



He Ritenga Whakaaro:
Māori experiences of health services



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Discussions with the Māori advisory committees for this project led to the adoption of the title He Ritenga Whakaaro: Māori experiences of health services. He ritenga whakaaro refers to the similar experiences that many Māori have when accessing mainstream services.

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nā, Peter Jansen

Whakarāpopototanga – Executive Summary

The Ministry of Health and the Accident Compensation Corporation (ACC) have identified addressing the poor health status of Māori as being of the highest priority (ACC 2005; Ministry of Health 2005). While Māori have lower life expectancy, greater morbidity and higher rates of disability, they have less access to health and rehabilitation services than do non-Māori. The perceptions of Māori consumers can contribute to understanding how the health system is or is not facilitating their access to health care. The present study explored these perceptions.

Background

Internationally, researchers have identified both barriers to, and facilitators of, access to health care for minority patients in their search for explanations for health disparities. New Zealand studies have similarly identified organisational, human resource, and patient-community issues in access to health care.

At the organisational level barriers include: the timing and availability of services, the universal, Western approach to health care, the under-representation of Māori in the health professions, appointment systems, and the lack of appropriate educational and promotional material.

At the human resource level barriers include: the characteristics of non-Māori health staff, including their perceptions of and attitudes about Māori patients; and appropriate provider-patient communication, or lack thereof.

At the individual or community level barriers include: the socio-economic position of many Māori which makes healthcare unaffordable; and patient attitudes, beliefs and preferences which may make healthcare inappropriate, feared and/or not a priority.

Patient feedback about their satisfaction with health care providers can provide valuable information about barriers to, and facilitators of, healthcare which, in turn, can aid clinicians in their ability to provide accessible healthcare to Māori. Legal services, car repairs and healthcare have been described as 'credence goods' in that consumers must rely on the credibility of the expert provider in diagnosis and treatment of their problem. The consumer cannot easily assess the technical competence of the health provider (such as diagnostic abilities, clinical knowledge and surgical skills) but is well placed to judge the interpersonal aspects of the service they receive.

The interpersonal skills of health providers are therefore most often critiqued by consumers with satisfaction dependent on, for example, consumers' perceptions of trust, respect, sensitivity and understanding. Good communication by the provider is one of the most important predictors of patient satisfaction.

The present research examined Māori perceptions of the healthcare system and what Māori themselves identify as barriers to access. Findings from an initial qualitative study examining Māori experiences of health care informed the development of a survey questionnaire that was then pilot-tested with a random sample of Māori from across the country.

Research Objective

Through analysing existing information on health service use and surveying Māori consumers, this research project sought to understand the expectations, preferences and experiences of Māori consumers of health and disability services, including Accident Compensation Corporation (ACC) services. The objective of the present research was therefore to increase understanding of:

Māori use of health and disability services,

Māori experiences, expectations and perceptions of, and satisfaction with, health and disability services,

Māori consumers' understanding of the information they are given by health and disability providers, and

Barriers to optimal use of health and disability services by Māori.

Furthermore, another objective of the present research was to test the survey tool with Māori consumers, including the testing of individual questions, so as to validate its use in future research into how well services meet the needs and expectations of Māori.

Methodology

The present research took a Kaupapa Māori, 'by Māori, for Māori', approach in that, for example, the research was led by, and guided by, Māori. Māori participant experiences were privileged. And the analysis of research findings was strengths-based and performed within a systems analysis. The research project was also overseen and guided by Kaumātua and consumer advisory groups.

The research focused on Māori only, as one goal of the project was to develop and validate a survey tool that was specifically designed for use with Māori populations.

The first part of the research involved a series of ten hui with Māori consumers of health and disability services. The number of participants at each hui ranged from five to 15, with a total of 86 people attending the hui.

The findings from the hui were used alongside existing 'experiences of care' surveys to develop a semi-structured survey questionnaire to collect data on Māori experiences with health and disability services. A telephone survey with a random sample of Māori from across the country, combined with face-to-face interviews with a sample of 50 deaf Māori, yielded survey responses from a total of 651 Māori (384 females (59%) and 267 males (41%)). Respondents were asked about the health and disability services, as well as ACC, they had been to in the six months prior to being questioned.

Limitations

As the research focused exclusively on Māori consumers, per the study's goal of developing a Māori-specific evaluation tool, it provided no comparative data.

The survey sample was representative of the Māori community but not comprehensive, and respondents for both the hui and survey phases were those who were willing to speak about their experiences. As a result the views of those who feel dis-enfranchised and refuse to participate may be under-represented in the findings. Nevertheless few of those contacted during the survey phase declined to participate.

The survey results are based on a survey that aimed to sample the responses of 650 Māori (including 50 Māori deaf) about their experiences with health care services in the six months prior to the telephone survey. To avoid over-representation from primary care experiences a quota was set to ensure that 30% of the final responses were from Māori reporting on non-general practice encounters.

The research aimed to develop a survey instrument that would be suitable for use with Māori consumers. Because of this, the goal of the research was to test the tool and its questions.

Ngā Tukunga Iho o Ngā Hui – Hui Findings

The hui participants talked about their experiences and opinions of a range of health and disability services. Although experiences differed according to the services being discussed, four key themes emerged about barriers to healthcare. These barriers were greatest for Māori with disabilities (ngā hunga hauā).

Organisational barriers included: the distance to travel for care, the availability of appointments at suitable times, waiting times, the (lack of) choice of provider, inflexibility of healthcare systems, and poor experiences (e.g., lack of response to complaints, lengthy resolution times).

Cost barriers included: direct costs (e.g., consultation costs, prescription charges), and indirect costs (e.g., loss of wages due to time off work while obtaining care, expenses relating to travel or childcare). Participants also questioned whether a general practitioner visit was 'value for money'.

Health provider barriers included: perceptions of negative or racist health provider attitudes toward Māori, and being talked 'down to' or treated with disrespect by staff. When both good communication and good health care provision was experienced, relationship building was reported.

Cultural fit barriers included: consumer attitudes such as 'shyness', reticence to challenge authority, a 'wait and see' attitude toward sickness or injury that was often related to cost, prior bad experiences and perceptions of being patronised, and a preference (often unfulfilled) for Māori clinicians or Māori providers.

Whakarāpopototanga – Executive Summary

Compared with previous research, the participants at the hui talked less about socio-economic barriers to healthcare and more about whether or not they were treated with respect, whether the service was 'value for money', and (for a few participants) the clinical skills of health workers. These judgements about respect, value and skill may signal Māori consumers' growing willingness to voice their concerns about their experiences of disrespect, racism and clinical practice.

Ngā Tukunga Iho o Ngā Rārangi Uiui – Survey Findings

Over half of the survey respondents (54.4%) had no health condition that required on-going treatment. The remaining respondents had health conditions (23.7%), physical conditions (10.6%), sensory conditions (9.8%), and/or a mental or intellectual disability (1.2%). General practitioners were the health service utilised most often by all participants in the six months prior to being surveyed.

Overall, respondents' experiences of different services were positive. The services were compared on a number of questions, with the following results as shown in Table 1.

Table 1. Respondents experiences of health service visits, percentage agreement

Question / Topic	GP	Hospital	A&E	Specialist	ACC	Other ¹
Number of visits reported on	502	200	139	174	77	137
Able to get a suitable appointment time	94% ²	N/A	N/A ³	90%	N/A	N/A
Seen on time	64%	N/A	N/A	80%	N/A	N/A
Confidence and trust in the service provider ⁴	92%	82%	N/A	91%	65%	93%
Receptionist was polite	96%	N/A	86%	93%	N/A	N/A
The service provider (e.g., doctor) asked enough questions	87%	83%	86%	88%	N/A	N/A
Service provider spent enough time listening	89%	N/A	N/A	85%	78%	84%
Service provider spent enough time with respondent	90%	84%	86%	90%	N/A	N/A
Service provider explained things well	87%	82%	81%	86%	58%	82%
Respondent given enough privacy	98%	83%	89%	94%	73%	97%
Respondent treated with respect	96%	87%	91%	97%	82%	96%
Service provider respected respondent's culture and beliefs	N/A	81%	N/A	N/A	75%	86%
Service provider said respondent's name properly	83%	N/A	N/A	86%	N/A	N/A
Overall satisfaction = 'Good'	79%	64%	63%	74%	48%	79%
Would visit this service again	93%	82%	82%	87%	82%	90%

Notes.

¹ 'Other' included other health and disability services that respondents had accessed (e.g., physiotherapy, occupational therapy). ² Percentage of participants agreeing with service statement. ³ 'N/A' indicates that this question was not asked for this service. ⁴ Respondents may have rated a doctor from their GP visit, a doctor or nurse from their A&E, other health professionals from their hospital visit, a staff member from ACC, or a health professional/worker from their other health services experiences.

With the exception of ACC (and A&E which was not rated on this question), most respondents (82%-93%) reported that

they had confidence and trust in most service providers. GP, specialist and other health services were rated as 'good' by most of the respondents (74-79%). Just under half (48%) of the respondents asked, rated their last ACC visit as 'good'.

Most respondents (78%-89%) reported that their GP, specialist, ACC staff member, or other health service provider had spent enough time listening to them.

With the exception of ACC, most service providers were rated as explaining things well by respondents. Just over half of the respondents (58%) reported that the ACC person they had met with had done so.

A majority of respondents reported that their service provider had given them enough privacy (73%-98%), and treated them with respect (82%-97%).

Most respondents reported that they would visit the same service again (82%-93%).

Respondents were also asked about their attitudes about their own health and about visiting different health services. Just over half of the respondents agreed with the statement 'I am in excellent health'. A similar number agreed with the statement that 'I have some concerns about my health'.

A cluster analysis performed on respondents' answers to the attitude questions, to look for groups of respondents with similar attitudes, differentiated between two groups: Group 1 comprised 73.3% of the total sample (78% of the sample included in the cluster analysis), while Group 2 comprised 20.7% of the total sample (22% of those included in the cluster analysis). The only significant demographic differences between the two groups were that:

Group 2 was younger than Group 1 (mean age = 39 vs. 47 years respectively; $t=6.284$, $p<0.001$), and

A larger proportion of Group 1 members were part of an older couple with no children at home (16% vs. 4% for Group 2).

Group 2 reported similar utilisation rates of healthcare services to Group 1 over the last six months. However Group 2 reported a greater reluctance to use health and disability services, and a greater dissatisfaction with the interactions they had with these services. Compared with Group 1:

A significantly higher proportion of Group 2 respondents agreed that: they had to be quite sick and usually waited until the last minute before going to the doctor, it was too expensive to go every time they were sick, the doctor was not good value for money, they have some concerns about their health, they do not like taking drugs for their illnesses, and they expect whānau to look after them when they are sick.

A significantly lower proportion of Group 2 respondents agreed that they were in excellent health.

A significantly lower proportion of Group 2 respondents agreed that: they were treated with respect by their GP, trusted their GP, were treated well by him or her, and that they had a good relationship with their GP.

A significantly higher proportion of Group 2 respondents agreed that: they did not like to ask the doctor questions, they were not treated like an adult by the doctor, doctors did not really listen to patients, and they were too shy to argue with the doctor if they thought s/he was wrong.

A significantly higher proportion of Group 2 respondents agreed that: they get looked after better if they deal with Māori people in their provider, and doctors do not really care about Māori patients.

A significantly lower proportion of Group 2 respondents agreed that: they get treated well in hospital, hospital staff recognises Māori culture, hospitals should not treat Māori differently to Pākehā, and that hospital staff treated them with respect.

A significantly higher proportion of Group 2 respondents agreed that: they got different answers from different people in their health provider, it is hard to get a straight answer from people in the health system, the people in their provider make it difficult for them to get what they want, and they did not get treated with respect by their provider.

A significantly lower proportion of Group 2 respondents agreed that overall, the health system in New Zealand provides very good or good value for money.

Scott et al (2000) found that the health-related attitudes of younger Māori were more similar to those of the

Whakarāpopototanga – Executive Summary

New Zealand European population than they were to older Māori (>45 years) or Pacific peoples. This may have enabled those in Group 2 to feel more empowered to express disapproval about the health care they had received. In contrast older Māori may have felt that it was less appropriate for them to express negative views of health providers (noho whakaiti) as they were concerned with relationship maintenance.

Discussion

The overall survey findings were that Māori were reasonably satisfied with their encounters with the health services, including ACC. However a subgroup of those questioned expressed disapproval for the health care they and the general Māori community receive.

This younger cohort of respondents may signal a growing trend among Māori, also noted in the findings from the hui, to critique the health system. If this is the case then the challenge for the health system is to 'up its game' by improving its delivery of health care services that are appropriate, accessible and effective for Māori. In this way, the health system can become a leading solution in the 'crisis in Māori health' that is evident in current disparities.

Tātaritanga ā Rangahau Hāngai - Literature Review

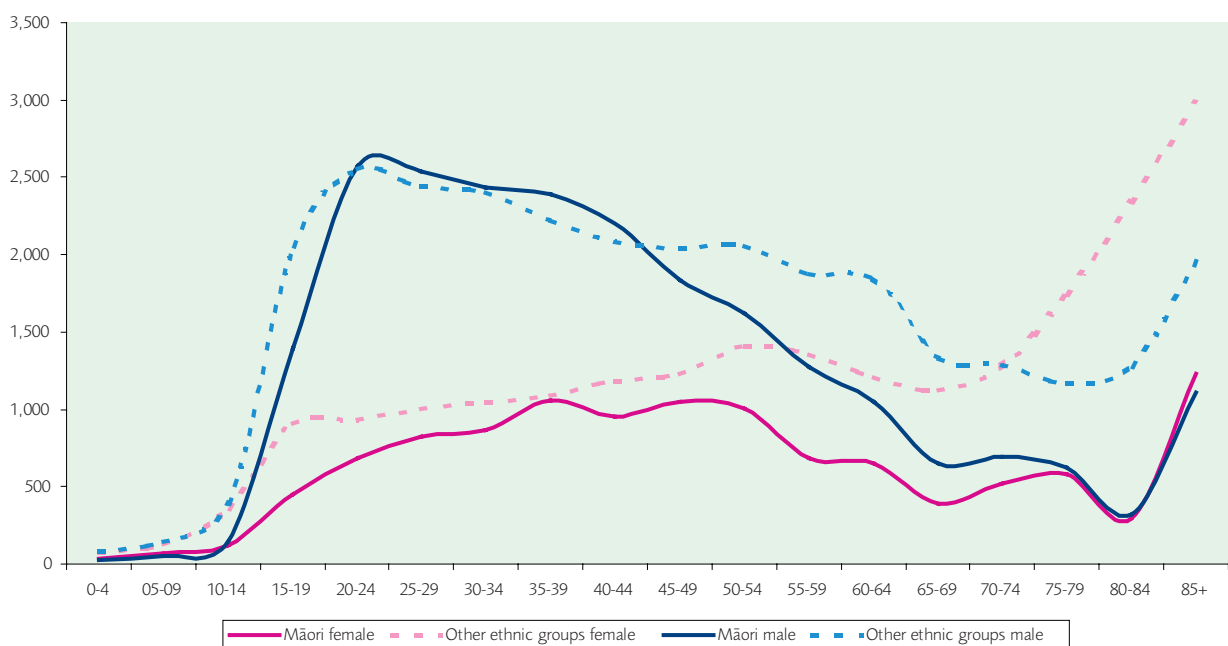
- A slightly larger proportion of Māori visits resulted in the prescription of a drug (69.6% versus 65.9% of non-Māori visits).
- While the average number of prescription items was higher for Māori than for non-Māori, other findings in the report suggest that some prescribing practices for Māori remain problematic. For example, among patients with a diagnosis (either new or existing) of chronic obstructive respiratory disease, only 62.6 percent of Māori received a prescription for a respiratory drug (compared to 71.0% of non-Māori), falling to 9.5 percent of new chronic obstructive airways disease problems resulting in a prescription for a respiratory drug (versus 77.8% of non-Māori with a new diagnosis of COPD).
- Overall, Māori and non-Māori received similar numbers of non-prescription treatments. Follow-up within three months was recommended for 54.6 percent of Māori and 57.5 percent of non-Māori visits, and referrals were slightly less common for Māori (14.7%) than for non-Māori (16.2%).

The authors note that this report confirms that, as a group, Māori have different experiences with general practice than do non-Māori. These differences (and disparities) are even more marked when the higher burden of disease among Māori is considered.

2.2.3 Access To Injury Treatment⁴

Māori serious injury claims account for 26.9 percent of all 'open' serious injury cases compared to the Māori census population of 16 percent, showing a disproportionately high rate of serious injury.⁵ Serious injury accidents to Māori have been concentrated in the Auckland, Bay of Plenty and Waikato regions, with 46.6 percent of the Māori serious injury claims related to motor vehicles (compared to 42.8% among non-Māori), and 28.9 percent (compared with 20.2% for non-Māori) of claims falling in the Non-earners category. Fatality rates are also disproportionately high among Māori according to ACC data (ACC 2005). Overall, claim rates show that Māori access ACC services less than other groups, with this disparity most marked in older age groups and non-earners (primarily those not in employment, mothers and their children) (see Figure 2).

Figure 2. ACC 2003 claim rates by ethnicity, gender and age group



Source: ACC

⁴ Injury treatment providers collect ethnicity data on over 90 percent of service users covered by the Accident Compensation Corporation (ACC),³ and 93.7 percent of new entitlement claims listed a known ethnicity in 2002/2003.

⁵ ACC data are not adjusted for age.

2.2.4 Secondary Care Services

Analysis of the National Minimum Database over the period 1990-1999 by Tukuitonga et al (2002) suggested bias against Māori receiving cardiac revascularisation procedures despite the much greater clinical need for intervention among Māori, with more severe illness, higher rates of risk factors and higher prevalence of disease amongst Māori. Similar evidence of bias is available for interventions and outcomes following stroke (Lillie-Blanton et al 2000), obstetric interventions (Sadler et al 2001), heart failure (Carr et al 2002), and asthma (Ellison-Loschmann et al 2002).

McNaughton et al (2002) found that Non-Europeans had longer hospital stays than Europeans following an acute stroke (median 36 days vs. 18 days), with this difference possibly related to the age of the patient as well as their ethnicity (McNaughton et al 2002). Māori and Pacific people admitted with acute stroke are younger on average than European patients, and it is harder to find inpatient rehabilitation services for younger patients. Put another way, the organisation of rehabilitation services (more beds for older patients) tends to reflect the needs of those of European descent.

2.2.5 Treatment Injuries, Complaints and Other Services

To assess disparities in the quality of hospital care, Davis et al reviewed records from 6579 admissions to 13 public hospitals in 1998 (Davis et al 2006). Preventable adverse events were used as an indicator of suboptimum treatment. After age standardisation, significantly more Māori admissions were associated with an adverse event compared with non-Māori/non-Pacific admissions (14% vs. 11%, $p=0.01$). This disparity persisted after controlling for age, other sociodemographic factors, and case mix (adjusted odds ratio 1.47; $p=0.05$), change to "indicating that Māori patients were more likely to receive suboptimum care while in hospital.

Bismark et al (2006) further examined access to ACC entitlements for treatment injuries and access to complaints about treatment services. A comparison of hospital records with Health and Disability Commission records and ACC records found that fewer than 5 percent of all eligible patients claimed ACC compensation (under the former 'medical misadventure' scheme), and only 1 in 25 patients who suffered serious preventable injuries complained to the Health and Disability Commissioner. In addition, when disability and eligibility for compensation was controlled, Māori had considerably lower rates of claims than did other New Zealanders (Odds ratio 0.4, $p<0.05$) (Bismark et al 2006).

Howell and Hackwell's (2003) study of disability allowances received by children in families whose source of income was welfare entitlements revealed that access to entitlements is also affected by ethnicity. Māori were found to be less than half as likely to receive a disability allowance (3.23% for Māori vs. 7.41% for non-Māori, non-Pacific) and, when in receipt of an allowance, received a lesser average amount than non-Māori, non-Pacific recipients (mean = \$11.05 vs. \$15.46 respectively).

2.2.6 Summary

In Aotearoa New Zealand, Māori access to, and use of, healthcare is reduced at every step of the pathway through care, from primary and pre-primary through to secondary or tertiary services and beyond (Barwick 2000; Arroll et al 2002; Ajwani et al 2003; ACC 2004; MOH 2004b; Crengle et al 2005). The barriers that exist for Māori to access care are evident in the different quality of care and less optimal clinical outcomes Māori experience compared to non-Māori. These differences exist even after other factors such as age and socio-economic factors are controlled for. The next section looks further at the possible reasons for these disparities.

2.3 Understanding Disparities

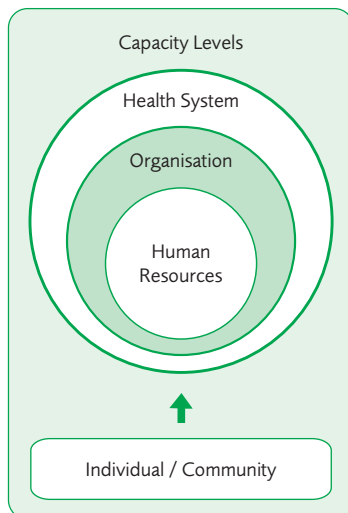
Internationally, researchers have examined both barriers to, and facilitators of, health care for minority patients (Cooper et al 2002). New Zealand studies of barriers to care have uncovered structural and system-level barriers; patient-perceived barriers to care and/or provider reports of patient-level barriers; and process of care issues. These may act separately or together to limit necessary health care, and the influence of each is related to the context of care (Barwick 2002; Baxter 2002; Cormack et al 2005).

Cormack et al (2005), for example, noted that access for Māori to cancer services is poor at all levels from primary prevention, through early detection and screening, to diagnosis, treatment services and rehabilitation or palliative care services. The authors concluded that barriers for Māori are complex, occur at many levels in the system, and require interventions at the health system, healthcare process, and patient/population levels.

Addressing Māori access to healthcare can be viewed as a capacity issue; that is, does the health sector have the capacity to deliver equitable health care to Māori? Capacity is defined here as 'the ability of individuals, organisations, and whole societies to define and solve problems, make informed choices, order their priorities and plan for their futures, as well as implement programs and projects to sustain them' (Nair, 2003:1). LaFond, Brown and Macintyre (2000) identify four levels of health sector capacity while emphasising the links between levels (see Diagram 1 pg 18).

These levels are a useful way of looking at the barriers to, and facilitators of, access to health care for Māori and, as such, each is explored below. Researchers often report barriers and facilitators across multiple levels and, when this occurs, the findings have been assigned to the appropriate levels. While this is a useful device for discussing access for Māori, it should be remembered that these levels are interdependent; for example, human resource capacity is often dependent on the organisation within which health personnel work (LaFond et al. 2002).

Locating reports of successful initiatives to overcome barriers to care for Māori is challenging. Recent evaluations of healthcare programmes include the ACC pilots aimed at reducing the barriers for disadvantaged populations and the evaluation of general practice projects aimed at reducing inequalities, are included below, mostly in relation to the individual/community level.



Source. LaFond et al (2002:17, Figure 1)

Diagram 1. Levels of health system capacity

Health system level – the entire health care system within a country, including organisations and personnel.

Organisation level – the processes, structures and management systems of health care organisations.

Human resource (health programme personnel) level – the people who work in health care.

Individual or community level – individuals who engage with the health sector; for example, as staff, as committee members, and as patients.

2.3.1 Health System

The focus of the 2000 New Zealand Health Strategy (Minister of Health 2000) is on tackling inequalities in health. This strategy sets the context for the Ministry of Health's 2002 Māori health strategy, 'He Korowai Oranga', as well as for a range of other research and policy initiatives from the Ministry that are designed to guide the health system in its task of reducing inequalities in health. Recent policy interventions (www.moh.govt.nz) have sought to improve Māori health by:

- Reducing cost barriers to care, such as capitation models for primary care funding with targeting to Māori, Pacific and low income groups;
- Reducing differential quality of care offered, such as evidence-based priority scoring systems for surgical interventions;
- Reducing the incidence of risk factors for disease, by targeted smoking cessation programmes;
- Creating targeted programmes such as the Māori Provider Development Scheme supporting health promotion and community based services;
- Developing health equity tools to assess the potential of initiatives to contribute to the reduction of inequalities (e.g., Health Equity Assessment Tool (HEAT), Whānau Ora Health Impact Assessment); and
- Monitoring of Māori – non-Māori health disparities (MOH 2006)

2.3.2 Health Organisation

Several organisational factors have been noted by researchers as barriers to Māori access to care, including primary care (Barwick 2000), diabetes care (Baxter 2002) and cancer care (Cormack et al 2005). These barriers include:

- The universal focus of the health system in which one service for all often means that services are not culturally appropriate for Māori patients (Ratima et al 1993; Barwick 2000; Baxter 2002).
- Workforce composition; that is, few Māori personnel (Barwick 2000; Baxter 2000; Health Waikato 2001; Cormack et al 2005).
- The timing and availability of services (Crengle 2000) including service configuration and location (Cormack et al 2005) and patients' lack of awareness of available services (Bryant & Campbell 1996).
- Funding and resources, including the physical environment (Health Waikato 2001; Cormack et al 2005).
- Appointment systems currently utilised (hospital-based systems were viewed as overly rigid) (Bryant & Campbell 1996).
- A lack of relevant educational and promotional material, and appropriate (e.g., Māori-specific) information (Bryant & Campbell 1996; Crengle 2000; Health Waikato 2001).
- Failure by providers to identify and treat those in greatest need (Crengle 2000).
- Unclear continuity of care, including follow-up and maintenance of treatment (Crengle 2000; Health Waikato 2001).
- Lack of use of the Māori language (Health Waikato 2001).

The provision of culturally appropriate services, including customised and targeted services, has been noted by several researchers as a key facilitator of Māori access to health care (Ratima et al 1993; Barwick 2000; Baxter 2002). Often this is closely associated with services having more Māori staff, and Māori-friendly non-Māori staff (Bryant & Campbell 1996; Barwick 2000; Health Waikato 2001). Māori women, for example, have often reported that they would prefer to go to services run by Māori women to have cervical smears (Lynch & Kanuku 1990).

Having a healthcare provider that is both understanding of and understandable to the patient has consistently been shown to predict patient satisfaction, the acceptability of treatment, and treatment success (Cross et al 1989; Isaacs & Benjamin 1991). When there is concordance between the cultural beliefs and understanding of the provider and the patient, access is improved and adherence to treatment is enhanced (Cross et al 1989; Isaacs & Benjamin 1991; Penn et al 1995). These findings also apply to Māori (Jansen 1998; Cram et al 2003). Generally speaking, however, there is a lack of cultural concordance between Māori patients and predominantly non-Māori health providers in Aotearoa New Zealand.

Evaluation of the 2005/6 ACC pilot programmes found that communications with disadvantaged communities need to be targeted appropriately and delivered in appropriate ways by relevant groups (rather than government agencies) (ACC 2007).

2.3.3 Human Resource

Human resource barriers to Māori access to health care include:

- Characteristics of non-Māori staff, including their perceptions, attitudes, biases, and beliefs (Cormack et al 2005; Health Waikato 2001) For example, staff's perceived (by Māori patients) lack of understanding of the social and cultural context of diabetes for Māori (Health Waikato 2001). In addition, McCreanor and Nairn (2002) found that non-Māori GPs 'blame Māori for their own condition or variously justify established approaches that doctors take'. These GPs were of the opinion that, for example, Māori do not take medication, do not attend follow-up appointments, and do not embrace preventative health practices. Perhaps a worse kind of blame emerged from a survey of New Zealand psychiatrists (Johnstone & Read 2000) which found that 11.3 percent (N=28) of respondents held the inaccurate belief that Māori were biologically or genetically more predisposed than others to mental illness.

Tātaritanga ā Rangahau Hāngai - Literature Review

- Provider-patient communication (Health Waikato 2001; Cormack et al 2005). In the NatMedCa study, for example, doctors themselves reported a lower level of rapport with Māori compared to non-Māori (Crengle et al 2005). Cram et al (2003) reported on Māori patients' views on the importance of rapport.
- There have not been studies conducted in this country of differences in the actual interactions Māori and non-Māori patients have with health providers. However local findings from interviews with clinicians (Buetow et al 2002; McCreanor & Nairn 2002) match those of Van Ryn and Fu (2003) who, in a study based on actual clinical encounters, found that, compared to white patients, doctors rated black patients as:
 - less intelligent;
 - less educated;
 - more likely to abuse drugs and alcohol;
 - more likely to fail to comply with medical advice;
 - more likely to lack social support; and
 - less likely to participate in cardiac rehabilitation.

These findings persisted even after patients' income, education, and personality characteristics were taken into account, suggesting that provider perceptions and attitudes toward patients are influenced by patient race or ethnicity. This is also supported by other international research findings (Maheux & Beland 1987; Crandall et al 1993; Crandall et al 1997; Rathore et al 2000; Wilson et al 2004). Van Ryn and Fu's (2003) findings may be further complicated by those of Bach et al (2004) that different groups of patients are 'to a large extent treated by different physicians', and that those clinicians who treat predominantly non-white patients are often less well trained clinically and have less access to clinical resources.

A report for the Henry J. Kaiser Family Foundation and the American College of Cardiology Foundation, entitled *Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence* (Lillie-Blanton et al 2002), reported on a review of 81 studies of cardiac care where racial or ethnic groups were compared. Of these, 68 studies found racial/ethnic differences in cardiac care for at least one of the minority groups under study. In a summary of the main findings it was reported that the majority of the peer-reviewed studies investigating racial/ethnic differences in cardiac care are methodologically rigorous and conclusively find that racial/ethnic minority groups are less likely than whites to receive the procedure or treatment under study. Furthermore the studies rated to be methodologically stronger 'provide credible evidence that African-Americans are less likely than whites to receive diagnostic procedures, revascularisation procedures and thrombolytic therapy' and document that 'racial/ethnic differences in care remain after adjustment for clinical and socioeconomic factors.' Studies reviewed by the Institute of Medicine (IOM) (Smedley et al 2002), including the van Ryn and Fu study (2003), found that:

- patients' attitudes, such as their preferences for treatment, do not vary greatly by race or ethnicity;
- there is considerable evidence of unconscious implicit negative attitudes and stereotypes towards ethnic minorities amongst providers;
- these implicit assumptions can result in self-fulfilling prophecies in social interactions, such as consultations with patients; and
- the time pressures and uncertainties that providers face when assessing patients or making treatment decisions can cause providers to incorporate implicit assumptions into their recommendations.

While it is likely that patients also have similar unconscious implicit attitudes and stereotypes about providers the IOM noted that little research has been conducted to date on how patients influence the clinical encounter. The report suggested that minority patients may appropriately perceive bias and therefore avoid care, or convey their mistrust in subtle ways to providers who may (mis)interpret that attitude and provide less intensive treatment or investigations. The authors' concluded that:

'Patients' and providers' behaviour and attitudes may therefore influence each other reciprocally, but reflect the attitudes, expectations, and perceptions that each has developed in a context where race and ethnicity are often more salient than these participants are even aware of'.

Schouten et al (2007) note the lack of research on the communication process between doctors and patients of different cultural backgrounds. Their own study examined how patients' active involvement (e.g., asking questions) in an interaction influenced white Dutch doctors' communication behaviour, as well as the effect this had on patient satisfaction and mutual understanding. The researchers found that patients differed in their participation, with less participation by non-Western patients compared to Dutch patients. However the strongest finding was that GPs' affective verbal behaviour was positively related to both patient participation and patient satisfaction, leading the authors to endorse communication training for GPs.

2.3.4 Individual or Community

Three individual or community barriers to Māori accessing health care are discussed by researchers: socioeconomic position, attitudes, and health status. Each of these is explored below.

Socioeconomic position

The cost of health services, including physically getting to the service (e.g., location, transport, and having to take time off work), is a concern for many Māori (Ratima et al 1993; Bryant & Campbell 1996; Crengle 2000; Cram et al 2001; Zgibor & Simmons 2002; Clemenger BBDO 2004). Financial barriers are more likely to impact on Māori due to the lower socioeconomic of many Māori compared with non-Māori.

Rameka (2006:50) writes that 'a lot of rural whānau do not go to the hospital or do not access secondary care because of the hidden costs associated with being in hospital'. These costs include transport, accommodation, food, and hospital car park rates. Even if whānau can be reimbursed for these costs, they must still be able to meet them in the first instance.

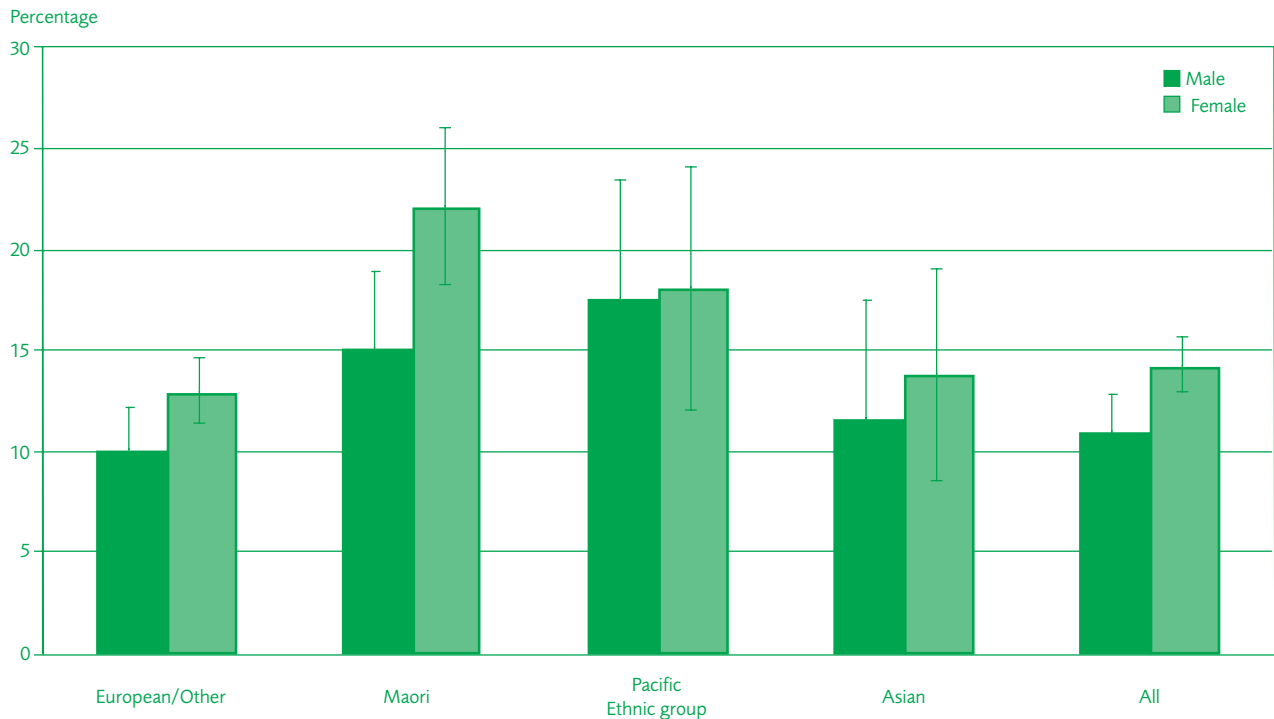
In the 2002/03 New Zealand Health Survey (MOH 2004b) 12 percent of adults said that they had needed to see a GP in the last 12 months but had not, with reasons including:

- Costs too much (49% of the 12%).
- Didn't want to make a fuss, or couldn't be bothered (26%).
- Difficulty getting an appointment (22%).
- Couldn't spare the time (18.8%).

The burden of such unmet need falls more on the Māori population (Figure 3).

A recent study for the Commonwealth Fund which assessed adult patients' primary care experiences in Australia, Canada, New Zealand, the United Kingdom and the United States confirmed that access to care is related to costs, with those countries having the highest cost barriers to primary care also reporting the highest rates of patients not being able to obtain timely medical treatment, prescriptions or preventative care (Schoen et al 2004).

Figure 3. Unmet need for general practitioner in last 12 months, by ethnic group and sex (age-standardised)



Source: Ministry of Health (2004)

Health insurance can improve access by allowing users to bypass the gatekeeper assessments by primary care providers and/or hospital specialists. However Māori at all levels of socioeconomic status are less likely to have health insurance (TPK 2000). These findings are in keeping with studies in other countries such as the United Kingdom and the United States where minority or deprived groups have lower levels of insurance coverage and lesser access to care (Miller 1996; Schoen et al 2002).

In New Zealand, ACC data demonstrate that Māori still receive reduced access to services even in those programmes for which there are no direct costs, such as home help or other social assistance packages (TPK 2000). This suggests that other access barriers are more important than the direct cost for these services. For example, people may not be willing to attend a culturally inappropriate service even if it is available and affordable (Durie 2001).

Patient attitudes, beliefs and preferences

Patient knowledge, attitudes, beliefs, values, and preferences are also associated with access to care (Baxter 2002; Buetow et al 2002; Mauri Ora Associates 2002; Zgibor & Simmons 2002; Cram & Smith 2003; Cormack et al 2005). Attitudes to health care are often informed by people's past experiences and/or the experiences of their whānau and others close to them (Cram et al 2003). Previous negative experiences with the healthcare system and/or perceptions of bias, such as Pākehā health services not being seen as acceptable or clients hearing negative comments from others, can prevent people from accessing health care (Bryant & Campbell 1996; Health Waikato 2001).

Māori taking part in ACC focus groups (Clemenger BBDO 2004) also talking about the indirect costs of accessing care. This was described as 'hoha' and included hassles or barriers such as having to 'stop and arrange my day' (i.e., arranging time off work, organising transport, changing clothes, etc.). There was also a perception within the ACC focus groups that there would be lots of forms and information to try and understand, collate, organise, and explain; all of which was perceived as an inconvenience that led many of them to choose not to engage with the health system.

Reluctance to access care may also stem from a belief, and its associated fear, that hospitals are places people go to die (Health Waikato 2001). Other sources of fear identified by health professionals talking about GP care for

asthma for Māori and Pacific peoples include fear of: embarrassment, wasting GP time, causing offence, receiving offence, loss of privacy (Buetow et al 2002). Māori diabetics also identified fears, including fear about: the disease, its consequences, the care environments, and the changes to lifestyle that are required (Health Waikato 2001). Members of ACC focus groups felt that Māori would be concerned that if they used ACC services they would most likely be 'pulled' up or 'told off' for lifestyle choices (e.g., smoking). They were also worried by what else the doctor may discover about their health, stating that they would prefer not to know (Clemenger BBDO 2004).

Attitudes to health care may also be important, such as not making personal health care a priority due to other roles and commitments within their community (Brant & Campbell 1996; MOH 2005b), and the perception that health care is irrelevant or that it is too late in life to worry (Bryant & Campbell 1996). A lack of support or encouragement from whānau members may also mean that a person does not access health care (Bryant & Campbell 1996). The isolation (social/physical) of some kuia may also be a barrier to health care (Bryant & Campbell 1996).

Whakamā, which is often translated as shyness or embarrassment, is also seen as barrier to health care (Bryant & Campbell 1996; Cram & Smith 2003). There is little discussion in the health literature about the cultural appropriateness of whakamā, particularly when Māori patients engage with health professionals who have little understanding of them and/or their circumstances (Cram et al 2003). Māori focus group members involved in an ACC study in 2004 reported that Māori are apprehensive about being 'put on the spot' and being unable to articulate their concerns or to understand the doctor's questions, thus looking unintelligent or foolish (Clemenger BBDO 2004).

Health status

Health status has also been reported as a barrier to access (Bryant & Campbell 1996). Many Māori are reluctant to access care services unless they feel ill with this probably intertwined with the above two barriers of cost and attitudes (Health Waikato 2001; ACC 2007). In the 2004 ACC study Māori also stated a reluctance to seek help for any injury unless it was thought to be severe enough (Clemenger BBDO 2004).

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