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

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1 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.

1 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

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

2

Considerable local and international evidence about inequalities in health has become available in the last decade (MOH 2002; Smedley et al 2002; Robson & Harris 2007). Health inequalities occur between population groups according to numerous factors, including cultural and historical, socio-economic status, geographical place of residence, ethnic identity, and gender.

A contributing factor to these inequalities is the unequal access to health services experienced by different population groups (MOH 2002). Disparities in access to health services have been found in many different health care settings (Todd 1993; Lillie-Blanton 2000; Geiger 2001; Fiscella et al 2002) including: home-based or community services; preventive and primary care services (Gemson et al 1988; Ashford et al 2000; Williams et al 2001; Franks et al 2005); injury treatment services (Bismark 2006; Bismark et al 2006); and a range of hospital services (Pruss et al 2000; Arroll et al 2002; Ellison-Loschmann et al 2002; McNaughton et al 2002; Tukuitonga & Bindman 2002; Davis et al 2006). In addition, ethnic disparities in healthcare have been shown to remain even after adjustment for socioeconomic differences and other healthcare access-related factors (such as life insurance) (Smedley et al 2002).

In order to understand these disparities, research has examined the barriers to, and facilitators of, marginalised groups' access to health care along the continuum of care. This research demonstrates that the capacity of the health sector to meet the needs of these groups is questionable at every level – from the individual patient to the interactions between patients and health professionals to the health system of a country (Smedley et al 2002; La Fond et al 2002).

The perceptions of patients themselves are important in understanding how the health system is (not) facilitating their access to care and operating to improve their health. While patients may not be able to accurately judge the technical aspects of their care, they can assess the structural and procedural components of the health care they receive (Newsome & Wright 1999). Patient feedback on these components is now integral to quality assurance and quality improvement in many countries (Fitzpatrick 1991; Steele 1992; Newsome & Wright 1999).

In Aotearoa New Zealand Māori experience the greatest levels of health inequality, with Māori mortality and morbidity being significantly worse than non-Māori (Sporle et al 2002; Ajwani et al 2003; Westbrooke et al 2001). The present chapter examines the extent of the health inequalities experienced by Māori, with a particular focus on the disparities that exist in the access Māori and non-Māori have to health care. Explanations for these disparities are then explored before attention is turned to the question of how patient feedback on the health system is best obtained. The following chapter then discusses issues related to Māori involvement in research, as gaining feedback on Māori patient experiences is a form of research. This sets the scene for a description of the approach taken in the present study. (See Appendix A for the methodology used for the literature review).

2.1 Health Inequalities

There are discrepancies in the health status of New Zealanders based on socioeconomic status, geographic place of residence, ethnic identity and gender (MOH 2002). Māori have the greatest level of health inequality, with measures of mortality and morbidity showing significant gaps even after controlling for deprivation, access to care and health needs (Westbrooke et al 2001; Arroll et al 2002; Carr et al 2002; Sporle et al 2002; Tukuitonga & Bindman 2002; Ajwani et al 2003; MOH 2006). Not only is the health status of Māori worse than that of non-Māori at all levels of deprivation, but the gap between Māori and non-Māori increases as deprivation increases (Tukuitonga & Bindman 2002; Ajwani et al 2003; MOH & University of Otago 2006).

In addition, analysis of the 2002/03 New Zealand Health Survey questions on self-reported racial discrimination and self-rated health led the researchers to conclude that both deprivation and experiences of perceived racial discrimination contribute to inequalities in health outcomes between Māori and European New Zealanders, noting that in spite of probable underestimation of the effects of discrimination (Harris et al 2006:2008),[1]

> *... the combination of deprivation and discrimination as measured seems to account for much of the disparity in the health outcomes assessed.*

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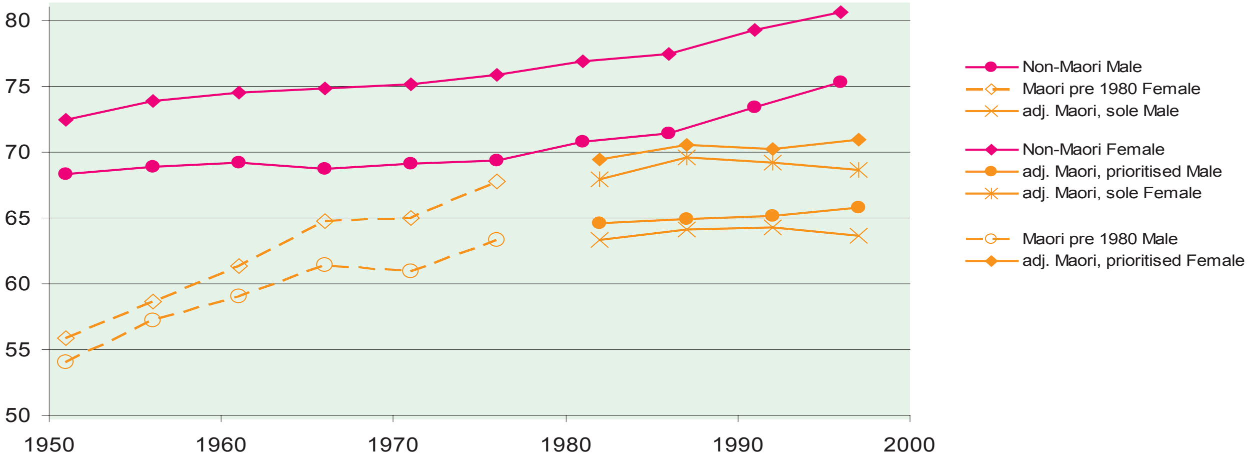
[1] The study included responses from Māori (n=4108) and Europeans (n=6269). The authors analysed the responses to five questions about discrimination: verbal attacks, physical attacks, and unfair treatment by a health professional, at work, or when buying or renting housing, with logistic regression analyses to assess the effect of adjustment for experience of racial discrimination and deprivation on ethnic inequalities for various health outcomes. It was reported that Māori were more likely to report discrimination in response to these questions, and were almost ten times more likely to report discrimination in three or more settings than were Europeans (4·5% [95% CI 3·2–5·8] vs. 0·5% [0·3–0·7]). After adjustment for discrimination and deprivation, odds ratios (95% CI) comparing Māori and European ethnic groups were reduced from 1·67 (1·35–2·08) to 1·18 (0·92–1·50) for poor or fair self-rated health, 1·70 (1·42–2·02) to 1·21 (1·00–1·47) for low physical functioning, 1·30 (1·11–1·54) to 1·02 (0·85–1·22) for low mental health, and 1·46 (1·12–1·91) to 1·11 (0·82–1·51) for cardiovascular disease.

Tātaritanga ā Rangahau Hāngai - Literature Review

Life expectancy is a key indicator of health and is showcased here before attention is turned to disparities in access to health care. Mortality data from the New Zealand Health Information Service confirms that, at all ages, Māori have a higher death rate than non-Māori (MOH 2006). For example, the death rate for Māori females in their 50s and 60s is roughly three times that of non-Māori females of the same age. As a result, in 2000-2002, life expectancy at birth was 8.2 years longer for non-Māori males and 8.8 years for non-Māori females, compared to Māori. In addition, when mortality rates over the 1980s and 1990s are recalculated to adjust for numerator-denominator bias[2], it is clear that the disparities between Māori and non-Māori life expectancy widened substantially over this 20 year period (Figure 1) (Ajwani et al 2003).

Figure 1. Life expectancy at birth 1950 to 2000, Māori and non-Māori



Adapted from Tatau Kahukura: Māori Health Chart Book (MOH 2006)

2.2 Access and Outcomes

In the 2002 Reducing Inequalities in Health (p.20-22) the Ministry of Health identified four possible sites for interventions to reduce inequalities and improve health:

Structural – social, economic, cultural and historical factors fundamentally determine health.

Intermediary pathways – the impact of social, economic, cultural and historical factors on health status is mediated by various factors.

Health and disability services – what services can specifically do.

Impact – minimising the impact of disability and illness.

Similarly the authors of the Decades of Disparity reports (Ajwani et al 2003; Blakely et al 2007; MOH 2005c; MOH & University of Otago 2006) outline the possible reasons for ethnic disparities as:

1. Social structural: inequalities in income and other economic or social benefits impact adversely on health.
2. Epidemiological: both risk factors for major chronic diseases (obesity, tobacco use and diet) and the diseases themselves (diabetes, cardiovascular disease and cancer) are more prevalent in Māori than non-Māori communities.
3. Health services: both lesser access to care and lower quality of care may contribute to disparities.

Although the relative importance of each factor or their combined effects has yet to be clearly resolved, Decades of Disparity III suggests that only about half of the disparity for Māori may be due to socioeconomic status MOH & University of Otago 2006).

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[2] During the 1980s and early 1990s Māori and Pacific mortality was seriously undercounted, because ethnicity was recorded differently on death registration forms than in the census. The New Zealand Census–Mortality Study (Public Health Intelligence, Ministry of Health), a record linkage study in which death registration data is linked anonymously and probabilistically to census data, enabled the extent of this 'numerator-denominator bias' to be calculated. Undercount adjusters derived from this study were applied to ethnic specific mortality rates for the 20-year period 1980–1999, giving rise to a mortality time series largely free of numerator – denominator bias.

Addressing inequalities across all these levels is imperative for both Māori health and the health of the entire population (Mackenback 2002). At the level of health and disability services Māori experience unequal access and unequal outcomes at all levels of the healthcare system in New Zealand (Ruakere 1998; Baxter 2002; Schoen et al 2002; Crengle et al 2005; MOH 2002). The following examples highlight this problem while the following section looks at the explanations for this denial of access.

2.2.1 Public Health

Skegg and McCredie show that excess cancer death among Māori accounts for two thirds of the excess death in males, and one quarter of excess death in females (in New Zealand compared to Australia) (Skegg et al 2002).

2.2.2 Primary Care

A number of studies have reviewed ethnic group differences in utilisation of primary care services or access to hospital services (Davis et al 2006; MOH 2006). These studies have shown lesser access for Māori compared with non-Māori New Zealanders. In addition, from an analysis of the 1996/7 NZ Health Survey, Scott concluded that there are barriers for Māori accessing primary care services that are in addition to those related to income and all other variables (Scott et al 2000).

Some studies have examined the processes and outcomes of care for ethnic groups. For example the 1997 National Nutrition Survey included measurement of blood pressure and the collection of information about the use of anti-hypertensive medication. About 10 percent of participants were taking anti-hypertensive medication and an additional 10 percent were hypertensive at the time of the interview but not taking medication. While nearly half of those taking anti-hypertensive medication were still hypertensive at the time of the interview, a greater proportion of Māori and Pacific participants were hypertensive while on medication.

Arroll et al (2002) studied the prevalence of depression and the use of anti-depressants at an Auckland-based university general practice. The prevalence of depression measured using the Beck Depression Inventory was 13.8 percent, and general practitioners (GPs) identified 51 percent of cases, with Māori patients no more likely to be depressed than non-Māori patients and no less likely to be correctly diagnosed as depressed. However only one of the 24 Māori diagnosed with depression was provided treatment compared with 24 of the 53 non-Māori patients.

The differential treatment findings of the Arroll study were supported by an analysis of the National Primary Medical Care Survey (NatMedCa) by Crengle et al (2005). NatMedCa is a nationally representative study of the characteristics of over 200 GPs and the practices they work in, the patients they see, the problems they manage and the investigations and treatments that they offer. Report 6 of the study compares the experiences of Māori patients with non-Māori patients. In total doctors logged 40,189 consultations, of which 12.2 percent were with Māori patients (a smaller percentage of Māori than in the general population). Detailed visit information was provided on 9124 visits, of which 12.3 percent were by Māori patients. Analysis of this information revealed that:

- The percentage of Māori patients in Māori provider practices (58.9%) was substantially higher than in private GPs (11.8%), or community governed non-profits (19.4%).
- Māori were more likely to hold a Community Services Card than non-Māori, and a high proportion of Māori resided in areas of high deprivation.
- On average Māori had had fewer healthcare visits in the previous year than non-Māori (mean=6.1 vs. 6.7).
- Doctors reported lower levels of rapport with Māori patients, and the overall mean length of consultation time spent with Māori patients was shorter than for non-Māori (mean=13.7 vs. 15.1 minutes).[3]
- Tests and investigations were ordered in 21.0 percent of Māori visits, compared to 25.4 percent of non-Māori visits.

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[3] These data were not standardised for age and, compared to non-Māori, a higher percentage of Māori patients were young. As paediatric patients are often seen for shorter times, this could account for some of the observed differences. However the authors also reported that the mean duration of consultation was slightly lower for Māori than for non-Māori in all age groups, for both sexes and across all deprivation groups.

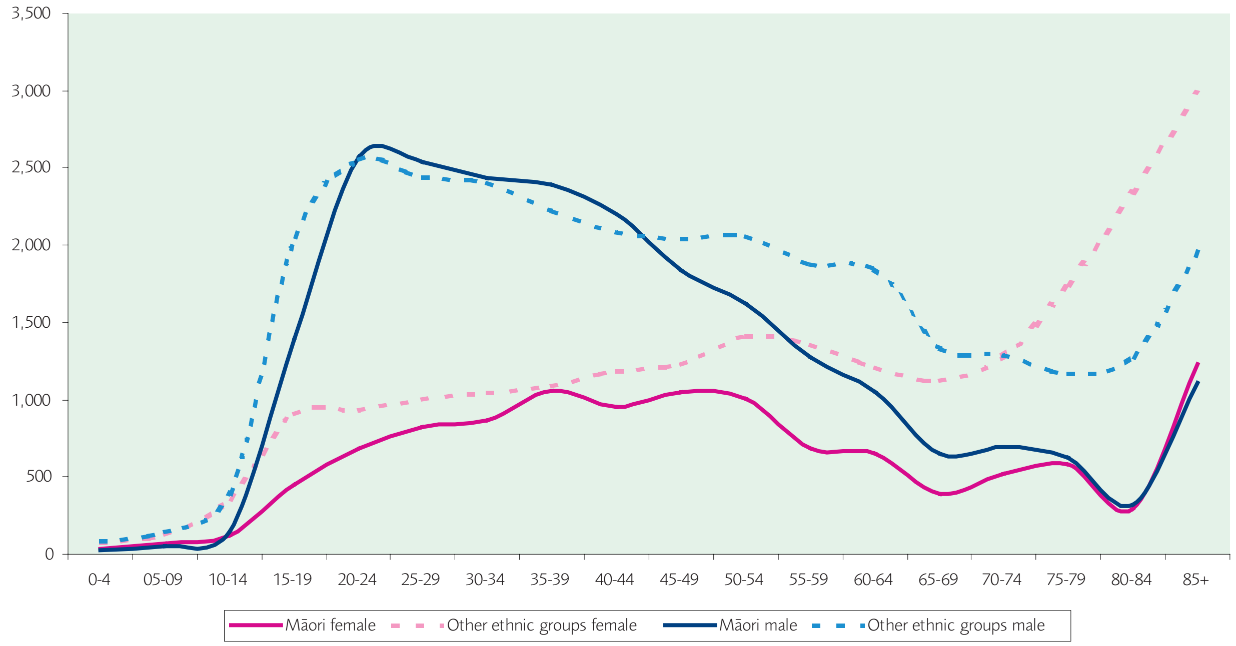
- A slightly larger proportion of Māori visits resulted in the prescription of a drug (69.6% versus 65.9% of non-Māori visits).
- While the average number of prescription items was higher for Māori than for non-Māori, other findings in the report suggest that some prescribing practices for Māori remain 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 Treatment[4]

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

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[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

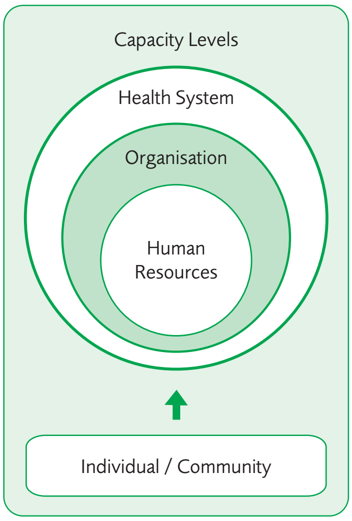
Internationally, researchers have examined both barriers to, and facilitators of, health care for minority patients (Cooper et al 2002). New Zealand studies of barriers to care have uncovered structural and system-level barriers; patient-perceived barriers to care and/or provider reports of patient-level 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.

- 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.

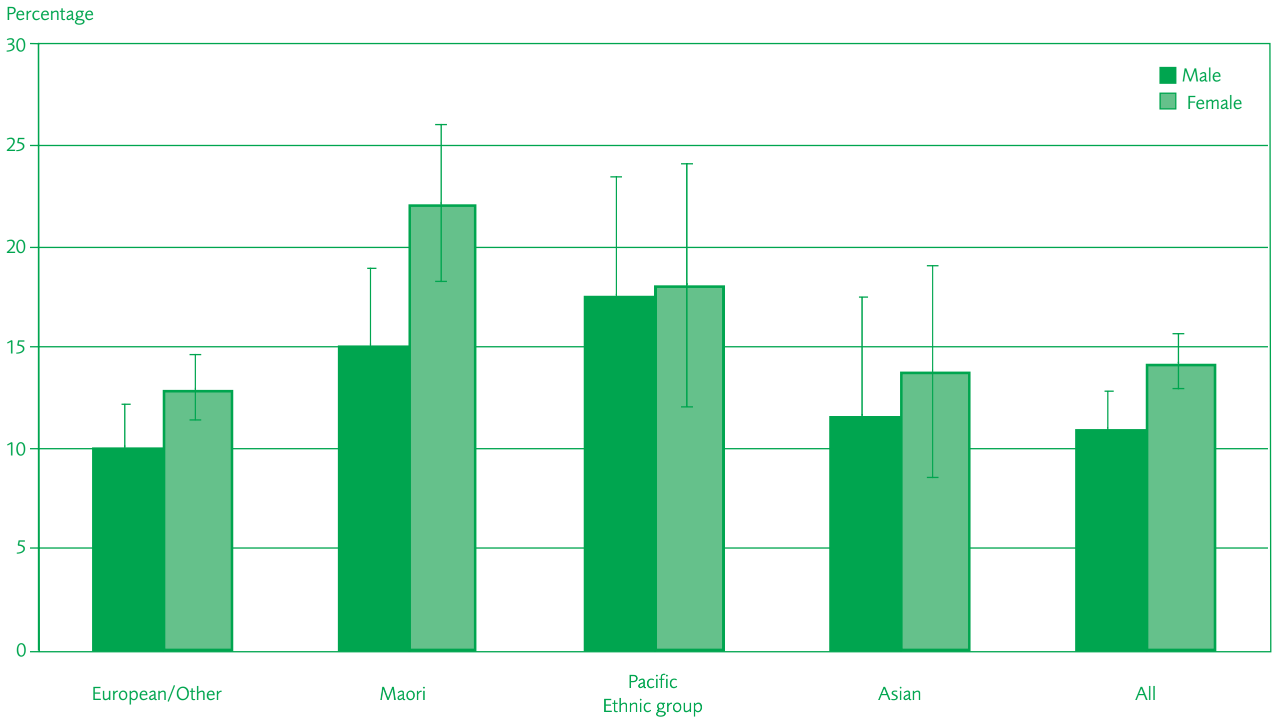
In the 2002/03 New Zealand Health Survey (MOH 2004b) 12 percent of adults said that they had needed to see a GP in the last 12 months but had not, with reasons including:

- 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).

2.3.5 Overcoming Barriers

During 2005 and 2006 ACC undertook pilot programmes focussing on Māori, Pacific, Asian people and those with low incomes (ACC 2007). One group of pilot programmes addressed financial barriers to general practice and radiology services, while the second group addressed non-financial barriers such as: a lack of information about available services, transport, or attitudes and perceptions of injured people. The evaluation report noted that transport did not appear to be a strong barrier (ACC 2007). The projects aimed at reducing financial barriers provided additional subsidies to all patients of selected providers; that is, the additional funding was not targeted to those with least access. These pilot studies did see a small increase in access for disadvantaged people but the most advantaged groups improved their access at an even greater rate, thus worsening the disparity. No evidence was found for faster rehabilitation.

Many of the 35 General Practice projects that were allocated funds from the 2002 Reducing Inequalities Contingency Fund (MOH 2005b) identified the direct cost of health services and transport as major barriers to health care and set out to address these. However the evaluators reported that for many clients, factors other than financial or transport barriers must explain reduced utilisation of services as clients may live close to services and face zero or very low fees, but still underutilise appropriate services. With regard to Māori clients the evaluators reported that access to services might be lessened because:

- Other priorities take precedence over individual health needs;
- Staff at primary care services can appear to be 'unwelcoming', causing some Māori to avoid the service;
- Even low cost access fees may be unaffordable for some.

The evaluation reported mixed results in terms of improving access, reducing the burden of illness, impacts on utilisation of services and continuity of care. Overall the evaluators noted that establishing services with hard-to-reach populations takes time and resources, as well as knowledge of the target community.

The Health Waikato Regional Diabetes (WRD) Service report (Health Waikato 2001) identified that, in order to improve the health of Māori, it was important to consider cultural factors when developing health promotion strategies, such as:

- Māori world view and reality;
- Links between socio-economic determinants, health and the setting of priorities within the whānau;
- Impact that whānau can have in influencing individual attitudes and behaviours;
- Importance of Māori language and customs to Māori and their healthcare;
- Māori centred routines, habits and behaviours (e.g., food related issues such as eating times and types of food and attending marae and hui);
- Need for more Māori-oriented services (including increases in Māori staff numbers, Māori specific resources, diabetes education hui and mobile marae and community based services);
- Targeting health promotion and treatment services for Māori groups in the community;
- Improving the existing service by providing education in the community focused on people with diabetes and their entire whānau in marae-based forums; and
- Educating communities with people of all ages, starting in Kōhanga Reo.

An example of such an intervention is seen in the findings of Lieu et al (2004) in a study of 1663 children with asthma from low income families in California who were followed over one year. In this study providers with high cultural competence scores were associated with less under-use of preventive asthma medications[6] and higher parent ratings of care. Similarly policies for access and continuity of care were associated with less under-use of preventive medications,[7] while feedback of outcomes of care to clinicians predicted less preventive medication

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[6] Odds Ratio: 0.15; 95% Confidence Interval: 0.06–0.41 for the highest versus lowest categories

[7] OR: 0.56; 95% CI: 0.34–0.93.

under-prescribing,[8] better parent ratings of care, and better asthma physical status at follow-up. This study Lieu et al (2004), and reviews by other authors (such as Beach et al 2004), demonstrates that targeted programmes are required to address minority health issues, incorporating:

- Policies that support cultural competence combined with best clinical practice;
- Training health workers in communications skills including cultural competencies;
- The use of reminder systems; and
- Performance measures with feedback reports to staff.

The Robert Wood Johnson Foundation in the United States has conducted systematic reviews of interventions to address racial and ethnic health care disparities for cardiovascular disease (Davis et al 2007), diabetes (Peek et al 2007), depression (Van Voorhees et al 2007), and breast cancer (Masi et al 2007). Two additional papers examined interventions using cultural leverage (Fisher et al 2007), and pay-for-performance and public reporting of performance measures (Chien et al 2007). The review of disparities in depressive order outcomes (Van Voorhees et al 2007) found that case management and socioculturally tailored interventions can play an important role in reducing disparities. Case management was also important in patient access to treatment following abnormalities being found during breast screening (Masi et al 2007). For screening itself, programmes that were culturally-tailored and/or addressed financial barriers were most effective.

In the area of cardiovascular disease Davis et al (2007) found value in: patient registries, multidisciplinary teams, and community outreach by nurses. Patient interventions, such as sodium restriction for African American patients, also yielded benefits. These authors concluded from their review 'that interventions in primary care should consider organisation-level interventions, such as clinic reorganisation, rather than provider-level interventions that attempt to change physicians prescribing behaviours' (p.82). They also recommended the involvement of nurses in outreach and management strategies that aim to address inequalities. A follow-up programme funded by the Robert Wood Johnson Foundation, entitled 'Expecting Success: Excellence in Cardiac Care', has also demonstrated the importance of hospitals collecting and analysing patient race, ethnicity and language data on patients (The George Washington University Medical Center 2007).

The review of interventions to address ethnic and racial disparities in diabetes (Peek et al 2007) identified the importance of: programmes tailored to the culture of the patients; one-on-one patient education and feedback; and the involvement of nurses as case managers and clinicians. The authors highlight questions that remain unanswered from their review, including what the ideal target for intervention is (e.g., patient, provider, organisation). They also conclude that the 'patients most at risk for poor outcomes are those on the fringe of health care systems' (p.144). That is, those without a regular healthcare provider who rely on emergency care for routine health care.

The key findings from the reviews are summarised by Chin et al (2007). The promising intervention strategies they identify are:

1. Multifactorial interventions that address multiple levels of change. Such interventions will operate across the levels of health care, and throughout the continuum of care.
2. Culturally tailored quality improvement. Individualised care, and thereby improved outcomes, may be improved by culturally tailored approaches with Chin et al (2007:23) arguing that 'ultimately the specific barriers facing particular individuals, communities, and health care organisations need to be addressed'.
3. Nurse-led interventions. Many of the qualities of nurses (e.g., ability to work in teams, providing patient-centred care, knowledge of culturally tailored approaches) mean that they are well-suited to providing health care identified as most effective for reducing ethnic and racial inequalities.

Overall, the reviews and Chin et al (2007) point to the need for more planned interventions that are then evaluated.

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[8] OR: 0.33; 95% CI: 0.16–0.69

2.3.6 Summary

Barriers to, and facilitators of, access to health care for Māori have been identified at four levels of the health system: system, organisation, human resource, and individual or community. While direct and indirect financial costs are often seen as key barriers to health care for Māori, research and evaluation has found that if services are not culturally appropriate then, even if they are free, they may not be fully utilised by Māori. Cultural appropriateness, in turn, rests on the tailoring of services to be more in tune with Māori through the provision of Māori staff and Māori-friendly, non-Māori staff. Often non-Māori staff bring attitudes and perceptions to health care delivery that reflect little understanding of Māori realities and cultural values. Turning this around will require both education and commitment to Māori health gains, as well as guidance through leadership and policy at a national level. This is explored under 'Interpersonal Relationship Skills' (2.4.2 pg 28).

The responsiveness of the health system to the current crisis in Māori health can be monitored in many ways; for example, the analysis of Māori : non-Māori disparities in terms of mortality and morbidity. Patient feedback on their experiences with health services, as well as their overall rating of each encounter, is another monitoring tool, albeit one that is not sensitive to accounting for those who do not get as far as engaging because the barriers to doing so are too great. Even so, patient feedback can provide valuable input into how a health organisation and health personnel can facilitate Māori access to health care. The next section examines the role of consumer assessments of health services.

2.4 Consumer Assessment of Services

Research has repeatedly shown that measures of patient satisfaction are correlated with health outcomes (see Stewart 1995,for example), and consumer evaluation of health services is increasingly seen as an important part of quality assurance and quality improvement activities (Fitzpatrick 1991; Steele 1992; Newsome & Wright 1999). This includes early identification of consumer concerns or service failures, and feedback to staff which can support professionalism and performance rewards. In addition, many studies that have examined patient preferences, satisfaction or priorities report that patients want healthcare providers to have both technical competence and high levels of interpersonal relationship skills (Bartlett et al 1984; Carroll et al 1998; Wensing 1998; Elwyn et al 1999; Mechanic & Meyer 2000). Of these two components, interpersonal relationship skills are easier by far for patients to assess and are the larger contributor to overall satisfaction (ProCare Health Ltd 1995). In this respect healthcare is similar to many other professional services.

Consumer assessments of healthcare services, along with their assessments of car repair services, legal services, and other services where technical competency is difficult for consumers to assess, were examined in a University of Auckland study (Colgate et al 2003). The researchers found that the reasons why most consumers remained satisfied with, and loyal to, their service providers fell into two broad categories: their relationship with the service provider and their not having a reason to leave. Furthermore the study noted that in spite of unease about the quality of services or the value of the service offered, consumers would often remain with an existing provider until a critical incident precipitated change.

Nicholls and Jaye (2002) also noted similar issues of a critical incident being required to change provider in a study of reasons why New Zealand patients change GPs. In large part the reasons for change were related to what patients perceived to be GPs' negative comments or unacceptable attitudes. Patients remained loyal even when diagnostic errors were made so long as the patient-physician rapport was good, but they would contemplate change if that rapport were damaged. The author noted that 'effective communication is the basis of good general practice and lack of this seems to be one common cause of dissatisfaction. Another is the patronising attitudes and behaviours of the doctor'.

Consumers of healthcare can and do make assessments of the care they receive and they focus these assessments primarily on their satisfaction with interpersonal relationship aspects until/unless a major negative incident occurs. With this in mind, the present section examines the two components of assessments of services; namely, technical competence and interpersonal relationship skills. Satisfaction as a key indicator of the performance of a health service is then critiqued. Following this an overview of the present study completes this chapter.

2.4.1 Technical Competence

Evaluating patients' perceptions of their health care is complicated by the fact that most patients have difficulty assessing the technical aspects of health services. Rather it is (only) health professionals who are able to judge the clinical quality of the service provided. This discrepancy between the ability of the patient and provider to assess technical competence is encapsulated in the notion of 'credence goods'. Dulleck and Kerschbamer (2006) define a credence good as,

> *'...goods and services where an expert knows more about the quality a consumer needs than the consumer himself [such as automotive repairs or computer services]. The consumer can ex post only observe (but might [still] be unable to verify) whether the problem still exists'.* (p 5)

If the problem no longer exists the consumer can not necessarily tell whether they got the appropriate level of service or one that was unnecessarily high (and therefore inappropriately expensive). Furthermore they may not even be able to tell whether a suggested treatment was provided or if they received the prescribed (and billed) level of service.

Dulleck and Kerschbamer (2006) cite several studies that demonstrate that, in keeping with the notion of a credence good, healthcare services are not provided in a uniform fashion, including reports that: an average person's probability of receiving a major surgical intervention is one third greater than that of a physician or member of a physician's family; optometrists often prescribe unnecessary treatment; the frequencies of caesarean deliveries compared to normal childbirths vary with the fee differentials of health insurance companies; and the frequency of cervical cytology treatments is correlated with the fee for the treatment. As the authors write (p. 32),

> *'Medical treatments offer the most complicated and maybe the most important environment [for credence goods]... Patients usually are either physically not able to observe treatment – as during an operation – or simply lack the education to verify the treatment delivered by [a clinician]'.*

Confirmation that patients cannot judge technical aspects of care was found by Rao et al (2006) who compared older patients' assessments of care with a review of practice records. They found that patients' assessments were not an adequate reflection of the technical quality of their primary care, concluding that both patient-based and records-based measures of quality are required.

Given that the technical aspects of healthcare are only imperfectly understood and evaluated by most patients, how can consumers assess quality? Despite unfamiliarity with many aspects of the credence good or service the consumer can still come to a judgment, even for those services that are complex or that have unclear outcomes (Newsome & Wright 1999; Leiper et al 2006) However, the criteria by which that judgment will be made are likely to be different from those that would be used by an expert in the field.

> *'Service users who cannot judge the technical quality of the outcome effectively will base their quality judgments on structure and process dimensions such as physical settings, the ability to solve problems, to empathise, time keeping, courtesy, and so on'. (Newsome & Wright 1999 p. 164)*

For example, in their research on consumer views and experiences of primary health care in New Zealand, Kerse and colleagues (2004) found that that, alongside good communication skills and the importance of the doctor-patient relationship, many participants also prioritised doctors' professional expertise. This incorporated medical knowledge (e.g., including their diagnostic skills and up-to-date professional knowledge) as well as communication and relationship skills, with participants possibly resting their judgements of doctors' professional expertise on criteria such as problem-solving and empathy.

A number of New Zealand (ProCare Health Ltd. 1995; Nicholls & Jaye 2002) and international (Edgman-Levitan & Cleary 1996; Booske et al 1999; Feldman et al 2000; Fowles et al 2000; Beaulieu 2002) studies have looked at consumer preferences for clinicians; that is, how consumers select health providers or what kind of information consumers want to receive about a provider. Consumer preferences for information about selecting a provider are influenced by what information they are given and how it is presented. Information on the technical performance of providers (e.g., from professional societies or government authorities) is often presented in ways that are not easy for consumers to understand as much of the information comes from a clinical or management perspective rather than from a consumer perspective. As a result, patients may prefer to rely on their own perceptions of care or on the experience and recommendations of friends and relatives.

In addition a Commonwealth Fund–supported study (Pillittere et al 2003) found that consumers understand and value information related to domains of quality such as effectiveness, patient-centeredness, and safety, if they are given a carefully constructed frame of reference. In this regard the researchers noted that the choice of words was critical to ensuring that consumers and providers had a common understanding of the concepts being described. For example, some patients have thought that the term 'patient-centred' meant 'a place where patients go for care' rather than 'having a focus on the needs of patients'.

The researchers also found differences within ethnic groups based on socioeconomic status and age. Older patients were more concerned with doctor-patient relationships compared with younger patients, while the lower socio-economic groups appeared to have different understandings of some concepts of health service quality. These findings (different concerns based on socio-economic status and a greater desire for a trusting relationship by older patients) have also been found in Māori focus group meetings convened by the ACC (Clemenger BBDO 2004).

In summary, technical competence is difficult for patients to assess accurately and, as such, their judgements about technical competence may rely upon assessments of other aspects of their care, such as physical setting, time-keeping and the opinions of friends and family. When care is taken to construct a frame of reference for patients' assessment of technical competence then differences are found based on age and socio-economic status.

2.4.2 Interpersonal Relationship Skills

Both New Zealand and overseas studies document the importance of patient-clinician rapport (and particularly the communication or interpersonal skills of the provider) for effective healthcare. For example, the 1995 ProCare survey of patient preferences for general practices in Auckland found that the majority of patient satisfaction was comprised of elements related to provider communications (ProCare Health Ltd 1995). The reports by Nicholls and Jaye (2002) and by Kerse and colleagues (2004) described above note that New Zealand patients place great importance on the communication and relationship skills of their GPs. Patients only leave a provider when these behaviours or attitudes are unacceptable.

In a qualitative study of the knowledge, attitudes, and healthcare experiences of deaf women (Steinberg et al 2002), the authors noted that deaf women have unique cultural and linguistic issues that affect healthcare experiences. Participants reported negative experiences and avoidance or non-use of health services when there was a lack of a common language with healthcare providers or insensitive behaviours towards the deaf. Smiler (2006) uncovered similar issues when researching the experiences of deaf Māori in New Zealand.

Satisfaction with care, then, is dependent on developing a trusting relationship with a provider that is in tune with the expectations, preferences and priorities of the patient. Krupat et al (2001) found that patients whose beliefs were congruent with the beliefs of their physician were more likely to trust and endorse their physician. In a Swedish study of ratings by psychiatric patients the authors reported that patients put the highest emphasis on staff empathic qualities such as being interested and understanding, respecting patients, while the least importance was ascribed to characteristics of the physical environment (Hansson et al 1993).

These findings are consistent across countries and ethnic groups. In a review of MEDLINE articles over the period 1983 to 1993, Stewart (1995) found that numerous studies reported a correlation between effective doctor-patient communications and improvements in health outcomes. The positive outcomes were in the areas of emotional health, symptom resolution, improved blood pressure or blood sugar control and control of pain. Similarly poor experiences of care, low satisfaction ratings and reduced trust have been shown to impact adversely on adherence to care and complaints. This need for effective communication requires doctors to be 'bilingual', able to communicate not only with their peers in the language of science but also in lay terms with their patients (Persaud 2005). Unfortunately doctors often communicate poorly with their patients – but do not realise they are doing so (Ford et al 1996).

Little et al (2001) also reported that a positive, patient-centred approach results in greater patient satisfaction, greater enablement, a lesser burden of symptoms, and lower rates of referral. Most of the 'patient-centred' approach relied upon good communications skills and relationship development.

Crow et al (2002) in a major review of literature for an NHS Health Technology Assessment of measurement of satisfaction, reported on studies that investigated the patient-clinician relationship and the importance of that bond to patient ratings of satisfaction.. The eight studies reviewed by Crow confirm that patient satisfaction is more closely related to provider communication skills (and attitudes) than to issues of service access or availability. Crow also reported on 43 studies that examined the features of patient-clinician relationships, noting that the key elements that predict satisfaction are:

1. Affective behaviours, such as those demonstrating:
    - worth and respect (Kenny 1995)
    - friendliness (Korsch et al 1968; Stewart 1989; Bertakis et al 1991; Greene et al 1994; Gross et al 1998; Hall et al 1998)
    - trust (Ben-Sira 1990; De La Cuesta 1997)
    - courtesy and empathy (Comstock et al 1982)
    - supportiveness (Greene et al 1994)
    - sensitivity (Holloway et al 1989)
    - understanding (Treadway 1983)
2. Clear explanations and information sharing (Korsch et al 1968; Stiles et al 1979; Kent Smith et al 1981; Comstock et al 1982; Brody et al 1989; Stewart 1989; Robbins et al 1993; Kenny 1995; De La Cuesta 1997; Kvamme & Hjortdahl 1997; Gross et al 1998; Hall et al 1998; Krupat et al 2000; Jackson et al 2001)

By contrast Crow et al noted that patient satisfaction decreased in studies that reported:

- overly technical discussions, (Kent Smith et al 1981; Wartman et al 1983; Bartlett et al 1984; Robbins et al 1993)or
- clinician-dominated discussions (Bertakis et al 1991; Buller & Buller 1987).

Furthermore Crow et al (2002) reported that the consistent finding from all parts of the health sector was that, ' ... the most important factor affecting satisfaction is the patient-practitioner relationship, including information giving'. The importance of this relationship has been suggested to underlie the public's interest in alternative and complementary therapies.

> *'Patients find these practitioners speak a language that is more easily understood than what they perceive as the unintelligible gobbledygook of the scientifically trained doctor... Alternative health practitioners are often better at communication because they use a more patient friendly and simplistic model; doctors' scientific training often leaves them wrestling with how to communicate the complexity of clinical uncertainties'. (Persaud 2005)*

Steinberg (2002) refined this further, concluding that good communication between the patient and clinician (as perceived by the patient) is perhaps the most important predictor of patient experiences, satisfaction, and trust, as well as being associated with improved clinical outcomes. The establishment of rapport is not only key to making the correct diagnosis, but it is also how patients (and their families) are convinced of the value of the recommended treatment plan (Cram et al 2003; Persaud 2005).

As mentioned above, doctors often lack good communication skills (Beckman & Frankel 1984; Buetow et al 1996; Falvo & Tippy 1998; Marvel et al 1999; Lamont & Christakis 2001), in spite of self-belief to the contrary (Ford et al 1996). International research clearly shows that these difficulties are exacerbated when communication crosses cultural boundaries, such as between white doctors and non-white patients (Schouten et al 2007). For example, non-white patients with advanced AIDS rated the quality of communication with white physicians about their end-of-life care lower than did white patients with advanced AIDS (Curtis et al 1999). In another study, Johnson et al (2004) used audiotape and questionnaire materials to assess the communication process, patient-centeredness, and emotional tone (affect) of 458 patient visits to 61 Maryland doctors in 1998 through 2002. They found that, physicians were 23 percent more verbally dominant and engaged in 33 percent less patient-centred communication with their African-American patients compared to their white patients.

Similarly, when analysing data of standardised patients from over 330,000 simulated encounters, Van Zanten et al (2004) found greater patient satisfaction when the patient and the doctors shared the same ethnicity. This finding may be explained in part by ease of communication, both verbal and non-verbal, that can arise when the provider and the patient share a common frame of reference due to their common cultural background. Even in the absence of this connection, however, there is evidence that good communication techniques have a beneficial impact for minority patients. For example, a study (McFall et al 2001) of 535 Cherokee Nation patients in five clinics found that patients were more satisfied when they received communications and advice (even from non-Cherokee clinicians) in terms that were understandable to them.

Cross-cultural training, including communication, was a key recommendation of the Institute of Medicine in its report 'Unequal Treatment' (Smedley et al 2002). Taylor (2004:SP1) defines 'culturally competent communication' as 'communicating with awareness and knowledge of healthcare disparities and understanding that sociocultural factors have important effects on health beliefs and behaviours, as well as having the skills to manage these factors appropriately'. For culturally competent communication to contribute to the reduction of health disparities, it needs to be an attribute of the patient-provider interaction, the health care organisation, and the health system (Taylor 2004). (Also see section 2.3.5, 'Reducing Disparities', above).

In summary, interpersonal relationship skills and communication skills are key to patient satisfaction and to patient outcomes. While communications may be facilitated when they occur between providers and patients who share the same cultural background, the potential for miscommunication when cultural backgrounds are different is lessened when communications are patient-centred. Communication skills can be taught (Lee et al 2002), and staff are often motivated to learn (Richardson et al 2006). However, even learning these skills does not necessarily lead to them being applied effectively or with all patients (Edwards et al 2005). Moving beyond mere communication skills to a culturally competent communication approach, across all levels of health care, holds more promise for addressing racial and ethnic disparities. The next section takes the notion of patient 'satisfaction' reports and inquires into what is being measured.

2.4.3 Satisfaction as a Measure

In recent times patient satisfaction has been seen as a key indicator of performance both in New Zealand and overseas (Jenkinson 1997; Jenkinson & McGee 1998; Hayes et al 2000). However 'satisfaction' as a concept lacks a clear definition and conceptual foundation (Avis et al 1995; Baker 1997), and traditional approaches to measuring 'satisfaction' may unintentionally omit some consumer considerations (Linnell 2005). Researchers also note that satisfaction ratings usually reflect three variables: the personal preferences of the patient, the patient's expectations, and the realities of the care received. The first two of these, and possibly also the third, are culturally based (Jenkinson 1997; Jenkinson & McGee 1998; Duff et al 2000; Hayes et al 2000).

Expectations, for example, are the result of things such as cultural norms, disabilities, health status, previous experiences, and public attitudes which are in turn influenced by many factors including the media. Expectations are often simply defined as a person's belief regarding desired outcomes, but more elaborate definitions also exist (Thompson & Sunol 1995; Staniszewska 1999). Models relating to the fulfilment of expectations have been described although these remain under debate. A common model used is one in which consumers compare their perception of the good or service against their pre-visit expectations, and 'satisfaction' is then defined based on how closely these expectations matched the post-visit perceptions. The value of this may by limited by, among other things, unrealistic expectations. For example, local expectations may be high because of historical patterns of service (such as historically shorter waiting times for elective surgery in the South Island). So if service levels were reduced to more 'usual' standards and patient expectations were no longer met, satisfaction ratings would likely decline even though overall services would be appropriate and conform to legitimate national requirements (Zeuthaml 1993).

There is also evidence that ethnicity affects patient satisfaction evaluations (Cooper et al 2003; LaVeist et al 2003). Using the SF-36 health status questionnaire Scott et al (2000) found that the health-related attitudes of younger Māori were more similar to those of the NZ European population than to Pacific people or older Māori (>45 years). However, Devlin et al (2000) using a EuroQol EQ-5D questionnaire, found no such differences between age or ethnic groups. This second finding may be explained by (a) heterogeneity of opinion in the Māori community, and/or (b) inadequate sample size to appreciate (subtle) differences (Perkins et al 2004)

A Californian study (Murray-Garcia et al 2000) that investigated patients' ratings of quality of primary care services (including technical competence, communication, accessibility, prevention and health promotion, and overall satisfaction) found significant race-based differences in satisfaction. The authors concluded that the findings may represent actual differences in quality of care or variations in: patient perceptions, patient expectations, and/or questionnaire response styles. These concerns run through much of the satisfaction research. The differences in levels of satisfaction, however, become harder to ignore in larger studies.

Using nationally representative data from over 120,000 respondents to the 1998 USA National Research Corporation Healthcare Market Guide survey, Havilland et al (2003) found that non-white minorities were less satisfied with their healthcare than white patients. This has been found in other studies including the survey by Taira et al (2001) of 6,092 employees in Massachusetts. In that study subjective ratings of care (knowledge of patient by doctor, skills of doctor), access to care, and continuity of care, varied by ethnicity with lower ratings given by non-white minority groups compared to white groups.

In a study of patient perceptions of their doctors, Doescher et al (2000) reviewed data from the 1996 and 1997 Community Tracking Survey. They examined two conceptually distinct measures, namely:

- trust in the doctor (e.g., patients' perception that the doctor: would place the patients' needs above other considerations, would refer when necessary, was not influenced by monetary considerations, would not perform unnecessary tests), and
- style of the doctor (e.g., listening skills, explanations, thoroughness).

After adjustment for socioeconomic and other factors, minority group members reported less positive perceptions of physicians on both of these two scales than did whites. Minority group members who lacked physician continuity on repeat clinic visits reported even less positive perceptions of their physicians on these two scales.

Saha et al (2003) analysed data from The Commonwealth Fund's 2001 Healthcare Quality Survey and found that barriers in the patient-physician relationship contribute to racial disparities in the experience of healthcare. In particular both satisfaction with care and use of health services were lower for some ethnic minorities than for white groups. The authors report that differences in the quality of doctor-patient interactions (i.e. communication skills) contributed to the observed disparities in satisfaction.

In a further analysis of the Commonwealth Fund survey, Johnson et al (2004) found that doctor-patient communication, along with demographics and source of care, explain most racial and ethnic differences in patient perceptions of their primary care providers' ability to interact with patients from different cultural backgrounds. However, even when controlling for these factors the authors found that non-white minority groups were still more likely to perceive that they were judged poorly by medical staff and that the care they received was of lower quality.

2.4.4 Summary

The measurement of patient satisfaction has been challenged on the basis of the culturally-embedded nature of patient preferences and expectations, and possibly also the realities of the care they receive. Even so large international surveys have found patient satisfaction to vary by race, with minority group patients reporting significantly lower levels of satisfaction (compared with white patients). An explanation for these findings based on the different expectations or perceptions of minority groups still leads to a conclusion that health services are not meeting their needs. And this, in turn, is probably related to the relationship and communication skills of health personnel and the cultural competence of the health organisation.

2.5 The Present Study

The objective of the present research was to develop a tool 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 were given by the health and disability providers, and
- Barriers to optimal service use by Māori.

The Accident Compensation Corporation (ACC) was also interested in:

- How Māori identify appropriate providers to consult when suffering an injury,
- How Māori identify when it is appropriate to seek treatment for injury, and
- Whether Māori with injuries differ in their expectations from other Māori health and disability consumers.

The research had the explicit goal of developing a survey tool and conducting Kaupapa Māori research. These two elements came together to set in motion the research that would address the above objectives.

2.5.1 Developing a Measure of Patient Experience

A typical satisfaction survey question such as 'How satisfied were you with your care in service X?' cannot reflect the diversity of patient backgrounds, expectations and experiences. A positive rating from a survey question like this reflects only that the (low) expectations of service users have been met but does not indicate whether the care delivered was appropriate to the patient's needs. To become tools for quality improvement, surveys also need to gather information on whether key elements of care did in fact occur, that is, to reflect patients' perceptions about normative expectations (Coulter 2001; Coulter & Cleary 2002; Jenkinson et al 2003). To do this requires a measure of patients' experience based on standard questions about whether or not certain processes or events occurred during the course of a specific episode of care (Jenkinson et al 2003). Instruments to measure patients' experiences were developed by researchers at Harvard Medical School with funds from the Picker/Commonwealth Program for Patient-Centred Care (http://www.pickereurope.org/research/publications.htm). The aim was to explore patients' needs and concerns as defined by patients.

The Harvard team developed a patient feedback programme derived from qualitative research designed to find out what patients value about the experience of receiving healthcare and what they considered unacceptable. They conducted focus groups with patients and their family members, reviewed the literature and consulted with healthcare professionals to determine key priorities. This approach to measuring patients' experience has since been adopted for use in the CAHPS surveys in the USA, the WHO responsiveness surveys and the national NHS patient survey programme in England.

A similar approach was developed for the present study; namely, focus group hui were held and feedback from health consumers at these hui, combined with a review of the literature and other satisfaction surveys, led to the development of a Māori health consumer satisfaction survey. The second consideration in the development and delivery of this survey was the need for a 'by Māori, for Māori', or Kaupapa Māori, approach. This is considered after a brief examination of Māori engagement with survey research.

2.5.2 Survey Research with Māori

There is some evidence that methodological problems exist in sampling Māori households. While Māori make up some 16 percent of the population (StatsNZ 2002), evidence suggests they are under-represented in research studies undertaken by market research companies in New Zealand. Digipoll, a Hamilton-based organisation that specialises in surveys and political polls, report that Māori typically made up only 6-8 percent of households in the New Zealand Herald political polls over 2003-2004, and that Māori men are even more likely to be under-represented (personal communication from Digipoll director).

Several factors could explain this, including that Māori are more likely to live in households containing two or more families, leading to undercounting, and that they are less likely to live in a household with a telephone and will thus be more frequently missed by telephone surveys (StatsNZ 2002). However other studies suggest that the under-representation is not entirely due to methodological problems. Although there is only limited research available, preliminary data indicate that Māori view participation in surveys differently than do non-Māori.

Māori have often expressed reluctance to being observed and researched by non-Māori (Harvey 2002). Other researchers have documented similar reluctance to be involved in research which is felt not to value Māori knowledge, recognise Māori aptitudes, or stands to benefit Māori (Bishop 1994; Smith 1999). In addition, previous poor experiences with researchers have led some Māori to reject research and academic theories (Smith 1990).

In an effort to encourage Māori participation one study developed interview questions from a Māori perspective, included an over-sample of Māori, and generated lists of Māori households from the electoral offices' ethnicity database (Dacey 1998). The authors report that this approach was successful in ensuring that Māori had a high response rate compared to other surveys.

Studies have also shown that:

- Māori-based research processes are preferred by Māori participants (Dyall 1999), including those that make use of whānau, hui, people-centred approaches (Barnes 2000), and face-to-face discussions (Bishop & Glynn 1992).
- A Kaupapa Māori approach is preferred – where Māori are involved at all stages in the research and research is designed to be empowering for the individuals participating as well as for the Māori community as a whole (Bishop 1994).

A literature search for Māori-oriented patient satisfaction surveys and contacts among all District Health Boards and major primary care organisations in New Zealand uncovered only three Māori-specific satisfaction survey tools. Like other satisfaction surveys a variety of methods for collection of data have been used including: kanohi-ki-te-kanohi (face-to-face), mail-out, and written questionnaires with reply-paid forms.

Lessons were also taken on board from a study of access to healthcare services for Medi-Cal enrolees in the United States (Solis & Rodriguez 2002). The response rates of minority groups (such as Asian American/Pacific Islanders, Native American, Blacks, and Latinos) in this study were greatly improved by:

- Offering telephone or in-person interviews rather than mail surveys (especially relevant to groups with lower literacy);
- Having appropriate reviewers examine the survey tool for cultural and linguistic relevancy;
- Using survey questions that had been validated in other studies and that were specific to the survey requirements; and
- Utilising bilingual/bicultural interviewers that reflect the target groups.

2.5.3 Kaupapa Māori research

Historically, the majority of research about Māori has been conducted by non-Māori, who perceived a 'problem' and then provided a 'solution' based on their non-Māori world-view. Since the 1970s Māori researchers have debated and discussed appropriate research methods when Māori are involved in research as subjects and participants (Bishop 1994).

Cunningham identifies three types of research approaches with Māori including (Cunningham 1999):

Research involving Māori – where Māori are a minor component in research controlled by non-Māori researchers.

Māori-centred research – where Māori are included as a significant part of a research project controlled by non-Māori researchers.

Kaupapa Māori research – where Māori data or participants are a significant or an exclusive part in the research project, the research methodology incorporates Māori and mainstream tools or methods, and the research is controlled and analysed from a Māori context.

Glover (1997) and Barnes (2000) have suggested that Kaupapa Māori research developed because of Māori discontent with the prevailing Western methods and control, and the revitalisation of Māori knowledge, culture and values. Reid (1998) agreed and added that Kaupapa Māori research challenges the universal approach by demonstrating that research methods may need to be culturally tailored to the study population in order to obtain valid results.

Linda Smith (1999) describes the Kaupapa Māori approach as the 'development and promotion of appropriate methodologies for research with Māori' (Smith 1999). Irwin describes it as 'research which is culturally safe, which involves the mentorship of kaumātua, which is culturally relevant and appropriate, while satisfying the rigour of research, and which is undertaken by a Māori researcher, not a researcher who happens to be Māori' (Irwin 1994).

Graham Smith (1990) suggests that the theory of Kaupapa Māori has several aspects, namely that it is aligned to being Māori; is based on Māori principles; assumes the validity and legitimacy of Māori language and culture; and is connected with the struggle for Māori self-determination. Kaupapa Māori research asserts that Māori are involved in the research and that the research outcome is intended to make a positive difference for Māori. Barnes adds that Kaupapa Māori originates from a Māori world-view.13

Pihama (1993, 2001) describes the link of Kaupapa Māori research with critical theory as an act that exposes the assumptions that underlie dominant groups and inequalities.

As Cunningham suggests, Kaupapa Māori research continues to develop, and critique by Māori and non-Māori researchers alike can assist in ensuring Kaupapa Māori research methods have a sound philosophical base (Cunningham 1999).

The Kaupapa Māori approach taken in the present research meant that:

- The research was led, and controlled, by Māori.
- Māori consumer voices were taken seriously and were used to inform the design of the research, including the analysis of the data gathered.
- Māori advisors, including kaumatua, consumers and academics, were involved to ensure that the study was culturally and scientifically sound.
- Māori communities were involved in organisation and running of the hui, to facilitate participant involvement and ensure the adherence to local protocols.
- The survey questionnaire was pre-tested with a Māori panel to ensure that it was worded appropriately and that the process for its delivery would facilitate Māori involvement.
- A strengths-based approach, as opposed to a deficit, victim-blaming approach, was taken to the data analysis and report. This centred Māori perspectives and looked for systemic explanations for findings.

Ngā Tapuae me Ngā Raraunga – Methodology

This methods section describes the advisory groups that were put in place to assist with the present research and the ethical protocols that were adopted. The research methods are then outlined, followed by a description of the implementation of the hui method and the survey questionnaire. Following on from this chapter, two findings chapters explore the results from the hui and from the survey.

3.1 Research Oversight

A project team was established in July 2004, including an expert Māori facilitator (Manujon Pemerika) and the Mauri Ora Associates Project Team. In addition a technical advisory committee, a kaumātua advisory committee, and a consumer advisory committee were established (refer to Acknowledgements for names). The Kaumātua and Consumer Advisory Committees included Māori with knowledge of health and disability and ACC services. The committee members came from all major iwi and geographic regions throughout New Zealand. The groups initially met separately but as the project progressed the preference of the Kaumatua and Consumer Advisory Committees was for joint meetings. This joint committee then met regularly for several months to review background material, advise on how the hui should be designed and run, and to review the hui findings.

Ethics approval was obtained from the Waikato Ethics Committee (WAI/03/12/089) on 13 April 2004. Representatives from the local Māori groups were then contacted to assist with participant recruitment, arranging facilities, holding the hui, and consulting with other key organisations.

In addition to obtaining ethical approval for the research proposal, the current project also:

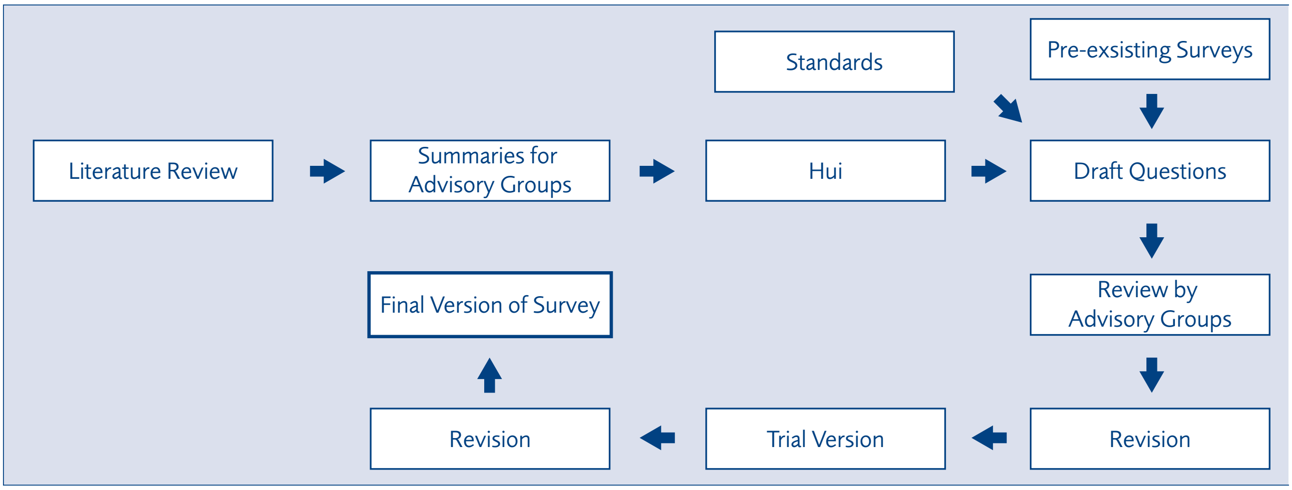
- Utilised Kaupapa Māori methodology and ensured the diverse needs of Māori were addressed;
- Directly involved and benefited Māori consumers;
- Gained informed consent from Māori consumers;
- Maintained strict confidentiality and privacy;
- Ensured that intellectual property issues were managed;
- Established a koha or reciprocity policy for participants;
- Encouraged full participation of Māori health consumers and services, while maintaining the safety of consumers; and
- Focused on community-based treatment or rehabilitation services (including Rongoā) rather than tertiary or institutional services.

Māori researchers were involved throughout this project, and other Māori staff were recruited and trained to undertake research roles as part of the commitment of building Māori research capacity. Collaboration with Māori communities and Māori healthcare organisations allowed for effective recruitment of Māori staff and also facilitated Māori participation in the research.

3.2 Overview of Research Methods

Building on available information, the current study first applied qualitative methods to examine barriers to Māori use of health services, together with the expectations, preferences, understanding and experiences of Māori consumers of injury, health and disability services. As described below, hui (focus groups) elicited the likes and dislikes arising from those experiences. The literature review was reviewed by the technical advisory group in developing a guide for the hui facilitator. Along with a summary of the literature review, this guide was then reviewed by Kaumatua and Consumer advisory groups.

Diagram 2. Survey development process



The findings from the hui, in turn, informed the second, quantitative, data collection phase in which Māori health consumers (or, in some instances, their caregivers) were surveyed via telephone or face-to-face (see Diagram 2). Using the results from the 10 hui and a literature search, a semi-structured[1] survey questionnaire was developed to gather information about issues, barriers, constraints, and incentives around Māori use and experiences of health and disability services.

The survey tool was designed to be applicable for Māori consumers or the parents of Māori children. Care was also taken to ensure that the survey questions would be easily understood by the majority of Māori respondents interviewed. This survey tool was developed in consultation with Māori individuals, consumers, and a panel of Māori health experts:

- The technical advisory group was provided with the results of the 10 hui, the literature review, information on surveys of consumers' experiences or satisfaction (e.g., Dacey 1998, Kers et al 2004, ProCare Health Ltd 1995, Picker Institute Europe 2005, Ministry of Health 'Confidence in Your Health Practitioner' 2004), and information about relevant standards of care for a range of health services in New Zealand. From this information the group considered components of care and questions that could be asked. The issues reported in the hui were incorporated into the questions to ensure that the tool accurately reflected Māori concerns. The team then reviewed and discussed the questions to ensure their appropriateness. Questions were rewritten or omitted if they were thought to be confusing, lacking in clarity, or phrased inappropriately.
- A panel of four Māori health professionals were asked to review the draft questionnaire for its understandability and validity (i.e., face validity, content validity, and construct validity). They were then interviewed as key informants and asked to nominate additional items and/or to indicate items they thought were irrelevant or redundant. Minor changes were made based on this feedback.
- The modified survey tool (along with the methods of use and the instructions for the interviewers) was then reviewed by the Kaumātua and Consumer advisory groups. These groups provided feedback on: the language used and the clarity and understandability of the questions, the methods of data collection, the flow of the survey, and the relevance of the issues canvassed.

Final revisions were then made and the survey was then ready to be administered to a Māori respondent sample (see below).

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[1] In other words, some open ended questions were included, but the majority of the questions were focused in nature, with a limited range of possible responses.

3.3 Hui Method

A series of ten hui were held in both rural and urban areas across the country between 7 September 2004 and 12 March 2005. All hui were organised in conjunction with leaders of local marae or community groups, followed local kawa, and were facilitated by Māori from the project team. Hui participants were Māori users of health and disability services and/or ACC services and included rangatahi, pakeke, kaumātua, tāne and wāhine. The number of participants at each hui ranged from five to 15, with a total of 86 participants attending the hui (Table 2).

Table 2. Hui dates, locations, and demographic characteristics of participants

Group	Date	Location (number of attendees)	Demographic Characteristics
1	7 Sept 04	Urban/Rural, Waikato (9)	Hauora/ Whara – Tāne
2	16 Sept 04	Urban, Wellington (5)	Hauā/ Whara – Wāhine
3	21 Sept 04	Rural, East Cape (9)	Hauora/ Whara – Wāhine
4	1 Oct 04	Urban, Auckland (8)	Hauā/ Whara – Wāhine and Tāne
5	8 Oct 04	Urban, Christchurch Rangatahi (6)	Wāhine and Tāne
6	8 Oct 04	Urban, Christchurch (8)	Hauora/ Whara – Wāhine
7	29 Oct 04	Urban/Rural, Waikato (8)	Hauā/ Whara – Tāne
8	22 Nov 04	Urban, Auckland Rangatahi (9)	Wāhine and Tāne
9	24 Nov 04	Rural, Waikato (15)	Hauora/ Whara – Tāne
10	12 Mar 05	Urban, Hawkes Bay Hauā (9)	Ngati Kāpō
		Total participants = 86	

Participants were recruited by the 'snowball' method.[2] Telephone or personal contact with local leaders was followed by written materials for distribution to groups associated with the marae or organisation, inviting their participation. Some hui were held specifically for people with disabilities while others were open to everyone. Many of the participants were supported at the hui by supporters, friends, and/or whānau members.

Each hui began with formal protocols, including the welcoming of participants, as appropriate for the location of the hui. These were followed by researcher introductions, followed by an explanation of the research objectives and the hui process. Participants then signed an informed consent form and filled in a demographic questionnaire. Group introductions followed. The hui then proceeded along the following lines:

- General reflections on experiences – participants were asked to describe a recent visit to a health service, with the group discussing the similarities and differences between their experiences.
- Important qualities – participants were asked to write down the things about the health services they dealt with that are important to them and their families. This was followed by discussion after which participants had a second opportunity to consider and identify the things that were important to them.

Participants were then asked whether there were other issues they wanted to raise and, following this, the hui was summed up by the facilitator and the hui was then formally closed.

The hui, with one exception, were video- and audio-taped and subsequently transcribed. At one hui the participants did not wish to be recorded and extensive notes were taken by project team members. All participant comments were included in a thematic analysis whereby the hui transcripts were read and re-read by the research team. The purpose of this reading and re-reading was to look for patterns or common themes within and across participants' talk (Quinn Paton 2002). These themes were then discussed and agreed upon by the research team. (A summary of the hui is in Appendix B).

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[2] This recruitment method starts with a small, target group of potential participants who are then asked to recruit others in their networks who, likewise, may also be invited to recruit others from their networks. This method is often used to recruit difficult to reach or 'hidden' subpopulations. Such participant samples are often neither random nor representative.

3.4 Survey Method

3.4.1 The Survey

To ensure adequate recall of events, coverage across the different services, and to keep the interview to a manageable length of time, people responded only to the health provider sections they had experience of in the past six months. A total of 651 Māori were surveyed.

The questionnaire (Appendix C) was set up in a series of sections:

- Introduction and explanation
- General health and health services visited over past 6 month period (6 questions)
- In the interests of time, it was decided not to ask every respondent to describe every visit for the purpose of the study. Instead, a quota system was used to ensure an adequate collection of information about all of the different services. The data collection therefore solicited information about different healthcare providers until a sufficient number of respondents from an appropriate demographic range had answered questions about that particular service. Once that quota had been reached, subsequent respondents were not asked about their experiences with that type of care provider. In this way, after a certain point, data gathering on the more commonly used services (i.e. primary care) was eschewed, and subsequent respondents were asked only about their experiences with other services, such as secondary care.
- GP section (38 questions)
- Specialist section (38 questions)
- A&E section (25 questions)
- Hospital section (26 questions)
- Funding Bodies (ACC primarily, but also WINZ) section (17 questions)
- Other services (e.g., physiotherapy, occupational therapist) section (15 questions)
- Attitudes towards health and service providers section (31 questions)
- Demographic section (11 questions)

The bulk of questions relating to health provider experience (Sections 3-8) used a binary 'Yes/No' response method. This was done to facilitate responses to a large number of questions. (The alternative of using a 5- or 7- point Likert-type scale would have imposed too much of a processing burden upon respondents, resulting in fatigue and early termination of the interviews.) In addition the 'Yes/No' response ensured that answers were not biased due to literacy or language issues. Lastly, the 'Yes/No' response minimised the time required to complete the survey.

At the end of each of these sections an overall experience question was asked using a 3-point scale (Good/Average/Poor), and two open-ended questions were asked relating to overall positive and negative impressions of the visit. Responses to these questions were recorded verbatim.

To assess attitudes a series of statements was read and subjects were asked to respond on a 3-point scale (Agree/Disagree/Neither agree nor disagree). The statements covered a range of topics including attitudes about: personal health, providers, quality of care, and cultural competency.

3.4.2 Delivery of the Survey

Although much of the literature on research with Māori recommends face-to-face interviewing, a modified telephone approach was proposed as the most appropriate method for this project because:

- Providers of research field services (e.g., Digipoll (Hamilton), BRC Marketing & Social Research (Wellington), SHORE (Massey University, Auckland)) have been successfully conducting telephone research with Māori for several years. In addition, there are published studies using this method (Dacey 1998).
- With a large sample preferred, face-to-face research would have taken a long time. Telephone offers the ability to quickly carry out projects.
- Telephone is by far the most cost effective approach to obtain a nationwide representative sample from a widely dispersed population.

The process was as follows: (1) a telephone call to recruit people, (2) a letter in English and Māori explaining the project (Appendix D), and then (3) a further call to conduct the study. The letters were on Mauri Ora letterhead, outlining the nature of the study and inviting people to participate when the call came. This was done to follow Kaupapa Māori research methods more closely and to increase response rates (Barnes 2000; Smith 1999).

On average each interview took 22 minutes to complete. The survey company used to provide the telephone data collection service (Digipoll) had Māori speaking interviewers available for the interviewing process.

Some Māori, particularly those in households without landline telephones, were excluded from our survey. In spite of this, demographic analysis of the final sample (see below) showed that a representative sample of the target population had been obtained.

It was expected that people with physical and sensory disabilities would be interviewed via the telephone, the deaf being the only group not possible to interview in this way. Fifty deaf Māori were recruited through the Deaf Association's Māori Deaf Development Manager and interviewed face-to-face with the help of interpreters to ensure coverage of this particular group. These interviews took approximately 45 minutes to complete. The Deaf Association also provided assistance with: re-designing the information leaflets and consent forms, advertising the research within the Māori Deaf community, sourcing trilingual interpreters, and arranging meetings with the interviewers.

3.4.3 Survey Sample

The sample for this study was chosen to obtain an even spread across the Māori electoral seats (7 in all, covering New Zealand) because the constituency of each of these seats encompasses equally the diversity and concentration of Māori community. A total of 1000 letters where sent to Māori on the electoral rolls advising them of the survey ahead of the telephone calls seeking information on their experiences of care.

During the survey phase respondents were asked about the last experience of health care they had received. The sample included a 30% quota for non-general practice contacts. This was included because the majority of health system contacts occur with GPs but feedback on the survey was required from people about other elements of the health system. Sampling continued until the pre-determined number of 651 surveys was completed by telephone and through interviews with Māori deaf using tri-lingual interpreters.

The sample was divided by gender (41% male, 59% female) to approximate both population demographics (49% male, 51% female[3]) and the gender bias of health system consumers (MOH 2006).

3.4.4 Survey Respondent Demographics

Fifty-nine percent (N=384) of the survey respondents were female, 41 percent (N=267) were male. The majority of respondents were aged between 25 and 60 years.

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[3] Statistics NZ (2005). National Ethnic Population Projections (2001 base)

Table 3.Gender and age groups of respondents'

		Count	%
Gender	Male	269	41%
	Female	382	59%
Total		**651**	**100%**
Age group	Lowest thru 19	10	2%
	20 thru 24	29	4%
	25 thru 29	43	7%
	30 thru 34	69	11%
	35 thru 39	96	15%
	40 thru 44	103	16%
	45 thru 49	76	12%
	50 thru 54	67	10%
	55 thru 59	48	7%
	60 thru 64	34	5%
	65 thru 69	29	4%
	70 plus	42	7%
Total		**646**	**100%**

Over half of the respondents' (59.3%, N=384) lived in households of two to four people (including themselves) (Table 4. Just under one in 10 respondents' lived by themselves (N=59, 9.1%).

Table 4. Number of people living in respondents' household (including respondent)

Number of people	N	%
1	59	9.1
2	133	20.5
3	98	15.1
4	153	23.6
5	90	13.9
6	67	10.3
7	24	3.7
8	10	1.5
9+	14	2.2
Total	648	100.0

Over two-thirds of the respondents' (N=465, 71.4%) lived in family households with children (Table 4). The children were mainly: school-age (N=270, 41.5%), adult (N=112, 17.2%), or pre-school (N=83, 12.7%).

Table 5 Household composition and working status

Household type	N	%
Family with mainly school age children	270	41.5
Family with mainly adult children living at home	112	17.2
Family with mainly pre-school children	83	12.7
Older couple with no children at home	81	12.4
Older single person living alone	53	8.1
Flatting with others	23	3.5
Young couple with no children at home	14	2.2
Young single person living alone	8	1.2
Refused to answer	7	1.1
Total	**651**	**100.0**

Working status		%
Employed full time (30 hours or more)	297	46%
Employed part-time (under 30 hours)	92	14%
Full-time student	32	5%
Unemployed/not working	63	10%
Homemaker	94	14%
Retired	69	11%
Refused	4	1%
	651	**100%**

Approximately one-fifth of respondents' (21.4%) had a household income of less than $21,000 per year (Table 6). Sixteen percent of respondents' had an annual household income greater than $77,000.

Table 6 Respondents' annual household income

Combined household income before tax	N	%
Under $21,000	139	21.4
$21,000 - $33,000	107	16.4
$33,000 - $52,000	135	20.7
$52,000 - $77,000	113	17.4
Over $77,000	104	16.0
Don't Know/Refused	53	8.1
Total	**651**	**100.0**

Half of the respondents' (N=327, 50.2%) did not have either a Community Services Card (CSC) or a High Use Health Card (HUHC) (Table 7). Just under half of the respondents' held a Community Services Card, either by itself (N=286, 43.9%) or in conjunction with a High Use Health Card (N=22, 3.4%).

Table 7 Respondents' with Community Services Card and/or High Use Health Card

Card(s) held by respondents	N	%
Neither	327	50.2
Community Services Card (CSC) only	286	43.9
High Use Health Card (HUHC) only	13	2.0
Both CSC and HUHC	22	3.4
Don't know/Refused	3	0.5
Total	**651**	**100.0**

Over half of the respondents' (61.8%) said that they could speak some Māori language, with one fifth of respondents' (21%) stating that they could speak the Māori language well or very well (Table 8). Nearly 15 percent of respondents' (N=84, 14.8%) said that they could not speak the Māori language at all.

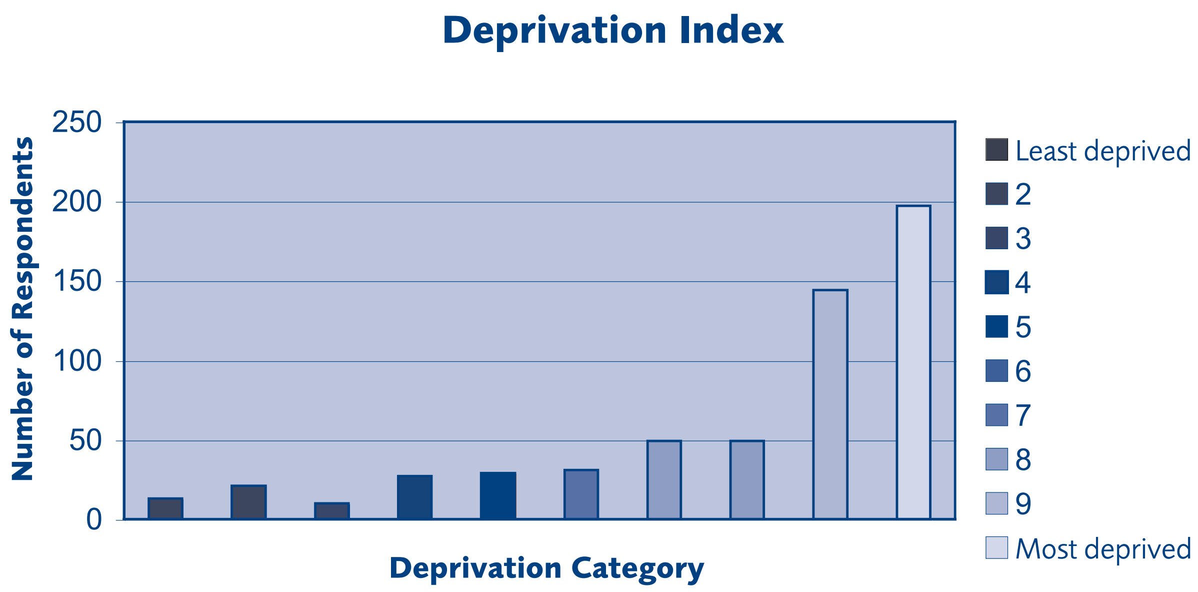
Table 8. Respondent's Māori language ability

Ability to speak the Māori language	N	%
Very well	81	14.3
Well	38	6.7
Fairly well	98	17.3
Not very well	133	23.5
A few words or phrases	132	23.3
Not at all	84	14.8
Total	**566**	**100.0**

The biggest groups of respondents' came from, or were based near, Hamilton/Cambridge/Te Awamutu (N=103, 15.8%); Auckland (N=99, 15.2%); and Whangarei (69, 10.6%) (see Appendix E).

Over half of the respondents' (N=341, 52.4%) lived in the areas that are described by the NZDeprivation Index as the most and second-most deprived in the country (Figure 4). Only 15.4% (N=100) of the respondents' lived in areas of least deprivation (1-5).

Figure 4. Deprivation Index



The majority of respondents' (N=553, 84.9%) chose to answer the survey about their own experiences (Table 9). Just over 10% (N=70) responded on behalf of a child or youth, and a small number of respondents' (N=25, 3.8%) responded on behalf of an adult or spouse who they looked after.

Table 9. Response on behalf of self or other

Focus of responses	N	%
Myself	553	84.9
A child/youth	70	10.8
An adult/spouse I look after	25	3.8
Other	3	0.5
Total	**651**	**100.0**

3.4.5 Analysis of survey results

Each health provider section (e.g., GP visit, Specialist visit) consisted of three main sets of measures:

- Service standards measures: These were measured using a dichotomous Yes/No response. These were analysed using simple counts. In investigating relationships between these variables and others of interest (e.g., income, location), appropriate statistics (e.g., chi square) have been used depending on the other variable (e.g., categorical, ordinal) under investigation.
- Overall experience: The overall evaluation of each visit was measured with a 3-point ordinal scale (Good/Average/Poor). These were analysed using simple counts and the mode. Related to the overall experience, comments were gathered on elements of the experience people liked, and another question on what was disliked. These were recorded verbatim, and have been coded into categories and analysed using simple counts.
- Importance of service standards: Elements of the different visits were modelled to determine which were significant in predicting the Overall Experience variable and Intention to Revisit.

More information about the quantitative analysis is in Appendix F. Tests of the surveys reliability and validity were also carried out and are reported in Appendix G.

4 Ngā Tukunga Iho o Ngā Hui – Hui Findings

The views expressed by hui participants are presented in this chapter. Participants talked about their experiences across a range of health services, including general practice, hospital and ACC. All participant comments were included in the thematic analysis except where comments were unclear (e.g., inaudible). The themes arising from this analysis are presented here: firstly grouped by service, and secondly grouped by three of the capacity levels described in the Introduction; namely:

Health organisation – the processes, structures and management systems

Human resource – the people who work in health care

Patient or community – the people who engage with the health sector

This second level of grouping has been used because the themes fitted easily into these levels and it allowed for an analysis of similarities and differences between the present findings and the findings from previous research outlined in the Introduction.

Hui participants have been quoted in order to illustrate the themes. Quotes are verbatim unless deliberate alterations were necessary to protect the identity of participants. Care has been taken that such changes have not altered meaning.

4.1 Participants' Experiences of General Practice

Participants' experiences of general practice were, in the main, related to how they had been treated by health staff, and their hesitancy about seeking treatment. This hesitancy, or 'wait and see' attitude, described by many participants was associated with their financial concerns and their values and beliefs, as well as with their knowledge of how general practice staff were likely to treat them based on their previous experiences. Participants' experiences of specialists are also included in this section as feedback in this area was limited.

4.1.1 Health Organisation

Issues such as inflexible schedules, distance to the nearest clinician, and waiting times, were raised by participants as barriers to them accessing a GP.

> *"I come home from work at odd hours now. I don't know when I can go." (Auckland)*

> *"We're from an isolated area and it will take you about two hours to get to the closest town."*

4.1.2 Human Resources

Participants expressed their views about how they were treated by general practice staff. Many participants felt that they were treated with disrespect because they were Māori. Participants were also critical of the way staff communicated health information to them. Finally, a criticism of staffs' clinical skills also began to surface at the hui.

Disrespect and racism

One of the participants' major concerns was their perception that non-Māori health providers were biased against Māori patients.

> *"Māori feel [clinicians] think, 'Oh, there they are again, bludgers.' No Māori wants to feel as if he's a bludger." (Waikato)*

> *"I think [clinicians] all look at us in that way. They're always asking if you've got a community card. If you are Māori, you get asked if you've got a card. Have you got a community card?" (Waikato)*

> *"I said to one doctor, 'Would you have been so rude if I was Pākehā?'" (East Cape)*

> *"The [Māori patients] are put aside, made to wait two to three minutes when they arrive before anyone talks to them. While they are waiting, five Pākehā go through." (East Cape)*

Sometimes staff behaviours were perceived as being inflexible or lacking in empathy.

> *"I'm actually here to see the doctor. I don't want to go through this huge process with everyone sitting around listening to what I'm saying to the receptionist." (Christchurch)*

> *"I felt that you were just a number." (Hawkes Bay hauā)*

Communication

Communication was frequently cited as a major barrier to healthcare, with staff described by participants as unable or unwilling to explain health issues to patients. Sometimes this was explicitly identified by participants as another form of prejudice against Māori, as in the third quote below.

> *"Sometimes they don't say it in an easy way that you can understand. I think they use too many medical words, and some people might not understand it. Not everybody can go to a medical textbook and open it and know what a word means in Māori or English." (Auckland)*

> *"I had a good doctor, he was a good doctor, but he explained nothing. I just went on my merry way doing everything that I shouldn't have been doing, but I didn't know that I shouldn't have been doing it." (Hawkes Bay hauā)*

> *"[There are] very few Māori doctors, so the majority of Māoris go to a Pākehā doctor. Whether [the Pākehā doctors] do it deliberately or not, they don't encourage [patients] to take the services that are available to them." (Waikato)*

Specialists were also noted as having difficulties communicating effectively. One way to improve their communication was by patients challenging their behaviour and attitude; as the participant quoted below did.

> *"They think they're above God and everything else. I said, 'Listen, what's happening here? What are you doing?' He said I don't need to know – more or less, shut up and let me get on with my business. I said, 'Look here!' He knew I had started to get a bit more serious. He started to explain things, and I said, 'Good man'." (Hawkes Bay hauā)*

Participants pointed out that communications might be better if staff learned about Māori, with some also acknowledging that to learn about another culture was far from an easy task:

> *"They're more interested in red tape than in the actual person. That red tape is on the other side, isn't it? So the atmosphere and all that, it's just totally different cultures." (Waikato)*

> *"I guess they need to know about Māori… It's not something you learn in a night. It's not like you can learn this mate, and you're onto it." (Waikato)*

There was also a belief that doctors from a similar cultural background to patients would provide better health care.

> *"[Doctors] need to meet your needs, but sometimes it doesn't happen unless you have a Māori doctor." (Christchurch)*

> *"Māori doctors… seem as though they care about you and they actually are interested in you and what is wrong with you." (Auckland Rangatahi)*

Clinical skills

Some participants questioned the clinical skills of the GP or nurse they were seeing, and tended to link this to a more general disrespect on the part of the health professional.

> *"How do you get through to doctors and nurses that think they know everything? How do you tell them? You have a doctor who goes and says to you, 'I had 20 years, and I know what I'm doing,' and the next minute the needle has gone right through the vein, but nothing has been drawn out." (Wellington)*

4.1.3 Patient - Community

Participants' reluctance to see a doctor has been described here as a 'wait and see' attitude; that is, wait and see if you get better before going to the doctor. There are multiple reasons for this attitude, including participants' knowledge of how they may be treated by the general practice, financial concerns, a perception that visits to doctors are often not good value, and participants' concerns about privacy. For some participants, however, access was often seen as a necessity, and there were calls for it to be seen by Māori as a right. These themes are explored below.

'Wait and see'

When discussing GP visits, many participants, both men and women, shared a philosophy that visiting the doctor should occur only when it is clear that the condition will not resolve itself on its own.

> *"I was sick for two weeks before I went to the doctor. The only reason I [went] was because I wasn't getting any better." (Christchurch Rangatahi)*

> *"That went on for a long, long time until I said [to him], 'Oh, I think I'd better ring the doctor.' He said," No, no, no, I'm not sick.' One day he said, 'I think you'd better ring the doctor.' He was – bang! – straight into hospital." (Hawkes Bay hauā)*

This 'wait and see' attitude was seen whether illness or injury was under discussion and was the same for those with disabilities and those without. The only difference suggested by some participants was a gender-based one, with Māori men seen as inclined to believe that they should be tough and not seek health care. The second quote above illustrates that sometimes participants waited and left health problems too long and, in this case at least, required hospitalisation as a result. A more serious consequence of this 'wait and see' attitude was death.

> *"I've seen so many of our whānau who have died because they tried to hang in there, hang in there, hang in there. We've got to be honest and say that a major factor is money." (Waikato).*

Financial concerns

Hui participants said that many times their own 'wait and see' attitude to health care was related to financial concerns.

> *"It costs a lot to go to the doctor and prescriptions on top of that. You really hold off until you're really desperate to go to the doctor." (Christchurch Rangatahi)*

Sometimes money problems prevented access to care, even when a GP visit is desired and sought after.

> *"I had an incident with mokopuna up from Wellington. He had to go to the doctor, but I was refused because I had an unpaid bill, so they wouldn't take my moko, my grandson." (East Cape)*

> *"The biggest thing on my mind is, how much is this going to cost me? Can I afford the prescriptions that they're going to give me?" (Waikato)*

It was also clear that 'low cost' is a relative term.

> *"They think you can afford it… with the community services card. [But] the medication might be $30 and they only reduce it to $15. That's still heaps of money."* (Auckland Rangatahi)

> *"Too many Māori deaf are very poor and they can't afford [health care]."* (Wellington)

A related financial factor influencing the decision to see a doctor or not was the lack of transportation.

Value

Many participants saw the GP visit as another burden associated with being ill, rather than as a tool to improve their health. There was also a perceived lack of value in many GP visits due to, for example, the shortness of the visit, not feeling any better as a result of visiting a GP, and the lack of willingness of the GP to discuss more than one health issue. Some participants also felt that regular visits (e.g., in conjunction with medication refills) were of no benefit to their health but merely a drain on their resources. All of these issues may also be linked with the communication issue explored above; that is, patients may question the value of a GP visit because the doctor has not explained things fully and understandably to them.

> *"[It] costs a mint to go to the family doctor for a two minute kōrero."* (East Cape)

> *"You're paying big money and then you come out dissatisfied. You don't mind paying that money if you come out and you feel good. [But it's different] if you have paid $30 or $40 and you don't feel as though they've helped you."* (Hawkes Bay Hauā)

> *"If you have an injury in your leg and something wrong with your ears too, they just want to know about your leg. You've got to then come back later about your ear. You're trying to explain that you've got a sore ear, and they're just trying to look at your leg. I like to go and get them all seen to, my ear and my knee."* (Auckland Rangatahi)

There were also participants who believed that a Western doctor could not heal them and was therefore of little value.

> *"Like all my family, they don't go. They stay true to their old medicine. My auntie who I live with… she's really sick at the moment… She won't go to the doctor because she doesn't think the doctor can give her anything for what she has. That's how she is. That is how she was brought up. She doesn't need a doctor to fix her."* (Auckland Rangatahi)

Drawing attention to oneself

For some participants the 'wait and see' attitude described above stemmed from their feelings that it was inappropriate to call attention to themselves or their individual needs.

> *"We don't make a noise; it's just not our way. We just sit there and just grin and bear it. It's just not our way to make a fuss, to formalise it, to challenge something. We will just sit there and bide time, hoping that someone will realise we need help."* (Waikato)

Sometimes drawing attention to individual needs was seen as a waste of a doctor's time because the health issue was perceived by the participant to be only minor.

> *"I was thinking, 'No, I'm not going in there wasting the doctor's time.' You know, this is only a bite; that's all it is. I can do it myself, which I did, until the end… I think a lot of us do this. Eventually it healed, but it took four months."* (Christchurch)

For some participants the problem was not simply the monetary cost, but the fact that the money was being spent on an individual and not the community. This posed a problem for those whose values included putting the whānau ahead of themselves.

> *"Basically it's my kids, my family. I look at them first before myself." (Waikato)*

> *"He's thinking of money and stuff. He would rather put that money aside for when we go to the doctors, or when we need something done to us. He's thinking, I'm already a man, so I should be looking out for us." (Christchurch Rangatahi)*

Spending money on their own health care was akin to drawing too much attention to themselves.

Shyness and privacy

Hui participants described different cultural norms regarding privacy that inhibit some Māori and prevent them from seeking help a doctor.

> *"I won't go and see a doctor. I'm too shy. I'm too shy to see a doctor and have him touching me." (Waikato)*

> *"If you have a personal problem to do with a private part of your body, you're not going to go. You don't want to do that." (Hawkes Bay hauā)*

> *"The other thing with us, I think, as kaumātua, we're still at that stage where we don't like standing there getting undressed in front of the men, if you like. That's a very sacred thing still to us and to all of our people, regardless of whether we are men or women. We don't like standing there. It doesn't matter how many babies we've had, we're still like that." (Christchurch)*

For some Māori this desire to keep personal things private extended to a general avoidance of doctors because they themselves did not want to know that they might be ill.

> *"If you go to the doctor, they're going to say something is wrong with you, and you didn't even know you had it. That's what my mum has always said, and that's why she hates going." (Christchurch Rangatahi)*

While this section has been included as part of the patients' beliefs and preferences, it also reflects on the health organisation and human resources. More Māori staff would facilitate access for Māori with issues of shyness and privacy. In addition, good communication and relationship building on the part of non-Māori staff may also facilitate access.

Accessing services

Sometimes the cost of going to see a doctor was off-set by the need for participants to ensure that their employment was not put at risk because they were sick or injured.

> *"My biggest [concern] is that I've got [to get] basically a letter to say to my employer, I've done the legal side of it, I'm allowed these days. That's safeguarding my job. That's the biggest thing for me, just taking time off when you are sick." (Waikato)*

Some participants felt that the health care they were receiving was appropriate.

> *"I come from a family that never had a doctor on [a named small] Island... Everyone lived and we used Māori medicine. Since [then] I've had a double bypass. I take 14 tablets a day, and I listen to that doctor. Whether it's transitional, or whatever it is, we have the best of two worlds. Our people should have the best of both worlds." (Waikato)*

And one participant suggested that a 'mind shift' was needed whereby Māori would know that they had the right to access health services when they were needed, rather than 'waiting to see'.

> *"I think a mind shift, or an attitude shift, that Māori have the right to go in straight away. We don't have to go, 'Oh, it's only us and there will be someone more important or something more important.' It's an entire mind shift that if there's the slightest thing wrong we deserve to have the best service and rightly." (Christchurch)*

4.2 Participant Experiences at Hospital, Including A&E

Hui participants' experiences at hospital, including A&E, were largely connected with the behaviour and attitudes of hospital staff. While participants voiced their concerns about hospital waiting times, particularly in A&E, they also noted that they wanted to be told why they were waiting and when they would be seen. Poor communication was a more general issue for those participants with disabilities, who reported that they were often treated like they were children. When participants perceived that health care was being delivered in a respectful way, and when communication was good, participants reported that they felt more comfortable in a hospital setting. These themes are explored below.

4.2.1 Health Organisation

Hui participants reported a number of organisational barriers related to hospital care, including location, waiting time, and service delivery:

> *"We used to live in Turangi, and there's nothing. We had to move down to Wellington for everything. There's just nothing up there. The nearest hospital was Rotorua." (Wellington)*

> *"I went to the hospital when I broke my arm, nearly three Christmases ago, and I had to wait for an operation for three or four days, because it was Christmas. There was a minimum of staff." (Auckland)*

Participants noted the lack of capacity within hospitals. For some this meant that they had to care for whānau members themselves rather than relying on staff.

> *"If my sister hadn't have been at that hospital with me, there are lots of things, like getting to the toilet, getting to the shower, [that wouldn't have happened]. She had to do all of that. The nurses came and thanked her and said that they were so short-handed." (Hawkes Bay hauā)*

Sometimes participants described how they had to wait for health care to be provided, not wishing to complain in case future care was compromised.

> *"They asked for the nurse to go and change her dressing. That nurse went out and never came back for eight hours. I stayed up there all the time. When that sort of thing happens, we don't want to go and complain, as we're frightened that it might get worse." (Waikato)*

Waiting times were frequently cited in the hui as a major barrier at the A&E.

> *"This was in the ambulance, mind you, and they said, 'She's got to wait out here.' I thought to myself, I'm not going to wait out there in the waiting room. I said, 'When you come in, it's an emergency thing, and you have to be seen straightaway.' Well, that was when I had to wait around for about eight hours before I went to the actual unit. I thought, why should I have to wait for that time?" (Hawkes Bay hauā)*

> *"Down in Otago I used to play rugby as well. Even if you did play rugby, and you got injured, you really didn't want to go to the A&E Clinic, because you'd sit for hours and hours." (Christchurch Rangatahi)*

> *"I took him up to the hospital. I handed over the letter which I was given by the doctor. I waited and waited and waited. It got to lunchtime, and I waited and waited. My dad was getting tired. I went back to them and said, 'My dad is really tired, and I'm sick, and I want to go home.' They said, 'Just wait'." (Hawkes Bay hauā)*

4.2.2 Human Resources

Disrespect and communication were closely linked in hui participants' discussion of their experiences of hospital care. Merely being Māori and/or engaging in Māori cultural practices, such as having whānau accompany a patient, were seen as engendering disrespect from health professionals. Participants also raised issues about the clinical skills of hospital staff.

Disrespect

Participants felt that being talked about, rather than being talked to, by health professionals was disrespectful.

> *"I went through that hospital system just like I was a box, or a letter with a stamp on having to go through as a letter being posted, you know? People talked about me, not to me. These very bright, intelligent, and capable people talked about me." (Hawkes Bay hauā)*

And a rangatahi participant felt that he should have been treated more kindly when he needed stitches, rather than what he perceived as his 'rough' treatment as 'just another drunk'.

> *"I was out of town, and I fell over on a piece of glass. I cut my hand open. I needed stitches, so I went to the hospital. I was intoxicated, but not abusive or anything of that sort. The way the nurse treated me, she was so rough. She was like, just another drunk, blah blah blah. She was really rough. It wasn't very nice. She was like, 'Have you had your tetanus?' I was like, 'I can't remember.' She was like, 'Oh.' And throws it into my arm, really rough. I wasn't impressed." (Christchurch Rangatahi)*

Communication

There was a perception of poor communication and uncaring attitudes among hospital staff.

"The doctor came in. He said, 'Okay, this is what's wrong with you.' I could see these photos, and obviously that's my body. I was like, 'What's that?' He said, 'You don't really need to worry about that.' I was really, really angry. My sister had trained to be a nurse for awhile, and she was trying to ask questions. He was there for about five minutes, and he said, 'I want you to take these.' He wrote out a prescription and I was like in shock." (Christchurch)

Poor communication was a barrier at the A&E as well.

> *"The thing is, when you get the service, it's usually good, but there is no one communicating with you during the time you're waiting. It's not like 'you're next in line' or 'there are a few more people before you'. That was really frustrating." (Christchurch Rangatahi)*

> *"Problems [exist] for deaf people when they go to emergency services. They have trouble communicating." (Wellington)*

Patients with disabilities also reported frustrations with the healthcare system, often related to issues of communication and a lack of respect for those with disabilities.

> *"Doctors and nurses need to know how to communicate with deaf patients." (Wellington)*

> *"They're only about four feet away from me. I said, 'Hey, are you talking to me or about me?' This sort of stuff. Because you are blind, you are dumb, you are thick. You get treated like that." (Hawkes Bay hauā)*

> *"They talk to us like we're simple minded. We're very intelligent people." (Hawkes Bay hauā)*

> *"I've had doctors that have treated me like a little child because of my disability, and that's not always easy [to endure]. Once I had a Pākehā doctor who gave me an injection. She said, 'This will be stingy, stingy, hurty, hurty.' She treated me like a little baby." (Auckland)*

> *"Some talk down to you, people do talk down to you because they don't understand that you might know more than they think you know. You get treated like a child, rather than an adult. You might behave like a child for that reason. It's just very hard some of the time." (Auckland)*

Sometimes hui participants associated this poor communication with the cultural differences between themselves and hospital staff.

> *"My father was in the [local] Hospital, and it's hard for Pākehā to relate to Māori needs." (Waikato)*

> *"There is a change in ethnicities. We have a lot of Asians coming over. They are totally different to us. Their ways and mannerisms are totally different. Some of those people have senior positions." (Waikato)*

When good communication exists within a hospital setting, a strong relationship can develop.

> *"They make people comfortable. They explain what your injury is about, how you did it, how they can work with it and stuff. They don't get too close too fast. Like say you've got something on you, they don't start examining you straightaway. They ask you to explain instead of just saying, 'Let's have a look' and getting straight into it." (Auckland Rangatahi)*

> *"They checked up on me regularly. I just came to expect that. I knew they knew what they were doing. They would wake me up in the middle of the night, but I knew they had to do their job... It was good." (Christchurch Rangatahi)*

> *"It was all right because I had my family there, my whānau was there. It was sweet because my mother was always there all the time, and my brother. There were family and friends coming in. I had a good support base. The nurses and the doctors were good." (Christchurch Rangatahi)*

Good communication and care did not always necessarily mean that all a patient's concerns were taken care of in an appropriate fashion. Sometimes patients still missed out on health care information.

> *"I went through the cancer, and I was treated actually quite good. One thing where they went kind of wrong, they didn't educate me on the different sorts, where the public health could pay you for. I was supposed to get all of my teeth done. I paid it through my own pocket, and there was a free dental clinic up there." (Waikato)*

Clinical skills

Sometimes the clinical skills of staff were questioned because of participants' experiences.

> *"I had to go to the hospital for a blood test, and the nurse stuck it in my arm, and she goes, 'Sorry, love, I've just missed the vein." She took it out and put it back in again. She was rattling it around. She was going, 'Hang on, it's around here somewhere.' I was like, 'Come on, hurry up,' and she took it out. On about the fifth time, she finally got the vein." (Christchurch Rangatahi)*

4.2.3 Patient - Community

There was not much comment about patient or community attitudes and values as a barrier to hospital care. Participants did talk about people being scared of going into hospital because it was seen as a place where people died.

> *"Our people are so frightened of going into doctors and so frightened of going into the hospital, that they are frightened they won't come out." (Waikato)*

Sometimes within the hospital the poor communication and lack of respect from health professionals was met by silence from Māori. Participants felt that Māori 'clam up' when they are not being listened to.

> *"If we haven't got the confidence in what they're saying, we're not going to say anything. Even in the hospital, when the doctors talk to us, we clam up. Well, I do. I'm not going to tell you all this, because you're really not listening to me. You only want to hear what you want to hear. I'm not going to tell you anymore. We [Māori] clam up a lot, we really do." (Christchurch)*

4.3 Participants' Experiences with ACC

Communication was the main issue that hui participants identified about ACC. There was a perception that ACC was reluctant to tell participants what they were entitled to, that what information was provided was not understandable, and that eligibility to entitlements was often a mystery. These issues are elaborated below.

4.3.1 Organisation

Two organisational issues were raised by participants: the lack of Māori staff at ACC, and information not being understandable.

Workforce composition

Participants with experience of ACC, often over a number of years, noted the lack of Māori staff within the organisation.

> *"In regard to Māori case managers, over the years we've seen out of, say, 30, we will have two Māori." (Waikato)*

Information

Participants complained that, even when ACC information is presented, it is often not understandable.

> *"Half the booklets that are out there, instead of sticking to the facts of what people want to know, you get a lot of booklets that have big long write-ups of each thing. People that aren't good at reading and writing, they can't understand. They look at it and don't bother straightaway." (Wellington)*

> *"Things have to be done in simpler form too, in that respect... so that our people understand." (Christchurch)*

4.3.2 Human Resources

Communication

Communication problems, compounded by lack of understanding about Māori culture, were often cited by hui participants as problems with ACC and other funding bodies resulting in the under-utilisation of these services by Māori.

> *"ACC has all this information. The onus is on them to get it out to the people, not on us to tell people [at ACC what we need]. Why should we have to? They're the ones who have the money. It's their onus. It's their baby. It's that minister that should send that information down to us. Why is that not happening? Why isn't that happening?" (Waikato)*

> *"They're not going to tell you what you're entitled to." (Waikato)*

> *"My doctor didn't say to me, 'Fill a form in for ACC.' I don't know nothing." (Hawkes Bay hauā)*

> *"They knew nothing about if you were working, you can get your wages compensated. Our men were just going to go on the sickness benefit." (Waikato)*

Sometimes participants' complaints about ACC were related to difficulties they had had getting ACC to respond to the issues they were experiencing.

> *"The ACC went back on everything we asked them about. They don't tell you anything, you've got to ask. That's what the worst problem is." (Wellington)*

> *"Everybody out there, especially ACC, they said we can't help [your young son]. [He had] no physical injuries, but he suffered more than me. There was nobody out there that could direct us to any place that could help him. It took 12 months before we actually found a Māori facilitator that would do it for nothing." (Waikato)*

Having the role of support people questioned was also seen as disrespectful.

> *"Doctors frown upon [bringing in the whānau], certainly ACC [does]... They frown upon the fact that we've got the whole whānau here. 'This is a bit rough; we can't have that.' I'm saying that I would see very much the need for, it's not intervention, but a support person being involved." (Hawkes Bay hauā)*

4.3.3 Patient - Community

Some participants emphasised that Māori behaviours could change as well. That is, Māori had to be less reluctant about asking for help.

> *"What our Pākehā counterparts did [was to ask], 'Have you got the ACC papers?' because the Pākehā doctors would tell them. Our people are too shy, our nannies are too shy to talk about that. It's our generation, we have to awhi [help] them, to teach them, plus our kids." (Waikato)*

> *"It's only the squeaky wheel that gets the oil. That's what we have to be. We just can't be too proud." (Waikato)*

4.4 Patient Experiences with Other Health Services

Hui participants also commented about other health services they had received or were receiving. The complaints that participants had about other services were often related to the support services they were receiving because of their health or disability. Participants were concerned about people not doing their job properly (e.g., housecleaning) and about staff turnover that meant that they often lost the services of good people.

4.4.1 Organisation

Several participants mentioned the lack of Māori staff as a problem. Expectations of, or requests for, Māori staff could often not be met by organisations and sometimes even 'knowledgeable' Pākehā were not appropriate service providers for Māori.

> *"They bring a Pākehā woman with them. The old [Māori] lady wouldn't undress, wouldn't undress. A Māori woman, kei te pai, take off her clothes, no trouble. Pākehā woman, very knowledgeable Pākehā woman. She had years in the nursing profession and you couldn't get a better person with the knowledge. They never got to first base, never. The old lady just would not take her clothes off in front of the Pākehā woman."* (Waikato)

> *"I had these people twice turn up on my doorstep. Now I was a bit confused, because one of them was an occupational therapist, and the other was a driving instructor. I was expecting a couple of Māori to come around."* (Waikato)

> *"For two years, I asked for a Māori careers officer to help me plan my future for where I am right now. Two years ago, I asked for it. They only gave it to me last month. They're saying, 'Oh, we didn't know we had one.'"* (Waikato)

Turnover of staff was a problem for some participants as it often meant starting over again to build a relationship with the new person who may or may not know what they are doing.

> *"A client gets used to how they want to be dressed, and then someone [new] comes along and okay, they might start putting the socks and slippers on first, and the rest of the body has got nothing on... Everyone is different in the way they work."* (Wellington)

> *"The only way she got to know me was having huis at home and to actually see my injuries and to feel. She actually had a heart, she had a heart. She went out of her way to try and help me. Once that was starting to happen for me, she got changed, and I got this dick who said it's just like having a baby."* (Waikato)

Problems related to having to wait for a service or to fill in too many forms in order to receive a service, were also evident. These often led to participants not using services.

> *"He's had to wait for ages before he could claim with ACC. He had to go in and get quotes and stuff and then ACC have to come back and say yes or no. Sometimes it can take longer, and you'd rather pay for it yourself and not wait."* (Christchurch Rangatahi)

> *"We just filled out the same thing everywhere we went. I filled out everything that was wrong with my shoulder and then when I went to the physio, I did it again."* (Christchurch Rangatahi)

4.4.2 Human Resources

Many hui participants reported good experiences with (often specialised) service providers. These good experiences were linked with both good communication and good health care provision.

> *"She's someone I could talk to and she made me feel better. When I get injured again, I'll definitely be going to Sports Med. They specialise in what they do. They make you feel like they know what they're talking about." (Christchurch Rangatahi)*

> *"They put me on this treadmill and said straightaway that it was cartilage. They took x-rays and in that five years before, no one had taken an x-ray. It was cartilage the whole time. It was five years with pain." (Christchurch Rangatahi)*

Others participants were of the opinion that good service depended very much on the individual providing it.

> *"There are physios that are really, really good, and there are others that aren't so good. It depends on who you go to." (Auckland)*

> *"Rehabilitation, they've got their own codes of rehabilitation, and it's got to be done their way. They don't understand that we're independent people, and we want to do it how we want to do it. Nobody can understand what pain, what level of rehabilitation we can go through." (Waikato)*

> *"[The housekeepers] shouldn't be asking me [questions] every five minutes. Look, people are using the scrubbing brush for the toilet in the bathtub. That's not me, that's not Māori or Pākehā. And that's what I said to her, 'Where's the hygiene? Aren't you guys teaching these people how to do their work?'" (Wellington)*

4.5 Patient Experiences with Funding Bodies

As with other services, participants felt that there was bias and malfeasance at the funding bodies, which made the participants less likely to seek their services. Participants' views were that these organisations went to great lengths not to provide services; that Māori were particularly disadvantaged by racism and (for some Māori) by their own shyness; and that people needed to start demanding their entitlements from these funding bodies.

4.5.1 Organisation

Explanations for the denial of service often revolved around the motivation services had for saving money. Money saved was seen by participants as, for example, payable as bonuses to staff responsible for the savings or used to fund overseas trips for staff.

> *"They don't give you any money, and that person [at the funding body] gets a bonus. I think that is why they tell you nothing. At the end of the day, or at the end of the year, there is supplementary money inside their pocket, and that will justify that the money is not being used for people like us." (Waikato)*

> *"They are trying to save money for themselves so that they can go on trips overseas." (Waikato)*

Participants also reported that their access to services varied according to the staff who were involved. A different doctor or case worker would mean different answers or advice, often leaving the participants with a feeling that they were getting the run-around from services.

> *"I have been pillar to post with doctors, WINZ. Doctor wants him on sickness benefit, [but] the doctors keep changing. I have been to three or four doctors. They can't make up their mind which illness, and WINZ won't pay a benefit until they know which illness." (East Cape)*

> *"In terms of service that's available and how service is received, it varies almost from man to woman, woman to man, from whoever is on the other side of that desk. The next person that comes along will give a different answer. This is from ACC to WINZ, to hospital admissions, to patient treatment and care, and the like." (Hawkes Bay hauā)*

> *"It was the same sort of thing: she's had five different case workers. You would talk to one and start to get things moving, and then they would change to another one. We would have to talk to another one. Things were going around and around in circles for a few years." (Waikato)*

This perception of a 'run-around' was also experienced by participants in relation to accessing information and having to provide certain information to a service.

> *"Trying to access things for me that I really needed took ages. It took ages for me to find out how I could get all of these resources. Not even the social workers knew how to go about it." (Waikato)*

> *"Food needs to get on the table, and you're delayed a week just running around and getting information. 'Oh, no, you need to see this doctor to get that, sir.' I mean, that's just my impression. I don't go to the doctor that often; well, I try not to." (Waikato)*

The overall impression hui participants had was of services that did not want to provide benefits or services to people, so that people had to literally plead for help.

> *"They have got to be more transparent, more open, more giving. At the moment, they're like this locked up, you can't get anything. We're standing here like this, please, please, please, begging." (Waikato)*

4.5.2 Human Resources

One participant offered the following hypothetical conversation to describe their perception that (1) non-Māori are more familiar with what services are available to them, (2) non-Māori are more forceful about demanding those entitlements and (3) that staff at funding bodies go out of their way to provide services to Pākehā ('Mrs Smith'), but tend to stonewall Māori ('Mrs Tupaki').

> *"How many of us have gone to WINZ and said, 'Is there any way that you can help with this and that?' 'I'm sorry, Mrs Tupaki. No, we can't, but it was nice of you to ask anyway.' Now Mrs Smith comes along and Mrs Smith says, 'I understand that I'm entitled to such and such a benefit to add to my benefit to buy myself a washing machine. I've broken mine and can't afford another one.' 'Oh, certainly, Mrs Smith!'" (Hawkes Bay hauā)*

Other participants also suspected that the service they were receiving was less than what a Pākehā person in the same position would receive.

> *"You see, my concern as a Māori is that if he was Pākehā, would he have that knowledge that there was dental treatment? That's what really gets me going. Would he, if he was Pākehā, what are the chances that he would have been empowered with that knowledge?" (Waikato)*

4.5.3 Patient - Community

Cultural differences in communication and behaviour were cited by hui participants as a reason for some Māori not accessing services.

> *"[Māori] won't ask them to explain it to them, because they think they will then sound dumb." (Christchurch)*

> *"Our people don't know how to express themselves. They get very shy and they don't know how to communicate to the ACC. You walk into the office, and you know they are very well dressed. People like our people, they are dressed casually and feel intimidated." (Waikato)*

> *"Too whakamā. What they don't know, they won't ask. It's a knowledge thing. Also [we're] brought up to think whānau will look after us." (East Cape)*

Some participants encouraged people to find out what they were entitled to and then to demand this for the services they were seeing.

> *"Everyone can go in there [to WINZ] and demand, but they need to do their homework first before they demand. You walk into WINZ, the brochures are there. A lot don't read those on what they can and can't do." (Waikato)*

> *"I'm a solo parent on the DPB. WINZ has a lot of benefits for me that I don't know about. Because they don't tell me about it, I will go and find out. I won't sit there and be whakamā and waikore. I will go and find out. I won't wait for someone to tell me."*

> *"You find with the younger generation, they do know how to access Māori services and everything, whereas the older generation don't. The younger generation do to a certain extent." (Wellington)*

4.6 Discussion

Hui to discuss Māori experiences of health and disability services were organised in conjunction with local communities that had been provided with information about the present research. While hui are the Māori way to meet and discuss ideas, they also serve to allay suspicion about the research. Particular attention was paid to ensuring the use of culturally appropriate approaches and language at the hui. Overall the approach taken helped maximise Māori participation; Māori came to the hui and talked openly about their experiences and opinions.

The hui reported that costs were greater for those with health problems who also have disabilities. Participants reported that providers are more likely to talk 'down' to these patients. In addition, these patients belong to another culture (e.g., deaf culture as well as Māori) with specific needs and preferences, but most services are not suited to the needs of hunga hauā (location, service arrangements, physical barriers, etc.).

The hui revealed that barriers to use of services by Māori differed by the type of service, but there was a great deal of overlap. This discussion touches upon three main barriers identified by hui participants: the 'cost' of health services, health professionals' engagement with Māori, and the prior experiences Māori have had of health services that influence and inform their expectations.

Following on from this some of the limitations of the hui research are explored, leading into the next chapter on the quantitative survey.

4.6.1 'Cost'

Unsurprisingly, given the disproportionately high levels of deprivation in the Māori community, financial considerations loomed large for most participants. Related issues of access (waiting time, travel distance, inconvenient appointment times) were also mentioned repeatedly. Systems and policies of the services were also perceived as unsuitable or unfriendly by many hui participants, who cited impersonal and disempowering environments as well as inflexible bureaucracies.

'Cost' refers to the larger issue of 'perceived value', which includes both financial and non-financial considerations. Monetary considerations will frequently be an important factor for Māori, as Māori are over-represented in lower socio-economic groups. The availability of lower cost primary care services does not appear to have eliminated this concern. This may indicate that even when out-of-pocket costs are reduced or eradicated, 'cost' remains a concern and thus is used broadly by patients to encompass fees paid to providers (GPs and physios for example), follow-on costs (prescriptions, for example), non-treatment costs (time off work, child care), and the question of value for money.

For this reason, it is important to realise that 'cost' relates not just to the amount of money needed to see a general practitioner, but to a perception that the effort required (financial effort, time commitment, associated inconveniences, etc.) to access or use the service outweighs its potential benefits. Other 'costs' include: difficulty arranging transportation to a healthcare provider (including bus fare, securing time off work and its concomitant reduction in income, affording the cost of gas, etc.), struggling to make an appointment (due to unwieldy clinic procedures, lack of a home telephone, or language differences), needing to arrange alternate child or elder care, costs of follow-up or follow-on needs such as medicines, x-rays or allied health visits, waiting times (an often unpredictable period) to see the clinician, and lost (or delayed) wages. It is the consideration of all these issues, together with the other barriers associated with health visits (see below), that leads Māori healthcare consumers (like other healthcare consumers) to assess the overall value (or 'cost') of a visit.

4.6.2 Health Professionals

Health and disability service providers were also mentioned as contributing to the problem of access, through behaviour that was perceived to range from uninformed to disrespectful to racist. Many hui participants felt that service providers generally do not provide the same quality or level of care to Māori as to non-Māori, in part because of different cultural mores. Māori participants reported that providers lacked respect and understanding and did not listen to them. All of this is in keeping with McCreanor and Nairn's (2002) findings about non-Māori GPs perceptions of their Māori patients. Providers' poor communication skills were mentioned repeatedly and included inconsistent explanations as well as a lack of awareness and understanding about Māori culture and values.

As noted in the literature review, communication skills have an enormous impact on healthcare satisfaction and treatment effectiveness. Good communication skills help to strengthen the relationships between providers and patients, increase mutual trust and respect, impact health outcomes (including adherence to therapy and physiological measures such as perceived pain, blood pressure, and blood glucose levels), as well as potentially reducing patient complaints (Cross et al 1989; Isaacs & Benjamin 1991). Where the provider and the patient do not share a common cultural background, there are increased difficulties in establishing effective communication and productive relationships (Cross et al 1989; Isaacs & Benjamin 1991; Penn et al 1995). In New Zealand, the majority of healthcare interactions for Māori patients do not involve clinicians from the same cultural background. There is therefore great potential for misunderstandings and reduced effectiveness (Cram et al 2003; Jansen 1998). This is a particular problem for Māori with disabilities, such as Māori deaf.

Many hui participants described their belief that certain attitudes that make it difficult to obtain care are more prevalent among Māori. These range from a more resigned approach to illness, a greater concern for privacy, a reluctance to put one's own needs ahead of others, and a mistrust of the overwhelmingly non-Māori healthcare system. In addition, many hui participants repeatedly expressed a conviction that some Māori have a culturally-based reluctance to ask for information, to question a doctor's diagnosis or treatment, or to be forceful when having difficulty with ACC.

From a Māori point of view, this attitude may be viewed as manuhiri– which is appropriate behaviour when interacting with unknown people in a new environment – or to be noho whakaiti – which is to be appropriately quiet and watchful when in the presence of someone of higher status. Quiet listening in this context demonstrates respect. Hui participants argued that these behaviours (to be manuhiri and to be noho whakaiti) may be both normal and polite for many Māori, but can be a source of misunderstanding for non-Māori clinicians. This in turn can lead to confusion and miscommunication, as documented in other comments made at the hui about providers' lack of knowledge of Māori culture and lack of respect for Māori patients.

There was also some overlap between the issue of being 'too shy' and that of a lack of 'cultural fit'. For some hui participants behaviours such as accepting all treatment advice without question and being reluctant to engage in self-advocacy were seen as a shortcoming of the patient (too shy), while other hui members clearly described the same actions as appropriate patient behaviour that was misinterpreted by a culturally incompetent provider (manuhiri: acting as a visitor and waiting to be invited to participate fully in the consultation).

4.6.3 Prior experiences

For any patient, past experience will influence current and future healthcare interactions (Bryant & Campbell 1996; Cram et al 2003; Health Waikato 2001). Perceptions of health services will also be shaped through community experiences and the media. All patients, including Māori and their whānau, will have expectations and perceptions of care that are formed from these collective experiences. Some patients reported repeated bad experiences as they progressed through the healthcare system from primary and pre-primary interactions through secondary and referred services to tertiary services and those involving return to the community, community placement or support services. Many Māori involved in the hui reported an expectation that care will be provided to them at a lesser quality, of a lesser intensity and by people who are either disrespectful, do not understand Māori or provide understandable information to Māori.

It was clear that all of these factors contribute to a reluctance among Māori (and presumably other groups, including those with limited financial resource and those with disabilities) to utilise healthcare unless the illness or injury grows more serious. A significant insight from the hui was the perception that as people progressed through the healthcare system, barriers to care were actually multiplied and loomed larger. This relates to the number and complexity of interactions with providers. The hui also highlighted that for many Māori there was a complex interplay between the barriers and their expectations of care, and that this impacts on both pre-visit and post-visit intentions.

4.6.4 Study Limitations

As with any study, there are limitations to this analysis that restrict the ability to generalise from the findings. When reading the sections on the qualitative aspects of this research it is important to keep in mind that it is an account of the experiences of Māori who participated in focus groups (hui) conducted by the research team. While a wide range of Māori participated in those hui the research does not represent the views of all Māori. We actively sought a diversity of views and, as a result, we believe the insights and perspectives expressed by hui participants reflect the barriers to healthcare access for most Māori.

4.6.5 Future Research

The most immediate influence of the hui findings on research was in the development of a survey questionnaire on Māori use and experience of health and disability services (see next chapter). Many of the findings from the hui reiterated and expanded upon previous research on barriers to health care for Māori. While socio-economic factors were less stressed, issues around 'value for money' and the clinical skills of health workers were more to the fore. Future research exploring how Māori judge 'value' and 'skill' may help Māori in assessing and providing feedback about their healthcare.

5 Ngā Tukunga Iho o Ngā Rārangi Uiui – Survey Findings

5.1 Health Status

Over half of the respondents reported that they had no health or physical conditions that required on-going treatment (N=354, 54.4%). (Table 10) Nearly a quarter of the respondents had a health condition(s) that required on-going treatment (N=154, 23.7%), of which the most common was a chronic illness such as asthma or diabetes. The remainder of the respondents who answered this question had a physical (e.g., loss of limb) (N=69, 10.6%), or sensory (e.g., deafness, blindness) condition (N=64, 9.8%), or a mental or intellectual disability (N=8, 1.2%). Two respondents refused to answer this question.

Table 10. Current health status

Health or physical conditions that require on-going treatment	N	%
No condition	354	54.4
Health condition e.g., asthma, diabetes	154	23.7
Physical e.g., lost a limb, polio	69	10.6
Sensory e.g., sight or hearing disability	64	9.8
Mental or intellectual disability	8	1.2
Don't know/Refused	2	0.3
Total	**651**	**100.0**

5.2 Service Utilisation

In the six months prior to being surveyed, most of the respondents (94.2%, N=613) had visited their GP (Table 11). In addition, 21.8% (N=142) of the respondents had visited an A&E, 31.3% (N=204) reported a hospital stay, 27.3% (N=178) had visited a specialist, 15.1% (N=98) had an interaction with a funding body (primarily ACC), and 30% (N=195) had utilised 'Other Services'.

Table 11 Number of respondents' who had used health services in past 6 months, N=651

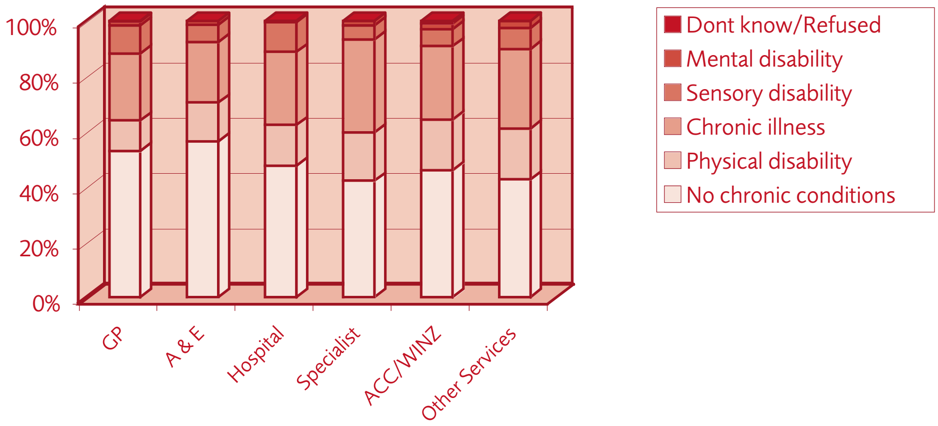
Health service	N	%
A GP	613	94.2
A hospital	204	31.3
A specialist	178	27.3
An A&E or A&M	142	21.8
ACC or WINZ	98	15.1
Other services e.g., x-rays, physio	195	30.0
Total	**1430**	

Between 42% and 56% of the visits made to different health services in the past six months were made by respondents with no ongoing health condition (Table 12, Figure 5). Respondents with chronic health conditions made between one fifth (to A&E, N=31, 21.8%) and one third (to a Specialist, N=60, 33.7%) of the total visits made by all respondents to different health services.

Table 12. Current health status and services used in past 6 months

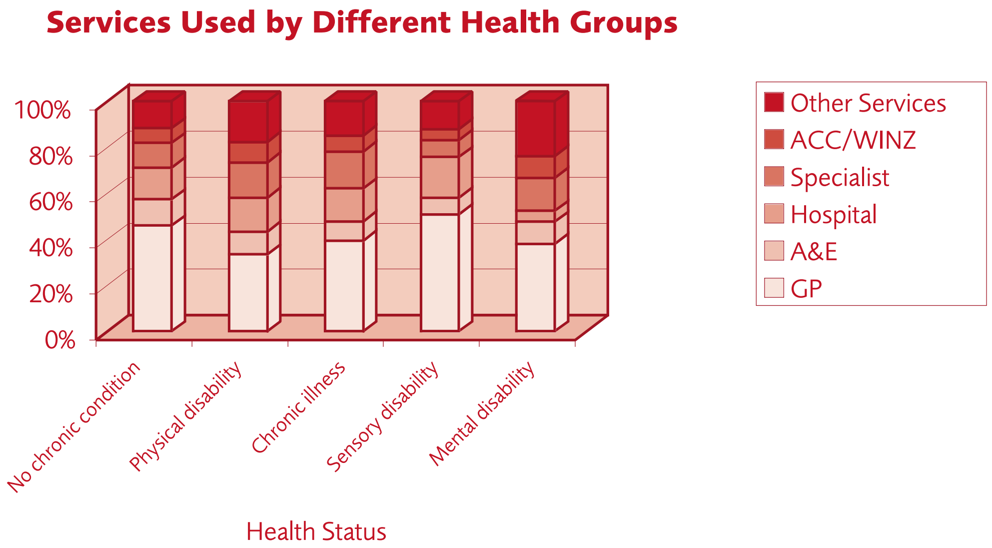
Health or physical conditions that require on-going treatment	Services been to in past 6 months					
	GP	A&E	Hospital	Specialist	ACC or WINZ	Other services
	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)
No ongoing condition	324 (52.9%)	80 (56.3%)	97 (47.7%)	75 (42.1%)	45 (45.9%)	83 (42.6%)
Chronic health condition	148 (24.1%)	31 (21.8%)	54 (26.5%)	60 (33.7%)	26 (26.5%)	56 (28.7%)
Physical condition	68 (11.1%)	20 (14.1%)	30 (14.7%)	31 (17.4%)	18 (18.4%)	36 (18.5%)
Sensory condition	63 (10.3%)	9 (6.3%)	22 (10.8%)	9 (5.1%)	6 (6.1%)	15 (7.7%)
Mental / intellectual disability	8 (1.3%)	2 (1.4%)	1 (0.5%)	3 (1.7%)	2 (2.0%)	5 (2.6%)
Don't know/Refused	2 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.0%)	0 (0.0%)
Total	**613**	**142**	**204**	**178**	**98**	**195**

Figure 5. Respondents' health status by service used (%)



Across all the health conditions, the most common service visited by respondents was the GP. This ranged from one-third (N=68, 33.5%, row percentage not shown in Table 12) of all health-related visits to different services made by those with a physical condition, to one half (N=63, 50.8%) of the visits made by those with a sensory condition (Figure 6).

Figure 6. Services used by different health groups



The survey quota system of asking respondents about different healthcare providers resulted in data being collected on visits to the GP from 77.1% (N=502) of the respondents; visits to hospital from 30.7% (N=200) of the respondents; visits to a specialist from 26.7% (N=174) of the respondents; visits to A&E from 21.4% (N=139) of the respondents; visits to ACC from 11.8% (N=77) of the respondents; and visits to other services (e.g., physiotherapist, x-rays) from 21.0% (N=137) of the respondents (Table 13).

Table 13. Health services respondents' surveyed about, N=651.

Health service	N	%
GP visit	502	77.1
Hospital	200	30.7
Specialist	174	26.7
A&E	139	21.4
ACC	77	11.8
Other services	137	21.0
Total	**1229**	

As described in the survey respondent demographics (see above), most of the respondents chose to answer the survey on their own behalf (N=553, 84.9%). This was reflected in the survey responses across the different services (Table 14). Between 74.8% (A&E visits, N=104) and 88.3% (other services visit, N=121) of the responses about the different services were made by respondents on their own behalf (Table 14). The highest proportion of responses made on behalf of another person were for A&E services, with respondents answering questions on behalf of a child or youth (N=24, 17.3% of A&E responses).

Table 14. Survey response and services used in past six months

		Survey responses made on behalf of:				
		Myself	A child/ youth	An adult/ spouse I look after	Other	Total
GP visit	Number	434	54	14	0	**502**
	(%)	(86.5%)	(10.8%)	(2.8%)	(0.0%)	
Hospital visit	Number	160	28	11	1	**200**
	(%)	(80.0%)	(14.0%)	(5.5%)	(0.5%)	
Specialist visit	Number	148	16	10	0	**174**
	(%)	(85.1%)	(9.2%)	(5.7%)	(0.0%)	
A&E visit	Number	104	24	8	3	**139**
	(%)	(74.8%)	(17.3%)	(5.8%)	(2.2%)	
ACC visit	Number	62	7	7	1	**77**
	(%)	(80.5%)	(9.1%)	(9.1%)	(1.3%)	
Other services	Number	121	10	6	0	**137**
	(%)	(88.3%)	(7.3%)	(4.4%)	(0.0%)	

5.3 Feedback on Health Services

This next section provides an overview of respondent feedback on the various health services they were asked about. A full account of the findings can be found in Appendices D-I. The findings from the modelling of overall satisfaction and intention to revisit are also summarised here, with the full description of this analysis in Appendix H. This section concludes with a look at how respondents' ratings of each service compared (Table 15).

5.3.1 General Practice Visits

Overall, respondents were satisfied with their visits to a GP (Table 15). They reported that they had confidence and trust in the doctor (92%); that the doctor asked enough questions (87%), explained things well (87%), treated them with respect (96%), and said their name properly (83%). The majority said that they would see the same doctor again (93%), and 73% rated their overall satisfaction with the doctor as 'good' (on a 3-point scale: 'good', 'average', 'poor').

On the whole, the 36% of the respondents who reported that they had to wait to be seen by a doctor, also reported that they were not told how long they would have to wait (86% of those who had to wait), or why they had to wait (84% of those who had to wait). Waiting time impacted significantly on respondents' overall satisfaction rating. Eight-six percent of those who were seen on time rated their overall GP visit as 'good' compared to 67% of those who reported that they were not seen on time (z-test, $p<0.05$).

Of the 81% of respondents who had some treatment or prescription (e.g., drugs, tests) prescribed by the doctor, most (87%) received a clear explanation of why this was necessary. However, only half (52%) reported that the side-effects of the treatment had been explained to them by the doctor. The majority (92%) of those given a prescription reported that they had had this filled.

Table 15. Respondents' experiences of health service visits

Question / Topic	GP	Hospital	A&E	Specialist	ACC	Other
Number of visits reported on	502	200	139	174	77	137
Able to get a suitable appointment time	410 (94%[1])	N/A	N/A[3]	154 (90%)	N/A	N/A
Seen on time	280 (64%)	N/A	N/A	80%	N/A	N/A
Confidence and trust in the service provider[2]	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. Percentage of respondents agreeing with service statement. 2. 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. 3. 'N/A' indicates that this question was not asked for this service.

The modelling analysis of the GP responses examined which elements were most associated with respondents: overall satisfaction, and intention to revisit. This analysis found that 'good' overall satisfaction was associated with: respondents being able to make an appointment in a timeframe they felt was appropriate, the doctor listening to them, the doctor clearly explaining their condition to them, and the doctor warning them of any potential side effects of the recommended treatment. This model correctly classified 88.2% of respondents' overall satisfaction ratings.

Intention to revisit was found to be less likely if the doctor did not ask enough questions to find out what was wrong, and the respondent did not have confidence and trust in the doctor. A revisit was more likely if respondents had seen the same doctor before.

Respondents were asked about what they liked or disliked about their last visit to the GP. Common answers (given by at least 10% of respondents) about their 'likes' were: the overall service/process, the usual/normal service, and the polite and respectful manner of the GP. The common dislike was the waiting time.

5.3.2 Hospital Visits

Overall, respondents were satisfied with their visits to the hospital (Table 15). Most respondents reported that they had confidence and trust in the people who were looking after them (82%); that the staff asked enough questions (83%), explained things well (82%), and treated them and their family members with respect (87%). Most respondents (81%) also said that their culture and beliefs were respected. And most (82%) rated their overall satisfaction with their visit as 'good'.

Seventy-three percent of the respondents reported that they were prescribed further treatment and/or drugs at hospital, and most of these respondents (88%) said that they had received an explanation for this.

Respondents were asked about what they liked or disliked about their last visit to hospital. Common answers (given by at least 10% of respondents) about their 'likes' were: that the overall service was good; that it was clean/warm/good food; and that they were treated with politeness and respect. The common dislike was the waiting time.

With respect to the overall visit rating, the modelling analysis found that a 'good' rating was less likely if the respondents felt (1) that the staff did not ask sufficient questions, (2) that the staff consulted with each other while ignoring the patient, (3) that they were not treated with respect, (4) that their privacy was not respected, or (5) that doctors did not tell them what to expect after they were discharged from the hospital. This model correctly classified 77.6% of respondents' overall satisfaction ratings.

Intention to revisit the hospital was found to be less likely if staff did not always introduce themselves, and respondents were not given enough privacy during their stay. A revisit was more likely if respondents felt that staff had not talked in from of them as if they were not there.

5.3.3 A&E Visits

Over half of the respondents described the reason for their visit to A&E as 'extremely serious' (N=40, 28.8%) or 'very serious' (N=41, 29.5%). Thirty-seven visits (26.6%) were described as 'serious', with the remaining visits (N=21, 15.1%) described as 'not that serious'.

Overall, respondents said that they, and the people they were with, had been treated with politeness (86%) and respect (91%) by the A&E receptionist. Just over half of the respondents (55%) were told how long they would have to wait, with 46% being told the reason for the wait. Most of respondents (77%) spoke to a nurse or doctor within 30 minutes of their arrival at A&E, and 70% were examined within this timeframe.

Overall, respondents were satisfied with their visit to A&E (Table 15). They reported that they and any people with them were treated with respect (91%); and that the doctor or nurse asked enough questions (86%) and explained things well (81%). The majority of respondents (86%) reported that the reason they went to A&E was dealt with to their satisfaction.

Seventy-three percent of the respondents reported that they were prescribed further treatment and/or drugs at the A&E, and the majority of these respondents (90%) had received an explanation for this.

Respondents were asked about what they liked or disliked about their last visit to A&E. Common answers (given by at least 10% of respondents) about their 'likes' were: that the service was thorough and efficient; that the treatment was good/excellent; and that they were treated with politeness and respect. The common dislike was the waiting time.

With respect to the overall visit rating, the modelling analysis found that a good rating was less likely if the respondents felt (1) that they were not seen in a fair and reasonable order, (2) the staff did not introduce themselves, (3) the staff did not spend sufficient time with them, (4) their privacy was not respected, or (5) the reason they went to the A&E was not dealt with adequately. This model correctly classified 78.4% of respondents' overall satisfaction ratings. Respondents were less likely to revisit the A&E if they felt that staff had not seen patients in a fair order.

5.3.4 Specialist Visits

Overall, respondents were satisfied with their visits to a Specialist (Table 15). They reported that they had confidence and trust in the Specialist (91%); that the Specialist asked enough questions (88%), explained things well (86%), treated them with respect (97%), and said their name properly (86%). Most said that they would see the same Specialist again (87%), and 74% rated their overall satisfaction with the Specialist as 'good' (on a 3-point scale: 'good', 'average', 'poor').

Most respondents (80%) reported that they were seen by the Specialist on time. A third of those who had to wait also reported that they were told how long the wait would be (32% of those who waited) and/or why they had to wait (27% of those who waited).

Sixty-seven percent of respondents were prescribed further treatment and/or drugs by the Specialists. The majority of this group (93%) said that they received an explanation for this, and 67% said that they received an explanation of potential side effects. Four out of five (78%) of those receiving a prescription collected it.

The modelling analysis of the Specialist responses examined which elements were most associated with respondents: overall satisfaction, and intention to revisit. This analysis found that 'good' overall satisfaction was less likely if respondents felt that the Specialist did not ask them enough questions about what was wrong with them. This model correctly classified 79.0% of respondents' overall satisfaction ratings.

Intention to revisit was found to be less likely if the Specialist did not spend enough time listening to them and explaining matters, and did not pronounce their name properly.

Respondents were asked about what they liked or disliked about their last visit to the Specialist. Common answers (given by at least 10% of respondents) about their 'likes' were: the overall service/process; the polite and respectful manner of the Specialist; and being consulted and kept informed. The main dislike was the waiting time.

5.3.5 ACC Visits

Overall, most respondents felt that they were treated with respect (82%) by ACC. Many reported that their culture and beliefs were respected (75%), that they were listened to sufficiently (78%), and that they were given enough privacy (73%). Approximately two-thirds of respondents felt that they were given all the information they needed about their claim or entitlement (68%), that they had trust and confidence in the person they met with (65%), and that they had received a clear explanation of what would happen after their visit (58%).

Respondents were asked about what they liked or disliked about their last visit to ACC. Common answers (given by at least 10% of respondents) about their 'likes' were: the polite and respectful service, being kept informed/listened to/receiving good explanations, and the thorough and efficient service. The common dislike was the waiting time.

With respect to the overall ACC visit rating, the modelling analysis showed that a good rating was less likely if the respondents felt (1) that they were not given all the information they needed or (2) that they were not given a clear explanation of what would happen after their visit. A 'good' rating was more likely if respondents had visited ACC before for the same issue. The model correctly classified 81.8% of respondents' overall satisfaction ratings.

Intention to revisit was found to be less likely if the respondent felt that the person they saw did not listen to their views.

5.3.6 Other Services Visits

The most common 'other services' were x-rays (30%) and physiotherapy (23%). Overall, the majority of respondents felt that they were treated with respect (96%), were given enough privacy (96%), and had confidence and trust in the service provider (93%). Most felt that their culture and beliefs were respected (86%) and that the service provider explained things well (82%) (Table 15).

Respondents were asked about what they liked or disliked about their last visit to the service provider. Common answers (given by at least 10% of respondents) about their 'likes' were: the polite and respectful service, being kept informed/listened to/receiving good explanations, the thorough and efficient service, and the outcome/speed of the treatment. There were no common dislikes.

With respect to the overall visit rating, the modelling analysis showed that a good rating was less likely if the respondents felt (1) that they lacked trust and confidence in their clinician, (2) that the staff did not communicate in an open and honest manner, or (3) they did not receive a clear explanation of why they needed the treatment. This model correctly classified 85.5% of respondents' overall satisfaction ratings. Similarly, a revisit was less likely if the respondents reported a lack of confidence and trust in the clinician.

5.3.7 Comparing Services

This section briefly draws some comparisons across service ratings.

- GP, specialist and other health services were rated as 'good' by most of the respondents (74-79%). Slightly less than half (48%) of the respondents asked, rated their last ACC interaction as 'good'.
- 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. Two-thirds (65%) of respondents said that they had confidence and trust in the ACC person they had met with.
- 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 respondents reported that their service provider explained things well. Just over half of the respondents (58%) reported that the ACC person they had met with had done so.
- The 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%).
- A common dislike about most services was the waiting time.
- Overall satisfaction was generally related to the nature of the interaction between the respondents and the service provider (e.g., whether it was respectful, polite, and informative).
- Respondents' intention to revisit a service was generally related to similar issues as their satisfaction (e.g., politeness, being listened to, being given privacy).

Ngā Tukunga Iho o Ngā Rārangi Uiui – Survey Findings

5.4 Respondents' Attitudes

Respondents were asked a series of questions about their attitudes towards their own health, doctors' attitudes towards Māori, and the overall health system. Ratings were collected using a 3-point scale ('agree', 'neither agree or disagree', 'disagree').

5.4.1 Respondents' Own Health

Just over half of the respondents agreed with the statement 'I am in excellent health'. A similar number of respondents agreed with the statement 'I have some concerns about my health'.

5.4.2 Visiting the Doctor

When asked about visiting the doctor, approximately two-thirds of respondents agreed with statements that: they would have to be quite sick before going to the doctor (73%), they would usually wait until the last minute before going (68%), and that it is too expensive to go to the doctor every time they felt sick (63%) (Table 16). Respondents were split over whether the cost of seeing the doctor was not value for money; 41% of respondents agreed that it was not good value while 48% disagreed. Two-thirds of the respondents (64%) did not expect their family/whānau to look after them when they were sick as an alternative to going to the doctor. And respondents were also split about taking drugs for their illness; half did not like doing it (51%).

Table 16. Respondents' attitudes towards visiting the doctor

Statement	Agree (%)	Neither Agree or Disagree (%)	Disagree (%)
I have to be quite sick before I'll go to a doctor	73	3	24
I usually wait until the last minute to go to see a doctor	68	4	28
It is too expensive to go the doctor every time I feel sick	63	4	33
The cost of seeing a doctor is not good value for money	41	11	48
I expect my family/whānau to look after me when I'm sick rather than going to the doctor	26	10	64
I don't like taking drugs for my own illnesses	51	8	41

The majority of the respondents agreed that were treated with respect (93%) by their GP. Most agreed that they had a good relationship with their GP (84%), could trust their GP (87%), and were treated as well as any other patient (85%) (Table 17). Most of the respondents also disagreed with statements about: their GP not treating them like an adult (89%), the respondent not asking questions (86%), and the respondent being too shy to argue with the doctor if they think s/he is wrong (76%). Two-thirds of the respondents (68%) disagreed with the statement that doctors do not listen to their patients. And just over half of the respondents (56%) agreed that their doctor had given them ACC information, with 29% neither agreeing nor disagreeing with this statement (possibly because it was not relevant for them.

Table 17. Respondents' attitudes about GPs and doctors

Statement	Agree (%)	Neither Agree or Disagree (%)	Disagree (%)
The GP I last went to treated me with respect	93	1	5
I can trust my GP	87	6	7
The GP treats me as well as any other patients he/she has	85	9	6
I have a good relationship with my GP	84	7	9
The doctor does not treat me like an adult	10	2	89
I don't like to ask the doctor questions	12	2	86
I am too shy to argue with the doctor if I think he/she is wrong	19	5	76
Doctors don't really listen to their patients	19	13	68
The doctor gave me all the information I needed to get ACC	56	29	15

5.4.3 Cultural Competency

Many respondents disagreed with the statement that doctors did not really care about their Māori patients (75%), or that hospitals should treat Māori differently to Pākehā (63%) (Table 18). Approximately half of the respondents disagreed with four other statements about cultural competency; namely: having a preference for a doctor from their own ethnic group (53%), having a Māori doctor rather than a Pākehā doctor (49%), hospital staff not recognising Māori culture (46%), and being looked after better by Māori health staff (46%), While less than one-third (26%-30%) of respondents agreed with these last four statements, a similar proportion of respondents (21%-30%) neither agreed nor disagreed.

Table 18. Respondents' attitudes about cultural competency

Statement	Agree (%)	Neither Agree or Disagree (%)	Disagree (%)
Doctors don't really care about their Māori patients	10	14	75
Hospitals should treat Māori differently to Pākehā	24	13	63
I would prefer to see a doctor of my own ethnic group	26	21	53
I would rather see a Māori doctor than a Pākehā doctor	22	30	49
Hospital staff don't recognise Māori culture	28	26	46
I would get looked after better if I was to deal with Māori people in my health system provider	30	24	46
I would prefer to see a doctor of my own gender	38	17	45

Respondents were split about preferring to have a doctor of their own gender; 45% disagreed with this statement while 38% agreed.

5.4.4 Health Providers & Health System

Two-thirds of the respondents (66%) felt that they were treated well in the hospital (Table 19). Many respondents disagreed with statements about them not being treated with respect by providers (80%), people in the health system making it difficult for them to get what they want (70%), and hospital staff not treating them with respect (68%). Respondents were split over whether they got different answers from different people in their health system provider (40% agreeing, 51% disagreeing), and it being hard to get a straight answer from people in the health system (39% agreeing, 48% disagreeing).

Table 19. Respondents' attitudes towards other health staff

Statement	Agree (%)	Neither Agree or Disagree (%)	Disagree (%)
I get well treated in the hospital	66	20	14
I don't get treated with respect by provider1	14	6	80
The people in my provider make it difficult for me to get what I want	21	9	70
Hospital staff don't treat me with respect	15	16	68
I get different answers from different people in my provider	40	9	51
It is hard to get a straight answer from people in the health system	39	13	48

Note. The term 'provider' is used in the question asked to refer to the respondent's health system provider (e.g., GP, hospital, ACC or other service provider).

Just over half of respondents (53%) agreed that the overall NZ health system is very good, while less than half (43%) agreed that it is 'good value for money' (Table 20). Approximately one in five respondents neither agreed nor disagreed with these statements.

Table 20. Respondents' attitudes towards the New Zealand health system

Statement	Agree (%)	Neither Agree or Disagree (%)	Disagree (%)
Overall I think the health system in NZ is very good	53	18	29
Overall I think the health system in NZ is good value for money	43	17	40

5.5 Subgroup Formation and Analysis

A cluster analysis (SPSS 2-step cluster analysis) was performed to look for groups of respondents with similar attitudes.[1] This was done using respondents' answers to the questions in the attitudes section above (i.e., questions 125 to 156, see Appendix C). After these two groups had been determined, they were compared on the demographic variables and then on respondents' responses to other survey questions.

Six percent of the respondents were classified as outliers in the cluster analysis and dropped from further consideration.[2] From the remaining respondents, two groups could easily be differentiated: 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).

5.5.1 Demographic Comparison

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

A significantly larger proportion of Group 1 members were part of an older couple with no children at home (16% vs. 4% for Group 2). Similarly, a larger (non-significant) proportion of Group 2 members were part of families with mainly pre-school children (18% vs. 12% for Group 1). These differences are likely to be closely linked to the age difference.

No differences were found between the groups in work or employment status, Māori language ability, reported service use, income, or health card status (see Appendix I).

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[1] The 2-step SPSS analysis links together the two clusters (or groups of individuals) whose answers to the attitude questions are most alike (technically this is done by computing a mean 'distance' between all individuals answers within the two clusters to determine which group has the smallest distance).

[2] Outliers are detected statistically and are removed from models fitted to small samples as they have the potential to badly skew the results.

5.5.2 Attitudinal Comparison

Groups 1 and 2 were significantly different (using z-tests at the 95% confidence level) in many of their attitudes, many of their visit ratings, and their intentions regarding future use of services. These differences are reported on below.

Compared with those in Group 2, a significantly higher proportion of respondents in Group 1 (i.e., the older group) rated their GP, Specialist, A&E and Hospital visits as 'good' (ratings from 73%-89% vs. 32%-53% for Group 2), and stated that they would go back to the GP, Specialist or Hospital if sick again (ratings of 98%, 93% and 89% respectively vs. Group 2 ratings of 80%, 74% and 59%) (Table 21). A significantly higher proportion of respondents in Group 2 rated their ACC visit as 'poor' (28% vs. 9% in Group 1) and their visit to other services as 'average' (29% vs. 11% in Group 1).

Table 21. A comparison of Group 1 and Group 2 respondents' satisfaction with, and willingness to revisit, health services

Issue	Group 1 %	Group 2 %
Overall GP visit rated Good*	89	51
Overall Specialist visit rated Good*	79	53
Overall A&E visit rated Good*	74	32
Overall Hospital visit rated Good*	73	37
Overall ACC visit rated Poor*	9	28
Overall Other Service visit rated Average*	11	29
I would go to this doctor again if I were sick*	98	80
I would go to this specialist again if I were sick*	93	74
If I had a choice, I would go to this hospital again if I were sick*	89	59
If I had a choice, I would you use ACC again if I needed to*	90	79
If I had a choice, I would go to this A&E again if I were sick	87	74
If I had a choice, I would use this other service again if I needed treatment	94	96

Note. * indicates that the difference between the two groups is statistically significant ($p<0.05$)

Compared to Group 1, a significantly higher proportion of respondents in Group 2 agreed that they had to be quite sick before visiting the doctor (92% vs. 69%); that it is too expensive to go to the doctor every time they feel sick (88% vs. 55%); that they usually wait until the last minute before going to the doctor (81% vs. 66%); that the cost of seeing the doctor is not good value for money (74% vs. 29%); and that they have concerns about their health (66% vs. 51%) (Table 22). Group 2 respondents were also less likely to agree that they were in good health (46% vs. 54%); were more likely to expect their family/whānau to care for them, rather than go to the doctor (56% vs. 17%), and did not like taking drugs for their illness (66% vs. 51%).

Table 22. Respondents' perceptions of health and willingness to visit

Issue	Group 1 %	Group 2 %
I have to be quite sick before I'll go to a doctor*	69	92
It is too expensive to go to the doctor every time I feel sick*	55	88
I usually wait until the last minute to go to see a doctor*	66	81
The cost of seeing a doctor is not good value for money*	29	74
I have some concerns about my health*	51	66
I don't like taking drugs for my own illnesses*	47	64
I expect my family/whānau to look after me when I'm sick rather than going to the doctor*	17	56
I am in excellent health*	54	46

Note. * indicates that the difference between the two groups is statistically significant.

Respondents in Group 1 and Group 2 differed significantly with respect to their reported relationship with their GP (Table 23). Compared to the majority of respondents in Group 1, only two-thirds of those in Group 2 agreed that they could trust their GP (69% vs. 99%), that their GP treated them as well as other patients (66% vs. 94%), and that they had a good relationship with their GP (63% vs. 95%). In addition, a significantly lower proportion of respondents in Group 2 agreed that their GP had treated them with respect the last time they went (82% vs. 99% in Group 1). These ratings may be confounded by the fact that members of Group 2 were more likely to be visiting that GP for the first time (29% vs. 16% of Group 1).

Table 23. Respondents' relationships with their GP

Issue	Group 1 %	Group 2 %
The GP I last went to treated me with respect*	99	82
I can trust my GP*	96	69
The GP treats me as well as any other patients he/she has*	94	66
I have a good relationship with my GP*	95	63

Note. * indicates that the difference between the two groups is statistically significant.

Compared to the low proportion of respondents in Group 1 who agreed with negative statements about rapport, a third to a half of Group 2 respondents agreed that: they did not like to ask the doctor questions (29% vs. 5%), the doctor did not really listen to them (51% vs. 9%), and they are too shy to argue with the doctor if they think s/he is wrong (42% vs. 10%, table 24). These differences were significant. In addition, respondents in Group 2 were significantly more likely than those in Group 1 to agree that the doctor did not treat them like an adult (33% vs. 3%).

Table 24. Respondents' rapport with health personnel

Issue	Group 1 %	Group 2 %
The doctor does not treat me like an adult*	3	33
I don't like to ask the doctor questions*	5	29
Doctors don't really listen to their patients*	9	51
I am too shy to argue with the doctor if I think s/he is wrong*	10	42
The doctor gave me all the information I needed to get ACC	58	53

Note. * indicates that the difference between the two groups is statistically significant.

Respondents in Group 2 were significantly more likely than those in Group 1 to agree that they 'would get looked after better' if they were being cared for by other Māori (70% vs. 18%, table 25). In addition, one third of those in Group 2, compared with only 2% of those in Group 1, agreed that 'doctors don't really care about their Māori patients' (38% vs. 2%).

Table 25. Respondents' perceptions of GP care

Issue	Group 1 %	Group 2 %
I would get looked after better if I was to deal with Māori people in my provider*	18	70
Doctors don't really care about their Māori patients*	2	38
I would prefer to see a doctor of my own ethnic group	13	67
I would rather see a Māori doctor than a Pākehā doctor	10	63
I would prefer to see a doctor of my own gender	30	59

Note. * indicates that the difference between the two groups is statistically significant.

The differences between Group 1 and Group 2 for agreement with the statements about their preference for a doctor from their own ethnic group and for a Māori doctor were not significant. Likewise, the groups were not significantly different in their preference for a doctor of their own gender.

Two-thirds of the respondents in Group 1 agreed that they got treated well in the hospital, compared to less than half of those in Group 2 (75% vs. 42%). This difference was significant (Table 26). Compared to respondents in Group 1, a significantly higher proportion of those in Group 2 agreed with negative statements about hospital treatment; namely, that 'hospital staff don't recognise Māori culture' (67% vs. 17%), and that hospital staff do not treat them with respect (37% vs. 9%). Half of those in Group 2, compared with 16% in Group 1, also agreed that 'hospital staff should treat Māori differently to Pākehā'. This was also a significant difference.

Table 26. Patient perceptions of hospitals

Issue	Group 1 %	Group 2 %
I get well treated in the hospital*	75	42
Hospital staff don't recognise Māori culture*	17	67
Hospital should treat Māori differently to Pākehā *	16	50
Hospital staff don't treat me with respect*	9	37

Note. * indicates that the difference between the two groups is statistically significant.

Most of those in Group 2, compared with around a quarter of those in Group 1, agreed that they got 'different answers from different people in my provider' (85% vs. 25%), and that 'it is hard to get a straight answer from people in the health system (82% vs. 24%, table 27). These differences were significant. Those in Group 2 were also significantly more likely to agree that: 'the people in my provider make it difficult for me to get what I want (59% vs. 8%), and 'I don't get treated with respect by provider' (34% vs. 6%).

The two groups also differed significantly in their agreement with overall statements about the New Zealand health system. More than half of those in Group 1, compared with a third or less in Group 2, agreed that: the 'health system in NZ is very good' (60% vs. 33%), and 'the health system is good value for money' (51% vs. 20%).

Table 27. Patient perceptions of the healthcare system

Issue	Group 1 %	Group 2 %
I get different answers from different people in my provider*	25	85
It is hard to get a straight answer from people in the health system*	24	82
The people in my provider make it difficult for me to get what I want*	8	59
I don't get treated with respect by provider*	6	34
Overall I think the health system in NZ is very good*	60	33
Overall I think the health system in NZ is good value for money*	51	20

Despite their reports of a greater reluctance to use the system and their greater dissatisfaction with it, Group 2 reported similar utilisation rates of healthcare services to Group 1 over the last six months (Table 28). Most respondents in both groups had seen a GP in the past six months, and between 13% and 31% had visited other health services, including ACC.

Table 28. Services utilised

Service	Group 1 %	Group 2 %
GP/Doctor	96	91
Accident and Emergency	21	26
Hospital	32	31
Specialist	26	27
ACC	13	21
Other services	28	29

5.6 Discussion

While general satisfaction surveys have been undertaken across New Zealand, little has been reported about Māori experiences of healthcare. The current study sought to learn about Māori perceptions of, and experiences with, the healthcare system within a Kaupapa Maori framework. Previous surveys of patient 'satisfaction' as a measure of quality in the healthcare setting tended to reflect the values of managers and clinicians; in other words, those who design and administer the survey rather than the values of the patients themselves. The current survey took into account previous research on Māori as well as the results of ten hui with Māori health consumers to produce a survey tool more in-tune with Māori health experiences.

The survey sought to test the instrument for validation purposes. The survey solicited feedback from Māori about a number of different health services, including ACC. Respondents were also asked a series of attitudinal questions which led to the identification of two sub-groups who held different opinions about health services. This discussion first looks briefly at service utilisation before discussing the findings about health services. The limitations of the methodology are then addressed, followed by the implications of the findings for health services as well as for future research.

5.6.1 Health Services Ratings

When asked about their experiences of the GP, hospital, A&E, specialist and 'other health provider' in the last six months, most respondents reported that the health provider had spent an appropriate amount of time with them, listened to them, and explained relevant health issues. Most respondent also reported that they had been treated with respect and given enough privacy, and that they had confidence and trust in the health service provider. ACC differed mostly in respect to the provider not explaining things well and the respondent not having confidence and trust in the provider. However, positive ratings on these issues were still given by over half of the respondents surveyed on their experience of ACC. Many of the respondents also said that their culture and beliefs were respected by the hospital, ACC and 'other health provider'. Most respondents said that they would visit these services again, and most reported that they were satisfied overall with the service they had received (with this dropping to half of those rating their ACC experience).

Overall satisfaction ratings and intentions to revisit were largely related to respondents' experiences of rapport and respect, with some variation across services. This is in keeping with other research that has found that overall satisfaction is dependent on developing a trusting relationship with a provider who is in tune with the expectations, preferences and priorities of the patient. It is more difficult for patients to know whether the technical aspects of care were delivered so patients often rate the interaction on the rapport and respect they perceive, forming an overall opinion about the service based on these aspects (see section 2.4 for fuller discussion).

5.6.2 Attitudes

Most respondents said that they put off going to see the doctor until the last minute. This corresponds with the `wait and see' attitude expressed at the hui. The hui participants linked this attitude with the costs of visiting their GP, with many challenging whether such a visit was value for money. The survey respondents were similarly split over whether the cost of seeing the doctor was value for money. This reinforces the findings of some studies (Zgibor & Simmons 2002; Clemenger BBDO 2004; Cram & Smith 2003) that cost poses a barrier to healthcare utilisation, while contradicting other study findings.(Ministry of Health. 2005; Scott et al 2003).

The similar split in respondents' attitudes toward taking drugs for their illness may reflect financial concerns as well as issues about the efficacy of GP communication to patients about prescribed drugs. While the majority of those who were recommended further treatment and/or drugs by their GP received an explanation, only half reported that they were told about the side effects of drugs. Even so, most collected their prescription. It is conceivable that a lack of explanation from the GP about the drug or its side effect made some respondents somewhat hesitant about taking their medicine.

Most of the respondents who were asked about GP visits agreed that they had a good relationship and good rapport with their GP. Most respondents also thought that they were generally respected by their health provider, whoever that provider was. Most also felt that doctors cared about their Māori patients, and while around half thought that they would get better care from Māori health providers, a sizable proportion of the respondents (20-30%) were ambivalent about this (saying that they neither agreed nor disagreed).

Respondents were split about the 'answers' they received from their health provider. Around two out of five respondents thought that they received different answers from different people, and that it was hard to get a 'straight answer'. On the other hand, half of the respondents disagreed with these statements. This may relate to health being a credence good whereby it is difficult for some patients to handle multiple opinions and advice without them seeming to be contradictory or not 'straight' answers.

The splitting of the respondent sample into two subgroups based on their attitudes revealed a smaller, younger group of respondents (Group 2) who were less likely to report that they intended to visit the same provider in the future and also less likely to report that their relationship with the doctor was good, respectful and enabling of rapport. This group was also more likely to be cynical about the care provided by doctors to Māori patients, and more likely to say that they would be better looked after by Māori health professionals. They were also more critical of the recognition of Māori culture within hospitals, wanting hospitals to treat Māori differently to Pākehā (presumably in a culturally appropriate way). Most of the respondents in this group also agreed that they got different answers from different people in the health provider, and that it was hard to get a straight answer from people.

One explanation for these findings is that while both groups have similar experiences with health professionals, Group 2 respondents are more likely to identify and articulate dissatisfaction. The one in five Māori respondents comprising Group 2 reported significantly less overall satisfaction with their experiences and had much lower intentions of revisiting providers compared with the older Group 1 respondents.

This explanation is in line with other research findings that the health-related attitudes of younger Māori were more similar to those of the New Zealand European population, than they were to older Māori (>45 years) or Pacific peoples (Scott 2000). Other authors have also found a diversity of views and cultural identities amongst Māori (Durie, 1994; Williams, 2000; Te Hoe Nuku Roa 1999; Houkamau 2000). In general these studies found that older Māori were more grounded in a Māori cultural identity while younger Māori were typically located within one or two groups: a disaffected group unconnected to the Māori world, or a cohort that moves easily and confidently within both Māori and Pākehā worlds (Houkamau 2000). Both of these groups may 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).

5.6.3 Limitations of Methodology

The pilot survey was delivered by telephone (or face-to-face with respondents who were deaf) to a sample chosen from the Māori electoral roll. Māori are becoming more accustomed to both research and to being surveyed over the phone, this method excluded people in households without landlines. Other limitations included:

- The sample was made up of people who had had some form of interaction with the healthcare service in the past six months. Therefore, the study does not analyse barriers to health system usage from the perspective of people who either choose not to use the system at all or who had not needed to use it in the past six months.
- Face-to-face interviews using trilingual interpreters were used (only) for the sample of 50 Māori deaf. This group faces significant barriers to care, so this style of interviewing was deemed necessary to obtain information for this study, despite the lack of methodological consistency that it introduced.

- The exact nature of the ailment or injury that resulted in a visit to a health professional was not asked in the survey.
- In order to explore the differences between Māori and non-Māori, it would be necessary to have a corresponding sample of non-Māori with which to compare these findings. Non-Māori comparisons were not performed because the scope of the research was to test the survey tool among Māori (only). The completion of a comparison study was never a goal of the current research.
- While the sampling was designed to ensure coverage of Māori across all regions, this is not a representative sample of Māori visits to health and disability providers, as a quota was used to ensure that a sufficient number of visits to each service was obtained. Without such a sampling frame, GP visits would have dominated the responses and limited the depth of the data obtained.
- Data from patient contacts with service providers relates to individual visits rather than episodes of illness. Furthermore the reliability and validity of the information provided by Māori patients has not been confirmed by independent measurement.
- While the survey instrument was derived from a number of sources (including comparison with validated measures of patient experience) the reliability of the instrument has not been independently tested. However, the sample size and response rate add validity to the instrument.

5.6.4 Implications for Health Policy and Services

The present pilot survey has stressed the importance of relationships and rapport if Māori are to have good engagements with health care providers. While the relationship element has been challenged by the Group 2 cohort, it is still important for the older Group 1 cohort (who made up 78% of the sample in the cluster analysis). This group is currently in the majority, with care needing to be taken to meet the criticism of those in Group 2 as they in all likelihood represent the future.

Based on the findings from the pilot survey the following implications for health policy and services are suggested:

- Continue to build the capacity of the Māori health and disability workforce so that consumers can have the option of seeing a Māori staff member at a health service.
- Encourage health organisations to tailor health education and promotional material (including ACC-related material) so that it is appropriate for Māori consumers. In addition, staff should be encouraged to use such material in their communications with Māori.
- Continue to provide cultural competency and communication skills training for non-Māori staff. Such training should include information about Māori cultural preferences as well as an analysis of Māori health disparities. Training should also address the needs and preferences of disabled Māori groups.
- Encourage frontline staff to explain to waiting patients and their whānau: why the wait is necessary and how long they might expect to be kept waiting. In addition, reduce waiting times when feasible.

5.6.5 Future Research

The findings from this pilot-test of the satisfaction survey have highlighted the different experience of health that a younger group of respondents has had, compared with their older counterparts. If it is assumed that this finding is generalisable and that it is a cohort effect, then it could be anticipated that Māori dissatisfaction with the health care they receive will continue in coming years as those who are more inclined to voice their disquiet grow older and their dissatisfaction spreads through subsequent cohorts.

- The challenge for future research is therefore to test these assumptions, namely:
- Are the attitudes and the lower level of overall satisfaction among the younger group of respondents in the present study replicable and generalisable?

- If so, can this be confidently attributed to expectations of lesser standards of service among this cohort or to expectations of greater levels of service than they have observed? And is this cohort more like Pākehā than they are like older Māori in their capability to express dissatisfaction?
- That younger Māori have both a personal and a systems analysis of the healthcare they receive. In other words, they have an opinion on how they are treated personally, within the context of how the system treats Māori.
- Future research should also continue to test the reliability and validity of the shorter version of the current satisfaction survey that is developed based on:
- The modelling analysis of which questions best predict overall satisfaction and intention to revisit services, and
- The attitude questions (perhaps selecting those which distinguish most reliably between the two attitude subgroups).

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Kupu Māori

The Advisory Komiti was asked to give advice on appropriate kupu Māori for the project and the reports. A list of kupu was provided by the Komiti and updated at successive meetings, following discussions:

An appropriate Māori title for the overall project was discussed. Proposed project titles were "People like me: Māori experiences of health services" or "He ritenga whakaaro: Māori experiences of health services"

Kupu Māori for the following were discussed, and conclusions about the preferred terms to describe consumers or users of services or patients are noted below:

a) kiritaki (source; Taura Whiri), consumer, customer

b) hunga whai wāhi (Modern Usage Māori dictionary), user

c) tūroro (Williams, Ngata) patient

d) tangata whai ora (common usage mental health, often abbr; whaiora), patient

e) hunga whara (common usage) people with injuries

Following discussion the following terms/kupu were confirmed:

te hunga whai oranga	consumers of health services
tūroro	patient
te hunga hauā	people with disabilities
hauā me te hauā kore rānei	sub-terms for those with disability and those without disabilities
kaupapa raha	health services that are not Kaupapa Māori
whara	injure, injury (a temporary state)
hauā	disabled (person) (a permanent state)
hunga hauā	disabled people (the group of people with disabilities)
hauātanga	impediment
kohekohe, kopa, hauā	lame
hauare	speech impediment
matapō, kāpō	blind
turi	deaf
wahangū	silent (unable to speak)
toti, koki, totitoti	limp
kutiwera	scarred by burns
nawe, riwha	scar

8

Glossary

Aotearoa — New Zealand (the land of the long white cloud)
atua — supernatural being
hapū — sub-tribe
hara — offence, fault, violation of tapu
hauā pekewhā — quadraplegic
hauāuki — permanently disabled
hauora — health
hinengaro — mind, emotion
hui — meeting
iwi — tribe
kai — food
kaiāwhina — helper, assistant
kāinga — house, cluster of dwellings, village
karakia — incantation, charm, prayer
kanohi kitea — a familiar face
kanohi ki te kanohi — face to face
kaumātua — elder
kaupapa — subject, plan, scheme, proposal
kawa — Māori protocols
koha — donation or contribution
kōhanga reo — Māori language pre-school
kuia — female elder
kura kaupapa — Māori language school
mana — power, influence, prestige, authority
marae — public area in front of a meeting house
mate — sick, dead
mate Māori — illness for which there is no obvious physical cause
mate taua — accident, injury sustained through combat
mirimiri — traditional form of massage
mokopuna — child, grandchild
nakawhiti — fit (able-bodied)
nēhi — nurse
Ngāti Kāpō — the Māori blind group
noa — free from tapu, common, profane
noho whakaiti — modesty (a lowly position of honour)
Pae ārahi/Pou ārahi — ACC Māori cultural advisors

Pākehā — person of European descent

pakeke — adults

pokanga — surgery

rāhui — prohibition order, temporary imposition of tapu

rangatahi — young adults, young person

rata — doctor

reo — language

ritenga — habit, practice, similarity

rohe — district

rongoā — Māori treatments including herbal remedies (rongoā rākau)

takawaenga — an intermediary or go-between

tangata whenua — people of the land, indigenous

tāne — men

taonga — property, anything highly prized

tapu — sacred, off limits

tauiwi — foreign race

Te Kaporeihana Āwhina Hunga Whara — The Accident Compensation Corporation

Te Puni Kōkiri — The Ministry of Māori Development

tikanga — Māori customs and codes of behaviour

tūpāpaku — body (of a deceased person)

wāhine — women

wai — water

wairua — spirit, spiritual

whakaaro — consensus, feelings and opinions

whakamā — ashamed, excessive shyness

whakapapa — genealogy

whakataukī — saying, proverb

whanaungatanga — family relationships or togetherness

whānau — family

whare — house, building

whare tapa whā — four-dimensional Māori perspective of health

whare wānanga — traditional Māori house of learning

For additional information on kupu Māori in relation to health and disability or injury, see He pukapuka reo hauora Māori, David Jansen, Ahuru Press 2005. Available from Mauri Ora Associates.

9 Appendices

Appendix A. Literature review methodology

In the first phase of the project, a literature search was performed, seeking information on (Māori) utilisation, perceptions and experiences of health and disability services, including ACC.

An electronic search of MEDLINE covering the years 1980 to 2004 was undertaken using a range of search terms relating to patient experiences of care, satisfaction with care, perceptions of care, survey methodology, and minority health or Māori health. This yielded several hundred articles including reviews and policy documents. Only English language articles were examined. The abstracts were screened for relevance, and reports that did not appear to be applicable to the research topic were excluded. The focus of the literature search was to locate key themes and models related to patient experiences and actual healthcare use, including barriers and enablers of care and minority health disparities. Articles retained were categorised as to: background, research evidence, survey instruments, methodology, cross cultural and Māori specific.

In addition to the published literature, utilisation data from researchers, the Ministry of Health and ACC sources were also reviewed for key trends and patterns. Supplementary information was sought from academic contacts and acknowledged experts in the field of Māori health.

A further search of all New Zealand Medical Journal articles from December 2000 to December 2004 was undertaken for any information related to Māori health and disability matters.

These searches were then updated at the end of 2007.

Appendix B. Hui data

Hui Information	Logistics	Key Issues Discussed	Most Important Needs Identified
Hauora/ Whara – Tāne	7 September 2004 held in Hamilton at Kirikiriroa Marae Participants: Hauora/Whara – Tāne, 9 people Facilitators: Manujon Pemerika, Catherine Dunkley, Steve Allen	The transition between traditional Māori culture and the Pākehā dominant culture Generational changes, with older Māori being quite different to younger Māori in the way they deal with their own health and subsequently the health system in NZ Lack of knowledge of the health system and funding opportunities that are available Māori culture of collectivism and receiving support from whānau when ill leads to not visiting doctor as soon as should The need for Māori to be more assertive and less fearful of the health system and the people running it Very few Māori doctors which is the preference Assertiveness will mean Māori get what they are entitled to as "the system" is not going to ensure it happens Older Māori prefer traditional medicine to Pākehā nurse or doctor	
Hauā/ Whara – Wāhine	16 September 2004 held in Wellington at Te Awakairangi/ Lower Hutt Hospital Participants: Hauā/ Whara – Wāhine, 5 people Facilitators: Manujon Pemerika, Catherine Dunkley	The lack of expertise shown by many of the people working in home assistance, and the issue of fragmented services – different people doing different things in the home The frequently poor interpersonal skills shown by these same people, and their lack of personal interest Lack of knowledge among Māori about what services and assistance is available, but also how that is changing with younger people being more knowledgeable and proactive The need for Māori to be more assertive and less fearful of the health system and the people running it. The perception among people who have experienced the hospital and ACC system that unless one asks, information will not be forthcoming Deaf and disabled people feel discriminated against by the system and people within it GPs general lack of expertise and interactive skills, especially with deaf people ACC's lack of practical expertise The bureaucracy at ACC, the length of time it takes to get resolution	Respect Good listener An interpreter Patience Ability to contact the person Information in the right format, in the right places for Māori to access

Hui Information	Logistics	Key Issues Discussed	Most Important Needs Identified
Hauora/ Whara – Wāhine	21 September 2004 held in Gisborne at Ngati Porou Hauora Participants: Hauora/Whara – Wāhine, 9 people Facilitators: Manujon Pemerika, Catherine Dunkley Note: This group would not allow video or audio recording. Written notes taken by Catherine Dunkley	Racial issues and discrimination against Māori and obese Māori women Significant barriers to using GPs - time and cost No flexibility in system around prescriptions – have to go to doctor to get repeats Pākehā GPs lack of cultural sensitivity and respect for Māori Doctors don't listen to patients – have preconceived notions about Māori people	Listen to person Same doctors all the time / family doctor Open all hours Not rushing you Not making you wait (1 hr plus) Nice to elderly women / respect elders Non judgmental Disability friendly Community knowledge Cultural knowledge Free
Hauā/ Whara – Wāhine and Tāne	1 October 2004 held in Auckland at Papakura Marae Participants: Hauā/ Whara – Wāhine and Tāne, 8 people Facilitators: Manujon Pemerika, Catherine Dunkley	Difficulty of effective interaction with GPs – their use of medical terms not easily understood. Also a tendency to talk down to people, treat them like children due to their intellectual disabilities GPs practical skills sometimes lacking, don't take the time to talk and understand the patient's problems, and as a result prescribing the wrong course of action Difficulty of effective interaction with hospital staff. Support needed from whānau or advocates to get the right treatment Individual characteristics of literacy and knowledge	Understanding people with an intellectual disability Treat you like an adult A good bedside manner, so make you feel okay and joke with you Friendly Not having to wait too long Treat you the same as others Use easy words Be patient with you For the service to be free Explain things to you Talk to you, not just the person who is with you Ask you the questions

Hui Information	Logistics	Key Issues Discussed	Most Important Needs Identified
Rangatahi – Wāhine and Tāne	8 October 2004 held in Christchurch at Māori Indigenous Health Institute Participants: Rangatahi – Wāhine and Tāne, 6 people Facilitators: Manujon Pemerika, Catherine Dunkley	Māori culture and the issue of Māori pride and stubbornness affecting visits to a GP Costs of visits and prescriptions means people wait until last minute. This happens with dentist as well Whānau support an important factor – when living in area with whānau more willing to go to family doctor. When moved out of town less familiar and put off visiting doctor Hospital staff and their expertise variable, some good experiences, some poor Kaumātua will work through illness or use Māori medicine rather than see a doctor This group seemed reasonably familiar with ACC and what they were entitled to	Cost – not too expensive Inviting atmosphere Knowledgeable Clean environment Culturally aware Enough time for consultation
Hauora/ Whara – Wāhine	8 October 2004 held in Christchurch at Māori Indigenous Health Institute Participants: Hauora/Whara – Wāhine, 8 people Facilitators: Manujon Pemerika, Catherine Dunkley	GP expertise with Māori, their ability to interact, develop rapport GPs practical skills, their knowledge about illnesses beyond the usual problems they encounter Acceptance rather than assertiveness is the Pākehā and Māori way Kaumātua won't go to doctor until last minute; frightened of cost and process Lack of confidence leads to either not going to see a doctor, or not talking when with a doctor Doctors need to be more empathetic with patients, especially elderly who may need more explanations Māori not in the mindset of going to doctor as soon as feel ill, would rather wait	Explanation of illness and treatment Cost Proximity, or location Take the time to understand the patient and their medical history
Hauā/ Whara – Tāne	29 October 2004 held in Hamilton at Life Unlimited, Palmerston St Participants: Hauā/ Whara – Tāne, 8 people Facilitators: Manujon Pemerika, Steve Allen	The whole issue of rehabilitation, where to get help and expertise from Generally negative perceptions of ACC – the bureaucracy, interaction with staff, cultural understanding, information flow Māori people and the general lack of knowledge about what is available from the health system Māori shyness and lack of assertiveness being a barrier to obtaining help	Honesty Respect Getting to know me Trust Recognition, manaakitanga, our kaiawhina Pamphlets and information Culturally sensitive

Hui Information	Logistics	Key Issues Discussed	Most Important Needs Identified
Rangatahi – Wāhine and Tāne	22 November 2004 held in Auckland at James Cook High School Participants: Rangatahi – Wāhine and Tāne, 9 people Facilitators: Manujon Pemerika, Catherine Dunkley, Peter Jansen	GP relationships – their interpersonal skills, understanding of Māori culture The cost of seeing a GP prohibitive Alternatives to the health system – traditional Māori medicine, alternative medicines, self management	Cheapest Communication (listening and talking) Relationship between doctor and patient Explanation of what is wrong Take time with patient Treat everyone the same
Hauora/ Whara – Tāne	24 November 2004 held in Waharoa at Raungaiti Marae Participants: Hauora/Whara – Tāne, 15 people Facilitators: Manujon Pemerika, Catherine Dunkley, Peter Jansen	Personal income is a barrier to accessing the health system GP interpersonal skills and costs are barriers Whānau support, generational, cultural barriers to hospital Adults will wait on going to doctor for themselves but will take children immediately when sick Kaumātua wait until the last minute, don't want to spend the money on themselves Māori relate to each other differently than Pākehā, and prefer and are more at ease with Māori doctors and clinics	Wairua Warm whānau environment Cheap/ affordable Cultural awareness Good explanation
Ngati Kāpō	12 March 2005 held in Napier at Te Poho Marae Participants: Ngati Kāpō – 9 people Facilitators: Manujon Pemerika, Steve Allen	Individual pride and stubbornness Māori not assertive enough, and need to display some proactivity to help themselves. Need to change doctors if not happy with him/her Māori wait and see what is wrong with them, rather than seeking help. Will wait until the last minute and this causes additional complications GP practical skills, need to listen to their patients, and willing to let patients bring whānau to support them	Trust in the doctor Confidence Doctors listen and take the time to understand Value for money Culturally sensitive, sensitive to patient's needs

Appendix C. Explanatory letter

Mauri Ora Associates
PO Box xxxxx
xxxxx

Information Sheet

Title: Māori Consumer Use and Experience of Health and Disability and ACC services

Who are we and what are we studying?

We are a team of Māori health researchers investigating Māori use and experiences of health and disability and ACC services. The research is funded by the Ministry of Health, Health Research Council and ACC. The information we have is that Māori do not use existing services in the same way as Pākehā, but the reasons why are not clear.

How will we investigate this issue?

In a series of 10 hui with a Māori facilitator in 2004, we gathered information about things that prevent Māori from using health and disability and ACC services. Using that information we have developed a survey that can tell us about Māori consumer experiences of care – that is what happened when Māori went to see a doctor or hospital or other health service or disability service.

A trained telephone interviewer may ring you in the next 4 weeks and ask you to take part in the survey. If you have a caregiver, you may give them permission to answer of your behalf. We think that the telephone interview will last for between 15 and 30 minutes.

Taking part is voluntary.

You do not have to take part, and if you choose not to take part this will not affect any future treatment or care. If you do agree to take part you are free to withdraw from the interview at any time, without having to give a reason. You do not have to answer all the questions. You must be over 16 years of age to take part in the interview.

What will we do with the information?

The aim of the study is to help in improving services by reporting on Māori experiences.
The results of the study will be published in scientific journals.

Confidentiality.

No information which could personally identify you will be used in any reports on this study. All information will be held in confidence by the researchers.

If you have a disability or health problem that prevents communication by telephone, you may request a private interview. You can have your supporters / whānau present in that interview.

We thank you in advance for your time and help in making this study possible. If you have any queries or wish to know more please phone me or write.

Peter Jansen
Mauri Ora Associates,
PO Box xxxxx,
xxxxx

Tel: xx xxx xxxx
Fax: xx xxx xxxx
Email: xxxxxx@mauriora.co.nz

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone:

Northland to Franklin xxxx xxx xxx

Mid and lower North Island xxxx xx xx xx (x xxxx)

South Island except Christchurch xxxx xxx xxx

Christchurch xx xxx xxxx

This study has received ethical approval from the Multi-region Ethics Committee. Reference WAI/03/12/089.

9 Appendices

Mauri Ora Associates
PO Box xxxxx
xxxxx

30 Pipiri 2005 Panui whakamārama

Kaupapa: Tā te Hunga Whai Ora Māori whakamahi, wheako hoki i ngā ratonga hauora me ngā ratonga o te Kaporeihana Hunga Whara (ACC).

Māori Consumer Use and Experience of Health and Disability and ACC services

Ko Wai Mātou?

Ko te kamupene nei Mauri Ora Associates, he ohu rangapū hauora, e mahitahi nei i a Tōmaiora, he ohu rangahau nō te Whare Wānanga o Tāmakimakaurau. Nā te Manatū Hauora, te Kaunihera Rangahau Hauora me te Kaporeihana Āwhina i te Hunga Whara te putea.

Ka rangahaua pēheatia?

I roto i ngā hui tekau i whakahaeretia i kohikohitia ētahi take a ārai nei te tangata Māori ki te kuhu i ngā ratonga hauora. I hangaia mai i kōrero tētahi patapatai hei whakaatu mai he aha tā te Māori whakamahi i te ratonga hauora, me ngā ratonga o te Kaporeihana Hunga Whara. Me pēnei - i ahatia te Māori ina haere ki te takuta, ki te hohipera, ki te ratonga hauora ranei.

Ka waea atu tētahi kaiuiui ki a koe i ngā wiki e whā kei te haere mai, me te inoi atu ki a koe kia uru mai ki te kaupapa pātaitai. Mehemea he kaitiaki tōhou, ka taea e koe te whakaae kia whakautu māhau.

Tō mātou, ka ahua 15 – 30 meneti te roa o te patapatai.

He mea tūao te uru mai. Kei a koe te tikanga.

Kei a koe te tikanga kia uru mai, te kore uru mai rānei. E kore rawa e whakararu i te rato i ngā ratonga hauora ki a koe, ki tō whānau rānei. Mehemea ka whakaae mai koe kia uru mai, ka taea hoki e koe te puta ki waho, ahakoa te wā, kāore he take, ā ka kore e whakararu a muri ake nei. Ka taea hoki kia noho tahi tētahi whānaunga, tētahi hoa rānei hei kaitautoko, hei whakamārama hoki i ngā painga me ngā hua o te kaupapa. Ka taea e koe te whakaatu, te kore whakaatu rānei i ngā pātai. Ka taea hoki e koe te whakakapi i ngā kōrero ahakoa te wā. Kei a koe te tikanga.

Ka ahatia ngā kōrero e kohia?

Ko te whāinga hei hāpai i te hauora o ngāi tāua. Ka whakapaoho atu ngā hua ki ngā pukapuka kaupapa hauora.

He mea huna.

Kāore hoki e whākina atu tētahi kōrero e āhei ana te whakamohio atu nāu ngā kōrero. Ka huna katoa ngā kōrero. Ka mea atu hoki ki ngā kaiwhakauru kia kaua e whāki atu ngā kōrero. Heoi anō ka taea hoki e koe te tono mō te kōrero takitahi, te kōrero me tō whānau, tō kaitautoko anake. Kei a koe tēnā.

Heoi anō he mihi kau ake ki a koe, ki a koutou e āwhina nei i te kaupapa. Mena he pātai āu, he pīrangi noa mō ētahi atu kōrero, waea mai koa ki ahau:

Peter Jansen
Mauri Ora Associates,
PO Box xxxxx,
xxxxx

Tel: xx xxx xxxx
Fax: xx xxx xxxx
Email: xxxxxx@mauriora.co.nz

This study has received ethical approval from the Multi-region Ethics Committee. Reference WAI/03/12/089.

Appendix D. Survey questionnaire

Introduction

Kia ora, I am calling from Digipoll, on behalf of Mauri Ora Associates about a letter we sent to you recently about a health survey.

Do you remember this letter?

If Yes: Are you able to speak with me now? We have Māori interviewers available if you would prefer to speak with them.

If No: We are conducting a survey about the health, disability and ACC system in New Zealand. We want to speak to people who have had contact with the health system sometime in the past 6 months. This is with people like your GP, A&E, a hospital, a specialist or x-rays, physios, occupational health people and so on. It also includes ACC for injury [or WINZ for health related claims]. The contact could have been for yourself, your children, or another child or adult you look after. Are you able to speak with me now? We have Māori interviewers available if you would prefer to speak with one of them.

Will you be responding to this survey about your own experiences or on behalf of someone else that you look after? Code all mentions

1	Myself
2	A child/youth
3	An adult/spouse I look after
4	Other specify

I'd like to ask you about your own general health. Do you have any health or physical conditions that require on-going treatment or affect your ability to do everyday things?

1	No
2	Physical – e.g., lost a limb, polio
3	Health condition – e.g., asthma, diabetes
4	Sensory – e.g., sight or hearing disability
5	Mental or intellectual disability
6	Other specify
99	Don't know/Refused

If answering the survey for someone else from Q2: And for the person you are answering on behalf of, how is their general health? Same scale as Q3

I'd like to speak to you about your most recent experience with the health system. [If answering on behalf of someone else instead of 'you' and 'your' will reword]. Can you tell me if you have had contact with any of these people or organisations in the past 6 months? Read list. Code all mentions

	Contacts	Relevant Service Standards Section
1	GP/doctor	SS1
2	Accident and Emergency or Accident and Medical Centre	SS2
3	Hospital	SS3
4	Specialist	SS1
5	ACC for injury or WINZ over health related issues	SS4
6	Other services like x-rays, physiotherapy, occupational therapist, osteopath, home help Specify service mentioned	SS5

For each mentioned: Can you tell me how long ago the contact with [insert contact from Q5] was?

1	This week
2	Within last month
3	Within last 3 months
4	Within last 6 months
5	Longer than 6 months ago
99	Don't know

If only one contact: Was this visit made for yourself or some other person?

If more than one contact: Were these visits made for yourself or some other person?

	Visit 1	Visit 2	Visit 3
1	Myself	Myself	Myself
2	Child/youth	Child/youth	Child/youth
3	Adult/spouse I look after	Adult/spouse I look after	Adult/spouse I look after
4	Other specify	Other specify	Other specify

Service Standards Section

If more than 3 visits I'd like to ask you about these 3 visits specifically [check quotas, want to get as many non-GP contacts as possible]. I'll ask you whether or not certain things happened and for most questions all I need you to tell me is a "Yes" or "No". Go to relevant SS Section

SS Section 1: General Practitioners/Doctor & Specialists

Firstly, thinking back to how urgently you needed to see the doctor for that last visit – did you need to see the doctor as soon as possible, the same day, that week, or sometime after that?

	Visit 1
1	As soon as possible
2	Same day
3	Same week
4	Later

Were you seen in that timeframe? Yes/No

Did you or someone else make an appointment for the visit? If No, skip to Q18

Was the time given suitable for you?

Were you given a choice of times?

Were you seen on time? If YES skip to Q22 else continue

IF NO to Q14: How long did you wait for your appointment? Record waiting time in minutes

IF No to Q14: Were you told how long you would have to wait?

IF No to Q14: Were you told why you would have to wait? Skip to Q22

If no appointment made in Q11: When you arrived at the clinic, were you given a time for your appointment?

Were you seen on time? IF NO to Q18: How long did you wait for your appointment? Record waiting time in minutes

IF NO to Q18: Were you told how long you would have to wait?

IF NO to Q18: Were you told why you would have to wait?

Was the receptionist/nurse polite to you?

Were you with anyone else for the appointment?

If YES: How many people were you with? Record number of people

And now the actual meeting with the doctor. And remember, I'm after straight (Yes or No) answers to most questions

Did the doctor ask you enough questions about what was wrong with you?

Did the doctor spend enough time listening to you?

Did the doctor spend sufficient time with you to find out what was wrong?

Did the doctor give you a simple, clear explanation of what was wrong with you?

Were you given enough privacy while being examined?

Did the doctor prescribe any treatment or drugs or tests or investigations?

If YES to Q30: Did the doctor give you a clear explanation of why the treatment/drugs/tests/investigations were necessary?

Did the doctor explain about side effects of the treatment?

Did you have confidence and trust in the doctor?

Were you and any other people with you treated with respect?

Did the doctor say your name properly?

Was this your first visit to this doctor?

If No How long have you been a patient of this doctor? Record number of years

Overall, thinking about the whole process of seeing the doctor for that visit, would you say that for you it was a Good, Average, or Poor experience?

1	Good
2	Average
3	Poor
99	Don't know/Refused

Was there anything at all about making the appointment or your visit to the doctor you didn't like, anything at all? What was it? Get verbatim comment

And was there anything at all about making the appointment or your visit to the doctor you did like, that did work well? Get verbatim comment

Would you go to this doctor again if you were sick?

Can you tell me the ethnicity of the doctor?

1	New Zealand European
2	Māori
3	Samoan
4	Cook Island
5	Tongan
6	Niuean

7	Chinese
8	Indian
9	Other
99	Don't know/Refused

If given a prescription in Q30: You said earlier the doctor gave you a prescription. Did you collect your prescription? If NO: Why not? Code all that apply

1	Yes, did get prescription
2	No – cost too much
3	No – will pick up medication if really need to/doctor wrote prescription just in case
4	No – don't like taking drugs
5	No – condition got better
6	No – thought medicine makes it worse/wouldn't work
7	No – lack of transport
8	No – can only pick up one month supply at a time
9	Other
99	Don't know/Refused

Did the doctor refer you to any other health services or people?

If YES: Who to? Code all that apply

1	Emergency referral Hospital
	Specialists (SS Section 1)
2	Orthopaedics
3	ENT
4	Cardiology
5	Gynaecology
6	Gastroenterology
7	Urology
8	Ophthalmology
9	Paediatrics
10	Psychiatry
11	Dermatology
12	Neurology
13	Rheumatology
14	Plastic surgery
15	Obstetric
	Other services (SS Section 5)
16	Physiotherapist
17	Radiology
18	Nursing
19	Counselling
20	Midwife
21	Dental
22	Audiology
99	Don't know

And have you been to see this person yet? If YES, but not coded in Q5, enter code in Q5 and ask Q6 and Q7 then return to Q47 If NO, skip to first appropriate SS Section

Is it OK if I ask you a few questions about that visit too?

Check quotas. Go to appropriate section

If no other health system visits to be asked about, skip to attitudes section at Q125

SS Section 2: Accident & Emergency

I'd like to ask some questions about the most recent A&E experience you had. And I'm after mainly Yes/No answers again here.

But first, I want to know how seriously hurt you or the person you went with was. Would you say the reason for your visit was Read out

1	Extremely serious
2	Very serious
3	Serious
4	Not that serious
5	Don't know

Have you been to this A&E before?

Was the receptionist polite to you?

Were you with anyone else for the appointment?

If YES: How many people were you with? Record number

Were you [if more than 1 person - and any other people with you] treated with respect by the receptionist?

Were you told how long you would have to wait before you would be seen by a doctor?

Were you told why you would have to wait?

How many minutes did you wait before you first spoke to a nurse or doctor?

1	less than 5 minutes
2	5-15 minutes
3	15-30 minutes
4	30-60 minutes
5	1-2 hours
6	longer than 2 hours
7	Don't know

How many minutes did you wait before you were examined by a nurse or doctor? [time periods from Q56]

Overall, from arriving to leaving again, how long were you at the A&E? [periods Q56]

Did you think the order in which you and other patients were seen was fair?

I'll now ask you about your meeting with the doctor or nurse that you saw.

Did the doctor / nurse introduce him or herself?

Did the doctor / nurse ask you enough questions about what was wrong with you?

Did the doctor / nurse spend sufficient time with you to find out what was wrong?

Did the doctor give you a simple, clear explanation of what was wrong with you?

Were you given enough privacy while being examined?

Did the doctor / nurse, nurse and any other staff talk in front of you as if you weren't there?

Were you prescribed any treatment or drugs or tests or investigations?
If YES Did the doctor / nurse give you a clear explanation of why the treatment or drugs were necessary?

Were you and any other people with you/family members with you treated with respect?

Was the reason you went to the A&E dealt with to your satisfaction?

Overall, thinking about the whole process of going to the A&E, would you say that for you it was a Good, Average, or Poor experience?

1	Good
2	Average
3	Poor
99	Don't know/Refused

Was there anything at all about this visit to the A&E you didn't like, anything at all? What was it? Get verbatim comment

And was there anything at all about this visit to the A&E you did like, that did work well? Get verbatim comment

If you had a choice, would you go to this A&E again if you were sick?
If no other health system visits to be asked about, skip to attitudes section at Q125

SS Section 3: Hospital
I'd like to ask some questions about the most recent hospital experience you have had. And I'm after mainly Yes/No answers again here.

Did the staff you dealt with always introduce themselves?

Did the doctor ask you enough questions about what was wrong with you?

Did the doctor spend sufficient time with you to find out what was wrong?

Did the doctor give you a simple, clear explanation of what was wrong with you?

Were you given enough privacy during your stay in hospital?

Did the doctor, nurse and any other medical staff talk in front of you as if you weren't there?

Did the doctor prescribe any treatment or drugs?

If YES Did the doctor give you a clear explanation of why the treatment or drugs were necessary?

Did you have confidence and trust in the people who were looking after you?

Did they communicate with you in an open, honest manner?

Did they respect your culture and beliefs? If NO, ask What happened? Record verbatim

Were you and any other people with you/family members with you treated with respect?

Did the doctor tell you what to expect with your illness after you left the hospital?

Overall, thinking about the whole process of going to the hospital, would you say that for you it was a Good, Average, or Poor experience?

1	Good
2	Average
3	Poor
99	Don't know/Refused

Was there anything at all about this visit to the hospital you didn't like, anything at all? What was it? Get verbatim comment

And was there anything at all about this visit to the hospital you did like, that did work well? Get verbatim comment

If you had a choice, would you go to this hospital again if you were sick?

If no other health system visits to be asked about, skip to attitudes section at Q125

SS Section 4: Funding Bodies (e.g., ACC)

I'd like to ask some questions about the last contact you had with ACC. And I'm after mainly Yes/No answers again here.

Was this your first visit to ACC over this particular issue?

If NO: How many other visits have you made for this particular issue? Record number

Were you with anyone else for the appointment?

If YES: How many people were you with? Record number

Were you given enough privacy while being interviewed?

Did the person listen to your views?

Did they recognise you might have been under emotional or financial stress?

Did you have confidence and trust in the person you met with?

Did they communicate with you in an open, honest manner?

Did they respect your culture and beliefs?

Were you and any other people with you treated with respect?

Did they give you all the information you needed about your claim or entitlements?

Did they give you an accurate timeframe as to when your issue would be resolved?

Did you get a simple, clear explanation of what would happen after your visit?

Overall, thinking about the last experience with ACC, would you say that for you it was a Good, Average, or Poor experience?

1	Good
2	Average
3	Poor
99	Don't know/Refused

Was there anything at all about this visit to ACC you didn't like, anything at all? What was it? Get verbatim comment

And was there anything at all about this visit to ACC you did like, that did work well? Get verbatim comment

If you had a choice, would use ACC again if you needed to?

If no other health system visits to be asked about, skip to attitudes section at Q125

SS Section 5: Other services – e.g., rays, physiotherapy, occupational therapist
I'd like to ask some questions about the last contact you had with [other services]. And I'm after mainly Yes/No answers again here.

Was this your first visit to [other service] over this particular issue?
If NO: How many other visits have you made for this particular issue? Record number

Were you with anyone else for the appointment?
If YES: How many people were you with? Record number

Were you given enough privacy while being treated?

Did the person listen to your views?

Did you have confidence and trust in the person you met with?

Did they communicate with you in an open, honest manner?

Did they respect your culture and beliefs?

Were you and any other people with you treated with respect?

Did you get a simple, clear explanation of why you needed the treatment?

Did you get a simple, clear explanation of what would happen after your visit?

Overall, thinking about the last experience with [insert other service], would you say that for you it was a Good, Average, or Poor experience?

1	Good
2	Average
3	Poor
99	Don't know/Refused

Was there anything at all about this visit to (other service) you didn't like, anything at all? What was it? Get verbatim comment

And was there anything at all about this visit to (other service) you did like, that did work well? Get verbatim comment

If you had a choice, would you use this (other service) again if you needed treatment?

Attitudes

I'd like to ask some questions about your attitudes towards your own health and the health system in NZ/Aotearoa. I'll read out some statements people have made, and I want you to tell me whether you agree or disagree with the statement. I'll get you to give me an answer using these words: Agree, Disagree, or Neither agree nor disagree

Rotate order

I usually wait until the last minute to go to see a doctor
I am in excellent health
I have to be quite sick before I'll go to a doctor
It is too expensive to go the doctor every time I feel sick
The cost of seeing a doctor is not good value for money
I expect my family/whānau to look after me when I'm sick rather than going to the doctor
I don't like taking drugs for my own illnesses

I have a good relationship with my GP
I can trust my GP
The GP I last went to treated me with respect
The GP treats me as well as any other patients he/she has
The doctor does not treat me like an adult
I don't like to ask the doctor questions
I am too shy to argue with the doctor if I think he/she is wrong
The doctor gave me all the information I needed to get ACC

Doctors don't really care about their Māori patients
Doctors don't really listen to their patients
I have some concerns about my health

I would prefer to see a doctor of my own ethnic group
I would rather see a Māori doctor than a Pākehā doctor
I would prefer to see a doctor of my own gender

I get well treated in the hospital
Hospital staff don't treat me with respect
Hospital should treat Māori differently to Pākehā
Hospital staff don't recognise Māori culture

I don't get treated with respect by provider
It is hard to get a straight answer from people in the health system
I get different answers from different people in provider
The people in provider make it difficult for me to get what I want
I would get looked after better if I was to deal with Māori people in provider

Don't rotate, leave these to the end
Overall I think the health system in NZ is very good
Overall I think the health system in NZ is good value for money

Demographic/Socioeconomic

OK, that is all apart from a few classification questions

Gender

1	Male
2	Female
99	Refused

Can you give me your year of birth

1	Record year
99	Refused

How many people are there living in your household, including yourself?

Which of the following best describes the make-up of your household?

1	Young single person living alone
2	Flatting with others
3	Young couple with no children at home
4	Family with mainly pre-school children
5	Family with mainly school age children
6	Family with mainly adult children living at home
7	Older couple with no children at home
8	Older single person living alone
99	Refused DON'T READ

Which of the following best describes your working status? Just stop me when I read out the right category

1	Employed full time (30 hours or more)
2	Employed part-time (under 30 hours)
3	Full-time student
4	Unemployed/not working
5	Homemaker
6	Retired
99	Refused DON'T READ

How would you best describe your ethnic origin?

1	New Zealand European
2	Māori
3	Samoan
4	Cook Island
5	Tongan
6	Niuean
7	Chinese
8	Indian
9	Other
99	Refused

Can you tell me your Iwi?

1	Don't know
9	Other
99	Refused

How well do you speak the Māori language?

1	Very well
2	Well
3	Fairly well
4	Not very well
5	A few words or phrases
6	Not at all
99	Refused

Do you have a Community Services Card (CSC) (also known as the Health Card, Exemption Card or Discount Card) or a High Use Health Card?

1	None
2	CSC
3	HUHC
4	Both
99	Don't know/Refused

What is the total gross household income from all sources and all income earners (before tax)…See if they just answer and code, otherwise start at $80,000 level work backwards - forwards

1	… More than $20,000 per year?
2	(IF MORE THAN $20,000) Is it more than $30,000 a year?
3	(IF MORE THAN $40,000) Is it more than $60,000 a year?
4	(IF MORE THAN $60,000) Is it more than $80,000 a year?
5	(IF MORE THAN $80,000) Is it more than $100,000 a year?
6	(IF MORE THAN $100,000) Is it more than $120,000 a year?
7	(IF MORE THAN $120,000) Is it more than $150,000 a year?
8	(IF MORE THAN $150,000) Is it more than $200,000 a year?
9	(IF MORE THAN $200,000) Is it more than $250,000 a year?
10	Refused DON'T READ

And in which, or near which, town, city or area are you based?

1	Whangarei
2	Auckland
3	Pukekohe
4	Hamilton/Cambridge/Te Awamutu
5	Tokoroa
6	Tauranga
7	Rotorua
8	Taupo
9	Whakatane
10	Other upper North Island
11	Gisborne
12	Napier/Hastings
13	New Plymouth
14	Hawera
15	Wanganui
16	Palmerston North
17	Feilding
18	Levin
19	Masterton
20	Kapiti
21	Wellington/ Upper Hutt/ Lower Hutt/ Porirua
22	Other lower North Island
23	Nelson
24	Blenheim
25	Greymouth
26	Christchurch
27	Ashburton
28	Timaru
29	Oamaru
30	Dunedin
31	Queenstown
32	Invercargill
33	Gore
34	Other South Island
35	Rangiora

Do you mind giving me your address please? I'd like your street address and suburb. (This is for classification purposes with NZ Statistics data)

Address: Record only street number and street (not flat number or A/B/C etc.). Get exact suburb

Appendix E. Survey respondents' nearest town, city or area

In which, or near which, town, city or area are you based?	N	%
Hamilton/Cambridge/Te Awamutu	103	15.8
Auckland	99	15.2
Whangarei	69	10.6
Wellington/Upper Hutt/Lower Hutt/Porirua	49	7.5
Gisborne	43	6.6
Whakatane	41	6.3
Napier/Hastings	33	5.1
Rotorua	27	4.1
Tokoroa	25	3.8
Christchurch	22	3.4
Other upper North Island	20	3.1
Tauranga	19	2.9
Other lower North Island	17	2.6
Taupo	12	1.8
Wanganui	11	1.7
New Plymouth	10	1.5
Palmerston North	9	1.4
Invercargill	8	1.2
Masterton	6	0.9
Nelson	6	0.9
Blenheim	5	0.8
Pukekohe	4	0.6
Levin	3	0.5
Dunedin	2	0.3
Other South Island	2	0.3
Hawera	1	0.2
Kapiti	1	0.2
Greymouth	1	0.2
Rangiora	1	0.2
Refused	2	0.3
Total	**651**	**100**

Appendix F. Detailed information about analysis of survey questionnaire

Compare Column Means (t-tests)

This option produces pair-wise tests of the equality of column means for tables in which at least one category variable exists in the columns and at least one scale variable exists in the rows. p values of the tests are adjusted using the Bonferroni method, alpha level of the tests conducted at 0.05.

Compare Column Proportions (z-tests)

This option produces pair-wise tests of the equality of column proportions for tables in which at least one category variable exists in both the columns and rows. p values of the tests are adjusted using the Bonferroni method, alpha level of the tests were conducted at 0.05.

Tests of Independence (Chi-square)

This option produces a chi-square test of independence for tables in which at least one category variable exists in both the rows and columns. Alpha level of the tests conducted at 0.05.

Two Step Cluster Analysis

The Two Step Cluster Analysis procedure is an exploratory tool designed to reveal natural groupings (or clusters) within a data set that would otherwise not be apparent. The algorithm employed by this procedure has several desirable features that differentiate it from traditional clustering techniques:

Handling of categorical and continuous variables: By assuming variables to be independent, a joint multinomial-normal distribution can be placed on categorical and continuous variables.

Automatic selection of number of clusters: By comparing the values of a model-choice criterion across different clustering solutions, the procedure can automatically determine the optimal number of clusters.

Scalability: By constructing a cluster features (CF) tree that summarises the records, the Two Step algorithm allows analysis of large data files.

Exploratory Data Analysis

Variance inflation factors were used to measure colinearity and values larger than 5 were considered prohibitive. Stepwise selection was primarily based on the AIC statistic however; likelihood ratio tests were also carried out on the AIC-based model and those covariates exhibiting p-values larger than 0.1 were also dropped from the model. The p-values resulting from these tests are shown in the table for each model.

Binary Models

Models for the binary outcomes were constructed using generalised linear models (GLMs) with a logic link (Equation 1) and Binomial errors (i); the GLMs were fitted using Maximum likelihood (ML).

Over Dispersion

Extra-binomial dispersion was not considered for the binary outcomes analysed here. While this can easily be permitted via estimation of the (dispersion) parameter Á, this parameter is constrained to be (0,1) for binary outcomes which could only result in more conservative models with, perhaps, more predictors. Further, estimation of under-dispersion for binary outcome models would mean variable selection could not proceed using likelihood ratio tests and/or the AIC statistic.

Three Outcome Models: Good/Average/Poor

Proportional odds models were used to fit the three outcome models.

Appendix G. Questionnaire reliability and validity

Service standards measures

In order to test construct validity, we investigated whether each service standard (nominal Yes/No response) was, as expected, significantly related to the overall visit evaluation question (3-point ordinal scale Good/Average/ Poor). This assumption was tested using Gamma in the SPSS Crosstabs procedure. Overall, results were significant, indicating strong construct validity of service standards.

For the GP section, all bar one of the service standards were significant at least to the $p < .05$ level.

For the Specialist section, all bar one of the service standards were significant at least to the $p < .05$ level. The one not at this level was significant at the $p < .10$ level.

For the A&E section, all bar one of the service standards were significant at least to the $p < .10$ level.

For the Hospital section, all service standards were significant at least to the $p < .05$ level.

For the Funding bodies section, all bar one service standards were significant at least to the $p < .05$ level

Tests of reliability – Attitudes Section

This section involved a series of questions about peoples' own health as well as their attitudes towards health providers. It was designed to capture attitudes along a series of dimensions as described below:

Current health status

I have some concerns about my health

I am in excellent health

Managing my health

I usually wait until the last minute to go to see a doctor

I have to be quite sick before I'll go to a doctor

I expect my family/whanau to look after me when I'm sick rather than going to the doctor

I don't like taking drugs for my own illnesses

Cost

It is too expensive to go the doctor every time I feel sick

The cost of seeing a doctor is not good value for money

Interpersonal relationship with GP/doctor

I have a good relationship with my GP

I can trust my GP

The GP treats me as well as any other patients he/she has

Sense of empowerment

The doctor does not treat me like an adult

I don't like to ask the doctor questions

I am too shy to argue with the doctor if I think he/she is wrong

Doctors don't really listen to their patients

Cultural fit

Doctors don't really care about their Māori patients

I would prefer to see a doctor of my own ethnic group

I would rather see a Māori doctor than a Pakeha doctor

I would prefer to see a doctor of my own gender

I would get looked after better if I was to deal with Māori people in provider

Hospital should treat Māori differently to Pakeha

Hospital staff don't recognise Māori culture

Dignity and respect

I get well treated in the hospital

Hospital staff don't treat me with respect

I don't get treated with respect by provider

The GP I last went to treated me with respect

Knowledge of the health system

It is hard to get a straight answer from people in the health system

I get different answers from different people in provider

The people in provider make it difficult for me to get what I want

The doctor gave me all the information I needed get ACC

Overall health system

Overall I think the health system in NZ is very good

Overall I think the health system in NZ is good value for money

Responses were gathered using a 3 point Agree/Disagree/Neither Agree nor Disagree scale. Coefficient alphas obtained for these scales ranged from .534 to .747 which are considered acceptable according to George and Mallery (2003) who provide the following rules of thumb: > 0.9: Excellent, 0.9 - 0.8: Good, 0.8 - 0.7: Acceptable, 0.7 - 0.6: Questionable, 0.6 - 0.5: Poor, and < 0.5 – Unacceptable.

Coefficient Alphas By Health Dimension

Current health status	(.669)
Managing my health	(.532)
Cost	(.556)
Interpersonal relationship with GP/doctor	(.609)
Sense of empowerment	(.534)
Cultural fit	(.745)
Dignity and respect	(.548)
Knowledge of the health system	(.575)
Overall health system	(.742)

The table below shows the results of an exploratory factor analysis used to group the questions according to the survey responses (Some items were reverse coded if the other items in the scale were worded oppositely e.g. I (don't) get well treated in the hospital). A total of 9 factors were extracted, explaining 55% of the total variance. The items generally loaded together as per the hypothesised list above. Cronbach's coefficient alpha is shown for each factor, and ranges from .281 to .757. As the table shows, the extracted dimensions fall into the questionable-acceptable range of coefficient alpha.

Dimensions, Individual Questions and Coefficient Alpha ()	Factor loadings
Cultural fit (.737)	
Q144 I would rather see a Māori doctor than a Pakeha doctor	.742
Q143 I would prefer to see a doctor of my own ethnic group	.717
Q154 I would get looked after better if I was to deal with Māori people in my health system provider	.712
Q148 Hospital should treat Māori differently to Pakeha	.619
Q149 Hospital staff don't recognise Māori culture	.476
Dignity and respect /Knowledge of the health system (.757)	
Q147 Hospital staff don't treat me with respect	.667
Q150 I don't get treated with respect by provider	.613
Q146 I (don't) get well treated in the hospital	.541
Q151 It is hard to get a straight answer from people in the health system	.532
Q153 The people in my health system provider make it difficult for me to get what I want	.522
Q140 Doctors don't really care about their Māori patients	.453
Q152 I get different answers from different people in my health system provider	.413
Interpersonal relationship with GP/doctor (.634)	
Q133 I can trust my GP	.748
Q132 I have a good relationship with my GP	.722
Q134 The GP I last went to treated me with respect	.595
Q141 Doctors (do) really listen to their patients	.441
Cost (.505)	
Q128 It is too expensive to go the doctor every time I feel sick	.616
Q129 The cost of seeing a doctor is not good value for money	.616
Q145 I would prefer to see a doctor of my own gender	.446
Q130 I expect my family/whanau to look after me when I'm sick rather than going to the doctor	.427
Overall health system (.742)	
Q155 Overall I think the health system in NZ is very good	.787

Dimensions, Individual Questions and Coefficient Alpha ()	Factor loadings
Q156 Overall I think the health system in NZ is good value for money	.785
Managing my health (.505)	
Q125 I usually wait until the last minute to go to see a doctor	.756
Q127 I have to be quite sick before Ill go to a doctor	.744
Q131 I don't like taking drugs for my own illnesses	.501
Sense of empowerment (.549)	
Q137 I don't like to ask the doctor questions	.784
Q138 I am too shy to argue with the doctor if I think he/she is wrong	.743
Q136 The doctor does not treat me like an adult	.434
Current health status (.669)	
Q126 I am in excellent health	.850
Q142 I (don't) have some concerns about my health	.847
Knowledge of the health system (.281)	
Q135 The GP treats me as well as any other patients he/she has	.587
Q139 The doctor gave me all the information I needed to get ACC	.524

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. A Rotation converged in 22 iterations.

Appendix H. Modelling analysis of overall satisfaction and revisit intention

Diagnostics for binary outcome Binomial GLMs are limited, however models with binary predictor variables (and factor variables with more than 2 levels) are reasonably simplistic. For these analyses, partial regression plots and the cooks distance measure was used to identify high influence points. To help assess the three outcome models (i.e. with response 1="Good", 2="Average" and 3="Poor") a table of observed versus predicted outcomes was constructed for each. For each model, the percentage of correctly classified outcomes, based on the model, is obtained and compared with the observed data.

Table 29. GPs: Intention to revisit

Question	Estimate	Lower CI	Upper CI	Odds	p-value
(Intercept)	-7.7446	-10.7671848	4.7219514	2309	5.12e-07
Q25	1.9628	0.1422415	3.7833625	7.119	0.0346
Q26	1.7127	-0.2329933	3.6583028	5.543	0.0845
Q33	2.6442	0.9591800	4.3293117	14.073	0.0021
Q36	-1.7034	-3.1384722	0.2682984	5.493	0.0200

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying 'no' to a GP revisit when answering "no" to each of the questions. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is evidence that a revisit appears less likely if the respondents answered "no" to:

Q25 Did the doctor ask you enough questions about what was wrong with you?

Q33 Did you have confidence and trust in the doctor?

This indicates that communication-related aspects are strongly associated with intention to revisit (and may therefore be a suitable indicator of experiences of care and good patient-provider rapport).

There is weak evidence that a revisit appears less likely if the respondents answered "no" to:

Q26 Did the doctor spend enough time listening to you?

A revisit appears more likely if the respondents answered "no" to:

Q36 Was this your first visit to this doctor?

In other words, people who have seen the same doctor before are more likely to visit him or her again.

Table 30. GPs: Overall visit rating

Question	Estimate	Lower CI	Upper CI	p-value
Q10	1.5750119	0.52599832	2.624025	3.366406e-03
Q26	2.4361128	1.06653723	3.805688	5.307880e-04
Q28	1.0549342	0.01472776	2.095141	4.686147e-02
Q32	0.7677958	0.04906621	1.486525	3.635701e-02
Q33	1.4426033	-0.09897715	2.984184	6.653759e-02
Q34	1.8395923	-0.22427072	3.903455	8.045990e-02
Q35	1.2709523	0.32354060	2.218364	8.709869e-02
1|2	13.2641	9.99076914	16.537398	2.569633e-14
2|3	17.1612	13.00103090	21.321290	9.643283e-15

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying 'no' to a GP revisit when answering 'no' to each of the questions. The final two parameters relate to the multinomial intercept parameter. The p-values for each term are based on likelihood ratio tests.

Under the specified model, there is evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to:

Q26 Did the doctor spend enough time listening to you?

Q10 Were you seen in that timeframe? (How urgently you needed to see the doctor)

Q28 Did the doctor give you a simple, clear explanation of what was wrong with you?

Q32 Did the doctor explain about side effects of the treatment?

There are large differences when respondents answered "no" to Q26 Did the doctor spend enough time listening to you (see Table 31 below). This re-emphasises the desire among patients to feel that their doctor listens to them and (in that manner) shows concern for them.

Table 31. GPs: Overall rating vs. time spent listening

	Good	Average	Poor
Yes	0.946701762	0.052156611	0.001141627
No	0.60848967	0.037861671	0.01289362

There is weak evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to:

Q33 Did you have confidence and trust in the doctor?

Q34 Were you and any other people with you treated with respect?

Q35 Did the doctor say your name properly?

The model appears to perform relatively well – correctly classifying 88.2% of the values. There is slight over-prediction of "Good" scores and under-prediction of "Average" scores.

Table 32. GPs: Observed vs. predicted ratings

Observed		Good	Average	Poor	Predicted Total
Predicted	Good	284	30	1	315
	Average	2	13	4	19
	Poor	0	3	3	6
Observed Total		**286**	**46**	**8**	**340**

Note. Model-based classifications. 300/340 (88.2%) were correctly classified.

Table 33. Specialists: Intention to revisit

Question	Estimate	Lower CI	Upper CI	Odds	p-value
(Intercept)	-8.1274	-11.0571483	-5.197574	3385	5.42e-08
Q26	1.6780	0.2818457	3.074140	5.354	0.01849
Q28	1.3845	-0.0708206	2.839844	3.993	0.06224
Q35	1.7911	0.4363195	3.145814	5.995	0.00956

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying 'no' to a specialist revisit when answering "no" to each of the questions. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is evidence that a revisit appears less likely if the respondents answered "no" to:

Q26 Did the doctor spend enough time listening to you?

Q35 Did the doctor say your name properly?

As with GP's, specialists were evaluated on how well patients felt they demonstrated respect (through proper pronunciation of names) and had good communication skills (including listening).

There is weak evidence that a revisit appears less likely if the respondents answered "no" to:

Q28 Did the doctor give you a simple, clear explanation of what was wrong with you?

Table 34. Specialists: Overall visit rating

Question	Estimate	Lower CI	Upper CI	p-value
Q10	1.33090	-0.32823632	2.990047	1.121308e-01
Q25	2.03519	0.51007571	3.560305	8.437935e-03
Q28	1.36181	-0.07561849	2.799257	6.080638e-02
Q34	2.67900	-0.26821479	5.626231	7.197321e-02
Q35	1.25795	-0.11380581	2.629720	6.950415e-02
1|2	10.6307	6.51007181	14.751398	5.123957e-07
2|3	13.0227	8.29175102	17.753655	9.081518e-08

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying 'no' to a specialist revisit when answering "no" to each of the questions. The final two parameters relate to the multinomial intercept parameter. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is strong evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to:

Q25 Did the doctor ask you enough questions about what was wrong with you?

There is weak evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to

Q10 Were you seen in that timeframe? (How urgently you needed to see the doctor)

Q28 Did the doctor give you a simple, clear explanation of what was wrong with you?

Q35 Did the doctor say your name properly?

The model appears to perform relatively well – correctly classifying 79% of the values. There is some over-prediction of 'Good' scores and under-prediction of "Average" scores.

Table 35. Specialists: Observed vs. predicted

Observed		Good	Average	Poor	Predicted Total
Predicted	Good	74	15	2	91
	Average	0	2	2	4
	Poor	1	1	3	5
Observed Total		75	18	7	100

Observed		Good	Average	Poor	Predicted Total
Predicted	**Good**	74	15	2	91
	Average	0	2	2	4
	Poor	1	1	3	5
Observed Total		**75**	**18**	**7**	**100**

Note. Model-based classifications. 79/100 (79%) were correctly classified.

Table 36. A&E: Intention to revisit

Question	Estimate	Lower CI	Upper CI	Odds	p-value
(Intercept)	-7.3878	-12.23388962	-2.5416343	1616	0.002809
Q49	1.4280	-0.10548663	2.9615832	4.171	0.067979
Q51	-2.0601	-4.47819909	0.3580158	7.847	0.094963
Q59	3.1635	1.49139273	4.8355738	23.653	0.000209
Q69	1.7849	-0.09568095	3.6654177	5.959	0.062851

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying 'no' to revisit the A&E when answering 'no' to each of the questions. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is very strong evidence a revisit appears less likely if the respondents answered "no" to:

Q59 Did you think the order in which you and other patients were seen was fair?

Perceptions of poor treatment, as indicated by unfairness in assigning priority, influence Māori patients not to return to the A&E.

There is weak evidence a revisit appears less likely if the respondents answered "no" to:

Q49 Have you been to this A&E before?

Q69 Was the reason you went to the A&E dealt with to your satisfaction?

There is weak evidence a revisit appears more likely if the respondents answered "no" to:

Q51 Were you with anyone else for the appointment?

Table 37. A&E: Overall visit rating

Question	Estimate	Lower CI	Upper CI	p-value
as.factor(Q57)2	-0.2662626	-2.0894248	1.556899	7.723745e-01
as.factor(Q57)3	0.8995558	-0.6911336	2.490245	2.642171e-01
as.factor(Q57)4	1.1108281	-0.6063278	2.827984	2.020270e-01
as.factor(Q57)5	4.3442132	0.8932379	7.795189	1.419744e-02
as.factor(Q57)6	0.2654433	-1.8838241	2.414711	8.067345e-01
Q59	2.8061657	1.0120353	4.600296	2.526328e-03
Q60	2.2936197	0.7219652	3.865274	4.698521e-03
Q62	2.4481540	0.6007472	4.295561	9.968824e-03
Q64	2.9883913	0.2619201	5.714863	3.205706e-02
Q69	1.8754365	0.2601985	3.490674	2.336656e-02
1|2	14.6873	9.5465310	19.828066	1.662812e-07
2|3	17.7789	11.7771088	23.780599	6.720310e-08

Note. Q57 is statistically significant within the model. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to revisit the A&E when answering "no" to each of the questions. The final two parameters relate to the multinomial intercept parameter.

The p-values for each term are based on likelihood ratio tests. Note. the effect of Q57 on the response (Q73) are compared to a baseline level = 1.

With the specified model, there is evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to:

Q59 Did you think the order in which you and other patients were seen was fair?

Q60 Did the doctor / nurse introduce him or herself?

Q62 Did the doctor / nurse spend sufficient time with you to find out what was wrong?

Q64 Were you given enough privacy while being examined?

Q69 Was the reason you went to the A&E dealt with to your satisfaction?

The model appears to perform relatively well – correctly classifying 78.4% of the values.

Table 38. A&E: Observed vs. predicted

Observed		Good	Average	Poor	Predicted Total
Predicted	**Good**	62	10	0	72
	Average	4	9	5	18
	Poor	0	3	9	12
Observed Total		**66**	**22**	**14**	**102**

Note. Model-based classifications. 80/102 (78.4%) were correctly classified.

Table 39. Hospital Intention to revisit

Question	Estimate	Lower CI	Upper CI	Odds	p-value
(Intercept)	-3.5492	-6.4491441	-0.6492684	34.786	0.01645
Q74	1.5971	0.5618886	2.6322193	4.938	0.00250
Q78	1.7378	0.5531925	2.9225052	5.685	0.00404
Q79	-1.6328	-2.7206695	-0.5449450	5.118	0.00326

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to a hospital revisit when answering "no" to each of the questions. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is strong evidence that a revisit appears less likely if the respondents answered "no" to:

Q74 Did the staff you dealt with always introduce themselves?

Q78 Were you given enough privacy during your stay in hospital?

There is strong evidence that a revisit appears more likely if the respondents answered "no" to:

Q79 Did the doctor, nurse and any other medical staff talk in front of you as if you weren't there?

It is important to Māori patients that they are treated with respect during their hospital stay, as indicated by the courtesy of direct conversations, proper introductions and appropriate privacy.

Table 40. Hospital: Overall visit rating

Question	Estimate	Lower CI	Upper CI	p-value
Q75	1.541884	0.1484806	2.9352876	3.031333e-02
Q78	2.611963	1.2865513	3.9373738	1.450048e-04
Q79	1.091863	2.0010354	-0.1826910	1.888789e-02
Q85	2.632466	1.2482066	4.0167264	2.407012e-04
Q86	1.387828	0.4433635	2.3322926	4.226361e-03
1|2	7.9719	4.5556703	11.3880697	8.165772e-06
2|3	11.8041	7.6812835	15.9268675	6.877881e-08

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to a hospital revisit when answering "no" to each of the questions. The final two parameters relate to the multinomial intercept parameter. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to:

Q75 Did the doctor ask you enough questions about what was wrong with you?

Q78 Were you given enough privacy during your stay in hospital?

Q79 Did the doctor, nurse and any other medical staff talk in front of you as if you weren't there?

Q85 Were you and any other people with you/family members with you treated with respect?

Q86 Did the doctor tell you what to expect with your illness after you left the hospital?

The model appeared to perform relatively well – correctly classifying 77.6% of the values. There is slight over-prediction of "Good" scores and under-prediction of "Average" scores.

Table 41. Hospital: Observed vs. predicted

Observed		Good	Average	Poor	Predicted Total
Predicted	**Good**	105	22	0	127
	Average	7	15	5	27
	Poor	0	4	12	16
Observed Total		112	41	17	170

Note. Model-based classifications. 132/170 (77.6%) were correctly classified.

Table 42. Funding Bodies: Intention to revisit

Question	Estimate	Lower CI	Upper CI	Odds	p-value
(Intercept)	-7.455	-11.701289	-3.208151	1728	0.00058
Q96	3.871	1.383436	6.358966	48	0.00229

Note. The logistic and ordered multinomial models used to examine the data for funding bodies were based on a relatively small sample size (n =44). The parameters estimates are likely to be unstable, and it is likely that the model is overly parsimonious.

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to a revisit when answering "no" to each of the questions. The p-values for each term are based on likelihood ratio tests.]

With the specified model, there is strong evidence that a revisit appears less likely if the respondents answered "no" to:

Q96 Did the person listen to your views?

Table 43. Funding Bodies: Overall visit rating

Question	Estimate	Lower CI	Upper CI	p-value
Q91	-2.127280	-3.88059852	-0.3739605	0.018692412
Q102	2.392787	0.64097655	4.1445972	0.008698881
Q104	1.736705	0.13994786	3.3334628	0.033800739
1|2	2.9068	-0.02764062	5.8411662	0.052091172
2|3	4.8336	1.52239257	8.1447261	0.005312575

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to a revisit when answering "no" to each of the questions. The final two parameters relate to the multinomial intercept parameter. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to

Q102 Did they give you all the information you needed about your claim or entitlements?

Q104 Did you get a simple, clear explanation of what would happen after your visit?

If consumers felt they weren't listened to (and respected) by funding body staff or if the visit was unhelpful (no information about what was needed or what to expect), they reported no intention of returning to the funding body; bad experiences are understandably off-putting.

A good rating (rather than a poor rating) is more likely if the respondents answered "no" to

Q91 Was this your first visit to ACC over this particular issue?

The model appeared to perform relatively well – correctly classifying 81.8% of the values.

Table 44. Funding Bodies: Observed vs. predicted

Observed		Good	Average	Poor	Predicted Total
Predicted	Good	26	5	0	31
	Average	0	4	2	6
	Poor	0	1	6	7
Observed Total		26	10	8	44

Note. Model-based classifications. 36/44 (81.8%) were correctly classified.

Table 45. Other Services: Intention to revisit

Question	Estimate	Lower CI	Upper CI	Odds	p-value
(Intercept)	-9.219	-12.337943	-6.09986	1008	6.91e-09
Q115	5.505	3.098388	7.912275	246	7.36e-06

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to revisit other services when answering "no" to each of the questions. The p-values for each term are based on likelihood ratio tests.

With the specified model there is strong evidence that a revisit appears less likely if the respondents answered "no" to:

Q115 Did you have confidence and trust in the person you met with?

As was seen with the other providers, establishing a good rapport, with confidence and trust, was important to Māori consumers of Other Services.

Table 46. Other Services: Overall visit rating

Question	Estimate	Lower CI	Upper CI	p-value
Q115	4.108094	1.0998288	7.116359	7.884604e-03
Q116	3.355021	-0.2210426	6.931084	6.566398e-02
Q119	2.843917	1.4083200	4.279514	1.505445e-04
1|2	13.1474	8.0184897	18.276345	1.540588e-06
2|3	16.9524	9.6828714	24.221920	1.036210e-05

Note. Parameter estimates and their upper and lower 95% confidence intervals (on the logit scale). The (multiplicative) effects of saying "no" to revisit other services when answering "no" to each of the questions. The final two parameters relate to the multinomial intercept parameter. The p-values for each term are based on likelihood ratio tests.

With the specified model, there is evidence that a good rating (rather than a poor rating) is less likely if the respondents answered "no" to

Q115 Did you have confidence and trust in the person you met with?

Q119 Did you get a simple, clear explanation of why you needed the treatment?

The model appeared to perform relatively well – correctly classifying 85.5% of the values. There is slight under-prediction of "Average" scores.

Table 47. Other Services: Observed vs. predicted

Observed		Good	Average	Poor	Predicted Total
Predicted	Good	99	11	0	110
	Average	2	1	1	4
	Poor	3	0	0	3
Observed Total		104	12	1	117

Note. Model-based classifications. 100/117 (85.5%) were correctly classified.

References

George, D., & Mallery, P. (2003). SPSS for Windows step by step: A simple guide and reference. 11.0 update (4th ed.). Boston: Allyn & Bacon.

Appendix I. Demographics for Group 1 and Group 2

Demographically, Group 2 is younger than Group 1 (average age: 39 vs. 47 (t-test results: t=6.284, $p<0.001$) while Group 1 members are more likely to be an older couple with no children at home. There are no differences with respect to gender or working status.

Table 48. Attitude group demographics

		Attitude clusters	
		Group 1	Group 2
Household description	Young single person living alone	1%	2%
	Flatting with others	3%	6%
	Young couple with no children at home	2%	3%
	Family with mainly pre-school children	12%	18%
	Family with mainly school age children	42%	40%
	Family with mainly adult children living at home	16%	20%
	Older couple with no children at home	16%	4%
	Older single person living alone	8%	7%
	Refused	1%	2%
Total		**100%**	**100%**
Working status	Employed full time (30 hours or more)	48%	44%
	Employed part-time (under 30 hours)	13%	21%
	Full-time student	4%	5%
	Unemployed/not working	8%	12%
	Homemaker	13%	15%
	Retired	14%	4%
	Refused	0%	
Total		**100%**	**100%**

There are no significant differences between the groups with respect to familiarity with Te Reo Māori.

Table 49. Attitude group Māori language ability

		Attitude clusters Group 1	 Group 2
How well do you speak the Māori language?	Very well	16%	11%
	Well	6%	8%
	Fairly well	16%	20%
	Not very well	26%	21%
	A few words or phrases	24%	23%
	Not at all	12%	17%
Total		100%	100%

There are no differences between the groups with respect to income or health card use.

Table 50. Attitude group demographics

		Attitude clusters Group 1	 Group 2
Do you have a Community Services Card (CSC) or High Use Health Card (HUHC)	None	54%	46%
	CSC only	40%	49%
	HUHC only	2%	2%
	Both	4%	2%
Total		100%	100%
Combined household income before tax	Under $21,000	19%	21%
	$21,000 - $33, 000	17%	16%
	$33,000 - $52,000	22%	19%
	$52,000 - $77,000	17%	20%
	$77,000 and over	17%	15%
	Don't Know/Refused	8%	8%
Total		100%	100%

Figure 7. Health card comparison

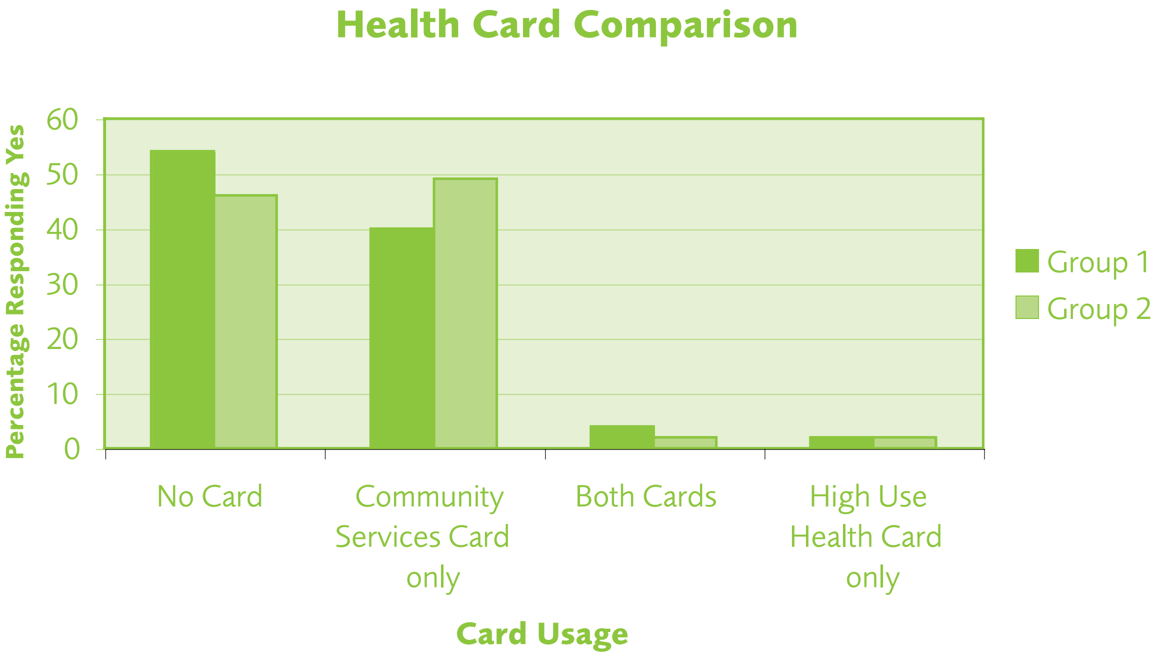

Figure 8. Income comparison

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