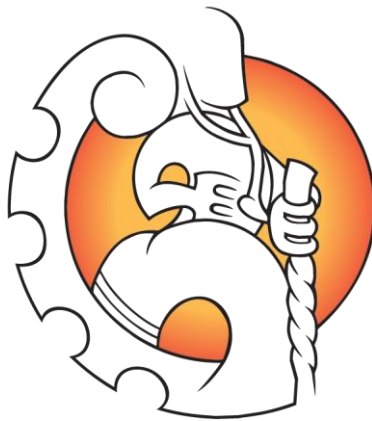


Māori Experience of ACC

Mauri Ora Associates Final Report for Department of Labour

2010



Mauri Ora Associates

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1.0 Executive Summary

1.1 Overview and Scope

Māori have the worst health outcomes of any group in New Zealand, and this is true for ACC-related services as well. There is a clear need to improve matters, but less clarity around the best way to achieve this.

This project has identified 5 key expectations that Māori have of ACC:

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 & communication** – in the absence of genuine interaction and co-development, no changes to ACC will be successful.

This research examined the experiences and opinions of Māori claimants, levy payers, business people, and providers towards both the ACC Scheme and the ACC organisation. We were asked to construct a narrative about the Māori experience of ACC and to give an overall picture of how changes to the ACC Scheme could affect Māori. Views were solicited through individual interviews and small group discussions, and a small number of telephone interviews.

Evidence and data that informs this report is drawn from ACC and Department of Labour sources, from other New Zealand health sector reports and research, and from international experiences and outcomes for indigenous, vulnerable, and underserved populations.

There was strong support for the ACC scheme among the respondents, and a fair amount of discontent with the ACC organisation. With regards to a new system which incorporated competition or choices for participants, many were wary of any changes as they might yield new ways for Māori to fall through the cracks of the system. However, there was also a surprising amount of enthusiasm for such change. This enthusiasm was, however, almost universally predicated on the assumption that any new system would embody a Māori world view and avoid the mainstream attitudes and processes that were felt to pervade the current ACC.

1.2 Key Insights

As described above, five major themes emerged from the study.

1) **Fairness**

Māori told us that they value fairness in the scheme and in the organisation. 'Fairness' means the scheme is designed and administered so as to ensure that everyone is eligible, is covered, is able to navigate the processes, is able to benefit from the treatment and entitlements, and receives optimal outcomes from the services. This notion of 'fairness' is aligned with that of the New Zealand Human Rights Commission: *"to achieve genuine equality it may be necessary to treat people differently, if treating them the same will simply perpetuate existing differences. **The point of special measures is to ensure equal outcomes rather than simply equal treatment.**"*¹

2) **Choice**

As part of the desire for self-determination, Māori value choice, but only if the various options are all perceived to be 'fair'. This means that the system, regardless of structure, must incorporate:

- universal coverage and retention of the no fault aspects
- a requirement for all providers and insurers to provide an equitable level of service for Māori **and** to achieve equitable outcomes
- participation of Māori as well as non-Māori organisations (including facilitation for Māori organisation to become involved)

- fairness with respect to levies and services for Māori
- support for Māori (and other) organisations to offer culturally appropriate services.

3) Improvement of services

Māori experiences of care in relation to ACC are dependent upon Māori experiences with the rest of the health system. ACC services are delivered through the larger New Zealand healthcare system and are therefore subject to the same disparities. For example, research has documented that Māori experience lesser outcomes from their GPs: less access, less care, and more barriers. The same is true in most areas of health: hospitalisations, obstetric care, psychiatric services, surgical procedures, oral health, and so on. All of these findings have effects on Māori access to and utilisation of ACC services. Similarly, the mainstream healthcare system, including ACC, is often poorly aligned with Māori views of health and well-being; a more holistic approach would better suit many Māori and reduce the barriers they experience.

4) Kaupapa Māori

Many Māori desire more culturally appropriate services and processes from ACC. However, the specific form(s) that these services and processes might take remains to be determined. This study did not seek comments on particular examples of “Māori programmes” nor did we undertake a ‘kaupapa Māori’ analysis of personal injury insurance. More research and consultation is required to determine the best, most appropriate ways for ACC (or its successor) to proceed.

5) Consultation and communication

To be considered credible by Māori, any proposed change to the scheme will require robust and transparent consultation with, and integration of advice from, the Māori community. Once agreed upon, changes to the scheme will need to be presented via communications targeted at Māori. The literature demonstrates that this will ensure that all groups within New Zealand society are familiar with the revised scheme. Furthermore, good communication skills and cultural competence are a requirement for all health professionals in New Zealand, and this is consistent with expectations from Māori for a health system that is more responsive to their needs.

2.0 Setting the Scene

2.1 State of Māori Health

Māori have the poorest health of any group in New Zealand. Māori do not access ACC entitlements as fully as other groups.^{2,3} This is hardly surprising, as there is extensive evidence in the literature that the health system disadvantages Māori at nearly every level.^{4,5,6,7}

Māori have a higher mortality rate than non-Māori as well as higher rates of illness. Māori infants die more frequently from SIDS and low birth weight than non-Māori children. Māori women have rates of breast, cervical, and lung cancer that are several times those of non-Māori women. Avoidable death rates are almost double for Māori than other New Zealanders, and Māori die, on average, 8-10 years earlier.

These disparities in overall Māori health persist even when compounding factors such as poverty; education and location are eliminated, demonstrating that culture is an independent determinant of health status.

Nor are these disparities solely the result of 'personal choices' such as diet, smoking, or medication adherence; the health care system bears a significant responsibility for them as well. For example, Hill et al⁸ found that Māori New Zealanders with colon cancer were not only less likely to receive chemotherapy but also experienced lower quality care than non-Māori patients. Crengle noted that only 9.5% of Māori patients, who were newly diagnosed with respiratory disease received a prescription for an appropriate drug, compared to 77.8% of non-Māori in the same situation and concluded that "several findings raised questions about quality of care".

Diabetes and cardiovascular disease are more common in the Māori population, and so "higher rates of lipid and glucose blood test investigations would be expected in Māori. However rates of requesting lipid and glucose blood tests were lower for Māori."⁹ In other words, although it would be reasonable for Māori to receive higher rates of tests and longer consultations because of their burden of disease, the reverse is actually true. This has nothing to do with patient behaviour or choice, but demonstrates how the health care system is not properly serving Māori.

The quantitative research provided by DoL confirms differences between Māori and non-Māori with respect to ACC claim rates, claim duration and treatments, indicating that **ACC follows the same pattern** as the rest of the health care system in disadvantaging Māori.

In summary, Māori are sicker for longer periods of their shorter lives, and yet they have less access to health services and receive lower quality of care when they do get it.

2.2 Structure of the Report

Themes are drawn from the discussions, interviews and conversations held over the course of this project. These are supported by relevant citations from both the New Zealand health research corpus, and the international literature. Evidence from ACC and the DoL is also quoted. Insights reflect MOA analysis of the findings and the literature and are intended to assist in identifying a path forward.

Supplemental information appears in Appendices following the current study's findings.

2.3 Themes

1) *Fairness*

The system must achieve fair outcomes for Māori and all New Zealanders.

Key evidence and discussion

Māori respondents were virtually unanimous on the need for an accident insurance scheme, on the benefits of a compulsory, no fault programme, and on the value of straightforward, automatic

claims processes and treatment of acute injuries. Furthermore, Māori clearly valued the scheme, particularly in areas like the Far North where rurality and isolation are major issues for the community, along with high levels of unemployment or transient employment. Māori appreciate that in the absence of such a scheme, many in the community would have no recourse if they were injured.

Māori value a scheme which is fair to all. The fairness principle is consistent with the Māori *tikanga* (code, rule, custom, habit) of *tika* (fair, just, straight, true). Given past and current disparities, it is not surprising that Māori feel a need to call for fairness in the system, as historically – and despite Treaty promises – Māori have had little experience in receiving fair treatment from public services and systems, including healthcare.

Note that 'fair' does not mean 'same'. 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 requires that attention be paid to the physical, emotional, spiritual, social, and cultural needs of its target populations. Māori in the current study were explicit in their belief that the ACC (in whatever future form it takes) must address their needs and achieve equitable outcomes for Māori in order to be 'fair'.

A DoL review of ACC quantitative data shows that the current system delivers some unfair results and some unexplained variation:

- Māori represent 11.55% of all claims (whilst constituting 14.6% of the population at Census 2006)
- Māori have lower than proportional claims in the earners account (9.47% of all claims in the earners account, yet 11.47% of the workforce)
- Māori have disproportionately low rates of social and vocational rehabilitation services (6.64% of all claims with other entitlements).

The DoL report notes that "Māori do not appear to access the scheme as much as non-Māori, especially for more 'minor' injuries. When Māori do access the scheme, they are likely to receive less social and vocational rehabilitation services and have a shorter claim duration" and postulates that the reasons for the differential access may be related to barriers to access, knowledge of entitlements, and different claiming behaviours such as Māori not claiming for minor injuries.¹⁰

Māori overall are uncertain of the services and benefits to which they are entitled, demonstrating the need for more tailored communications for Māori. There is evidence that when programmes to improve health are focused 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.^{11,12,13} Tailored communication is preferable when attempting new public health initiatives, along with other potential strategies designed to improve outcomes,^{14, 15} and thus should be part of any strategy to change or improve ACC.

Marck notes that, "a significant number of New Zealanders are significantly underinsured or not insured at all. This group includes young people, certain ethnic groups, and the rural community."¹⁶ Many respondents in this study contended that unless the ACC scheme is compulsory, many Māori (and particularly those with limited income) will opt to spend their money elsewhere, leaving themselves vulnerable in the event of an injury or accident.

This attitude is common to a number of countries, as demonstrated by a study by Keckley et al, which found that many people, regardless of nationality, support the notion of compulsory, no fault coverage.¹⁷ Enthusiasm comes from several considerations, including the unpredictability of trauma and the belief that it is an aspect of the social contract to provide care to those who might otherwise not be able to afford it. This last is an expression of the Māori belief, *manaakitanga*.

Insights

- Any system (improvements to current or new) must retain the compulsory and no fault aspects
- Any system (improvements to current or new) must incorporate requirements to verify that service provision and outcomes are equitable

2) Choice

All choices must be fair and open.

Key evidence and discussion

A major driver in Māori interest in 'choice' or 'competition' is the assumption that any new system will be required to incorporate a greater role for Māori providers as well as a greater appreciation of Māori beliefs and tikanga.

Māori interest in competition (a.k.a. 'choice') is entirely contingent upon Māori organisations being significant players in offering these potential choices. The major motivation for competition in this community is to achieve a system more in tune with Māori needs and values, along with a wish for lower costs and more efficiency.

Māori view cultural competency and, where possible, cultural concordance as being of great importance. The possibility of a new system which will be aligned with Māori tikanga, rather than being seen to, at best, shoehorn it in on the edges, is very appealing to many within the community. Evidence from international research suggests that any new system that does *not* incorporate such concepts will be unlikely to improve the situation and, in fact, may well worsen existing disparities.^{18,19}

By contrast, scepticism for the idea of competition is based on concerns that a mainstream service will never be able to authentically incorporate Māori values, and that the new system will therefore serve Māori no better than the current system, and possibly quite a bit worse. Many feel change will lead to confusion, profiteering, further decreases in access to and quality of services, disregard or exploitation of Māori interests, and increased costs. A sizable group of respondents indicated their preference that efforts be directed towards improving the current ACC, rather than developing a new competitive system which is unproven and undefined.

Whilst respondents were eager to see Māori providers having a larger role in a new system, they also realise that many Māori will still, by necessity or preference, receive their care from a mainstream provider. For this reason, it is important to note that inclusion of Māori providers will not relieve mainstream providers of their obligation to offer culturally competent care nor to document equitable outcomes.

The "choice" process will also require transparency, with rules around which providers or organisations can participate and how choices can be offered. This is critical to ensure both that, consumers will be able to make an informed choice and that smaller providers are not disadvantaged. It will also be important to have regulations which prevent providers from refusing coverage to certain groups (i.e. cherry picking). Choice must remain with the consumer, not the provider.

Both proponents and opponents of competition voiced concerns that changes could, regardless of intentions, widen the cracks in the system through which Māori already fall at a disproportionately high rate.^{20,21} The Māori community is well versed in well-meaning initiatives that don't end up benefiting the underserved, such as New Zealand's 1980's public health campaigns to reduce smoking rates. As a result, Māori are understandably wary of new initiatives that might interfere with parts of the healthcare system that currently work well for them, such as the no fault,

universal coverage and (reasonably) automatic claim process. There is similar concern in international settings around privatisation of existing public services leading to negative outcomes for underserved populations.²²

Insights

- Any new system must incorporate a greater role for Māori providers.
- Any new system must incorporate a greater appreciation of Māori beliefs and tikanga.
- Providers must demonstrate that they offer culturally competent care.
- Choice must remain with the consumer, not the provider.

3) Improvement of Services

Disparities must be addressed within both the larger healthcare system and ACC.

Key evidence and discussion

The participants in the current research are aware that Māori aren't as well served by ACC as non-Māori, and this impacts upon their likelihood to file a claim. Negative Māori experiences with ACC²³ as well as services that are not aligned with Māori values and limited knowledge of the claims process all contribute to reduced access by Māori to full ACC entitlements and services. This in turn leads to frustration with the current system and a desire for improvement.

Respondents made it clear that ACC has not provided adequate information about entitlements and claim processes. This in turn hinders access by reducing ACC's perceived value within the community as well as making it less likely for people to pursue the correct pathway to obtaining ACC services. This can become a vicious cycle, where recognition of the lesser service results in less motivation to file claims, which results in further diminished services, which lead to further perceptions of lack of care, and so on. The international literature demonstrates widespread unequal access to health care services and resulting disparities for minority and indigenous groups.^{24,25,26,27,28,29,30,31}

The literature also shows that mainstream society often underestimates these disparities. For example, Diggs and Berger asked white, black, and Hispanic Americans about their views of healthcare disparities.³² Whites were more likely to view the system as fair, with equal outcomes for all, while blacks viewed the system as disadvantaging them, and Hispanics were somewhere in the middle. Actual outcomes data showed that black respondents most accurately described the realities of the American medical system. This difference in perceptions can compound the issue, when mainstream organisations and communities dispute the underserved group's accurate assessment of the situation; expressions of disbelief can make the underserved populations even less likely to seek help from mainstream providers.

Māori reported dissatisfaction with ACC, particularly around ACC staff and processes, which are perceived as slow and cumbersome and not attuned to Māori values. Dissatisfaction is more evident when considering medium term issues such as weekly compensation. Blanchard and Lurie confirm that negative perceptions influences health care utilisation and can contribute to disparities.³³

Negative interactions with the health care system can also lead to decreased likelihood of engaging with the system. Taylor has demonstrated the importance of cultural competency as a means to mitigate health care disparities,^{34,35} and this concept underpins New Zealand's Health Practitioners Competence Assurance Act.

This Act requires registered health providers in New Zealand to demonstrate cultural competency, clinical competency and ethical behaviour and is founded in research that suggests that training providers in cultural competency and communication can minimise misunderstanding and barriers

to healthcare services.^{36,37} Respondents in the current study clearly wanted ACC to have a more culturally competent staff and also voiced their dissatisfaction with the communication skills of many ACC staff and providers. It was clear that these aspects created barriers for respondents, who felt that ACC staff were unresponsive to their needs and unaware of issues (such as Māori concepts of health) which were important to them.

This study also uncovers an appreciation from Māori that ACC is there to assist everyone after an injury. This positive view reflects the ease of claim lodgement, the ease of access for acute treatment of injuries, and support for those with serious injuries.

The international literature confirms that protocol driven processes providing little scope for individual variation or interpretation are associated with fewer disparities. For example, emergency departments often deliver care based on best practice guidelines and protocols. Tsai and Camargo demonstrated that patients with chronic pulmonary disease received equivalent levels of medical care in the emergency department, despite patients' racial and ethnic differences.³⁸ By contrast, general practice is less likely to use protocol driven care, and Crengle showed significant variation in New Zealand GPs' treatment of Māori and non-Māori patients.³⁹ As respondents' comments showed, ACC's routine and seamless processes are perceived to work well for Māori.

Because all ACC services are not delivered separately from the rest of the health care system, the existing disparities within the larger system also impact on ACC outcomes. It is important, therefore, for ACC (or its successor(s)) to work to improve outcomes across the sector as well as within its own infrastructure.

Another area where improvement is needed is into ACC levies. Despite the availability of some public information,⁴⁰ these are poorly understood, with many respondents desiring a better understanding of them. Many felt they are not given enough information about how their money is being spent and what value they are receiving from their payments. Others wanted programs that reduced levies in exchange for use of good practices. This idea has been supported by other groups and has been implemented in places: "Programmes offering a reduction in ACC levies in exchange for evidence of health and safety systems and processes (such as the Partnership Programme, Workplace Safety Management Programme and Workplace Safety Discounts) were seen by a number of stakeholders as being a key mechanism in affecting change in businesses."⁴¹ However, the existence of such programs did not appear to be widely recognised or understood. Such dissatisfaction with perceived 'value for money' is not unique to Māori levy payers, nor even to New Zealanders in general. A Deloitte study across several countries demonstrated a similar lack of familiarity with health systems, regardless of nationality or health system structure.⁴²

Insights

- Entitlements and claim processes must be made easier and more understandable
- Staff and providers must receive improved training in cultural competency and communication to minimise misunderstandings and barriers to services
- ACC levies must be more fully explained and justified
- ACC (or its successor) must partner with the larger healthcare system to improve disparities.

4) Kaupapa Māori

Māori world views and values must be included and respected in the design and delivery of ACC services.

Key evidence and discussion

Many participants stated that ACC is not aligned with Māori views of health and wellness and this makes it less valued by many Māori. Māori have repeatedly emphasised the importance of retaining their cultural heritage and utilising services that respect and reinforce those values. The resurgence of Māori language, development of kura kaupapa schools and the popularity of Māori

radio and television demonstrate the high regard Māori have for their cultural heritage. Similarly, cultural competence in their healthcare services is critical to many Māori. Professor Mason Durie describes cultural competency, including familiarity with the *Te Whare Tapa Wha* model of Māori health, as a means to reduce health inequalities⁴³, yet the respondents' experiences with ACC indicated that cultural competency initiatives had often not filtered down to frontline staff or were perceived to be unimportant to them.

Māori providers do not feel fully utilised or respected by ACC; for example, rongoā services and wraparound or integrated services, though well established in the health sector, are not utilised by ACC. As described above, many Māori maintain high levels of interest in traditional Māori culture, including traditional Māori medicine. This interest in rongoā and traditional medicines is readily apparent on Māori websites⁴⁴. Many Māori told us that ACC's perceived rejection of such practices is viewed as another example of ACC's non-Māori focus. In addition to the issue of disrespect and non-alignment with Māori preferences, there is also evidence in the literature that such approaches contribute to reduced outcomes. Dresang looked at Cuba's health system and noted that "Community-oriented primary care and complementary and alternative medicine are well developed within the Cuban medical system" and were felt to play a role in the excellent outcomes observed.⁴⁵

There is an overall sense that ACC processes are not attuned with Māori needs (e.g. amount of required paperwork, lack of face to face communication, frequent staff turnover/case reassignment, etc). Respondents described at some length how the lack of concordance between Māori preferences and abilities (including such things as literacy levels) and ACC processes creates barriers for the Māori community. ACC and DoL reports confirm that Māori claim rates are less than non-Māori. This position is supported by research findings and reports, such as that by Singleton and Krause, who describe the importance of understanding cultural and literacy barriers when providing health care.⁴⁶ Additional work from overseas and within New Zealand similarly emphasise the importance of clear communication and continuity of care.^{47,48,49,50} Crow, for example, documented that a provider's communication skills are more important to patient satisfaction than virtually any other issue.⁵¹

Insights

- Any new or improved system must reflect Māori views of health and wellness, not just focus on physical injury
- Any new or improved system must include Māori providers and a kaupapa Māori approach to claims and services.

5) Consultation and Communication

In the absence of genuine interaction and co-development with the Māori community, no changes to ACC will be successful.

Key evidence and discussion

For changes to the ACC to be considered credible by Māori, appropriate consultation methodologies must be employed. In the absence of a rigorous and genuine consultation process, it is unlikely that any substantive improvements can be made, and respondents' concerns about the inability of a mainstream organisation to incorporate Māori values will be proven accurate.

The change process should begin with a more detailed consultation into current Māori opinions around ACC, in order to determine if any changes are in fact desired. If indeed such is the case (as the current research would suggest) then consultation around the form these changes might take will be required, and advice from the process integrated into any potential plan.

Indigenous research methodologies must be employed, such as those described by Drs Russell Bishop,⁵² Linda Tuhiwai Smith,⁵³ and Leonie Pihama.⁵⁴ Once agreed upon, changes to the scheme

will need to be presented via targeted communication to the community, as this has been proven most effective in sharing information, raising awareness, and minimising disparities.

Insight

- Any new or improved system can only be credible if it is achieved through a robust and transparent consultative process using indigenous methodologies.

2.4 Data and methodology considerations

The sample of Māori voices in this study has been drawn from settings and locations that have an overtly Māori character. We focussed recruitment efforts on areas and institutions with an increased proportion of Māori and a strong Māori identity, such as Māori educational institutions (e.g. kōhanga reo, Māori immersion programmes) and Māori provider organisations and businesses (e.g. Māori broadcasting and television). While Māori society includes people with varying degrees of affiliation, our informants are likely skewed towards those with higher degrees of association with Māori culture and stronger expressions of Māori identity. In our opinion, this is not a significant limitation, as we make no attempt to provide a single 'Māori view' or consensus position on behalf of the entire community.

This study does not capture Māori reactions to any particular change, proposed change, or any other specific option for the ACC scheme or the ACC organisation. We have reported both the range of views and the predominant themes expressed by respondents and compared these themes with findings from other research on Māori experiences of health and related services, as well as international literature into indigenous health and unequal levels of care.

In our conversations, we did not describe any new options for ACC. This may have led to the overreporting of dissatisfaction with the current ACC and overenthusiasm for change, as people were put in the position of comparing a very real, and somewhat lacking, organisation with an imaginary, utopian ideal.

Lastly, with regards to the quantitative data analysis provided to this study by the DoL, it is worth noting some of the difficulties inherent with the raw data. Issues with ethnicity data collection are numerous. Different organisations use different methods of collecting ethnicity information, so the DoL, MoH, ACC and census data sets are not directly comparable. In fact, ACC ethnicity data collection methods differ depending on the type of claim. As a result, the current work was developed to elicit qualitative responses from a known subset of the Māori community and to compliment quantitative work undertaken by the DoL.

3.0 Narrative

Māori in Aotearoa are well aware of the historical inequities in our nation. Māori are also familiar with the data which shows that they currently experience the worst health of any group in the country; in other words, that the health care system still does not meet their needs – in access to care, in quality of care, and most importantly, in health outcomes. Māori see their whānau die earlier (on average 8-10 years earlier), become ill at earlier ages, and suffer from more complications, including medical errors.

The no fault, compulsory nature of the ACC scheme is one of the aspects which works relatively well for Māori. Research documents that automatic, protocol-driven systems tend to show fewer disparities than systems that depend upon personal initiative or discretion, whether that belongs to the provider or the patient. For example, GPs order fewer tests for Māori patients, despite Māori being sicker and therefore intuitively needing more tests. GPs also refer Māori to specialists at lower rates, and there are similar disparities in care by specialists. International research shows that, even when protocols exist to standardise care, providers often misapply the rules and guidelines, re-establishing historic disparities.

Māori are understandably wary about new initiatives, particularly those which tamper with the parts of the medical system that are less inequitable. However, there also aspects of the ACC which are not working for Māori and which the community is anxious to see improved. The participation of Māori providers, for one, is felt to be unacceptably low. The ACC's approach to injury is also felt to be misaligned with Māori holistic approaches to health and general wellbeing, and instead focuses purely on the physical aspects of an injury. Māori would prefer a system more in tune with their beliefs and one which facilitates their engagement, through more user-friendly, face to face, and culturally competent processes and staff. They hope that changes in these areas will correct the disproportionately low claim rates by Māori and improve overall outcomes.

4.0 Research Report

4.1 Background

Mauri Ora Associates was contracted to undertake qualitative research to inform the Stock-take of ACC Accounts that is currently being undertaken. Specifically, the research aimed to examine the experiences that Māori claimants, levy payers, businesses and providers have of both the ACC Scheme and the ACC organisation.

Our research was substantively qualitative in methodology but draws upon other information sources (e.g., previously published research, ACC documentation) as well as citing a complementary quantitative analysis which was undertaken by the Department of Labour (see Results and Analysis below).

Specifically, we were asked to examine the relationships Māori have with ACC at both the Scheme and organisational levels and the impact of these relationships on Māori, as well as the range of these relationships by viewing Māori broadly (as claimants, business owners, levy payers, Treaty partners and Iwi Mana Whenua). We were asked to construct a narrative about the Māori experience of ACC and give an overall picture of how changes to the ACC Scheme could affect Māori.

The specific research questions we were asked to address were as follows (numbers in brackets refer to the number of the equivalent question on our questionnaire):

1.0 Māori claimants

- 1.1 Is ACC's design able to be as easily accessed by Māori as compared to non-Māori (access in this case refers to claim initiation, subsequent treatment, rehabilitation and entitlements)? [2.1, 2.2]
- 1.2 What is the current situation regarding Māori access of ACC. Do Māori show any difference in access rates? If so, what possible reasons are there? [This question was addressed through the quantitative research arm]
- 1.3 What is the experience of Māori in initiating access to ACC? What barriers to initial access exist for Māori? [2.5, 2.6]
- 1.4 What is the experience of Māori in relation to treatment, rehabilitation, and weekly compensation? [2.7, 2.8, 2.9]
- 1.5 Do Māori experience any difference in claim duration, treatment duration, or completion as compared to non-Māori? [This question was addressed through the quantitative research arm]
- 1.6 What aspects of ACC work well for Māori claimants? [2.10]
- 1.7 Does the current structure of the ACC Scheme allow for appropriate services to be offered to Māori? [2.12]
- 1.8 What alternative structures would allow for appropriate services for Māori claimants, including improved access? [2.13, 2.14]
- 1.9 What would Māori claimants change about ACC? [2.15]
- 1.10 What would Māori claimants' preferred relationship with ACC be? [This question was not asked explicitly due to concerns that it was difficult to understand and therefore difficult to answer]
- 1.11 Do Māori experience poorer rehabilitation outcomes? If so, what are the possible reasons for this? [This question was addressed through the quantitative research arm]
- 1.12 Do Māori claimants have different needs from non-Māori, and if so, what are they? [2.17]

- 1.13 Are the needs of seriously injured Māori claimants well met? How could these needs be better met and what type of structures could better deliver services to meet those needs? [2.18, 2.19, 2.20]
- 2.0 Māori levy payers (business owners / employers/ employees)**
 - 2.1 Does the ACC Scheme represent good value for Māori levy payers? If not, what alternative structures could improve this proposition? [3.1]
 - 2.2 Are the needs of Māori levy payers well met by the current structure of the Scheme? Could alternative structures improve the situation and if so, what would those structures be? [3.2, 3.3]
 - 2.3 Is the current system of levy payment efficient for Māori levy payers? What is the likely effect of alternative structures on this process? [3.6, 3.7]
 - 2.4 What would Māori levy payers change about ACC if they could? [3.10]
 - 2.5 What would Māori levy payers' preferred relationship with ACC be? [3.11]
- 3.0 Māori providers (treatment, rehabilitation, and claims management)**
 - 3.1 What would Māori providers change about ACC if they could? [4.2]
 - 3.2 Are the interests of Māori providers well served by the current structure? [4.1]
 - 3.3 How would Māori providers prefer to function within the ACC Scheme? [4.3]
 - 3.4 What would Māori providers' preferred relationship with ACC be? [4.4]
 - 3.5 What opportunities exist for Māori providers under the ACC Scheme or under potential future structures? [4.6]
 - 3.6 How could changes in the way Māori providers are used within the Scheme benefit Māori claimants? [4.7]
- 4.0 Other questions**
 - 4.1 Do participants distinguish between the ACC organisation and the ACC Scheme? What is the nature of this distinction and what does it tell us about the relationship Māori have with both of these? [1.2, 1.6]
 - 4.2 What is the view of Māori on the 'no fault' aspects of ACC? How does this aspect of the Scheme benefit or hinder Māori and what alternatives, such as recourse to the courts, are viable for Māori? [1.3, 1.4, the last question was not asked explicitly in accordance with advice from the DoC research manager as its language may be too complex and potentially confusing]
 - 4.3 How does the existing ACC Scheme serve the needs of Māori wellbeing? Specifically: [1.5]
 - taha wairua (spiritual wellbeing)
 - taha tinana (physical wellbeing)
 - taha hinengaro (emotional wellbeing)
 - taha whānau (family and community wellbeing).
 - 4.4 Would an alternative structure serve these wellbeing needs better, and if so, what might that look like? [1.7, 1.8]

Further, we were asked to ensure that we spoke with a variety of informants via individual interviews, focus groups, or combinations thereof, including the following populations:

- Māori claimants from each of the ACC Accounts, as well as self employed people
- Māori seriously injured claimants
- Māori levy payers including Māori business owners/operators
- Māori treatment and rehabilitation service providers
- Māori providers of other relevant services e.g., home help

- Māori public health or development researchers.

Lastly, we were asked to integrate information from other sources as appropriate in order to provide additional context and robustness to the current work.

4.2 Methods

Upon awarding of the contract, Mauri Ora Associates developed a questionnaire (see Appendix One) based on the specific research questions delineated above. It was reviewed and approved, following minor revisions, by the funder. The questionnaire had several sections and could be filled out electronically or manually.

The questionnaire opened with a universal section that was intended for all informants. Separate sections then existed for claimants, levy payers, and treatment providers, before finishing with a second universal section that was asked of everyone. Informants self-reported their appropriate category or categories and were then queried with the relevant section. It was possible for a single informant to meet more than one category, for example a levy payer could also be a claimant.

After the questionnaire was completed, the interviewers (see Appendix Two) were trained in its use as well as provided with a historical overview of the ACC Scheme and Organisation. The interviewers were experienced in both interviewing techniques and Māori health research and had extensive networks within Te ao Māori, in addition to those of MOA.

Following consultation with the funder, the following areas were identified for informant recruitment: Nelson, Auckland, Whangarei and Kaitia. Informants were then recruited in a variety of ways. Because this project was specifically concerned with the views of Māori, we utilised methods of recruitment that are common within te ao Māori. Specifically, we utilised our database and networks to locate marae and Māori health providers within the interview regions. We also located local kura kaupapa schools (schools operating under Māori custom and using Māori as the medium of instruction). Māori business owners were identified in the regions we were interviewing from the following websites:

<http://whakapapa.Māori.org.nz/directories.asp>
<http://www.southernMāori.business.org.nz/>
<http://www.whakatuMāori.biz.co.nz/index.php>
<http://www.mbpa.co.nz/index.asp>
<http://www.Māori.businessdirectory.co.nz/>

MOA staff and the two consultants also contacted people in the areas who are known to them personally.

Due to the timeline we contacted the above via email initially, with the consultants telephoning as a follow up.

Consistent with Māori cultural preferences for kanohi ki te kanohi, we sought face to face contact wherever possible. Additionally and due in part to the limited time frame for this project as well as to the convenience and preference of some Māori for telephone communication, a total of 8 interviews were conducted remotely.

To ensure that respondents reflected the breadth of contemporary Māori society, we sought as wide a breadth of respondents as possible, ranging from parents at the kura kaupapa schools, to self-employed business people, to Māori health providers to non-earners to kaumātua to those with serious injuries (past or present). We requested assistance from the schools and health providers as well as our personal acquaintances in soliciting respondents from this wide variety of backgrounds.

The study was consistent with kaupapa Māori research guidelines^{55,56}: respondents were provided with information sheets in Māori and English⁵⁷ and were given the opportunity to answer our questions in either te reo Māori or English; interviewers began and ended sessions with appropriate

greetings and introductions, koha were provided to acknowledge the time and contribution of the respondents.

Interviewing was done over a period of 13 days on the following schedule (includes telephone and face to face interviews):

15 th March	16 th March	17 th March	18 th March	19 th March
Interview planning and telephone interviews	Auckland	Auckland	Auckland	Auckland
22 nd March	23 rd March	24 th March	25 th March	26 th March
Auckland & Nelson	Auckland & Nelson	Auckland	Waiheke & Central Auckland	Auckland
29 th March	30 th March	31 st March	1 st April	Easter Friday
Kaitaia	Kaikohe	Whangarei	Telephone interviews and wrap interviews	

Individual interviews were sought wherever possible (and a slightly higher koha provided). In total, 29 interviews were conducted in a one on one fashion, 22 were conducted in small groups (maximum of 3 people), and 4 or more hui (58 people) were held.

The following table documents where each of these took place.

Regions	Number of Interviewees by Region		
	One on One	Small Group	Hui
Nelson	1	2	8
Auckland	21	15	24
Whangarei & Kaikohe	5	0	16
Kaitaia	2	5	10
	29	22	58

A digital recorder was used to document all interviews, as well as contemporaneous note taking (electronic and/or handwritten). Written summaries by the interviewers were completed daily to identify major themes from the day's informants as well as to highlight similarities and differences across days and sites. Random audits of the digital recordings were carried out to confirm that the daily summaries accurately reflected the conversations that occurred and presented informants' opinions without revision or undue interpretation.

Following the interviewing process, data was analysed through examination of the daily summaries, contemporaneous notes, questionnaire responses, and digital recordings. A preliminary report was crafted from the responses and major themes identified. The interviewers were then asked to review the document to ensure that the informants' opinions were accurately captured. This preliminary report was forwarded to the funder on 16th April 2010 for initial review. (See Appendix Three)

Following receipt of the quantitative data mentioned above, the research team met with the DoL Research Manager to facilitate integration of the two research themes. The current report was then drafted.

4.3 Limitations

It is worth noting that while some of the interviews were conducted one on one and therefore could be considered somewhat confidential in nature, others were held in a public setting and tend to

reflect consensus opinions rather than individual ones. This is in keeping with the kaupapa Māori approach specifically sought by the funder, along with the preferences of the informants.

Our efforts to reach out to Māori exclusively in this study caused us to focus recruitment efforts at those areas and institutions with an increased proportion of Māori and a strong Māori identity, and included Māori educational institutions (such as kōhanga reo, Māori immersion), Māori businesses (such as Māori broadcasting and television). The research design also called for soliciting views from Māori health provider organisations. This in turn suggests that while Māori society includes people with varying degrees of affiliation (or assimilation), our informants may be skewed towards those with higher degrees of association with Māori culture. This is tempered by the fact that our respondents universally chose to answer our questions in English, rather than te reo Māori.

Wording of survey questions is always challenging as different words can convey very different messages. In the current work, we sought to make our questions easily understandable while retaining a word choice which was as neutral as possible. We also wished to avoid unnecessary repetition and provide a logical flow of ideas. Towards this end, we reorganised the order of the questions provided to us and reworded some to better capture the essential issue and avoid unwanted connotations (both positive and negative).

With regard to satisfaction with a particular, extant service, it is unsurprising to hear many stories of difficulties people have encountered. Similarly, when conceiving a new service, many people will automatically view it favourably in comparison to the old, particularly when the details of the new service are not defined, so there is little available to question or criticise. By contrast, the existing service has a great deal known about it, and it often seems that the experiences of dissatisfied customers are shared more widely than those of satisfied customers. Existing institutions can therefore be at something of a disadvantage when compared with a new, largely theoretical proposal that each person can envision through his or her own (often rose-colored) lens.

This study does not capture Māori reactions to any particular change, proposed change, or any specific options for the ACC scheme or the ACC organisation.

4.4 Results

The following section reveals the opinions of the study respondents, arranged in the same way as the questionnaire. Each question is described, with selected quotes to reflect the informants' viewpoints, and supporting (or opposing) research from the literature to enable appreciation of the larger context.

1.0 Opening Questions (all respondents)

1.1 Would you prefer to answer my questions in te reo Māori or English?

All of the respondents preferred to answer the survey questions in English. This is perhaps unsurprising given that only 24%^{58,59} of Māori self-report fluency in te reo Māori.

1.2 ACC covers the treatment of personal injury caused by an accident, no matter who was at fault in the accident. Do you think this is a good thing?

There was nearly universal support for the ACC scheme across the three categories (claimant, levy payer, treatment provider), though in each, there were concerns that 'criminals' were getting care.

The scheme was particularly viewed as a good thing in the Far North where rurality and isolation are major issues, where there is a high proportion of unemployment and transient or seasonal employment (i.e. fruit picking) and many are in low socio-economic circumstances. The feeling was that at least there is something for these people if they are injured accidentally.

<i>ACC is a "super scheme" because it ensures that everyone is covered, regardless of socioeconomic status or background</i>	<i>DUI cases shouldn't get ACC and criminals should be accepted [from ACC services].</i>	<i>You never know when an accident can happen. It's nice to know [ACC is there].</i>
<i>Even if it is hard to regulate payments, we don't agree [with a system] where criminals are</i>	<i>It keeps families safe and helps to keep money coming in to the household if you're unable to work.</i>	<i>If you didn't have it, you'd be stuffed. You'd only have sick days. I wouldn't like to</i>

<i>receiving entitlements and victims do not</i>		<i>see it [ACC] disappear.</i>
<i>[ACC is] good as Māori won't get personal insurance.</i>	<i>If you commit a criminal offence and injure yourself, it shouldn't be covered</i>	<i>It makes treatment affordable for people, especially in emergencies.</i>
<i>[ACC] provides peace of mind.</i>		

Claimants were slightly more supportive of the Scheme, while a few levy payers were less positive and some treatment providers were not enthusiastic about overseas visitors being covered.

<i>[Non-emergency ACC cover] should be for people residing in NZ. Cover to overseas people is no good, because they're not taxpayers in NZ, so [their care] increases costs to New Zealanders.</i>	<i>[ACC] allows all claims to be covered. Private healthcare would be a barrier.</i>	<i>[ACC is an] imperfect Scheme but it's what we're used to.</i>
<i>The ACC scheme from a provider perspective adds value to Hauora Provider service delivery for our registered clients</i>	<i>[It's important that we have ACC as] some sort of cover for people without insurance.</i>	<i>It means everyone gets basic cover.</i>

1.3 What is your view of the 'no fault' aspects of ACC?

Unsurprisingly, claimants were strongly positive of the 'no fault' aspect, as some of them were likely to have benefited from it. Levy payers once again raised concerns about covering overseas visitors and also mentioned accountability as important, but they too were generally positive about it. Treatment providers were also very supportive of the 'no fault' aspect, though a few felt it prevented people from taking responsibility for their actions, and others were concerned that the present scheme fosters dependency.

<i>[ACC is good] because it's not about blame; when people have an injury they need to be cared for regardless of fault.</i>	<i>It's a good thing, the most human thing we can do for each other.</i>	<i>Anyone who's injured should be able to get treatment.</i>
<i>As a levy payer, I object to tourists not being required to make payments to ACC but being covered anyway. If they have an accident in NZ seems unfair to NZ [for us to pay for their care].</i>	<i>There's a need for insurance in NZ to cover injuries. Too many people are now taking advantage [of ACC], e.g. sports injuries. [People] should have some accountability... [ACC] fosters their dependency, people should take more responsibility – it makes rehab more difficult.</i>	<i>[No fault is] no good. People should take ownership. Stand up and take responsibility of their actions.</i>
<i>No fault doesn't bog you down</i>	<i>There would be problems if we had to justify our need to access [services].</i>	<i>[No fault aspect is good because it] stops lawyers, lawsuits, court cases.</i>
<i>It is good. If someone is hurt, family is most important and it's very stressful if the main earner is off work.</i>	<i>People that cause accidents should be liable for some of the costs. They shouldn't necessarily get cover if they are at fault</i>	<i>[No fault is] not okay if [the accident] is caused by stupidity.</i>
<i>We seem to be moving away from 'no fault'; it's very politically driven.</i>	<i>It's good that it's no fault as that keeps lawyers out of it</i>	<i>No fault is good because that's what we pay levies for.</i>

1.4 Does the 'no fault' aspect of the scheme benefit or hinder Māori?

Levy payers almost uniformly felt the 'no fault' aspect benefited Māori, and while the majority of claimants and treatment providers felt the same way, there was a minority in each group who felt it could hinder Māori.

<i>Benefits Māori because sometimes it's difficult to explain the situation and this way avoids the feeling of having to go cap in hand to feed the whānau. This, for me is a privacy</i>	<i>Shouldn't hinder Māori but probably does, as it doesn't encourage people to take necessary safety precautions in their lives</i>	<i>It probably helps Māori. Many Māori do not have the resources required to fund a process where blame had to be proven in order to claim</i>
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<i>issue.</i>		
<i>Benefits due to us being in lower socio economic [group].</i>	<i>Benefits because there's always people who can't afford cover but needs treatment</i>	<i>Benefits because everyone is covered</i>
<i>It both benefits and hinders. [Benefits], because if it's an accident they're still covered. [Hinders] because of the scrutiny applied and being made to feel like criminals. Māori don't pursue claims because they are hōhā.</i>	<i>Potentially benefits Māori because there is a disparate claiming rate for number of issues: knowledge, personal attitudinal beliefs, culturally whakamā, plus other systematic barriers. The "no fault" aspect is an enabler for access.</i>	<i>It doesn't hinder Māori but we're not accessing our entitlements</i>

1.5 How well does the existing ACC Scheme serve the needs of Māori wellbeing?

Most people in all of the groups answered "not well". There were some stories of good experiences (especially amongst claimants) but the majority felt that Māori wellbeing in particular was poorly understood and poorly served by ACC. In particular, many felt that 'there is no transparency built into scheme' around what people can claim for and what entitlements there are, with the result that implementation is largely based on individual case managers, many of whom are viewed as incompetent (culturally and otherwise) at best and racially biased at worst.

<i>I cared for [severely injured people] – their biggest needs were emotional health and well being but ACC did not support their emotional needs. This has a huge impact of whānau & carers. ACCs policy on Whare Tapu Wha not filtered down into practice.</i>	<i>Not very well. ACC is not looking at wider aspects of a person. Their focus is more on short-term injury. Many Māori are unaware of their entitlements. Literacy rates of Māori mean forms are incorrectly completed. This results in delays or no access.</i>	<i>Someone contacted their ACC case manager for assistance with self-care, was told to get her 16 yr old son to wash her himself - unacceptable. There is too much focus on the physical - actually need the holistic approach</i>
<i>Quite well, ACC offered to pay for transport to access my specialist</i>	<i>Not as many Māori use ACC as non-Māori because many can't afford the surcharge.</i>	<i>In many cases, access to ACC has only been the result of our advocacy services and our intervention</i>
<i>I have the perception that Māori access ACC less than non-Māori based on the number of claims made by the PHO's providers on behalf of clients.</i>	<i>No, ACC is focused only on the physical. It's detrimental to a person's emotional wellbeing having to justify that her injury is genuine</i>	<i>Not very well. Certain things are covered, some aren't: Māori practitioners e.g. mirimiri are not included.</i>
<i>Quite well in some respects. My case manager advised it was ok for me to move back home (to where I'm from) if I wanted. This was very special to me, to know I could go home and it would not be harmful to my case/situation. On the negative side, ACC stuffed up my medical certificates. I had to keep faxing, phoning, visiting ACC, and visiting my GP which was stressful & inconvenient. Eventually, I got through to someone who could help, after getting the run around & having to state how stressed I was becoming. Finally, I got some help. Many other Māori (or anyone) would have given up.</i>	<i>ACC assistance received by my whānau has been very good at improving their wellbeing. My whānau member's toddler was hit by a car and seriously injured, forevermore wheelchair bound. ACCs help provided financial support for the whānau. As the child grew so too did her needs & ACC continued to fund adaptations to the household which enabled her to be cared for by her whānau. The ability to also put kai on the table, a roof over their heads, helped the whānau's wellbeing greatly</i>	<i>ACC ignore the advice/opinion of a Māori practitioner about a claimant. If it's not what ACC want to hear, they'll send you to a non-Māori practitioner. This is a deliberate act on the part of ACC to withhold entitlements e.g. giving claimants their choice of practitioner. Theoretically the options are available but in reality there is no choice. Lack of communication is another big problem. I felt backed into a corner & returned to work early as a result</i>
<i>Not well - ACC is a 'faceless' organisation with too much reliance on email, internet, and telephone. They should set up support groups to provide info for those who are seriously injured because of time between appointments (surgery &</i>	<i>ACC the scheme is good in theory [for claimants] as all people can access the scheme, however dealing with the organisation itself has been difficult [comment from a treatment provider]</i>	

1.6 Is it a good thing that the ACC organisation is the only one to administer the ACC scheme of nationwide, compulsory personal injury insurance?

All groups shared negative stories about the ACC, most of which depicted it as a “faceless” organisation that relies too much on electronic forms of communication. But there was praise for the organisation as well, though some of it was cautious.

ACC has not been found to be culturally responsive. Despite having policies in place (e.g. Treaty of Waitangi, *Whānau Ora*) and pockets of goodwill throughout the organisation, this is not seen as having filtered through into practice within ACC nor within ACC’s preferred providers. Moreover, there seems to be no mechanism by which clients can ensure accountability for cultural responsiveness/ appropriateness in either ACC or its preferred providers

Several providers who had experienced the previous system, recalled the old days with a shudder, describing the multiple provider system as ‘terrible and cumbersome’. Most seemed to prefer the single, simple system, though some hoped that a new competitive system would be more attuned to Māori needs and more holistic in outlook. Levy payers were similarly split; some felt that competition would drive down levies, whilst others feared that more players in the market would simply increase administrative costs and increase confusion. Amongst claimants, there was a great deal of dissatisfaction with the current system, mixed with hope that a new system would bring improvements, but this was leavened by the opinions of a great many who preferred to ‘fix what we have’ and avoid the confusion that they felt a new system would bring.

<i>No, because ACC is not effectively managed and is government-controlled. There's no choice for people – many would prefer to choose a Māori organisation because a Māori organisation has 'dual accountabilities' - to the government & to the Māori people – this overcomes systemic racism.</i>	<i>From the cost point of view, No. There is no benchmark for what are appropriate levies. On the other hand, there are efficient administration costs when only one organisation involved. If there were other players, it would be complex to determine where to go, who to speak to & where the bill goes</i>	<i>No, we need competition, to take the power & the market monopoly away from ACC. There are opportunities for hapū, who understand the needs of their local whānau & communities, to move people forward. Need more support for hapū to support whānau better i.e. to provide a scheme/service that is holistic, sustainable & connected to the land. e.g. supporting collective vegetable gardens etc</i>
<i>Not sure - better the devil you know. May be messy if too many organisations.</i>	<i>Yes, a system like the US would be detrimental to lower socioeconomic [groups].</i>	<i>No, we need the ability to look into other options; choice is good</i>
<i>Yes, competition doesn't increase quality. Many Māori won't be able to afford care. Multiple players would be chasing the same dollars. [It would become like the] US market.</i>	<i>No, because they have the monopoly [and] because they are a mainstream organisation. If there's competition, there are often more benefits to Māori.</i>	<i>Yes, they're well known. Existing bureaucratic organisations tend to be more aligned to Māori values, meeting needs of Māori, and putting in place better accountabilities.</i>
<i>No, because they have a monopoly which doesn't give us options or lower fees</i>	<i>No, if other organisations became involved & these could be targeted to Māori that would be good</i>	<i>No, they need some opposition as it means ACC would have to lift their game, up-skill</i>
<i>Yes, consistency [is important].</i>	<i>Yes, one organisation [is best]. Many insurers was a nightmare!</i>	<i>ACC is the only option, which is good. Too many [choices] will confuse Māori.</i>
<i>Yes, less is best. It needs to be kept simple.</i>	<i>No, competition breeds better systems</i>	<i>Yes, one [organisation] is confusing enough</i>
<i>No, we need some competitors to see who can manage the scheme better, to decrease costs and improve efficiency.</i>	<i>No - dealing with the organisation has been difficult as there is no opportunity to speak with someone face to face. You are often referred to someone who</i>	<i>No, based on poor performance to date. (e.g. reducing claim disparities between Māori and non-Māori) as systems and structures</i>

	<i>lives out of town. The 0800 number is good but then you get passed around which is frustrating</i>	<i>don't encourage Māori claiming.</i>
<i>Yes, the majority of New Zealanders know about ACC & what they do</i>		

1.7 Would an alternative structure serve Māori better?

There was a great deal of uncertainty over what an alternative structure would look like, and therefore most felt unable to say whether Māori would be better served by an alternative structure. Most respondents did, however, feel comfortable discussing the shortcomings of the current system and sharing ideas of what an alternative structure might/should look like.

Most agreed that the current ACC meets claimants' physical needs reasonably well, but in terms of other aspects of Māori wellbeing (hinengaro, wairua, whānau), most felt that if these are met, it is usually as a coincidental by-product of the physical needs being met, i.e. weekly compensation to enable the whānau to have the essentials (kai, place to live etc), home modifications to enable the person to live and be cared for at home by whānau, reduced stress due to financial assistance available.

No one wanted the current system simply to 'carry on', but there was debate as to whether the ACC should (or could) simply change the way it does business so as to improve matters within the current system, as well as concern as to whether (and how) Māori would be consulted in any restructuring. There was great scepticism that, in the absence of effective consultation, any new structure could improve matters for Māori.

These preferences for a more culturally concordant form of care are supported by evidence from the literature, in which cultural competence and/or concordance are associated with better outcomes.^{60,61,62,63,64}

<i>Not sure</i>	<i>Not really thought about it</i>	<i>Only if reduced costs are passed onto Māori.</i>
<i>A Māori (ACC-type) organisation would focus more on Whare Tapa Whā, holistic needs of whānau</i>	<i>Can't see clearly enough to give truthful answer</i>	<i>No, need more return to work schemes targeted to Māori</i>
<i>Restructure based on Treaty partnership... Māori need to be consulted before restructuring. Can't have a restructure unless consultation occurs.</i>	<i>Need someone to sit and speak to who will give clear information and not make you feel like an idiot/dumb as some case managers do.</i>	

1.8 What might that alternate structure look like?

Most claimants' suggestions focused around increasing cultural appropriateness, involving the community and hapū of claimants, co-locating services on a marae or other community-based healthcare provider, and enhancing face to face contact and responsiveness of the ACC staff. Levy payers also mentioned an increased focus on Māori philosophy and community, but they were – as one might expect – also concentrating on lower premiums and more explanation of the payments (i.e. a greater understanding of what exactly they are getting for their money). Treatment providers emphasised the need for 'more': more community based services, more Māori providers, more communication, more partnerships, and more cultural advocates.

<i>Hapū as the leaders. They know whānau & are able to dispense the scheme. This would mean a stronger connection between hapū/whānau</i>	<i>Māori providers in the mix providing ACC-type services. Allows for a broadly-relevant response e.g. marae based</i>	<i>Have set protocols - set flow chart to navigate the process. Consistent practice, not personal judgement. Same protocols as A&E</i>
<i>General systemic barriers - these organisations front these m/s [main stream] values & beliefs. Determined & driven by Māori for Māori to have the authority. Māori</i>	<i>Face to face opportunities - a local presence is essential to get information re: entitlements. Opportunities to involve whānau in planning long-term. Sometimes</i>	<i>One that provides all of the rehabilitation necessary and the equipment needed. (beyond initial treatment, x-ray & physio) such as</i>

<i>more easily relate to Māori. One that reduces systemic barriers due to institutional racism. Having to ask for assistance is a barrier for Māori. And the ability to advocate for oneself - a sense of Māori being humbled.</i>	<i>only part of the physical needs are met, e.g. if a serious injury has occurred, ACC focus on this & ignore the 'crooked finger'</i>	<i>crutches, which I chose to purchase as it was cheaper than hiring & straps for supporting my ankle. I'd prefer to receive info from ACC whether I'm able to claim back any of my initial treatment/x-ray, crutches, strap costs & if so how. At the moment I just don't know</i>
<i>Possibly a specialist team</i>	<i>Focussed sport, workplace, accident wrap around</i>	<i>One where clear info is provided & people are available to speak to in person</i>
<i>Literacy of claimants is a larger issue. Lack of info & understanding of what's available especially overseas Drs who don't complete the forms at all. One off JV between Waipareira & ACC to advocate for patients & talk to them give them support with their claims. Glen Mohe (see first interviewee) very useful role & should be rolled out</i>	<i>Outsource Māori responsiveness to high performing providers or - improve internal capacity to respond to Māori needs. -Not OK to keep status quo - ACC not capitalising on opportunities for Māori providers, missing the innovation. E.g. a culturally adapted NASC (Needs asst & service coordination) model.</i>	<i>Taking services to marae, including ACC case managers to the marae. Use a multi-disciplinary team approach. Lack of information re: entitlements - this would be a good model to address this</i>
<i>Use Māori frameworks & 'mana-enhancing models'</i>	<i>One that includes advocates that are culturally responsive</i>	<i>Representatives for areas - a face to talk to.</i>
<i>An alternative structure could be one in which claims history was accounted for & where the 'premium more accurately reflected the risk'. I.e. if claims history is good, lower premiums should apply</i>	<i>Regular opportunities for face to face discussion so case managers can assist with onerous logistics of paperwork requirements. Non-Māori case manager maybe make a phone call once per week to check how you are doing</i>	<i>Provide emotional/mental health care for claimants/whānau/carers. More money on things other than the physical problem. More support for communities & whānau, especially those with serious/long-term injuries</i>
<i>More Māori ACC staff. Training for ACC staff to be culturally responsive</i>	<i>Just get the bill - more explanation about the bill. Seasonal variances. Good to get discounts</i>	<i>Would be provided via a holistic Māori worldview & adopt a Māori philosophy</i>
<i>Competition for competition sake - no consultation. Needs to be consultation - look, choice, options. As Māori, if mandatory we & have to pay it's our right!</i>	<i>Face to face communication, less email, cultural awareness, cultural responsiveness</i>	<i>User friendly - people friendly - professional - community focussed. Support workers. Help people access entitlements. Know the community. Process good when you get what you want. ACC worker based in community. Kia ki te kanohi</i>

1.9 Would it be more attuned to Māori values?

All respondents hoped that an alternative structure was more attuned to Māori values, though few seemed to regard it as inevitable. There was a pervasive lack of confidence that a new structure would be more aligned with Māori values and it was emphasised several times that consultation would be needed to make any alternative structure(s) appropriately attuned.

At the same time, there was a clear desire for more culturally competent and culturally concordant care, as would be expected from the literature.^{65,66,67,68}

<i>It depends on governance of the structure. I have no sense that ACC is responsive to Māori</i>	<i>ACC doesn't cater for the holistic needs of Māori. One process is used by ACC for all claims.</i>	<i>Of course! We are over tokenism. We want a Māori structure with Māori leaders</i>
<i>Yes... or maybe not if a Māori case manager makes you feel dumb, or like an idiot. Māori often need help & this takes lots of time to</i>	<i>ACC does not cover dental, so how can it cater for your total wellbeing? [My] mokopuna got her teeth knocked out at softball, and</i>	<i>Māori work as a collective. This breaks down the isolation e.g. if someone can't work, they become</i>

<i>chase up paperwork. Māori literacy levels are often lower and ACC forms therefore are frequently incomplete or incorrect. This causes delays & requires lots of time for people to chase up. Māori often drop out of the process.</i>	<i>ACC approved her stitches but not her teeth. The mokopuna was whakamā that her front teeth were knocked out [but ACC wouldn't do anything], so ACC does not consider the holistic wellbeing of Māori</i>	<i>scared for the whānau & worried about how to support them. A hapū-led structure would provide local support for people in those situations & would help ease their fears.</i>
<i>Māori like to have support; don't want to go in by ourselves. An extra pair of ears is necessary for involving whānau & making the most of the face to face contact with ACC</i>	<i>If it were more culturally responsive, locally appropriate. Many Māori choose not to access now as it's too hard to sort out.</i>	<i>Values are critical to organisations & organisations are set upon mainstream values. - Awareness of being Māori & different differences are heightened for Māori.</i>
<i>[We need a different structure because] Māori don't separate things. Māori tanga is 'across the board' & something we practice everyday. Māori are more open-minded to other cultures & ideas, plus more respectful.</i>	<i>We'd hope so, but the current deficit is huge. It's all about cost cutting/containment - this environment would need to change if positive changes were to happen.</i>	<i>ACC has an injury focus. Can't get benefit in terms of Rongoā Māori. Only conventional Western medicine is covered.</i>
<i>If it took into account wellbeing of the family.</i>	<i>It might help overcome people's shyness/whakamā</i>	<i>If cheaper fees were offered, that would appeal to Māori</i>
<i>It should be attuned with modern day Māori values - i.e. promote Māori to succeed</i>	<i>Māori are an oral people, many aren't able to manage the paperwork - when you're sick this is really hard to manage</i>	

1.10 How important would this be to you?

Claimants and treatment providers were both uniform on the notion that this would be 'VERY' important to them, while levy payers were more mixed, though even there most felt it was very important.

<i>Very important. Could be improved cost savings</i>	<i>Yes, important to whānau. Refer to other holistic services</i>	<i>Important in relation to reduced costs</i>
<i>Yes, we need to get more Māori using the system.</i>	<i>Māori are not part of the dominant culture. There's a negative perception of Māori as 'bludgers'. Māori can't necessarily verbalise their needs - which leads to reduced communications and increased frustrations</i>	<i>Consultation is first step. Consultation must happen otherwise how can you set up structure</i>

1.11 What do you think a "competitive" scheme might look like?

Many claimants said they didn't know what such a scheme might look like, but several suggested something in which Māori organisations could take a major or lead role. Providers also mentioned the participation of Māori providers but the majority seemed to feel that such a scheme would be complicated and confusing. Levy payers appeared somewhere in the middle - hopeful that such a change would encourage Māori organisations to offer a Māori scheme while yet others had no idea what it would look like and several felt that it would be the beginning of the end of the 'no fault' aspect, which they were keen to retain.

<i>One [i.e. a scheme] that uses Te ao Māori models for assessment of cover for injuries</i>	<i>Whatever it looks like, it needs to be accessible to all & of high quality</i>	<i>I don't know - hard to tell, depends on what they plan to do</i>
<i>I expect that [the current] ACC is far more accessible and easier to access for claimant [than a competitive scheme would be</i>	<i>[A competitive scheme should be one in which] individual organisations got their insurance from separate organisations.</i>	<i>[A competitive scheme should be one in which] Māori have own insurance co-operative</i>
<i>One in which Māori providers have the opportunity to participate -</i>	<i>Competition would be good if it benefitted Māori. We would need</i>	<i>It should be free to use, easy to report to, and have a</i>

<i>giving people the option of mainstream or Māori providers</i>	<i>to understand & have input into [the new scheme]</i>	<i>lot of face to face communication.</i>
<i>[The debate should be] more about making ACC better. [The current] ACC 'feels white'</i>	<i>Opportunities for this to be run from a marae, services could be based there too.</i>	<i>There's the potential for existing insurance plans to include aspects currently held by ACC</i>
<i>Opportunities for Māori providers to be in the game - this would be based on Whānau Ora, unlike ACC. - this [scheme would] allow work with whānau & communities, taking the info out to the people</i>	<i>It must retain the 'no fault' aspect. ACC was originally set up to provide 'no fault' cover. It would also be better to have local (Māori) organisations to meet local needs</i>	<i>[It should be] breaking down the parts with ACC, giving people the choice of putting their dollars where it is relevant to them</i>
<i>One where specific ethnic groups and/or specific injuries e.g. sports injuries, are grouped and handled together</i>	<i>I'd be worried about money, cost cutting. [Competition] opens it up even more to inconsistency [in handling claims, etc]</i>	<i>One that offered greater value for money - where people aren't penalised for accidents that could be prevented.</i>
<i>I don't know if it [a competitive scheme] would work.</i>	<i>It would be disorganised and spread out (fragmented)</i>	<i>[A competitive scheme would be] confusion</i>
<i>Not sure but "form follows function". What it looks like is secondary to what it achieves; sort out what outcomes you want to achieve then structure things around this to achieve these outcomes.</i>	<i>There is opportunity at present to have a Māori scheme through [a number of groups] eg the Māori PHO Coalition; Iwi; Mana Whenua; PHO's. Or a joint venture with a mainstream provider and a Māori partnership in a commercial sense. Private, personal insurance for accident cover could be purchased by the PHO on behalf of the enrolled population</i>	<i>Having a choice of Māori organisations is not seen as competition – it's more about choice & a self determined pathway & cultural appropriateness, NOT competition</i>

1.12 Do you think such a change would be a good one?

All three groups responded to the possibility of change with mixed views. Most felt it would depend upon how it was handled and opinions ranged from quite positive and enthusiastic hopes to more pessimistic predictions. Many levy payers feared cost increases, while others liked the idea of having a choice. Similarly treatment providers were split between those who welcomed the opportunity to organise new ways to care for whānau while others saw it as leading to decreases in quality, access and number of services.

<i>Yes - current insurance organisation policies don't align with ACC</i>	<i>Maybe - if by Māori for Māori. As Māori will deal with injuries their own way</i>	<i>It's potentially bad for whānau, but good as it could make providers uplift their game and yield cost savings.</i>
<i>No - why fix something that's not broken? Fix what is there.</i>	<i>Good - nice to have a choice, but we'd have to help whānau choose</i>	<i>No - tension created by competition.</i>
<i>No – it would be a huge disadvantage to Māori. A profit focussed vs people focussed scheme</i>	<i>No - because it won't be driven by quality. The premiums would still be out of reach of many Māori</i>	<i>Maybe - It could be [good] if set up properly. It would not be good to be like the US, where people are disadvantaged</i>
<i>Yes - because we can provide locally responsive services around our whakawhanungatanga, whakapapa & based on tikanga. Māori are probably more accepting of the messages when delivered in a culturally appropriate manner by Māori for Māori. Local providers know about local needs of the people</i>	<i>Yes - whānau would feel more comfortable [dealing with a Māori organisation] & therefore more open about the circumstances of the injury - More confidence amongst whānau of how the provider would relate to them (Note: this and many other responses regarding competition were predicated on the assumption that 'competition' would mean Māori could choose to go to Māori organisations instead of ACC. In the absence of such an</i>	<i>Yes – [competition leads to] innovation. Māori need options and choices. How integrated are Māori policies across ACC? What are the outcomes of these policies? The whole infrastructure is wrong. The system should be accessible to all, despite levels of literacy, as tax payers.</i>

	<i>option, the response would likely have been very different)</i>	
<i>Maybe - if costs don't go up for claimants.</i>	<i>Yes - if we could participate.</i>	<i>No - because it would be harder to access</i>
<i>No – [it would be] confusing, trying to figure out 'which will I get the best out of?'</i>	<i>Mixed: Yes - as it would be possible to pay cheaper levies - No, as it could cause confusion</i>	<i>It would be good to have options if there was a Māori alternative.</i>
<i>Yes – it would be good if the [new] organisation is attuned to Māori values</i>	<i>No - ACC should not be profit focused, they should be care focused</i>	<i>I would like to think so; however, there are always gaps for Māori.</i>
<i>Not sure - need to compare apples to apples to see if there would be a benefit [i.e. can't answer the until know what the proposed competitive scheme would be]</i>	<i>Maybe - as long as it is stacked with the right people at the helm. It could have the whānau ora, wrap around approach. If we weren't involved it would be scary.</i>	<i>No – there would be multiple organisations to navigate; markets change so people may change their minds – there would be increased hassles and more drawn out claims.</i>
<i>Yes - I prefer to have a choice of where my money goes. There could be flexible options for people to choose to suit their needs at the time</i>	<i>Yes - because of options it gives people & the potential to save money on fees</i>	<i>Yes - potential benefits for the community. There would be different schemes & costs</i>

2.0 Claimants' Questions

2.1 Do you think Māori can access ACC as easily as non Māori?

Most felt that Māori can in fact access ACC as easily as non Māori, but there was a sizable minority who disagreed. These responses reflect Māori perceptions of access.

ACC data demonstrate that Māori represent 11.55% of all claims (compared to 14.6% of the population at Census 2006). Māori have a higher than proportional rate of weekly compensation claims (15.98% of all claims with weekly compensation), but lower than proportional claims in the earners account (9.47% of all claims in the earners account, yet 11.47% of the workforce), and in social and vocational rehabilitation (6.64% of all claims with other entitlements). The quantitative analysis of ACC claim data report discusses some potential reasons for these results. For instance, if Māori are more likely to be seen for injuries in a hospital emergency department and the claim may represent a single episode of care. The report notes that "Māori do not appear to access the scheme as much as non-Māori, especially for more 'minor' injuries. When Māori do access the scheme, they are likely to receive less social and vocational rehabilitation services and have a shorter claim duration" and postulates that the reasons for the differential access may be related to barriers to access, knowledge of entitlements, and different claiming behaviours such as Māori not claiming for minor injuries.⁶⁹

There is extensive evidence in the literature that Māori have barriers to accessing health care services,^{70,71} ranging from general practitioners^{72,73} to secondary care services.^{74,75,76,77,78} It would thus be unsurprising to find that Māori experience barriers to accessing ACC, despite its universal nature, as Māori are likely to show access barriers to all the standard entry points into the ACC system (primary care, emergency care, etc).

Respondents' comments included:

<i>We can get in the door but when you get in the door then it's different</i>	<i>Differences [in access] depend on area rather than ethnicity. In big cities like Auckland, access is good</i>	<i>Yes, it's the same for us as the GP logs everything automatically</i>
<i>Probably not because Māori self-efficacy is not as high as non-Māori - results in self-disbelief & negativity so we present at ACC or GP being angry & is cyclical</i>	<i>They should be able to but you need to be articulate in order to access ACC, especially for older people & the younger whānau. 'Equal' systems to access mainstream system are inefficient for Māori.</i>	<i>No, because the framework for access has been derived from a mainstream perspective. There is commitment to Māori and the ToW at the top but it's not put into practice, same as any mainstream organisation.</i>

<i>Depends where they are [when they try to access]. If they go to hospital, all good. Access to further treatment & rehab not as good.</i>	<i>Once you are at the doctor's there would be no difference [in access]</i>	<i>We should be able to access the same as non-Māori but we don't</i>
<i>It's the same for everyone, so it should be.</i>		

2.2 Why do you think this is?

Those who felt there was little disparity cited the 'no fault' aspect and automatic filing as was to ensure equal access, while the others argued that Māori were disproportionately disadvantaged by problems with ACC's processes, negative staff attitudes, poor communication (including lack of face to face interactions), a lack of knowledge on the part of patients and whānau about the system in general (i.e. how to use it to best advantage) and the need to 'push' for your own rights, which Māori are culturally more averse to doing.

<i>I feared the breakdown in my relationship with ACC would harm me (I could get less money)</i>	<i>Communication is a problem: Māori wait for info to be given to us (especially older Māori), younger Māori are more likely to ask. Māori are whakamā</i>	<i>Māori have less understanding of the system & their entitlements & are less able to ask/state what they want</i>
<i>Some Māori are unable to put it [what they need] into words</i>	<i>It's difficult to get information or an answer out of them</i>	<i>Process to access is easy & good</i>
<i>Pākehā understand the system better than Māori. Pākehā push - Māori don't.</i>	<i>Because the mainstream systems are mono-cultural</i>	<i>An accident is an accident so we can all access ACC</i>
<i>Some people use their annual leave rather than claim ACC as claiming ACC is just too much hassle. Some people don't access assistance they are entitled to because they don't follow through when they hit a barrier.</i>	<i>[You need to be willing and able to fight for your claim:] I had to challenge their [ACC's] statement that the medical certificates were incorrect. The system was complex to navigate, very resource intensive. Help from the health provider was received, too, so between me and the GP, I got it sorted out.</i>	<i>Because by the way ACC phrases questions on the phone, it limits what I'm able to say. Everything is scripted. They aren't talking to me. They're not very helpful. Methods used are not aligned with Māori values – (it's better for us to have face to face korero). ACC needs more flexibility to encompass suggestions/solutions suggested by the whānau - not be so dictatorial.</i>

The quantitative data provides additional information into this question. As described above (2.1), if Māori are more likely to be seen in an emergency department context, this will have cumulative effects through to claim duration. Access to, or the likelihood of additional treatment, follow-up or referral to rehabilitation providers may be more likely when initial presentation is made via the primary care provider. This is consistent with both the data on rates of claims (see section 2.1) and the data on claim duration, and social and vocational rehabilitation.

There is also data in the literature that Māori are not as well served by their primary care providers as are non-Māori, with providers being less respectful, listening less well, spending less time and referring on to specialist care less frequently.^{79,80,81} This would suggest that even when Māori present through their GP, they may still be less likely to be referred onward for services, a supposition supported by several respondents in the current study.

2.3 What sorts of changes might improve access for Māori?

Most comments had to do with improving communication and minimising cultural discordance.^{82,83,84,85,86,87,88} Specific examples include: more Māori ACC staff, a more whānau friendly culture at ACC, more communication and transparency by ACC, more perseverance by claimants, the use of advocates, networking ACC services with Māori services, and more Māori providers available via ACC.

<i>ACC is an oligopoly. To improve things, you first need to understand</i>	<i>More information on who/where to go. It was a waste of time</i>	<i>Need better communication & more timely service. There is</i>
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<i>the root causes for barriers to access ie internal causes. You must first identify & then configure around this to achieve outcomes. Much research exists, but it's not transferred into practice. One-off pilot approaches used in ACC for innovations, but not about outcomes but instead about productivity.</i>	<i>calling, as we were unable to get same case manager twice. They need different forms of communication, like whānau hui, kanohi ki ti kanohi, listening to whānau solutions</i>	<i>a deliberate strategy to delay or reject claims because they know only a percentage will continue. They need a different approach</i>
<i>More timely payments. Competent processes. More information [to the public]. Access to move into face to face communication, with someone to speak to, like an ACC person</i>	<i>Māori case managers. Face to face talks. Hui. Marae based offices. Māori providers. Targeting groups such as Māori employers, Māori health providers & sports groups etc. Information delivered in appropriate ways for Māori</i>	<i>Options to access Māori providers for ACC-type services. Access to alternative & natural Māori health practitioners - not just physio etc. Face to face korero</i>
<i>Help for Māori with navigation through the service.</i>	<i>There should be GP's on board to help. ACC should be free at the A&E</i>	<i>Networking out to Māori organisations, communities & marae in the local areas</i>
<i>They should have a stronger Māori workforce. Stronger commitment to Māori and the ToW as an organisation, throughout all levels</i>	<i>They need advocates who can relate to Māori to help with access.</i>	<i>A more whānau – friendly, mana - enhancing approach</i>
<i>Direct access through other services (not just GPs) e.g. district nurses, practice nurses. There's a lack of information on entitlements for people</i>	<i>Marae based services. More Māori case managers. ACC liaison roles in ED's in hospitals</i>	

2.4 What effect might competition have?

This was a very mixed bag. Some felt competition was likely to bring lower fees, more options, more of a Māori focus, and more customer service, while others predicted more confusion, more delays, more complexity, and more 'hoops to jump through'.

<i>It would be more supportive for Māori if it was run by a Māori organisation</i>	<i>It would depend on claimant's ability to navigate the system. You have to organise yourself.</i>	<i>Lower fees. More options for people</i>
<i>It would cause a lot of uncertainty - Māori are cautious but very trusting</i>	<i>It would make it disorganised & harder to get to for people</i>	<i>ACC is a waste of time, so hopefully they will be better</i>
<i>If there is competition, there has to be education with it.</i>	<i>Passing the buck - ACC will be passing the buck</i>	<i>Most Māori will want to stay with ACC.</i>
<i>It should make it easier but may create more 'hoops' for people to go through</i>	<i>It would be important that competition doesn't drive up costs. They'd have to guarantee access.</i>	<i>If Māori outcomes don't drive the new structure, it will be a replication of status quo.</i>
<i>It would have a negative effect on Māori. The socioeconomic status of Māori is generally lower, so a voluntary scheme means some families won't take it up - preferring to spend their money on essentials</i>	<i>Wider choice for people, but I have concern that it may become more focussed on money efficiencies of the market/economic drivers</i>	<i>ACC will have to review their systems & improve their processes to be more efficient</i>
<i>Negative – the client may lose out – it would be focussed on money/profit, not clients. Who will have control of it???</i>	<i>Depends on the provider. If it's a Māori organisation it might help. Some Māori prefer not to access ACC because of a lack of trust because of previous bad press</i>	<i>Streamlined processes & greater efficiency in processing claims</i>
<i>Lower premiums +/- more benefits. More choice for people</i>	<i>I don't know – it may cause longer delays</i>	<i>It would be beneficial to have Māori-tailored schemes</i>
<i>Any kind of competition makes people "lift their game" – there is</i>	<i>It would fragment access even more. They should move away</i>	<i>Options for a better service</i>

<i>nothing currently to stimulate performance. Need to have options & choices,</i>	<i>from multiple providers/agencies and focus on a transformational approach for changing ACC</i>	
<i>Would cause confusion</i>	<i>Not sure, maybe none.</i>	.

2.5 What is your experience in getting access to ACC services?

This also garnered very different responses from claimants. Some had little to no trouble accessing services. They described the process as 'fast', 'effective', and 'automatic'. These people tended to have only short term medical issues and reported having 'good' case managers. Those who reported bad experiences in getting access reported felt it was 'inefficient', 'cumbersome', 'frustrating', 'unresponsive', 'confusing', 'offensive', 'a headache', and 'too much work' [for the assistance you receive].

This is very much in keeping with the literature, in which Māori and other indigenous or minority populations have lesser access to healthcare services in general, not only to ACC.^{89,90,91,92}

<i>After being injured, I visited the GP & was referred to the hospital. I received rehab & treatment with no barriers experienced.</i>	<i>I had to be "on to it" otherwise, it [the claim] didn't move</i>	<i>Mixed experience – I had good access to dental treatment, but no help accessed for injury to hip</i>
<i>Access is fine it's the navigation through that's the problem</i>	<i>It was time consuming and frustrating.</i>	<i>My case manager was not forthcoming; they don't let claimants know all of their entitlements. You don't find anything out unless you push for it.</i>
<i>Couldn't access alternative health providers (acupuncturist) under ACC. Rongoā also isn't part of this</i>	<i>Initial access is good, but follow up is problematic. Services, treatment etc are often offered but not taken up due to the time required</i>	<i>It's a headache.</i>
<i>Paperwork was hard – I needed assistance with form filling. The case worker spoke English as a second language and was no help. It's hard, not knowing what you're entitled to.</i>	<i>I always felt questioned as to the validity of my claim - had to constantly prove injury. It comes back to basing it on values & relationships between organisation & the people.</i>	<i>It was good; I went to the GP, the GP did everything [for ACC]</i>
<i>Rural & isolated locations hinder access very much.</i>	<i>I was entitled to cover but it's too time-consuming [to pursue the claim] & I can't manage it within my busy life</i>	<i>I had to travel to see GP, then travel again to the ACC office</i>
<i>It required persistence & perseverance.</i>	<i>Too much paperwork, lack of culturally appropriate communication</i>	<i>Only after speaking with management did things progress</i>
<i>I was made to feel like a bludger</i>	<i>ACC expect claimants to go to them – bring all paper work & evidence - travel required. No time to rehabilitate.</i>	

2.6 What barriers did you experience?

Although a few people reported no barriers, most claimants experienced some kind of barrier, such as unhelpful staff, their own lack of knowledge, mixed messages, staff turnover, co-payments, poor communication, and forms to fill out (which many identified as something that preferentially affects Māori, due to their lower literacy rate⁹³).

Many felt marginalised and stereotyped as "ACC bludgers" by ACC staff when visiting ACC offices, and a majority reported that ACC has very poor communication – unclear information about claims, no information at all, etc – and that as a result people tended to learn from other claimants what they needed to do rather than from the organisation itself. Several felt it was easy to access ACC via their GP but hard (and frustrating) to try to find out how and why their claims were later rejected.

This is in keeping with numerous studies documenting increased barriers for Māori at most levels of the health care system.^{94,95,96}

<i>I had no phone so would use any I could get to. ACC's 0800 number took ages for someone to help. I usually gave up after a while</i>	<i>I had to stay on top of certificates & the 'where to from here?' when things weren't going right. I had to ask to speak to a manager/supervisor</i>	<i>Increased barriers if claimant has no phone. It was difficult to reach case manager, who seemed to be too busy to talk to me. Written requests get better response.</i>
<i>Staff – we were unable to access case managers that are competent/skilled, only saw overworked case managers and increased case loads. Communication is often delayed</i>	<i>When paperwork wasn't done, ACC considered it because he was Māori. ACC's attitude changed when he established he was non-Māori</i>	<i>Paying for crutches, travel, (having to come up with actual cash). I was put under another region so that caused confusion.</i>
<i>I didn't know what to do or how to ask for things</i>	<i>People in ACC. The whole thing. 'You do as I say'</i>	<i>Lack of knowledge of assistance available.</i>
<i>ACC thought my [relative] was Māori and my perception is that his needs & surgery appointments were bumped. My perception is this happened because they thought he was Māori</i>	<i>A previous injury (whiplash) was covered at the time by ACC but it happened again because of a similar but entirely separate accident. ACC refused cover, saying it was a previous injury.</i>	<i>Lack of information is a barrier. Processes are complex and complicated, it would be better if GPs sent Medical Certificates directly to ACC, the employer and the claimant</i>
<i>Communication breakdown with ACC - no point talking to anyone unless they were a manager. Too many papers, had to get them all exactly right. There was no communication from ACC if there were problems with the forms.</i>	<i>Onerous form filling, restricting questions leading to restricted answers. Previous experiences were not good, put me off. ACC talked down to me. Visit by a case manager to my home was disrespectful. I complained & received a follow up letter but can't recall an apology</i>	<i>After hours access is a cost issue & travel – having no choice of a Māori provider. - Co-payments - no where tapa whā experience. - Payment was delayed because paperwork wasn't coming from coroner's office, needed a lot of running around (3rd party engagement)</i>
<i>I won't go back on weekends, it's too expensive: \$100 for xray, \$70 for weekend. I'm scared to go back</i>	<i>Staff are not very friendly, not approachable. Don't make you feel comfortable. Punctuality poor.</i>	<i>Turn over of staff affected continuity of service delivery, bringing in someone new to tell story to & establish a bond with</i>
<i>Mixed messages, inconsistencies, inexperienced staff, won't come out and talk</i>	<i>Multiple people dealing with your case. It would aid recovery if you had one dedicated case manager</i>	<i>Fear of reducing the household income by 20%</i>
<i>Mistrust towards ACC</i>	<i>Processes</i>	<i>None</i>

2.7 What is your experience of treatment through ACC?

The claimants appeared reasonably evenly split between those who reported good experiences and those who rated their experience as 'negative' or poor'.

Good experience, I was referred to a really good specialist. Case Manager had good communication, reminded me of appointments was informative - provided info, ACC claimant rights

<i>Help took months after the accident to get. Hoha! I was tired; it took lots of energy for little gain</i>	<i>Really good. Physio was excellent</i>	<i>Very good through the hospital - very good doctor. Case manager offered other services. Had kai bought, offered other services</i>
<i>Good experience with ACC</i>	<i>Shocking!</i>	<i>You're not told of what you can get. It's hit & miss.</i>
<i>Mixed. No assistance for hip/tooth capped. Podiatry good.</i>	<i>Good, straight forward, and it was accessed in a timely way</i>	<i>Negative experience, with lots of confusion</i>
<i>Good, although the travel was problematic & the paperwork</i>	<i>Difficult as I had to go through hoops to get it, & I have a fax &</i>	

<i>required was too hard & too much</i>	<i>phone</i>	
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2.8 What is your experience of rehabilitation through ACC?

Those claimants who received rehab services tended to like them and to be positive about the ACC overall. Many however said they didn't receive services they needed at all, while others had to constantly justify the need for them (making them feel like bludgers). Others got the services but in inadequate amounts.

Regarding the question of whether Māori experience poorer rehabilitation outcomes and what might be possible reasons for this, there is evidence in the literature that suggest Māori are disadvantaged when it comes to interventions and outcomes following (for example) stroke, cancer, and heart disease.^{97,98,99,100} Consistent with the earlier discussion regarding access (2.1) and claim duration, and treatment duration (2.5) the lower rates of claims and the lesser access to social and vocational rehabilitation, may have a cumulative effect in terms of the rehabilitation outcomes.

<i>I wasn't covered once I left hospital</i>	<i>They came to the house - very good</i>	<i>ACC supplied resources only - whānau assisted</i>
<i>I didn't know if I had a choice. You have to buy things</i>	<i>Often only physio is the rehab option offered</i>	<i>It occurred through the hospital not ACC</i>
<i>Physio was funded for a limited number of sessions. Despite me & my physiotherapist feeling more sessions were required, there was no more entitlement - instead I would have been required to go through a lengthy, time consuming process to try to appeal their decision, but I chose not to as I just didn't have the time</i>	<i>Some treatment providers gave different service, Need to monitor provider about types of care. It seems now you have to pay part charge and more whānau will moss out</i>	<i>Very good - e.g. physio, good experience - this physio was so good because she used 'best practice' techniques or things that really worked for me & gave me lots of education re: how to get well & stay well. Previously the experience was not effective, not fixing the problem</i>
<i>Physio access was ok but ineffective for me. No other options were offered but I would have liked to access alternative Māori therapies</i>	<i>Good experience, I was referred to a nearby medical centre for rehab and enjoyed the rehab exercises</i>	<i>Rehab was ok but no follow up. No support for whānau. How do people cope, if they're alone?</i>

2.9 What is your experience of weekly compensation through ACC?

There were many stories of weekly compensation being significantly delayed and problematic to receive, but when, in the end, the cheques did seem to come, they were very helpful and most welcome.

<i>Off work, 4/12. Receiving 80% of wages during this period. All managed by case manager e.g. she liaised with my employer. Did it all for me</i>	<i>I contacted ACC, then was referred back to the doctor to get the forms again. It turned out that ACC had lost my forms, even though I'd hand delivered them</i>	<i>My weekly compensation was very delayed. I was off for 6 weeks and I got the money after I'd returned to work</i>
<i>I had to travel just under the required 26km per one-way trip to visit my case manager (to sort out the ongoing paperwork problems) and was not eligible for travel assistance. This was a very big barrier for me and costly. I had no choice, I had to go</i>	<i>I wasn't informed of any problems with the medical cert's & then my payments were ceased without notice. This was a problematic area for me during my time off work</i>	<i>My partner was referred to ACC specialist, who confirmed person was fit for work yet during the consultation said was ok to still be off work. It resulted in my partner returning to work early & doing more damage. There was no opportunity to get a second opinion and he finally went on the Sickness Benefit</i>
<i>ACC agreed to support me to re-training for a new career. ACC paid all fees/books/ & weekly earnings compensation</i>	<i>I was off work for 3 months, and there was lots of paperwork to manage, but I had a supportive employer</i>	<i>Generally okay; there were a few examples of misadministration & lack of communication</i>
<i>Lump sum payment was late - took</i>	<i>Weekly compensation was</i>	<i>Good experience, re: home</i>

<i>1 year</i>	<i>delayed, but when it came it was good</i>	<i>help/child care</i>
<i>Lack of communication delayed payments (alternative options to contact me were ignored, led me to miss appointment), when payment was received it wasn't the full amount – and no explanation was given for less than full rate (80%) being paid</i>	<i>Timesheets, mileage, evidence of doctor visit. There's a lot of unnecessary paperwork e.g. timesheets. It's really difficult when you're unwell</i>	<i>It took lots of work to get the payments set up. Some occasions where the payments were stopped due to Med Certificate issues with no communication beforehand from ACC</i>
<i>I know of a Māori man who turned up at the ACC office at the end of his tether and said the delays in payment were such that he couldn't feed his family. They had to get a Māori kaumātua to help</i>	<i>Weekly payments commenced 3 weeks after my injury. This delay was due to lack of information about required processes -</i>	

2.10 What aspects of the ACC organisation work well for you?

Claimants complimented ACC for treatment services, rehab services, the automatic nature of ACC claims, and a few mentioned helpful individual staff (usually by name).

<i>Treatment & rehab access was great. I can't speak highly enough of that lady [the case manager]</i>	<i>Some staff were really helpful. Arranged automatic application for cover by service providers & for employers.</i>	<i>They taught us to look at the law (entitlements), made me do lots of research</i>
<i>Once they got it right, it was ok. Then the case manager went on holiday and all went to kaka</i>	<i>Not having to pay except on weekends</i>	<i>Being able to see any doctor under ACC for an accidental injury</i>
<i>Automatic processing of initial claim is good.</i>	<i>That it's available. One form to fill out. Application by health provider online at time of appointment</i>	<i>It's great to know it's there if you need it</i>
<i>Automatic access through health provider. Case manager sent letter confirming cover. Employer provided earnings info to ACC directly</i>	<i>Confirmation of cover letters is sent through automatically although onus is on the claimant to keep/look after this.</i>	<i>Treatment was good. Case manager was good - case manager used whakawhanungatanga to connect</i>
<i>My case worker. They made good connections, founded on mutual relationship [non-Māori case manager]. Got me into a retraining programme to invest in my future, enabled me to contribute to the world - helped to improve my overall well being</i>	<i>Case manager was very good at explaining things. I met her face to face, she had very good communication. She was interested in my case, not just the claim. She allowed a friend to be the caregiver</i>	<i>I had a consistent key contact person. Phone/email are good communication options for me. Contact person was helpful. The delay was not of ACC's accord and they kept me informed. When I access a Māori health provider, I always get a good service; I can combine reasons for visits as my provider is a competent Māori provider. - ACC should facilitate more of these.</i>
<i>The fact that it happens automatically – I want to keep this</i>		

2.11 What aspects of ACC cause problems for you?

This question elicited many more answers than 2.10. People described medical certificates to be especially difficult, along with unpleasant, unhelpful, and/or uninformed case managers, poor communication, their own lack of knowledge about their entitlements (which was difficult to change given the previously mentioned poor communication skills on the part of ACC staff), paperwork, delays, and the inability many Māori reported of being able to engage with ACC staff in their preferred manner (e.g. face to face) and develop a longstanding relationship.

<i>Need support to help recovery. You have reduced confidence in yourself when seriously injured or off long-term. You get frustrated and feel devalued. Some people feel guilty at not providing for whānau, feel worthless, low self-esteem</i>	<i>Case manager was focused on me returning to work, this was stressful for me. They made me feel guilty at being a user of the system, so I returned to work early.</i>	<i>I got sick of chasing it up. I had no phone & couldn't rely on mail system. They have no consideration for anyone's cultural considerations</i>
<i>Communication. Lack of cultural responsiveness</i>	<i>Lack of info about what I 'CAN' access, it's all what I CAN'T</i>	<i>Payments.</i>
<i>ACC don't operate within a Māori tikanga or with Māori values.</i>	<i>Not being able to get someone helpful/empathy on the phone - 2nd opinion</i>	<i>Initiating weekly payments is tricky paperwork is often lost/un-locatable. Disorganised management of paperwork for weekly</i>
<i>Paperwork is confusing for me – it's hard to get assistance with the forms, you're kept on hold for ages; by the time someone came to the phone, I'd forgotten why I rang!</i>	<i>Its priority is [just] to save money - not everyone is trying to rip them off.</i>	<i>Case managers – lack of competence, poor communication, no cultural sensitivity especially when discussing things with kaumātua/kuia</i>
<i>Turnover of case managers</i>	<i>Inconsistency</i>	<i>Paperwork too complicated.</i>

2.12 Do you feel that you are currently well served by the ACC Scheme and that it allows for appropriate services to be offered to you?

This generated a mixed response. There was no consensus among those who felt they were well served and those who felt otherwise.

From analysis of ACC data,¹⁰¹ average weekly compensation costs and days of compensation are higher for Māori. This may reflect that Māori are less likely to claim weekly compensation for minor injuries (which is consistent with other characteristics of Māori claim rates) or that Māori may be exposed to higher risks of more severe injury in certain occupational classes (perhaps indicating that Māori are more likely to engage in higher risk jobs and less likely to engage in desk jobs), or that Māori receive less rehabilitation or less effective rehabilitation.

Māori have a lower average number of treatments and shorter claim duration. Māori may perceive treatments as less effective and choose not to pursue them.

- Barriers to treatments may mean Māori are less likely to see a regime through (e.g.: co-payments, inability to exist on 80% of wages).
- Māori may experience better rehabilitation outcomes (recover from injury faster) – though there is little evidence in the literature to support this suggestion; by contrast, most of the literature indicates Māori are likely to experience worse outcomes not better, including more adverse effects associated with treatment.¹⁰²

Opinions from respondents include:

<i>We're well served by ACC</i>	<i>Nothing to compare to</i>	<i>Not as well served as we could be</i>
<i>Adequate, only. Southern Cross does it very well compared to ACC</i>	<i>As Māori, we're still not being served well</i>	<i>The funeral grant scheme is well-managed</i>
<i>No Someone I know was not entitled to cover as the injury occurred in the last week of their employment with an organisation that was in receivership. When the person began a new job, the injury (although still recent) was considered a previous injury & not covered</i>	<i>Not really - my experiences with ACC & those of my whānau give me no confidence I'd be offered the care & support needed by me & my whānau</i>	<i>No - organising paperwork & travelling into town to sort things out is too difficult. It's painful to sit in the car too long</i>
<i>No Probably not. 'You don't know what you don't know'.</i>	<i>Yes, because I know where to go & what to ask for & how to access</i>	<i>I think so, so far it's been good</i>
<i>Yes - because I've learnt from my bad experiences the first time around</i>	<i>Overall, not really. Lots could be improved about quality. There are few options and choices</i>	<i>Only if you know what to ask for – for example option for massage acupuncture rather than just physio</i>

2.13 What alternative structures would allow for appropriate services for you or your whānau?

There were many suggestions, especially for marae-based locations for ACC offices and locally based staff (who could be Māori, but it was generally felt to be preferable to have a local person of whatever background than a Māori stationed at a distant site).

<i>No change is needed to ACC. Having Māori providers as an option, more choices</i>	<i>Hapū & marae based services Face to face meeting with case manager.</i>	<i>Wrap around services Prefer to talk to someone locally.</i>
<i>ACC community liaison people to walk through it with you - to give info & options. Access to easy info in a variety of ways. Alternative therapy availability</i>	<i>Need to look to the future to build & prepare for the future. Create Māori authority & Māori self-determined pathways. Retaining our mana & dignity is all we have. 'Cap in hand' is not a good feeling. There's a need for long-term investment in Māori to ensure they can contribute</i>	<i>Marae-based services. Face to face opportunities to talk with ACC people with life experience and who can give me clear & relevant info</i>
<i>More flexible use of funds such as for travel in rural areas</i>	<i>Having Māori staff available</i>	<i>Health provider staff member employed to act as a local ACC-type person. (support person, as opposed to advocate)</i>

2.14 What alternative structures would allow for improved access for you or your whānau?

Advocates, face to face contact and better communication were felt to be the things that would lead to improved access, more than changes to the overall structure.

<i>Preventative - place to do that is in kura. Speaking with whānau in Māori environment. Wrap around services with a whole range & delivery</i>	<i>Having someone to talk to about it - face to face</i>	<i>Provision of advocates for Māori to enable access (culturally appropriate)</i>
<i>Better communication.</i>		

2.15 As a claimant, what would you change about ACC?

Responses included: having more Māori ACC staff, improving communication between ACC and claimants, more timely service, more consistency in delivered services, more opportunities for face to face interactions, better follow up, more efficiency, and less paperwork. This is in keeping with international studies which show that most consumers desire more information and better communication from the healthcare system.¹⁰³

<i>Shorter time frames for assessment of claims</i>	<i>Provide more information on entitlements</i>	<i>Better attitude of staff: open, friendlier, accessible</i>
<i>Have someone from ACC based in the hospital or have a kaiāwhina</i>	<i>Consistent provision of services (I had a friend who didn't get the same services)</i>	<i>It's a hassle going to the doctor, & filling out forms. Electronic data entry by doctor at time of visit</i>
<i>Need ongoing support to connect More options & choices. Lower co-payments for after hours services. Radiology services still have to be paid. No universal high quality of providers.</i>	<i>Culturally responsive People to the things 'that keep you well' - need investment into this - it's about prevention & staying well. Support quality of living, help them on their journey</i>	<i>More approachable attitude Don't outsource - think of Telecom!!! Wouldn't look at competitor due to funding, incentives, profit driven, patient safety is compromised</i>
<i>ACC should ask if the whānau has ideas for the plan</i>	<i>More Māori case managers and staff. More of a community approach</i>	<i>ACC assessors to clarify situation, entitlements & to help with the paperwork at people's houses</i>
<i>Proactive assistance for ACC e.g. with form filling</i>	<i>Look at the values on which the service is based</i>	<i>Involve whānau in all initial conversations.</i>
<i>Improved communications.</i>	<i>Opportunities to allow korero</i>	

<i>More visits to long term claimants initially.</i>	<i>Schools being involved with ACC injury prevention</i>	<i>Provide transport for people to access services</i>
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2.16 As a claimant do you like having a compulsory, nationwide scheme, or would you prefer a choice of insurers?

Answers to this question were mixed. Some wished for choice, while others liked things 'as is'.

<i>ACC with improvements</i>	<i>Stick with ACC</i>	<i>Compulsory</i>
<i>Like one scheme - not confusing</i>	<i>Prefer a choice</i>	<i>Choice of insurers</i>
<i>As it is</i>	<i>Choice - but only if better</i>	<i>Happy with ACC</i>
<i>Choice. Looking for the best deal for my family, responsive to our needs</i>	<i>I like it now because everyone is covered</i>	<i>Choice - but better to leave as it is</i>
<i>Having one organisation does make it easier especially for those without health insurance. Low Māori literacy levels would hinder access.</i>	<i>For those who don't know, status quo is fine & they get covered. Those that do know are for choice/options</i>	<i>One preferably - would need to research the options, this would be time consuming</i>
<i>ACC to be run by a Māori PHO.</i>	<i>I prefer choice because of potential for lower fees/levies</i>	

2.17 Do you think Māori claimants have different needs from non-Māori?

Some felt Māori claimants had the same needs as non-Māori, but most felt Māori do have different needs than mainstream claimants. Some of the different needs were felt to relate to cultural aspects (e.g. preferring face to face communication, being whakamā, wanting Māori traditional medicine, having a more holistic outlook), while others related to education and income issues that are more prevalent among Māori (e.g. not being comfortable with paperwork, being unable to afford co-pays).

<i>Some - Māori access to services is hindered by low socioeconomic class. We have less information, and more isolated locations. More pressure from employers to be at work</i>	<i>Yes - Kanohi ki te kanohi. Home help - ability to involve whānau to do the mahi - more likely to have whānau who could help. Doesn't have to be cash payments</i>	<i>Yes - Māori have a greater need for their spirituality to be taken care of, Māori are a more wairua (spiritual) people [and ACC does not recognise this]</i>
<i>Yes - we need not just to focus on physical, but to meet other needs too.</i>	<i>Yes, they need info there straight away & visible - Māori can be very whakamā</i>	<i>No - although Māori have particular needs re: the land</i>
<i>Yes - Māori have alternative treatments we'd like to use e.g. mirimiri</i>	<i>Yes - we need to have relationship/connections. Also Māori values, tikanga.</i>	<i>Yes - whakawhanungatanga is important. It helps claimants to feel comfortable</i>
<i>Some - More holistic & spiritual needs.</i>	<i>Yes - Māori like to see the person</i>	
<i>Yes - we require more affordable care. Some Māori are very whakamā & don't like to ask for help</i>	<i>Yes - we have particular cultural needs, e.g. language on forms. Some Māori consider where tapu important</i>	<i>Yes - need cultural sensitivity, especially of doctors for elderly to feel comfortable going there</i>
<i>Yes - Māori have a holistic Te ao Māori. Lower levels of education in Māori (&Pacific) compared to non-Māori. More involving whānau as 'more heads are better than one' as there is more understanding across the whānau. Philosophy of sharing the load. Not making it too onerous for any one person. Social cohesion/promotion of Whānau Ora. Better outcomes for all. Increased support from Whānau to encourage self-esteem</i>	<i>Yes - Māori generally are aware of etiquette, for example, if a case manager doesn't turn up or return the call, the person may take it personally, imagine reasons why the case manager didn't do this & it can become a barrier.</i>	<i>Yes - some needs are the same, like universal access to high quality care. Alongside this is a Whānau Ora approach, taking into account the wider aspects of Māori needs & how you translate Whānau Ora into practice.</i>

2.18 Does (or did) ACC meet your needs when you were seriously injured?

Seventeen claimants answered 'Yes' (though only 2 gave specific detail) while eight answered 'No'. (The remainder of informants did not reply to the question, suggesting they had not

suffered a serious injury.) Those replying in the affirmative also tended to qualify their answers, describing some problems that had to be addressed along the way, such as delays, inefficient processes, or having only their physical needs met. This last fits in with the desire stated above for more holistic services, in keeping with the Te Whare Tapa Wha model of health, rather than simply focusing on the physical aspects of injury.

<i>ACC was very good at meeting his physical needs. Costs - e.g. travel to specialists – were covered and modifications to the home enabled him to be cared for at home by whānau</i>	<i>Process became very prolonged, not all needs were met & it wasn't timely</i>	<i>My case manager was changed without my knowledge. I found out when I repeatedly tried to make contact. I asked my new case manager why it had changed & was told because I was now a 'long term claimant'</i>
<i>Not as much as I thought it would, but it did help; it kept family fed & bills paid</i>		

2.19 How could these needs be better met?

Suggestions included: more information about the claims process, better communication by ACC staff, longer cover, less paperwork (and/or more help with the paperwork), having a consistent contact person, and more face to face communication (a very common refrain).

<i>Needed to know how to go through claim process.</i>	<i>Longer cover period</i>	<i>Need to know all the facts</i>
<i>Face to face communication</i>	<i>Better paperwork management processes</i>	<i>Having a consistent contact person</i>
<i>ACC should've been more transparent about entitlements, to allow for those who find asking for such help difficult</i>	<i>Relationships & values, these are critical. Should have an initial meeting face to face where they come to you</i>	<i>ACC did not provide information, like what we could expect as a whānau from the impact of my husband's injury. We had no option for face to face meetings.</i>

2.20 What type of structure could better deliver services to meet those needs?

Claimants felt that the structure should be decentralised (i.e. community-based), located in hauora, and have more transparent processes with face to face communication available.

<i>More upfront, transparent</i>	<i>Located in a hauora</i>	<i>One that has someone to speak to face to face and get help & info from</i>
<i>De-corporatise – ACC seems to be a big organisation with lots of people in one place. Diffuse this mass into 'your friendly local ACC person'. This would help facilitate the relationship. More consultation with Māori & seeking user input</i>		

2.21 Are your needs as a non-earner well met by ACC?

Only three claimants self-identified as non-earners, but they felt their needs were being met currently.

2.22 How could these need be better met?

Non-earners, like the other claimants, wanted to see better communication between themselves and ACC staff.

<i>More contact from ACC</i>	<i>Some communication as to what's happening with my case.</i>
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2.23 What type of structure could deliver better services to meet these needs?

None of the three respondents suggested an alternative structure to deliver better service.

2.24 What impact would you imagine a change by ACC to a competitor structure might cause you?

Answers to this question ranged far and wide, from 'not sure' to 'more complicated' to 'more choices'.

<i>Not sure</i>	<i>It would make it complicated. I like having just one organisation to deal with</i>	<i>Cheaper levies, wider range - better service</i>
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2.25 Would these changes be positive or negative?

Claimants were evenly split as to whether the benefits of such a change would outweigh the negatives.

<i>Negative - definitely</i>	<i>Positive - good thing, cheaper levies. It's good to have choice.</i>	
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3.0 Levy Payers' Questions

3.1 Does the ACC Scheme represent good value for you?

Answers reflected differing opinions. Many small business owners, typically those working in administrative or low risk clinical environments, had lower usage of ACC and therefore tended to feel they did not get good value in comparison to the levies they pay. In fields where staff often suffered minor injuries, e.g. kitchen/catering incidents, they felt they received good value from the scheme.

Many levy payers complained that they were unable to assess the Scheme's value as they 'don't know what we pay for'.

<i>Don't know - I am unable to query increases, unable to access other quotes. Competition would provide opportunities to query increases & enable me to obtain other quotes</i>	<i>No - as an employer you don't have any input into the pricing. No input that you get a reduction through no claims bonus. Would like a breakdown and right of review</i>	<i>No - because we don't claim & have other insurance. ACC could work in-line with insurance companies</i>
<i>No - we make very few, if any, claims but we pay a lot in levies</i>	<i>Don't know - not sure as haven't compared the levies paid with number of staff and of claims</i>	<i>Yes & No Yes - had a accident. No - motor vehicle is excessive</i>
<i>Yes - provides peace of mind</i>	<i>No - don't know what we pay for</i>	<i>Yes - happy with levy amounts</i>

3.2 As a levy payer, are your needs well met by the current structure of the Scheme?

The vast majority of respondents answered 'no' to this question.

<i>No- No opportunity to challenge. No information is received from ACC to know what's available</i>	<i>Yes - the process we went through was good</i>	<i>What does that mean? 'Well met' compared to what?</i>
<i>No- we need more communication between ACC & us, even if by email. We don't know who their contact person is</i>	<i>Yes - fiscally, my needs are not being met as I'm propping up a system I'm not using. However, I am happy to support ACC from a social investment perspective</i>	<i>No - there is currently no differentiation in services for Māori & non-Māori. Evidence shows that the same approach to service delivery for non-Māori is not effective</i>

3.3 Could alternative structures improve the situation?

It was felt that improving the situation would require better communication, better wait times, the creation of Māori/community advisers, lower levies, and programs targeted at Māori.

<i>Employee to pay for it</i>	<i>Improved communications processes with employers</i>	<i>Better communication - know what you are paying for</i>
<i>Would prefer to deal with a Māori Advisor or a Community Advisor - similar to what IRD offers for business owners</i>	<i>Would need to do an analysis of the option & cost benefits. Process of ascertaining business owner levies was cloudy, lack of info/transparency (what is paid; how paid; why paid)</i>	

3.4 What difference do you think a competitive scheme would make for you as a levy payer?

Respondents were uncertain as to the changes – for better or worse – that competition would mean for them. Several speculated about lower costs, more paperwork, and less waiting as possibilities.

<i>Able to look around for best deal provides me with options and choices. Helps me to know what's happening</i>	<i>Might be cheaper. Improved services. Increased services. Service better - once you compete you have to lift service</i>	<i>It could: give the option of targeting cover to areas where you really need it; give the option of targeting to influence amount you pay; give the option of targeting to increase options around treatment for staff (e.g. paying for elective surgery for a staff member or wait 6 months on the public health system)</i>
<i>More paperwork</i>	<i>Depends on structure.</i>	<i>More headache & heart-ache</i>
<i>More room for lower fees & access to appropriate services</i>	<i>Choice – get to choose provider. Hopefully cheaper</i>	<i>Opportunities to off-set levies due to low utilisation</i>
<i>I would watch ACC & its competitors more closely just like with banks & insurance companies</i>	<i>Produce proof around how competition can make things easier for the levy payer</i>	<i>Most important thing would be to balance cover provided and money paid.</i>
<i>Wouldn't be any different</i>		

3.5 Would this be a good change? Why?

Most did feel competition would be a good thing, perhaps because they were not fully satisfied with the current system and felt competition – or any change – might improve things.

<i>It depends - have to be careful not to throw 'baby out with the bath water'</i>	<i>Yes - subject to prioritising Māori outcomes</i>	<i>Don't know yet. Don't know how it would work</i>
<i>Yes - if it doesn't cost the organisation more and retains same level of cover (as a minimum)</i>	<i>It could be if done correctly with streamlined & more effective/efficient processes</i>	<i>Yes - as it's good to know that you're getting the best value for their money</i>

3.6 As a levy payer, is the current system of levy payment efficient for you?

Despite their frustrations with some aspects of the ACC, most levy payers did feel that the current system of payment was efficient for them.

<i>Yes - because things just happen automatically</i>	<i>Yes - annual lump sum payment, no problems</i>	<i>No - annual payment is a significant cost, not spread across the year. Process is efficient though</i>
<i>Mixed – we are able to negotiate with ACC to reduce or eliminate administration fees for paying in instalments. But sometimes invoices from ACC have been delayed, i.e. received mid-August instead of mid -June. This has caused problems with managing overall budget and organisational cash flow</i>	<i>No - invoicing is inappropriate. All wages are electronic so ACC & IRD can work together</i>	

3.7 What would be the likely effect of alternative structures on the efficiency of this process?

Although most levy payers seemed receptive to the idea of competition, most suggested negative effects when asked about the effects of alternative structures on the efficiency of the current process. Many felt that things would be more complicated and therefore more time consuming for them with a change to the structure.

<i>Hope not for the worse ideally will go with one provider</i>	<i>Unsure, would need to look into it more, just like with insurance - to compare levies paid with the amount of cover provided - where's the best deal</i>	<i>Competition might lead to fragmentation regarding cover. A competitive environment would probable increase pressure for people to return to work</i>
<i>Opportunities to increase the efficiencies of the levy payment system</i>	<i>It might complicate the process</i>	<i>More time spent looking at appropriateness of levies</i>
<i>Might be more complicated</i>		

3.8 What kind of 'alternative' changes might you expect?

There were a wide variety of ideas put forward for 'alternative' changes.

<i>Long term ACC/benefit dependency not good for anyone, including Māori. It would be of long-term benefit overall if reduced costs to business trickle down to service user</i>	<i>Off set revenue against claims. Matching costs with revenue</i>	<i>Why not have both - have ACC but also specialist insurance, such as for motorbike?</i>
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3.9 Would you like to see these changes?

While only a small number of levy payers answered this question, the majority did want to see changes of this nature.

<i>Yes, if well researched evidenced based</i>	<i>Yes, if managed well</i>	<i>Nice to have choice. ACC could be the default along with other options</i>
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3.10 Is there anything else you would like to change about ACC?

Levy payers wanted a breakdown of their invoice, along with more of a people centred approach and 'a Māori face on the [ACC] organisation'. One also wanted the 'no fault' aspect to change.

<i>ACC has image of being bureaucratic, hard-nosed about claims. This means Māori have less access to ACC. If data on Māori access to ACC exists, it should be published</i>	<i>The ACC 'no fault' aspect is not supportive if staff are at fault, particularly if you have made significant investment into staff health and safety training for that staff member. Staff who are unsafe should be held liable</i>	<i>Unlikely that more money can be made available although it would be good. They need a more people centred approach</i>
<i>Policy on how to deal with clients, it's very impersonal</i>	<i>Needs to be a Māori face</i>	<i>Administration fee</i>
<i>Lower levies & recognising previous low or nil claims</i>	<i>Breakdown of invoice. Overall picture of service - what's paid & overall per employee</i>	

3.11 As a levy payer, how would you like your interaction with ACC to work?

Answers to this question varied from 'no change' to 'have more communication' with the ACC staff. Levy payers as a whole did not seem to have a clear idea or one particular issue that they would want to change.

<i>I am happy with current interaction although I have requested claimant info and this has not been received. Also, no assistance received to help providers manage ACC claims & process. Overall lack of info from ACC. ACC has not embraced changes in primary care ie PHO's</i>	<i>Don't mind paying a levy but need to know what they levy is used for</i>	<i>Face to face relationship would be good - this would give an opportunity to educate them on the services we provide, especially due to high cost of levies paid. Improved communication to enable participation eg on consultation on levies & receiving information</i>
<i>Kanohi ki te kanohi be the best way to start. It would be nice to see them down here</i>	<i>No change to current interaction desired</i>	

3.12 As a levy payer do you like having a compulsory, nationwide scheme, or would you prefer a choice of insurers?

Most levy payers wanted to have a choice of insurers, rather than the current situation.

<i>A choice, competition</i>	<i>Choice of insurers but only if it's free</i>	<i>Prefer a choice. Compulsory is good but just not one insurer</i>
<i>Keep ACC</i>	<i>Choice of insurers would lead to problems. Cover may be more restricted than currently</i>	

4.0 Treatment Providers' Questions

4.1 As a provider, are your interests well served by the current ACC structure?

The majority of providers did not feel that the current ACC structure served them particularly well.

<i>Advocacy role involved liaising with ACC on behalf of claimants to access entitlements. ACC had inflexible approach & few options given for alternative Māori therapies. Resolution only once manager involved</i>	<i>Speaking as someone who completed the paperwork, forms were comprehensive with 'pointed questions' that would specifically aim to keep the claims from being successful</i>	<i>I have made claims on behalf of clients, I needed to keep ringing, never go answers, repeated requests for information. Only got satisfaction from manager. Questions asked of claimants are not 'mana enhancing'</i>
<i>There are gaps in information and access</i>	<i>With long-term patients when case managers changed, there was no consistency & continuity as the new case manager doesn't know their story</i>	<i>ACC standardised packages for care enabled easy access to info & the next steps (for providers) & probably claimants</i>

4.2 What would you change about ACC if you could?

Providers wanted to change many aspects of ACC, including revising its claims process, minimising its bureaucracy, promoting a more holistic view, providing more information sharing, having better staff training, requiring less paperwork, and promoting an open door policy. Some providers see ACC not as an organisation that cares for people, but as one that cares only for process and saving money.

<i>Increase staff cultural competence - 'branch medical advisors' to look at cases as a clinician not lawyers, with compassion. Increase communications from case managers</i>	<i>Multiple forms caused confusion. Electronic forms would've been better, especially for radiology. This resulted in wasted time</i>	<i>ACC could support social interaction. Working with Māori health provider for holistic care. Holistic view of client - social worker</i>
<i>ACC ask health practitioners to do what's asked by them, but they don't follow suit.</i>	<i>Māori need to be considered at the early stages of a strategy or changes</i>	<i>ACC people who know the community - those with life experience & common sense (not straight out of school)</i>

<i>Have an open door policy for people to access face to face information</i>	<i>Make it easier for people to get what their entitled to without having to fight so much</i>	<i>'Take it to the people' All the paperwork, make it less & simple</i>
<i>Review staff recruitment processes</i>	<i>Change the claim process</i>	<i>Information sharing, simple, easy.</i>

4.3 As a provider, how would you prefer to function within the ACC Scheme?

There were a variety of ideas regarding ways for providers to function within the ACC Scheme, but the lack of any clear consensus suggested that there were no overarching issues.

<i>First contact - with Case Manager - reassurance & understanding that claim will be taken care of. Pararahi - but no-one knows what they do.</i>	<i>For people that require more treatments, I have to send more paperwork to a separate agency - they are slow to respond - processes make things slower. Severe or complex increase injuries decrease flexibility</i>	<i>End product should be an environment to understand each other's roles to ensure needs of whānau met in timely fashion</i>
<i>Would like to be at the front (beginning) of the change process</i>	<i>More liaison between providers & ACC.</i>	<i>Currently in preferred position</i>
<i>An 0800 helpline would've been useful</i>	<i>My role did not have 'mana' in the view of ACC - not taken seriously</i>	<i>Consultative with case manager</i>
<i>No change; happy with status quo</i>		

4.4 What would your preferred relationship with ACC be?

Some providers were happy with the status quo, while others wanted to see a variety of potential changes implemented.

<i>Face to face meeting, with senior managers to discuss opportunities, to build relationships</i>	<i>Good, clear lines of communication including delegated authority - open communication</i>	<i>ACC liaison worker in hospital to assist in accessing ACC. I'm a go-between for claimants & ACC. Case manager should have an overall view of the care of the person to get people back to work, even on restricted hours/duties</i>
<i>Current relationship is very good</i>	<i>On equal basis, respectful, taken seriously</i>	<i>As it is</i>

4.5 As a provider, do you like having a compulsory, nationwide scheme, or would you prefer a choice of insurers?

Most providers did not want a choice of insurers but rather wanted the existing ACC 'fixed'.

<i>ACC that works.</i>	<i>ACC, if it runs well. Prefer to keep ACC & improve it</i>	<i>A nationwide scheme is needed to cover all groups.</i>
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4.6 What opportunities exist for you under the ACC Scheme or under potential future structures?

There were a variety of responses to this question.

<i>If services cut - then Māori organisations can provide the service themselves.</i>	<i>Need to have a pou ārahi / advisor</i>	<i>Limited under current. Limited if competition</i>
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4.7 How could changes in the way Māori providers are used within the Scheme benefit your Māori claimants?

There was a clear belief that Māori providers work better with Māori patients. How this would result from changes within the Scheme was less clear.

<i>Better communication with Māori clients - respectful, culturally</i>	<i>It will allow closer contact with Māori, through kuna, marae, iwi</i>	<i>Previously had local Māori staff in ACC to ensure needs</i>
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<i>appropriate. - this is essential for people to get what they need & are entitled to.</i>	<i>organisations. Finding links with Māori going to where Māori are.</i>	<i>of Māori claimants were met. No longer any dedicated local Māori team</i>
<i>Māori liaison officer who provided info on entitlements would be great.</i>	<i>Māori providers would provide culturally responsive support, a focus on korero & sharing experiences</i>	<i>Unsure how many Māori providers actually engage with ACC on behalf of clients</i>
<i>Holistic needs can be better met by Māori provider - Whare tapa wha</i>	<i>Supportive for clients</i>	<i>Māori provider delivering exclusively to Māori. Tino rangatiratanga</i>

4.8 What do you think competition would mean for ACC?

Very few providers viewed competition in a good light. The vast majority were highly suspicious of how such a thing might impact them or their patients.

<i>They'd have to streamline thing more efficiently - increase employer responsibility for safety</i>	<i>They'd have to 'smarten up their act'</i>	<i>Go more to privatisation - following America</i>
<i>Have to up their game</i>	<i>Only beneficial if Māori</i>	<i>No good</i>

4.9 How do you see competition helping you?

Most providers did not see competition as helping them.

<i>Multiple organisations to work through - wouldn't help</i>	<i>Give option to link up with Māori providers to get culturally appropriate services aligned to your own tikanga</i>	<i>Gives employers different options. Opportunity to support high-performing providers - we're a preferred provider for many insurance companies</i>
<i>Previous experience with competition was not good.</i>	<i>Won't</i>	<i>Depends. Some pro's & con's</i>

4.10 How do you see competition hindering your work?

Providers were able to list numerous ways in which they felt a competitive structure (or another change) would hinder them. For example, they cited anticipating more paperwork, more 'hoops' to jump through, a learning curve associated with each insurance plan, and that it was likely to be more costly.

<i>More work</i>	<i>Having to jump through hoops, more checkpoints</i>	<i>Higher costs</i>
<i>Managing more paperwork & to coordinate care. Have to learn about multiple contact points/providers</i>	<i>Would encroach on work time in order to be informed about the choices</i>	<i>Would take longer to learn the different schemes, more paperwork</i>

4.11 How do you see it affecting your clients?

As with the above system, doctors tended to be pessimistic about the changes competition might bring, mentioning that it would be more confusing and harder for most to navigate the system.

<i>Confuse them potentially leading to disruption in treatment</i>	<i>Make it more difficult, hard enough for providers to navigate</i>	<i>More questions required to be asked while person is in pain</i>
<i>They'd have to navigate a new system.</i>	<i>More time intensive for clients - confusing/complex</i>	<i>Confusion, harder</i>
<i>Gives whānau a choice</i>	<i>Clients were confused about who was their insurer.</i>	

4.12 What concerns do you have about competition?

Providers were concerned about competition causing: greater confusion, harder times for patients trying to file a claim, fewer referrals, a need for more training for their staff (ie the provider's staff, not the ACC's staff), more disparities, less focus on Māori, fragmentation of services, lower quality of staff and services, higher costs for much the same services, and an increased workload for them in terms of filing,

<i>Increase disparity for Māori</i>	<i>More reluctant to pay</i>	<i>Fragmented - increased complexity</i>
<i>The average kiwi would be 'priced out' especially Māori & Pacific.</i>	<i>ToW & commitment to Māori values wouldn't be at the forefront</i>	<i>More training required for staff</i>
<i>Fragmentation for everyone - disheartening for nurses - clinician/claimants</i>	<i>No infrastructure for people injured through no fault of their own</i>	<i>May impact the amounts/cover people are entitled to, & could increase stress of claimants</i>
<i>Didn't see any advantages</i>	<i>Increased workload.</i>	

4.13 What would you like a competition scheme to achieve?

Providers wanted a new scheme to be client focused, with more Māori accessing the service, a strong Māori kaupapa pervading the scheme, increased coverage, faster and better outcomes, more parity, best value, a fair and collaborative approach, and more support for claimants. They also wondered about lower costs and more options, which naturally appealed to them.

<i>Client focussed - more Māori accessing</i>	<i>Quality outcomes for clients & whānau.</i>	<i>To get best value at least cost to claimant</i>
<i>Delivery of a range of services to the claimant without negatively impacting on claimants</i>	<i>Use the best from tauwiwi but must have a strong Māori kaupapa</i>	<i>Increased coverage & schemes for return to work</i>
<i>To ensure the families I care for have the necessities of lie & good wellbeing in the event of an accident</i>	<i>Better & faster patient outcomes that are effective. Might give a fresh perspective on genuine vs. non-genuine claims</i>	<i>To provide a fair & collaborative approach to each case &/or level of accident</i>
<i>Ensuring info is available on accessing assistance for people with disabilities. People with disabilities are vulnerable so the system must be simplistic</i>		

4.14 Can you describe how you'd like a competitive scheme to work?

Respondents felt creation of such a scheme would have to begin with consultation, so as to incorporate Māori values and tikanga, followed by more streamlined and more transparent processes. Most also wanted the new scheme to be marae based.

<i>Mainstream system inefficient for Māori</i>	<i>Don't know.</i>	<i>More transparent, more info</i>
<i>for Māori. Call centres are alien to us. Consistency of service provision</i>	<i>Previous experience with competition was that it was burdensome to manage the paper work</i>	<i>Māori organisations & marae-based service provision, more streamlined processes</i>
<i>Begin with a consultation phase with iwi, enabled to participate in the development & structure & right through to implementation. Māori in high labour jobs = increased risk of injury - increased needs for ACC but co-payments are too much sometimes</i>	<i>Encompass the values & tikanga</i>	

5.0 Closing Questions

5.1 Do you have an opinion on another aspect of ACC that we haven't asked about?

Most groups did have some comments to offer, though there was not consensus either within or between the groups regarding the best option(s).

<i>More marae based services needed & reduced barriers</i>	<i>ACC staff don't look after the people. Don't hui with people</i>	<i>Originally set up with a good kaupapa but now not sure</i>
<i>Review process I've recently gone through, was advised the meeting would be attended by ACC & the independent reviewer. ACC linked in by phone - inadequate for establishing goals</i>	<i>Understand that it's hard for them but at the moment doesn't seem that they are trying. Client has to jump through hoops. Too hard.</i>	<i>Inter govt / cross sector relationships could be improved. WINZ & MoH & ACC & CYPS & Housing</i>
<i>Need better definitions around what you can and can't receive</i>	<i>More reflection of ToW & commitment to Māori at the top & have it filter down.</i>	<i>How often does decision maker go out to meet people?</i>
<i>If you're compliant with ACC, you'll have a good rapport with case managers. If not, the relationship is bad & you get a bad service</i>	<i>Back to work scheme. Very good to get back to work. Very good for serious accidents</i>	<i>ACC is a 'white' organisation, heartless, 'no feelings'. - not attuned with Māori values</i>
<i>Appalling - 6 months to get information</i>		

5.2 Is there anything else you'd like to share with us about your opinion on ACC?

Many claimants had suggestions which seemed largely unrelated to anyone else's ideas. Levy payers wanted to see the situation improve a bit, perhaps by incentivizing staying in shape and not becoming injured. Providers had several thoughts, including that "it's ACC's fault if Māori don't understand".

<i>Need to have more flexibility. Same hat doesn't fit all</i>	<i>ACC see you as a potential ACC thief</i>	<i>Got to go to them. Not very useful</i>
<i>Give Māori providers a chance to participate as an ACC-type provider</i>	<i>Complex system to navigate through for patients.</i>	<i>Need to improve getting people back into work</i>
<i>Easy process it all worked</i>	<i>Burton - killed people, gets a titanium leg! Dad has a wooden leg</i>	<i>ACC staff are there as Civil Servants to serve the people. Not vice versa</i>

5.3 Is there anything else you'd like to share with us about your experiences with ACC?

Claimants offered the sage advice that claimants both needed to wait and to be persistent in pursuing the claim. They also pointed out the need to be able to deal with bad attitudes on the phone. Levy payers had numerous stories, most of them were generally negative. Providers also had a wide range of ideas to share.

<i>Māori won't push. They will just accept what ACC say and won't fight. Don't know how they would set it up to make it better for Māori</i>	<i>People that have claimed ACC are not generally satisfied. Rehab is short-lived. Programmes - entitlement is limited. Contribution vs. entitlement is very unbalanced. Would like to have a choice, Māori mirimiri Rongoā vs. Western treatment</i>	<i>Employers are giving back handers to employees not to disclose injury.</i>
<i>Started out rocky as a claimant but then that became better</i>	<i>Patients have to wait long periods of time for surgery when they could get back to work</i>	

5.4 Would a change to include competition be a good one or a bad one in your opinion?

All three groups were mixed in their response. Claimants' responses ranged from 'good' to 'bad' and 'I don't know', but a larger group felt competition would be an overall negative. Levy payers, while mixed, had a slightly larger group who favored competition while even those providers who

viewed competition as a positive, qualified it by having a caveat of any change being led by and oriented towards Māori.

<i>If Māori looking after Māori - ka pai. If not Māori, it would be building another wall for us.</i>	<i>Good, as long as government compares what works best for New Zealanders</i>	<i>Good if specific requirements to deliver to Māori</i>
<i>Māori owned competition would be better</i>	<i>Depends on how it's set up. Don't want to see NZ become like US</i>	<i>Wouldn't know because you can't compare</i>
<i>Unsure, should be a good change but it depends on how it's implemented</i>	<i>It might change processes but could increase costs & be harder to access</i>	<i>Competition that wasn't corporate - that was set up with Māori values & based on relationships. Not one that's driven by profits</i>
<i>Competition would be good, not sure how that would look</i>	<i>Good - as long as we have participation in the process.</i>	

5.5 Would it help Māori or hurt us?

This too received very mixed reviews. Claimants were generally of the opinion that competition would hurt Māori, while levy payers and providers were more evenly split.

<i>Theory is great but good for govt but not for user</i>	<i>Help, as long as it's structured for Māori needs</i>	<i>One choice is easiest</i>
<i>It depends, but mostly it would help</i>	<i>Could hurt Māori if they are 'priced out' & can't afford the payments</i>	<i>Can't get any worse. No ACC would be worse</i>
<i>If it's not compulsory, people won't buy into it</i>	<i>It all depends. If it is designed in relation to Māori it would be a positive thing</i>	<i>It's hard enough to access one place for some people already</i>
<i>Choices are required to consider Māori. Competition is fair for Māori to participate in. Consultation is mandatory for all. Good if it went to Iwi</i>	<i>Have to pay for quality. Changes needed include the availability of: Mirimiri services; options for whānau to care for their loved ones. Currently \$13 per hour for caregivers</i>	<i>It could help some, not all. Lower levies would be good as many families are struggling financially. Needs to be balanced in order to be fair to Māori and whānau.</i>
<i>Depends on how they're (it's) run</i>		

5.0 Quantitative Data

The quantitative research undertaken by the DoL (see Appendix Four) reviewed ACC claims by ethnicity and found that Māori lodge only 11.55% of ACC claims, despite representing 14.6% of the population of New Zealand.¹⁰⁴ Māori appeared to be more seriously injured (as indicated by a higher rate of weekly compensation claims, commonly accepted as a proxy for injury severity). One reason for this, as mentioned above, is that Māori perceive filing a claim to be hoha – a great deal of frustrating effort for (frequently) no reward. Another possible reason is that Māori are disproportionately represented in serious injuries, which is in keeping with other data showing that Māori are more than three times more likely than non-Māori to be hospitalised after a motor vehicle accident.¹⁰⁵ Māori are also significantly more likely to die in such an accident, with a provisional age-standardised road death rate of 21 (per 100,000 population) in 2006, compared to 8 for non-Māori.¹⁰⁶ This suggests that serious road accidents and their sequelae occur more frequently for Māori and one would therefore expect higher utilisation of ACC services. Māori also may either work in industries with higher accident rates or work at jobs with higher accident rates (i.e. fewer desk jobs, more manual jobs or those with heavy machinery, etc).

The quantitative report also finds Māori with a very low rate of claiming social and vocational rehabilitation, which is in keeping with the current study's findings that Māori often find it very difficult to initiate claims and that there is a widespread lack of knowledge regarding what entitlements exist and what they are eligible to claim. An extremely widespread (almost universal) theme was that it was exceedingly difficult to obtain services unless you were (a) willing and able to advocate quite aggressively on your own behalf, (b) already experienced with the ACC system, and/or (c) had an exceptionally good case manager. There was even a perception that only one of these might not be sufficient.

This may also help to explain the shorter claim duration which the quantitative study found, as many respondents talked about the need to repeatedly chase medical certificates and other tasks whakamā, hoha, lack of time (and other resources) to devote to the claim, it would not be difficult to understand why Māori might be more willing to 'let it go', rather than pursuing the claim, therefore causing their average claim duration to drop. International studies support the idea that culturally discordant interactions (i.e. encounters where doctor and patient are from different cultural backgrounds) contribute to healthcare disparities, and similar forces may be at work here between ACC personnel and Māori claimants and levy payers.¹⁰⁷

As the quantitative report states, "the data shows that [Māori] spend a shorter amount of time interfacing with the Corporation." This mirrors data from GPs which shows that (non-Māori) GPs spend, on average, less time with their Māori patients, despite their having higher burdens of disease.¹⁰⁸ In another study,¹⁰⁹ exit rates suggested that Māori were leaving care earlier than other groups, which strengthens the finding of disproportionately shorter claims, despite the pattern of more injuries of greater severity. The interviews would suggest that this is because many Māori find ACC to be a culturally discordant, unhelpful, and unfriendly institution and that interactions with ACC are insufficiently productive as to be worth their time and effort (including stress, anxiety, lost wages, etc).

The quantitative study also found that Māori have a particularly low rate of claiming in the earners account, which was postulated to be due to a lack of knowledge of the coverage ACC offers. This is entirely in keeping with the current study's findings as well as with previous work in New Zealand¹¹⁰ and internationally¹¹¹ which demonstrates a general lack of understanding of health care systems.

Based on our work with healthcare organisations we predict that once adjusted for age and employment status the differential rates of Māori claims will be more similar to other ethnic groups in NZ with some specific exceptions (especially in serious claims, treatment injury and in motor vehicle account). A mitigating factor will be the use of injury related needs assessments and protocols within ACC which will likely ensure that Māori receive more equitable assistance once engaged with ACC.

As mentioned above, numerous studies have demonstrated that Māori tend to be less well served by the New Zealand health system.^{112,113} The quantitative study's finding that Māori receive a lower number of treatments on average supports this, as does its suggestion of 'endemic under-claiming by Māori'. Other data from the ACC also support this, highlighting disparities in Māori access to/use of home support services and elective surgery.^{114,115}

Further research to develop our understanding of why Māori experience of ACC is so different to non-Māori may contribute to our understanding of:

- Why Māori have lower claim rates (Māori only lodge 11.55% of ACC claims)
- Why Māori have a rate of weekly compensation claims more in keeping with their population (including barriers to access or lack of knowledge of the scheme).
- Whether Māori carry a higher moderate to serious injury burden
- Why Māori have a very low rate of claiming social and vocational rehabilitation (including barriers to access or whether there is a bias in discretionary entitlements or treatments).

6.0 Summary

The current research investigated Māori experiences with the current ACC and opinions about potential change to the scheme or organisation. Though diverse views are held within the community, there was widespread, nearly universal support for a compulsory¹¹⁶, no fault programme of coverage for personal injury. There was also the expectation that any change would prioritise equitable outcomes for Māori (whether under the existing scheme and provider or a new scheme). Equitable outcomes will be achieved through consultation with Māori before any potential change, tailored communications of new initiatives, culturally appropriate processes and services and culturally competent staff and providers.

Appendix 1: Questionnaire

Department of Labour Research into the Māori Experience of ACC Questionnaire	
1	Would you prefer to answer my questions in te reo Māori or English?
	Use the language specified
2	ACC covers the treatment of personal injury caused by an accident, no matter who was at fault in the accident. Do you think this is a good thing?
	Why?
3	What is your view of the 'no fault' aspects of ACC?
4	Does the 'no fault' aspect of the scheme benefit or hinder Māori?
5	How well does the existing ACC Scheme serve the needs of Māori wellbeing?
	Specifically: taha wairua (spiritual wellbeing), taha tinana (physical wellbeing), taha hinengaro (emotional wellbeing), taha whānau (family and community wellbeing).
6	Is it a good thing that the ACC organisation is the only one to administer the ACC scheme of nationwide, compulsory personal injury insurance?
	Why?
7	Would an alternative structure serve Māori better?
	No, go to question 11
	Yes, go to next question
8	What might that alternate structure look like?
9	Would it be more attuned to Māori values?
	How?
10	How important would this be to you?
11	What do you think a "competitive" scheme might look like?
12	Do you think such a change would be a good one?

Why?

Are you a levy payer?

No, go to relevant section

Yes, continue below

1 Does the ACC Scheme represent good value for you?

Yes, go to next question

No, ask what alternative structures could improve the situation?

2 As a levy payer, are your needs well met by the current structure of the Scheme?

Yes, go to next question

No, ask for details

3 Could alternative structures improve the situation?

No, go to next question

Yes, ask what would you like those alternative structures to be?

4 What difference do you think a competitive scheme would make for you as a levy payer?

5 Would this be a good change?

Why?

6 As a levy payer, is the current system of levy payment efficient for you?

7 What would be the likely effect of alternative structures on the efficiency of this process?

8 What kind of 'alternative' changes might you expect?

9 Would you like to see these changes?

10 Is there anything else you would like to change about ACC?

11 As a levy payer, how would you like your interaction with ACC to work?

12 As a levy payer do you like having a compulsory, nationwide scheme, or would you prefer a choice of insurers?

Are you a healthcare provider?

No, go to relevant section

Yes, continue below

1	Are you in treatment, claims management, or rehabilitation, or some other role?	record which one or, if other, what their role is:
2	As a provider, are your interests well served by the current ACC structure?	
3	What would you change about ACC if you could?	
4	As a provider, how would you prefer to function within the ACC Scheme?	
5	What would your preferred relationship with ACC be?	
6	As a provider, do you like having a compulsory, nationwide scheme, or would you prefer a choice of insurers?	
7	What opportunities exist for you under the ACC Scheme or under potential future structures?	
8	How could changes in the way Māori providers are used within the Scheme benefit your Māori claimants?	
9	What do you think competition would mean for ACC?	
10	How do you see competition helping you?	
11	How do you see competition hindering your work?	
12	How do you see it affecting your clients?	
13	What concerns do you have about competition?	
14	What would you like a competition scheme to achieve?	
15	Can you describe how you'd like a competitive scheme to work?	

Have you ever been a claimant?

No, go to next relevant section

Yes, continue below

1	Do you think Māori can access ACC as easily as non Māori?
	Yes, go to question 5
	No, ask following questions
2	Why do you think this is?
3	What sorts of changes might improve access for Māori?
4	What effect might competition have?

5	What is your experience in getting access to ACC services?
6	What barriers did you experience?
7	What is your experience of treatment through ACC?
8	What is your experience of rehabilitation through ACC?
9	What is your experience of weekly compensation through ACC?
10	What aspects of the ACC organisation work well for you?
11	What aspects of ACC cause problems for you?
12	Do you feel that you are currently well served by the ACC Scheme and that it allows for appropriate services to be offered to you?
13	What alternative structures would allow for appropriate services for you or your whānau?
14	What alternative structures would allow for improved access for you or your whānau?
15	As a claimant, what would you change about ACC?
16	As a claimant, do you like having a compulsory, nationwide scheme, or would you prefer a choice of insurers?
17	Do you think Māori claimants have different needs from non-Māori?
	No, go to next question
	Yes, go to final questions
18	What are the differences?
19	Have you ever been seriously injured?
	No, go to final questions
	Yes, ask next questions
20	Does (or did) ACC meet your needs when you were seriously injured?
21	How could these needs be better met?
22	What type of structures could better deliver services to meet those needs?
23	Are you a non-earner?
	No, go to final questions
	Yes, ask next questions
24	Are your needs as a non earner well met by ACC?
25	How could these needs be met better?
26	What type of structures could deliver better services to meet these needs?
27	What impact would you imagine a change by ACC to a competitive structure might cause you?
28	Would these changes be positive or negative?
	Why?

Final Questions

Do you have an opinion on another aspect of ACC that we haven't asked about?

Is there anything else you'd like to share with us about your opinion on ACC?

Is there anything else you'd like to share with us about your experiences with ACC?

Would a change to include competition be a good one or a bad one in your opinion?

Would it help Māori or hurt us?

Why?

Appendix 2: Personnel

MOA Principal Consultants



Dr David Jansen

MBChB, MRNZCGP, BHB, BA (Māori), Dip Tchg, GradCert Clin Tch
Co-Director

David is Ngāti Raukawa and was formerly a resource teacher of Māori studies and language in the Hawkes Bay before he completed his training as a medical practitioner at Middlemore Hospital in South Auckland. David's main focus is running clinical teaching, Te Reo and Tikanga Māori programmes for Māori health professionals throughout the country. He is also Chairman of Te Ataarangi Educational Trust. David has also published a phrase book of Māori medical terms that was released in February 2006 as a resource for the Māori health sector. He is currently a General Practitioner in Auckland.



Dr Kira Bacal

MD PhD MPH FACEP
Co-Director

Dr Kira Bacal is originally from the United States and completed her professional training there. She has a master's degree in public health, a doctorate in molecular physiology, and specialty board certifications in emergency medicine and public health medicine. Prior to joining Mauri Ora Associates in 2006, Kira worked at NASA-Johnson Space Centre, developing an improved medical system for use in space, and served as a health policy fellow in the United States Senate. She held academic positions at the University of Texas and Ohio University. Kira is a director of Mauri Ora Associates, as well as the Phase Two Director at the University of Auckland Medical Programme Directorate. She also works in a local Emergency Care Center and serves as a coordinating doctor for International SOS.

Karen Vercoe is owner and Principal Consultant of KTV Consulting Ltd. KTV Consulting Ltd specialises in Organisation Development from governance to operations and has a focus on working with Māori organisations. Karen has a background working with Iwi in the health, sport and social sectors, and recently worked in Government developing strategy for Māori engagement, and undertook the interviews for this project.

Melanie McFarlane is a senior manager and registered nurse specialising in sexual health and experienced in accident and emergency, Melanie has also led and managed healthcare teams to provide high quality, timely services which are responsive to client needs and utilise available resources effectively. She is currently a project manager/consultant with Communio New Zealand Ltd, and undertook the interviews for this project.

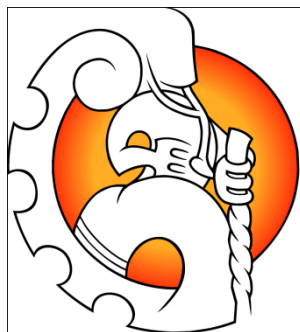
Appendix 3

Preliminary Report 16th April 2010

Department of Labour

Draft Preliminary Report for Research into the Māori Experience of ACC

April 2010



Mauri Ora Associates

Research into the Māori Experience of ACC

PRELIMINARY REPORT

OVERALL NUMBERS

CATEGORY	NUMBER
Total # of category-specific interviews	206 ¹¹⁷
Total # of informants	119 ¹¹⁸

CONTENTS

1. The relationships Māori have with ACC at the Scheme level and the impact of these relationships on Māori.
2. The relationships Māori have with ACC at the Organisational level and the impact of these relationships on Māori.
3. A narrative about the Māori experience of ACC.
4. An overall picture of how changes to the ACC Scheme may affect Māori.

SECTION ONE: OPINIONS ABOUT THE ACC SCHEME

Overall

- ACC is a “super scheme” (i.e. a great scheme) because it ensures that everyone is covered, regardless of socioeconomic status or background
- ACC Scheme is imperfect but it’s what we are used to
- ACC scheme from a provider perspective adds value to Hauora Provider service delivery for their registered clients
- ACC as a scheme is good as all Māori are covered
- ACC the scheme is good in theory for claimants as all people can access the scheme, however dealing with the organisation itself has been difficult
- Many small business owners, typically those working in administrative or low risk clinical environments, had lower usage of ACC and therefore tended to feel they did not get good value in comparison to the levies they pay. In fields where staff often suffered minor injuries, e.g. kitchen/catering incidents, they felt they received good value from the scheme
- “It’s a good idea in principle”
- The ACC Scheme helps if you cannot work
- The ACC “no fault” aspect for business owners is not supportive if staff are at fault, “particularly if you have made significant investment into staff health and safety training for that staff member. Staff who are unsafe should be held liable”
- “It’s good that it’s no fault as that keeps lawyers out of it”
- Many people want accountability despite the no fault nature – e.g. DUI cases shouldn’t get ACC and “criminals should be excepted” from ACC services
- “There is no transparency built into scheme” re what you can claim for and what entitlements there are – the result is that implementation is largely based on individual case managers
- “ACC should not be profit focused, they should be care focused”

No fault aspect – pro:

- It’s good that Māori can claim without blame being a factor
- “The ACC scheme and no fault policy are good in that they ensure all New Zealanders including Māori and disadvantaged peoples are covered”
- “It’s a good idea”
- The no fault scheme is viewed as a good thing especially in the Far North where rurality and isolation are major issues, where there is a high proportion of

unemployment and transient or seasonal employment (i.e. fruit picking) and many are in low socio-economic circumstances – at least there is something for these people if they are injured accidentally

No fault aspect – con:

- ACC cover for injuries sustained while people are involved in a criminal activity was viewed unfavourably
- ACC cover for overseas visitors (unless an emergency) was seen as an unnecessary waste of NZ taxpayer money – these people should take out travel insurance
- “Even if it is hard to regulate payments, we don’t agree [with a system] where criminals are receiving entitlements and victims do not”

SECTION TWO: OPINIONS ABOUT THE ACC ORGANISATION

Overall

- ACC is a “faceless” organisation that relies too much on electronic forms of communication
- ACC as an organisation is good to deal with from a Hauora Provider perspective as they provide good information for the provider to access the scheme
- Overall, ACC has not been found to be culturally responsive. Despite having policies in place (e.g. Treaty of Waitangi, *whānau ora*) and pockets of goodwill throughout the organization, this is not seen as having filtered through into practice within ACC nor within ACCs preferred providers. Moreover, there seems to be no mechanism by which clients can ensure accountability for cultural responsiveness/ appropriateness in either ACC or its preferred providers
- “Dealing with the organisation has been difficult as there is no opportunity to speak with someone face to face. You are often referred to someone who lives out of town. The 0800 number is good but then you get passed around which is frustrating”
- Navigation through the scheme is “complex as!” More education is needed to understand the components of the scheme particularly for patients. GP’s understand the scheme but information that can be given to clients is poor.
- The ACC was felt to process claims, not care about people and to be a generally “cold” organisation
- “ACC is essentially a call centre”
- The organisation’s processes are felt to be not transparent and the quality of service/results depend on the generosity of the individual ACC staff member; the case manager seemed to make all the difference in terms of the experience (good or bad) the claimant had
- One person was told by an ACC staff member that cost savings was ACC’s focus, so they couldn’t approve a claim
- Respondents didn’t condone abuse of the ACC system but were made to feel like “ACC thieves” when trying to discuss their claims with ACC staff
- Theoretically claimants have a choice of practitioner, but many people reported that in reality, “there’s no choice”
- Many felt marginalised and stereotyped as “ACC bludgers” by ACC staff when visiting ACC offices
- Many respondents reported that ACC has very poor communication – unclear info re claims, no info at all, etc – and that as a result people tended to learn from other claimants what they needed to do rather than from the organisation itself
- Several felt it was easy to access ACC via GP but hard (and frustrating) to try to find out how and why claims are rejected

Holistic approach observed:

- Some gave examples of ACC affecting wider aspects of Māori wellbeing (especially *taha hinengaro* and *taha whānau*)
- ACC help to meet claimants' physical needs, for which people are very grateful. In terms of meeting other aspects of Māori wellbeing (*hinengaro*, *wairua*, *whānau*), if these are met, it is usually as a by-product of the physical needs being met, i.e. weekly compensation to enable the *whānau* to have the essentials (*kai*, place to live etc), home modifications to enable the person to live and be cared for at home by *whānau*, reduced stress due to financial assistance available (although stress was increased due when ACC's communication was poor)

Non-holistic approach observed:

- "ACC focuses more on short-term physical injuries rather than the whole person"
- "The ACC scheme does not treat Māori holistically; it treats specific injuries"
- "ACC does not cover dental, so how can it cater for your total wellbeing? [My] *mokopuna* got her teeth knocked out at softball, and ACC approved her stitches but not her teeth. The *mokopuna* was *whakama* that her front teeth were knocked out [but ACC wouldn't do anything], so ACC does not consider the holistic wellbeing of Māori."
- Some providers see ACC not as an organisation that cares for people, but as one that cares only for process and saving money
- "ACC treats me as an injury, not as a whole person"
- "The ACC scheme is injury specific not about wider Māori wellbeing"
- "Māori have a greater need for their spirituality to be taken care of, Māori are a more *wairua* (spiritual) people" [and ACC does not recognise this]
- ACC was not felt to provide adequate support and access to alternative Māori therapies is important (e.g. *miri miri*, *rongoā Māori*)

Pro-competition:

- "ACC should be competitive for business owners as it provides choice and hopefully get insurers to pitch for our business"
- A role developed as a joint venture between ACC and a West Auckland Māori primary care provider was seen as very successful as it provided someone from ACC for people to speak to when they attended clinic about ACC and their ACC claims – a role such as this would be more attuned to Māori values, especially in environments like ED (where claims are barely processed at all)
- Some felt accreditation of smaller provider organisations would be a good thing for increased accountability at the provider level and would decrease "double-dipping" where providers insist patients pay high co-payments and also claim from ACC
- "ACC should not be the only organisation to provide [ACC-type cover and services] as we need more choices. Hopefully these choices will decrease levies, improve service delivery and make the scheme easier to access"
- "ACC hasn't embraced the changes in the primary care sector, e.g. PHOs, and significant opportunities go untapped for Māori to actively participate in this market"
- Some feel competition will provide opportunities for Māori providers to participate in the personal accident insurance market which would enable a more culturally responsive approach to be taken, including –
 - Provision of community and *marae*-based (ACC-type) services as these are places where Māori gather, this would allow Information can be imparted through using real-life stories and examples
 - Enabling *whānau* to be included in discussions with ACC about their *whānau* member as "more heads are better than one". One *whānau* member may have

trouble remembering all the things they want to discuss or ask or may not feel confident to ask such things if on their own. By involving the *whānau* in the discussions, it increases the understanding across the *whānau* and enables the “load to be shared” so it does not become too onerous on any one member – also fosters social cohesion and *whānau ora* for the claimant and their *whānau*

- Opportunities for *kanohi ki te kanohi korero* both at a *whānau* level and through *hui* – this is what works best for many Māori
- Māori are *whakama* and don’t like to ask for help, especially older Māori. It’s recognised that young Māori are more likely to be aware of their entitlements and will ask for assistance and be able to access information electronically
- Development of ACC-type services that are based on a *Whānau Ora* model would encompass the whole person in the context of their *whānau*, *hapu* and *iwi*
- Some feel competition might lead ACC to “smarten up their act” and look at ways of improving
- One levy payer did not consider ACC to provide good value due to low/nil ACC utilisation and would be keen to see competition introduced as it would provide opportunity to off-set their levies
- Alternatives to ACC could include ACC as the default scheme but employees would have the choice to choose other providers.
- “Change to a competitive environment would be a positive thing if it was based on Māori values and allowed Māori to self-determine their own pathways”
- Many viewed competition as an opportunity for Māori provider development although the opinion was that ACC was not focused on this issue
- Competition might provide opportunity for Māori organisations to be involved to provide programmes targeted to Māori
- “Competition could provide opportunity for a more culturally responsive approach, not a “one size fits all” approach which has not worked for Māori in the past”

Anti-competition:

- “Competition would be detrimental to Māori as it would not increase quality – choice does not equal quality”
- It was felt by many that a competitive scheme would generally be confusing, so the change would not be good for Māori as “we can barely navigate our way through the existing system”
- Many would be happy with ACC being the only provider if the ACC’s systems and processes could be reviewed and streamlined to make it less confusing and more understandable
- “When the ACC scheme was previously competitive, it was costly and complicated”
- Many people had concerns that competition would lead to increased complexity, fragmentation of cover and ultimately reduced access for Māori to ACC
- Overall, the feeling was that competition would not be a good thing for Māori
- Many support ACC as the sole organisation to administer the scheme as Māori would not benefit from more choice “because competition would be focussed on profit, not people”
- “Having one organisation is great” – due to the perceived ease of filing claims with the single entity
- “Competition will cause confusion, we hardly receive services as it is, others in the market will only make it more confusing”

- “Competition will create more confusion and barriers for Māori who are already under-accessing the scheme – how will things improve if we introduce multiple providers/options (i.e. more confusion)?”
- “Competition does not [automatically] equate to better serving the needs of Māori”
- “It’s a good thing that there is only one organisation. When they had multiple insurers it was a nightmare!”

Mixed feelings re competition:

- In terms of having a choice of insurers, several informants recalled the previous competitive structure and while one liked it (because of the levy savings although they did admit the paperwork was burdensome), the other didn’t (because of the increased complexity of the system)
- Some felt that choice would be good but they were afraid of the complexity this would add to an already non-transparent and complicated system
- Those who support competition felt government would need to ensure competitors are wellbeing-focused, not profit-focussed
- Some felt ACC should be improved (or improve itself) rather than have a whole new system/structure set up
- Some people argued that “the government would still ultimately have control, so what would change?”
- Many people felt that competition would merely allow the government to “pass the buck” and promote deniability, and it would be even more frustrating to have to deal with 2 or 3 organisations versus just the one
- Some voiced the opinion that there has already been a reduction in approved claims and expressed their belief that the scheme is about to be changed (the implication was that the decision to change ACC had already been made, but the government just hasn’t admitted it yet)
- “I like that things happened automatically (i.e. the clinic did all the paperwork)” – the implication of this is that any alternate structure would need to have the same ‘automatic’ filing processes

Experiences with ACC staff and processes:

- “ACC invoicing is appalling. It takes roughly 5 months to receive an invoice and most contracts have been finished before the invoice has been sent and paid. (Contracting ends 31 June but the invoice does not arrive until September, and then payment is due in October)”
- Some commented that ACC staff need further training including in cultural competence and compassion, because many case managers and branch medical advisers are “very jaded”
- “Staff on the phone are heartless”
- People like the fact that claims are automatically submitted by the treatment provider upon presentation and where necessary, employers send through salary details directly
- People repeatedly voiced feelings that there was no consistency or standards around how the ACC entitlements are awarded: “Access to entitlements is proportional to the relationship with the case manager”
- Several providers reported finding ACC staff case managers and ACC staff to be “judgmental and inflexible” in their approach to Māori clients
- One provider reports having a positive experience with ACC, but notes this is because the provider has worked extremely hard to establish a relationship with ACC. In a new scheme, those relationships would be less effective, or more time and effort would be required to establish similar relationships with the new players

- Providers often feel they must support clients and *whānau* with their engagement with ACC in order to optimise outcomes for the client.
- A “Māori face” is needed for the ACC
- ACC communication is felt by many to be poor, and claims information on PHO provider organisations is unavailable, therefore it’s difficult to determine whether good value is achieved
- Many people reported experiencing a lack of communication from the ACC to the claimant, e.g. not informed of change of case manager and reasons why; claimant not informed of an issue regarding medical certificates and payments were ceased without notice which not only caused stress and frustration but also required persistent effort by claimant to overcome
- Some provided good feedback about case managers, although others commented about a perceived lack of competence of case managers
- A great many voiced a desire for more Māori case managers
- One advocate felt she was not taken seriously by ACC staff as she was “just a CHW” (community health worker)
- Rural and isolated communities felt they face significant access barriers and ACC staff (who are usually not local) sometimes do not appreciate this, e.g. when asking for an appointment time to be changed
- Some claimants report difficulty in receiving help with their claims over the phone and being given the “run around” by unhelpful ACC staff
- Some ACC staff from overseas are problematic, for example, a case manager who spoke English as a second language and who was extremely difficult (“impossible”) to understand or an ACC specialist doctor from a foreign country who the claimant felt provided a substandard service
- Efficiency of current payments systems is straightforward and easy, however a follow up letter in addition to the annual invoice would be appreciated in addition to face to face opportunities for discussion
- “If your case manager is supportive and ensures you receive all the services you are entitled to [then] the experience is good, however this is not usually the case”
- One problem frequently reported was that although claimants wanted to return to work, they often had to wait long periods of time for specialist care or surgery and were out of work for a prolonged time as a result; if the system had provided their care more rapidly and efficiently, they would have been back at work much sooner (and paying into, rather than using up, ACC funds)
- Māori were more often unhappy with how they were treated by ACC staff than satisfied with their service. Comments about ACC staff included: rude, disrespectful, lack of privacy, “made me feel *whakama*”
- Many cited a need for onsite assistance for ACC-related at *marae*-based and community services, and hospital emergency departments as this would provide opportunities for common barriers to be overcome, including:
 - For some, the complexity and amount of paperwork
 - Being “*whakama*”, not wanting to go “cap in hand” to ask for assistance
 - Feelings of frustration at the depersonalized service received when following up on issues and problems with claims
 - Lack of effective assistance from ACC staff, especially by telephone

Experiences filing claims

- Access to ACC was generally thought of as a “headache”, and that people “need to stay on ACC’s back to get traction” with their claim

- Several people identified the paperwork as being problematic – reports of missing or “unlocatable” forms despite them being hand delivered to ACC office; lack of communication from ACC to employer and claimant if paperwork is incomplete or inaccurate; lower literacy levels among Māori pose a real barrier to completing forms correctly first time around, if at all, and to accessing information about entitlements and processes
- When all paperwork is completed, claims approved etc, then all was well and ACC tended to be viewed positively
- Providers reported that needs are met and claims for clients are managed well (only) if the claims are straightforward
- “Reduction in the number of Sensitive Claims being approved has had a detrimental effect on the health and wellbeing of clients so although ACC is saving money in the immediate term, the long term effects to *whānau* and the ongoing costs to *whānau* will be significant. This includes increased suicide and generational unwellness”
- Claimants’ opinions of the ACC varied based on the outcome of their claim. They thought ACC was great **if** they had claims approved and received entitlements. Others thought ACC was not transparent, that it was hard to navigate through and ACC don’t communicate or explain
- One claimant described having to go to ‘60 Minutes’ before their claim was processed. They had been battling ACC for 3 years but as soon as ‘60 Minutes’ did the story the claim was processed in a week. That suggested to them that all the previous delay had been unfounded and their associated frustration and stress wholly unnecessary
- “Access to ACC is good, but navigation through the system is difficult, sometimes information about entitlements is obtained accidentally and not from ACC”
- Several people reported good experiences with treatment and rehabilitation services used via ACC
- Some feel ACC paperwork is lengthy, onerous, and unnecessary
- Some claimants chose not to access weekly compensation because of the associated reduction in household income by 20%. For some *whānau*, this is too much of a reduction and they choose to return to work early which can impair healing of their injury
- Where claimants are confident they are able to access ACC, it is often because they have previously made claims, or attempted to, and had negative experiences. However, with experience, hindsight and knowledge about entitlements, their subsequent claims have been more satisfactory
- Many claimants are entitled to cover but choose not to pursue their claims due to the difficulty of navigating the system, lack knowledge and/or confidence to challenge and/or to have to ask or be required again to justify the validity of their claims – this was noted across all types of claimants
- Long term claimant experiences varied from person to person and for individuals. Positive experiences were characterised by having understanding case managers (although very few of the case managers were Māori), good communication, proactive provision of information about entitlements and assistance with processes/paperwork etc. Negative experiences included delayed payments, lack of communication about any issues with their claims such as incomplete paperwork, changes in case managers etc
- It was noted that patients sometimes have to wait long periods for treatment or surgery, however “if they were dealt with quicker people could go back to work faster. Patients want to go back to work”

Specific Groups:

- Treatment Providers
 - Many providers voiced the feeling that they must do a great deal of liaising with ACC on behalf of claimants – competition could thus create great difficulty if other organizations require similar time commitments
 - ACC standardised packages of care enabled easy access to information and ‘the next steps’ for providers (and probably for claimants too)
 - ACC respond well to requests by service providers for items/equipment for claimants as long as they have a good rationale (“ACC trusts sound clinical judgment of service providers”) and this has made positive differences for (long-term or seriously injured) claimants
 - Some providers thought that competition might provide additional opportunity for Māori organisations to provide Māori-targeted programmes, also that more return to work schemes were needed (along with promotion of same)
 - Administration is time intensive from a provider’s perspective. The processes ACC use are repetitive; they have to enter a client’s details each time instead of entering in the NHI and having all of the relevant information automatically appear
 - Competition would be particularly detrimental to claimants, less so for providers, as it might enable service providers to choose ACC-type providers that are most likely to achieve good outcomes for their particular clients
 - Being an ACC approved organisation is good as an added value for the organisation but it is not cost effective. The administration time is not factored into the cost
 - “Competition might be good but we don’t know what that will look like so can’t really make any comment. In general, we support the notion of competition BUT we can’t support the idea if we don’t know what that would look like.”
 - “As an organisation our needs are well served by ACC however we vet claims here in-house before we send off the claims to ACC for our patients and this usually means all of our patients claims are accepted and processed”
 - “ACC communication with our organisation is very good, we have a good case manager and they regularly travel to us [Kaitaia], and we have a good relationships with ACC.”
 - Some treatment providers would be unhappy if multiple insurers provided the scheme: “The workload would double for us as patients don’t usually remember who their insurer is, then the provider has to ring the insurer to find out the patient’s details. It can be very time consuming from a provider’s perspective”
 - Competition would not be good as usually insurers are “more reluctant to pay out”. Filling in the incident forms becomes more rigorous when there are multiple insurers which means more time spent on the form filling
 - Competition would mean insurers would be more focused on making more money and paying out as little as possible
 - “It is not cost effective [for us as treatment providers] to administer” ACC
 - Some treatment providers were “not sure exactly what ACC does or can do for our clients. We would like to build a relationship with ACC to stay informed about what people can access so the organisation is aware and informed of the services ACC provides
 - Some employers were giving backhanders to employees not to disclose the workplace injury. One GP had recently experienced this with a patient
 - Some raised questions as to how ACC staff were recruited, given the providers’ less-than-satisfactory encounters with numerous ACC staff members

- Claimants
 - A large number felt that ACC should facilitate greater access for claimants rather than claimants having to rely so heavily on their own ability to navigate the system and advocate for themselves or to have *whānau* to assist them (though younger Māori were felt to be more able to navigate the system and articulate their needs than older Māori)
 - There were many, many examples given of lack of communication between ACC and claimants, including changes in case managers and problems with medical certificates resulting in cessation of weekly payments without prior notification
 - ACC assistance is felt to be great once it starts, but more often than not, obtaining anything beyond initial treatment, diagnosis and rehab often requires claimants to have **persistence** and **perseverance** in order to access their entitlements
 - In trying to resolve issues, claimants report success only comes after speaking with a manager and this is usually after multiple attempts and contact with other staff (this experience is echoed by service providers)
 - Long term claimants' responses seemed to vary based on their relationship with their case manager. Positive experiences were had by those who described understanding case managers (most of whom were not Māori), good communication, and proactive provision of info and assistance (such as about claims processes, etc)
 - Many prefer to speak with someone face to face to talk through the claim but this is often not available. "There is no-one based in our city so we have to travel to the regional office (which is an hour 15 minutes away). This is a barrier"
 - "It's hard to navigate through the system, it is very complex"
 - "I had to complain and be insistent to ensure that someone heard and dealt with my case"
 - Some claimants have had good experiences with ACC, smooth transition from claims to approval and treatment but this was usually due to the fact that the claimant had knowledge of the scheme and so knew what forms needed to be filled in and how to go through the process
 - The back to work scheme was very good for one claimant as it moved her back into work fast and she appreciated this

- Levy payers
 - Levy payers' opinions re the scheme's values hinged on the utilisation of ACC services by themselves or their staff: those who ran low risk businesses (e.g. clerical, admin) had lower usage and felt it wasn't good value for money. Those in higher risk categories (e.g. catering) felt it was good value
 - One business owner said he felt he was "propping up a system" he and his company didn't use but they were willing to do it 'from a social investment perspective' (*ta tau ta tau*)
 - Many felt that ACC did not represent good value for their money because "we are not sure how ACC levies are calculated nor what we are paying for" and "it seems like the levies are increasing every year without the levy payer knowing why"

- Levy payers generally felt that the current payment system was very straightforward, and competition may introduce more complexity and increase paperwork, however, options for lower levies would be a good thing
- Improved communication is needed between ACC and employers, especially if staff members are off work for more than 6 weeks and for cases in “grey areas” – in these instances, options for face to face discussion would be good as these claimants represent financial (and other) risks to the employer
- Levy payers anticipated competition would increase choices/options but would need increased knowledge to be able to calculate cost-benefit ratios
- Many felt that competition would NOT be a good change for them
- Business owners feared that while the efficiency of the current payment system is very good, it would likely become more complicated in a competitive environment
- Some business owners don’t like the fact that ACC has a monopoly and would appreciate competition for more choice and for specialist ACC cover from industry specialists, e.g. Forestry, Gyms, Backpackers, Tourism)
- “ACC provides good value because even we have low claim rates, the organisation can have ‘peace of mind’”
- The ACC scheme and the invoicing of the scheme is not clear. Many business owners want a breakdown of what their invoice relates to. It is hard for them to say that they get value for money as they don’t know exactly what their invoice relates to
- “ACC billing is late so a business has to do accruals which are time consuming”
- “ACC payments could be spread over a year for business owners to better manage cash flow”
- Many complained that ACC doesn’t account for seasonal variances for business owners within different sectors, e.g. tourism peak times are around Christmas and holidays, gym owners’ peak times are pre summer and pre winter sports seasons
- Generally speaking, the value of the ACC scheme only noted when it is utilized by the levy payer
- Many suggested that the ACC should have business account managers
- “Paperwork and waiting time is a barrier for levy payers which means levy payers weigh up whether claiming is worthwhile”
- It was felt that a competitive scheme could make a difference as (in theory) it would lower levies and processing times for claims
- Many felt automatic payment of levies would be preferable (i.e. through staff wages etc or at the end of each month in line with PAYE)

SECTION THREE: NARRATIVE ABOUT THE MĀORI EXPERIENCE OF ACC

- Many Māori are unaware of entitlements and this is compounded by low Māori literacy rates
- “ACC cover is not good because although everyone pays, not all get the benefit and when you try to access benefits even if you’ve worked 40 odd years, you’re still not guaranteed to receive it. It’s a waste of money.”

- Access for Māori is sometimes good but navigation through the system is difficult due to its complexity – people have to ‘be on to it’ in order to get their entitlements – many Māori wouldn’t have the resources to do this and therefore miss out.
- Most thought ACC was not transparent, hard to navigate through and ACC don’t communicate.
- Communication and a lack of information from ACC was felt to be a major barrier for Māori to accessing assistance
- Hospitals (e.g. emergency departments) rarely process ACC claims which leads to difficulties when patients present at primary care and no record is available of any ACC claim made from the hospital – many people miss out on entitlements as a result
- Many Māori give up on following up on entitlements either for themselves or their clients because the process is too time-consuming and resource-intensive on top of everything else that needs to be done
- For many Māori, the cost (or perceived cost) of co-payments for consultations and x-rays etc are barriers that some are unable to overcome – people won’t tell the GP necessarily that they can’t afford the co-payment for an x-ray and they just don’t go. This isn’t known to the provider until the person eventually returns to clinic and by then, they are usually no longer entitled to cover
- We heard several positive examples such as how one *whānau*’s toddler sustained serious injuries and over the years the *whānau* has received wonderful support from ACC which led to decreased stress for the *whānau* and the ability for the child (now a woman) to be cared for at home by her *whānau*
- One claimant living in a rural location with no phone and where mail is often intercepted by local youngsters provided alternatives for ACC to contact her, but these were ignored, which resulted in delayed compensation payments
- Access barriers encountered by claimants have included difficulty with the paperwork as, for example, one claimant was unable to read and write. It was widely felt that lower level of literacy of Māori compared to non-Māori is a major barrier. For these people, face to face communication and proactive assistance is essential for accessing ACC, especially as some people don’t have *whānau* to help them with the forms; written information in pamphlets (in *te reo Māori*) is useful but only for people that can read
- Māori are *whakama* and don’t like to ask for things; especially elderly Māori
- Some people reported very positive experience of access, treatment and rehabilitation, while others had problems (e.g. injuries deemed to be ‘previous’, lack of travel reimbursements for journeys just under the limit of 26km per one way trip)
- The closing of branches and location of offices in main cities disadvantages Māori in terms of access
- Several complained that although there were now more Māori at the ACC, some in quite senior positions¹¹⁹, the number of denied claims were still rising and no improvements to Māori inequalities were perceived
- There is no logic in how case managers are assigned – stories of people in one part of the country having case managers in another part – which does not support Māori preferences for *kanohi ki te kanohi* or face to face encounters, and it also makes it hard to establish a relationship with a disembodied voice at the other end of the phone... which rarely happens because the managers change frequently and claimants continually have to start from scratch and explain their situation to a new person
- Lack of timeliness in processing claims – one *whānau* was told to book specialty surgery as would be covered but didn’t get authorising letter until 2 days ahead of time and this was very stressful

- Several felt the scheme could be managed better through local *kaiawhina* helping claimants to navigate through the scheme
- There's overall wariness about competition among Māori, and although there are many potential positives seen (people like the idea of having choice/options, they see opportunities for Māori providers to become involved; and they hope that ACC would be forced to improve their service and streamline their processes) there is a fear of the system becoming even more complex and the good things about ACC (i.e. there being only one organisation to understand, work with and deal with; automatic initiation of claims by service providers upon presentation to the service etc) being lost.
- Most Māori would prefer ACC to retain its monopoly but for its systems and cultural responsiveness to be improved

SECTION FOUR: IDEAS ON HOW CHANGES TO THE SCHEME MAY AFFECT MĀORI

Overall comments

- Many voiced that they like the idea of having options yet were afraid of increased complexity leading to worse outcomes
- A competitive scheme may result in lower levies for people and provide choice but would also increase complexity, possibly lead to fragmentation and stricter rules for appropriateness of claims
- Most people are unable to visualize and/or articulate how alternative structures for ACC or how a competitive environment may look. Regardless of the structure and competition, people say they want a system that:
 - is easy to navigate
 - has its information accessible in a variety of ways including the option of face to face communication
 - offers access to help with completing forms
 - has culturally responsive processes, systems and staff (including more Māori staff) and
 - is of a high quality

Changes people would like to see

- Real consultation is required if the scheme is to change and become competitive i.e. privatised
- Incentives, e.g. no claims bonus which reduces your levies
- Provisos which include having a set criteria for available cover and the cost of this cover across a sliding scale would be helpful (i.e. establish some non-negotiables)
- If the scheme were to change, the new organisation(s) should make sure that Information is readily available and thus avoid the need for people to have to ask (as Māori won't); having someone at hand to speak to about ACC claims would be really helpful (in a clinic setting for example) – more information is needed on what people CAN claim, not what they CAN'T
- Exemptions to blanket 'no fault' policy – criminals injured during commission of their crime, non-emergency (i.e. life-saving) care for visitors to New Zealand
- Māori Advisors or community advisors could aid in relationship-building and serve as a first point of contact. IRD have community and Māori advisors who are very good at assisting business owners; why don't ACC?
- People want clear information on entitlements – what is covered when they present at a GP clinic or medical centre - how much is OK for providers to charge as co-payments for consultations and diagnostic procedures? Am I able to claim back any money on

the additional things I paid for as part of my recovery (e.g. crutches, ankle straps etc)? And if so, how?

- The idea of more choice initially appeals, but as more thought is given to how the choices will be offered, by whom, and other such details, people change their opinion due to concerns that Māori would (again) be left out, exploited, or underserved
- People feel that any alternative structures should include more (and more effective) education and prevention programmes
- Many providers want a relationship with ACC and not be thought of “After the Fact”
- An alternative structure could/should provide opportunities for Māori organisations to become involved, for *hapu* who know their communities to manage these services for *whānau*
- We know that service delivery methods that are the same for Māori and non-Māori are not effective for Māori, unless this changes, Māori will continue to access services less
- More inclusion of *whānau* as partners in client health, more “wrap around” services at local community level (e.g. integration with local Māori health provider)
- Less reliance on electronic communication and more on face to face relationships would be a huge benefit for many, especially Māori.
- Avoiding the sense that filing a claim is “asking for help”, since we know that many Māori won’t do this
- Provision of support groups e.g. for seriously injured people, especially as the waiting times between steps/specialist appointments etc can be lengthy which can lead to increased stress for claimants and their *whānau*, reduced self-esteem and confidence of claimants and guilty feelings in claimants at being “unable to provide” for their *whānau*
- “More (holistic-oriented) information from ACC for the *whānau* of someone with a serious injury would be good – i.e. to advise that it is likely to be difficult for everyone affected”
- “An alternative structure would (only) support Māori if it was founded upon Māori principles of *manaaki*, *awhi*, *tautoko*. If the alternative structure is not founded on Māori principles nothing will change”
- As described above, many felt *marae* could be used as hubs for services, information and assistance where people can “*korero kanohi ki te kanohi*” with an ACC liaison who could work alongside health, treatment and rehabilitation service providers. This would enable sharing of information with the community providing people with assistance to navigate through the system, and it was felt that local services would be more responsive “so people wouldn’t have to fight for their entitlements”
- People felt there was a need for more return to work schemes and increased promotion of these
- The main differences anticipated from competition are an increased availability of choice and options, but this requires increased knowledge of the different cost benefits (e.g. to balance the amount paid with the amount of cover provided)

Changes people fear

- More confusion – already too confusing for many Māori who feel filing claims isn’t worth it
- Easier to deny claims – more confusing rules, greater deniability, opportunity to claim it’s ‘someone else’s problem’
- If the plan is not mandatory, many Māori won’t ‘opt in’ and then won’t have necessary care/cover when they need it
- “If the alternative structure continued to be mainstream it will continue to disadvantage Māori”

- If the scheme was privatised without **true** consultation (this project was not be deemed to be part of what respondents consider a consultative process) then once again Māori would be disenfranchised
- Efficiency of payments systems is likely to become more complicated in a competitive environment

Appendix 4

Quantitative analysis of ACC claim data – The Māori experience of ACC

Introduction

This work has been completed to inform and compliment the research being completed into the Māori experience of ACC, which is being undertaken as part of the stocktake of ACC accounts. This paper is a discussion document intended for synthesis into the wider research project.

The following analysis is not designed to be a complete analysis of ACC claim data as it pertains to Māori, but more supplying context to inform the wider research. Further analysis may be possible and justified but is outside the scope of this work.

Data notes

Claims data was obtained from ACC. The data set includes claims that have been lodged or have had activity in the past 5 years (from 1st July 2004 to 30th June 2009).

Ethnicity is derived from a self-report at the time of claiming and we have presented is here in two categories: Māori and non-Māori (all those who did not endorse being Māori). These two groups are mutually exclusive.

Injury vs claim

The constant issue that exists when looking at claim data is that a claim represents an injury, but all injuries are not necessarily recorded as claims (claims are not lodged). This is the persistent 'unknown' factor in ACC claim data.

Where a particular category of claimants show lower claim rates than another, there are two possible mechanisms at work:

- 1) That the population in question experiences lower injury rates that result in proportionally less claims.
- 2) That the population in question experiences similar or even higher injury rates, but claiming patterns are, for some reason, different resulting in lower lodged claims.

From ACC data, it is very difficult to tease out these causal mechanisms so caution must be exercised when interpreting claim data.

Key questions

The following research questions are addressed:

- What is the current state of Māori access to ACC? How does this differ across accounts and claim characteristics?
- How do claims lodged by Māori differ from non-Māori in their characteristics
- What is the exposure of Māori to accident risk in the workplace, and how does this compare with claim rates?
- How are Māori differentially affected by Serious Injury?

What sort of claim rates should we be seeing for Māori?

When considering access rates, we should, all things being equal, expect a claim rate proportional to the Māori proportion of the population covered by the scheme (ignoring at this time particular factors to do with the age structure of these respective populations and coverage patterns).

For the purposes of interpreting high level conclusions, at census night 2006, Māori accounted for **14.6%** of the NZ population and at June 2009, Māori accounted for **11.47%** of the working population (StatsNZ, HLFS).

The state of access to ACC for Māori
Proportion of claims lodged by Māori

The most recognised measure of access to ACC is the number of claims lodged. Table 1.1 presents claim lodgement data sorted by Ethnicity, ACC account and claim type.

The most recognised measure of access is usually 'all claims' – indicating all accepted claims lodged with ACC in the reporting period. This has been the traditional measure used by ACC.

Note that claim numbers in the 'medical misadventure' and 'other' categories have small cell counts so proportions should be interpreted with caution.

The 'all active claims' category includes those bulk funded claims lodged through DHB's (usually acute admissions through emergency departments).

Table 1.1: Claims Lodged by Ethnicity, Account and Claim Type

<i>Account</i>	<i>Ethnicity</i>	<i>Claims with WC Payments</i>	<i>Claims with other Entitlement Payments (social and voc rehab)</i>	<i>Claims with Non-Entitlement Payments (treatment only)</i>	<i>All Active Claims</i>	<i>All Claims incl. Bulk funded</i>
Work Account	Māori	22,143	2,346	112,406	136,895	153,895
	Non-Māori	116,400	29,176	835,825	981,401	1,071,799
	Proportion Māori	15.98%	7.44%	11.85%	12.24%	12.56%
Non-Earners Account	Māori	126	7,513	432,824	440,463	513,374
	Non-Māori	935	108,679	3,115,803	3,225,417	3,499,613
	Proportion Māori	11.88%	6.47%	12.20%	12.02%	12.79%
Earners Account	Māori	25,916	3,662	232,319	261,897	287,202
	Non-Māori	167,195	54,068	2,376,282	2,597,545	2,744,263
	Proportion Māori	13.42%	6.34%	8.91%	9.16%	9.47%
Motor Vehicle	Māori	2,896	892	19,397	23,185	26,765
	Non-Māori	16,988	6,443	144,606	168,037	184,316
	Proportion Māori	14.56%	12.16%	11.83%	12.12%	12.68%
Medical Misadventure	Māori	185	180	772	1,137	1,208
	Non-Māori	2,027	3,433	9,273	14,733	15,456
	Proportion Māori	8.36%	4.98%	7.69%	7.16%	7.25%
Other	Māori	38	227	342	607	630
	Non-Māori	379	6,657	5,779	12,815	12,995
	Proportion Māori	9.11%	3.30%	5.59%	4.52%	4.62%
<i>All accounts Māori</i>		51,304	14,820	798,060	864,184	983,074
<i>All accounts non-Māori</i>		303,924	208,456	6,487,568	6,999,948	7,528,442

<i>All accounts All ethnicities (total claims)</i>	355,228	223,276	7,285,628	7,864,132	8,511,516
<i>Proportion Māori</i>	14.44%	6.64%	10.95%	10.99%	11.55%

Key points:

- Māori still lag behind in a proportional sense in accessing the ACC scheme. While representing 14.6% of the population (at Census night 2006), Māori only lodge 11.55% of ACC claims ('all claims' category).
- While accessing the scheme proportionally less in general, Māori have a higher rate of weekly compensation claims (a reasonable proxy for more serious injuries), more in keeping with their population. This may be due to one or a combination of the following causal factors:
 - Māori are likely to access the scheme when injuries are more serious but not as much for less serious injuries. This assumes there are reasons Māori do not lodge claims for less serious injuries. Such reasons might include barriers to access or lack of knowledge of the Scheme.
 - Māori may carry a higher moderate to serious injury burden (e.g. work in industries with higher accident rates, have more motor vehicle accidents resulting in moderate injury etc). This theory is supported by higher rates of weekly compensation in the work and motor vehicle accounts.
- Māori have a very low rate of claiming social and vocational rehabilitation ('other entitlements' category). This may be because this aspect of the scheme is difficult to access (favouring better informed clients who ask for or demand services).
- Māori have a particularly low rate of claiming in the earners account, possibly indicating a lack of knowledge of the coverage ACC offers (i.e. coverage for injuries sustained outside the workplace). The Māori rate of claiming in the earners account is 9.47% while StatsNZ data indicates that 11.47% of the working population is Māori (HLFS, June 2009).
- There is an increased proportion of Māori accessing the scheme through DHB's (manifested as the difference between the 'active claims' and the 'all claims' categories). This may indicate that Māori are more likely to use Emergency Departments to access the scheme and not receive any subsequent entitlements.

Taken together, these data may point to the fact that Māori do not appear to access the scheme as much as non-Māori, especially for more 'minor' injuries. When Māori do access the scheme, they are likely to receive less social and vocational rehabilitation services and have a shorter claim duration.

How do the characteristics of claims lodged by Māori differ from non-Māori?

Table 1.2 compares various characteristics of claims sorting data by ethnicity and ACC account.

Table 1.2: Characteristics of claim lodged by ethnicity and ACC account

ACC account	Ethnicity	Average Weekly Comp Costs (Active Claims)	Average Entitlement Costs (Active Claims)	Average Non-Entitlement Costs (Active Claims)	Average total Costs (Active Claims)	Average Claim Duration (Days: Active Claims)	Average No. of WC Days (Active Claims)	Average days from Lodgement to Last Treatment	Average No. of Treatments
Work Account	Māori	\$1,010	\$303	\$334	\$1,647	73.99	14.18	41.29	4.70
	Non-Māori	\$847	\$361	\$413	\$1,621	93.14	11.16	60.69	5.65
Non-Earners Account	Māori	N/A	\$92	\$229	\$324	44.65	N/A	30.12	3.01
	Non-Māori	N/A	\$137	\$278	\$418	59.63	N/A	44.11	4.55
Earners Account	Māori	\$556	\$245	\$308	\$1,109	67.90	7.39	50.46	4.86
	Non-Māori	\$405	\$244	\$349	\$998	81.22	5.11	66.22	6.11
Motor Vehicle	Māori	\$1,540	\$2,037	\$1,292	\$4,870	111.27	19.99	79.15	5.82
	Non-Māori	\$1,107	\$1,185	\$903	\$3,194	110.84	13.90	86.94	6.99
Medical Mis-adventure	Māori	\$3,818	\$6,046	\$3,518	\$13,382	253.01	50.00	199.25	11.12
	Non-Māori	\$3,159	\$5,293	\$2,821	\$11,272	261.89	37.48	202.21	10.84
Other	Māori	\$1,361	\$3,240	\$3,113	\$7,714	394.63	15.46	280.10	4.44

Non-Māori	\$839	\$3,038	\$3,894	\$7,771	424.83	9.34	313.29	4.50
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From the above table, the following points are salient:

Average weekly compensation costs and days of compensation are higher for Māori.

This can be interpreted in two ways:

- Māori may be less likely to claim weekly compensation for more 'minor' injuries, therefore skewing the data to show a higher average cost and duration of compensation.

Or/

- Māori are experiencing a set of circumstances that lead them to spend longer on weekly compensation than non-Māori. This may be caused by injury severity, economic circumstances or they are experiencing worse rehabilitation outcomes.

Māori experience a shorter claim duration on average.

This could be for a number of reasons, but the data shows that they spend a shorter amount of time interfacing with the Corporation.

Māori have a lower average number of treatments

This again has multiple possible causal factors including:

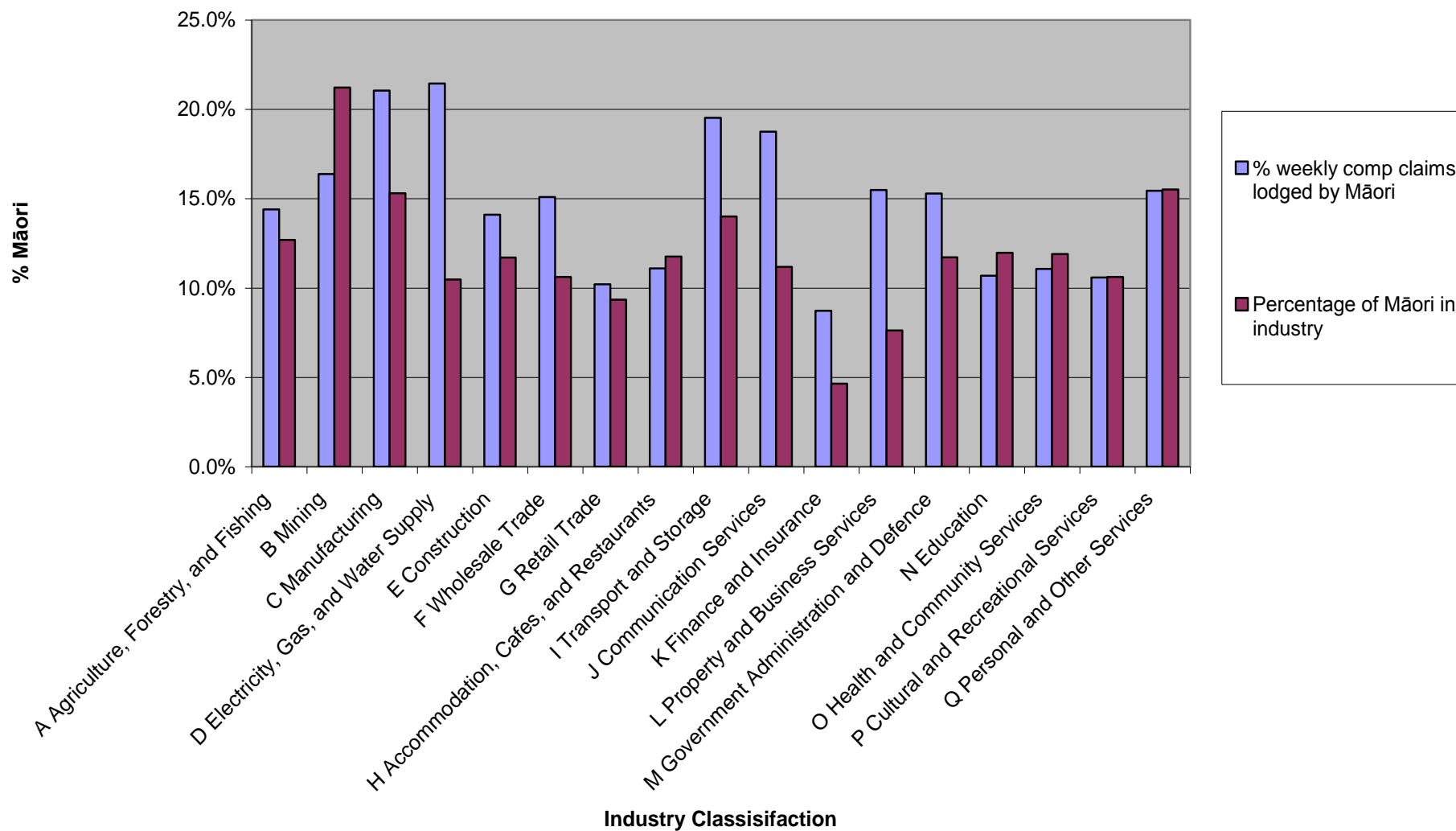
- Māori may perceive treatments as less effective and choose not to pursue them.
- Barriers to treatments may mean Māori are less likely to see a regime through (eg: co-payments).
- Māori may experience better rehabilitation outcomes (recover from injury faster).

Do Māori carry a higher than proportional accident burden in the workplace?

If access and accident risk was proportional across all ethnic groups, we would expect to see the claim rates for Māori in each industry to be proportional to the representation in that industry. To investigate whether this is the case, we have compared Māori claim rates by industry with Māori representation in that industry, taken from the Household Labour Force Survey (StatsNZ).

We have compared these rates using two 'measures' – Weekly Compensation claims (again, a proxy for more serious injury) and 'all claims'.

Weekly Comp claims vs representation in industry



The weekly compensation claim data shows that Māori appear to lodge a significantly higher proportion of weekly compensation claims than their representation in the industries in question would predict. This may be due to Māori being exposed to a higher accident risk in those industries or other factors may be at work.

Moreover, the disparity between industry representation and claim rates has a tendency to be greater in those industries that are more likely to have significant hazards (eg: manufacturing, construction and transport) as opposed to more sedentary industries (eg: education, health and community services). While this pattern is not universal, it may point to a real difference in exposure to risk that Māori experience in some industries.

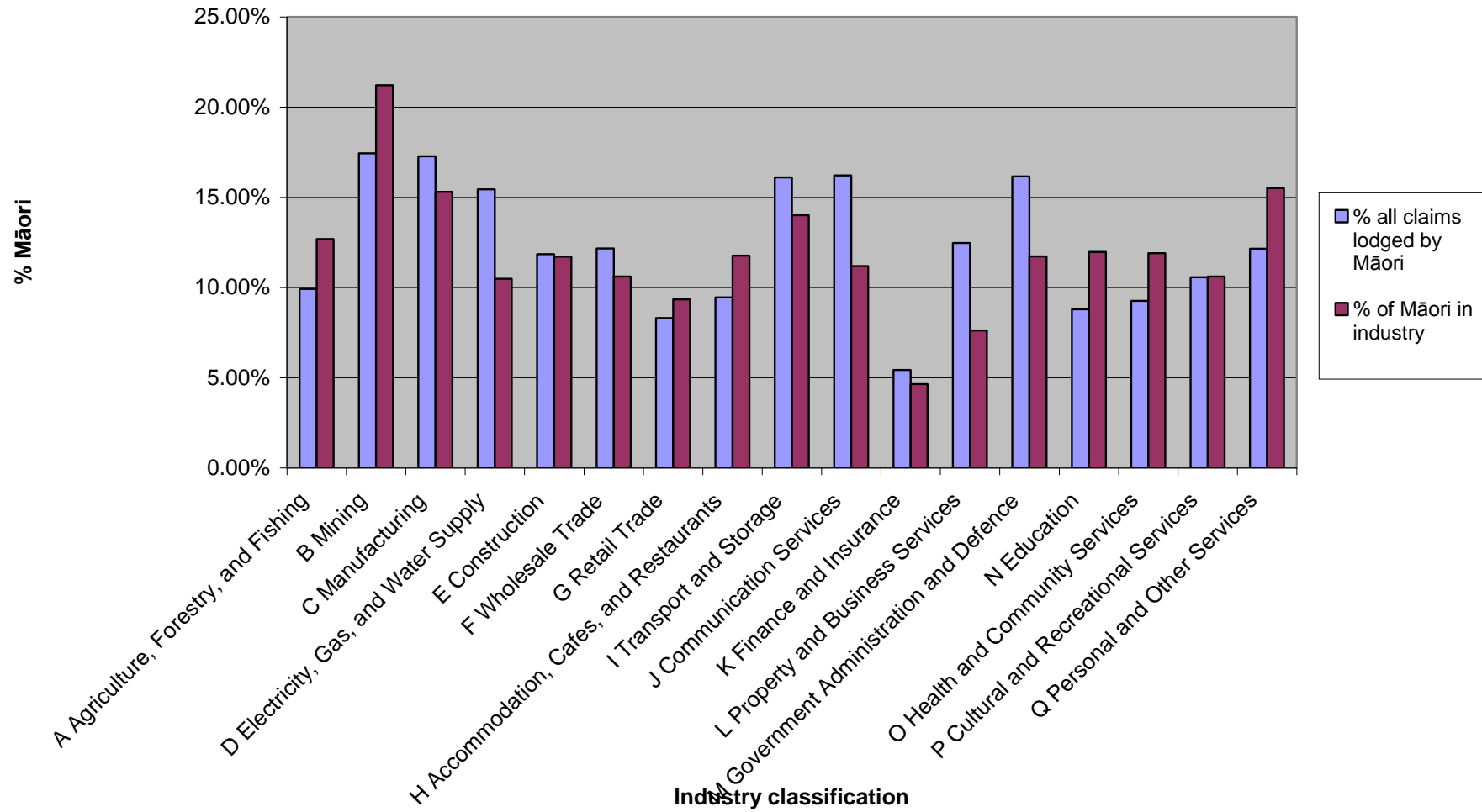
Note that the 'mining' and 'electricity, gas and water supply' categories have very small workforces, so any differences noted here may be due to chance.

'All claims' data

The chart below explores the same analysis, but this time looking at the 'all claims' category. Recall that we have already observed a proportionally lower claim rate in the overall data, indicating that Māori may not be accessing the scheme as much as non-Māori over all claims.

The following chart shows that this increased exposure to risk is not as apparent when all claims are considered. However, as we have already discussed, this may be due to endemic under-claiming by Māori.

All claims vs representation in industry



Māori and serious injury

A major human cost and liability for the Scheme is reflected in those injuries in the 'serious injury' portfolio. Broadly these injuries involve severe trauma resulting in multiple amputations, serious burns, traumatic brain injury or combinations thereof.

Claims lodged in the past five years that were added to the serious injury group are presented (as a proportion) in the table below.

Table 1.3 : Serious injury claims involving Māori

Account	Percentage Māori claimants
Work Account	13.19%
Non-Earners Account	24.93%
Earners Account	12.15%
Motor Vehicle	22.18%

We can see here a large extra burden of injury being born by Māori, especially in the case of non-earners and the motor vehicle account.

There are many possible reasons why this may be occurring but the causality is difficult to determine.

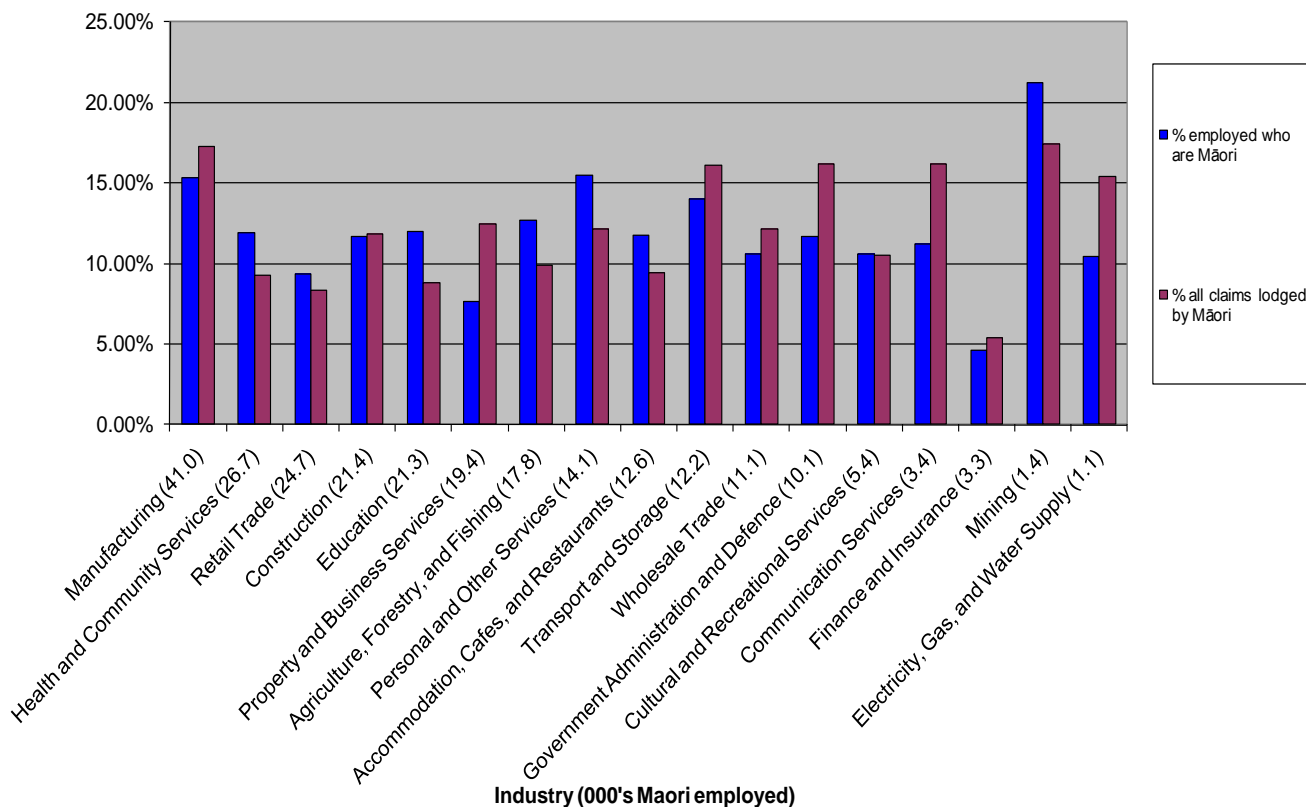
It must be noted that, as a result of this high rate of serious injury, Māori are major consumers of the Corporation rehabilitation services post-injury.

ACC Serious Injury Numbers – Raw data

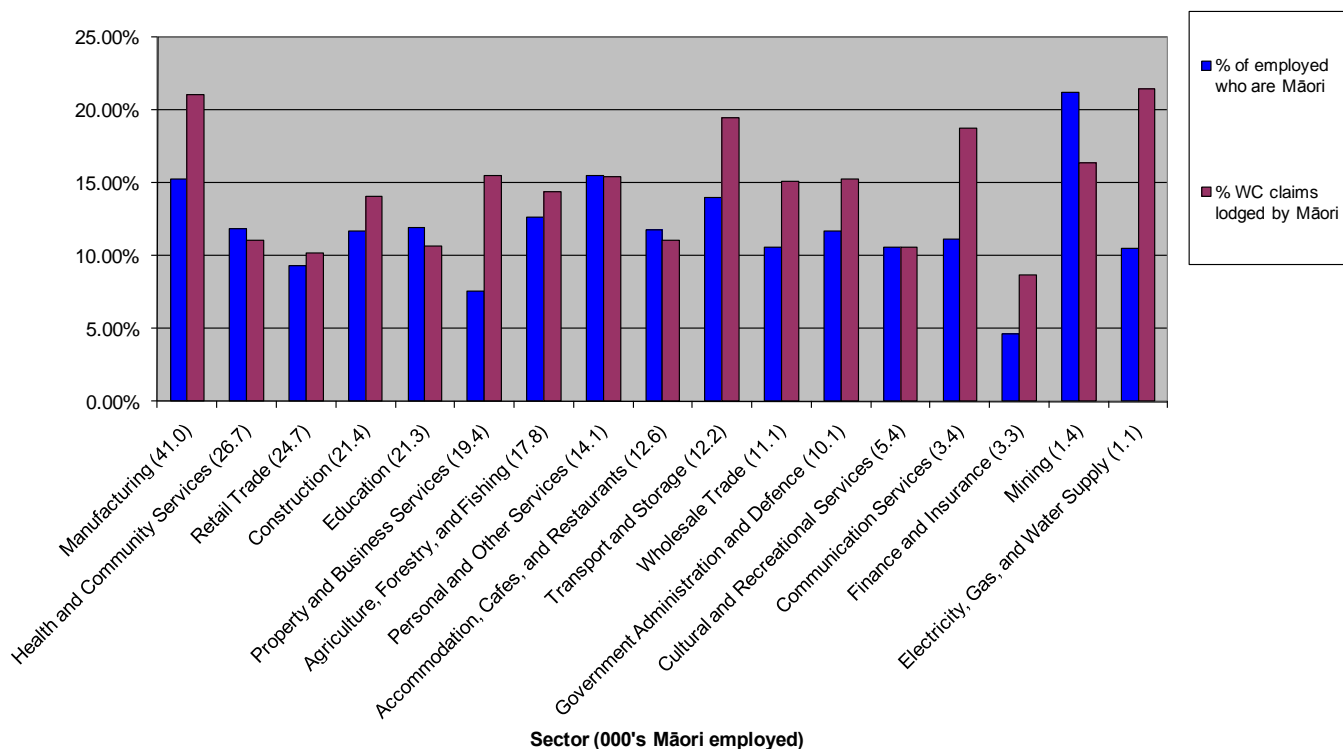
Account	Ethnicity	Serious Injury Claims
1 Work Account	Maori	12
1 Work Account	Non-Maori	79
	Proportion Maori	13.19%
2 Non-Earners Account	Maori	86
2 Non-Earners Account	Non-Maori	259
	Proportion Maori	24.93%
3 Earners Account	Maori	35
3 Earners Account	Non-Maori	253
	Proportion Maori	12.15%
4 Motor Vehicle	Maori	116
4 Motor Vehicle	Non-Maori	407
	Proportion Maori	22.18%
5 Medical Misadventure	Maori	16
5 Medical Misadventure	Non-Maori	162
	Proportion Maori	8.99%
6 Other	Maori	1
6 Other	Non-Maori	0
		100.00%

ACC Claims Lodged Modified

% all claims lodged by Māori vs industry representation



% WC claims lodged by Māori vs Māori participation in workforce



Raw Data for the above two tables

Industry	# Māori employed	Claims with WC Payments	% Māori	wc claims/1000	Claims with other Entitlement Payments	Claims with Non-Entitlement Payments	All Active Claims	All Claims - includes Bulk Funded	% Māori		Average WC Costs excl GST (Active Claims)
Manufacturing (41.0)	41	7405	21.04 %	0.18060976	611	27464	35480	39833	17.28 %	0.971537	1027
Health and Community Services (26.7)	26.7	884	11.07 %	0.03310861	50	3472	4406	5031	9.25%	0.188427	1180
Retail Trade (24.7)	24.7	1145	10.21 %	0.04635628	102	5850	7097	7885	8.31%	0.319231	782
Construction (21.4)	21.4	2960	14.10 %	0.13831776	276	11444	14680	16243	11.84 %	0.759019	1821
Education (21.3)	21.3	221	10.69 %	0.01037559	44	2600	2865	3083	8.79%	0.144742	754
Property and Business Services (19.4)	19.4	1222	15.49 %	0.06298969	80	5348	6650	7579	12.47 %	0.39067	977
Agriculture, Forestry, and Fishing (17.8)	17.8	2550	14.40 %	0.14325843	305	7408	10263	11400	9.91%	0.640449	1979
Personal and Other Services (14.1)	14.1	685	15.45 %	0.04858156	112	3134	3931	4304	12.15 %	0.305248	1186
Accommodation, Cafes, and Restaurants (12.6)	12.6	416	11.10 %	0.03301587	27	2138	2581	2940	9.45%	0.233333	749
Transport and Storage (12.2)	12.2	1693	19.52 %	0.13877049	155	4953	6801	7406	16.11 %	0.607049	2261
Wholesale Trade (11.1)	11.1	750	15.09 %	0.06756757	61	3851	4662	5062	12.17 %	0.456036	878
Government Administration and Defence (10.1)	10.1	141	15.29 %	0.0139604	162	2189	2492	3718	16.16 %	0.368119	423
Cultural and Recreational Services (5.4)	5.4	320	10.58 %	0.05925926	85	2733	3138	3330	10.56 %	0.616667	715
Communication Services (3.4)	3.4	355	18.75 %	0.10441176	72	1252	1679	1809	16.21 %	0.532059	604
Finance and Insurance	3.3	28	8.72%	0.0084848	5	216	249	271	5.42%	0.08212	761

(3.3)				5						1	
Mining (1.4)	1.4	94	16.38 %	0.0671428 6	31	604	729	813	17.44 %	0.58071 4	2097
Electricity, Gas, and Water Supply (1.1)	1.1	134	21.44 %	0.1218181 8	15	493	642	701	15.45 %	0.63727 3	3014

Table continued over page

Industry	Average Entitlement Costs excl GST (Active Claims)	Average Non- Entitlement Costs excl GST (Active Claims)	Average Costs excl GST (Active Claims)	Average Claim Duration (Active Claims)	Average WC Duration (Active Claims)	Average No. of WC Days (Active Claims)	Average days from Lodgement to Last Treatment	Reactivated Claims	Average No. of Treatments	Serious Injury Claims	# emp (thn 000's)
Manufacturing (41.0)	285	345	1657	72.91	18.91	16.24	29.22	2666	4.62	<=3	41
Health and Community Services (26.7)	336	444	1961	91.04	24.23	20.12	51.48	409	6.5	0	26.7
Retail Trade (24.7)	275	306	1364	72.86	16.96	13.72	41.9	541	5.12	0	24.7
Construction (21.4)	558	432	2811	82.99	23.84	21.36	56.33	1157	5.3	<=3	21.4
Education (21.3)	229	325	1308	81	14.42	10.33	61.97	245	5.6	0	21.3
Property and Business Services (19.4)	294	323	1595	68.19	18.92	16.96	41.96	448	5.13	<=3	19.4
Agriculture, Forestry, and Fishing (17.8)	582	507	3068	106.62	30.55	26.6	76.14	984	5.72	<=3	17.8
Personal and Other Services (14.1)	399	399	1985	82.46	20.22	15.68	38.3	331	5.34	<=3	14.1
Accommodation, Cafes, and Restaurants (12.6)	286	323	1357	70.18	15.83	13.97	49.39	183	5.04	0	12.6
Transport and Storage (12.2)	555	463	3280	101.96	28.76	24.87	65.7	649	6.14	<=3	12.2
Wholesale Trade (11.1)	222	293	1393	65.57	15.54	12.92	43.12	296	4.82	0	11.1
Government Administration and Defence (10.1)	452	440	1315	85.6	6.93	4.69	21.05	242	5.66	0	10.1
Cultural and Recreational Services (5.4)	403	406	1524	142.83	14.98	10.37	46.77	525	6.38	<=3	5.4
Communication Services (3.4)	237	362	1203	85.5	23.62	14.51	14.64	168	6.05	0	3.4
Finance and Insurance (3.3)	293	392	1446	87.13	12.16	11.52	42.61	24	6.68	0	3.3
Mining (1.4)	433	421	2951	91.23	19.78	16.89	48.62	74	5.25	0	1.4
Electricity, Gas, and Water Supply (1.1)	620	560	4194	112.86	32.75	27.46	76.65	67	7.12	0	1.1

Table continued over page

Industry	Total employed	prop Māori
Manufacturing (41.0)	268	15.30%
Health and Community Services (26.7)	224.3	11.90%
Retail Trade (24.7)	264.5	9.34%
Construction (21.4)	182.8	11.71%
Education (21.3)	178	11.97%
Property and Business Services (19.4)	254.7	7.62%
Agriculture, Forestry, and Fishing (17.8)	140.3	12.69%
Personal and Other Services (14.1)	90.9	15.51%
Accommodation, Cafes, and Restaurants (12.6)	107.1	11.76%
Transport and Storage (12.2)	87.1	14.01%
Wholesale Trade (11.1)	104.6	10.61%
Government Administration and Defence (10.1)	86.2	11.72%
Cultural and Recreational Services (5.4)	50.9	10.61%
Communication Services (3.4)	30.4	11.18%
Finance and Insurance (3.3)	71.1	4.64%
Mining (1.4)	6.6	21.21%
Electricity, Gas, and Water Supply (1.1)	10.5	10.48%

ACC Age Group Analysis

		Male-0-14	Female-0-14	Male-15-24	Female-15-24	Male-25-34	Female-25-34	Male-35-44	Female-35-44	Male-45-54	Female-45-54	Male-55-64
1 Work Account	Māori	148	79	30,446	8,014	27,937	7,904	26,338	11,484	18,251	9,686	7,690
1 Work Account	Non-Māori	754	440	143,830	46,680	158,850	49,526	179,976	67,159	161,832	74,432	107,839
	Proportion Māori	16.41%	15.22%	17.47%	14.65%	14.96%	13.76%	12.77%	14.60%	10.13%	11.51%	6.66%
2 Non-Earners Account	Māori	165,143	115,165	62,236	39,369	18,017	20,915	14,124	17,925	8,900	12,033	6,599
2 Non-Earners Account	Non-Māori	748,648	556,160	347,491	226,746	70,405	106,427	61,505	128,781	56,224	102,049	78,263
	Proportion Māori	18.07%	17.15%	15.19%	14.79%	20.38%	16.42%	18.68%	12.22%	13.67%	10.55%	7.78%
3 Earners Account	Māori	684	510	55,463	21,130	52,896	27,319	37,018	28,632	22,684	21,127	8,722
3 Earners Account	Non-Māori	4,302	2,763	309,143	158,317	353,730	229,557	366,576	295,267	305,970	301,958	178,384
	Proportion Māori	13.72%	15.58%	15.21%	11.78%	13.01%	10.64%	9.17%	8.84%	6.90%	6.54%	4.66%
4 Motor Vehicle	Māori	2,197	1,697	5,649	4,322	2,607	1,994	2,096	1,708	1,404	1,231	539
4 Motor Vehicle	Non-Māori	7,681	6,075	28,199	26,102	14,971	15,766	14,443	15,352	11,210	13,319	7,042
	Proportion Māori	22.24%	21.83%	16.69%	14.21%	14.83%	11.23%	12.67%	10.01%	11.13%	8.46%	7.11%
5 Medical Misadventure	Māori	67	68	58	66	54	105	71	152	110	151	88
5 Medical Misadventure	Non-Māori	454	375	327	588	374	1,053	704	1,502	960	1,703	1,311
	Proportion Māori	12.86%	15.35%	15.06%	10.09%	12.62%	9.07%	9.16%	9.19%	10.28%	8.14%	6.29%
All accounts Māori		168,239	117,519	153,852	72,901	101,511	58,237	79,647	59,901	51,349	44,228	23,644
All accounts non-Māori		761,839	565,813	828,990	458,433	598,330	402,329	623,204	508,061	536,196	493,461	372,837
all accounts all ethnicities		930,078	683,332	982,842	531,334	699,841	460,566	702,851	567,962	587,545	537,689	396,481
Proportion all claims Māori		18.09%	17.20%	15.65%	13.72%	14.50%	12.64%	11.33%	10.55%	8.74%	8.23%	5.96%
Population denominator												

Māori popn		102642	97275	49371	51933	35649	41916	35175	40689	26574	29520	14964
non-Māori popn		341388	326274	238155	231717	212451	234645	258726	280659	240789	249270	188599
% Population Māori		23.12%	22.97%	17.17%	18.31%	14.37%	15.16%	11.97%	12.66%	9.94%	10.59%	7.35%

		Female- 55-64	Male- 65+	Female- 65+
1 Work Account	Māori	3,503	1,798	606
1 Work Account	Non-Māori	40,124	33,202	7,130
	Proportion Māori	8.03%	5.14%	7.83%
2 Non-Earners Account	Māori	9,276	10,267	13,399
2 Non-Earners Account	Non-Māori	146,644	320,065	550,168
	Proportion Māori	5.95%	3.11%	2.38%
3 Earners Account	Māori	8,059	1,672	1,280
3 Earners Account	Non-Māori	171,980	39,650	26,656
	Proportion Māori	4.48%	4.05%	4.58%
4 Motor Vehicle	Māori	582	318	421
4 Motor Vehicle	Non-Māori	8,488	6,504	9,164
	Proportion Māori	6.42%	4.66%	4.39%
5 Medical Misadventure	Māori	87	64	67
5 Medical Misadventure	Non-Māori	1,537	2,165	2,402
	Proportion Māori	5.36%	2.87%	2.71%
All accounts Māori		21,507	14,119	15,773
All accounts non-Māori		368,773	401,586	595,520
all accounts all ethnicities		390,280	415,705	611,293
Proportion all claims Māori		5.51%	3.40%	2.58%

Population denominator				
Māori popn		16476	10476	12651
non-Māori popn		193155	210669	261810
% Population Māori		7.86%	4.74%	4.61%

¹ NZ Human Rights Commission, Guidelines on Measures to Ensure Equality

² Quantitative analysis of ACC claim data – The Māori experience of ACC, 2010

³ Population disparities in ACC Entitlements and Services, 2010

⁴ Blakely T et al. 2007. "Tracking disparity: trends in ethnic and socioeconomic inequalities in mortality, 1981-2004" Wellington: Ministry of Health

⁵ Tukuitonga C, Bindman A. 2002. "Ethnic and gender differences in the use of coronary artery revascularization procedures in New Zealand." NZMJ 115 (1152).

⁶ Crengle S, Lay-Yee R, Davis P, Pearson J. A Comparison of Māori and Non-Māori Patient Visits to Doctors: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 6. Wellington: Ministry of Health; 2005

⁷ Bramley D et al. "Disparities in Indigenous Health: A Cross-Country Comparison Between New Zealand and the United States" 2005; Am J Pub Health 2005, 95(5):844-850

⁸ Hill S et al. "Ethnicity and management of colon cancer in New Zealand: Do indigenous patients get a worse deal?" Cancer. Published Online: 21 Apr 2010

⁹ Crengle S. 1997. Mā Pāpātuanuku, ka tipu ngā rākau: A case study of the well child health programme provd by Te Whānau o Waipareira Trust. Master of Public Health, University of Auckland

¹⁰ Quantitative analysis of ACC claim data – The Māori experience of ACC

¹¹ Fisher TL et al. 2007. "Cultural leverage: interventions using culture to narrow racial disparities in health care" Med Care Res Rev 64: 243-82

¹² Kreuter MW and Wray RJ. "Tailored and Targeted Health Communication: Strategies for Enhancing Information Relevance" Am J Health Behav.2003;27(Suppl 3):S227-S232

¹³ Wilson DK. "New Perspectives on Health Disparities and Obesity Interventions in Youth". Journal of Pediatric Psychology. 2009;34(3):231-244.

¹⁴ Cooper LA et al. 2003 "Patient centered communication, ratings of care, and concordance of patient and physician race" Ann Int Med 139(11):907-15

¹⁵ Coulter A and Cleary P. 2002. "Measuring and improving patients' experiences" Measuring Up: Improving health systems performance in OECD Countries. Canada: OECD

¹⁶ Marck R, The Annual Insurance Industry Review 2006 – 07, <http://www.icnz.org.nz/news/review/06-07/presidents-report.php>

¹⁷ Keckley PH et al. 2010. Deloitte 2010 Global Survey of Health Care Consumers: Behaviours, attitudes, and unmet needs.

¹⁸ St Leger L. "Evaluating community-based health promotion initiatives: an ongoing necessity and challenge". Health Promotion International Advance Access published online on October 29, 2008

¹⁹ Pittz W et al. "Closing the Gap: Solutions to Race-Based Health Disparities". 2005. Applied Research Center & Northwest Federation of Community Organizations.

²⁰ Robson B & Harris R. 2007. "Hauora Māori standards of health IV" Wellington: Te Roopu Rangahau Hauora a Eru Pomare

²¹ Blakely T et al. 2007. "Tracking disparity: trends in ethnic and socioeconomic inequalities in mortality, 1981-2004" Wellington: Ministry of Health

²² Izen M. "Bush's Proposal to Privatize Healthcare Worsens Race Disparities". Color Lines Commentary, posted: Feb 08, 2006

²³ Jansen, P, and K Bacal. *He Ritenga Whakaaro: Māori experiences of health services*. Auckland: Ministry of Health, 2009.

²⁴ Wilson D. The Practice and Politics of Indigenous Health Nursing. Advances in Contemporary Indigenous Health Care 2006. 22(2): x – xiii,

²⁵ Smedley BD et al. 2002. "Unequal treatment: confronting racial and ethnic difficulties" Washington DC: National Academy Press

²⁶ The Morehouse Medical Treatment and Effectiveness Center. Racial and Ethnic Differences in Access to Medical Care: A Synthesis of the Literature. Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2000.

²⁷ Sylvia Atdjian, M.D. and William A. Vega, Ph.D. , Disparities in Mental Health Treatment in U.S. Racial and Ethnic Minority Groups: Implications for Psychiatrists Psychiatr Serv 56:1600-1602, December 2005

²⁸ Todd KH et al. 1993. "Ethnicity as a risk factor for inadequate ED analgesia" JAMA 269:1537-9

²⁹ Adelson N. "The embodiment of inequity: health disparities in aboriginal Canada." Can J Public Health. 2005;96 Suppl 2:S45-61.

³⁰ Atdjian S and Vega WA. "Disparities in Mental Health Treatment in U.S. Racial and Ethnic Minority Groups: Implications for Psychiatrists" Psychiatr Serv 2005; 56:1600-1602.

- ³¹ Shavers VL et al. Race/ethnicity and the receipt of watchful waiting for the initial management of prostate cancer. *J Gen Intern Med*. 2004 Feb;19(2):146-55.
- ³² Diggs, A., and Berger, B. (2004). Cultural Competence: Overcoming Bias *U.S. Pharm.*, 2004, 29(6), 94-97
- ³³ Blanchard J, Lurie N. "R-E-S-P-E-C-T: patient reports of disrespect in the health care setting and its impact on care." *J Fam Pract*. 2004 Sep;53(9):721-30.
- ³⁴ Brach C and Fraserirector I. Can Cultural Competency Reduce Racial And Ethnic Health Disparities? A Review And Conceptual Model. *Medical Care Research and Review* 2000; 57 (S1): 181-217
- ³⁵ Taylor SL. 2004. "The role of culturally competent communication in reducing ethnic and racial healthcare disparities" *Am J Manag Care* 10:SP1-4
- ³⁶ Jansen P. 1998. "Improving consultations with Māori Clients" *NZFP* 25(2)
- ³⁷ Joe JR and Frishkopf S. Recommendations for health care providers working with native families. *Healthy Weight Journal*. 1999. Sept/Oct. 13(5):75-76.
- ³⁸ Tsai CL and Camargo CA. Racial and ethnic differences in emergency care for acute exacerbation of chronic obstructive pulmonary disease. *Acad Emerg Med*. 2009 Feb;16(2):108-15. Epub 2008 Dec 6.
- ³⁹ Crengle S, Lay-Yee R, Davis P, Pearson J. A Comparison of Māori and Non-Māori Patient Visits to Doctors: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 6. Wellington: Ministry of Health; 2005
- ⁴⁰ http://www.dol.govt.nz/initiatives/workplace/acc/acc-levies/acc%20levies_03.asp
- ⁴¹ <http://www.whss.govt.nz/review/report/page11.html>
- ⁴² Keckley PH et al. 2010. Deloitte 2010 Global Survey of Health Care Consumers: Behaviours, attitudes, and unmet needs.
- ⁴³ Durie MH. 2001. *Mauri Ora: The Dynamics of Māori Health*. Auckland: Oxford University Press.
- ⁴⁴ <http://www.kawhia.Māori.nz/Intro-healing-plants.html>
- ⁴⁵ Dresang, Family Medicine in Cuba: Community-Oriented Primary Care and Complementary and Alternative Medicine. *The Journal of the American Board of Family Practice* 18:297-303 (2005)
- ⁴⁶ Singleton K and Krause E. "Understanding Cultural and Linguistic Barriers to Health Literacy" (Sept. 30, 2009) *OJIN: The Online Journal of Issues in Nursing*. 14(3), Manuscript 4.
- ⁴⁷ Cram F et al. "Mapping the themes of Māori talk about health". 2003. *Journal of the New Zealand Medical Association*. 116(1170)
- ⁴⁸ Jansen P et al. 2008. *He Ritenga Whakaaro*. Auckland: Mauri Ora Associates.
- ⁴⁹ Lee SJ et al. 2002. "Enhancing physician-patient communication" *Am Soc Hematology*
- ⁵⁰ Stewart MA. "Effective Physician-Patient Communication and Health Outcomes: A Review" 1995. *CMAJ* 152(9):1423-33
- ⁵¹ Crow R et al. "The measurement of satisfaction with health care". 2002. *Health Tech Assess* 6(32)
- ⁵² Bishop R 1996 "Addressing issues of self-determination and legitimization in kaupapa Maori research" *He paepae korero: research perspectives in Maori education*. Wellington: Council for Educational Research. pp.143-160.
- ⁵³ Smith L T. 1999 "Decolonizing Methodologies Research and Indigenous Peoples". Martin's Press New York: St.
- ⁵⁴ Pihama L, et al. 2002 "Creating Methodological Space: A Literature Review of Kaupapa Māori Research" *Canadian Journal of Native Education* v26 n1 p30-43
- ⁵⁵ Kaupapa Māori research is an attempt to 'retrieve some space' (Smith, L. 1999) to plan, organise, conduct, analyse and give back culturally responsive research primarily by Māori, and for Māori. Kaupapa Māori as research provides clear directions of how to conduct research in 'Māori ways' and the impetus to explore new research methods (Lee, forthcoming). Cited in <http://www.kaupapaMāori.com/research/10/> accessed 23/4/2010.
- ⁵⁶ Barnes H. 2000. "Kaupapa Māori: explaining the ordinary". *Pacific Health Dialog* 7(1).
- ⁵⁷ Taonga Tuku Iho – The Principle of Cultural Aspiration. This principle asserts the centrality and legitimacy of Te Reo Māori, Tikanga and Mātauranga Māori. Within a Kaupapa Māori paradigm, these Māori ways of knowing, doing and understanding the world are considered valid in their own right. In acknowledging their validity and relevance it also allows spiritual and cultural awareness and other considerations to be taken into account. See <http://www.rangahau.co.nz/research-idea/27/> and Smith, G. H. (1990) 'Research Issues Related to Māori Education', paper presented to NZARE Special Interest Conference, Massey University, reprinted in 1992, *The Issue of Research and Māori*, Research Unit for Māori Education, The University of Auckland.
- ⁵⁸ *Cultural Identity: The Social Report 2009*. Department of Social Development
- ⁵⁹ *Survey on the Health of the Māori Language in 2006*, Te Puni Kokiri, Wellington 2007
- ⁶⁰ Buetow S et al. 2002. "Reasons for poor understanding of when and how to access GP care for childhood asthma in Auckland, NZ" *Fam Prac* 19(4):319-25
- ⁶¹ Chin MH et al. 2007. "Interventions to reduce racial and ethnic disparities in health care" *Med Care Res Re* 64:7-28
- ⁶² Cooper et al. 2002. "Designing and implementing interventions to eliminate racial and ethnic disparities in health care" *J Gen Int Med* 17:477-86
- ⁶³ Fisher TL et al. 2007. "Cultural leverage: interventions using culture to narrow racial disparities in health care" *Med Care Res Rev* 64: 243-82
- ⁶⁴ LaVeist TA et al. 2003. "The association of doctor-patient race concordance with health services utilization" *J Pub Health Policy* 24 (3-4):312-23
- ⁶⁵ Harris R et al. 2006. "Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in NZ" *Lancet* 367:2005-29
- ⁶⁶ Jansen P. 1998. "Improving consultations with Māori clients" *NZFP* 25(2)
- ⁶⁷ Johnson RL et al. 2004. "Patient race/ethnicity and quality of patient-physician communication during medical visits" *A J Pub Health* 94 (12): 2084-90

- ⁶⁸ Jansen P, Bacal K, Crengle S. 2008. He Ritenga Whakaaro: Māori Experiences of Health Services. Auckland: Mauri Ora Associates.
- ⁶⁹ Quantitative analysis of ACC claim data – The Māori experience of ACC
- ⁷⁰ Jansen P, Bacal K, Crengle S. 2008. He Ritenga Whakaaro: Māori Experiences of Health Services. Auckland: Mauri Ora Associates.
- ⁷¹ Harris R et al. 2006. "Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in NZ" *Lancet* 367:2005-29
- ⁷² Ministry of Health. 2008. A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey. Wellington: Ministry of Health.
- ⁷³ Crengle S, Lay-Yee R, Davis P, Pearson J. A Comparison of Māori and Non-Māori Patient Visits to Doctors: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 6. Wellington: Ministry of Health; 2005
- ⁷⁴ Carr J et al, "Heart Failure: Ethnic Disparities in Morbidity and Mortality in New Zealand", *NZMJ* 15 (1146), 2002.
- ⁷⁵ Tukuitonga C, Bindman A. 2002. "Ethnic and gender differences in the use of coronary artery revascularization procedures in New Zealand." *NZMJ* 115 (1152).
- ⁷⁶ Westbrooke I et al. 2001. "Are Māori underserved for cardiac interventions?" *NZMJ* 114 (1143).
- ⁷⁷ Cram F & Smith L. 2003. "Māori women talk about accessing health care" *He Pukenga Korero* 7:1-8.
- ⁷⁸ Sadler L et al. 2002. "Associations between ethnicity and obstetric intervention in New Zealand" *NZMJ* 115(1147)
- ⁷⁹ Ministry of Health. 2008. A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey. Wellington: Ministry of Health.
- ⁸⁰ Crengle S, Lay-Yee R, Davis P, Pearson J. A Comparison of Māori and Non-Māori Patient Visits to Doctors: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 6. Wellington: Ministry of Health; 2005
- ⁸¹ Malcolm, L. Inequities in access to and utilisation of primary medical care services for Māori and low income New Zealanders. *NZMJ* 1996;109:356-8
- ⁸² Jansen P, Bacal K, Crengle S. 2008. He Ritenga Whakaaro: Māori Experiences of Health Services. Auckland: Mauri Ora Associates.
- ⁸³ Taylor SL. 2004. "The role of culturally competent communication in reducing ethnic and racial healthcare disparities" *Am J Manag Care* 10:SP1-4
- ⁸⁴ Lee SJ et al. 2002. "Enhancing physician-patient communication" *Am Soc Hematology*
- ⁸⁵ LaViest TA and Nuru-Jeter A. 2002. "Is doctor-patient race concordance associated with greater satisfaction with care?" *J Health Soc Behav* 43 (3):296-306
- ⁸⁶ Jackson J et al. 2001. "Predictors of patient satisfaction" *Soc Sci Med* 52:609-20
- ⁸⁷ Jansen P. 1998. "Improving consultations with Māori Clients" *NZFP* 25(2)
- ⁸⁸ Chin MH et al. 2007. "Interventions to reduce racial and ethnic disparities in health care" *Med Care Res Rev* 64:283-304
- ⁸⁹ Robson B & Harris R. 2007. "Hauora Māori standards of health IV" Wellington: Te Roopu Rangahau Hauora a Eru Pomare
- ⁹⁰ Blakely T et al. 2007. "Tracking disparity: trends in ethnic and socioeconomic inequalities in mortality, 1981-2004" Wellington: Ministry of Health
- ⁹¹ Todd KH et al. 1993. "Ethnicity as a risk factor for inadequate ED analgesia" *JAMA* 269:1537-9
- ⁹² Smedley BD et al. 2002. "Unequal treatment: confronting racial and ethnic difficulties" Washington DC: National Academy Press
- ⁹³ Satherley P & Lawes E. 2008. "The Adult Literacy and Life Skills (ALL) Survey: gender, ethnicity, and literacy". Wellington: Ministry of Education.
- ⁹⁴ Blakely T, Tobias M, Atkinson J, et al. Tracking Disparity: Trends in Ethnic and Socioeconomic Inequalities in Mortality, 1981-2004. Ministry of Health: Wellington; 2007.
- ⁹⁵ Ajwani S, Blakely T Robson B Tobias M & Bonne M. 2003. Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999, Wellington: Ministry of Health and University of Otago.
- ⁹⁶ Malcolm, L. Inequities in access to and utilisation of primary medical care services for Māori and low income New Zealanders. *NZMJ* 1996;109:356-8;
- ⁹⁷ Lillie-Blanton M et al, "Race, Ethnicity, and the Health Care System: Public Perceptions and Experiences", *Med Care Res Rev*, 57 (S1): 218-35, 2000.
- ⁹⁸ Penney L. 2005. Māori and Health Practitioners Talk About Heart Disease. Draft Summary Report on Phase 1 Findings, Palmerston North: Massey University
- ⁹⁹ McNaughton H et al. 2002. "The comparability of community outcomes for European and non-European survivors of stroke in NZ" *NZMJ* 115(1149)
- ¹⁰⁰ Cormack D et al. 2005. "Access to cancer services for Māori" Wellington: Ministry of Health and Wellington School of Medicine and Health Sciences
- ¹⁰¹ Quantitative analysis of ACC claim data (Appendix Four)
- ¹⁰² Jansen P et al. 2008. He Ritenga Whakaaro. Auckland: Mauri Ora Associates.
- ¹⁰³ Keckley PH et al. 2010. Deloitte 2010 Global Survey of Health Care Consumers: Behaviours, attitudes, and unmet needs.
- ¹⁰⁴ Quantitative Analysis of ACC Claim Data – The Māori Experience of ACC, DoL research project, 2010
- ¹⁰⁵ Land Transport Safety Authority (2000), quoted in The Social Report 2009 (<http://www.socialreport.msd.govt.nz/notes-references/endnotes.html#n105>)
- ¹⁰⁶ Ministry of Health, New Zealand Health Information Service, quoted in The Social Report 2009 (<http://www.socialreport.msd.govt.nz/notes-references/endnotes.html#n105>)
- ¹⁰⁷ Taylor SL. 2004. "The role of culturally competent communication in reducing ethnic and racial healthcare disparities". *Am J Manag Care*. 10:SP1-4.
- ¹⁰⁸ Crengle S, Lay-Yee R, Davis P, Pearson J. A Comparison of Māori and Non-Māori Patient Visits to Doctors: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 6. Wellington: Ministry of Health; 2005
- ¹⁰⁹ Population disparities in ACC Entitlements and Services, 2010
- ¹¹⁰ Jansen P et al. 2008. He Ritenga Whakaaro. Auckland: Mauri Ora Associates.
- ¹¹¹ Keckley PH et al. 2010. Deloitte 2010 Global Survey of Health Care Consumers: Behaviours, attitudes, and unmet needs.

¹¹² Ajwani S et al. 2003. Decades of Disparity: ethnic mortality trends in New Zealand, 1980-1999. Wellington: Ministry of Health.

¹¹³ Robson B, Harris R. (eds). 2007. Hauora: Māori Standards of Health IV. A study of the years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

¹¹⁴ Population disparities in ACC Entitlements and Services, 2010

¹¹⁵ Clemenger. 2004. "Encouraging Māori to claim their entitlements" Prepared for ACC

¹¹⁶ This research project did specifically dismantle the concept of a 'compulsory' scheme or attitudes specifically related to compulsion. It is possible that the widespread support is for the total coverage, or that the current scheme reduces entry barriers into the scheme, avoids risk profiling based on ethnicity, or all of these. Other explanations are also possible.

¹¹⁷ Through 1 April 2010; one informant could provide several category-specific interviews, e.g. a self-employed person who was also a short-term claimant; numbers are approximate until final draft

¹¹⁸ Through 1 April 2010 ; numbers are approximate until final draft

¹¹⁹ One person named in this context was Dr Peter Jansen, a co-founder of our consultancy'