Residential Movement, Camping Grounds and Access to Health Services[1]

Philippa Howden-Chapman,

Chrissie Severinsen and

Rebecca Osborne

He Kainga Oranga/ Housing and Health Research Programme
University of Otago

[1] Maps were provided with the help of Alistair Osborne and Catherine Schroder. Map coordinates of primary, secondary and tertiary health facilities were supplied by the Ministry of health and Capital and Coast District Health Board.

1. Introduction

Residential mobility, which can be defined by measures of frequency, distance, time since last shift, and the reason for shifting, is more common in New Zealand than in most other developed countries.[2] This paper explores the relationship between residential movement, those in insecure housing in camping grounds, and access to health services.

The geographical location of health services can have an impact at the community level on choices about where and when health care is sought, as well as on decisions to stay or leave a community. Access to health services may provide an important pathway to community attachment. Given that a wider range of services are available in urban locations than rural areas, we were interested in the differences between the rural and urban experience of health and residential movement.

To explore this, we analysed the distance to heath care services in Opotiki and Porirua and undertook in-depth interviews with health service providers and residents of camping grounds in these areas. We chose to interview residents in camping grounds because their accommodation is by definition temporary and therefore insecure. They generally have low incomes so are less likely to have phones or the networks arising from employment and are more vulnerable to health problems.[3]

Different types of neighbourhoods vary in their ability to cause or regulate patients' illnesses through providing formal and informal health and social support.[4] In New Zealand, these neighbourhood effects operate within the government's formal population approach, providing services at different area-based administrative areas.

Tertiary hospitals are in the main urban areas, so those living outside these areas, as well as people who move houses relatively often, or choose to live part of the year in different places, are often disadvantaged because referral to specialist health services is only available through primary health organisations (PHOs), which require patients to enrol. People who live in camping grounds can have difficulty accessing tertiary and primary health care, when the local primary health organisation has restricted access. Furthermore, the nature of their housing also adds to their mobility and propensity to move, making it more difficult to maintain regular and easy contact with their local primary health organisation.

In this paper, we look more closely at the implications of a population approach to primary health care for two communities: one a provincial town, Opotiki and one an urban area, Porirua. Firstly, we look at the geographical location of health services by mapping the approximate distances of primary, secondary and tertiary health care facilities. We consider both issues of access relating to these services, and also what this access, or lack of access, means to the local community and to health care providers. These maps are supplemented by a description of service availability, which emphasises different access-based issues for each community.

[2] Jellyman and Spencer, 2008
[3] Graham, 2007
[4] Gleeson, Hay et al., 1988; van der Linden, Drukker, et al., 2003; Drukker, Driessen, et al., 2004

Using in-depth qualitative interviews, we then consider the perspective of camping ground residents, who were selected because they were living semi-permanently in camping ground facilities. Nonetheless, there were indications from our interviews with providers and residents, that these people had relatively high levels of residential mobility. Within this context, we wanted to understand better how camping ground residents fared in accessing both primary and specialist health services.

2. Residential Movement and Geographic Access to Health Care

A review of the international literature on residential movement and health consistently shows a complex relationship between the two factors: some studies show positive health effects from moving, while others show negative effects. Stokols and Shumaker (1982) advise against using simplistic explanations to describe this relationship. Neither good nor poor health is an inevitable result of residential movement. Instead there are a number of factors that mediate between moving and health.[5] These factors may be located in individual or social aspects of a move, such as the degree of choice over the movement event and the destination[6] or the presence of social networks and support.[7] Mediating factors may also be located in the community, for example, proximity and access to services.

Access, or lack of access to health care, may have an influence both on the health and well-being of those who are in need of such services, and also on decisions to move into or out of a community. According to Rosen et al. (2001), access to health care can be understood in a number of ways, including geographic, financial, educational, cultural and age-based access. Geographical access to health care has been explored as an issue of concern in a wide range of literature, and research focusing on access for residents in rural communities has been noted as being especially relevant.

Various international studies cite the challenges that may be faced by rural communities in relation to accessing health care. These include difficulties accessing primary care, diagnostic services and specialist treatment; issues with retaining health professionals; and a limited number of health facilities.[8] For residents of rural communities who have ongoing health needs, for example older people and those with long-standing illness, the lack of access to nearby health and specialist services, or the closure of existing services[9] is believed to prompt movement out of the community to a place with better access.[10]

[5] Osborne, Milne, et al., 2004
[6] See Boyle, Norman, et al., 2002; Gilman, Kawachi, et al., 2003
[7] Franks, Campbell, et al., 1992
[8] Ryan-Nicholls, 2004
[9] Muus, Ludtke, et al., 1995
[10] Larson, Bell, et al., 2004

Other access-related challenges for rural communities are associated with travel for primary, secondary and tertiary health care, and service centralisation.[11] It is generally accepted that there is a relationship between distance to a health care provider and use of their service. Therefore, in simplistic terms, the greater the distance to the health service, the less likely the service will be utilised.[12] The implications reach further, as lack of access to primary health care can impact on secondary and tertiary care, where such services require a referral from a primary health care practitioner.[13]

There are obviously other factors involved in this relationship, and problems of access due to distance may represent these other issues. Rosen et al. (2001) point out that in many cases, concerns such as the time and cost involved in travelling for care, or difficulties securing reliable transport can be more crucial than the physical distance. These issues are likely to be felt more keenly by some sections of the rural population over others. A review of literature on access to primary health care for people with disabilities living in rural areas identified those with long-standing illness or disability are particularly vulnerable.[14] Older people living in rural locations are also at a significant disadvantage compared to those living in an urban setting due, among other things, to a lack of health professionals and limited financial resources.[15] These issues are not so pressing in urban areas, where a range of health care facilities are geographically closer.

Frequent Residential Movement

A final issue concerning residential movement and health is the claim by a number of international studies that residential movement itself can have an impact on access to health care. Research has suggested that individuals and families who move more than average for the society in which they live, may be less likely to access preventive health services such as screening and immunisations, particularly if their contact details are not updated.[16] One United States study found that children who moved more frequently than average had fewer visits to a general practitioner (GP) than more residentially stable children,[17] while access to a regular doctor can also be affected by residential movement.[18] Furthermore, health providers may be less inclined to retain or follow up patients who have a history of frequent movement.[19] Clearly these factors can impact on the health of the movers, and may have an effect on the delivery of health services in communities that experience relatively high residential movement.

---

[11] Bourke, 2001; Rosen, Florin, et al., 2001; Ryan-Nicholls, 2004
[12] Nemet and Bailey, 2000; Lovett, Haynes, et al., 2002. For a more detailed discussion of the complex relationship between distance to health care and access see Nemet and Bailey, 2000.
[13] Lovett, Haynes, et al., 2002
[14] Lishner, Richardson, et al., 1996
[15] Dwyer and Miller, as cited by Lishner, Richardson, et al., 1996
[16] Jacobson, 1992
[17] The Providence Plan, 2002
[18] The Providence Plan, 2002; Bures, 2003
[19] Lamont, Ukoumunne, et al., 2000

These issues are also pertinent to New Zealand, where there are relatively high levels of residential movement, and where access to health services may also be affected by the structure of the PHOs and their focus on enrolment of a stable patient population.

Previous New Zealand studies have shown considerable evidence of unmet need for health care services, particularly in times of economic recession.[20] Moreover, practices in more socioeconomically deprived areas, although they charged lower fees, tended to be less flexible in their payment schedules, which had the effect of inhibiting integrated care. In consequence, there was increasingly evidence of poorer health status among disadvantaged populations, as well as increasing rates of acute and readmissions and preventable avoidable admissions.[21] This approach also caused problems for those who did not have had a regular GP, or were residentially mobile.

In 2001, the Primary Health Care Strategy signalled a policy move away from this individualised fee-for-service model to a more community health model, where GPs had less professional sovereignty.[22] The Strategy provided for the formation of PHOs, set up with community governance, to be the contracting agency on behalf of DHBs, for general practice and other primary care services. The aspect of the policy that was to have the most impact on people and households on the move, was that PHOs were funded on a capitation basis and were required to have enrolled populations for whom they, alone, were responsible. In addition, they were expected to identify and address health inequalities.

As a consequence of the development of PHOs and increased patient subsidies, patients now have lower doctor fees overall, particularly in more deprived communities.[23] However, one unintended consequence of enrolling patient populations, has been the "closing of the books" of many PHOs particularly in urban areas.[24] This has created a serious access problem, particularly for residentially mobile people who are less likely to be enrolled with a PHO, or find it difficult to enrol when moving into an area where PHOs are no longer taking on new patients.

3. Method

After ethical approval was obtained from the Wellington Regional Ethics Committee the first round of data collection with health service providers was conducted between May and November 2004 and involved in-depth, semi-structured interviews with key informants from each of the participating communities. Key informants were identified through existing contacts in each of the communities and "snowball" sampling was used to recruit further participants. The initial set of 18 interviews were held with health and social service providers and included practice managers, a doctor, a nurse, a pharmacist, Plunket staff, emergency care staff, social support staff and mental health workers, as well as community leaders with experience

[20] Barnett, 2001
[21] Barnett and Lauer, 2003
[22] Barnett and Barnett, 2008
[23] Gribben and Cumming, 2007
[24] Ratcliffe, 2008

or interest in issues related to health and residential movement. Prior to the interview, each participant was provided with a consent form and was asked for permission to tape record the session. The interview topics included the perceived effects on the individual and community of residential movement and attachment, the effectiveness and appropriateness of local health provision and services, and particular community-based issues relating to health in the context of residential movement. Health care providers were not only asked to reflect on their own issues related to provision of care, but were also asked to comment on what they believed to be the experiences and concerns of their registered population, as well as the community as a whole.

The second round of data collection was conducted in 2006 and 2007 in four camping grounds, two in Opotiki and two in Porirua. Camping ground residents were selected because according to local by-laws they were not able to live permanently in camping grounds and as such were not covered by the Residential Tenancies Act. After gaining ethical approval and informed consent from the residents, 22 interviews with campers were taped and transcribed by the second author in two of the four regions in this project: Opotiki and Porirua. While some of the residents interviewed were long-term "permanent" residents, others maintained an unsettled or transient lifestyle allowed by, or forced by, their social and economic circumstances. Both the first and second authors read the transcripts and discussed the analysis of the narratives. Whereas thematic analysis was used to analyse the health providers' interviews, narrative analysis was used for the camping ground interviews. Narratives, the stories people tell of their lives, provide access to meanings of experience, and also illuminate the wider societal influences on their perspectives of health.[25] One key aspect of the narratives was how these residents, who were almost all on benefits or low incomes, saw their health and how they accessed health care services from their campsites.

4. Access to Care

In the following sections, we describe the services that were available in the Census Area Unit (CAU) areas in 2001. Maps of each area showing the location and approximate distance of primary, secondary and tertiary health care facilities available to each community were created using ArcGIS 9.0, with map coordinate information supplied by the Ministry of Health and Capital and Coast District Health Board. The Census Area Units from the 2001 Census were used.

Cannons Creek/Waitangirua

Cannons Creek/Waitangirua encompasses the CAUs for Cannons Creek North (CAU:571100), Cannons Creek South (CAU:571200), Cannons Creek East (CAU:571300), Waitangirua (CAU:571400) and Ascot Park (CAU:571600).[26] As can be seen in Figure 1, at the time of the research (2004), there were a number of primary health facilities in or nearby the study area (shaded brown). However, dividing the number of primary health services in or very close to the study area (five) by the usually resident population in 2001 of approximately 15,700, it might be assumed that

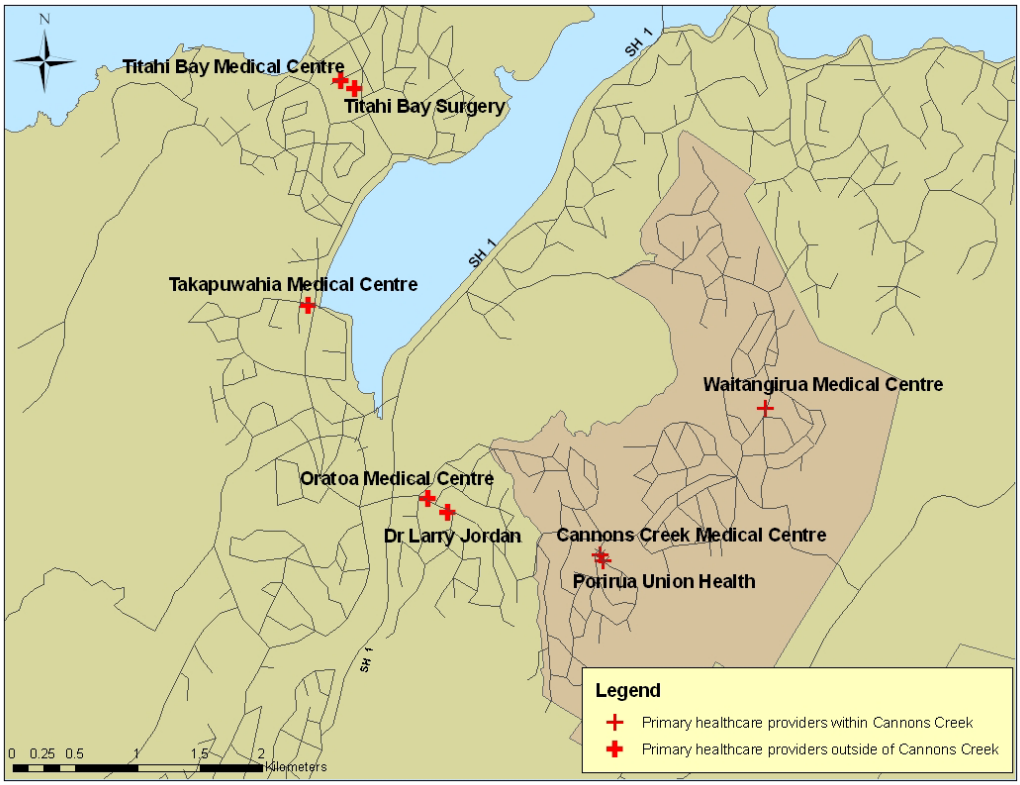
[25] Wiles, Rosenberg, et al., 2004
[26] Stevenson, Kiddle, et al., 2003

these health facilities serve a large population. After hours medical care (not shown on map) is provided nearby, in central Porirua. A number of preventive health and social service providers were also located in or nearby the Cannons Creek area, which are not GP-based but focus on preventative/health promotion services. These include:

- Maraeroa Marae Health Clinic
- Pacific Health Services
- Vakaola (Pacific Community Health)
- Taeaomanino Trust

Cannons Creek/Waitangirua maps

Figure 1: Primary health care providers in Cannons Creek/Waitangirua



Kenepuru Hospital, located in Porirua, provides close secondary health care to people living in Cannons Creek/Waitangirua (see Figure 2). The hospital provides significant outpatient and day services following a Capital and Coast District Health Board strategy to "provide as many services as possible close to where people live".[27] Inpatient services focus on the elderly and mental health services (particularly for adolescents and the elderly). The hospital also provides a range of other services including maternity and child health, rehabilitation, medical and surgical services.[28] Wellington Hospital in Newtown, Wellington, is the closest tertiary hospital to residents in Cannons Creek/Waitangirua.

[27] Capital and Coast District Health Board, year unknown
[28] Capital and Coast District Health Board, year unknown

Figure 2: Secondary and tertiary health providers for Cannons Creek/Waitangirua residents

Opotiki

For the *Building Attachments* project, the CAUs defined as Opotiki cover the area of the Opotiki District local government, including Opotiki (CAU:542800), Te Kaha (CAU:542901), Cape Runaway (CAU:542903), Oponae (CAU:542904) and Waiotahi (CAU:542906).[29] Together, these areas make up a large geographic area (see Figure 3). At the time of the research (2004) Opotiki town had three primary health providers: Church Street Surgery, Opotiki Community Health Centre and Whakatohea Health Centre (see Figure 4). There is also a medical centre based in Te Kaha. A small hospital in Opotiki provides four GP beds and two maternity beds, as well as an x-ray machine. The centre provides a base for one GP, nurses (inpatient, district and public health), and a physiotherapist. The centre runs regular clinics (medical, surgical, paediatric and gynaecology); education programmes (diabetic, nutrition and asthma); and has mental health outpatient services. After hours services are managed by nurses at the centre, with weekend clinics provided by GPs. Other secondary and tertiary hospital services (see Figure 5) are provided by Whakatane, Tauranga, Waikato, Auckland and Starship Hospitals. However, it should be noted that residents living in the far Eastern Bay of Plenty need to travel a significantly greater distance for secondary and tertiary health care than do residents in Opotiki town.

[29] Stevenson, Kiddle, et al., 2003

Opotiki maps

Figure 3: Primary health care providers in Opotiki (town)

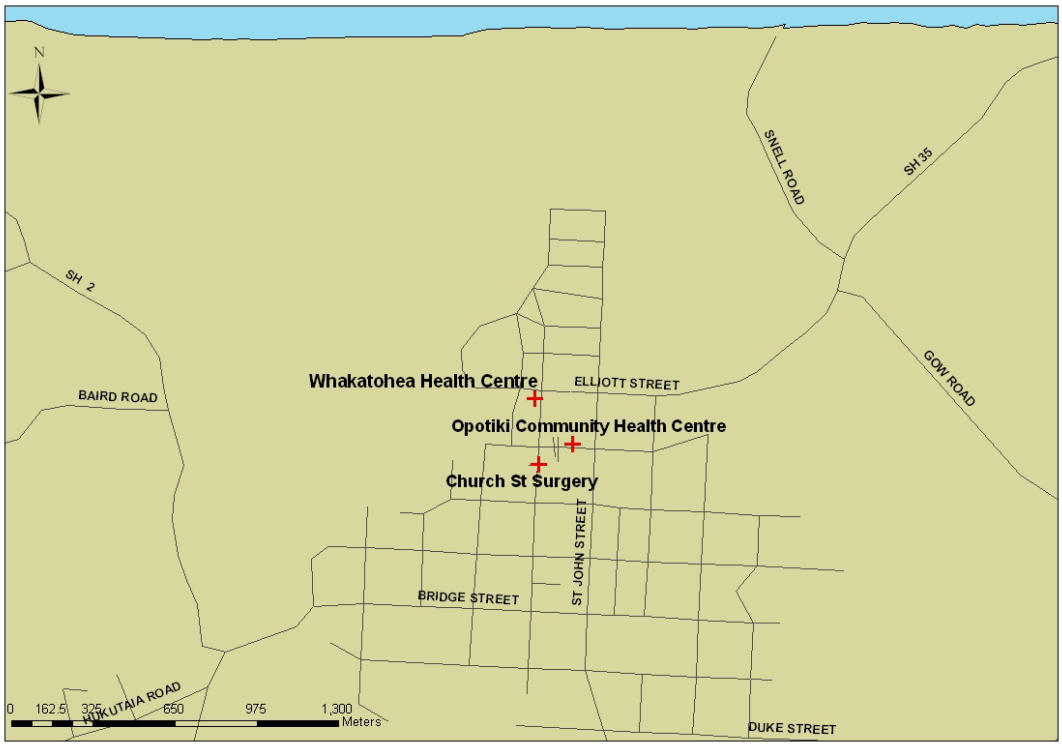


Figure 4: Primary Health Care Providers in the Wider Opotiki Area

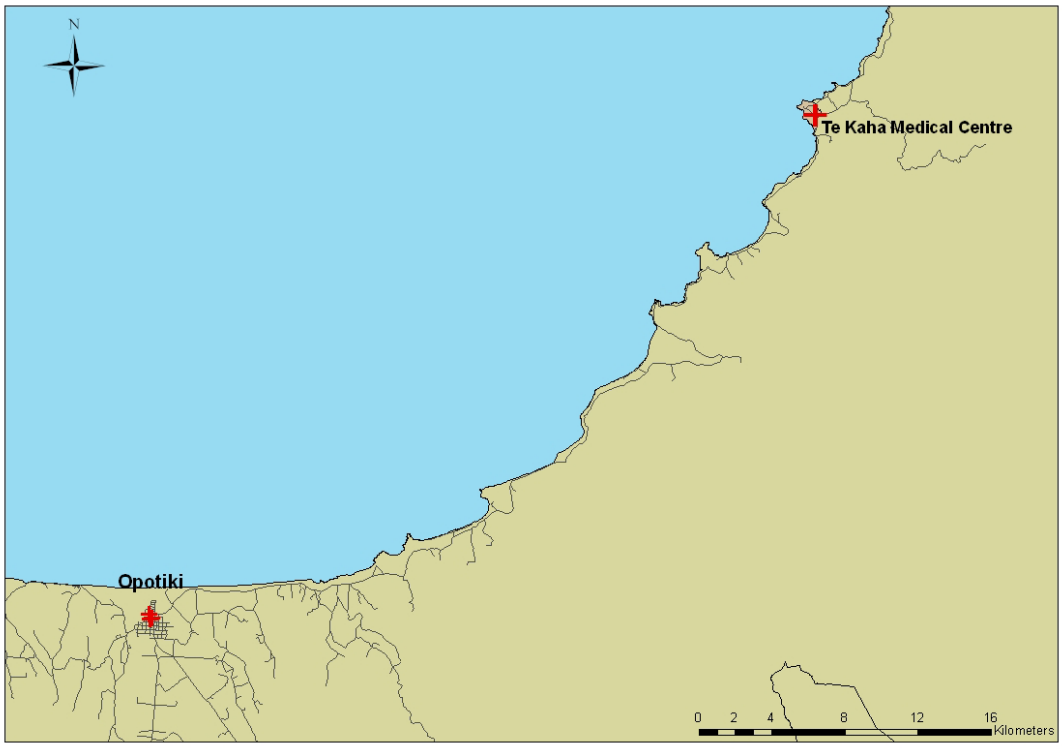
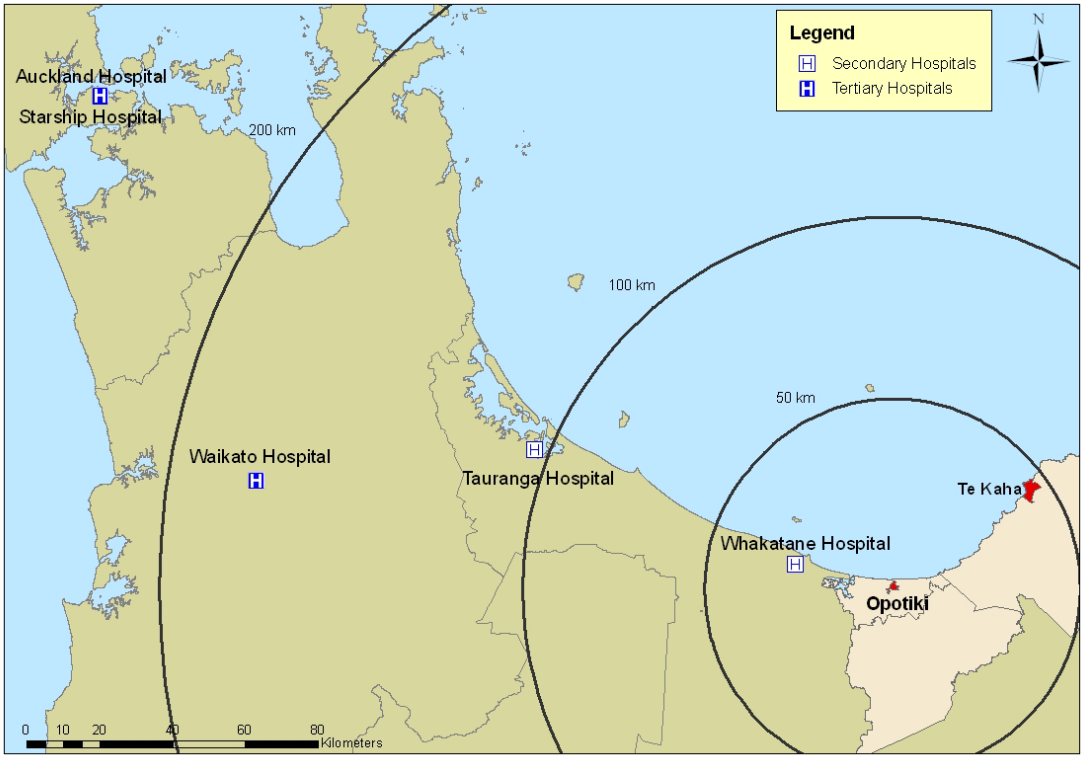


Figure 5: Secondary and tertiary health providers for Opotiki residents



5. Accessing Health Care: Findings from the Interviews

This section explores the perspectives of those involved in maintaining health service provision in relation to residential mobility and patient access. Three broad themes emerged from the health service provider interviews that related to access: resource and service issues, access issues, and attachment to the community.

Resource and service issues

Three resource and service issues were apparent: the impact of location on resources, lack of person resources, and lack of health services.

Impact of location on resources

Interviews with health providers indicate that their different locations play a role in shaping their services, but staffing was identified as a particularly pressing resource issue in both areas. In Opotiki, many providers believed that the difficulties surrounding staffing and service availability after hours was a source of stress for residents in their community, as well as for the providers themselves.

This is not only an issue for rural/small town communities. A provider in Cannons Creek/Waitangirua also discussed difficulties related to staffing, although the issues faced in this urban community were different and were framed in terms of a service that

provided culturally appropriate health care to a large urban population. In this case, it was noted that:

> *It is well known for Pacific [services that] we don't have enough in specialised workforce development. We don't have enough doctors ... I've only got two nurses that have to look after a population of 12,000 [in the area], and of that the majority is Samoan, so ... you can imagine there's quite a lot to be done.*

Lack of personal resources

Personal resources relates to the kinds of material resources an individual or household can draw on in accessing health care, as opposed to either more intangible resources like social networks, or other material resources located in the wider community. Examples of personal resources from the interviews include money, a car or a telephone.

While lack of resources within a health service can impact on the way health care is delivered to the local community, health providers saw the lack of personal resources as another issue that could influence the way health care is accessed and utilised. This influence has been seen at various points in the process of seeking care. Within the context of new movers into a community, providers noted that those with lower incomes tend to make early contact with health service providers less often than others, and for this reason can be more vulnerable to difficulties relating to access and continuity when care is needed.

Furthermore, restrictions in personal resources, such as limited finances to pay for a consultation or a previous medical bill, or lack of transport to a health centre, can impact on both when and where health care is sought.

> *These children, with a cough in the morning have to wait for Dad to come home, or wait for somebody to bring some money or wait for the receptionist at the medical centre to say "no you can't because you haven't paid your bill" or just wait until the night time because they think that in A&E they're going to get in.*

This can have serious implications for the health of those seeking care, as well as leading to "crisis care" by some, placing strain on both emergency services and other community and health facilities. Finally, for others, lack of resources can lead to health care not being sought at all or being downgraded in priority as greater and more immediate needs emerge in the family.

Lack of health services

Some provincial providers brought up the lack of health services in their areas as a driving force for residential movement. This was generally discussed in the context of rural health services that were available in comparison to urban services, and particularly in relation to those who need regular access to health care, for example the elderly or those with long-standing illness. For these people, lack of particular services can be a strong influence in decisions to move out of the community to places with easier access.

Some of the people that move into the area, they find it really hard accessing other services and agencies so they move to Rotorua or to Whakatane where there is easier access. Especially to the hospital.

While the move can provide a source of stress or a sense of relief for the mover, it can also have an effect on the source community, particularly if those who move away have long-term connections with the area. A health provider in Opotiki described the impact of such movement due to lack of services, saying:

[It] is very disruptive when people in a community like ours, which is a particularly close-knit one, have to move for reasons of services not [being] available whether they be medical or otherwise. It's a very sad thing and it does undermine, [it] undermines the whole community.

Lack of health services in Opotiki could also have some bearing on whether people decide to move into the area. One provider pointed out, "Because of the [lack of] after hours services some people *aren't* coming in!" This can have implications for towns attempting to attract new people into the community, and can provide a disincentive for this, especially in the case of retirees and older people as they look for a place that meets both their lifestyle and health needs.

[People] talk about [Opotiki] being a happening place in the future, what have we got to offer it, if it's a happening place, if we're scaling down all the medical services? You want to attract people here.

Access issues

The main access issues concerned older people, those with chronic illness and transport.

Health care for older people and those with chronic illness

Health providers in each community consistently stated that, in their opinion, health was not a major consideration for *most* people who moved in or out of their areas. Two groups of people provided exceptions: those with long-standing illness requiring regular medical care, and the elderly. Like many of the issues outlined above, it is those who live in rural areas or small towns that are more likely to have to move for care. Older people were more inclined to move closer to the city if they need long term hospital or residential care, where such facilities are not available in their present community. In this context, one health provider explained, "I'm aware that the elderly people who have retired to a place like Opotiki … in time they find that the medical services offered are not sufficient." Furthermore, if it is their spouse who moves for medical or residential care, the travelling to visit them may become much more of a burden for the elderly.

For the rural or small town elderly, moving closer to the city might also indicate the need for a greater sense of security, where health services may be more readily available. As lack of access to the hospital and medical services in the city is a strong motivation for moving away from a rural community, places with extra services like

transportation can provide aspects of rural or small town living, while offering the added security of easily accessible health services.

Transport and travel

Health providers talked about the issues their communities faced related to long-distance commuting as a means to access health services. Travelling for health care is significant for residents who choose to reside in rural/small town areas, but, according to health providers, it is also an issue for residents in Cannons Creek/Waitangirua, who have to travel into Wellington Hospital for specialist care.

While health providers in Opotiki pointed out that "strangely enough … people don't really complain about having to go away for health services", the comment that followed this indicated that, beneath the surface, travelling to access appropriate health care can take a considerable toll in other ways:

> *The cost is a problem, that's the major barrier, the travel cost and the accommodation when they get there but the actual having to* go *somewhere is not. People accept that if you live in this area you are going to have to do that.*

This is also an issue for residents in Cannons Creek/Waitangirua: "If you haven't got a car and you're on a low income it's $120 return by taxi. You can't do that every day. Or you get the bus … or you get the train and that's a hike."

Some providers carry out unfunded transportation services as a strategy to deal with this problem. While these provide a valuable service to people in the community, often it means that services that may already be under pressure become stretched further, as their role increases to provide such social support.

Attachment to the community

Health care providers suggest that the lack of services can prompt retirees to move out of an area, and can discourage movement into a community. However, it was also acknowledged that there are significant numbers of people who move into each community for lifestyle or other reasons. Providers thought that the rural/small town character of such places as Opotiki were attractive to retirees and older people, as well as others, and that these people weigh up the positive and negative factors of living in such an environment. Positive features might be health-related or family-related, such as "the opportunity of living with whānau". Once their lifestyle choice was made, they may be more inclined to accept the difficulties of living in such a place, which may include the acceptance of limited health services.

Another aspect to attachment, mentioned by a small number of service providers, relates to sense of ownership of a health care facility. In most cases, while a sense of ownership of a practice was viewed as an ideal situation, this was usually discussed in the context of a health care provider somewhere else: "down the coast", or of a previously existing facility. Not only were these health facilities important to the community for being a local place to access health care, but in some cases they also provided a physical representation of community attachment, existing as spaces for residents to meet up and rally around: "it's the person that you go [to] and it's a *place*

you go to socialise". Understandably, in situations where health facilities have been closed, such as in Opotiki, the impact on the community has been felt very strongly.

Some health providers strongly expressed the feeling that, despite localised difficulties, their service was improving and making a positive impact on their community: "I know that we have made a difference since we've been here" (Cannons Creek provider). In the provider interviews, this was often shown through their resolve to generate a successful service in their communities, and to be forward thinking in their approach to this. Furthermore, the provision of good services was seen as being crucial for generating loyalty and attachment to the local community: "We feel that the community is entitled to more and then [we] wouldn't have the drift-off, you know? People love being here. They don't want to leave" (Opotiki provider).

Each of the health providers interviewed used a range of strategies to encourage use of their services by local residents, and to attract potential users who were new to the area. Some strategies included a proactive stance, while others took advantage of existing processes, like advertising at health promotion days. Networking with a wide range of social and other organisations, both in the community and outside it, was common to many providers. This increased their "catchment" area, allowing wider promotion of their services and a larger base for referral to health care. Other strategies included advertising in local newspapers and letterbox drops, using family and employer networks for enrolment, creating information packs and using existing social networks and advertising by word-of-mouth.

For rural and small town communities general services not provided by the local health facilities were often supplied through specialists and other health professionals travelling from urban centres. These services were generally regarded as being a positive feature of health provision, not only for the providers in terms of numbers who used them, but also for community residents who were able to avoid the difficulties associated with travel.

Other services, outside the general range were frequently more time-consuming to provide, and very often not funded for. However, health care providers also regarded these as necessary to the community in one way or another. These services include advocacy and language translation, transportation, crisis/information phone lines and support during consultations, and are often set up in response to a need identified in the community.

6. Camping Ground Residents

This section explores the views of the living spaces and access to health care services of camping ground residents, a population group who by definition have insecure housing. During 2005 and 2006 when the second round of key informant interviews were conducted by the second author, seaside property prices were rising exponentially and several high profile camping grounds were sold. Permanent or long term residents in camping grounds have no rights under the Residential Tenancies Act and there were a number of newspaper articles about their plight. Furthermore, The Camping Ground Regulations 1985 state that people are not permitted to stay longer than 55 days. In these ways the camping ground residents face uncertainty of further forced movement out of the camping ground at any time. On the other hand, residents

feel this type of housing allows them to take advantage of the freedom and ability to move on easily at any stage, heightening their residential mobility.

People who live in camping grounds can also have difficulty in accessing tertiary and primary health care, especially when local governments close municipal camping grounds or enforce the regulations requiring permanent or long term residents to move on. Similarly, camping ground residents face force relocation when land is redeveloped by investors.

Examining the spatial contexts in which camping ground residents live entails looking at the actual dwellings, which included caravans (with and without annexes, rigid or otherwise), trucks, buses, and relocatable homes. Many of the camping ground residents lived in conditions that would be considered marginal in light of current Building Code standards.

One underlying reason for living in camping grounds, or remaining in this type of housing, was economic. The financial advantages of living in camping grounds, and the shortage of alternative "cheap" housing, was widespread in the narratives.

> *We still pay $100 a week, which is what we paid when we first came in, and if we go away, even though this might still be sitting here, if we go away for a week, we don't pay for that week, and this is still sitting here, and it's still plugged into power, but because we're not here, we don't pay, you try telling that to a landlord, "I'm not there, so I'm not paying my rent."* [Laughter] (Hihi)

Others were faced with exclusion from mainstream housing, and identify youth, discrimination, employment status, relationship status and mental health as explanatory factors. Conventional families tend to get preferential treatment from social housing agencies. In addition, as Pipipi and Koekoea describe, various aspects of the housing market and their financial inability to enter the housing or rental market create(d) barriers for some in accessing mainstream housing, resulting in them having few options but to rent a caravan for a period.

> Pipipi: *It's nice and peaceful, you know, a way back from everything, laid back, no one's in your face, and no one's right there, it's just our little space, little but it's ours you know, that's what it is ... it's not, well it sort of was a last resort, we tried looking for a house for a while first, it was just oh fuck, it's nearly impossible to get a house these days, you got to have so much shit together ... yeah, they just won't take us, don't like the looks of us, you know, people think young people are rowdy, and fucking loud, and party people, where some of us aren't, it's just one of those things.*
>
> Koekoea: *We looked at a few houses before we came here, about six or seven houses, or so.*
>
> Pipipi: *One house we had though, it was nice, 250 a week though, a bit expensive.*

Koekoea: *The bond was just too high, so we couldn't get it, it was real high.*

Pipipi: *Like 12, 1300 bucks.*

Koekoea: *We couldn't get that, but it was really nice.*

Pipipi: *We wanted that eh.*

Koekoea: *Yep, but it was through like Professionals, so they have like a letting fee as well.*

Pipipi: *250 dollar letting fee, yeah, on top of the bond, they wanted three weeks for this house, plus two weeks in advance, plus a letting fee, so it was like six weeks worth of 250 bucks ... but here it's good, it's peaceful, it's quiet, good atmosphere, I'd recommend it to anyone who wants time out for a bit.*

The barriers to accessing affordable housing (e.g. bond, letting fee, rent) to obtain a house for this couple prevented them from being able to secure a "really nice" house that they wanted. However, they work to counter their sense of exclusion while living in a challenging living space by highlighting the advantages of the space they now have.

Many of the camping ground residents lived in dwellings without kitchens and bathrooms, and access to these amenities required movement outside their actual dwelling. Many camping ground residents described a lack of basic amenities including access to a telephone and transport. Quite a number of people were reliant on others for transport.

Kereru's account of Kokako's chronic health conditions show space as a limitation on his access to health services and illustrates the limitations of what the health services consider substandard housing and arguably the eventually untenable nature of camping ground life for a person with a serious chronic health problem, that requires oxygen.

Kereru: *The only problems you've found with the health system is if they wanted him to have oxygen 16 hours a day, they won't let him have it in a caravan, he wouldn't be able to live in his caravan and have oxygen 16 hours a day like they want him to have. Um, the other thing is that if you needed home help or something like that, I doubt very much whether they'd bring it to a caravan rather than a house, now I don't see what the difference is, whether you're living in a flat or a caravan, but I doubt very much whether they'd give it to you in a caravan, we haven't tried it yet, but I don't know if anybody ever has.*

Kokako: *Well both of them are like granny flats, it's the same.*

Kereru: *Yeah, the same size as a flat, and a person needs help for a shower no matter where they are, and that's probably why we tend to look after each other more, because no body else is going to look after you.*

Here both Kokako and Kereru recognise that Kokako will no longer be able to die at home, with this narrative reflecting a sense of his downward mobility. While Kokako is able to receive a certain level of services, his options for long term medical care are limited by his dwelling. Their narrative show how the regulations and requirements of the health services flows through place, impinging on his options and choices. Non-local processes, by way of national external regulations, impact on his health with the space within which he lives not conducive to allowing him to have oxygen at home. When not having oxygen available becomes life-threatening, he may have to move residence in order to access the preventative health care he needs.

While some narratives emphasised the convenience of camping grounds, there was also a recognition that living in a caravan could be detrimental to health and that active intervention might be necessary to be resilient and maintain health in these circumstances. Thus, the impact of the spaces they lived in was to some extent dependent on the individual's actions. It is important, however, to note that this individual agency does not necessarily mean that residents were more accustomed to these housing standards. As Kearns and Parkes (2003:849) suggest:

> *"It would appear that neighbourhood means no more nor less to residents in poor areas as to the general population: residents in poor areas were neither more immune or accustomed to poor neighbourhood conditions (which would have lowered their probability of wanting to move or actually moving compared to what would otherwise be the case); nor were they more sensitive to conditions, or to put it another way, more fickle or unstable (which would have meant them having higher probabilities of wanting to move or actually moving, given certain conditions) ... Residents in poor areas respond to negative residential conditions in the same way as the rest of the population; they just experience those conditions more often than others."*

Many of the residents had to cope with chronic conditions, which they attributed to their previous living and working conditions:

> *He was quite sick when he retired ... through doing shift work ... but since we've been down here ... yeah he's improved.* (Mohua)
>
> *Did you notice differences in your health when you moved here?* (Interviewer)
>
> *Yeah, definitely, I noted my pain factor has been a lot better, because a lot of it can be state of mind too, you know, and when you're in a good state of mind you can deal with your pain a lot better.* (Tieke)

They saw the camping grounds as helping to restore not only their previously unhealthy lifestyles, but also to build up their families' health stores.

Place and access to services

Camping ground residents' actual experiences of health services is often characterised by poor service coordination, travelling, and troubles with enrolment. While some residents' narratives illustrated precarious access to services, it is apparent that service access is also an issue of invisibility. In many instances, camping grounds remain "hidden" — there exists failure on the part of social agencies to be aware of this housing situation.

Many residents of camping grounds maintained their enrolment in the place where they have previously lived. As Kokako's Porirua narrative shows:

> *You've got a GP here locally?* (Interviewer)
>
> *No, my one, he's in Upper Hutt, I stayed there because he's looked after me for so many years, I know sometimes it's inconvenient, but it just feels worthwhile, I understand this PHO business, you have trouble getting in, if you're in one doctor you stay there ... yeah, it's hard to get into another one.*

His narrative is similar to many camping ground residents interviewed. The narrative of Riroriro, who has moved regularly around New Zealand in his bus, indicates that being mobile has risks for access to health care:

> [Access to health services] *is the only trouble, got to tell you and to get into a doctor, my wife's in a doctor up here, my wife's got diabetes a bit, so she's got her own doctor in Wellington, and I can go through him now if I wanted to, but no, when you're travelling around, it's blimmin' terrible, it's hard to get into a quack you know, that's the only fault against travelling.*

Shortages in available GPs and difficulties in accessing primary medical care was a common experience for camping ground residents. After periods of residential movement, many residents had maintained their enrolment at the PHO of their previous location. This phenomenon of being enrolled in a PHO outside their present locality is linked closely to their residential mobility and health. Firstly, it entails in some instances considerable costs and travelling time. Secondly, their residential mobility disrupts links to a particular GP. Many residents when they move and cannot enrol in a new PHO where they now live, appreciate the sense of continuity from being enrolled in their previous PHO despite the costs in time and money involved in maintaining the link.

The perceived poor access and experience of primary health care services may also be linked to a focus on emergency services, as Tui's narrative reveals:

> *Yeah, I've got a doctor here, but ah, there's always an accident and emergency service somewhere, some doctor you go to, they go, 'Are you registered with us? You can't come here', well that can be tricky.* (Tui)

The difficulties in identifying a GP in a local PHO is obvious in the following narratives:

> *What do you do if you get sick?* (Interviewer)
>
> *Oh go over and see one over in Epuni, if was that bad there's Kenepuru just up the road down there, I did some work there for Allied Workforce, building an extension and that, some labouring work there but, I don't know, just got sick the mate would take us down there in the car or a fucking ambulance I don't know, just, there's some way to get some one some where, but in general doctor's surgeries or whatever you call them, and dentists and stuff, I wouldn't have a clue mate, my teeth are rotten, ah, I haven't seen a dentist in years, I should.*
>
> *What about your girl, if she got sick?* (Interviewer)
>
> *Well, she'd go, she could go to my doctor, over the Wainui, but I mean, that's a long way away from here.* (Matuhi)
>
> *But we know that if anything happens the helicopter comes, we belong to the rescue helicopter, and the ambulance service here is great.* (Piopio)

Many of the camping ground residents spoke of the availability of care provision within the camping ground. Kokako and Kereru's previous narrative highlights the importance of Kereru's role in providing care for her neighbour, Kokako. Kereru is an important resource for Kokako within the camping ground, against the assumption that camping ground residents have to go outside to access services. Similarly, many residents spoke of the role the owners and managers play as social workers and advocates on their behalf. Many owners take responsibility for residents' actual access to services through actions such as providing transport.

7. Conclusion

This paper explores the effects of the geographical location of primary, secondary and tertiary care of health services on access to health services within both an urban and rural community. Primary health care reforms were designed to increase access and lower the barrier of affordability to population groups that have previously had difficulty accessing health care services, but they have been designed for a residentially stable population. It was thought that the stability or consistent presence of a regular local doctor and health service might provide some encouragement for local residents to stay in their community, due to the build up of reciprocal trust between service users and providers, which resulted in loyalty to the health care provider. There is some evidence from the interviews with local health care providers and camping ground residents that this continuity with health care providers has indeed happened to some degree, even to the extent that patients will sometimes travel considerable distances to maintain these relationships.

Nonetheless, there have been a number of important issues highlighted in these interviews. Maintaining health service staffing levels to facilitate vulnerable people with chronic health conditions accessing both primary and specialist health service remains an ongoing problem. The capitation funding of primary health organisations, while encouraging integrated care may, as is emerging from the residents' accounts and newspaper reports referred to earlier, also be leading to local rationing which seriously disadvantages the vulnerable members of the community and means that those who move regularly from one place to another can be disadvantaged when it comes to accessing integrated care, which often requires proactive and consistent intervention by the local GP.

This paper also highlights the difficulties of accessing health services by exploring the narratives of people living in camping grounds, which by definition in the Residential Tenancies Act and related regulations are a population, who do not have secure housing and can therefore have relatively high levels of residential mobility compared to people renting with tenancy agreements or owning a house with a mortgage. Having low incomes also means they are also more vulnerable to ill health.[30] The experience of living in a camping ground, in some cases, was presented as problematic, especially where it interfered with day-to-day activities, privacy and access to health services. However, residents also used their narratives to show various advantageous aspects of the camping ground setting, often allowing a better sense of health and well-being, or at the very least, a lack of deterioration of health status.

[30] Graham, 2007

Bibliography

Barnett, J.R., 2001, "Coping with the cost of primary care? Household and locational variations in the survival strategies of the urban poor" *Health and Place*, 7, 141-157.

Barnett, J.R. and Barnett, P., 2008, "Reinventing primary care: the New Zealand case compared" in Crooks, V. and Andrews, G., *Primary Health Care: People, Practice and Place*, Ashgate Press, Aldershot.

Barnett, J.R. and Lauer, G., 2003, "Urban deprivation and public hospital admissions in Christchurch, 1990-1997", *Health and Social Care in the Community*, 11, 299-313.

Bourke, L., 2001, "Australian Rural Consumers' Perceptions of Health Issues", *Australian Journal of Rural Health*, 9(1), 1-6.

Boyle, P., Norman, P., et al., 2002, "Does migration exaggerate the relationship between deprivation and limiting long-term illness? A Scottish analysis", *Social Science & Medicine*, 55(1), 21-31.

Bures, R.M., 2003, "Childhood Residential Stability and Health at Midlife", *American Journal of Public Health*, 93(7), 1144-1148.

Capital and Coast District Health Board, year unknown, "General Information", retrieved 04/04/2005, from http://www.ccdhb.org.nz/AboutCCH/Hospitals.asp#Kenepuru.

Capital and Coast District Health Board, year unknown, "Kenepuru Community Hospital: Porirua", retrieved 04/04/2005, from http://www.ccdhb.org.nz/SS/RH/Porirua.asp.

Drukker, M. Driessen, G., et al., 2004, "The wider social environment and mental health service use" *Acta Psychiatrica Scandinavia*, 110, 119-129.

Franks, P., Campbell, T.L., et al., 1992, "Social Relationships and Health: The Relative Roles of Family Functioning and Social Support", *Social Science & Medicine*, 34(7), 779-788.

Gilman, S.E., Kawachi, I., et al., 2003, "Socio-economic status, family disruption and residential stability in childhood: relation to onset, recurrence and remission of major depression", *Psychological Medicine*, 33, 1341-1355.

Gleeson, B., Hay, C., et al., 1998 "The geography of mental health in Dunedin, New Zealand", *Health & Place*, 4, 1-14.

Graham, H., 2007, *Unequal Lives: health and socioeconomic inequalities*, Open University Press, Maidenhead, Berkshire.

Gribben, B., and Cumming, J., 2007, "Evaluation of the Primary Care Strategy: Practice Data Analysis 2001-2005", CBG Health Research Limited, Auckland.

Jacobson, B., 1992, "Public health in inner London", *British Medical Journal*, 305(6865), 1344(4).

Jelleyman, T., and Spencer, N., 2008, "Residential mobility in childhood and health outcomes: a systematic review", *Journal of Epidemiology and Community Health*, 62(7), 584-592.

Kearns, A., and Parkes, A., 2003, "Living in and leaving poor neighbourhood conditions in England", *Housing Studies*, 18(6), 49-65.

Lamont, A., Ukoumunne, O.C., et al., 2000, "The geographical mobility of severely mentally ill residents in London", *Social Psychiatry and Epidemiology*, 35, 164-169.

Larson, A., Bell, M., et al., 2004, "Clarifying the relationships between health and residential mobility", *Social Science & Medicine*, 59, 2149-2160.

Lishner, D. M., Richardson, M., et al., 1996, "Access to primary health care among persons with disabilities in rural areas: A summary of the literature", *Journal of Rural Health*, 12(1), 45-53.

Lovett, A., Haynes, R., et al., 2002, "Car travel time and accessibility by bus to general practitioner services: a study using patient registers and GIS" *Social Science & Medicine*, 55(1) 97-111.

Muus, K.J., Ludtke, R. L., et al. 1995, "Community Perceptions of Rural Hospital Closure", *Journal of Community Health*, 29(1), 65-73.

Nemet, G. F., and Bailey, A.J., 2000, "Distance and health care utilization among the rural elderly", *Social Science & Medicine*, 50(9), 1197-1208.

Osborne, R., Milne, S., et al., 2004, "Residential Movement, Attachment and Health: A review of the literature", He Kainga Oranga/Housing and Health Research Programme, Wellington.

Ratcliffe, L., 2008, "Tears of frustration in Hutt Valley", 10 March 2008, New Zealand Doctor, http://www.nzdoctor.co.nz/news?article=2f8f0349-52bf-45f4-b9a3-6caf36fc568a

Rosen, R., Florin, D., et al., 2001, "Access to Health Care - Taking Forward the Findings from the Scoping Exercise", National Co-ordinating Centre for NHS Service Delivery and Organisation, London.

Ryan-Nicholls, K., 2004, "Health and sustainability of rural communities", *Rural and Remote Health*, 4 (online),(Article number 242), 1-11.

Stevenson, C., Kiddle, R., et al., 2003, "OPOTIKI: A Community Profile", Centre for Research Evaluation and Social Assessment (CRESA), Wellington.

Stevenson, C., Kiddle, R., et al., 2003, "WAITANGIRUA/CANNONS CREEK: A Community Profile", Centre for Research Evaluation and Social Assessment (CRESA), Wellington.

Stokols, D., and Shumaker, S.A., 1982, "The psychological context of residential mobility and well-being", *Journal of Social Issues*, 38(3), 149-171.

The Providence Plan, 2002, "Development and Use of Neighbourhood Health Analysis: Residential Mobility in Context", The Providence Plan.

van der Linden, J., Drukker, M.G., et al., 2003, "Children's mental health service use, neighbourhood socioeconomic deprivation, and social capital", *Social Psychiatry and Psychiatric Epidemiology*, 38, 507-514.

Wiles, J. L., Rosenberg, M.W., et al. 2004, "Narrative analysis as a strategy for understanding interview talk in geographic research", *Area*, 37(1).