Improving Māori Access to Health Care: Research report

Prepared for the Ministry of Health, 2014

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1. Leadership
2. Knowledge
3. Commitment
Improving Māori Access to Health Services: Research report

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Executive Summary

According to the World Health Organization, ‘in both poor and industrialised countries in which they live, the health status of indigenous peoples is invariably lower than that of the overall population’ (World Health Organization 2011). In Aotearoa New Zealand the unequal health outcomes experienced by Māori have been documented in a number of academic and government documents (Ministry of Health 2010; Robson, B & Harris, R (Eds.) 2007). The focus of the present research was the contribution that health services can make to the reduction of Māori health inequalities through ensuring equity of access to health care (Ministry of Health 2002: 21). The aim of this project was to answer the question, How can access to health services be improved for Māori? The project focused on cardiovascular disease, diabetes and cancer, and had three objectives.

- Increase the health sector’s understanding of the issues affecting Māori access to health services
- Provide an evidence base for action to improve access to health services for Māori
- Provide solutions to improve access to health services for Māori

Method

The research examined the recent (post-2006) literature on interventions to improve access to cardiovascular, diabetes, and cancer health care for Māori, Indigenous peoples, and ethnic minority (largely Hispanic American and African American) groups. These interventions were profiled across the continuum of care for each condition.

Forty-seven key informants working in cancer, CVD, diabetes, Māori health, funding and planning, Ministry of Health, and health research were interviewed. Key informants were asked about their knowledge of evidence- and practice-based interventions to improve access to health for the general population, as well as improving access specifically for Māori.

Findings

This report summarises the findings from the literature reviews and the key informant interviews and presents them for: Māori patients, health practitioners, health organisations, and the health system.

Patients

Intervention research and health practitioners dispelled the notion that Māori do not care about their health and wellness. Key informants described the cost of health services, lack of transportation, and health service characteristics as barriers to Māori access to health care. Interventions that address financial and logistical barriers have been found to be effective at increasing access to healthcare.

Health literacy was described by key informants as being about health providers’ ability to provide culturally responsive information and services to Māori patients and their whānau. Tailoring information in response to patient-specific health care barriers supports health literacy. Home-
based tools, and holistic interventions for patients and their whānau can also support patients’ self-management of their health condition.

**Health Practitioners**

Establishing relationships is the foundation of working with Māori in a culturally responsive way. This facilitates the building of rapport, good communication and Māori-centred clinical practice.

Community health workers can help bridge the cultural ‘gaps’ between non-Māori health practitioners and Māori patients and communities. Good relationships between community health workers and Māori patients also provide a platform for education initiatives with patients about self-management of their health.

The cultural competency of health practitioners facilitates rapport and communication with Māori patients. Education can improve the communication skills of health practitioners, as well as their ability to deliver culturally responsive care. Decision-making tools and guidelines can also support health practitioners’ provision of equitable health care.

**Health Organisations**

Within health organisations a commitment by leadership to the reduction of Māori health care disparities is an important driver of organisational responsiveness. This is informed by the organisation’s analysis and use of their local data to plan and monitor services.

Health organisations can engage with Māori patients and whānau by investing in people who can reach Māori, such as community health workers, and in services that are culturally responsive. Navigators can also connect Māori with health care and other services, while organisations can work to make their own services and clinical pathways clearer so they are easier to navigate.

Participation of health practitioners in teams where some team members are culturally competent can facilitate the delivery of culturally competent health care by all team members. When this happens organisations need to ensure that team members are respectful of each others’ knowledge and expertise.

Important roles are played by nurses working in the community and in health care organisations. Patient satisfaction increases and referrals to general practitioners decrease when nurse practitioners are able to take a lead in patient care.

The cultural tailoring of health organisation policies and health care models enhances access. Organisational changes that improve adherence to guidelines, implement case management, ease time pressures, and support cultural sensitivity training also improve access.

Health organisations benefit from having networks with other health organisations, and other agencies and organisations whose services impact upon Māori health and access to health care.

Regional networks can engage with local communities to provide comprehensive approaches to health care, including the reduction of cost and logistic barriers.
Health System

The articulation of a health system commitment to the elimination of disparities is foundational to improving Māori access to health care. The establishment of universal health targets also supports a focus on health care access for Māori.

Regulatory reform and policy drivers can shift health organisation practice, including the collection of accurate ethnicity data, the development of local level plans and initiatives, and engagement with Māori leaders and communities.

Changes in health workforce roles and health funding formulas may improve access, especially changes that support the roles of nurses.

Public campaigns can be successful at raising awareness, increasing knowledge, and promoting family and community discussions and decision-making and accessing health care.

Conclusion

Māori access to health care is about the entry of Māori into health care, as well as their journey through health care. Overcoming financial (e.g., cost) and logistical (e.g., transportation) barriers to access is important, as is facilitating Māori access through intermediaries such as community health workers, navigators and health practitioners who have the time to build relationships of trust with Māori patients and their whānau. Changes in health organisation policies, structures and practices can further improve Māori access when the changes reflect an understanding of Māori health needs and aspirations. The health system can support Māori health care access by articulating expectations (through strategy, policy and funding formulas) that health organisations will engage with Māori in the development, implementation, and monitoring of local initiatives to improve Māori access to health care.
1 Introduction

Māori experience high rates of cancer, cardiovascular disease and diabetes (Ministry of Health 2010; Robson, B & Harris, R (Eds.) 2007). Not only are Māori more likely to be diagnosed with these conditions they are likely to have worse health outcomes than non-Māori, even when the stage at which the disease is diagnosed and the socio-economic status of Māori patients is taken into account. In 2011 the Ministry of Health’s Briefing to the Incoming Minister of Health acknowledged the ‘substantial differences in health outcomes’ for Māori, as well as the increasing burden of long-term health conditions such as cancer and cardiovascular disease on New Zealand’s ageing population (Ministry of Health 2011: vi). Interventions to decrease this burden need to reduce Māori exposure to the risk factors for these diseases, and improve access to health care for those Māori who are already living with one or more of these conditions. This research focused on improving Māori access to health care for diabetes, cardiovascular disease and cancer.

The aim of this project was to answer the question of

How can access to health services be improved for Māori?

The objectives of the project were to:

- Increase the health sector’s understanding of the issues affecting Māori access to health services
- Provide an evidence base for action to improve access to health services for Māori
- Provide solutions to improve access to health services for Māori

This report provides an overview of the findings from the literature reviews and key informant interviews that were conducted in the present research (Cram, 2014a,b,c,d). Three reviews of the literature were carried out. These reviews examined interventions to improve access to health care for each of the conditions – cancer, cardiovascular disease, and diabetes – for Māori and other Indigenous and ethnic minority patients (in particular Hispanic and African American patients). The reviews drew on research conducted in the United States, Australia, New Zealand and, to a lesser extent, Canada and the Pacific.

Key informants working in community, primary, secondary and tertiary health care in New Zealand were asked to speak about improving access to health care for patients, and in particular Māori patients if more population-based initiatives to improve access did not work for Māori.

This report begins with a general introduction to understanding unequal health outcomes, and the role access to health care plays in these outcomes. This is followed by a brief overview of the health disparities for Māori for each condition, and an introduction to health system ecologies and capacity. The method for the present research is then described, followed by an integrated overview of the findings from the literature reviews and key informant interviews.¹

¹ The literature reviews and the report on the key informant interviews are available as separate background papers (Cram 2014b,c,d,e).
2 Understanding Unequal Health Outcomes

Improving access to effective health services was one the four levels of intervention proposed by Benzeval, Judge and Whitehead (1995) in their framework for tackling socioeconomic inequalities in health. This framework also stressed the importance of changing behavioural risk factors by reducing the barriers to people adopting healthy lifestyles, along with improving the physical environment and addressing social and economic factors. In 2002 the Ministry of Health published ‘Reducing Inequalities in Health’. This included an intervention framework to improve health and reduce inequalities that calls for comprehensive strategies across four levels (see Diagram 1):

**Level 1** encompasses the structural or root causes of inequalities and most often requires policy intervention. The role of the health system at this level is to advocate for such policies, including health policy, and to work collaboratively with other agencies that also have a role to play in the reduction of health inequalities.

**Level 2** encompasses the factors that mediate the effect of socio-economic position on health. These include: material circumstances, psychosocial factors, and behaviours. The health system’s response at this level is about health promotion and education, and health protection. There is also a role for health in collaborating with other agencies that are taking actions to intervene along these intermediary pathways.

**Level 3** focuses on health and disability services and their contribution to the reduction of inequalities through ensuring ‘equity of access to care [and] removing barriers…that inhibit effective use of services’ (Ministry of Health, 2002b, p.21)

**Level 4** is concerned with interventions that prevent the downward socioeconomic mobility of those who are ill or disabled (for example, ACC, support services).

In their 2008 report, ‘Closing the Gap in a Generation’, the WHO Commission on the Social Determinants of Health placed the health-care system within a similar broad context as a way of understanding the multiple aspects of people’s lives that affect their health and wellness (CSDH 2008). Being treated equitably and fairly in the many aspects of this broader context is part of people’s right to health; that is, the ‘…entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health’ (Hunt and Bueno De Mesquita 2007: 7).

The provision of health and disability services, and equitable access to these services, is therefore an important component of ensuring the health and wellbeing of a population. The focus of the present research was on this component, and the next section explores what we mean by ‘access’ to health care.
2.1 Access to Health Services

The focus of the present research is the contribution that health services can make to the reduction of Māori health inequalities through ensuring equity of access to health care (Ministry of Health 2002: 21). Improving access to health care is an important contributor to the elimination of racial, ethnic and social class disparities in health (Allin et al 2007). Access has been described as ‘the degree to which people are able to obtain appropriate care from the health care system in a timely manner’ (Escarce 2007: 3). In Gulliford et al's (2002) proposal access is also about the potential to use a service ('having access') and, for the underserved, it holds the promise of a range of accessible services that they might choose among. ‘Access’ then exists even if an individual chooses not to use a service that they might potentially use (Gulliford 2009).

The New Zealand Human Rights Commission uses the ‘interrelated and essential elements’ outlined in the United Nations International Covenant on Economic, Social and Cultural Rights, General Comment 14 (United Nations 2000) to assess the promotion and protection of the right to health. These are:

**Availability** envisages a sufficient number of functioning public health services, facilities and programmes being available.

**Accessibility** means that the services and facilities are available to everyone without discrimination. They also have to be physically accessible and affordable, and people should be aware of their existence.

**Acceptability** means that the services must respect medical ethics, be culturally appropriate and respect confidentiality.

**Quality** means that health services must be scientifically and medically appropriate, and of good quality (Human Rights Commission 2004).

While ‘accessibility’ is defined here as one component of the right to health it is proposed that access to health services encompasses all four of the components of the right to health.

2.2 Māori Access to Cancer, Cardiovascular Disease and Diabetes Health Care

This research focused on improving Māori access to cancer, cardiovascular disease and diabetes health care. The disparities experienced by Māori for each of these conditions is briefly explored next.

2.2.1 Cancer

Māori adults have a higher rate of diagnosis of cancer than non-Māori (19% higher than the non-Māori rate), and their risk of dying from cancer is substantially higher still (78% higher risk of death from cancer compared to non-Māori) (Robson et al 2010). Robson et al. (2010: 47) concluded that ‘the higher exposure of Māori to neighbourhood deprivation contributes to the disparities between Māori and non-Māori in cancer incidence, mortality, stage at diagnosis, and survival’. Differential access to healthcare has also been found to contribute to ethnic disparities in cancer survival (McKenzie et al 2011; Stevens et al 2008). Hill and colleagues (2013) describe cancer care pathways as complex so that Maori are not necessarily disadvantaged at one step...
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but rather suffer from accumulated disadvantage as they journey through the health care system and experience waits, delays and differential treatments.

Research has highlighted the barriers to Māori accessing cancer-screening programmes that would pick up cancer at early stages of disease progression. These barriers include people's lack of awareness about services, embarrassment, worry about the procedure, and fear about the results (Beutow et al 2007; HSC 2012). Organisational barriers include cost, incomplete patient registration, issues with booking systems, and discouraging health professionals (Pitama et al 2012; Thomson et al 2009).

The provision of a culturally responsive environment has previously been identified by researchers as important for improving Māori access to cancer screening and treatment services. This includes good relationships between health care providers and Māori, the observance of cultural norms and holistic service provision, the availability of educational material that facilitates Māori health literacy, and having whānau friendly services (Pitama et al 2012; Walker et al 2008).

The health targets for 2013 to 2016 include 'shorter waits for cancer treatment', with the target being 'All patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy' (Ministry of Health 2013: 12). The Ministry of Health Statement of Intent also prioritises cancer screening (p.7), and generally better access to cancer services.

2.2.2 Cardiovascular Disease

The general term cardiovascular disease is used to describe diseases of the heart and blood vessels, including ischaemic heart disease, stroke and heart failure (Curtis et al 2007). Overall, Māori are more than twice as likely as non-Māori to be hospitalised, and two-and-a-half times as likely to die from cardiovascular disease (Ministry of Health 2010). A large proportion of these deaths are preventable (Ministry of Health 2007). In 2004 Bramley and colleagues (2004: 1) described the progress made in the reduction of these disparities as 'alarmingly slow' considering that they had been documented for many years. In 2012 Ellis, Pryce, MacLeod and Gamble (2012) also concluded that comprehensive strategies were still needed to eliminate cardiovascular disease health disparities.

As with the cancer care pathway above, the ways in which Māori are disadvantaged in their access to cardiovascular disease health care are likely to be multiple, and occur across the continuum of health care. Hotu and colleagues (2010) describe barriers for patients and whānau related to the costs associated with accessing care (e.g., transportation, medication, and lost employment time), as well as those related to low health literacy. Physician-related barriers include limited time and cultural misunderstandings (Hotu et al 2010; Brown et al 2010). A key barrier was addressed when the age to start cardiovascular disease risk assessments was set at 35 years for Māori, Pacific and Indo-Asian peoples (compared to 45 years for Pākehā New Zealanders).

2.2.3 Diabetes

Diabetes was one of the top five causes of death for Māori men and women in 2004-2006 whereas it did not feature in the top five causes of death for non-Māori men and women (Ministry of Health 2010). In addition, the prevalence of both type 1 and type 2 diabetes is increasing in children (Ministry of Health 2007). Diabetes can be prevented (Harwood and Tipene-Leach 2007). Preventative programmes such as those related to diet and physical exercise need to attend to the cultural beliefs, values and practices of intended recipients (Hindelang 2006). Similarly,
Spencer and colleagues (2006, p. 88) note that diabetes programmes for those with diabetes need to understand the ‘personal, family and community context of living with diabetes’ if they aim to contribute to the reduction of disparities.

Of Māori with diabetes the majority have type 2 diabetes, with this being diagnosed through a blood test that is offered to Māori and Pacific people from the age of 35 years (Harwood and Tipene-Leach 2007). Māori are diagnosed with diabetes at a younger average age than non-Māori, and Māori are admitted to hospital with more severe diabetes compared to non-Māori (Harwood and Tipene-Leach 2007).

Diabetes increases people’s risk of heart attack, stroke, and gangrene (Harwood and Tipene-Leach 2007). Increasing access to diabetes services will improve rates of cardiovascular disease. Likewise, improving access to cardiovascular disease risk assessment will improve screening and diagnosis of diabetes (Ministry of Health 2007). Herman and Zimmet (2012, p. 944) describe the processes that must be put in place to successfully address the diabetes epidemic; namely that ‘we must measure it, understand its risk factors, develop valid and efficient approaches to screening and diagnosis, and develop and implement culturally specific interventions for prevention and treatment’.

The Ministry’s Statement of Intent includes ‘More heart and diabetes checks’ as one of six health targets for 2013-16 (Ministry of Health 2013: 12). The Statement of Intent also reiterates the Ministry’s commitment to working collaboratively across government, and with communities (via the 2011 Kia Tūtahi/Standing Together Relationship Accord, and the Office for the Community and Voluntary Sector) (Ministry of Health 2013).

2.3 Health System Ecologies and Capacity

Wagner’s (1998) Chronic Care Model sets out an agenda for comprehensive health system change to better meet the needs of patients and their families living with chronic illness. The Chronic Care Model stresses the importance of clinical system reconfiguration so that patients can access the health care they require. Reconfiguration can be thought of as increasing the health system’s capacity to provide accessible health care services. This capacity can be conceptualised at three levels: the health system, health organisation, and health resources, with individual patients, their family and the community sitting outside as those needing to access health care (LaFond et al 2002). This is illustrated in Diagram 2 below from Jansen, Bacal and Crengle’s (2008) report on Māori experiences of the health service. (Also see Appendix A for an overview of the New Zealand health system and health organisations.)

Capacity building to promote Māori access should therefore enhance system level policy, organisational performance, and health personnel capability. Improved access can also be contributed to by facilitating individual and community capacity to engage with health services (e.g., through initiatives to facilitate health literacy).

This approach is aligned with the 2003 Unequal Treatment report by the Institute of Medicine in the United States, which described the sources of health disparities on three levels: system, clinical encounter, and patient. It is also compatible with ecological approaches to understanding the burden of disease on communities. Castro, Shaibi, and Boehm-Smith (2009), for example, take an ecodevelopmental approach to understanding diabetes prevention. Interventions within
Diagram 2. 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.

Source. Jansen et al. (2008, p. 18)

This approach range from the microlevel (e.g., individual and family-based prevention programmes) to the macrolevel (e.g., policy, social norms). Bhattacharya (2012) adds to this the influence of sociocultural determinants on peoples’ health and health behaviours. Critical factors include a population’s history of oppression, discrimination and marginalisation, and their culturally informed beliefs about health and illness. For example, Indigenous concepts of health are holistic, and encompass spiritual and environmental connectedness; they ‘…constitute more than physical and mental well-being, or being free from diseases. They incorporate a state of balance between mind, body and spirit, and of being in harmony with nature’ (ILO 2003: 58).

Māori models of health bring a cultural lens to understanding Māori access to health services. He Pae Mahutonga, for example, aligns with the Intervention Framework and brings the added value of looking at Māori gaining access to health and disability services ‘as Māori’. This acknowledges that Māori wellness is interwoven with cultural integrity, and that many of the barriers to access are about health organisations and the health system rather than about patients. Māori models of health and the current Whānau Ora initiative both speak to the need to reduce Māori health and disability disparities and facilitate Māori aspirations for whānau ora (Māori family wellness) (Ministry of Health 2003; Taskforce on Whānau-Centred Initiatives 2010).

In summary, an ecological approach asks whether health care is available, accessible, acceptable, and of quality. A capacity perspective asks what capacity the health system has to deliver accessible health care at system, organisation, and personnel levels. Like the Chronic Care Model, frameworks for improving health care access tend toward the view that health is a complex, adaptive system. These frameworks seek more integrated services by acknowledging the roles that multiple stakeholders play in informing accessibility. For Māori these stakeholders also include individuals, whānau (families), hapū (subtribe), Iwi (tribe) and communities.

This report looked within the health system for evidence-informed actions to improve Māori access to health care services. A Māori cultural lens provided by Māori models of health and the articulation of these within strategic documents reinforced the need for the analysis of the literature-based evidence and the questioning of key informants to be grounded in a Māori kaupapa (agenda) of Māori gaining access to health services as Māori, and as whānau.
3 Improving Māori Access to Healthcare

This project looked along the continuum of care for initiatives that could improve Māori access to health services. The project canvassed interventions to improve access to cancer, cardiovascular and diabetes services for Māori, Indigenous and ethnic minority groups. Māori and non-Māori key informants working in or researching the health care system were also interviewed for their expert advice about what works to improve Māori access to health care, especially for cancer, cardiovascular disease and diabetes. Cancer and circulatory system diseases were chosen as they are prominent causes of Māori illness, hospitalisation, and deaths. Māori are also more likely to get circulatory system diseases at an earlier age than non-Māori (Ministry of Health 2010).

3.1 Method

3.1.1 Literature Search and Review

Multiple electronic databases were searched for evaluation studies of interventions designed to improve access to care for those suffering from cancer, diabetes or cardiovascular disease, published from 2006 to 2012. Indigenous peoples or ethnic minority groups (Hispanic, African American) had to be the main, or a substantive, focus of the research. This initial search was complemented by hand searches of the last two years of key journals for relevant content, and examination and follow-up of article reference lists and key authors' publication lists. Literature reviews and synthesis papers as well as individual intervention studies published in peer review journals were included in the present reviews.

3.1.2 Key Informant Interviews

Key informants were chosen in consultation with the Ministry of Health and have included people in a number of different roles in the health sector. Twenty-seven individual and group interviews were conducted, involving a total of 47 key informants. Key Informants were questioned about their tested, experiential and intuitive ideas about:

1. Interventions that improve access to health services for the general population
2. Instances when these interventions (in #1) do and do not work to improve Māori access
3. Targeted interventions that improve Māori access
4. Future ideas for improving Māori access

Interviews took between 30-50 minutes and were audio-recorded. Key informant interview notes and transcriptions were data analysed. These were read and re-read for an emergent conceptual framework. As key informants spoke about both barriers to, and facilitators of healthcare access at a range of levels, from the individual patient to health system policies the capacity framework from Jansen, Bacal and Crengle’s (2008) research on Māori satisfaction with health care services was used to organise key informant information.
3.2 Findings

The individual reports on the literature reviews and the key informant interviews are available as separate documents (Cram 2014a,b,c,d) (also see Appendices B and C for tables summarising key findings). The purpose of this findings section is to pull together the findings across all four pieces of work to describe the elements that have the potential to improve access to health care for Māori across four levels: health system, health organisations, health practitioners, and patients.

Each level of the health care system (health practitioners, health organisations, health system), as well as Māori patients, is showcased (Diagram 3). The health system (mainly the Ministry of Health) regulates and assures the quality of health care through legislation, regulations, strategy, and policy that guides health organisations and health practitioners and also reduces logistical barriers (e.g., cost, transportation) for patients. Health organisations (e.g., district health boards, primary health organisations, Māori providers) are primarily responsible for the delivery of health care within communities. (The details of the health system and health organisations within this country can be seen more fully in the Ministry of Health diagram in Appendix A.)

Health practitioners are those who deliver health care for health organisations. This care delivery might be within hospitals or clinics, or the mobile delivery of health care within communities. Patients are the key recipients of health care and it is acknowledged that patients also reside within whānau and within communities.

Diagram 3. Overview of intervention levels to improve health service access

- **Health System**
  - Enforcement of legislation & regulations
  - Strategy, planning & policy
  - Quality assurance
  - Resource allocation
  - Research & monitoring

- **Health Organisations**
  - Governance & management
  - Structures & systems
  - Policies & processes
  - Planning & funding
  - Human resource management
  - Service delivery

- **Health Practitioners**
  - Clinical & cultural competencies
  - Professional development

- **Patients - Whānau - Communities**
3.2.1 Patients

The key informants talked about barriers to Māori patient access to health services as well as barriers to self-management. The main barrier mentioned was the cost or affordability of health services. When cost was not a barrier key informants mentioned people’s lack of knowledge about services, lack of transportation, and service characteristics (e.g., inconvenient opening hours, lack of Māori staff, inhospitality). Interventions that address financial (cost) and logistical (transportation) barriers have been found to be effective in improving access to health care, particularly health screening services (Han et al., 2011; Masi, Blackman, & Peek, 2007).

Other access barriers raised by key informants were whānau crises that deprioritised health care, and whakamā (reticence) that stopped Māori talking about their health issues with health practitioners. The importance of intermediary links (e.g., community health workers) in overcoming the hesitancy Māori feel about engaging with health services is described in the next sections.

Key informants and the literature also addressed health literacy, including how health literacy might be facilitated to benefit patients’ self-management of their health condition(s). A key informant described health literacy as being about patients’ perspectives or knowledge and not about incompetence. This knowledge could be informed by the internet, older whānau (who may have out-of-date disease information), or experience. Patients’ low awareness that their chronic illness will probably be with them for life and low adherence to treatment and lifestyle regimes can be attributed to the illness’s having no symptoms or nonspecific symptoms, especially in the case of type 2 diabetes (Bhattacharya 2012). Expectations about their life expectancy, and battle fatigue were suggested by key informants as potential barriers to patients’ self-management of their condition.

Interventions to facilitate patients’ ability to manage or self-manage focused on increasing patients’ knowledge and confidence. The importance of the cultural responsiveness of such interventions is now well-accepted (Herman and Zimmet 2012). These interventions can also be improved by exploring and then using knowledge about individual patient barriers to tailor information and other options to support health literacy (Han et al 2009). Screening patients for depression adds to the knowledge that can be used to tailor support (Indian Health Service 2011).

Patient self-management can also be supported by home-based tools, and interventions that combine education, support and fellowship (e.g., preparing and sharing a meal with patients, whānau and health practitioners). Mendenhall and colleagues (2010), for example, developed the Family Education Diabetes Series, a six-monthly programme of fortnightly meetings. The meetings involve support, education and fellowship for groups consisting of patients, their families, tribal elders and health providers. The group cooks and eats together, and engages in activities and talking circles. In a pilot test of the programme participants’ blood pressure, metabolic control and weight improved significantly.

Key informants’ recommendation for the involvement of whānau in the care and support of Māori patients fits well with interventions that include patients and their families in education and navigation initiatives that improve access to health care (Hotu et al 2010).
3.2.2 Health Practitioners

Key informants described three integrated components of health practitioners’ delivery of culturally competent clinical care to Māori patients: establishing relationships, building rapport and communicating, and Māori-centred clinical practice (see below). These components flow into one another with the first two setting a firm foundation for, and being essential parts of culturally competent, Māori-centred clinical practice. In the literature reviews there were many names used to describe interventions to assist health practitioners to deliver culturally responsive health care. There is also strong agreement that the delivery of such care is important for the health of Indigenous and ethnic minority patients. Interventions to build health practitioners’ capability to deliver culturally- and linguistically-tailored health interventions improve access to health care for Indigenous and ethnic minority patients, and contribute to the elimination of health care disparities (Stuart-Shor et al 2012). These interventions are likely to be most effective when there is backing and support from the health practitioner’s organisation.

Establishing relationships

Key informants described the importance of making a connection with Māori patients. This can be through a whakapapa (kinship) connection, or shared experiences of a place, or common knowledge of people and relationships. As a key informant stated, ‘Māori are personal in order to be professional’. If non-Māori want to connect with Māori patients they may also need to become comfortable embracing their personal side within their professional practice.

Community health workers can help bridge the cultural ‘gaps’ between non-Māori health practitioners and Māori patients and communities (Huffman and Galloway 2010). They can support patients through home visits and coaching patients in self-management (including nutrition and diet, and medication adherence) (Cooper et al., 2011). Nurse-led interventions, for example, that involve local community personnel have been found to be very effective at delivering health education within communities (Stuart-Shor et al 2012), and reducing health disparities (Crook et al 2009). Community health workers can also help build health professionals’ cultural competence (Hawthorne et al 2010).

Building rapport and communicating

The North American Coalition to Reduce Racial and Ethnic Disparities in Cardiovascular Disease Outcomes (credo) endorses ‘cultural competency’, which is aligned with patient-centred care and includes:

- Understanding the patient as a unique person
- Exploration of and respect for patient beliefs, values, meaning of illness, preferences, and needs
- Awareness of one’s own biases and assumptions
- Provision of information and education tailored to patient level of understanding (Yancy et al 2011: 249)

These ‘culturally competent’ practices facilitate rapport and communication as they help demonstrate a health practitioner’s genuine interest in a patient. As a key informant explained, in his general practice they talk to patients ‘like they’re normal people’. (Also see Example 1 below.)
Example 1. Māori nurse

A Māori nurse speaks about her knowledge of Māori patients, from her work as a community-based health practitioner.

Communication is the key. That’s what we quickly worked out. We realised that our Māori patients need education. We did a lot of kōrero, talking to them, because if you put a whole heap of pamphlets in front of a Māori, what they’re going to do is say, ‘Thank you’, then they’re going to move the pamphlets to the side; they always do. Whereas if you talk to them and explain things to them you find that all they want is to say, ‘You tell me’, because they need to build that trust up themselves. So if you can tell them what you know they’ll say, ‘Oh yeah, she knows’ and then you’d be surprised how much they trust you.

So the first thing they want to know when a nurse comes in is, ‘How did you get my information; who told you?’ Once you can get through that, then you can get talking. Then you can start breaking down the logistics of cervical testing, in small doses. You can ask them, ‘Did you know there’s a 90 percent success rate?’ They don’t know that. ‘Did you know that smoking affects the makeup of your cervix?’ They don’t know that. We’ve learned to take it slowly with our Māori women because they are whakamā, they are embarrassed, but the key is the education. You can’t just talk to them about it and think, ‘Oh yeah, they’re going to jump on.’ I often have to do a couple of sessions to familiarise them with the information and build up that trust.

The relationships that community health workers are able to establish with Māori patients can be built upon so that there is rapport and a good context for health communication. A local intervention highlighted the importance of the trust and rapport community people were able to build with Māori and Pacific Island patients, which laid the foundation for successful education about their type 2 diabetes and chronic kidney disease (Hotu et al 2010). Training Aboriginal health workers to be advocates and cervical smear takers likewise increased the Pap smear rates at a clinic in Townsville, Australia (Panaretto et al 2006).

Ashton and colleagues (2003) proposed that the incongruence in patients’ and health providers’ explanatory models of illness underpinned the communication disconnects that contribute to disparities in health care. Key informants talked about the importance of building rapport as it enabled them to tailor their educational messages for patients and whānau, and to inform their care decisions. This might be as simple as listening to the responses given by patients and their whānau to a question of, ‘Tell me what you know about diabetes?’

The way the clinician communicates …is picked up easily by patients. If the communication is effective and it feels like a good relationship, and the person cares about you and can relate to you it’s going to make follow-up a whole lot easier. (Key Informant)

White, Beech and Miller (2009, p. 110) describe the key role that health practitioners can play in the reduction of disparities in health care ‘through understanding and addressing patient factors such as health literacy and focusing on improved patient communication and cultural competence’. This would help avoid the situation described by two key informants that even though Māori men might have had all or part of a cardiovascular disease risk assessment, the nature of the care they received had not been articulated for them in ways they understood. They therefore said ‘no’ to an initial question about whether they had had their cardiovascular disease risk assessed. Key informants responsible for providing cervical smears for Māori women also highlighted the
importance of developing rapport and communicating well. This enabled Māori women to access
smears, and to also seek information about other aspects of sexual and reproductive health that
were concerning them.

Good communication skills are the health practitioner’s contribution to facilitating patient’s health
literacy and access to health care. This may mean, for example, finding out from patients how
they would like to be communicated with about appointments. Rather than sending patients an
appointment letter saying ‘come to clinic’, some Key Informants text-speak – ‘cm 2 clc’ – or use
other words that are relevant and recognizable by their patients. The communication skills of
health practitioners can be improved; for example, the skills of oncologists to communicate
difficult cancer issues with Hispanic patients (Quinn et al., 2011), or the ability of health
practitioners to manage American Indian patients’ pain (Haozous et al., 2012).

Māori-centred clinical practice

A key informant suggested that the timing and pace of service delivery were important when
providing health care to Māori patients and their whānau. Another key informant talked about
listening to older patients and developing their care plans from these conversations rather than
doing more formal assessments with them using her laptop. (Also see example 2 below.)

Interventions aimed at increasing health practitioner cultural sensitivity or competencies have
been successful at increasing physician cancer screening recommendations and nurse
practitioner screening rates (Gorin et al 2006; Masi et al 2007; Naylor et al 2012). Workforce
training for culturally responsive care has also improved access to cardiovascular disease care
(Jeremy et al 2010). Other educational interventions have improved cancer knowledge and
attitudes among Indigenous health practitioners (Croager, Eades, Pratt, & Slevin, 2010; Hill et al.,
2010).

The provision of clinical decision-making guidelines and other uncertainty reduction tools for
health practitioners can support their delivery of accessible and equitable health care (Masi et al
2007). Formalised training and education also support good decision-making, for example,
training of health practitioners to recognise depression in patients with diabetes (Joshu et al 2007).

It was suggested by key informants that health practitioners may need to partner with others so
there is cultural competency within their teams, rather than each individual practitioner having to
be fully culturally competent. A number of Māori key informants also described their own
partnering, especially with general practices for the deliver of cervical screening and community-
based diabetes care. This was possible when they were seen as adding value to general
practices, rather than as a ‘threat’ to patient enrolments.

Building health practitioners’ capability to deliver culturally competent clinical care may have the
added benefit of giving health practitioners the confidence to go to Māori communities to deliver
care, rather than staying inside a clinic and expecting Māori patients to travel to them (Tibby and
Walters 2010). This is one way to overcome access barriers related to, for example, patient time,
transportation, or childcare needs. If they are considering this step out into a community, it is
recommended that the model of health care be developed collaboratively with that community
(Jeremy et al., 2010). In other words, health practitioners should ‘strive for collaboration’ with their
community (Stuart-Shor, Berra, Kamau, & Kumanyika, 2012, p. 180). A key informant described
this as listening to communities and being responsive to the voice of Māori health care consumers.
Example 2. Mobile primary nursing team

*The diabetes nurse and social worker in a mobile nursing team discuss how they work with Māori in their community.*

**Diabetes nurse** As a nurse out in the community I look for something I can do for that whānau. It's something we describe as 'purposeful'. I go out there and make that time purposeful. A whānau might think there's nothing wrong with them so I can go through a comprehensive nurse assessment with them and identify needs. Then I can start navigating. It might be a nanny who thinks she doesn't need support in the home when actually she does, and it's about selling that to her as well because it's changing her mindset from, 'Oh no, it's all right, I don't need this'. It's about encouraging them, saying actually it'd be great if they had this and that support at home. And then I navigate them to the appropriate services.

**Social worker** You need to engage well with families before you get to do any interventions. That's the most important thing. Once you've built that trust, no matter what age you are, they're going to respect and value the things you tell them. Whakawhānauungatanga is one of our core values that we work by.

**Diabetes nurse** We do develop that whakawhānauungatanga. When we meet someone for the first time they want to know who you are, where you're from. We establish that with them first. I'll find I have a connection with that person; they may know someone I know. It evolves from there.

**Social worker** People don't understand what a social worker is. They think I'm another nurse or doctor, but once I've established my role I do a needs assessment and we'll work out whether they're getting educational workshops in their home, as one of the workshops is about diabetes. We've had a mutual client who's not really engaging with one of us, so we're working together to make sure that education is given to him and he's agreed to have a diabetes workshop. I don't think he could have had that opportunity if we hadn't both been walking alongside him, and if it was just a straight approach he'd have put barriers up. There's another family where he's been reluctant to take medication because of his partner's beliefs, and now those barriers have come down and the wife wants her children to be educated about diabetes. Whereas once upon a time she was arguing, now she's really welcoming.

**Diabetes nurse** We chip away at some of them too, because they've got their own beliefs about health and the disease progress of diabetes. A lot of them have their perception of diabetes from their nannies and their uncles and aunties and seeing them go through that journey. I think that instils a bit of fear in them and creates non-engagement with health services at times. We try and get them re-engaged and try and sell our health services to them to make it more interesting for them, or more important for them. We also try to break down those barriers they might have about diabetes by explaining to them that we know a lot more about diabetes now. I also simplified the description of diabetes and created an understanding that I thought they'd be able to grasp and they said, 'Oh, I get that'. Now we can show them online clips like 'What is diabetes?' on the laptop we have with us.
3.2.3 Health Organisations

Initiatives taken by hospitals involved in the ‘Expecting Success’ pilot in the United States demonstrated the value of organisational change for improving access for minority patients (Billings et al 2010). Key informants discussed an organisation’s culture as an example of where change needed to occur. This required leadership, good quality data, and a change in the organisational discourse or ‘talk’ about Māori health from one of individual deficits to an organisational issue that required practice changes. Jones and colleagues (2010) also stressed the importance of organisations moving beyond educating and encouraging patients to use an unchanged service. More structural organisational changes also need to take place in order to make the service more culturally responsive and accessible (Hayman 2010).

Māori have described the lack of a culturally responsive workforce as a barrier to their access to a health organisation. This goes hand-in-hand with Māori patients desiring better relationships with health practitioners. The addition of community health workers to a health organisation’s workforce can bridge the gap between the organisation and the Māori communities it is trying to serve. Key informants talked about the added value community health workers bring to an organisation because they are able to engage more easily with Māori patients and support their health literacy through culturally tailored education and information (also see health practitioner section above). Community health workers might also be tasked with arranging appointments, transportation, and supporting patients during their health visits. This third task will put them into close contact with any internal, organisational navigation support and help ensure these two workforces (along with peer educators, kaiawhina, community nurses and nurse practitioners, etc.) are networked with one another. Community health workers can be thought of as exerting ‘cultural leverage’ within communities; that is,

‘…a focused strategy for improving the health of racial and ethnic communities by using their cultural practices, products, philosophies, or environments as vehicles that facilitate behavior change of patients and practitioners. Building upon prior strategies, cultural leverage proactively identifies the areas in which a cultural intervention can improve behaviors and then actively implements the solution’ (Fisher et al 2007: 245).

Community health workers (or promotoras within Hispanic communities) figured large in the intervention literature reviewed. They are often from the communities they are engaging with and, in some instances, are also managing the same long-term conditions (e.g., diabetes, cardiovascular disease) or have experienced the same cancer as the people they are in touch with. The key characteristics of successful community health workers included their personal qualities as well as the training they received to do their work (Reinschmidt et al 2006). The training of community health workers often recognises the culture and learning styles of both the community health workers and the communities (Look et al 2008). Reinschmidt and colleagues (2006, p.261) describe why promotoras improve patient access to health care.

In general, clients accepted the support because they accepted the promotora as a bridge to the clinic. The promotora established relationships that were at the center of her success. Clients perceived the promotora as a community member who embodied the characteristics of a natural helper. They responded to the promotoras efforts and her different types of social support because they related well to her socio-cultural and personal characteristics. These characteristics built the foundation for trust.
Community health workers or navigators may be valuable team members; however organisations need to ensure that other team members are respectful of the knowledge and expertise these practitioners bring to the team (Stuart-Shor et al 2012).

Patient navigation is also well studied in the intervention literature and found to be successful. It has been extended in Hawaii to a culturally responsive family intervention for Native Hawaiians (Mokuau et al 2008). Training of navigators is also a good opportunity for them to network with one another, as well as improve their knowledge and attitudes (Braun, Allison, & Tsark, 2008; Hill et al., 2010). Navigation should not, however, be a substitute for, or an excuse to ignore a lack of internal organisational connectivity and clarity of patient health pathways.

Nurses have important roles to play within health organisations, either working in communities or within health organisations. Key informants expressed concern that places for Māori nurses, particularly Māori nurse practitioners, were not being made available within health organisations. It was also acknowledged that funding formulas often made it difficult for health organisations (in this case PHOs) to employ nurse practitioners, even when they recognised their value. Patient satisfaction increases and referrals to GPs decrease when nurse practitioners are able to take a leading role, including the adjustment of patient medication, in health care (Curtis et al., 2009; Kenealy, Eggleton, Robinson, & Sheridan, 2010). In addition to workforce changes, the cultural tailoring of clinic policies, organisation and health care models was seen as important by key informants and in the literature. Decision-making (e.g., guidelines) and uncertainty reduction tools (e.g., more information in patient notes) that support quality improvement can help ensure that health practitioners are delivering equitable health care to Māori patients. Māori patient access can also be improved by the organisational use of an 'electronic backbone' that supports clinical decision-making. For example, the use of one such tool, Acute Predict, in a coronary care unit led to the elimination of disparities in access to in-hospital cardiac rehabilitation (Kerr et al 2010).

Organisation changes that improve adherence to guidelines, implement case management, ease time pressures, and support cultural sensitivity training can improve health care access. The implementation of multiple strategies may be warranted and successful (Han et al., 2011). This was the approach taken by a rural general practice serving a predominantly Māori community, with the result being almost full community coverage in the number of women participating in breast screening (Thomson et al 2009). (Also see example 3 below.)

Finally, key informants looked beyond the organisation’s own walls and described the importance of health organisations being part of a hub with other health and non-health services, and being networked more generally with other organisations and agencies. Regional networks of health providers and practitioners can provide comprehensive approaches to disease control. In the United States Comprehensive Cancer Control (CCC) efforts have facilitated local participation in planning to help ensure that local communities are engaged and included in supporting efforts to reduce cancer disparities (Behringer et al 2010). Other projects (e.g., REACH project) have partnered with tribal communities to reduce cancer disparities (Centers for Disease Control and Prevention 2007). Many of the principles underpinning these initiatives are similar for those that Indigenous peoples want to see drive inter-personal relationships between, for example, patients and health professionals, and patients, their families and health navigators and educators (Cormack, Purdie, & Ratima, 2005; Pitama, Cave, Huria, Lacey, Cuddy, & Frizelle, 2012). For example, trustful, inclusive, strengths-based relationships that acknowledge and build upon existing knowledge and skills.
A DHB Funding and Planning Manager discusses the DHB’s moves to improve access to health care in its region.

Our focus is on population health, the patient experience, and cost and productivity. We’re interested in the data on where we sit and how we compare with other DHBs of a similar size, and how we compare with Australian hospitals. We’re getting good data to show where to improve services in the hospital, including where we can improve quality and save costs. My main focus now is on how we’re going to organise, coordinate and integrate planning and reporting so we can measure if we’re having an effect.

We also need to get GP practices to work differently to improve access. Our patient experience headline targets are: same day access to primary care for urgent health care, and more than 95 percent of patients would recommend the service provided. The second one is our quality measure – so there’s some stretch needed there. We’re constantly talking about how we can improve the connectivity of data – practice by practice data inside PHOs. The next five years’ demand projections suggest we’ll run out of beds for diabetic and obesity-related problems. We have to change now and get primary care working more efficiently and effectively to improve access so they play a big part in reducing demand at the front door of our hospitals.

Next month we’re going to receive an indicator report by practice within a PHO. The PHO is happy to exchange data with us so we’ll know who’s doing well and who’s not doing so well, and we’ll be able to work with those not doing so well to spread the practice of those doing better.

We’re also going to work regionally to develop and agree best evidence-based models for diabetes care improvement, with us probably leading in that regard. This is mainly because of our long-standing relationship with primary care and PHO colleagues. This makes it easier for us to get together and focus on patient outcomes.

We’ve had a pretty comprehensive engagement process about the direction we’re taking, with a wide range of health leaders across the sector and other more purposely focused workshops (eg, on how to improve urgent access from rural into secondary). The final wrap-up workshop had around 90 attendees, and we recently did a launch with about 120 people, most of whom had been at earlier workshops.

Now we’re planning for an inaugural governance oversight committee that will include at least two Chief Executives of Māori health practitioner organisations. We’ve done a lot of marketing leading up to it. Every district health board employee has a copy of the plan. Specific projects identified as actions in the plan are already under way. Long-term conditions programmes are all in place. We’re looking at developing up to 30 projects, many of them intersectoral. We want a wide, joined-up approach that integrates and coordinates for best population health outcomes, with better quality, while living within our means in constrained times. We’re prepared to divest in anything not currently aligned with Ministerial priorities, the regional work programme or our own regional health service plan, and reinvest in initiatives that better support the outcomes outlined in the plan.
Local regional cancer networks have had mixed success engaging with Māori (Herbert and Peel 2010). Key informants from a regional cancer network reported that their analysis of disparities, the inclusion of Māori expertise in their workforce, the establishment of Māori advisory groups, and their commitment to engaging with Māori and using health equity tools put them in a good position to be responsive to, and work to improving Māori access to cancer health care and contribute to the reduction of Māori cancer disparities.

3.2.4 Health System

Regulatory reform can shift health organisation practice to reduce or even eliminate access disparities for minority groups (Curtis et al. 2010; Cantor et al., 2009; Cohen et al., 2010). Policy drivers can also be exerted to ensure the collection of accurate ethnicity data, the development of local-level plans and initiatives, and engagement with Māori leaders and communities (Bramley et al 2004). (Also see example 4 below.)

Several key informants talked about the need for good data. For a key informant in the Ministry of Health the issue was also about getting health organisations to agree on an information technology system that would ensure analysts have access to good data.

A key informant also suggested extending regulatory reform to the exertion of more control over the country’s food supply so that Māori and Pacific people would be more protected against their genetic predisposition to cardiovascular disease and renal disease.

System leverage for improving Māori health access includes the setting of universal targets. Meeting universal targets for breast and cervical screening means that the focus is now on Māori, Pacific and Asian women. Key informants from the Ministry of Health’s Screening Unit described how their focus on equitable access to screening services is now being extended to re-screening and assessment services. The cost barrier for Māori women accessing screening was being addressed, and service location issues were being addressed through the provision of mobile screening services. Some contracted providers also offer breast and cervical screening in moves to make screening services more holistic.

Changes in the health workforce and funding formulas were suggested by key informants, including the inclusion of nurses in discussions about primary care funding and more flexibility to fund nurse practitioners within primary care. A key informant was disappointed that nurses had been excluded from the diabetes care improvement package when

…there is a huge nursing workforce working in communities who could fulfil that role and others I believe more efficiently with good outcomes as nursing care system places us at the forefront giving patients the time to build their knowledge to self manage (Key Informant).

Public campaigns can also be successful at raising awareness, increasing knowledge, and promoting family and community discussions and decision-making. For example, the mass media communications for Māori women about attending breast and cervical cancer screening were culturally tailored, building upon Māori cultural values of whānau (family), and their importance for Māori women. These communications connected with the importance of Māori women’s relationships with whānau, hapū (sub-tribe), Iwi (tribe) and the land (Ministry of Health 1997). The provision of these communications has led to an increase in screening by Māori women (Mokuau et al 2008).
Example 4. National Screening Unit, Ministry of Health

The National Screening Unit (NSU) is part of the National Health Board of the Ministry of Health. The NSU is responsible for developing, managing and monitoring nationally organised, population-based screening. This example summarises discussions with four NSU staff members about how the NSU is working to improve access to screening services, particularly for Māori women.

The NSU has an equity focus on Māori and Pacific women’s access to cervical and breast screening. This has been informed by research carried out in 2004/05 about Māori and other groups of women who are at greatest risk of breast and cervical cancer, and the difficulties they had accessing screening services. The NSU’s equity focus to get women to screening services is beginning to be applied across the screening pathway.

As at September 2013, 69.1 percent of Pacific women (aged 25-69 years) had a cervical smear in the previous 36 months, and approximately 6 percent fewer Māori women had been screened in that period. National coverage for all women aged 25-69 years is 76.9 percent.

Breast screening coverage for Pacific women (aged 50-69 years) as at September 2013 was 73.6%. Coverage for Māori women in the same period was 65.4%. National coverage for all women aged 45-69 years was 72.3%

For cervical screening, research showed that Māori, Pacific and Asian women participate less than ‘other’ women for a wide range of reasons including cost, anxiety, and embarrassment. As a result the NSU continues to focus screening provider contracts on invitation and recall of Māori and Pacific women, as well as on Asian women for cervical screening. Overall the NSU has seen a change in health providers’ approaches in that they are making their services more accessible (eg, enabling group bookings, providing mobile services, subcontracting with Māori organisations to support Māori women’s access).

“Over time our programmes have moved away from the population-based health promotion strategy to focusing on invitation and recall and the more one-to-one contact to get women in.”

National communications campaigns are also successful in informing women about screening, and the cervical screening media campaign launched in 2007/08 worked ‘extremely well’. The NSU attributes the large increases in the rates of screening of Māori, Pacific and Asian women to this campaign. Due to budgetary restrictions, screening campaigns have been reconfigured and targeted to those areas of the country where women’s access to breast or cervical screening is low.

Despite the NSU’s activities, cost remains a big barrier to cervical screening access for many women. A Parliamentary Review Committee has recommended that cervical smears should be free.
4 Discussion

The aim of this project was to inform strategies to improve health care access for Māori through an examination of successful local and international health care interventions identified in the literature and through discussions with key informants working within the health sector. While recognising that health is a complex system it is important to realise that Māori patients and their whānau are looking for signs from this system that it cares for them. This is often reflected in the ways that health services show Māori that their values, beliefs and culture are important and valued. The absence of this may mean that no matter what barriers are taken down, Māori will still not find a service accessible. This is because cultural appropriateness and responsiveness infiltrates so much, if not all, of health care provision.

Grant et al. (2009: 11) maintain that one of the first steps in the reduction of disparities is the articulation of a priority to eliminate disparities. The legislative and strategic approaches taken by the government are therefore important in setting the scene for a commitment to reduce disparities. The Ministry of Health Statement of Intent (SoI) set three high-level outcomes for the Ministry:

- **New Zealanders are healthier and more independent**,  
- **Health services are delivered better, sooner and more conveniently**, and  
- **The future sustainability of the health system is assured** (Ministry of Health 2013: 16).

Universal health targets that include more heart and diabetes checks, and shorter waiting times for cancer treatment provide leverage at a system level for improved access for Māori, at least in the early stages of being diagnosed and seeking treatment. Only one intervention was found that examined funding levers for reducing health care disparities. This intervention, which only allowed those organisations that reduced health screening disparities to deliver the next, well-funded components in patients’ health journey, eliminated the previous health care disparity between white and black Americans (Cantor et al 2009).

Some of the most researched and successful initiatives internationally involve the training and deployment of community-based health workers or navigators. Educators equipped with culturally tailored health information are able to inform patients and their families about how to live with a chronic condition and assist them to access services. These workers often come from the communities in which they work and may themselves have experience of the same conditions they are assisting people with. While they are successful, they are responsive only to the patient journey component of access (Aday and Andersen 1974). As such they are a reasonably easy add-on to existing services as they require little or no change from health organisations. This may be a reason for their frequent appearance in the literature on reducing health care disparities.

The provision of navigators or educators who assess and then tailor their services to the needs of individual patients and their families is both compatible with the health literacy literature and responsive to the diverse realities of Māori (Ministry of Health 1997). Although not explicitly written about in much of the health navigator literature, the importance of whanaungatanga (respectful and supportive relationships) must also be considered for Māori if such navigation and education interventions are to be successful (Mauriora ki te Ao 2010). Mead (2003, p. 28) describes the whanaungatanga principle as reaching ‘beyond whakapapa relationships and [including] relationships to non-kin persons who have become like kin through shared experiences’. It would be surprising to find that the successful navigation approaches canvassed in this review did not also rest upon a foundation of connectivity, support and respect.
When tailored health information and community health workers are combined with health clinic reorganisation the potential gains in improved access increase. This reorganisation can include the provision of group-based educational sessions and other opportunities for support within the clinic; the training of clinic staff to be more culturally responsive; changes to appointment regimes; and the use of guidelines and tools by clinical staff to support their evidence-based decisions about patient care. The development of relationships with local community leaders, combined with the analysis of local health care data, can lead to collaboratively developed, implemented and evaluated initiatives. These initiatives can also be supported by information technology systems that monitor disparities and targets and inform decision-making and the allocation of resources, and ‘electronic backbones’ that support clinical decision-making.

These interventions need to acknowledge that health organisations are complex adaptive systems where access improvements for Māori will rest upon cycles of research, action and reflection. The people who power these cycles are pivotal to the success of initiatives. These include organisational and community leaders as well as people showing leadership through their health care delivery or health care support within a whānau. In their discussion of the importance of people to Māori patients’ access to cancer care small changes to improve access at each of the many steps patients need to take on their health care pathway (e.g., tailored communications, supportive navigation, respectful engagement) may add up to a large overall improvement in Maori access to healthcare (Hill et al 2013).

**Limitations of the Present Study**

The focus of the present study has largely been on improving access for Māori adults. Any generalisation of these findings to Māori children and young people will need to take into account the even greater importance of whānau involvement. One advantage in improving access for children and young people is that paediatric health personnel are already seen as family focused and good at establishing and maintaining respectful relationships.

It was noted by some interventions that any lay health practitioners (e.g., community educators or navigators) need to be incorporated into and respected by health teams in order for them to achieve their promised success at improving access. However there was limited information in the present study about the role of health care teams. Quality improvement practices such as peer review and clinical guideline development occur within teams so it is natural that they will also be important initiators of improved health care access for Māori (National Health Committee 2002).
References


Ellis C, Pryce A, MacLeod G, et al. 2012. The most deprived Auckland City Hospital patients (2005–2009) are 10 years younger and have a 50% increased mortality following discharge from a cardiac or vascular admission when compared to the least deprived patients. New Zealand Medical Journal 125(1357): 1-21.


Appendices

Appendix A. Diagram of the New Zealand Health System

Source. New Zealand Ministry of Health
## Appendix B. Key Informant Summary

<table>
<thead>
<tr>
<th>Focus</th>
<th>Key Findings</th>
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| **Patient**      | • Barriers to Māori access to health care include affordability (or cost), knowledge about services, service location and hours of operation, transportation, everyday whānau crises, and patient whakamā (reticence)  
• Barriers to patient self-management of their long-term condition include expectations and “battle fatigue”  
• Māori patients may not understand that their long-term condition will be with them for life.  
• Patients’ health literacy was facilitated by many sources, including the internet, whānau members, and experience, as well as health practitioners  
• Patients can be supported in the self-management of their condition by whānau and health practitioners  
• Community leaders can provide leadership for Māori health  |
| **Health Practitioners** | a. Establishing relationships  
• Establishing relationships is a foundation for improving Māori access to health care  

b. Building rapport and communicating  
• Building rapport and communicating well with Māori patients facilitates patient education and helps put patients at ease with health care procedures  
• Communication with patients works with patients and their whānau (families) to improve their understanding and knowledge of their health condition and their health care  
• It takes time to communicate well so if this is not possible within a GP’s limited consultation time other health personnel take this responsibility on  
• Health personnel find novel ways of communicating with and educating patients whose literacy levels are low  
• Humour, used at the right times with the right people, helps build rapport and puts patients at ease  
• Communication can be more effective when it is done face-to-face with patients  
• Patient segmentation allows health practitioners to tailor communications with Māori patients  |
| **c. Māori-centred clinical practice** | • Patients are partnered in their health care  
• Patient assessments facilitate the planning of a patient’s care, including connections with other services  
• Some health practitioners still hold deficit-based views about Māori and health care, and this is a barrier to Māori access to health services  
• Health practitioners are either culturally competent, or working in teams with others who are culturally competent  
• Community health practitioners are facilitating relationships with other health practitioners and health organisations, although being seen as a threat was a barrier to this partnering  |
| **Health Organisation** | a. Organisational culture  
• The is organisational leadership for improving Māori access to health care and the reduction of Māori health disparities  
• Organisational leaders, including clinical leaders, are informed and motivated by evidence of disparities  
• Māori leadership comes from within different levels of an organisation, and Māori leaders have credibility with their community and health providers  
• The discourse about health disparities has been shifted from ‘Māori at fault’ to an organisational issue requiring practice changes  
• The organisation has quality data  
• Health targets, monitoring, research and evaluation are important drivers of organisational planning and action to improve access for Māori  
• Positive feedback about what is working well within an organisation motivates staff  |
| b. Patient engagement | • The organisation connects with Māori at community events |
### Focus

#### Key Findings

- Community health workers are employed to reach Māori in the community, and may also arrange appointments, transportation and support for clinic visits.
- Navigators facilitate patient and whānau access to the wider landscape of health and social services
- The organisation has provisions for communicating with patients who have low literacy levels
- Mobile services provide organisational outreach into Māori communities

#### c. Care delivery system design

- The organisation is seen by Māori as for them
- Māori responsiveness includes embedding health services within other Māori or whānau activities, enabling group bookings for screening and health care, and facilitating whānau-centred health care
- The organisation is able to provide better care because they have a more detailed picture of patients' lives (e.g., gained through home visits by community health workers, or by finding out what matters to patients)
- Organisational resistance that has the potential to be a barrier to Māori access, and to resource allocation decisions that do not improve Māori access, is recognised and countered
- Access is improved by the organisation reducing its own, internal fragmentation of services and lack of clear care pathways
- Organisational cultural responsiveness is embedded through requirements that equity tools be used in decision-making and resource allocation

#### d. Workforce

- Nurses forge and maintain strong links with patients and whānau
- Positions are made available for Māori nurse practitioners, and for Māori nurses more generally
- Social workers are an important part of the health care workforce
- Whānau Ora offers an opportunity to build a specialist navigator workforce, although caution is taken to avoid duplicating the work of community health teams
- Mechanisms are in place to ensure that community health workers do not burn out
- Workforce capability is built through organisational initiatives that also bring staff closer together so they can work well as a team
- Multidisciplinary teams allow different, or the most appropriate practitioner, to take a lead role in patient care
- Care is taken that initiatives to increase the scope of practice of health practitioners do not increase demands on specialist medical staff
- Establishing and supporting a Māori health workforce is seen as important

#### e. Cosmopolitanism – connectedness with other organisations and agencies

- Good relationships and the complementarity of services are the foundations of cosmopolitanism
- Primary care health organisations benefit from being located in hubs with other health care providers and service organisations
- Health organisations benefit from networking with other organisations and agencies

### Health System

- A commitment to the reduction of Māori health disparities and the establishment of universal health targets guides organisational action to improve Māori access to health care
- The health system can facilitate IT solutions to ensure good data is available
- Funding and resource allocation can be leveraged to improve access, including the reduction of cost and service location as barriers to health care
## Appendix C. Literature Search and Review Summary

A total of 84 individual papers and 14 review papers were included in this literature review. These were reviewed for their contribution to understanding how access to health care could be improved at each stage of the continuum of care for cancer, diabetes and cardiovascular disease (CVD). Successful interventions involved one or more of the following intervention elements: knowledge and self-management education; community health workers or navigators; the re-organisation of health clinics; medication adjustments; smoothing of care pathways; health system response (see Table 1.).

<table>
<thead>
<tr>
<th>Strat</th>
<th>Description</th>
<th>Cancer Care interventions</th>
<th>Cardiovascular Care interventions</th>
<th>Diabetes Care interventions</th>
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<tbody>
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<td></td>
<td>Community-based health workers (including promotoras, community nurses) assist patients with education, self-management, and access to health services by being a bridge between the community and health clinic.</td>
<td>Employ community health workers to support care through culturally tailored: • home-based education, for women (about screening) and for patients and their families (about cancer journey) • individual counselling • community-based education and discussion • coaching for patients (including telephone calls) • family-based support • cervical screening. Employ community-based and clinic-based navigators to liaise with each other.</td>
<td>Provide community health workers support care through: • patient coaching • home visiting. Facilitate nurse-led interventions that involve community personnel.</td>
<td>Employ community health workers to provide culturally appropriate: • community conversations • assistance and support (eg, encouragement, motivation) • mentoring and advocacy • education about and practice of skills (eg, healthy living, blood glucose monitoring) • community-based libraries of resources.</td>
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### Improving Māori Access to Health Services: Research report

<table>
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<tr>
<td><strong>Build a culturally competent health workforce</strong></td>
<td>Health practitioners are supported to deliver culturally competent clinical care (including the use of reminders and protocols, as well as professional development).</td>
<td>Conduct provider-directed training (eg, cultural sensitivity, communication) on its own or combined with reminders. Provide navigators will training and networking opportunities. Provide Indigenous health professionals with training to improve knowledge of common cancers. Provide multicomponent physician screening education, including screening training. Provide chart-based reminders to health practitioners. Provide oncologists with training on culturally responsive communication with patients and their families. Provide cancer patients and survivors with training about pain management.</td>
<td>Provide students in health education programmes with community-based participatory experiences. Provide communication training to support trusting and effective relationships, including participatory (with patient) decision-making. Provide ongoing workforce support, including by providing clinical decision guidelines and other uncertainty reduction tools. Enable practitioners to work in multidisciplinary teams.</td>
</tr>
</tbody>
</table>
| **Reorganise health clinics to improve accessibility** | Clinics change the way they organise and provide services. Involve local community and tribes. Enable communities to have input into the design and evaluation of programmes. Improve registration and appointment processes. Undertake case management of patients to improve patient monitoring and follow-up. Provide structured counselling and navigation assist patients with diagnostic resolution and treatment. Conduct needs assessments with patients following treatment. Include spirituality and social support in cancer survivor programmes. | Involve communities in planning, development of health care models, and delivery of health care. Ensure clinics are accountable to communities. Locate clinics within communities, or practice staff make visits in the community. Ensure clinic waiting rooms are culturally appropriate. Recruit and train local people, including making space for volunteers. Commit to comprehensive quality improvement, including allocation of resources for quality improvement and reduction of disparities. Collect accurate patient ethnicity data (and train staff to do so). | Establish strong community partnerships; for example:  
• valuing of self-management as central to diabetes management and part of the continuity of care  
• collaboration of clinic staff, including community workers, to develop self-management interventions. Promote quality, consistency and safety within policies; for example:  
• decision support that includes evidence-based guidelines  
• quality assurance  
• use of monitoring and evaluation information to refine services  
• dissemination of information about successful practices |
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| Reorganise health clinics to improve accessibility, continued | | | Use data and performance measures to inform solutions.  
Monitor, evaluate and report on outcomes.  
Use information technology tools to ensure patients receive evidence-based medicine.  
Use community-oriented and culturally responsive models of care, including:  
• traditional methodologies (eg, spiritual treatments)  
• patient-centredness  
• behavioural and pharmacological care strategies  
• Indigenous health practitioner workforce  
• team-based care.  
Build pathways go from primary to secondary care and to specialist care. | | • use of dashboards for ongoing reports and evaluation.  
Define team structure, roles and delivery methods through delivery systems; for example:  
• clear roles and responsibilities for community health workers  
• consistency of key messages being given by all staff to patients about diabetes  
• clinic staff as self-management mentors  
• proactive identification and stratification of patients based on risk assessment  
• appropriate information technology system to support sharing of patient information among care team members.  
Actively support Patient self-management; for example:  
• a package of culturally responsive self-management activities (eg, classes, drop-in, breakfast club, individual and whānau nurse consultations). |
| Health system | The health system can respond through funding formulas and strategies that reduce the barriers imposed by patient financial resource limitations.  
Provide financial (reducing the cost) and logistical (provision of transportation) that support that facilitates access to screening services for low-income clients.  
Build tribal capacity to deliver education programmes.  
Conduct national communication campaigns about screening. | Reform hospital regulatations to include:  
• minimal procedure volume standards for angiography  
• requirement for health organisations to prepare annual ‘community outreach, access and prevention’ plans. | Authorise pharmacists or nurse case managers to adjust patients’ diabetes medications.  
Support chronic care management through district-wide programmes, including:  
• community-based management  
• supports for provision of nursing care.  
Coordinate primary and secondary care. |

Source. Inspired by Chin, et al. (2012: 996, Table 3)