

Improving Māori Access to Cancer, Diabetes and Cardiovascular Health Care: Key informant interviews

Prepared for the Ministry of Health, 2014

Prepared by Fiona Cram, for Katoa Ltd

1. Leadership

2. Knowledge

3. Commitment

Acknowledgements

Many thanks to the key informants who gave of their time and expertise to be involved in this research.

Thanks also to those who provided peer review of earlier versions of this report, including supportive and helpful colleagues in the Ministry of Health. The Ministry of Health funded this research.

He mihi mahana ki a koutou.

Citation: Cram F. 2014. *Improving Māori access to cancer, diabetes and cardiovascular health care: Key informant interviews*. Auckland: Katoa Ltd.

Cover design: Ariki Creative

Published in June 2014 by Katoa Ltd
PO Box 105611, Auckland City, Auckland 1143, Aotearoa New Zealand
ISBN 978-0-9941081-1-1 (Online)

This document is available on the Katoa website:
<http://www.katoa.net.nz>

Other Reports in this Series

Cram F. 2014. *Improving Māori access to health care: Research report*. Auckland: Katoa Ltd.

Cram F. 2014. *Improving Māori access to cancer health care: Literature review*. Auckland: Katoa Ltd.

Cram F. 2014. *Improving Māori access to diabetes health care: Literature review*. Auckland: Katoa Ltd.

Cram F. 2014. *Improving Māori access to cardiovascular health care: Literature review*. Auckland: Katoa Ltd.

Contents

| | | |
|---|---|----|
| 1 | Executive Summary | 4 |
| 2 | Background..... | 7 |
| 3 | Method | 8 |
| | 3.1 Key Informants | 8 |
| | 3.2 Interviews..... | 8 |
| | 3.3 Analysis | 8 |
| 4 | Findings | 9 |
| | 4.1 Overview..... | 9 |
| | 4.2 Patient..... | 10 |
| | a. Barriers to access..... | 10 |
| | b. Health literacy..... | 10 |
| | c. Whānau | 11 |
| | 4.3 Health Practitioner | 11 |
| | a. Establishing relationships | 11 |
| | b. Building rapport and communicating | 12 |
| | c. Māori-centred clinical practice | 14 |
| | 4.4 Health Organisation | 15 |
| | a. Organisational culture | 15 |
| | b. Patient engagement | 18 |
| | c. Care delivery system design | 20 |
| | d. Workforce | 21 |
| | e. Cosmopolitanism..... | 23 |
| | 4.5 Health System | 24 |
| | a. Commitment to disparity reduction | 24 |
| | b. Funding, incentives, resources | 24 |
| 5 | Discussion..... | 25 |
| | References | 26 |

List of Tables

| | |
|---|----|
| Table 1. Overview of key informant comments about improving access to health services | 5 |
| Table 2. Overview of key informant comments about patients and improving access to health services | 10 |
| Table 3. Overview of key informant comments about health practitioners improving access to health services..... | 12 |
| Table 4. Overview of key informant comments about health organisations improving access to health services..... | 16 |
| Table 5. Overview of key informant comments about the health system improving access to health services..... | 24 |

I 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 and 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.

In addition to literature reviews on interventions to improve access to diabetes, cardiovascular and cancer health care, key informants were interviewed for their views about improving access. The findings from these key informant interviews are reported here.

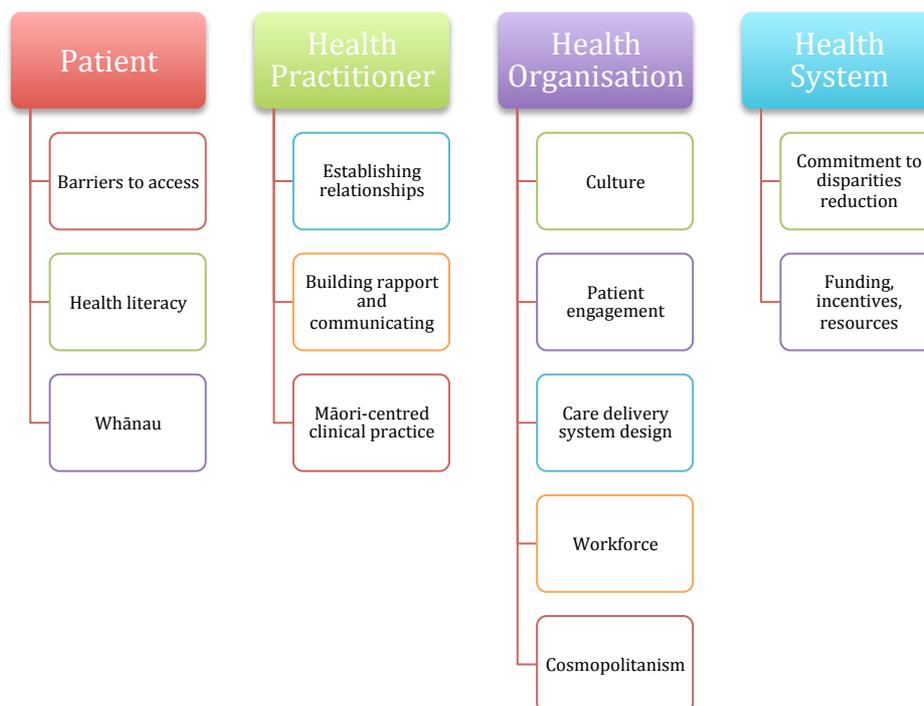
Method

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 care for the general population, as well as specifically improving access for Māori.

Interviews took between 30-50 minutes and were audio-recorded. Key informant interview notes and transcriptions were the data analysed. These were read and re-read for an emergent conceptual framework. As key informants spoke about both barriers to, and facilitators of health care 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.

Findings

Diagram 1. Representation of key informant interview analysis themes and sub-themes



The four themes of patient, health practitioner, health organisation, and health system provided a broad structure for the analysis of key informant interviews comments. Each of the themes contained two or more sub-themes (see Diagram 1). The key findings from the key informant interviews are listed below in Table 1.

Table 1. Overview of key informant comments about improving access to health services

| Key Findings - Patients |
|---|
| <ul style="list-style-type: none"> • Barriers to Māori access to health care include affordability (or cost), knowledge about services, service location and hours of operation, transportation, everyday whānau (family) 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 |
| Key Findings – Health Practitioners |
| <p>a. Establishing relationships</p> <ul style="list-style-type: none"> • Establishing relationships is a foundation for improving Māori access to health care <p>b. Building rapport and communicating</p> <ul style="list-style-type: none"> • 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 whānau and improves 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 general practitioner’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 <p>c. Māori-centred clinical practice</p> <ul style="list-style-type: none"> • 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 |
| Key Findings – Health Organisations |
| <p>a. Organisational culture</p> <ul style="list-style-type: none"> • 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 |

Key Findings – Health Organisations continued

b. Patient engagement

- The organisation connects with Māori at community events
- 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 practitioners 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

Key Findings – 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

Conclusion

Key informants highlighted several opportunities for improving Māori access to health care. Māori patients need to be considered within the context of their whānau (family) and reached out to by health care providers who can operate in relationship-based ways while delivering professional health services. These providers can introduce and facilitate access for Māori to health services that may not be so relationship-based but are important for the health care they can provide. Māori staff, and culturally competent non-Māori staff, can help make these organisations places where Māori are welcomed. In the long term the commitment of organisational leadership to reducing health care disparities may see the strengthening of organisational capacity to deliver culturally responsive health care.

2 Background

According to the World Health Organization (WHO), '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).

In 1995 Benzeval, Judge and Whitehead proposed a framework for tackling socioeconomic inequalities in health. This framework stressed the importance of changing behavioural risk factors by reducing the barriers to people adopting healthy lifestyles, improving the physical environment and addressing social and economic factors, and improving people's access to effective health services. The Ministry of Health's (2002) Intervention Framework to Improve Health and Reduce Inequalities also called for comprehensive strategies to:

- address the structural causes of inequalities
- mediate the effect of socioeconomic position on health, and of poor health on socio-economic position
- reduce health service barriers to equitable access to effective health care.

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 this broader context as a way of understanding the multiple aspects of people's lived reality that impact upon 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).

There is now international recognition that social and economic determinants play a large part in health inequalities (CSDH 2008). Access to health services needs to also be considered within a determinants framework. This will take into account the factors that facilitate or compromise the ability of Māori to make it to the door of a health service (i.e., 'access to' health care), and then journey safely within that service (i.e., 'access through' health care) (Ellison-Loschman and Pearce 2006: 614).

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). Since the 1970s authors have noted the difficulties in, and debate about, how 'access' or 'equitable access' to health care is defined. Goddard and Smith (2001), for example, note that a focus on equity of access is only responsive to the issue of supply, with demand being overlooked even though the preferences, perceptions and barriers experienced by patients are an important aspect of access. The New Zealand Human Rights Commission uses the 'interrelated and essential elements' outlined in ICESCR 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 above components.

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.

3 Method

3.1 Key Informants

A long-list of more than 60 potential key informants working in cancer, CVD, diabetes, Māori health, and health research was initially developed through a review of documents and liaison with key practitioners in the Ministry of Health.

- Those involved in the development of Ministry of Health chronic care initiatives, including guidelines and reports (e.g., authors, advisory group members, consultation participants), including Ministry staff,
- Authors of research publications about health care disparities,
- District health board Māori health managers, and funding and planning managers,
- Hospital clinical staff and managers,
- Primary health organisation Chief Executives,
- Nursing staff (recommended through nursing organisations), and
- Chief Executives and staff of NGOs who work with chronic conditions (e.g., community nurses, general practitioners).

Key informants were then chosen in consultation with the Ministry of Health to reflect a range of roles and responsibilities, as well as locations. Both Māori and non-Māori key informants were interviewed. Of a short list of 30 key informants contacted, 27 responded and agreed to be interviewed.

Key informants were invited to include others in their interview if they felt this was appropriate. Twenty-seven individual and group interviews were conducted, involving a total of 47 key informants. Key Informants have been identified by position descriptions in this report.

3.2 Interviews

An open interview format was adopted. Key informants were sent a project information sheet that included the interview topics before the interview. There were four interview topics.

- Interventions that improve access to health services for the general population
- Instances when interventions do and do not work to improve Māori access
- Targeted interventions that improve Māori access
- Future ideas for improving Māori access

Where available reports, brochures and/or website information was accessed prior to the key informant interviews so that the interviewer had some idea about the context for key informants' work and could frame follow-up questions. The interviews began with greetings, further explanation about the project, and general discussion about the key informants' work before the interview moved to the interview topics. Key informants were asked to provide both evidence- and practice-informed (practitioner anecdote) comments and examples of interventions that improved access to health services.

The key informant interviews took between 30-50 minutes. The interviews were audio-recorded and the notes taken during the interview were expanded upon from the audio recording after the interview was completed. The interviews were also transcribed.

3.3 Analysis

Key informant interview notes and interview transcripts were the data analysed. These were read and re-read for an emergent conceptual framework. As key informants spoke about both barriers to, and facilitators of health care 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. This approach is close to Elaborative Coding; that is, 'the process of analysing textual data in order to develop theory further' (Auerbach and Silverstein 2003). This resulted in the coding of key informant discourse into the broad themes of Health System (i.e., Ministry of Health policy, legislations, funding, etc.), Health Organisation (e.g., interventions promoted within district health boards, primary health organisations, hospitals, general practices), Health Practitioner (i.e., where specific interventions were being applied by or to health disciplines), and Patient (i.e., where interventions were working directly with patients and their whānau (family), or alongside communities). A fifth possible theme from the literature on the Health Microsystem (i.e., health teams) was mentioned only infrequently in the key informant interviews and incorporated into a more general workforce sub-theme within Health Organisation.

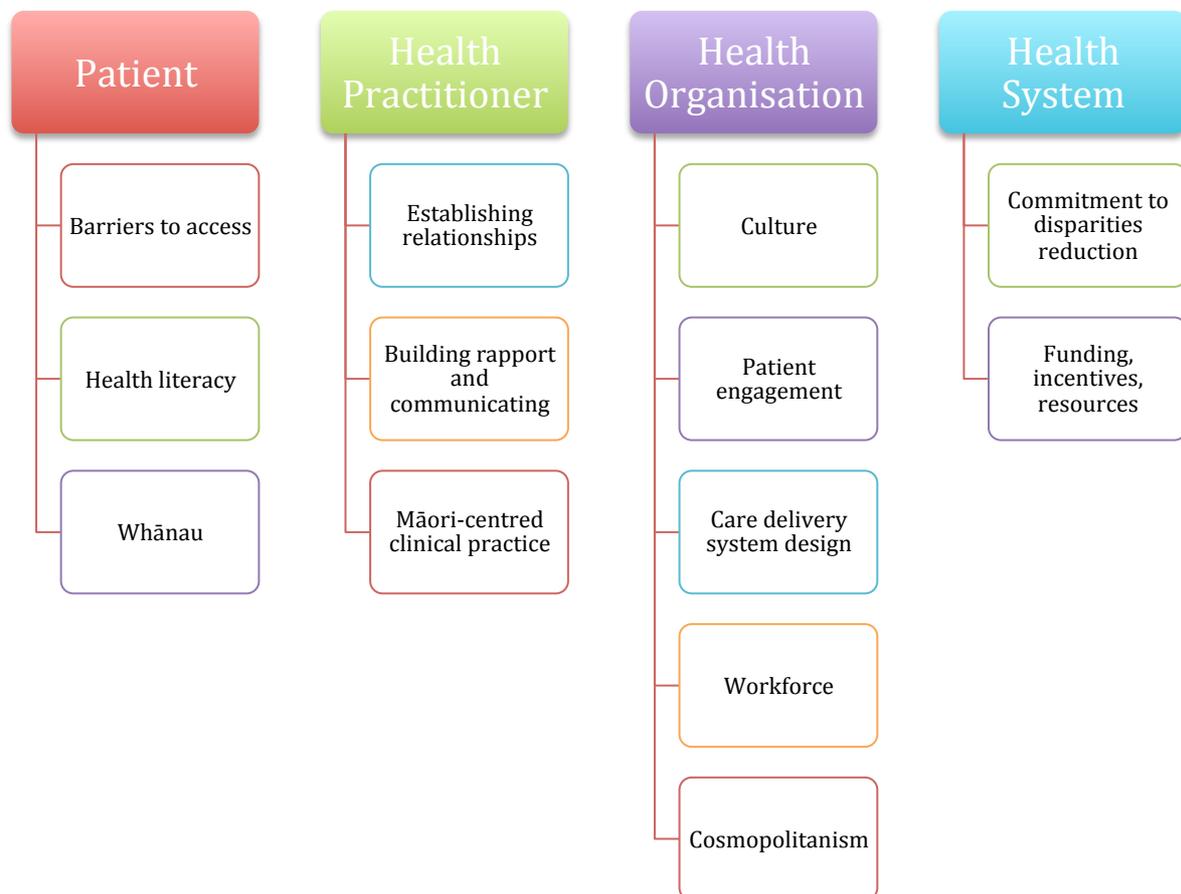
The literature review and the reading and re-reading of key informant interviews informed the development of the subthemes under each theme. Coding of key informant interviews into themes and subthemes was done using Dedoose (SocioCultural Research Consultants, LLC 2011). Following coding the content for each sub-theme was read and organised so that the feedback from key informants could be written about in a way that grouped their talk about common issues, and how these issues were inter-related. There was very little quantification of key informant talk; rather the contribution of individual key informants has been layered within a narrative about each sub-theme.

4 Findings¹

4.1 Overview

The four themes of patient, health practitioner, health organisation, and health system provided a broad structure for the analysis of the key informant interviews according to the focus of comments. Each of the themes contained two or more sub-themes that were used to organise key informants' comments (see Diagram 2). Each of these themes and accompanying sub-themes is described below. 'Key informants' is used to describe general points of agreement among the key informants. When a key informant makes a specific point they are identified according to their role within the health system.

Diagram 2. Representation of key informant interview analysis themes and sub-themes



¹ All due care has been taken to ensure that Key Informant quotes are accurate. Some minor re-wording of quotes may have occurred to add readability. When this has happened any additions are signalled by square brackets and any deletions or omissions by ellipses.

4.2 Patient



Key informants talked about the barriers to Māori accessing services as well as Māori knowledge about health and issues related to self-management of health conditions, especially chronic diseases. Leadership was also a minor consideration. The key points raised by key informants are listed in Table 2. and then described more fully below.

Table 2. Overview of key informant comments about patients and improving access to health services

| Key Findings | |
|----------------|---|
| Patient | <ul style="list-style-type: none"> • Barriers to Māori access to health care include affordability (or cost), knowledge about services, service location and hours of operation, transportation, everyday whānau (family) 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 |

a. Barriers to access

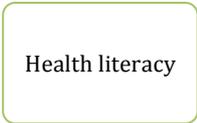


Although barriers to Māori accessing health care were not the focus of this investigation, this topic arose in many of the key informant interviews in recognition that these barriers needed to be addressed in order for access to be improved. The barrier mentioned most often was the cost, or affordability of health services. When cost was not a barrier key informants mentioned people's lack of knowledge about services, or lack of transportation. The everyday crises being faced by whānau (families) may also mean that patients do not prioritise health concerns. Patients may also not want to be a problem so whakamā (reticence) may prevent them from accessing services, or speaking out about their concerns to health practitioners.

Service location, inhospitable services, the lack of Māori staff, insufficient appointment time, and opening hours were also mentioned as potential barriers. As a general practitioner said, 'And there's a whole lot of factors that are the health provider characteristics'. These barriers were a reason offered by an immunisation coordinator for the decision to place the HPV vaccination within schools to increase accessibility.

Key informants also talked about potential barriers to patient self-management of their long-term condition; namely, 'battle fatigue' from having to deal with several things over extended periods of time. Māori expectations about life expectancy may also mean that many Māori with chronic conditions are convinced they are running a different, shorter race. A Ministry of Health informant also discussed the role of the environment as a potential barrier to, or facilitator of self-management, giving the example of how different built environments can either encourage or discourage physical exercise.

b. Health literacy



When key informants talked about what Māori did or did not understand or want from a health service it was coded as health literacy. At the heart of accessing health care for a chronic illness is an understanding of what chronic means as most people's knowledge of illness, according to a medical specialist, is that it goes away. This could account for a general practitioner's comment that patients with diabetes do not know why they have to go back to their health provider for blood pressure and feet checks every three months. Another key informant in the screening unit commented about people's lack of understanding that screening is about cancer prevention, rather than 'picking up cancer'.

A regional cancer network manager described health literacy as being about patients' perspective or knowledge and not about incompetence. This knowledge could be informed by the internet, older whānau members (who may have out-of-date disease information), or experience. A chronic disease management nurse described how patients with diabetes did not know what a podiatrist was until they had experienced the service. Another key informant, a clinical assessor (nurse) for a general practice, described how patients getting referrals to services

from their general practitioners and other health practitioners could facilitate new experiences. Support workers and support groups were mentioned as another avenue for people to find out about services.

Health literacy also extended to patients' judgements about services. Key informants described these judgements as being informed by people's experiences of feeling safe, and knowing that their visit would be confidential, as well as by word-of-mouth from other people in their community about their experiences. However a general practitioner described how merely being able to get a service was more important for some Māori than who was delivering it or their reputation. Another general practitioner talked about patients managing their own access to a walk-in primary care clinic. They also talked about patients owning their own health record.

In terms of patients' self-management of chronic disease a Ministry of Health informant described her mother's 'I'm all good' attitude, in the face of a chronic condition, as informing her own doubts about whether self-management interventions would work for anyone. A district health board manager was more hopeful, talking about the importance of anecdote and persuasion as facilitators of patients' self-management and doctors' learning.

c. Whānau

Whānau

Key informants' mention of leadership included the importance of community leaders and connectors being informed about health initiatives so they could spread health information back to their communities.

Key informants also stressed the important leadership role played by members of a patient's whānau, with whānau and other things that were 'bigger' than the individual patient being the push for patients to find out more, seek out support, and change so they were self-managing better. This role and support included whānau representatives attending health appointments alongside patients, and grandchildren taking a lead by escorting their grandparents to health checks being provided at community events.

...what seems to motivate change...is around, and it's something for Maori, bigger than someone being told when they're thirty that they've got predisposition, and they're on the track of becoming insulin dependent, something before that is actually locked around them, so their whānau, and their relationship is enough to investigate, that I know someone who knows more about it, so they're be able to help me and, if they explain it properly, I can make a difference, I can change (general practitioner).

A general practitioner talked about the importance of general practitioners and community health workers supporting patients within the context of their whānau. Another general practitioner talked about an empowerment model that was about working with patients and their whānau to help them understand health information and set realistic management goals. This model impacted positively on blood pressure, whānau relationships, and disability risk. A primary health organisation manager promoted self-management courses, run by Māori for patients and their whānau, as a way to increase people's ability to confidently self-manage/whānau-manage their long-term condition.

4.3 Health Practitioner

Health Practitioner

Key informants' comments about their own or other individual health practitioners' health practices were included under the Health Practitioner theme. Building rapport and communicating with patients was the most frequently mentioned sub-theme, followed by establishing relationships. Establishing relationships is described first as it begins the engagement between Māori patients and health practitioners. Both establishing relationships and building rapport and communicating provide a foundation for Māori-centred clinical practice. The key points raised by key informants are listed in Table 3. and then described more fully below.

a. Establishing relationships

Establishing relationships

Several key informants described the importance of whakawhanaungatanga (building relationships) as the foundation for working with Māori in the community.

If you don't have that trust and that rapport then they won't let you in the door, and they'll never be home (cervical screening nurse).

Building relationships with Māori might take health practitioners time but once connections are made, a member of a mobile primary nursing team said, Māori are 'going to respect and value the things that you tell them'.

Table 3. Overview of key informant comments about health practitioners improving access to health services

| Key Findings | |
|-----------------------------|---|
| Health Practitioners | <p>a. Establishing relationships</p> <ul style="list-style-type: none"> Establishing relationships is a foundation for improving Māori access to health care <p>b. Building rapport and communicating</p> <ul style="list-style-type: none"> 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 whānau and improves 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 general practitioners' 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 <p>c. Māori-centred clinical practice</p> <ul style="list-style-type: none"> 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 |

The mobile primary nursing team also worked in this way with Pacific Island families. For a chronic disease management nurse this way of working was part of being a Māori health practitioner, saying 'We're taught to be professional but Maori are personal in order to be professional'. While this key informant saw the personal and professional as intertwined, a primary health care nurse manager wanted recognition of the potential stress on the Māori health workforce of holding these dual roles.

A district health board manager described how Māori access and service success was built upon having the right people to establish good relationships.

Like our cancer screening team performs quite well. It's around building relationships and having the right people to broker those relationships because they need to be built on trust in order to be convinced to access into whatever it is, be it development of a programme or access to a service because [this person] said so or because [that person] said, so I'll go because I trust her. We need those right people doing the right thing (district health board manager).

b. Building rapport and communicating

A primary health organisation manager described the aim of patient communication in a health literacy sense as 'not so much [about] trying to lift up a person's knowledge but about trying to change the behaviour of the health provider [to] discussing things in such a way that people can understand'. A district health board kaiwhakahaere hauora (Māori health manager) pointed out that it was also about listening to communities and being responsive to the voices of consumers.

Building rapport
and
communicating

Building rapport was an important part of a chronic disease management nurse's diabetes care work with Māori communities. From there she tailored her messages according to what she thought might work for a patient and their whānau, and encouraged the delivery of consistent messages to patients from nurses and doctors. A mobile primary nursing team's communication to patients in a community setting was about engaging them (often through whanaungatanga (relationships and shared connections), see above), putting them at ease when they are fearful, and updating their knowledge.

So what we do is we have to 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. And break down those barriers they might have had about diabetes and explain to them that we know a lot more about diabetes now; that it used to be this but now it's this (mobile primary nursing team).

This key informant always asked people to tell her what they knew about diabetes, with this helping to inform care decisions. She had also simplified a description of diabetes that worked well with patients and their whānau, and now she was able to use her laptop to show patients on-line videos that explained diabetes in easy to understand terms. When another member of this team wanted patients to attend exercise classes she asked them to 'come and tautoko [support] me by coming to exercise class' and found this approach worked well.

A cervical screening nurse described how communications with Māori women about and during cervical screening were important because of tapu (sacredness) and Māori women's whakamā (reticence) about being screened. She thought that the advertising campaigns had helped women talk more about screening and when they came to see her she used humour to build rapport and help put women at ease.

I'll say, 'Come on down', like they're in the Price is Right, 'Come on Down!' It makes them relax, it really does. You know the people you can do that with and you know the ones that you can't (cervical screening nurse).

This key informant talked about being contacted by women for their next smears and having on-going relationships with clients that makes it all 'like a whānau'. She found that rapport made screening an opportunity for women to talk with her about their sexual health and general health concerns (e.g., menopause), and she described the importance of this for Asian women as well as Māori women. She was sceptical about whether her work would be possible within strict time constraints, and she gave the example of the long time she might spend talking with and supporting women who have been sexually abused in order for them to have a good smear taking experience as part of their healing journey. Another key informant also talked about the importance of kōrero (talk) rather than written information as a way of building trust as well as providing Māori women with information about cervical screening.

Notions of rapport and trust were expressed by a general practitioner when he described how they 'actually engage or capture people when they come in, and we talk to them like they're normal people. We text them, talk to them, fax them...' He saw this engagement with people as foundational to good practice. The limitations on general practitioners' time was acknowledged by two key informants as a possible barrier to this type of engagement, and their suggestion was that another health practitioner (e.g., nurse, community health worker) might be able to develop an on-going relationship with patients that would support primary care as well as patients' self-management. A health initiative evaluator described the positive pay-offs of good communications with Māori patients.

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 (health initiative evaluator).

This health initiative evaluator and her colleague talked about how a personal relationship was more important than an advertising campaign for engaging Māori in cardiovascular disease risk assessments. They expressed their concern that their evaluation work had shown that Māori men might have had part or all of a cardiovascular disease risk assessment but had not had this communicated to them in a way they understood. Their suggestion was to communicate to the men and their whānau so that all could hear and take in information, and whānau could then be supportive once they had the 'full picture'. While they did not see written information as being as effective as personal communications, they had found that Māori would pick up brochures if they have local Māori imagery on them.

A primary health organisation manager talked about the importance of meeting with patients and whānau kano ki te kano (face-to-face) in order to communicate appropriately. Seeing people face-to-face over the internet was also part of the organisational capability mentoring a general practitioner was doing with Māori organisations to help them improve their data collection and monitoring.

When it came to cancer treatment an oncologist's experience was that 'most people want to just do what you say, sometimes at the expense of quality of life'. He described question and answer sessions with patients and their families when treatment decisions were being made, and the responsibility he feels to say 'I don't have all the answers'. His view was also that he saw patients who were motivated to attend their specialist appointments so he was not able to comment about those who did not.

Patient segmentation came up in key informants' talk about communication, and was also the topic of a general practitioner's current research. This might mean communicating in different ways with Māori in different age groups, judging who to use humour with, or communicating differently depending on what people already know or whether or not they are already engaging with health services.

c. Māori-centred clinical practice

Māori-centred
clinical practice

Much of what key informants said reflected an ethic of patient- and whānau-centred care whereby Māori are partnered in their health care. As key informants noted, timing is important in this work; that is, the timing and pace of service delivery needs to be responsive to patients and their whānau. This is especially important for long-term conditions, as patients' health is dependent upon both medical care and self-management.

Two key informants, a hospital nursing manager and a cervical screening nurse, talked explicitly about Māori practice models, and a third nurse key informant described a Māori-centred nursing practice model, Te Kapunga Putohe (the restless hands). Other key informants also described the way they worked with Māori patients and whānau, and the different components of this work are described next. This builds upon what has been covered above.

Three key informants described assessment as the stage that followed their relationship and rapport building with patients. An assessment gave them a clear idea about patient and whānau needs. One of these key informants, a clinical assessor, described how she used to take her laptop to do assessments of rehabilitation, medical and social needs with older people but now she listens to their stories and finds that she is able to get all the information she needs this way. She found that the part of the assessment that asked older people what their goals were did not work for them; 'it's foreign to them...they're just getting on with their lives'. The development of a care plan follows assessment for this key informant, with the care plan based on people's needs and what the service can offer. Once the care plan is developed she goes to the different providers to coordinate services. The other key informants used their assessments to identify and then navigate patients to services that can help them. They also talked about their navigation being about supporting patients to access services, like in this next example of providing information to patients about what a blood test is for.

I can go to the homes and take the bloods but rather than do that I'll take them to the lab because I'm trying to create behaviour, create change... I want them to experience, "This is what I've got to do for my diabetes" so that when a blood form gets sent to them they know they actually have to physically get up and go to the laboratory to get it done. And I'm reiterating the importance behind why they have to have those bloods, explaining to them each blood they're having, explaining to them why they're having it (mobile primary nursing team).

A primary health organisation manager talked about the challenge for non-Māori health practitioners as he saw a 'humongous gap in understanding of this cultural competency stuff' within his organisation, even though staff 'believe they're doing a good job and are working really hard at it'. At the same time he shared that some of the reasons staff had for the lack of Māori engagement were victim-blaming and not helpful; for example: 'Māori don't take their pills', 'Māori are fatalistic'. This key informant saw this lack of cultural competency as a barrier to the organisation meeting its health targets. Yet he was also concerned that staff should not feel cultural competency was being imposed on them as it would then become a 'negative thing'.

A district health board nurse manager talked about getting 'some traction with practitioner development around cultural competency' but qualified this by saying that those who attended the training were not in decision-making roles within the organisation so there were still structural barriers to the implementation of more culturally responsive care. A primary health organisation manager pointed out it might be a matter of recognising 'where your scope starts and finishes and who you need in your team to help you, cause it's all about you and me working together'. In other words, non-Māori staff may only be able to go so far with respectful and culturally responsive health care practice, so they need to work in teams with Māori staff in order to provide the fullest access to health care for Māori. This was exemplified by the community-based nurse informants who saw themselves in an advocacy, collaborative role with general practitioners to provide services to Māori.

Partnering with other services was important for a number of key informants. A cervical screening nurse partnered with general practices in provincial towns to provide cervical smears to their patients. This partnering was built upon good relationships and possibly also worked because it came free for the practices. A chronic disease management nurse partnered with general practices in a similar way to provide diabetes care. This key informant also talked about discharging Māori patients from her care, describing this as a slow process that ended with 6- or 12-monthly appointments and an open-door if patients found they were not managing their diabetes well. The rationale she gave patients for the reduced contact was that other whānau needed the service and that she did

not really need to see them if they were well as they would be going to their general practitioner regularly. This key informant had also just taken patients to a conference so that they could talk about their journey with diabetes.

To me that was the most inspiring kōrero [talk] so now I'm thinking we need to start collecting those stories (chronic disease management nurse).

Facilitating the sharing of patient success stories was part of her practice model. A diabetes specialist also discussed the value of patient stories, although in their case they were describing a 'warning story' that communicated the risks of ingesting sugar-filled drinks.

There were times when key informants had not been able to partner with other organisations and in at least one case had had their funding cut. Some key informants talked about other providers (in particular general practices) seeing them (nurses offering community-based services) as a threat even though the providers were not providing accessible services for Māori and the key informants were clear that their service was complementary. A key informant attributed this 'misunderstanding' to their own service being delivered by Māori nurses at a time when the 'nurse voice' was being 'lost because all we'd see is the doctors' (cervical screening nurse). The commitment of these Māori nurses and their whānau to their work meant that they continued to provide their service in a piecemeal fashion.

4.4 Health Organisation

Five sub-themes (organisational culture, patient engagement, care delivery system design, workforce, cosmopolitanism) make up the health organisation theme. The focus here is on the responsiveness of health organisations to issues related to Māori access to health care. The key points raised by key informants are listed in Table 4. and then described more fully below.



a. Organisational culture

This sub-theme examines the general culture of health organisations and the support shown for improving Māori access to services and reducing Māori health disparities. Leadership for health disparity reduction is explored, followed by organisational learning climates.



Three rationale were given by key informants for health organisations having a commitment to improving Māori health care access: controlling the potential blow-out in future health care costs if disparities in both health care access and Māori health were not reduced, committing to equity and equitable service provision for Māori, and improving access for Māori to improve access for all people.

Key informants described leadership at many levels as being important to the commitment organisations have to the reduction of disparities. As a key informant described,

...you really need strong leadership and political will, and character. I don't think there's any shortage of leadership really, I think people seem to be outspoken about these things if that's their field of expertise, whether or not they make a difference (Ministry of Health informant).

A district health board manager described how the Chair of their board was helping to shift thinking. However two other district health board managers talked about institutional governance being a barrier in their discussion of health services being shutout of a Māori educational institution.

A regional cancer network manager described the importance of shifting the discourse about health disparities from 'their fault' to an organisational issue that required practice changes. A governance oversight committee was being established by another organisation to oversee such practice changes. These changes were based, in turn, on what the district health board manager described as a comprehensive engagement process with a range of health leaders. A primary health organisation informant pointed out a leadership gap in a governance group that, if filled, would help put equity to the fore of the organisation's work. Three key informants discussed the evidence that CEOs had gained – through data analysis and personal experiences – that informed their leadership of organisations committed to reducing disparities.

A regional cancer network manager described the importance of clinical leadership that was gained through getting people sitting round a table. A hospital nursing manager talked about the role of clinical leaders championing organisational changes designed to reduce health care disparities, describing how they 'brought in one of the general practitioners who's really passionate about Māori patients and doing something about

Table 4. Overview of key informant comments about health organisations improving access to health services

| Key Findings | |
|----------------------------|---|
| Health Organisation | <p>a. Organisational culture</p> <ul style="list-style-type: none"> • 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 <p>b. Patient engagement</p> <ul style="list-style-type: none"> • The organisation connects with Māori at community events • 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 <p>c. Care delivery system design</p> <ul style="list-style-type: none"> • 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 <p>d. Workforce</p> <ul style="list-style-type: none"> • 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 practitioners 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 <p>e. Cosmopolitanism – connectedness with other organisations and agencies</p> <ul style="list-style-type: none"> • 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 |

readmissions'. The championing of research evidence by clinical leaders was described by two other key informants as important to organisational commitment to improved Māori access to health care.

A district health board manager talked about Māori leadership happening within their organisation at several levels – from the Board to managers and staff. Three key informants talked about the importance of Māori leaders having credibility within their community and with health providers. As one said, 'the system has to recognise you in order to want to work with you' (primary health organisation manager). A district health board manager also spoke about the need for those within an organisation to whakamana (authorise) their leaders; that is, to work hard to provide them with evidence and outcomes that support organisational goals.

A regional cancer network manager described how leadership and strategic direction was provided to her organisation by a Māori leadership group. A number of key informants described formal relationships between health organisations and local Iwi. These relationships were considered long-term, with the health organisations drawing guidance on such matters as their Māori health planning.

Key informants described the learning climate in an organisation as being about targets, data, monitoring, research and evaluation, strategy and opportunities for reflective practice. Each of these is discussed in more detail below.

A district health board manager stated that the Ministerial health targets were driving a lot of the activity within their organisation. This was also reflected in their, and other key informants' discussion of how strategy is created in response to the targets and is linked with the wider regional strategic direction. They also talked about the importance of buy-in from the sector as an enabler of implementing strategies. The first key informant described how the organisation's high-level target was the reduction of disparities and they

...now needed to change the way the organisation develops as an organisation so it has the right capacity and capability and the right enablers to achieve the outcomes we're after in the next five years (district health board manager).

They had therefore managed as an organisation to strategise for the Ministerial targets within the context of a broader disparity reduction goal, and now had an implementation plan that would enable them to achieve this alongside patient satisfaction and service cost effectiveness. Part of this was a commitment to dis-investing in services that were not effective by these measures.

Several key informants mentioned the importance of quality data as this allows organisations to understand what is going on. A general practitioner raised the issue of classification of ethnicity, saying that it was not as bad as it had been but was still a problem within health data. A screening unit informant described the difference between a population register and health service data, saying that women may miss out on programme enrolments because of the reliance on health service data that excluded those considered to be 'casual' patients by primary care practices. They speculated that those who missed out might be the ones at highest risk and in most need of enrolment.

A district health board project manager described the existence of multiple, incompatible databases about the same client group as a barrier to data use. This key informant also expressed their frustration that managers within their organisation did not appear to understand the data. By comparison a regional cancer network manager described how data-savvy practitioners in secondary and tertiary health services were, such that data discussions preceded any discussions about what actions to take in response to health care disparity data.

The data has to come from them, from their service. They agree on inclusions and exclusions. And then you can start to have discussions about the real issues (regional cancer network manager).

According to a district health board manager the use of data by their organisation provided them with a sense of control; that they knew what was going on. Key informants suggested that organisations could then think about linking internal datasets, linking primary and secondary data, and sharing data for comparison purposes. This last point goes hand-in-hand with key informants' comments about monitoring to see if organisations are being effective over time, celebrating successes, and learning from other organisations that are doing better. This latter task was described by a general practitioner as the function of 'collaboratives'; that is, practices working with other practices that were doing better to see what they could improve.

A primary health organisation manager said that monthly reporting enabled their organisation to identify supports that can be put in place to improve access for Māori. Other key informants also said their organisations continuously adapted in response to their analysis of service data. A barrier to this type of analysis and adaptation

raised by a primary health organisation manager was the broadness of contractual outcomes that made it difficult to review exact achievements. Their organisation was in discussions about this with their funders.

Key informants also talked about the role of research and evaluation, including the evaluation of pilot initiatives to improve access. A chronic disease management nurse described service evaluation findings that Māori patients were satisfied but clinicians still thought they were unwell. Monitoring patients' health data was the next step in examining this further although this was hard for their community-based organisation to obtain from the district health board. Another key informant described how the end result of evaluating a pilot programme was so that 'practices will understand what the things are that they need to do and change in terms of engaging Māori' (district health board funding and planning staff member). Consumer surveys provided similar feedback for another organisation, as well as positive feedback about what was working well that motivated staff within the organisation.

Key informants highlighted Wendy Steven's research on lung cancer as an excellent example of research that informed understanding of health care access. This study was described by a key informant, who praised the language and systems-based analysis used.

The study was really good in that they delineated responsibility between primary, secondary care. And there was a clear understanding of and use of language in the study that didn't put patients in the position of fault, which I think is a really key thing (regional cancer network manager).

Similar research on colorectal cancer was currently underway. Primary health organisations and individual general practitioner practices were also conducting research on health care access that was letting them know if they were making a difference and informing their practice. A note of caution was sounded by a diabetes specialist about drug trials not reflecting the real-life experiences of patients (i.e., external validity) and so these interventions, although found to be successful, were often difficult to replicate.

For a district health board project manager the role of data, monitoring, research and evaluation was to inform reflective practice that would empower practices and organisations to become 'learning organisations'. They did caution however that it takes dedicated time for practices to analyse their data and then to decide what to do to improve access in 'problem' areas. A general practitioner had also found that while other general practitioners were interested in his research on diabetes care, they did not show any inclination to replicate the effort in their own practices. Another key informant was working with primary health organisations to facilitate their capacity to collect and analyse their own data. A district health board manager summarised other barriers to reflective practice, including data quality, systems not being in place, poor contracting, workforce capability, lack of policies, and lack of training. Other key informants stressed the importance of leadership, especially clinical leadership, to overcoming these barriers.

b. Patient engagement

Patient engagement

Patient engagement was separated out from organisations' care delivery system design (see below) in recognition that before organisations could provide health care they need to reach out and engage Māori. This section reports on key informant talk about how this is achieved.

Key informants stressed the importance of connecting with Māori at events such as festivals or out in the community. At events health checks could be provided in conjunction with things that whānau enjoy such as haircuts or mirimiri (massage). Sometimes these opportunities were missed by organisations. For example, a key informant expressed her disappointment that only one nurse from her organisation had attended an event for 600 children and their whānau. Her explanation for this was that 'we just weren't prepared to go out into their world' (district health board manager).

Community health workers can be employed to reach Māori in communities. As a district health board manager described, their community health workers were

...actually making the phone calls, going out, knocking on the door, having a cup of tea and saying 'when you're ready' and not saying 'I'm here to take you, I'm here to do it'. It's actually 'I'm gonna explain it to you first' so that whakamarama [explaining] first (district health board manager).

As a district health board kaiwhakahaere hauora (Māori health manager) said, this investment in reaching people pays off in terms of their wellness, and the benefits of this for their whānau and their community. A general practitioner shared that patients often described the community health workers as aunty figures. Having kaimahi (community health workers) who are from the community was important for a general practice manager, as they

are able to facilitate the connections between whānau and the health service. She also stressed the importance of using opportunities to connect with whānau.

...we have to use every opportunity to interact with our whānau, because otherwise we won't be able to help. Trust is a huge thing for them, if you break that trust, through something that's not even your fault, it cuts you out, they won't let you in the door (general practice manager).

Key informants also described navigation services as a way of engaging Māori patients. A primary health organisation manager talked about navigation enabling patients and their whānau to understand and access the wider landscape of health and social services, rather than only navigating them to and through specific health services. This was being undertaken well by public health nurses in their organisation, while Māori staff more generally used their connections with communities as opportunities to provide navigation advice and assistance. The organisation was now challenging Te Puni Kōkiri to navigate whānau who had completed whānau ora plans that included health priorities, to appropriate health services. A district health board manager talked about the importance of Whānau Ora navigators being practitioners, and organisations making sure they signed off on ethics and privacy to ensure that whānau engagement was done correctly.

A key informant talked about the importance of navigation services when a whānau member is diagnosed with cancer. Another key informant was aware of the Ministry of Health's initiative around cancer care coordination that would 'put people in to support whānau, as a consistent point of contact when they come in contact with complex systems' (regional cancer network manager). They speculated that navigation in these circumstances was most likely going to be done by a nurse who would also be a care coordinator. A clinical nurse assessor saw this type of navigation service as useful for coordinating services for older people.

A hospital nursing manager provided an example of when she had stepped into the role of care coordinator and what this might mean for streamlining patients' interaction with health services.

Let me give you the example of a woman with diabetes with multiple appointments with many doctors... I interviewed her at home, and her family. And a key stressor for her was all the appointments. She was up at the hospital every day. By me doing a letter to all the different doctors, I became her case manager (as I was asked to get involved). Because of that one letter the doctors figured out who really needed to see her and she ended up with two doctors (associate director of nursing).

A general practice manager talked about their clinic's experience of many Māori in their community being illiterate so they could not assume that patients would understand words on paper. They had learned to pick up the clues for this and their solution was to talk with patients about the words to send to them so they would understand when their next appointment was, for example, '...we send them a letter and it says 'come to clinic' written as 'cm 2 clc', because they understand text words and that's how they prefer it' (general practice manager). This was recorded on patients' files. All this was done within a relationship context that also resulted in patients seeking out staff members' help with other information they were being sent.

...we know how important the relationship is to establish with them, and so we have a lot of whānau that bring their mail in to us. So they come in for their blood pressure check, or whatever, and they also bring their mail for us to tell them whether it's important (general practice manager).

Mobile services as a way of connecting with communities was mentioned by key informants and are discussed further below. Other means of making services more accessible included making them more affordable and improving the reception Māori were given. A general practitioner talked about having a script for receptionist so that they would not 'dismiss patients'. Another general practitioner described the opportunistic diabetes screening of patients who were accessing health care as another way of engaging Māori.

Key informants also talked about the importance of organisations engaging with whānau. For a key informant there was too much individual rangatiratanga (self-determination), 'people saying no-one's telling me what to do' (primary health organisation manager). She saw individuals as having mana (status), whereas the rangatiratanga belonged to the wider whānau group so it was this wider group that should be engaged with about health care and decision-making.

c. Care delivery system design

Care delivery system design

The Māori responsiveness of care delivery systems was succinctly described by a key informant, 'There needs to be some perception that the service is provided for Māori' (health initiative evaluator). The perception was that this was more straightforward for Māori providers, with their care delivery embodying Whānau Ora, Kaupapa Māori (by Māori, for Māori) and/or tino rangatiratanga (self-determination). The importance of the cultural responsiveness of non-Māori organisations was acknowledged, as these organisations needed to be seen by Māori as for them. However for a general practitioner the heterogeneity of Māori was an issue in the consideration of responsiveness; namely, that 'it is very hard to be specific about what it is to be Māori' and therefore difficult to make generalisations about what good health care is for Māori.

At an organisational level whanaungatanga (relationships) and manaakitanga (hospitality) were described by a district health board manager as reaching out from the service to the whānau that staff members are related to in order to facilitate their health knowledge and access to services that they might not otherwise have. This included the embedding of health services within other activities that whānau are engaging in, such as pig hunting, work, or school, so that whānau were already gathering for a group activity. A key informant in a district health board described how whakawhanaungatanga (establishing relationships) could help organisations meet their Māori health targets by enabling them to identify individuals and whānau in communities the organisation could then provide services for; for example, cardiovascular disease risk assessments. As stated by a key informant, 'Māori are much more motivated... when there's a purpose to it and it's done in a group setting' (district health board manager). The availability of group bookings for breast screening was also recognised as making the service more accessible for a number of cultures. Other forms of Māori responsiveness come into play when Māori patients are engaged with a service. Key informants talked about mainstream services having a family-centred approach, using Māori cultural advisors, connecting whānau with kaumātua (elders), facilitating wider whānau meetings, providing information to whānau on DVDs, and doing home visiting. The use of a patient satisfaction target was one way a district health board was ensuring that quality improvements were facilitating Māori access to services, and this would also test assumptions about what improved the health experience of Māori patients.

A general practitioner talked about long-term condition nurses seeing patients in their homes and gaining good insight into how patients and their whānau were living their lives, and what might be achievable or not in terms of them managing their own care. Three key informants in the same primary health organisation interview group talked about the difficulty of being responsive if they did not know what else was going on in patients' lives (e.g., poverty, abuse). One described moves within their primary health organisation toward 'What matters to you' medicine, and away from 'What's the matter?' medicine, where they worked with whānau and what is important to them. A second key informant described this as the first stage of whanaungatanga; that is, 'making that connection with the person, and finding out what matters to them'. The second stage described by this key informant is *hauora* and the mobilisation of health services, and the third stage is *whānau ora* and engaging with other practitioners and providers who need to be on the team for that whānau. A third key informant acknowledged the important role played by kaiawhina kaumatua (supportive elders) in assisting Māori patients and their whānau. For a district health board manager a whānau ora approach underpinned the holistic Māori models of health care that she saw as needed in secondary care.

The enthusiasm of screening providers who, in the words of a screening unit key informant, 'just continue to raise awareness and encourage and promote' their health services to Māori has been reflected in increased service coverage for Māori. Māori women's access to breast screening was facilitated by culturally-tailored media campaigns and education, combined with community health workers who liaised with them and arranged appointment times, transportation and support. A cervical screening nurse talked about Māori women needing to have time spent with them until they were ready for a cervical smear. A primary health organisation manager who also raised the issue of time suggested that more responsive care for patients with long-term conditions might be provided by practice nurses or in nurse-led clinics, rather than by general practitioners.

Community-based care was discussed by a cervical screening nurse (who also talked about taking time with cervical smears, see above) as a form of cultural responsiveness that would make services more accessible for Māori. Another cervical screening nurse described the need to offer a mobile cervical screening nurse service within small communities in order to engage with Māori women. As well as providing a 'by Māori' service, this key informant found that women were assured of confidentiality within their small community because she was not a local provider. She now wanted to provide a mobile service to Māori women working in factories. A screening unit key informant reported that a breast screening service had recently become more mobile, offering community-based screening from vans. They were liaising and sub-contracting with Māori providers and organisations to ensure good access to the service for Māori women.

Key informants talked about their experiences of times when organisational resistance or making bad decisions can be barriers to an organisation becoming more responsive. For a Ministry of Health informant this was as simple as an initiative that was aiming to reduce hospitalisations not having any signal on its website that it was inclusive of Māori or Pacific peoples or committed to the reduction of disparities. A district health board kaiwhakahaere hauora (Māori health manager) described how the provision of gowns for women getting mammography was initially resisted by an organisation because of laundering costs and when others supplied the gowns the organisation signage discouraged their use. There were also some unsuccessful initiatives named by a primary health organisation manager, with reasons for these not improving access for Māori to primary care including: clinics sited in the wrong locations, general practitioners not referring Māori patients, and text messaging (to reduce DNAs) not being appropriate for older Māori patients.

A hospital nursing manager talked about her attempts to initiate Kaupapa Māori units and Māori models of care as part of secondary care being thwarted by managerial attitudes about treating everyone the same. Her experience was a reminder that many of the responsiveness practices listed above are about connecting Māori with the same service that everyone receives, rather than inherently changing the service delivery model to a Māori model of care. For the district health board kaiwhakahaere hauora a Māori model of care meant not reducing Māori women to their body parts of cervixes and breasts. They advocated for treating women as 'whole people' by offering them a more holistic health service.

Key informants raised the importance of clinical pathways. Two district health board managers talked about the fragmentation of services inside district health boards and primary health organisations and the need for this to be fixed before people looked for external reasons for Māori not accessing services. Key informants mentioned the development of cancer care, cardiovascular disease and diabetes pathways. As a district health board manager described it, there were very positive payoffs from having a 'wide, joined up approach, that was integrated and coordinated for best population health outcomes, with better quality services, and living within our means in constrained times'. Other key informants were excited by the possibilities presented by the development of regional Whānau Ora pathways or generic pathways to Māori health improvement. Key informants also saw pathways connecting various health practitioners who could then work with the same whānau.

Key informants talked about developing or changing organisational systems and policies, developing guidelines, and using equity tools such as HEAT and the Whānau Ora Tool to embed organisational responsiveness. As a key informant described, '...we are trying to address whānau health issues and equity issues in specific ways. One of my staff members and I have developed tangata whenua guidelines which form the basis of workshops for general practices' (primary health organisation manager). A regional cancer network manager described how their organisation was using equity tools to guide the development of standards of care that would then be used by everyone to understand cancer care pathways.

d. Workforce

Workforce

The emphasis within key informants talk about workforce was on the roles and responsibilities of nurses. A primary health organisation manager described how outreach nursing contracts enabled them to maintain strong links between patients and their family care providers. Social workers were also seen as an important workforce, with a mobile primary nursing team member describing the teamwork between a community-based nurse and social worker. As a team they are often able to engage with patients and whānau who might not respond to a direct approach from one or other of them. Additional navigators were not seen as needed.

[The social worker is] a navigator: she identifies needs and directs/navigates them in to social services. I may identify our whānau need social support, I refer them over to her, and she does her own assessment and identifies where she can help them with that need (mobile primary nursing team).

For another key informant the Whānau Ora initiative had the potential of building a practitioner navigator workforce that could engage the whole whānau in their home so that "they're able to actually do stuff" (general practitioner). However this sounded very much like the role that social workers were currently filling within community health teams.

A primary health organisation manager talked about their concerns that Māori nurses working in the community were very busy, and that more capacity was needed to support their work with Māori with long-term conditions. For example, a chronic disease management nurse providing community based diabetes care had about 350 registered patients and just her 'doing nursing, administration, travelling, relationship building'. A general practitioner acknowledged the workload of community-based nurses and health workers and talked about the need for organisations to put in place mechanisms (e.g., policies that guide service provision) to prevent staff burnout.

For a general practitioner a higher nurse to general practitioner ratio in primary care allows for nurse-led clinics and the relational context that supports regular patient checks and management, especially if patients may not have access to the same general practitioner at each visit. A potential barrier to this was general practitioners' concern over losing patients and the funding associated with their care. Another general practitioner described how a practice nurse and a physicians assistant would work together in primary care – the practice nurse doing immunisations and smoking cessation, and the physicians assistant triaging patients. They saw this as a 'systematic approach to the needs of the population that has the correct range of skills aligned with needs'. Their view was that patients found it a rewarding experience to be care for by a team. Another team operation described by a key informant was in a small rural community that has

'...a sole [general practitioner] who works four days a week, a receptionist, a practice nurse in the clinic, as well as a practice manager, and then we have a community nurse, a community worker, and a health promoter... That's unique in the sense it's allowed us to work services not only in the clinic but outside in our community too' (primary health organisation manager).

Workforce capability building in primary care can happen through organisational initiatives that also bring staff closer together so they can work as a team. A key informant described how they had 'educated a whole workforce. It's collegial, we have to tackle things together' (primary health organisation manager). This was motivated by the recognition that general practitioners could not do it all themselves and all the staff had to take ownership of improving health care. A general practitioner described a goal of multidisciplinary clinics as improving patients' ability to live well, with the added bonus of more workforce satisfaction. Staff education may also involve building staff's cultural competency because, as noted by a key informant, some health providers have still not come to grips with this (although many have). Investment in staff from a district health board manager's perspective was about building their capability for system change that aimed to reduce health care disparities.

Opportunities were seen by a chronic disease management nurse to grow the number of nurse practitioners in primary care, and to engage fully with the apprenticeship style of training that nurse practitioners required. This key informant's concerns about the lack of positions within primary care for nurse practitioners were echoed by another key informant who had to 'scratch around' to fund three Māori nurse practitioners in their primary health organisation. They described the craziness of getting nurses to do post graduate work and then 'not honouring them' with positions within primary care because of funding formulas. This key informant also talked about the Māori nurse practitioners being part of their organisational commitment to match the ethnicity of their workforce to the ethnicity of their population.

A key informant made suggestions for additional changes within primary care, including staff who have 'real good interviewing skills, motivational interviewing for example, are very patient orientated ...and may be good as an advocate if that's required; empowering the patient, co-ordinating, and thinking outside the square' (Ministry of Health informant). While they saw nurses as having or being able to develop these skills, they also suggested other practitioners such as occupational therapists and social workers. This key informant was also keen for primary health care providers to build their public health expertise, because 'we're increasingly operating this ambulance at the bottom of the cliff' rather than thinking about prevention. A general practitioner talked about how multidisciplinary team clinics in primary care could work well and suggested a case management system whereby any one of a range of team members could be the point of contact and case manager for a patient.

Other key informants also discussed the importance of having a Māori health workforce, with a key informant describing the establishment of an organisational target to increase Māori staff within their district health board that sat with their human resource general manager. They now monitored health training programmes to keep track of Māori graduating and becoming potential employees. A regional cancer network manager reflected on the evolution of skills within the Māori health workforce over the past 10-15 years that meant that people were more astute about influencing systemic changes. The recognition of the importance of growing the Māori workforce was coupled with a note of caution from a key informant about ensuring that Māori staff were well supported and not elevated above their skills and expertise. Mentoring and organisational support for Māori staff (e.g., leadership, opportunities for career development, flexible hours for those with whānau responsibilities) were also talked about by other key informants.

A hospital nursing manager was concerned that the number of Māori nurses working in secondary care in their region had 'dropped remarkably'. They had put in initiatives to support Māori nurses through a leadership programme but remained concerned about whether there would be positions for these nurses, commenting 'When you grow your own you don't actually employ them'. This key informant also promoted the need for nursing to have a 'Māori lens' so that nurses could contribute to the reduction of health care disparities. They described how they had had 'really good results' teaching non-Māori nurses about cultural competency and the use of Māori

health care models. However the workload of nurses in secondary care remained a concern for this key informant, as it was a barrier to good practice and a reason for nurses leaving.

An oncologist questioned the role of nurse practitioners in secondary and tertiary cancer care because of what they saw as the extra demand it placed on specialist medical staff. Their experience was that it was 'not necessarily saving time as a nurse practitioner can have and see their own patients but they are darting in and out for prescribing and complicated patients... and sometimes the easiest things are the ones that can kill someone if they are gotten wrong'. However they were not opposed to nurse practitioners but rather wanted to ensure that a changing workforce did not increase risk. Current and predicted workforce shortages in medical specialists may make workforce changes inevitable. Key informants, for example, pointed to the shortage of medical oncologists that was expected very soon that raised many issues, including 'how many centres needed, how roles get delineated, proper engagement with primary care, role of nurse practitioners' (regional cancer network manager) and finding ways of getting patients to present earlier to health services.

A regional cancer network manager described social workers as fulfilling important roles in tertiary care as patient advocates and navigators. Nurses also supported patients moving into palliative care, and helped them with their pain. This key informant also discussed the role of multidisciplinary teams in clinical decision-making in tertiary care. A number of variables were considered, including patient variables such as distance from the hospital, and medical specialists' timetables. While they saw potential in this decision-making process for the hard access issues often faced by whānau (e.g., distance from services, poverty) to be taken into account in a way that negatively affected 'best care' decisions, they stated that teams were very careful about dealing with such issues.

e. Cosmopolitanism

The term 'cosmopolitanism' is used here to describe an organisation's connectedness with other, health and non-health service, organisations, and agencies. This links in with navigation services and health practitioners partnering (see above) as practitioners and organisations need to have relationships with other services if they are to successfully work with them or navigate patients and whānau to them. A key informant described how the National Hauora Collective talked about every door being an open door to health care, so there is an opportunity for opportunistic health care being the result of Māori encounters with all sorts of non-health services and agencies, practitioners. Key informants saw good relationships and the complementarity of services as the foundations of cosmopolitanism.

Cosmopolitanism

A primary health organisation manager talked about choosing to locate their Māori primary health service in a hub with other service organisations so that they could get to know and collaborate with the providers around them. They also invited other services (e.g., podiatrist, dietician, physiotherapist) to use their facilities so that their whānau would have ready access. This key informant added that as most Māori providers are not clinically led it was especially important for them to be in such hubs where they also had access to clinical services for their patients and communities.

Another primary care organisation manager was leveraging her organisational relationships with health providers to promote the development of a Whānau Ora health care pathway. She also talked about making friends with secondary health services and getting over the idea that they were 'always trying to get our contracts'. Another key informant talked about the need for primary health organisations and the district health board in her region to work more closely together so that service coverage improved. Another key informant endorsed this and gave the example of better discharge planning as a place where primary-secondary health service relationships could be improved.

A manager talked about how their district health board was looking to work more closely with other government departments, including justice, housing, social development and Te Puni Kōkiri, and local councils. This was starting with the local CEOs of these organisations coming around the table to discuss collaboration. They were also strengthening their relationship with the local Iwi. For them this was a move aligned with Whānau Ora as it was designed to better meet the needs of Māori whānau.

Commercial relationships were also being brokered and a key informant talked about their partnership with a telecommunications company.

A barrier to cosmopolitanism raised by key informants, that has also been touched upon in other sections, is health providers' resistance to let other services access their patient population. This was even the case when there was no cost to the other health providers but they were still fearful of losing their patients. For a clinical nurse assessor this perception was based on historical facts and their organisation practised differently in the current day.

4.5 Health System



Key informants also commented on what they thought the health system (i.e., the Ministry of Health) could do to improve Māori access to health care. Staff from the Ministry's screening unit were also key informants so many of their comments reflected a health system response and are included here. The key points raised by key informants are listed in Table 5. and then described more fully below.

Table 5. Overview of key informant comments about the health system improving access to health services

| Key Findings | |
|---------------|--|
| Health | <ul style="list-style-type: none"> • 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 |

a. Commitment to disparity reduction



A diabetes specialist talked about Māori being more biologically prone to cardiovascular disease and renal disease when exposed to our current environment, much like white people '...are more likely to get melanoma than Maori and Pacific people under the influence of the sun', and that this needed to be taken into account in any system responsiveness. They wanted to see the same sort of commitment from the health system to the reduction of these Māori health disparities as there is to getting people to quit smoking; for example, taking action about the country's food supply.

The Ministry of Health Screening Unit's main focus is now on Māori, Pacific and Asian women and ensuring that they have access to cervical and breast screening services so that universal screening targets are met. They are also looking at assessment and re-screening services and what equitable access means for these services. Part of this commitment is about data matching so that unscreened women can be identified, and this has been successful for breast screening.

Key informants from a regional cancer networks 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.

Another Ministry of Health key informant talked about the importance of good data and the IT solutions needed to ensure this. The issue they were facing at the moment was difficulty getting primary care organisations to agree about what that solution would be so her work within this Ministry was being slowed by lack of access to data.

b. Funding, incentives, resources



The screening unit was trying to make their provider contracts for screening services focus on the recruitment and retention of Māori, Pacific and Asian women, as a way of ensuring equitable access to health care. They also have the discretion to increase provider smear volumes and are seeking reassurances that if they do so the additional volume will be for Māori and Pacific women.

A general practitioner was looking for policy change that would provide more flexibility about who could provide primary health care, rather than the current funding incentives that were about doctors seeing patients. This key informant saw changes that allowed nurse practitioners to enrol patients as a good move. They also suggested the revision of other health funding models that were based on fee-for-service, giving the example of how this funding model was an incentive for getting people into hospice even if their whānau wanted them at home and was coping well.

A chronic disease management nurse called for specialist nurses to be included in discussions about funding primary care services, rather than these being solely general practitioner driven. Her example was the exclusion of nurses 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 (chronic disease management nurse).

The screening unit were currently working to address the cost barrier to screening by providing free cervical screening. They were also pleased with the change to mobile breast screening that had taken place in Waitemata. They described how they contract with the lead provider as well as Māori providers that assist with support services to ensure that Māori women access screening. They also contract with some 'dual providers' who offer both cervical and breast screening in response to feedback 'that women didn't want to just hear about one part and they wanted the holistic service'.

5 Discussion

Key informants were asked to talk about improving access to health care generally, and in particular what helped improve access to health care for Māori. Improving access was more than merely addressing the established barriers to Māori access. The main barrier recognised by key informants was cost and there were moves to address this, particularly in relation to cervical screening. Key informants who had reduced the cost of primary health care for their communities found that other aspects were also important for ensuring service accessibility. These included the location of services (in hubs, with other services, and close to where Māori were working or living), and what services were provided (multiple services providing multiple access points for Māori, including in one case a gymnasium attached to the health centre). Having what the National Hauora Collective describe as many open doors to health care makes sense given key informants' comments that Māori build health knowledge from both information and experience. Facilitated introductions by general practitioners, nurses, or other services to 'new' health services can therefore inform Māori about services that they would not otherwise know exist or realise are helpful for their own health and self-management.

These facilitated introductions to health services do not happen by chance. Rather they take place within the context of relationships based on respect and trust. This can be considered a proxy for what key informants in this study talked about as the importance of whakawhanaungatanga, or establishing relationships. For Māori health practitioners the intertwining of their practitioner and personal lives was reflected in the ways they engaged with and provided health services for Māori patients and their whānau. First and foremost they established personal links between themselves and patients. These could be about shared genealogy and/or shared experiences (e.g., going to the same school, growing up in the same place, knowing the same people). This connection with whānau then enabled them to engage in health care. The discussion by key informants of the time it took to engage with Māori women so that they would feel comfortable with, and consent to, having a cervical smear illustrated the importance of this. The success of Māori smear takers in undertaking this work demonstrates that even when the health issue raises concerns and potential barriers related to tapu (sacredness) and whakamā (reticence), and sometimes issues of abuse, it is possible to provide accessible health care for Māori women.

Key informants also talked about treating Māori patients like they were people, and generally working in respectful ways. When this was difficult for non-Māori health practitioners to grasp or implement, the solution suggested was that they work with Māori staff and take a team approach to providing culturally responsive care. This approach was most evident when organisations employed community health workers, community nurses, or patient navigators to facilitate the connections between Māori communities and the organisation.

Culturally responsive health care for Māori builds upon this foundation of whanaungatanga (sense of connectedness and relationship) and supports patients and their whānau to access health services as well as self-manage their chronic condition(s). This was exemplified in a key informant's story about building the capability of patients with diabetes by educating them about what different health care was (e.g., blood tests), why they needed it, and how they could go about getting it when appointment times and recall notices were posted to them by health services. This approach is one of inter-dependency with the aim of improving Māori patient's health and handing them over to the health services that should rightly be caring for them. Although key informants reported that general practices were sometimes suspicious of the assistance they were giving Māori patients, it was clear from what key informants were saying that their role was to fill accessibility gaps and strengthen Māori patients' access to their general practitioners, rather than replace their general practitioner.

The connections provided by community-based health practitioners facilitated Māori access to services provided by Māori health providers, as well as mainstream health services. Getting Māori into mainstream services is just the beginning of ensuring that they have access. The next part is about their access through services. Organisational commitment to increasing their Māori workforce is part of improving Māori access through services, as is the development of clinical pathways. However these initiatives are window-dressing if the way health care is delivered within mainstream services is not inclusive of Māori models of health and health care.

Organisational commitment to the reduction of Māori health care disparities rests upon committed leadership and the analysis of quality, local data. These factors should also influence the inclusion of Māori models of health care. In one case, at least, a key informant reported that organisational leadership excluded Māori models of health care because of their lack of understanding of health care disparities. Plans by a district health board key informant to collect patient satisfaction data may add impetus to changes being made at a practice level.

In conclusion, key informants highlighted several opportunities for improving Māori access to health care. Māori patients need to be considered within the context of their whānau and reached out to by health care providers who can operate in relationship-based ways while delivering professional health services. These providers can introduce and facilitate access for Māori to health services that may not be so relationship-based but are important for the health care they can provide. Māori staff, and culturally competent non-Māori staff, can help make these organisations places where Māori are welcomed. In the long term the commitment of organisational leadership to reducing health care disparities may see the strengthening of organisational capacity to deliver culturally responsive health care.

References

- Auerbach C F, Silverstein L B. 2003. *Qualitative analysis: An introduction to coding and analysis*. New York: New York University Press.
- CSDH. 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization.
- Ellison-Loschman L, Pearce N. 2006. Improving access to health care among New Zealand's Maori population. *American Journal of Public Health* 96(4): 612-617.
- Goddard M, Smith P. 2001. Equity of access to health care services: Theory and evidence from the UK. *Social Science & Medicine* 53: 1149-1162.
- Human Rights Commission. 2004. *Human rights in New Zealand today*. Wellington: Human Rights Commission.
- Hunt P, Bueno De Mesquita J. 2007. *The rights to sexual and reproductive health*. Essex: Human Rights Centre, University of Essex.
- Jansen P, Bacal K, Crengle S. 2008. *He Ritenga Whakaaro: Māori experiences of health services*. Auckland: Mauri Ora Associates.
- Ministry of Health. 2002. *Reducing inequalities in health*. Wellington: Ministry of Health.
- Ministry of Health. 2010. *Tatau Kahukura. Maori health chart book 2010*. 2nd Edition. Wellington: Ministry of Health.
- Robson, B & Harris, R (Eds.). 2007. *Hauora: Māori standards of health IV: A study of the years 2000-2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pomare.
- SocioCultural Research Consultants, LLC. 2011. Overview. dedoose. URL: www.dedoose.com/LearnMore/ (Retrieved January 12, 2013).
- United Nations. 2000. Substantive issues arising in the implementation of the International Covenant On Economic, Social And Cultural Rights. General Comment No. 14. Geneva: Economic and Social Council, United Nations.
- World Health Organization. 2011. *Health and Human Rights. Indigenous peoples right to health*. World Health Organization. URL: www.who.int/hhr/activities/indigenous_peoples/en/index.html (Retrieved May 4, 2011).