers to 'cultural fit' identified in our research included perceptions of being patronised; being treated without respect and previous experiences of bias, and differences in perceptions of illness and death. In addition, Maori patients and non-Maori providers may misinterpret each others' behaviours compounding the feelings of discomfort in each. For example, a (culturally appropriate) polite agreement and reluctance to challenge the authoritative doctor or nurse can be misinterpreted as shyness. Similarly Maori patients may feel uncomfortable in the clinic setting when there is little acknowledgment of typical Maori processes such as the desire for whanau to be present, and a preference for the Maori patient to quietly accept recommendations without question.

As a first step, practices should be alert to the barriers noted above. The importance of each of the barriers and components will vary in relation to factors such as the severity of illness, the age of the patient and their sociodemographic status. Skilled providers will continually adjust their interactions to take account of such changes.

References

1. Vause J. Pounamu: Service providers should consider disparity in developing policies on access to care, continuity of care and cultural competency. J Primary Health Care 2009;1(2):144.
2. Jansen P. Maori consumer use and experience of health and disability and ACC services. Mauri Ora Symposium. Wellington; 2006.

Further reading

Baxter J. Barriers to health care for Maori with known diabetes. Te Ropu Rangahau Hauora a Ngai Tahu; 2002

Ellison-Loschmann L, Pearce N. Improving access to health care among New Zealand's Maori population. Am J Public Health 2006;96:612–7.

Harris R, Tobias M, Jeffreys M, et al. Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: cross-sectional study. Lancet 2006;367:2005–09.

For more information on research into Maori experiences and perceptions of health care see: www.mauriora.co.nz