BARRIERS TO MĀORI UTILISATION OF ACC FUNDED SERVICES, AND EVIDENCE FOR EFFECTIVE INTERVENTIONS: MĀORI RESPONSIVENESS

REPORT 2

JOHN WREN
ACC RESEARCH

SUGGESTED CITATION

Wren, J. (2015). *Barriers to Maori utilisation of ACC funded services, and evidence for effective interventions: Maori Responsiveness Report 2.* ACC Research, Wellington. August 2015.

ISBN

ACKNOWLEDGEMENTS

I would like to particularly acknowledge and thank:

- Dr Peter Jansen, Director of Mauri Ora Associates and ACC Senior Medical Advisor for peer review and other insights into Māori perceptions of injuries, their severity and claiming behaviour
- Ronald Karaitiana and Jason Kurei, ACC Cultural Services, for their support and encouragement.

I thank the following individuals and organisations for their peer reviews, which significantly contributed to improving the two reports:

- Te Puni Kokiri, policy and research staff
- Dr Hilary Stace, Research Fellow, Health Services Research Centre, School of Government , and external member of ACC Research Ethics Committee
- Lesley Gray, Senior Lecturer in the Department of Primary Health Care and General Practice, University of Otago, Wellington; a registered Public Health Specialist and Fellow of the Faculty of Public Health (UK).

I also thank Gaylia Powell, ACC Research, for her editing and proof reading on earlier drafts.

CONTENTS

TABLES AND FIGURES

WHAKATAUKĪ

Whakataukī (proverbs) are used as a reference point in Māori speeches and also as guidelines spoken to others day by day. It is a poetic form of the Maori language often merging historical events, or holistic perspectives with underlying messages which are extremely influential in Maori society.[1]

The following whakataukī represent the author's intent and reflections with the contents of this report and the companion one on the evidence for Māori utilisation of ACC funded injury treatment and rehabilitation services. They are offered as a plea and hope for the future. The intent of the two reports is to help move things forward rightly.

Kua takoto te manuka

The leaves of the manuka tree have been laid down

The challenge is laid down. How do we want to respond?

I orea te tuatara ka patu ki waho

A problem is solved by continuing to find solutions.

Tē tōia, tē haumatia.

Nothing can be achieved without a plan, workforce and way of doing things.

Naku te rourou nau te rourou ka ora ai te iwi

With your basket and my basket the people will live

By working together in co-operation and combining our collective resources we can get ahead.

---

[1] http://www.maori.cl/Proverbs.htm

EXECUTIVE SUMMARY

AIM OF THIS REPORT

This report is the second of two. It should be read in conjunction with Report 1 (Wren, 2015) which discusses the evidence for Māori under-utilisation of ACC funded injury treatment and rehabilitation services.

Report 1 found that given the Māori burden of injury and from the 'health lens' viewpoint the available evidence is sufficient to indicate that there is inequity and inequality in Māori use of ACC funded injury treatment and rehabilitation services. However, from a business insurance and actuarial view there is little evidence for Māori underutilisation of ACC services as service utilisation is seen as a matter of personal choice, and policies to promote equality (defined in the health perspective) run counter to established business insurance principles.[2]

This Report addresses two questions:

1. What are the barriers to Māori utilisation of ACC funded services?
2. What is the evidence for effective interventions that could be used to help address the identified barriers to full Māori utilisation of ACC funded services at the levels expected given the burden of injury borne by Māori?

Part 1 reviews the results of a series of ACC survey material since 2005 and published external reports that addresses the questions. Part 3 identifies a number of implications for ACC.

The report is intended to help ACC deliver on the Māori Responsiveness Actions agreed with the Minister for ACC in 2014. The actions include the dissemination of information to the health sector about the evidence around Māori utilisation of ACC funded injury treatment and rehabilitation services. Consequently, the report is intended to enable an informed discussion between ACC, health service providers, injury prevention practitioners, policy analysts and service programme designers about the issues, with the intention of informing policy and operational decisions about what a appropriate Māori response could include.

---

[2] This view also does not recognise that the monopolistic design of the Scheme means that there are no other options for cover and receipt of services, which means the only choice is to use or not use and to suffer the consequent health and financial loss.

CONCLUSIONS

BARRIERS TO SERVICE USE

Research with Māori has consistently reported similar views expressed over time about Maori experiences with utilisation of many government agency services (including ACC services) and the barriers faced when trying use mainstream services.

In health, the barriers can be broadly grouped as social, cultural, economic and geographical.

Research with Māori has shown there is strong support for the principles of the ACC Scheme; however there is a fair amount of discontent with the operation of ACC. Five key expectations that Māori have of ACC are:

1. Fairness – the system must achieve fair outcomes for Māori and all New Zealanders
2. Choice – all choices must be fair and open
3. Improvement of services - disparities must be addressed within both the larger healthcare system and ACC
4. Kaupapa Māori – Māori world views and values must be respected and integral to the design and delivery of ACC services for Māori
5. Consultation and communication – in the absence of genuine interaction and co-development, no changes to ACC services will be successful in improving Māori trust and confidence in ACC as an organisation or the utilisation of ACC services.

The same research has shown that these views are commonly also shared by non-Māori as well.

REMOVING THE BARRIERS - WHAT WORKS

- There is a substantive body of evidence about what works for Māori in a range of social and economic areas.
- Māori service delivery, particularly health service delivery, emphasises the importance of having a holistic view of health incorporating spirituality and whānau ties, a focus upon community and community taking ownership, provision of leadership that has integrity and an ability to build and/or utilise strong community networks.
- Responding to Māori starts with acknowledging that:
  - Mainstream programmes on their own are insufficient to address the disparities and inequities observed between Māori and non-Māori population groups.
  - There is a well-argued case for Māori specific programmes on the basis of fairness and equity, and Treaty of Waitangi obligations for Crown agencies.
  - Māori specific interventions are likely to need funding at higher levels than non-Māori (i.e. mainstream) programmes given the significant community and workforce capacity gaps that need to be closed, and given the much lower community resource base that any programme will be working in.
  - Programmes will need to be established on a medium to long-term basis – more than five years, and the success of the programmes measured not only

    in terms of importance to ACC, but crucially, in terms of community development measures important to Māori.
    - There is good evidence that an effective organisational response will require clear senior leadership and sustained commitment across the whole organisation about the need for a Māori specific response, and the value it can bring to the organisation (in terms of both trust and confidence and better service delivery such as integrated care services).
    - As a Crown entity and agent, ACC has a responsibility to actively support Crown obligations under the Treaty of Waitangi, and to respond to Māori. As such, Māori responsiveness should not be seen as the sole responsibility of Maori staff or a dedicated cultural unit. Rather, the organisation as a whole should respond, with specialist support in Māori knowledge and community networks to assist with delivering a credible response to Māori across the organisation.
    - Development of trusting relationships is important, and the traditional ACC approach of a top-down and short-term focus (less than three years) on return on levy investment, or change in programme priorities, will significantly undermine any Māori specific programmes that may be developed; they require a longer time frame to deliver the outcomes desired.
    - A Māori strengths based approach is preferable to a deficit model, because such an approach recognises the value, insights and capability that Māori can bring to the design and delivery of health care service provision; this is likely to significantly improve engagement with Māori authorities and representatives, and Māori perceptions of the organisation.
    - There is merit in beginning a process of engagement with Māori primary health care providers and Iwi Authorities to develop pilot models of Māori specific injury treatment and rehabilitation services – including claims management. ACC can learn from the pilot projects undertaken in 2005/06.
- Māori health service delivery should be set within a Māori world view of health if it is to be effective. There are several models available, all of which share common principles that stem from Mason Durie's Te Whare Tapa Whā model (M. Durie, 2012).

RECOMMENDATIONS

On the basis of the evidence reviewed, a Māori response requires:

- acknowledging that Mainstream service provision alone is insufficient
- a deep organisational commitment to responding to Māori
- better funding and longer term commitment to Māori programmes to ensure success
- applying the evidence for effective responses to Māori reported in the literature.

ACC Research recommends consideration is given to:

1. Collaborating with Te Puni Kokiri to learn from their knowledge, experience and network of relationships to develop and implement Māori responsive actions.
2. Adopting the Te Pae Mahutonga (Durie, 1999 & 2005) model to inform the development of service responses to Maori. This model has the advantage of combining both a Māori holistic view of health (including injuries, concepts of risk and

safety), and a process for promoting health in Māori communities. However, before adopting any particular model, best practice evidence clearly indicates that the organisation should consult appropriately with the relevant Māori authorities about use of a model to inform action. This extends to recognising that no one Māori model may fit all Iwi authorities and Māori health providers.

3. Beginning a process of engagement with Māori primary health care providers and Iwi Authorities to develop pilot models of Māori specific injury treatment and rehabilitation services – including claims management. The models should be aimed at improving the utilisation of ACC funded services according to Māori injury treatment and rehabilitation need, and to improve Māori trust and confidence and satisfaction with ACC. Examples for this can be found in the approaches by Ratima et al (1995), Counties Manukau DHB (Maniapoto & Gribben, 2003), and the ACC pilot projects of 2005/06.
4. Revitalising activities such as patient decision aids so that they are more nuanced and sophisticated in their targeting of audiences, design and modes of delivery including use of Māori specific service channels.
5. Making more ACC resources available in Te Reo, and designing resources in ways that resonate with Māori.
6. Recruiting more Māori leaders and front line staff, and raising awareness within ACC staff of the importance of understanding and appreciating how social and cultural differences impact upon people's perceptions of the appropriateness of treatment and the service options available to them.
7. Working closely with the Ministry of Health and other health sector leaders such as Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA)[3], Te Akoranga a Maui the Maori faculty of the Royal New Zealand College of General Practitioners and the New Zealand Medical Association to promote utilisation by Māori of ACC funded services.
8. Working in partnership with Statistics New Zealand and the Health Quality Service Commission respectively to undertake activities aimed at:
    - routinely publishing directly comparable Māori and non-Māori injury statistics, using the model presented in the MOH and ACC 2013 New Zealand Burden of Injury Report
    - developing Māori health indicators reflective of Māori aspirations for their health and development, for comparisons over time and between regions
    - developing and publishing measures of Māori and non-Maori utilisation of ACC funded injury treatment and rehabilitation services

---

[3] 'Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA) is a professional body representing Māori medical students and doctors working as clinicians, researchers and teachers. With approximately 340 active members, Te ORA represents the majority of the Māori medical workforce.' Source: http://www.teora.maori.nz/   .

- aligning the collection and reporting of ethnicity data on ACC claims forms with Statistics New Zealand standards
- adopting Statistics New Zealand classification standards on Iwi affiliation, and exploring the possibility of capturing hapū affiliation.

SCOPE OF THE REPORT

The companion report to this one (Wren, 2015) argued that there was evidence for Māori underutilisation of ACC funded injury treatment and rehabilitation services. In a recent editorial in the New Zealand Medical Journal it has been argued that

> *"Maori experience higher exposures to risk factors for poor health, more injury, more disability and poorer outcomes when they interact with health services….*
>
> *Underlying the reported results…are entrenched systemic drivers of disparities and poor outcomes for Maori. These include social and environmental drivers, health system factors, health professional behaviours and institutional resistance to innovation….*
>
> *(T)he determinants of Maori health outcomes…include low incomes, poor housing, inadequate education, erratic employment and racism.*
>
> *The impacts are complex and intergenerational…. We use them to address 'confounding' although in the real world they are 'compounding'….*
>
> *How do we generate new forces for change, and activate the next leap forward in Maori health?" (Carr, 2013)*

As ACC is part of the New Zealand health system[4], two questions arise from this editorial:

1. What are the barriers to ACC service utilisation and funded injury treatment and rehabilitation services?

   This question is addressed in Part 1.

2. What is the evidence for effective interventions that could be used to help address the identified barriers to full Māori utilisation of ACC funded services?

   This question is addressed in Part 2.

Implicit in these two questions is another:

3. What is the role of ACC in addressing inequities and inequalities in Māori utilisation of ACC services, including those injury treatment and rehabilitation services funded by ACC – what is an ACC response to Māori?

---

[4] ACC sits alongside the tax-funded health system as funder of injury treatment and rehabilitation services. In 2010 it is estimated that 83.2% of total health expenditure came from government, of this ACC provided 8.4%. The rest came from patient charges, private health insurance, and a small percent from non-profit organisations (Cumming et al., 2014).

PART 1: BARRIERS TO MĀORI USE OF GOVERNMENT FUNDED MAINSTREAM HEALTH SERVICES

WORTHINESS OF INJURY, VALUE OF WORK AND TREATMENT SEEKING BEHAVIOUR

Research has shown that Māori report very consistent experiences over time with utilisation of a wide range of government agency (including ACC) services (Williams & Cram, 2012). The experiences typically are described in terms of difficult to access, unresponsive and alien to the lived experience and value systems of those who do not share the dominant 'mainstream' world view represented in many government services. In the health context, the barriers have been broadly grouped as being social, cultural, economic and geographical (Russell, Smiler, & Stace, 2013).

Researchers in the area of the sociology of work have also argued that the experience of industrial injuries and workers compensation claim seeking behaviour is more the product of how work is organised within society, and cultural (ethnic) and social differences about the value of work, beliefs about the causes of injuries and what an appropriate response to an injury is (Dwyer, 1991; Grint, 1991).

As an illustration of the importance of Māori cultural values influencing decisions about the value of work and the 'worthiness' of claiming for an injury consider the following whakataukī (Māori proverbs) (Jansen, 2015b):

- *Mauri mahi, mauri ora. - A working soul is a healthy soul (or the industrious live well)*
- *He toa taua, mate taua; he toa piki pari, mate pari'; he toa ngaki kai, ma te huhu tena. - The warrior is killed in war; the fearless scaler of lofty cliffs (in search of sea-fowl) can be smashed to pieces; while the industrious gardener lives long and dies peacefully of old age.*
- *He toa paheke te toa taua; tena ko te toa mahi kai ekore e paheke. - The warrior stands on insecure footing; but the industrious cultivator of land will never slip or fall*.

Each of these whakataukī speaks to the value of hard work and how warriors accept death or injury. This can be seen in some sports people attitudes to injury – where sports injuries are viewed as worthy injuries from a battle that will lead to seeking help, while a stumble in the dark at home causing similar injury might be seen as not worthy as it "is just my own mistake" – so help is not sought. An injury at work may be considered in the same way. In this context, help seeking may be influenced by the degree to which the injury is thought to the person's fault, or whether it 'was inflicted on me in honourable circumstances (is it a battle injury / paid work injury) which may be perceived as more worthy of help seeking from mainstream services (Jansen, 2015b).

In addition, when there are perceived barriers to care, Maori (and arguably people from similar Pacifika cultures) may judge whether to seek treatment in the context of not only is the injury worthy of taking further action, but also in the context of the prior experiences of whānau members in similar circumstances. Where the experiences have been bad, the result may lead to delay or no presentation at mainstream services, or to a preference for self-treatment or the seeking of assistance from alternative health providers first (Jansen, 2015b).

Some evidence for this social dynamic can be seen in a range of ACC commissioned research since the early 2000s, which is publically reported for the first time in the following sections.

MĀORI PERCEPTIONS OF INJURY SEVERITY AND TREATMENT SEEKING BEHAVIOUR – 2005 SURVEY EVIDENCE

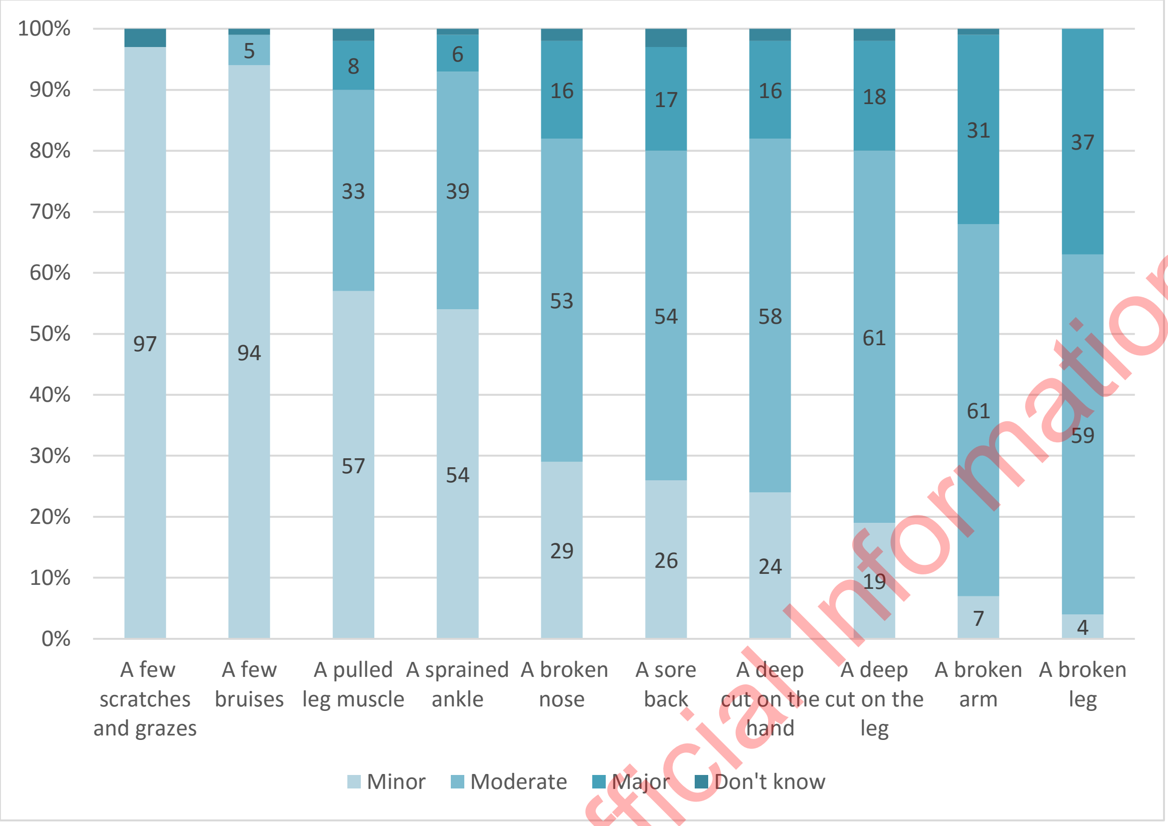
In the early 2000s ACC saw a need to improve Māori knowledge about the Scheme in order to improve Māori utilisation of ACC services and therefore help meet Māori injury treatment and rehabilitation need (Jansen, 2015a). To enable this, the ACC "You're Covered" campaign was developed (ACC., 2007a). Originally it was targeted for Māori and initially planned to run in the Māori media alone. However, this focus was lost in 2004 when the campaign was extended across all media and the whole population. In May 2005 an evaluation of the communication strategy was commissioned which included a benchmark survey of approximately 1500 Māori clients (Research New Zealand, 2005). The survey sought to identify:

- who Māori approach for injury treatment
- their level of awareness and understanding of ACC entitlements available to them
- their attitudes, beliefs and perceptions of the services.

The 2005 survey found that perceptions about the 'severity' of the injury (minor, moderate, major), whether it would 'self-heal', and could Māori 'treat themselves' were important influencers of when treatment was first sought (Research New Zealand, 2005). Unfortunately, the survey did not include non-Māori responses, which means it is not possible to assess how the behaviours identified might differ significantly, if at all, from other ethnic groups.

The following figure presents Māori views on whether common types of injury represent a minor, moderate or major injury. The graph shows that significant numbers of respondents viewed injuries such as 'a broken nose, sore back, deep cut on the hand or leg, broken arm' as representing minor or moderate injury for which early treatment would not be necessarily be sought in a timely manner from a health service and claim management view.

Figure 1: Maori perceptions of injury severity, 2005



In addition approximately 60% of those who defined themselves as sustaining a moderate injury reported they may initially ‘elect to self-treat themselves’. This was especially the case for Māori males. However, if self-treatment did not work, virtually all would seek initial treatment from a health provider who was usually a doctor or nurse, or from a hospital Accident & Emergency Department.

One implication of this is, when Māori do seek treatment, it is likely the services required will be more complex, costly, and require longer rehabilitation. It also suggests, that many Māori are not using ACC services for many injuries they perceive as ‘minor or moderate’ even though they are entitled to receive ACC funded injury treatment services for these injuries.

AWARENESS OF ACC SERVICES, 2005

The survey found a very significant information gap about what services were available from ACC for those injured.

While many respondents were aware that they could access services, significant numbers could not name what the services were. For example on an unprompted basis, approximately 65% were not aware that patients with work related injuries could get ‘income support’. Only 20% of respondents mentioned ‘subsidies for visiting the doctor’, and only 1% were aware of ‘subsidies for dental treatment’. Even when prompted, approximately 25% of respondents were not aware of weekly compensation support, and approximately 40% were not aware of any of the other services available. In addition, it was reported that

> ‘while awareness of support services and entitlements…is clearly an issue, exacerbating this are…misconceptions about who provides these services…who is entitled to them, and on what basis’ (Research New Zealand, 2005).

BARRIERS TO USE OF ACC SERVICES, 2005

Barriers identified in seeking treatment from a health provider included:

- affordability
- access
- availability of providers
- appropriateness of services given cultural differences (for example how Home Support Services are delivered, and how surgery is talked about)
- personal attitudes towards injuries and treatment
- awareness and knowledge of the range of services available.

While cost was commonly mentioned, it is not necessarily the most significant barrier; beliefs about services, and trust and confidence in the service provider, are equally important. For example:

- 33% reported ‘they could not afford to go’ to a health professional
- 37% said seeking treatment would mean ‘going without essential items’
- 54% of respondents believed that ‘most injuries fix themselves if you give them half a chance’
- 76% stated that the service provider ‘must be someone I feel comfortable with and trust’
- 33% said it was ‘too much of a hassle’ to go to a doctor or health professional
- 32% claimed they ‘usually had to wait too long before they could get an appointment’ (Research New Zealand, 2005).

Segmentation analysis identified that, for 44% of respondents, these issues represented a ‘moderate to high’ barrier to uptake of services. The most impacted group was the segment most representative of the low socio-economic groups:

- under 30 years of age
- families with children
- provincial / rural based
- sole income and vulnerable workers on low incomes and in receipt of a range of government subsidised services
- less likely to have a regular doctor or health professional they see.

This segment also had the lowest knowledge of the services available, displayed less help seeking behaviour compared to the three other segments. Since this work, additional internal Recent ACC research continues to report similar results. Very little appears to have changed over time.

A KEY REPORT: “HE RITENGA WHAKAARO: MĀORI EXPERIENCES OF HEALTH SERVICES” (2009)

The 2009 Mauri Ora report is widely referenced and available in the health sector. The report presents the results of a thorough literature review, survey and a set of in-depth focus group interviews with Maori about their experiences with government agencies and health providers – including ACC.

PERCEPTIONS OF CARE

The researchers concluded that while most Māori were getting good service from their health professionals, a sizable number of Māori patients (20%) feel that health workers have negative attitudes towards them and this group is more likely to state they will avoid future interactions with the provider last seen. However, analysis indicated that the group with the most negative perceptions report health service use in patterns similar to the group with more positive experiences. This finding is consistent with the health economics literature that health purchasing is relatively inelastic in New Zealand (New Zealand Institute of Economic Research, 2005a, 2005b). This means that if the health need is deemed sufficient, the person will make substantive efforts to secure treatment in spite of their views of the service. However, if they are making a substantive effort to seek care, then it is likely they will expect substantive benefit, and / or that the provider will also make an effort to meet the patient’s needs. Failure to perceive such a reciprocal benefit is likely to lead to dissatisfaction and loss of trust and confidence in the service provider – including the funder of the service.

Additional key findings were that younger Māori were far more likely to express strong dissatisfaction with the services compared to older Māori. Perceptions of care, respect, and confidence appear to impact on intention to revisit, and many Māori have low expectations for future interactions with health services.

COST AND CULTURAL BARRIERS TO SERVICE UPTAKE

A range of social, economic and institutional barriers to service uptake, and ways to improve Māori patients’ use of healthcare services, were identified by the researchers.

It was noted that barriers to care vary by type of provider, location and age, and it is harder for people with disability. For Māori patients, a lack of engagement with services due to past poor experiences is an issue. Lack of engagement was due to breakdown in communication and relationships with practitioners. Cost was seen as a major barrier that crosses all areas, including:

- cost of consultation
- cost of prescriptions
- cost of house calls
- time off work

- waiting time
- cost of travel
- ability to travel
- follow-on costs
- value for money.

While each of these cost barriers may be considered minimal by those in higher socio-economic categories and close to urban based services, this is not the case if the patient is on a low income, a vulnerable worker (defined in industrial relations terms), comes from a different cultural background, and / or is based in a rural community distant from services. For these client segments, such costs individually and cumulatively are a prohibitive barrier, and typically involve making trade-offs against other pressing individual and whānau/family commitments.

Cultural 'fit' barriers identified included:

- beliefs that whānau will look after them
- patients were frightened of the outcome - better to grin and bear it
- tension over following the views expressed by the provider vs taking a stronger self-advocacy approach
- poor conduct of the consultation (including pākehā provider attitudes and the non-allowance of whānau/Māori processes), which leads to misperceptions of each other, misinterpretation of discussion, confusion over expectations of behaviour and follow-up actions, and an overall bad experience.

ORGANISATIONAL BARRIERS TO SERVICE UPTAKE

The researchers identified nine organisational (systemic) factors or barriers that negatively impact on Māori utilisation of services and health outcomes:

1. The universal focus of the health system in which one service for all often means that services are not culturally appropriate for Māori patients (Barwick, 2000; Baxter, 2002; Ratima, Ratima, Durie, & Potaka, 1993).
2. Workforce composition; that is, few Māori personnel (Barwick, 2000; Baxter, 2002; Cormack, Robson, Purdie, et al, 2005; Health Waikato, 2001).
3. The timing and availability of services (Crengle, 2000) including service configuration and location (Cormack et al, 2005) and patients' lack of awareness of available services (Bryant & Campbell, 1996).
4. Funding and resources, including the physical environment (Cormack et al, 2005; Health Waikato, 2001).
5. Hospital based appointment systems that were viewed as rigid (Bryant & Campbell, 1996).
6. A lack of relevant educational and promotional material, and appropriate (eg Māori - specific) information (Bryant & Campbell, 1996; Crengle, 2000; Health Waikato, 2001).
7. Failure by providers to identify and treat those in greatest need (Crengle, 2000).

8. Unclear continuity of care, including follow-up and maintenance of treatment (Crengle, 2000; Health Waikato, 2001).
9. Lack of use of the Māori language (Health Waikato, 2001).

WHAT DO MĀORI WANT FROM SERVICE PROVIDERS?

The authors concluded that what Māori want from their service providers, including ACC, is:

- to be understood - more time to be listened to
- trusting relationships - more time for relationship building
- service providers communicate in ways that are clear and understandable by the patient - more assistance to assess technical aspects of their clinical treatment and associated expected outcomes; explanations in clear language about what was wrong, rather than just information on paper and in medical or organisational focussed claims management language
- better value for their effort (including expenditure) to access and use services
- to see themselves in service agencies (they would like to see more Māori in their interaction with agencies and service providers, and people who understand Māori culture).[5]

A MĀORI CLIENT VIEW ON ACC SERVICES

In 2010 Mauri Ora & Associates submitted to the Department of Labour (now MBIE) a report on Māori experiences and expectations of ACC (Mauri Ora & Associates, 2010). The report examined the experiences and opinions of Māori claimants, levy payers, business people and providers towards both the ACC Scheme and the organisation. The authors were asked to construct a narrative about the Māori experience of ACC and to give an overall picture of how changes to the Scheme proposed at the time could affect Māori. Views were solicited through individual interviews and small group discussions, and a small number of telephone interviews.

The researchers found there was strong support for the Scheme and a fair amount of discontent with the ACC organisation. Five key expectations that participants had of ACC were identified:

1. Fairness – the system must achieve fair outcomes for Māori and all New Zealanders
2. Choice – all choices must be fair and open
3. Improvement of services – disparities must be addressed within both the larger healthcare system and ACC
4. Kaupapa Māori – Māori world views and values must be included and respected in the design and delivery of ACC services
5. Consultation and communication – in the absence of genuine interaction and co-development, no changes to ACC will be successful.

---

[5] This research also piloted and validated a survey tool measuring clients experiences of health care.

The authors reported that participants believed that many Māori had negative experiences trying to engage with ACC and were not being well served by ACC. Māori were not aware of their entitlements, services were poorly communicated to Māori and claims management processes were not understood or well aligned with Māori values. Maori are also hindered in their ability to access services because of the way services are delivered through the health care system. Consequently, not only are Māori bearing a disproportionate burden of injury, they were less able and willing to access the treatment and rehabilitation services they need, and to which they are entitled.

ACC RETURN TO WORK SURVEY RESULTS

In the 2010/11 Return to Work Monitor, ACC clients were asked about their return to work expectations and experiences. While this survey comprised only 71 Māori respondents and 530 non-Māori, the results indicated differences between Māori to non-Māori.

Māori:

- reported finding ACC claims processes more complicated, and rated ACC significantly lower compared to non-Māori on a wider range of aspects of client engagement, including:
    - providing accurate information
    - responding to enquiries
    - communicating with the worker
    - providing advice about the claim
    - being helpful in returning to work (ACC Research, 2011).

While the sample size is too small to draw any statistical conclusions, the results are consistent with the 2005 survey results.

In response to the small Māori sample in the 2010/11 survey, a larger and weighted sample was commissioned for the 2014 Monitor. This resulted in a total response of 705 participants and statistical weights were applied to the Māori responses to improve confidence about the statistical significance[6] of the observed differences between Māori and non-Māori.

The survey also asked where treatment services were initially sought, and whether respondents were aware of any referral for specialist services such as elective services and advanced imaging. Analysis showed clear differences in key areas of service utilisation and expectations about recovery between Māori and non-Māori:

- Māori and non-Māori sought their initial injury treatment at similar levels from the same providers

---

[6] Statistical significance refers to whether any differences observed between groups being studied are 'real' or whether they are simply due to chance. Mathematical tests are used to establish the probability about whether the differences are 'real' and these are typically presented in term of 95% confidence intervals.

    - 45% of Māori going to an Accident & Emergency service, compared to 48% for non-Māori, and 52% for Other ethnicities
    - 36% of Māori going to a GP compare to 35% of European and 38% for Other ethnicities
- approximately half of claimants were subsequently referred for additional treatment from either a specialist (48%), or a physiotherapist (47%)
    - however Māori were statistically significantly less likely to be referred to a specialist or physiotherapist compared to non-Māori
        - 34% of Māori were referred to Specialist services compared to 48% of New Zealand European and 59% of Other ethnicities
        - 30% of Māori were referred to Physiotherapy services compared to 46% of New Zealand European and 60% of Other ethnicities
- 95% of those referred for additional treatment reported that they experienced no difficulties in accessing this treatment
- a significantly smaller proportion of Māori rated their own health as 'excellent' prior to the injury compared to non-Māori (21% vs. 38%); there were no significant differences following their injury
- there were significant differences between expectations about recovery, with Māori expecting to recover sooner at levels much higher than European and Other (48% compared to 32% and 11% respectively)
- a greater proportion of Māori reported returning to similar levels of hours of work compared to European and Other (56% compared to 46% and 43% respectively),
    - and only 7% of Māori reported taking extra time off work after first returning to work compared to 11% of European and 18% of Other ethnicities
- there was no difference between Māori (5%) and European (4%) about whether they felt 'physically' not ready to return to work; in contrast 12% of Other reported feeling not ready
- there was little difference between Māori and European over how they felt 'emotionally' about returning to work
- interestingly Māori reported higher levels of motivation for return to work as coming from 'themselves' and 'whānau / friends' and less so 'GP' compared to European and Other ethnic groups (refer Table 1 and highlighted blue lines). It is also interesting to note the influence of 'the boss' and 'ACC representative' for 'Other' ethnicities is significantly higher compared to Māori and European.

Table 1: Key sources of return to work decisions, by ethnicity, 2014

Influencer	Māori (%)	European (%)	Other (%)
Other health professional	35	40	30
Themselves	20	14	13
Whānau and/or friends	21	11	14
GP	12	7	7
The 'boss'	5	6	11
ACC representative	9	5	13

- there was little difference between the ethnicities in terms of belief about the benefits of returning to work for their recovery
  - however, twice as many Māori (35%) reported returning to work because ‘it provides structure’ compared to non-Māori (17%).

WHAT DO CLINICIANS SAY ABOUT EQUITABLE ACCESS TO ELECTIVE SURGERY

Through the use of in-depth interviews and a review of the literature McLeod et al (2004) identified a range of ways that GPs and Specialists influence access to health services.

Factors identified included:

- the perceptions of clinicians regarding their patients’ ability to benefit
- patients’ ability to make informed decisions about surgery
- patients’ social and cultural perceptions of the health system
- low socio-economic status of many patients in need, which restricts their ability to utilise public services, or access private services.

The authors noted that:

> “General practitioners …felt that socio-economically disadvantaged patients were less able to advocate for themselves and were more vulnerable to being lost to the elective surgical booking system as well as being less able to access private care. Both GPs and secondary care clinicians …would personally advocate for individual patients to improve their access. Advocacy was related to clinicians’ perceptions of the value that patients would receive from the surgery and patients’ needs for public sector funding” (McLeod et al, 2004).

Specialists commented that achieving equal access was complicated, ‘…it’s access to health care, access to education and information, financial reasons, cultural reasons, and all the other complexities of overcrowding…’, which means it is easy for particular individual needs to get lost when they don’t readily fit the mainstream service delivery path (McLeod et al, 2004).

It was also pointed out that:

> ‘when resources are constrained, subjective decision-making by clinicians has the potential to further advantage or disadvantage patients through the weighting surgeons implicitly place on socio-demographic factors when making rationing decisions’ (McLeod et al, 2004).

PART 2: THE EVIDENCE FOR EFFECTIVE INTERVENTIONS

WHY ADDRESS DISPARITIES AND INEQUITIES IN MĀORI SERVICE UTILISATION?

A central tenet to guiding various Governments' responses to addressing Māori health inequities is the Crown's obligations under the Treaty of Waitangi. These obligations include principles about relating to each other in good faith with mutual respect, co-operation and trust. Over the years, these obligations have been extended beyond central agencies to include a wider set of state agencies and Crown entities.

In a 1998 paper developed for the New Zealand National Health Committee for the health sector, of which ACC is a part, Woodward and Kawachi (2000) identified four arguments in favour of reducing health inequalities due to social, cultural and economic factors. The arguments were:

- Inequalities in health are inherently unfair, especially in circumstances where personal responsibility is least relevant; the Treaty of Waitangi places further emphasis on the health of Māori.
- Reduction in health inequalities benefits everyone, largely because the conditions that lead to health inequalities are detrimental to all society, but also because some consequences of health inequalities have obvious spill-over effects (for example, infectious diseases).
- Health inequalities are largely avoidable.
- Interventions to reduce health inequalities may be cost-effective.

Another aspect is that given ACC is a monopolistic provider this means users of Scheme services really have only two choices, which are to either use, or not use Scheme services as there are no other alternative providers. In this context the strict business insurance view emphasising personal choice argument is not viable as there is in reality little room for service choice by the consumer – choices are largely determined by the health provider and the claims manager. The responsibility then is upon the government owned Scheme to provide services that are more responsiveness to the population's needs.

WHY A SPECIFIC MĀORI RESPONSE? MAINSTREAM SERVICES ARE INSUFFICIENT

Hauora: Māori Health Standards of Health IV, (Robson & Harris, 2007) describes in detail the significant disparities in between Māori and non-Māori health standards, which have existed in New Zealand for many years. The reasons for these disparities have been widely debated and researched. The most compelling evidence points to the role of poverty (low socio-economic status, low incomes and poor housing) as accounting for approximately 50% of all the Māori health disparities (Ministry of Health, 2002, 2004; Robson, 2003, 2008).

Reliance upon mainstream programmes to close the significant gaps in health experience between Māori and non-Māori has clearly failed. In *Hauora (*Ratima et al, 2007), the authors argue that:

> “The needs-based case for distinctive strategies is clear in light of the wide inequalities between Māori and non-Māori in the disability sector that have not been addressed by homogenous approaches. Key points of difference in addressing Māori needs will relate to the disadvantaged position of Māori within New Zealand society and cultural requirements”.

Furthermore they argue:

Mainstream services are insufficient because

- They have demonstrably not closed the gap in health disparity or equity experience between Māori and non-Maori.
- ‘Same’ does not mean ‘fair’, when responding to significant disparities and inequities in the burden of injury and use of ACC services.
- As a Crown agency operating in the health sector, there is an expectation by Māori that ACC should abide by Crown obligations under the Treaty of Waitangi in similar ways to other Crown agencies operating in the health and social services areas. This includes examples of:
    - services by Māori for Māori, and
    - the design and delivery of services specifically with Māori in mind in order to close the disparities and inequities in health experience.

(Ratima et al. 2007)

The need for a distinctive Māori response was developed further by Mauri Ora & Associates in a 2010 report for the Department of Labour on Māori views of ACC. The Mauri Ora researchers commented that:

> “Disparities research demonstrates that treating everyone ‘the same’ does not lead to similar results for underserved and vulnerable populations. It would not be ‘fair’ to hand everyone the same sheet of written instructions if half the group is visually impaired. Similarly, ‘fairness’ in a health system (which ACC is part of) requires that attention be paid to the physical, emotional , spiritual, social and cultural needs of its target population….
>
> There is evidence that when programmes to improve health are focussed at the ‘average’ consumer, who is invariably a member of the majority culture, levels of access or quality of care for the mainstream community may rise, but those for underserved groups generally lag behind, thereby widening disparities. By contrast, if communications are customised and

> directed at those groups who are most disenfranchised, then they, along with the mainstream population, benefit from the programmes, thus reducing disparities as well as improving the status of everyone" (Mauri Ora & Associates, 2010).

This imperative of a specific cultural response is even stronger when responding to Māori, compared to other ethnicities, because of the longstanding size of the disparities, and Treaty of Waitangi obligations on government agencies.

THE CHALLENGE FOR ORGANISATIONS, AND RECOMMENDATIONS ON HOW TO RESPOND

LESSONS FROM 2005/06 ACC INITIATIVES TO REMOVE BARRIERS

In response to ACC surveys in the period 2003 - 2006 that highlighted the lack of knowledge among Māori, Pacifika and Asian peoples about the range of support available via ACC following an injury, a suite of pilot interventions was undertaken in the 2005/06 financial year aimed at removing the barriers (ACC., 2007b).

REMOVING FINANCIAL BARRIERS INTERVENTION

One intervention focussed upon 'affordability' and tested whether providing higher subsidies to GPs and radiologists would increase the use of these services by injured people on low incomes and other low users of primary care services (ACC., 2007b).

Subsidies were raised in the Whangarei, Rotorua, Wanganui, Wellington, Nelson and Dunedin regions, with the rest of New Zealand providing a control against which results were measured.

The subsidy for injury-related visits to GPs was raised by $10, and the radiology subsidy was increased by $8.53.

At the end of the pilot, a 3% overall increase in GP visits was recorded in the pilot sites, with radiology visits up 2.3%.

The rate of increase among Māori, Pacifika, Asian and people on low incomes was not significantly higher than that recorded by other sectors of the population. Māori and low-income people did make slightly more use of radiologists during the trial than other users, but no group recorded a significantly higher increase in GP visits than any other.

While the relatively small behavioural change shown by Māori, Pacifika, Asian and people on low incomes was disappointing, there may be a number of reasons why these groups didn't respond more positively during the pilot compared to those in the second pilot intervention group.

REMOVING NON-FINANCIAL BARRIERS TO MĀORI INTERVENTIONS

This group of pilot interventions focused on five contracted providers in Māori communities, and aimed to identify key non-financial barriers that prevented community members from accessing ACC's primary care services (ACC., 2007b).

The communities involved were Tui Ora Limited (Taranaki), Ruakura Hauora o Tainui (Waikato), Arai te Uru Whare Hauora (Dunedin), Korowai Aoha Trust (Rotorua) and Te Ha o Te Whānau (Opotiki).

Potential barriers identified during the studies included:

- lack of information in the community about the type and scope of services available for injury care
- lack of knowledge among treatment providers about ACC's services and entitlements
- physical isolation and lack of affordable transport
- attitudes / perceptions of injured people and their communities.

Each contracted community was responsible for developing their own solutions to the barriers identified.

Key findings that emerged from the pilots were that communities responded well to information and advice delivered by providers based within their community, rather than by outside government agencies.

It was also clear that communications material needs to be specifically designed for these types of communities. The studies highlighted the nature of the message, and when and how it is delivered, are all important points to consider when designing communications.

LESSONS FROM OTHER GOVERNMENT AGENCY INITIATIVES

Williams and Cram (2012) in a recent report for the Department of Corrections reviewed the published literature from the areas of economic development, education, health, and whānau and wellness, to identify what works for improving Māori life outcomes. Lessons for organisations and programme design were identified.

The authors concluded that there is good evidence across all the areas looked at, and considerable consistency about what works for programmes aimed at responding to Māori.

What works is recognition of the centrality of whānau (Māori family system) as a major influence on individual whānau members[7], and extending outward to hapū, iwi and particularly to community organisations. Associated with whānau effects was the importance of the kaupapa Māori (by Māori, for Māori) approach to service provision and to understanding what works and how. The authors commented these effects were pervasive across types of intervention and government agency.

The evidence reviewed showed particular success for Māori designed community programmes that were associated with a promise of establishing greater integration with

---

[7] In this context, the results of the 2014 ACC Return to Work Monitor Survey are consistent with the published literature showing the importance of whānau in influencing early return to work decisions.

mainstream organisations. A central theme to these effects was recognition of culture and respect for a Māori world view, values and beliefs, the importance of relationships, and acknowledgement of the merit and necessity of enabling some self-determination by seeking more direct involvement by Māori in programmes affecting Māori.

Williams and Cram (2012) suggest that the challenge for organisations is to integrate the following characteristics according to their own contexts, and to continue to develop their operations in evidence-informed ways so that they can ensure their responsiveness to and for Māori is ongoing and sustainable.

The characteristics of successful Māori programmes are:

Organisational

- ‘Leadership that is effective in establishing clear goals, objectives, strategies and processes of implementation as well as fostering a strong sense of responsibility and of shared values.
- An inclusive and participatory style of management.
- Communications systems that effectively flow through all levels of the organisation and include partners, stakeholders and appropriate community groups.
- Professional development for staff and succession planning.
- Building and maintaining appropriate resources (finance, people, facilities).
- Self-review and external review mechanisms for ongoing evaluation….’ (Williams & Cram, 2012).

Successful programmes also:

- ‘Recognise the authenticity of Māori, its culture, its philosophy, its principles and values.
- Build relationships through understanding, a sense of equality, mutual respect and trust.
- Ensure that Māori participate fully in delivery and governance.
- Provide opportunities for Māori to develop their own priorities and kaupapa as part of mainstream organisations.
- Incorporate language and culture into policy, management and delivery.
- Ensure strong links and communication with Māori communities.
- Tailor services to Māori needs and preferences.
- Ensure that the tools of measurement and evaluation are reliable and valid for use with Māori - particularly when they are utilised to assess perceptual, attitudinal and cognitive behaviours’ (Williams & Cram, 2012).

WHAT WORKS IN HEALTH SERVICE DELIVERY: NECESSITY OF RESPECTING A MĀORI WORLD VIEW OF HEALTH

Cherrington & Masters (2005), in their review for ACC of Māori models, frameworks and strategies that could inform Māori health promotion, including injury prevention, conclude that it is important to have a Māori model which places emphasis upon adopting a holistic approach incorporating elements of both spirituality (wairuatanga) and whānau (family). Furthermore successful indigenous people's injury prevention and health promotion programmes require community consultation, a sense of community ownership, holistic approach and co-ordinators with strong community networks.

In the Māori sphere several health frameworks have been put forward in the last 30 years. The most commonly cited and utilised for health promotion are:

- *Te Whare Tapa Wha* (The Sacred House) (Durie, 1985), which has been widely used in the health sector, particularly since 2002 when it was referred to in the Ministry of Health *He Korowai Oranga*: *Māori Health Strategy.* This framework has become the accepted standard holistic Māori view of health.

- *Te Wheke* (The Octopus) (Pere, 1988) is used particularly in family focused interventions and mental health promotion. The framework extends the basic concepts described in Te Whare Tapa Wha.
- *Te Pae Mahutonga* (The Southern Cross) (Durie, 1999), is increasingly being used in a wide range of sectors and organisations. It has the advantage of combining all the core elements of Te Whare Tapa Wha along with guidance about implementing an intervention in a Māori setting, which is highlighted by the two pointer stars.

- *Mauri Ora* (Well-being) (Durie, 2001), has been put forward as framework to guide Māori family violence prevention.

A common theme in all these frameworks is the importance of wairuatanga (spirituality) and whānau (family), hapū and iwi. It is interesting to note that the emphasis upon the wider collective, rather than just the individual, is also common in much of the non-Māori literature on health promotion and community injury prevention literature.

One clear implication of this community focus is the need to invest in community capacity building when implementing intervention programmes, adopting a long-term view on any return on investment and one that includes community development measures. In addition, mainstream rehabilitation measures of independence and functionality may not be appropriate for many Māori as mainstream measures do necessarily reflect Māori views of health – a point made by researchers in a recent paper from the Otago University Prospective Outcomes of Injury Study (Wilson et al, 2013).

A MĀORI CLIENT HEALTH SUPPORT SERVICE FRAMEWORK (INCLUDING DISABILITY)

Specifically in terms of health service delivery, Ratima et al (1995) have put forward *He Anga Whakamana* as a framework for the delivery of Māori focused health support services. While the framework has been set in the context of disability support, the elements of the framework may be equally appropriate for an ACC Māori client centred injury treatment and claims management programme aimed at addressing the inequities in injury treatment utilisation.

The framework has the following components:

- Whaka piki: Enablement of client decision-making on service options
- Whai wahi: Participation of clients, whānau, and Māori institutions
- Whakaruruhau: Safety including both physical and non-physical safety
- Tōtkia: Effectiveness with a focus on health status issues and health gains
- Putanga: Accessibility which requires good service information, service availability
- Whakawhānaungatanga: Integration by making links with other appropriate services.

Ratima et al (2007) emphasise that:

> 'Key features of the approach are that services need to be based on Māori concepts of health (therefore service goals and measures would be reflective of Māori notions of health), reflect client, caregiver, and whānau participation and preferences, and be linked to wider Māori development initiatives (and therefore have relationships with Māori institutions) if needs based care is to be delivered adequately. [Furthermore it is] recommended that enhanced function and client participation in the community should be primary drivers of disability support services for Māori, and that services need to meet high professional and cultural standards. In order to meet these standards, a technically and culturally competent workforce would be necessary' (M. Ratima, 2007).

The value of such an approach in practice has been demonstrated by Counties Manukau District Health Board in their Maori Case Management Clinic Project (Maniapoto & Gribben, 2003).

WORKING WITH MĀORI BUSINESSES

Similar themes to those articulated above have been put forward by the Equal Employment Opportunities Trust in their advice on working with Māori business and encouraging Māori staff within organisations (EEO Trust, 2010).[8] The Trust suggests that in order to work successfully with Māori businesses it is important to understand the ethos driving many of the organisations, which can be described in terms of the 'Four Ps':

- Purpose
- Principles
- Practices
- Performance measurement.

The EEO Trust describes each as follows:

Purpose

This is the stated reason for which the business exists. A distinctly Māori business for example, might:

- Aim to optimise cultural, social, environmental and economic wealth over generations
- Operate in terms of collective shareholder value; for example, there is no free entry and exit of shareholders
- Use profits to help develop social capital, which in turn benefits the shareholders as they are members of the community
- Apply social responsibility throughout the business
- Seek to protect and enhance the physical environment
- Take account of shared cultural values of Māori and others in the community.

Principles

These are the beliefs that guide the business' actions. In addition to commercial principles a Māori business might be guided by principles such as:

- Iwitanga: expression and celebration of those qualities that make an iwi or hapū unique
- Kotahitanga: respect for individual differences and the desire to reach consensus, unity and solidarity

---

[8] See Pages 18 and 19 of the EEO Trust report for advice on working with Māori businesses.

- Kaitiakitanga: stewardship or guardianship of the environment
- Manaakitanga: caring, sharing and hospitality
- Whanaungatanga: the bonds of kinship that exist within and between whanāu, hapū and iwi; it is also used broadly in an organisational context to denote building and encouraging relationships
- Tau utuutu: acts of giving back or replacing what you receive, the principle of reciprocity
- Urunga-Tu: developing a spirit of mutual respect and responsibility through participation.

Practices

These are the actions that an organisation takes to fulfil its purpose. Māori business practice may address the concerns of stakeholders, including shareholders, customers, employees, suppliers, the community and the environment.

Examples include:

- Community dialogue and partnerships
- Environmentally, socially and culturally responsible production and product development
- Employee training in Māori language and culture
- Long-term partnerships with suppliers
- Profitability and investment of dividends in initiatives benefiting shareholders and stakeholders alike.

Performance management

A sustainable Māori business accounts for cultural, social and environmental, as well as economic performance. This involves quantitative and qualitative measures, using both stakeholder perceptions and business data to determine performance. A Māori business also takes account of intangible concepts such as ‘mauri’ or life force.

CONCLUSIONS

On the evidence presented, there are well founded public policy and health fairness, equity, and effectiveness arguments to justify the development and implementation of Māori specific service utilisation programmes aimed at closing the gaps between Māori and non-Māori health outcomes and ACC funded service utilisation.

Mainstream approaches to ACC service delivery have been shown to be insufficient to reduce the observed health and injury related disparities and inequities between Māori and non-Maori.

There are well established Māori health frameworks for government agencies to work within, and evidence for effective programmes addressing Māori health inequalities – including the suite of pilot studies undertaken by ACC in 2005/06.

There is a substantive body of evidence for effective Māori specific health promotion programmes in areas such as alcohol, smoking, violence, and Māori women's health services, which can be used to inform thinking about other health service delivery design.

All the evidence clearly shows that effective programmes interweave current scientific knowledge and best-practice about health promotion and agency service delivery with:

- a Māori world view of health
- a meaningful partnership approach where the needs of both parties are met
- the aspirations of Māori for self-determination and development are recognised
- success is measured not only in terms of health outcome and the short-term (less than three years), but rather in terms of participation, engagement and wider aspirations for social, cultural and economic development and the long-term
- resourcing (financial and people) is appropriate for the task. This is likely to mean funding has to be at levels higher than mainstream programmes given that many of the issues being addressed are long standing and interventions are starting from a position of significant gaps in community and workforce resiliency, capability and resourcing.

There is good evidence that an effective organisational response will require clear senior leadership and sustained commitment across the whole organisation about the need for Māori specific response, and the value it can bring to the organisation (in terms of both enhanced trust and confidence and service delivery).

There will be need for substantive professional development for all staff about the issues and ways of responding appropriately to cultural differences, and a willingness to meaningfully communicate and engage in partnership with Māori over the development of Māori responsive injury treatment and claims management services (including implementation of injury prevention programmes).

Development of trusting relationships is important, and the traditional ACC approach of a top-down and short-term focus will significantly undermine any Māori specific programmes that may be developed if traditional organisational management practices continue.

PART 3: IMPLICATIONS FOR ACC

There are a number of implications for ACC if the Scheme is to deliver effective claims management, treatment, rehabilitation and injury prevention programmes that address the disproportionate Māori burden of injury, under-utilisation of ACC services, and improve the trust and confidence of Māori in the organisation.

MAINSTREAM SERVICE PROVISION ALONE IS INSUFFICIENT

Given the size of the disparities and inequities between Māori and non-Māori health outcomes and service utilisation at the population level, the evidence shows that mainstream programmes on their own are clearly insufficient. Best practice recommendations include the development and implementation of Māori specific components and/or specific programmes for Māori by Māori (with the programmes being open to all who may wish to use them).

There is a well-argued case for Māori specific programmes on the basis of health fairness and equity, and Treaty of Waitangi obligations on Crown agencies.

On the research evidence presented in this review and associated recommended reading (see Appendix 1), it is imperative that future services provided by ACC and partners should include the adoption of a Māori world view of health, and adopt well established Māori processes for community consultation and engagement with Māori, in future service design.

Te Pae Mautonga could be an appropriate Māori model of health promotion for ACC given that it brings together a Māori view of health along with programme implementation principles that could be applied to service design across the whole of the organisation. However, in keeping with the evidence around following established Māori consultation processes, the application of the model should only be considered after consultation with the relevant Māori authorities active in the geographic area, or service area of interest.

On the evidence presented, effective programmes should have a strong sense of ownership by Māori. Ownership is defined here as meaning that Māori and Māori communities can recognise their values, beliefs and priorities in the programme or service delivery at whatever level they are pitched. There is good evidence to suggest that if the programmes are successful, then mainstream communities will also benefit, as the lessons learnt can be applied to other client groups to improve trust and confidence across the mainstream population. This has already been shown in the primary health care sector, where interventions designed for Māori, have had positive spin-offs for non-Māori communities of need.

Ideally, interventions should include components that address Māori aspirations for social and economic development, as these components have been shown to account for approximately fifty percent of the gap in health outcomes.

Furthermore, it is recommended that a Māori strengths based approach be adopted when engaging with Māori authorities and representatives. This is an approach that explicitly recognises and values the belief systems, skills, knowledge, and abilities that reside within Māori culture and communities, and uses these strengths to build more responsive services that are recognised, utilised and owned by Māori.

ORGANISATIONAL COMMITMENT IS REQUIRED TO RESPOND TO MĀORI

There is good evidence that an effective organisational response will require senior leadership and sustained commitment across the whole organisation for the need of a Māori specific response.

As a Crown entity and agent[9], it can be argued that ACC has a responsibility to strongly support Crown obligations under the Treaty of Waitangi, and to respond to Māori. As such Māori responsiveness should not be seen as the sole responsibility of Maori staff or a dedicated cultural unit. Rather, the organisation as a whole should respond, with specialist support made available in Māori knowledge and community networks to assist with delivering a credible response to Māori across the organisation and country.

Organisationally, there will be a need for substantive professional development for all staff about the issues and ways of responding appropriately to cultural differences. There must be a willingness to meaningfully communicate and engage in partnership with Māori over the development and implementation of claims management services and injury prevention programmes. There are many examples of such programmes already in place in the health sector, which ACC could readily adopt and implement.

Development of trust relationships is important, and the traditional ACC approach of a top-down and short-term focus (less than three years) on return on investment or change in programmes will significantly undermine any Māori specific programmes that may be developed. A longer term time frame should be allowed that better aligns with Māori aspirations for social and economic development.

MĀORI PROGRAMMES REQUIRE BETTER FUNDING AND LONGER TERM COMMITMENT

In addition, it is highly likely Māori specific interventions will need to be funded at higher levels than non-Māori mainstream programmes given the significant community and workforce capacity gaps that need to be closed, and given the much lower community resource base with which most programmes will be working.

Programmes will need to be established on a long-term basis – more than five years – and the success of the programmes measured not only in terms of claims duration, claims costs or other return on investment frameworks, but also by measures oriented towards Māori community development.

RECOMMENDATIONS

While ACC builds its capacity, the most effective short-term responses that ACC could consider would be to lend its support and resources to other agencies already active in

---

[9] Crown Entities Act 2004: http://www.justice.govt.nz/publications/global-publications/d/directory-of-official-information-2013/alphabetical-list-of-entries/a/accident-compensation-corporation

developing and implementing Māori specific interventions. For example, by working alongside the following agencies, ACC could be seen to be responding to Māori by:

- beginning a process of engagement with Māori primary health care providers, whānau ora providers, and Iwi Authorities to develop pilot models of Māori specific injury prevention programmes in the priority areas; and the design and delivery of injury treatment and rehabilitation services – including claims management – aimed at improving the utilisation of ACC funded services according to their health need, and to improve Māori trust and confidence and satisfaction with ACC
    - the pilot projects should build upon the lessons learnt from the 2005/06 Māori access improvement initiatives
- collaborating with Te Puni Kokiri to learn from their knowledge, experience and network of relationships to develop and implement Māori responsive actions
- working in partnership with Statistics New Zealand and the Health Quality Service Commission respectively, to undertake activities aimed at:
    - routinely publishing directly comparable Māori and non-Māori injury statistics, using the model presented in the MOH and ACC 2013 New Zealand Burden of Injury Report
    - working with Iwi Authorities and other agencies to develop Māori health indicators reflective of Māori aspirations for their health and development, and for comparisons over time and between regions
    - developing and publishing measures of Māori and non-Maori utilisation of ACC funded injury treatment and rehabilitation services
    - aligning the collection and reporting of ethnicity data on ACC claims forms with Statistics New Zealand standards
    - adopting Statistics New Zealand classification and standard on Iwi affiliation, and explore the capture of hapū affiliation with Iwi partners.

REFERENCES

ACC Research. (2011). *Return to Work Monitor Survey*. Wellington, New Zealand.

ACC. (2007a). ACC Launches “Covered” - Public Information Campaign. *ACC News: A Newsletter for Health Care Professionals*, (98 (February)), 1.

ACC. (2007b). Pilot Studies Explore Access Issues. *ACC News: A Newsletter for Health Care Professionals*, (98 (February)), 2.

Barwick, H. (2000). *Improving Access to Primary Care for Māori and Pacific Peoples*. Wellington, New Zealand.

Baxter, J. (2002). *Barriers to Health Care for Māori With Known Diabetes: A Literature Review and Summary of Issues*. Wellington, New Zealand.

Bryant, S., & Campbell, S. (1996). *Final Evaluation of Te Mammography Pilot Project for Māori Women in the Waikato Waiora Region*. Te Awamutu.

Cherrington, L., & Masters, B. (2005). *Literature review of Maori models of health and indigenous injury prevention and health promotion interventions Prepared for Ronald Karaitiana Cultural Strategies Manager Injury Prevention Accident Compensation Corporation Lower Hutt Prepared by Lisa Cher*.

Cormack, D., Robson, B., Purdie, G., & et al. (2005). *Access to Cancer Services for Māori: A Report Prepared for the Ministry of Health*. Wellington, New Zealand.

Crengle, S. (2000). The Development of Māori Primary Care Services. *Pac Health Dialog*, *7*(1), 48–53.

Cumming, J., McDonald, J., Barr, C., Martin, G., Gerring, Z., & Daube, J. (2014). *New Zealand Health System Review: Health Systems in Transition* (Vol. 4).

Durie, M. (1985). A Māori perspective of health: Te Whare Tapa Wha: Maori Health Model. *Social Science & Medicine*, *20*(5), 483–486.

Durie, M. (1999). Te Pae Mahutonga: A Model for Maori Health Promotion. *Health Promotion Forum of New Zealand Newsletter*, *49*, 2–5.

Durie, M. (2001). *Mauri Ora the dynamics of Maori health*. Auckland: Oxford University Press.

Durie, M. (2012). Te Whare Tapa Wha Maori Health Model. *Ministry of Health*. Retrieved June 4, 2015, from http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

Dwyer, T. (1991). *Life and Death at Work: Industrial Accidents as a Case of Socially Produced Error*. New York: Plenum Press.

EEO Trust. (2010). *Making a Difference: Why and how to employ and work effectively with Maori*. doi:10.4016/19470.01

Grint, K. (1991). *The Sociology of Work: An Introduction* (1st ed.). Cambridge, UK: Polity Press.

Health Waikato. (2001). *He Whakawhaititanga O Ngā Ratonga Mate Huka Integrated Diabetes Project: A Cultural Stocktake of Health Waikato Diabetes Service Investigating Māori Preferences for Service Delivery*. Hamilton.

Jansen, P. (2015a). Peer Review of Wren Maori Responsiveness reports.

Jansen, P. (2015b). Whakataukī: Worthiness of Injury and the Value of Work. Personal email communication from Dr Peter Jansen (ACC Clinical Lead Complex Cover) to author, July 2015.

Maniapoto, T., & Gribben, B. (2003). Establishing a Maori case management clinic. *The New Zealand Medical Journal*, *116*(1169), 1–8.

Mauri Ora & Associates. (2010). *Māori Experience of ACC: Final Report for Department of Labour.* Mauri Ora Associates.

McLeod, D., Dew, K., Morgan, S., Dowell, A., Cumming, J., Cormack, D., … Love, T. (2004). Equity of access to elective surgery: reflections from NZ clinicians. *Journal of Health Services Research & Policy*, *9*(Suppl 2.), S2: 41–47.

Ministry of Health. (2002). *Reducing Inequalities in Health*. Wellington, New Zealand: Ministry of Health. doi:10.1308/135576100322578852

Ministry of Health. (2004). *Living with Disability in New Zealand*. Wellington, New Zealand.

New Zealand Institute of Economic Research. (2005a). *ACC healthcare costs: trends and drivers: Report for ACC*. Wellington, New Zealand.

New Zealand Institute of Economic Research. (2005b). *Part I: Co –payments, utilisation, and health outcomes: Report for ACC.* Wellington, New Zealand.

Pere, R. (1988). *Te Wheke (The Octopus) Maori Health Model*.

Ratima, M. (2007). “Māori Experience of Disability and Disability Support Service.” In H. R. Robson B (Ed.), *Hauora: Maori standards of Health IV. A study of the years 2000-2005.* Wellington, New Zealand: Victoria University, Te Rōpū Rangahau Hauora A Eru Pōmare.

Ratima, M. ., Ratima, K. ., Durie, M. ., & Potaka, U. . (1993). *Te Runanganui Taura Here o Manawatu Incorporated: Health needs assessment survey*. Palmerston North.

Research New Zealand. (2005). *Maori Development & Customer Access Communication Strategy Benchmark Survey*. Wellington, New Zealand. doi:10.2111/1551-501X(2005)27[75:REMJ]2.0.CO;2

Robson, B. (2003). *Economic Determinants of Māori Health and Disparities: A review for the Public Health Advisory Committee.* Wellington, New Zealand.

Robson, B. (2008). What is driving the disparities? In A. M. (eds) In: K. Dew (Ed.), *Health Inequalities and need in Aotearoa New Zealand.* Dunedin: Otago University Press.

Robson, B., & Harris, R. (2007). *Haoura: Maori Standards of Health IV: A study of the years 2000-2005*. Te Ropu Rangahau Hauora a Eru Pomare.

Russell, L., Smiler, K., & Stace, H. (2013). *Improving Maori Health and Reducing Inequalities between Maori and Non-Maori: Has the Primary Healt Care Strategy Worked for Maori?: An evaluation of the period 2003-2010*. Wellingtion, New Zealand.

Williams, L., & Cram, F. (2012). *What Works for Māori: Synthesis of Selected Literature: Prepared for the Department of Corrections*. Wellingtion, New Zealand.

Wilson, S. J., Derrett, S., Cameron, I. D., Samaranayaka, a., Davie, G., & Langley, J. (2013). Prevalence of poor outcomes soon after injury and their association with the severity of the injury. *Injury Prevention*, (table 1), 1–5. doi:10.1136/injuryprev-2012-040690

Woodward, A., & Kawachi, I. (2000). Why reduce health inequalities? *Journal of Epidemiology and Community Health*, *54*(12), 923–929. doi:10.1136/jech.54.12.923

Wren, J. (2015). *Evidence for Māori under-utilisation of ACC injury treatment and rehabilitation support services: Maori Responsiveness Report 1*. Wellingtion, New Zealand.

APPENDIX 1: ADDITIONAL RECOMMENDED READING

Māori experiences and expectations of ACC, and barriers to health service use

- Mauri Ora & Associates. (2009). *He Ritenga Whakaaro: Maori Experiences of Health Services*. Mauri Ora Associates.

- Mauri Ora & Associates. (2010). *Māori Experience of ACC: Final Report for Department of Labour.* Mauri Ora & Associates Ltd. May, 2010.

Both these reports provide a range of insights into Māori experiences of health services including ACC.

The 2009 Mauri Ora report is widely referenced and available in the health sector. The report presents the results of a thorough literature review, survey, and a set of in-depth focus group interviews with Māori about their experiences with government agencies and health providers including ACC. A wide range of barriers is identified, and the report provides interesting insights into economic and cultural behavioural influences.

The 2010 Mauri Ora & Associates report was prepared for the Department of Labour (now MBIE) on Māori experiences and expectations of ACC. The report examined the experiences and opinions of Māori claimants, levy payers, business people and providers towards both the ACC Scheme (the Scheme) and the organisation. Views were solicited through individual interviews, small group discussions, and a small number of telephone interviews. The authors were asked to construct a narrative about the Māori experience of ACC and to give an overall picture of how changes to the Scheme proposed in 2009 could affect Māori.

The researchers found there was strong support for the principles of the Scheme, but there was also “a fair amount of discontent with the ACC organisation”, and in particular how services are delivered.

What works for working with Māori and implications for organisations

- Williams, L. & Cram, F. (2012) W*hat Works for Māori: Synthesis of Selected Literature.* Katoa Ltd. Prepared for the Department of Corrections, November 2012.

Williams and Cram outline a set of common themes of what works for improving Māori life outcomes, and implications for state agencies and organisations wanting to work with Māori. The themes were identified through a literature review of what works in helping to improve Māori outcomes in the areas of economic development, education, health, whānau and wellness.

Introduction to Māori health perspectives, injury prevention and implications for ACC injury prevention

- Cherrington, L. & Masters, B. (2005) *Literature review of Māori models of health, indigenous injury prevention and health promotion interventions.* Report for Ronald Karaitiana, Cultural Strategies Manager, Injury Prevention, ACC. June 2005.

Cherrington & Masters provide a comprehensive overview of Māori models of health and how they relate to injury prevention (in essence, injuries are one experience of health). The report provides some discussion of the evidence for effectiveness of a range of intervention activities, and outlines Ministry of Health and Ministry of Social Development strategic responses to improving Māori health and welfare in line with Māori perspectives of health. The report identifies and discusses implications for ACC in undertaking Māori injury prevention.

What works for responding to the Māori Burden of Injury?

- Wren, J. (2014). *What Works for Responding to the Māori Burden of Injury? An Introduction to the Literature Describing the Burden of Injury and Ways to Respond to Address the Disparities and Inequities Observed: Promoting Māori Families (Whānau) Injury Free – at home, at work, at play, on the road, and on the marae.* ACC Research. Accident Compensation Corporation, Wellington. July 2014

This report provides an overview of the Māori burden of injury, and the evidence for what works to address the issues. A wide range of implications for ACC are identified and recommendations made about how the organisation could respond.