Psychocultural Influences on Health Care Acceptability Among Elderly U.S. Pacific Islanders

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ABSTRACT. There is widespread recognition of the influence of ethnic variation on immigrant response to health care services, but far less is known about source of variation among nonimmigrant ethnic enclaves. Pacific Islander populations under U.S. administration for more than a century illustrate the potential influences of cultural factors on health care. Focus groups among elderly Samoan, Native Hawaiian, and Chamorro residents of southern California in 2002 found ethnic variation in such characteristics as expectations of publicly financed health care and in the willingness to discuss alternative sources of help with clinicians. These variations appear influenced by the colonial health care experience of these U.S. territories and, in the case of Samoan women, in distinctive perceptions of the role of prayer and traditional healing methods in care. Such psychocultural factors appear more potent than English language proficiency as an influence on the acceptability of health care among Pacific Islander elders. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

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Journal of Health & Social Policy, Vol. 22(1) 2006
Available online at http://jhsp.haworthpress.com

doi:10.1300/J045v22n01_05

KEYWORDS. Pacific Islander, Guam, Samoa, Hawaii, health care, elderly, ethnicity

In 2002, as part of a federal initiative to address the health needs of Asian Americans and Pacific Islanders, the Center for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services authorized a preliminary study of health beliefs and health-related information preferences among Pacific Islander Medicare beneficiaries. The study, conducted by Magna Systems, Inc. with the help of several community-based organizations, is the first to systematically compare qualitative data from Pacific Islander elders and caregivers residing in the U.S.

THREE CULTURALLY DISTINCT ETHNICITIES

As shown in Figure 1, Census 2000 reported more than 16,800 U.S.-born Pacific Islanders over 65 years old living in the 50 states. Of these, 7,417 (44%) were Native Hawaiians and Samoans living in the State of Hawai'i. The Los Angeles metropolitan area was home to an additional 1,620 Pacific Island elders (9.5% of the total) while smaller con-

FIGURE 1. Elderly Pacific Islander Population Among the 50 States April 1, 2000

Location	Number of Native Hawaiians Aged +65 Years	Number of Samoans Aged +65 Years	Number of Chamorro Aged +65 Years
California	1,462	1,398	1,174
Los Angeles Area	549	750	321
SF Bay Area/San Jose	380	309	249
San Diego County	147	210	286
Other California	386	129	318
Hawai'i	6,709	708	56
Washington State	199	210	217
Nevada	210	47	60
46 Other States	1,871	1,204	1,338
Total in 50 States	10,451	3,567	2,845

Source: Census 2000, Summary Tape File 2

centrated populations of Pacific Island elders were located in the San Jose/San Francisco Bay, San Diego, Seattle, and Las Vegas/Henderson metropolitan areas.

Most Pacific Islanders in the U.S. are descendants of the original populations of Hawai'i, Guam, and Samoa. Although all three populations have been under U.S. administration since the late 19th century, their unique historical experiences shaped development of distinct modern Native Hawaiian, Chamorro, and Samoan cultures.

Native Hawaiians. The Polynesian kingdom of Hawai'i was overthrown in 1893 by immigrants from the U.S. mainland, with the help of American military forces. The islands were formally annexed by the United States in 1898 (cf. Tabrah 1984). Concerted efforts by missionaries and the territorial government during the 19th and early 20th centuries suppressed many aspects of the Polynesian culture of Hawai'i, including its religion and healing arts. Cody (1974) states, for example, that:

> Many Hawaiians came to believe their time-honored method of family therapy was a "stupid heathen thing" . . . today, *ho'oponopono* has been accurately delineated once again and is beginning to be appreciated as one of the soundest methods to maintain and/or restore health family relationships that any society has ever devised. (p. 207)

Hawai'i achieved statehood in 1959. Disease, importation of laborers, and intermarriage have reduced Native Hawaiians to fewer than 7 percent of the state population (U.S. Census Bureau 2000). Introduction of the Hawaiian Federal Recognition Bill of 2003 (S. 344), however, evidences renewed interest in restoring Native Hawaiians as a cultural and political entity.

Chamorros (Natives of Guam). Modern Chamorros are a culturally Hispanic mix of the original natives and immigrants from Spain and the Philippines. Guam was a Spanish colony from the 17th century until 1898; during the first 50 years of this period, more than 90 percent of the indigenous population succumbed to disease and resistance to Spanish rule (Political Status Education Coordinating Commission 1994). Following the Spanish-American War of 1898, Guam became an unincorporated territory under U.S. Navy administration (cf. Rogers 1995). Japanese forces invaded in December 1941 and remained in occupation until late 1944 (ironically, Japanese tourism today is a mainstay of the island's economy). Largely self-governing since 1950, nearly half of the permanent population of Guam today is ethnically Chamorro and the

Chamorro language, after decades of neglect, is enjoying resurgence as an official language of the territory.

American Samoans. Samoans are Polynesians who retained their political independence until 1899, when their islands were occupied by rival German and U.S. military forces. The western portion of the Samoan archipelago passed from German into New Zealand administration and regained independence in 1962. The eastern islands of the archipelago, in contrast, have been governed for 105 years as an unincorporated U.S. territory. Local self-government with an elected governor and legislature was established in 1977 but the President of the United States, through the Secretary of Interior, has the ultimate responsibility for the administration of the territory (U.S. Department of the Interior, Secretary's Order No. 3009, September 13, 1977).

Although most Samoans converted to Christianity during the mid-19th century, the American colonial government did not interfere with the traditional language, culture, and clan-based socioeconomic structure of Samoan society. Following the Second World War, Samoans emigrated in large numbers to the Hawaiian Islands and the U.S. mainland (Ahlburg and Levin 1990, pp. 1-2); today, the number of Samoans living among the 50 states is roughly equal to the number living in American Samoa.

ISLAND HEALTH CARE SYSTEMS AS A SOURCE OF VARIATION

The evolution of the health care systems serving the indigenous peoples of Guam, the Hawaiian Islands, and American Samoa are closely tied to the distinct colonial experience of each of the territories. The U.S. never attempted to establish a common health or social service policy for its colonies; as a result, the Pacific Island territories under U.S. rule have experienced significant differences in how health care is provided and funded. These experiences potentially influence health care expectations and the acceptability of health care among older members of the population living on the U.S. mainland.

Hawai'i. Missionary activity, royal sponsorship, and entrepreneurial ventures all contributed to development of Western patterns of medical care under the Kamehameha dynasty which ruled independent Hawai'i throughout most of the 19th century. The royal government's role in establishing progressive public health institutions is rarely appreciated outside the islands. Nevertheless, by 1860, the Kamehameha dynasty had organized all medical missions under a national Board of Health and es-

tablished the public hospital that evolved into the Queen's Medical Center of modern Honolulu. During the next 30 years, rural areas evolved a well-organized but often underfunded system of plantation clinics that performed public health functions under contract to the Hawaiian government (Hiscock 1935, p. 58).

American rule was accompanied by the rise of private, for-profit health care providers (Hiscock, p. 142) and creation of an elaborate military health care system devoted exclusively to the care of U.S. armed service personnel, veterans, and dependents (Hiscock, p. 61). Overtly discriminatory health policies were practiced after the ouster of the Kamehameha dynasty (Tabrah, pp. 110-111); Hiscock, for example, reports that a mother's ethnicity played a significant role in determining the length of postpartum hospital stays. The social history of health care in the Hawaiian Islands from annexation until statehood chronicles the parallel development and slow integration of effectively segregated care systems for various populations of the territory. For example, immediately after annexation, a Japanese Medical Society and Japanese hospital were organized to care for the Japanese population of Honolulu; the degree of segregation is indicated by the monolingual Japanese nursing staff and the use of Japanese for the hospital records through 1940 (Tasaka and Suehiro 1985).

Guam. In contrast to the robust care system developed prior to U.S. annexation in Hawai'i, the Spanish colonial regime in Guam invested negligible resources in the health of the indigenous population (Nelson and Nelson, pp. 69-70; Maga 1998, pp. 24-25). In direct contrast to Hawai'i, subsequent U.S. Navy administration of the island witnessed the dramatic spread of health care among the Chamorros (Rogers, p. 160). The official report from an American governor in 1899 requested at least two resident Navy doctors and a large corps of assistants to improve public health among the Chamorro population and lower the death rates (Nelson and Nelson, p. 152). The Navy responded by establishing a hospital open to civilian patients and by creating a network of community clinics tasked with ridding the island of recurrent epidemics of smallpox and tuberculosis. Although the Navy charged civilians for care, fees were not designed to recoup the costs of treating the population. A significant percentage of Chamorros also became entitled to free care by reason of Navy enlistment or employment (Carano and Sanchez, p. 73).

The Navy's health care monopoly on Guam ended after the Second World War. Guam Memorial Hospital was transferred from the Navy to local government control in 1956, followed by civilian administration of the community clinics. A small but growing number of private specialty

and emergency care clinics have supplemented the activities of the government-operated hospital during the past 45 years.

Health care financing on the island today includes a mix of cash payments for service, as well as private health care insurance and HMOs, Medicaid, Medicare, and the TRICARE system for Navy personnel, retirees, and dependents. The Government of Guam began to provide health insurance to its employees in 1966; Family Health Plan, a local HMO financed by mainland companies, was established in 1973 (Rogers, p. 257). In 1981, the island was rocked by scandal when operators of the Guam Memorial Health Plan, owned by the island government, fled Guam with the money for millions of dollars of unpaid medical bills (Rogers, p. 257). Understandably, older Chamorros often are nostalgic about the period when Navy doctors, nurses, and corpsmen provided all health care with little thought of payment.

American Samoa. Organized health care emerged very slowly on American Samoa, facilitating retention of traditional healing practices in the archipelago. Religious missions and public health facilities provided virtually all health care until an investor-owned hospital opened in 1999. Territorial law guarantees government-financed access to health services to all Samoans without charge (Legislature of the American Samoa Government 1998, P.L. 25-22). Not surprisingly, private insurance is not widely accepted, as evidenced by the 2001 "State of the Islands" address of Governor Tauese Sunia:

> Our health care services have improved facilities and certainly some of the services. We still need more specialized doctors and definitely more nurses. The basic solution is to provide adequate compensation. We definitely need funds to do that. Our Hospital Board will have to generate more revenues to counter that need. The sad thing is that some of our people are taking out medical insurance, but only as a gimmick to make money since the hospital charges a lot less than is claimed from the insurance company. We will have to face the reality that health insurance is the only avenue available to pay for excellent medical care. We are contemplating a group health insurance plan for all American Samoa Government workers to be presented to the *Fono*. I hope the major corporations and businesses will do the same for their workers. (Sunia 2001)

Ironically, Governor Sunia died in 2003 during a medical evacuation to Honolulu for diagnostic tests that could not be performed at any facility in American Samoa.

In summary, the health care systems of each colony evolved along virtually independent paths. Hawaiian medical care during the first half of the 20th century was largely segregated by ethnicity and occupation, including separate care for military and civilian families. During the same period on Guam, the Navy was the sole health care provider for all residents, although the Navy at least practiced lip service to the concept of fee-for-service for civilians. American Samoa presents a third pattern, in which the U.S. colonial regime neglected the development of health and human services and kept the territory effectively isolated from patterns of health care delivery and financing prevalent on the mainland. Samoan elders thus were born into a society where traditional healing arts continue to be practiced, where access to health care is enshrined as a right rather than a commodity, and where the concept of health insurance is described as a dubious scheme by even the highest elected official. In effect, the absence of a coherent policy for developing the health and human services of the Pacific territories meant that Pacific Islander elders born under the U.S. flag had radically different experiences with health care and health care providers during their youth.

METHODS

To learn how culture and health care experiences may affect the health-related needs and beliefs of Pacific Islander Medicare beneficiaries, CMS convened six focus groups in August and September 2002 in the Los Angeles metropolitan area, home to the largest number of Pacific Islander Medicare beneficiaries outside of Hawai'i. The focus group is a method that provides maximum latitude to participants to express views on a topic directed by the research team. Focus groups thus are considered to be naturalistic (Krueger and Casey 2000), enabling the trained researcher to develop insights from the expression of emotions, ironies, contradictions, and tensions, as well as from individual content.

Each focus group in Los Angeles consisted of four-to-eight Pacific Islanders born between 1917 and 1939; modal age was 76. The groups were segregated by birthplace (Samoa, Guam, and Hawai'i) and by gender. All participants over 65 years old were Medicare beneficiaries. The focus groups were recruited by community-based ethnic organizations operating in the Los Angeles area, following guidelines on recruitment preferences provided by Magna Systems. Facilitators for each group consisted of a younger member of the ethnic community trained in field research methods for psychology, sociology, or social work; facilitators received

additional training and a focus group facilitator's guide developed by Conwal. The facilitators explained to participants that their identities would be known only to the other members of the focus group, and that their responses would have no effect on health care or government benefits.

The Samoan focus groups were conducted in the Samoan language, in part because only two of the elderly focus group participants described themselves as fluent in English. In contrast, although the Chamorro and Hawaiian focus groups were conducted in English, most of the participants interspersed their conversation with words of the island languages. Significantly, no participant in any Hawaiian focus group claimed to be fluent in the Hawaiian language.

Following the conclusion of the Los Angeles focus groups, Magna Systems convened an expert panel of Native Hawaiians who professionally provide assistance or care to Native Hawaiian elders (*kapuna*) on the Hawaiian island of Oahu in September 2003. Information from this panel helped distinguish attitudes and beliefs which are common among all *kapuna* from those which are prevalent only among Native Hawaiians on the U.S. mainland.

All focus group proceedings were subjected to thematic analysis as well as analysis of the level of consensus expressed for each belief or statement. In effect, analysis of the comments made during the focus groups catalogued the factual and affective responses of the participants, including identification of those which achieved consensus and those which reflected intragroup and intergroup differences.

HEALTH CONCERNS AND HEALTH-SEEKING BEHAVIORS

Participants in all of the focus groups of elderly Pacific Islanders agreed on the widespread prevalence of chronic conditions associated with aging such as hypertension, cardiovascular disorders, diabetes, and gout and other forms of arthritis. Asthma, kidney problems, chronic skin conditions, and prostate disorders other than cancer also were cited. Some members of both male and female focus groups cited emphysema and lung cancer as widespread problems among smokers. Three conditions were cited as specifically prevalent among elderly Samoans: eye problems, kidney stones, and chronic obesity.

Although the Samoan and Native Hawaiian participants attributed most of the age-related conditions to the aging process or to poor preventive care, most Chamorro participants ascribed these chronic conditions

to such dietary factors as high-fat foods (e.g., coconut milk), salty foods (e.g., flavored with soy sauce), pork, shellfish, and consumption of Spam and canned vegetables. Chamorro participants also attributed diabetes and arthritis to overindulgence resulting from recurrent family and clan feasting.

Native Hawaiians agreed that "the island way" is to do without services rather than bring shame. Professional clinicians were characterized as technically competent but cold, impersonal, and insensitive, regardless of their ethnicity. Friends and relatives were viewed as more trustworthy and warm sources of help, but there was reluctance to impose on them. Regardless of a patient's choice of clinical care or more informal sources of care, initial consultations often are delayed as long as possible to avoid appearing helpless or ignorant. Caregivers in Hawai'i confirmed that similar attitudes are widespread among *kapuna* on Oahu, adding that a fatalistic philosophy contributes to this perception:

> We have it even among the elementary schoolchildren. . . . For example, they say, "I'm o.k. with the fact that I'm going to die from diabetes because everybody in my family did."
>
> If I don't have the money to pay for it [effective care], why would I want to know [what's wrong]? I'll just not know and then die.

One-third of the Hawaiian participants believed in the efficacy of traditional healing arts (*la'au lapa'au*) and folk remedies (*'uhaloa*) as supplemental care for several conditions, including chronic pain, recurrent coughing, diabetes, and even cancer. These remedies have the additional advantage of lower cost compared to pharmaceuticals. *Kapuna* rarely discuss these remedies with conventional medical staff for fear of disapproval or disdain.

Among the Chamorros, the focus group results suggest a gender difference in health-seeking behaviors. The elderly Chamorro men supported contact with a primary care physician, the Veterans Department, or HMOs at the onset of illness, regardless of the ethnicity of the clinician. Some elderly women, however, reportedly prefer to approach a family or clan member involved in health services. In some cases, the family member is a technician or office worker rather than a clinician. Use of such informal sources of health care advice among Chamorros is consistent with *inafa'maolek* and *chenchulé*, traditional values that identify reciprocal exchange of obligations with members of an extended family as the source of welfare and assistance.

The Samoan focus groups reached consensus that elderly Samoans–like Native Hawaiian *kapuna*–are unlikely to seek a clinician at the onset of disease symptoms. In contrast to the Native Hawaiians, the Samoans did not cite shame or embarrassment as the motivation for their reluctance to use Western health care. Older Samoan women seek to address illness through prayer or traditional remedies, and resort to a physician only if symptoms persist:

> Illness is where you seek God first because it's the Devil that gives you the illness. You seek God first and he'll provide you with an answer. If there isn't anything else to kill the illness, then I visit the doctor.
>
> I pray first and wait to see if it goes away and, if it doesn't go away, then I visit the doctor at Kaiser Hospital or I get my sister who is a [traditional] healer. Doctor visits cost money and many forms.

Older Samoan men reportedly prefer to self-medicate to alleviate symptoms, citing cost and inconvenience as reasons to avoid a clinical intervention. In effect, the Samoans based avoidance of clinicians on their assessments of the relative effectiveness, accessibility, and affordability of self-care and traditional remedies rather than the acceptability of care.

Overall, the focus groups reached consensus about the most common conditions affecting Pacific Islander elders. The assessments of prevalence appear reasonable in the absence of detailed epidemiological studies. However, participants disagreed on mechanisms responsible for chronic conditions: some Samoan women advocated faith-based explanations and most Chamorro participants ascribed problems to diet. Health-seeking behaviors also exhibit wide variation. Surprisingly, gender may be more influential than English language fluency in the decision to seek an early physician consultation: Native Hawaiian women fluent only in English were more reluctant to consult with a physician than either bilingual Chamorro men or Samoan men with limited English.

AFFECTIVE RESPONSE TO HEALTH CARE CHOICES

In all of the focus groups conducted for CMS, the Pacific Islander participants viewed Medicare positively, emphasizing its effectiveness as a means to reduce financial burdens on the family. However, focus group participants often perceived navigation of the Medicare health care sys-

tem as very confusing. In addition, the Pacific Islander elders recognized that Western health care's reliance on Medicare-exempt medications for chronic conditions raises the cost of health care for themselves or for their extended families.

Native Hawaiian *kapuna* repeatedly expressed confusion about entitlement to health services. They voiced concern that frequent changes in Medicare meant that they could no longer receive care, and they disagreed over whether Social Security beneficiaries automatically are enrolled in Medicare Part B. Native Hawaiian women were enthusiastic about Medicare coverage for health screening, including mammography, but reportedly are reluctant to use the services because they are forced to either rely on the Los Angeles area's limited public transportation or to appear helpless to younger family members who can drive them to caregivers.

Significantly, a majority of the Native Hawaiian *kapuna* expressed fear or embarrassment about asking government health authorities about entitlements and about admitting to use of traditional health care practices. *Kapuna* women reportedly were intimidated by the "cold" demeanor of staff members who handle Medicare billing and inquiries, concerned about receiving inaccurate information, and fearful of facing a long waiting period to receive benefits. Hawaiian men were embarrassed by written materials "too difficult to understand" and by an often-confusing health care system. As a result, "elders are unable to make choices for themselves" and must rely on their children's help.

In the aftermath of the terrorist attack on the World Trade Center, Native Hawaiian men attending the focus groups expected a requirement for security clearances prior to visiting government offices or even the public library: the incident apparently triggered memories of restrictions on Hawaiian civilians following the Japanese attack on Pearl Harbor. Significantly, caregivers in Hawai'i advised removing the image of the U.S. flag from Medicare information materials distributed among *kapuna* because of the flag's association as a symbol of mainland domination rather than as a source of freedom and assistance.

In contrast to the Native Hawaiians, the Chamorro focus groups produced no comment suggesting distrust or suspicion of government sources of help. Participants reported only positive experiences with Medicare, although one woman enrolled as a beneficiary only after a Chamorro neighbor advised her on eligibility. Several participants volunteered favorable comparisons between the preventive care offered by Medicare, TRICARE, and private insurance with the much more limited care available in Guam.

Members of both Samoan focus groups evidenced widespread confusion between MediCal [i.e., California's Medicaid system], Medicare, and private HMO coverage. One beneficiary, for example, assumed that a co-pay charge was assessed because the billing nurse failed to understand that he is "fully insured":

> I have three insurances right now: Medicare, MediCal, and Secure Horizon. You [billing nurse] figure out from those insurances which one you use to pay the medical bills. I don't pay any co-payment.

Samoan elders with better English comprehension cited English-language newspapers and news broadcasts as useful sources of their understanding of health care benefits for the elderly. However, these participants expressed concern that many less sophisticated Samoan beneficiaries do not use Medicare because they do not understand how it operates.

Although male Samoan Medicare beneficiaries attending the focus groups appear more accepting of Western health care than some of the Samoan women, their comments occasionally reflected a lack of trust. One HMO enrollee, for example, changed clinicians because he didn't approve of a doctor's advice to surrender some of his autonomy over his dietary preferences:

> The doctor tries to stop me from certain types of food, like pig. I like to eat pig very much. If he tries to stop me, I usually find another doctor who will allow me to have some. Other than that, I usually listen to what the doctor says.

The male participants discussed at length their concern over tests and over interventions during follow-up visits after symptoms had subsided. The consensus among the group was that procedures performed in the absence of symptoms are conducted merely to enrich the health care providers. This belief is consistent with the perception expressed by some Samoan focus group attendees that the purpose of medical care is to alleviate symptoms rather than to cure conditions or maintain health.

Both male and female Samoan beneficiaries in the focus groups tend to be passive about health care issues. The beneficiaries claimed to lack sufficient understanding of doctors, the health care system, and Medicare to make effective decisions. Unlike other groups of elderly, the Samoan focus group participants generally described health-related information as

a low priority. Some reported reading materials about health problems only when they were currently suffering symptoms of the specific condition. Selection of a primary care physician generally was made for elders by younger family members or by assignment from an HMO. Samoan beneficiaries eligible for TRICARE military health coverage appeared to exercise more control over health care choices, such as traveling to a military pharmacy to receive medications without paying out-of-pocket costs.

Overall, focus group participants displayed ethnic-influenced variation in affective attitudes regarding the acceptability of Medicare and health care. Chamorro elders exhibited trust in both doctors and the Medicare system. Native Hawaiians, in contrast, evidenced suspicion and distrust of the government in general and concern about their continued eligibility for Federally provided health care benefits. Several Native Hawaiian *kapuna* appeared to perceive Medicare as a charitable benefit that could be removed at the whim of an impersonal, uncaring regime. The participants of the Samoan focus group expressed trust in government as a source of health care financing, but by consensus were suspicious of the integrity of their clinicians. In contrast to the concerns about "socialized medicine" that influence attitudes among many mainland elderly Americans, Samoan elders appear to distrust the profit motive in health care.

DISCUSSION: PSYCHOCULTURAL INFLUENCES ON PERCEPTIONS OF HEALTH CARE AND HEALTH POLICY

Focus groups, as a form of exploratory research, produce suggestive insights rather than definitive results (cf. Kreuger and Casey 2000). The value of this format of group interview for formative research has been recognized for several decades:

> Procedurally, the strength of focus groups lies in their ability to explore topics and generate hypotheses. When the researcher is relatively new to an area, or puts a priority on not repeating the received wisdom in a field, focus groups have much to offer. The fact that group interviews can produce useful data with relatively little direct input from the researcher may be a distinct advantage, especially in comparison to other interviewing techniques. (Morgan 1988, p. 21)

Analysis of the focus groups of elderly Pacific Islanders living in Los Angeles specifically was designed to reexamine widely held assumptions regarding the origins of their attitudes on the acceptability of Medicare-financed health care.

Health policy analysts addressing the acceptability of health care among minorities in the U.S. often ascribe variation to immigration status or to familiarity with English language. There often is a presumption that patients born in the U.S. and fluent in English should be accepting of mainstream health care delivery. This is demonstrably not true among Pacific Islanders. The observed differences in perceptions and attitudes among elderly from different Pacific Islanders cannot be attributed to immigration status because all participants were born on U.S. territory. Familiarity with English did not appear to produce better understanding or a more favorable impression of the health care system serving the mainland elderly: bilingual Chamorros and Samoan-speaking elders appear more certain of the benevolence of Medicare-financed services than many Native Hawaiian *kapuna* who are fluent only in English.

A more promising explanation for observed differences is suggested by the application of culture-specific psychocultural conceptions. Health care and health care financing systems are institutions which are perceived as performing given societal roles. According to Fisher (1988):

> . . . institutions themselves are abstract entities with meaning and nuance derived from the many interconnected qualities of the larger cultural system. Therefore, a cultural lens colors expectations of an institution's actual operations. It is a mater of "role behavior," in effect, for institutions. (p. 87)

In effect, the psychocultural perspective anticipates that past experience with health care institutions and health care financing affect expectations of how the institutions operate, but that these expectations, in turn, color subsequent experience with the institutions. The culturally influenced perception of an institution's operation thus is both a reflection and a determinant of its interaction with the patient population.

The psychocultural perspective provides a potentially valuable explanation for the apparent variation associated with the three Pacific Islander ethnic groups. For example, *kapuna* reluctance to discuss traditional healers with Western clinicians is a logical outcome of the history of suppression and denigration of indigenous health practices by ruling authorities in Hawai'i. Similarly, the general distrust of government authority expressed by Native Hawaiian elders is an understandable reaction

among an ethnic group who lost their independence to an invading power less than 40 years before their birth. Experiences during the military administration of Hawai'i in the 1940s could explain concern about needing "security clearances" to talk with government officials about their rights under Medicare. At best, the experience of segregation between military and civilian health care probably reinforced the sense of access to government-financed care as a privilege that can be revoked.

Chamorro elders, unlike the *kapuna*, were raised on an island where the U.S. Navy was the sole health care provider. In effect, the same institution that liberated the Chamorro people from both oppressive Spanish rule and Japanese occupation was responsible for their medical services. Under these circumstances, it is rational that the Chamorro generally anticipate benevolence from mainland authorities. Medicare, TRICARE, and other publicly financed health services may appear to the natives of Guam as extensions of an essentially benevolent federal bureaucracy.

Samoan attitudes appear more complex. Unquestionably, the Samoan elderly in Los Angeles are highly skeptical about Western health care, but the origins of that skepticism are unclear. The widespread acceptance of a right to free health care and Samoan inexperience with private insurance probably raise suspicions about the normal billing practices of mainland health care providers and, consequently, their ethics. The retention of traditional beliefs about the efficacy of prayer and Polynesian healing arts contribute to the perception of Western health care as a competitor to truly Samoan methods of dealing with illness. It is possible that Samoans are uncomfortable with the intrusiveness of Western medicine in their preferred lifestyles, which would be described as *mataga faa Samoa* (literally, "ugly to the Samoan Way"). In total, the Samoan elderly appear to have more fundamental issues with Medicare and mainland health care than the relatively simple problem of limited comprehension of the English language.

The focus group results also suggest variations in the influence of gender on health care practices among the elderly Pacific Islanders. Concern about interacting with the government appears to cross gender lines among the Native Hawaiians. Among the Chamorros and the Samoans, however, traditional gender roles appear to remain important sources of differences in the perception of appropriate response to illness. Additional research would be helpful to verify whether the experience of living in an ethnically segregated society transcends gender differences as a source of health care-related beliefs and attitudes.

Issues of language, ethnic discrimination, and immigration status as determining variables often dominate discussion of the impact of culture

on the acceptability of health care. Scholars and policymakers should suspect that these variables are studied in part because they are relatively easy to define, track, and quantify. The apparent variation in the acceptability of Medicare financed health care among U.S.-born Pacific Islanders elders serves as a reminder that cultural influences affecting perceptions of health care and health care policy are more complex than the date stamped on an entry visa.

The variation in health care values and expectations observed among U.S. Pacific Islanders also should caution against the assumption that English comprehension and U.S. citizenship automatically lead to mainstream perceptions of health care institutions and health care financing. The focus groups suggest that complex historical experience of populations with health care systems is potentially a long-lived source of alternative perceptions about what health care professionals are expected to accomplish, how they are expected to behave, and how patients should respond. For example, when the Navy responded to the threat of communicable disease immediately after the annexation of Guam, it is unlikely that any of the Navy personnel considered that they might be creating expectations for government-provided health care that would persist in the mindset of the Chamorro population for at least 100 years.

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