Organisational views on health care access for hauā (disabled) Māori in Murihiku (Southland), Aotearoa New Zealand: A mixed methods approach

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ABSTRACT

We report and discuss the findings of a survey of a range of health care providers serving hauā (disabled) Māori in the Murihiku (Southland) region of Aotearoa New Zealand. To explore hauā Māori access to health services, we used a mixed methods approach beginning with a quantitative survey and followed by qualitative interviews. Twenty-nine (58%) completed surveys were returned and we interviewed representatives from 15 organisations. We found all organisations were disability accessible in the physical sense, but were less accessible from a cultural perspective. There appeared a misunderstanding between what could be deemed a non-racial, human rights approach of respect for all people, no matter the ethnicity *("We treat everyone who walks through the door the same")* and the importance of tikaka (customary Māori practice), for services provided for Māori. The most significant proposal resulting from this research was for organisations to have a local, trusted, cultural advisor to regularly discuss and review Māori clients. Individually, health facilities that provide services to Māori should evaluate their cultural awareness, service access and promotion, health information, and service effectiveness. This paper provides insights and suggestions to health organisations, such as physiotherapy services, on how they can improve their service accessibility to hauā Māori.

INTRODUCTION

Both Article 25 (Health) of the Convention on the Rights of Persons with Disabilities (United Nations, 2006) and the Aotearoa/New Zealand Disability Strategy (2016-2026) (Office for Disability Issues, 2016) explicitly state the right of persons with disabilities to the highest attainable standard of health without discrimination on the basis of disability. One action detailed in the Aotearoa/New Zealand Disability Strategy's Action Plan (2014-2018) to achieve this right is to "increase access to health services and improve health outcomes for disabled people" (p.14). In Aotearoa New Zealand it is also an inherent right of an individual to receive culturally appropriate assessment, care and service; this holistic approach meets the Treaty of Waitangi principles of partnership, participation, and protection (Kingi, 2007; Wyeth, Derrett, Hokowhitu, Hall & Langley, 2010). This right extends to hauā Māori (Māori experiencing disability), and their whānau (family). Despite these

fundamental principles, in Aotearoa/New Zealand we continue to be presented with data that identifies that hauā Māori access and utilisation of rehabilitation and disability support services is disparately poor compared to Pākehā (New Zealanders of European descent) (Hickey & Wilson, 2017; Ministry of Health, 2012; Robson & Harris, 2007). This is despite hauā Māori being more likely than disabled non-Māori to have a functional disability requiring assistance (Harwood, 2010). Although there are likely numerous and complex reasons for these disparities, one important influence may be how health and disability services are offered and whether they are appropriately accessible for hauā Māori.

This collaborative project was based in Murihiku/Southland, in the Southern region of Aotearoa New Zealand, and explored hauā Māori access to health services from two perspectives, that of hauā Māori themselves, and that of the services and organisations that support them. The latter perspective is the focus of this paper, where we explicitly wished to investigate how accessible to hauā Māori health services and organisations considered themselves to be. This paper's primary aim is to report and discuss the findings of a mixed methods study with health care organisations serving hauā Māori in the Murihiku/Southland region.

A second aim of this paper is to disseminate our findings to the New Zealand physiotherapy profession. As very little has been published on Māori access to physiotherapy we consider the findings of this study pertinent and informative to physiotherapy practice, even though the research focused on health and disability services in general. We could only find one study that has explored Māori perception of physiotherapy. In 1999, White, Mavoa, and Bassett reported on a mixed methods study exploring the perceptions of physiotherapy of 19 people identifying with the Ngati Tama iwi. Most participants had relatively good understanding of physiotherapy and were of the opinion that it could be delivered in a more culturally appropriate manner. The new Physiotherapy Practice Thresholds in Australia and Aotearoa New Zealand (Physiotherapy Board of New Zealand, 2015) explicitly state that "to practise effectively in Aotearoa New Zealand, a physiotherapist therefore needs, in addition to meeting cultural competence, to understand the relevance and be able to demonstrate contemporary application of Te Tiriti o Waitangi / the Treaty of Waitangi's three principles of partnership, participation and protection and incorporate the four cornerstones of Māori health, which are whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health)" (p.10).

As no appropriate questionnaire addressing accessibility of health and disability services in terms of both cultural responsiveness for indigenous peoples and disability could be sourced, we had to develop our own survey questionnaire. We did this by reviewing local and international literature on disability and indigenous populations' health service access experiences. Our survey (available on request) contained five sections, specifically identified by our funding partners as important, related to workforce competencies, quality standards, service effectiveness, access and promotion of services, and health literacy/information needs (The Centre for Health, Activity and Rehabilitation Research (CHARR), 2014).

Recently a new Māori glossary called Te Reo Hapai (The Language of Enrichment) was released for mental and disability services and the word for disability, attained from the Māori disability community, is now whaikaha or tangata whaikaha. Whaikaha means "to have strength, to have ability, otherly abled, enabled" (New Zealand Doctor, 2017). Also recently Hickey and Wilson (2017) have argued for the term "whānau hauā" to be used as an alternative indigenous approach to disability. As our project from inception used the term hauā Māori, we have kept to this language for this paper, whilst acknowledging the new terminology. In Māori concepts of health, the distinction between health and disability is blurred. The notion of "wellness", as opposed to disability, is embraced more as it better encapsulates an individual's ability to contribute to their iwi (tribe) and whānau, reflecting the collective orientation of the Māori worldview (Ministry of Health, 2012, 2011). Harwood (2010) contends that it is up to each whānau to define for themselves who their whānau are. Therefore, our research viewed both Māori experiencing disability and their whānau as entwined and not separate entities, thus a broad perspective was taken within our research, and the terms "disability" or "whānau" were not predetermined.

METHOD

Literature review protocol

A comprehensive international review of the published literature in CINAHL, Medline, Embase, Pubmed, Google Scholar, Web of Science, and Scopus electronic databases was conducted to ask the following questions: With regards to the five identified sections (workforce competencies, quality standards, service effectiveness, access and promotion of services, and health literacy/information needs), what questions have previously been used to investigate the accessibility of disabled / indigenous disabled people to health services? Why is it important to ask these questions? The search strategy involved using the keywords *questionnaire* or *survey* and *indigenous in combination with disability, Māori, health literacy, service effectiveness, quality standards, workforce competence, health promotion, and accessibility*. The terms were truncated where possible. Inclusion criteria required articles to be published between 1 January 2000 and 31 October 2011, to have an indigenous or disability element, to be written in English or Te Reo Māori (Māori language), to have a qualitative aspect or questionnaire included in the study, and to meet the appraisal requirements of the Critical Appraisal Skills Programme (CASP), a tool including ten questions designed to appraise qualitative reports (CASP, 2017). Opinion pieces and quantitative studies were excluded. Titles and abstracts were independently screened by the two researchers (AR, AM) according to above criteria, and full text articles of the studies that met the inclusion criteria were appraised by these researchers using the CASP qualitative research assessment tool (CASP, 2017). Relevant data were extracted by three investigators (AR, AM, KB) and used to form the final questionnaire.

The search resulted in 763 articles, 234 of which were duplicates, and 442 of which were deemed irrelevant after screening the titles and abstracts. The remaining 87 articles were assessed using the inclusion and exclusion criteria, as well as the CASP tool criteria. Twelve studies met all criteria (Bolitho

& Huntington, 2006; Casamassimo, Seale, & Ruehs 2004; Cram, Smith & Johnstone, 2003; Crengle, 2000; Edwards & Merry, 2002; Edwards, Merry & Pealing, 2002; Mead, Bower & Roland, 2008; Ministry of Health, 2004, 2010; Nikora, Karapu, Hickey & Te Awekotuku, 2004; Wiley, 2009; Wilson, 2008) (see Table 1). From these 12 studies we extracted data relating to the questions asked that spoke to their importance related to our project and the reasons the questions were asked. To ensure reliable data extraction, two researchers extracted data independently and then compared (AR, AM), discrepancies and relevance of these data were then discussed and debated with other research team members (KB, LH, SM). Table 1 reports these data as well as the relevance the questions had for our study. Based on review findings of important and relevant questions to ask, our questionnaire was developed. The final questionnaire contained a total of 20 questions (14 closed questions, 6 open ended questions), with several questions on each of the pre-nominated categories (workforce competencies, quality standards, service effectiveness, access and promotion of services, and health literacy and information needs). The questionnaire was discussed at length with our community research partner (Ngā Kete Mātauranga Pounamu Charitable Trust) and our study's Rōpu Kaiarahi (Māori Research Advisory Group), then refined based on their feedback and previous work with hauā Māori in Murihiku/Southland (CHARR, 2014).

Design and procedures

Ethical approval was gained from the University of Otago Human Ethics Committee (Ethics Committee's reference codes 12/028 and 12/175). We utilised a mixed methods explanatory sequential approach (Creswell & Plano Clark, 2011), beginning with the quantitative survey described above, followed by concomitant qualitative interviews among health providers and organisations offering services to hauā Māori in the Murihiku/ Southland region. This dual approach was chosen to allow for a more insightful understanding of how organisations perceived their accessibility for hauā Māori and their whānau. Organisations were free to consent to participating in both the survey and the interview, or just in the survey.

We used a broad definition of "organisations" for our survey, namely, any organisation in the Murihiku/Southland region that provided a health or disability service of any nature for disabled people. As no database listing such a broad spectrum of organisations existed, we consulted with our above-mentioned Murihiku research partners and appropriate local stakeholders (such as the Southland district and city councils, known health and disability services, appropriate websites, Māori networks, and local people by "word of mouth") to identify organisations. We identified 66 organisations.

To ensure an adequate response rate to our survey we followed the strategies described in the modified Dillman approach (Dillman, 2007). One author (KB) telephoned all potential providers and organisations explaining the survey and obtaining their consent to mail the survey to them. The survey was posted to 50 organisations, along with an information sheet, a consent form, and a stamped, addressed envelope for return of the completed survey. Follow-up telephone calls were made one week after the deadline had expired. If organisations so wished, one researcher (KB) completed the survey during these calls.

The survey was followed by on-site face-to-face semi-structured interviews with representatives from consenting organisations. Two researchers (KB, LH) undertook these interviews with the person, nominated by the organisation, who had completed the survey. Using the organisation's completed survey as a prompt, the interviews probed the survey answers in more depth, asking respondents to clarify and expand on their answers. Interviews, approximately an hour in duration, were audio-recorded and fully transcribed.

Data analyses

Survey responses were analysed descriptively in terms of frequency and responses to the open-ended questions were collated. Interview data were analysed thematically guided by the process described by Braun and Clarke (2006). This data-driven process semantically identified patterns within the entire data set. Initial data coding, based on data familiarisation and multiple readings, was driven by the survey questions but subsequent categorisation across all codes allowed for the generation of broader themes. Adhering to our explanatory sequential approach, these broader themes were then consolidated with the quantitatively derived data to identify themes of key importance to the research aim. One researcher (LH) undertook the preliminary analysis. To ensure robustness and trustworthiness of this process and to finalise the thematic analysis and integration with the quantitative findings, findings were discussed and debated multiple times by research team members (KB, KT, BVM), with re-coding and reliability coding checking undertaken. Time constraints however precluded member checking by participating organisations.

RESULTS

Of the 50 surveys distributed, 29 (58%) completed surveys were returned, from medical centres (n=7), community workers (n=1), district nurse or nursing service (n=3), physiotherapists (n=4), Māori health providers (n=4), special needs school (n=1), and other rural (n=3) or town-based services (n=6). Representatives from 15 (30%) organisations were interviewed onsite.

Apart from the specific Māori heath providers, most organisations had less than 5% clients and staff that identified as Māori. Over half (n=16) indicated they offered same-day service, and 22 organisations said they worked with disabled people "very often" or "often". All organisations responded that their organisation was physically accessible. Thirteen organisations rated their access as "excellent", ten as "very good", and four as "good".

Table 2 shows the answers to the "yes/no" questions asked in the survey and a collation of the comments written in relation to these questions, and Table 3 indicates answers to open-ended questions. From the survey responses small "good practice" strategies were identified and these are listed in Table 4.

Table 1: Summary of studies included in the literature review

Author, date, article title, methodology	Area explored	Study population	Main findings	Relevance to present study survey questionnaire
Wiley (2009): *At a cultural crossroads: Lessons on culture and policy from the New Zealand Disability Strategy.* Qualitative	Analysis of workforce competencies.	Mainstream health services. Four key areas: interviews conducted on Ministry officials, service providers, consumers and caregivers of health care.	• Discrepancies between staff and consumer perceptions on the quality of culturally appropriate health care given. • Inter-service collaboration could aid in the distribution of knowledge about agency activities which could improve consumers' access to health services. • Financial concerns as families with disability often have higher health and living expenses. • Not one Māori consumer felt that their cultural needs were addressed	• Are client satisfaction surveys encouraged to gauge whether the staff cultural training that has been put in place is having a satisfactory and effective outcome on the recipients of the health care?
Cram et al. (2003): *Mapping the themes of Māori talk about health* Qualitative	Analysis of workforce competencies.	Māori consumers of health care.	• *Wairua* (spiritual aspect) is the most widely mentioned aspect of Māori Health. • Patients view *wairua* as the key to understanding health and illness as it gives access to the whole person. • Important to integrate Māori beliefs into the treatment.	• Importance of Māori Health models such as Te Whare Tapa Wha and the influence it can have on patient-provider interaction and treatment.
Nikora et al. (2004): *Disabled Māori and disability supports* Qualitative	Analysis of workforce competencies.	Māori experiencing disability and/ or their whānau carers.	• Māori with a disability and their carers express a desire for Māori health providers. • More culturally sensitive staff. • Needing financial support as well as increased emotional support when very stressed.	• Need to identify percentage of Māori health providers. • Identify staff training.
Bolitho & Huntington (2006): *Experiences of Māori families accessing healthcare for their unwell children: a pilot study* Qualitative	Analysis of workforce competencies. Health literacy and information needs. Service Effectiveness.	Māori consumers of health care.	• Limited research exploring individual experiences of Māori when accessing health care. • Financial barriers, doctor's fees and cost of medications. • Families feeling vulnerable, 'you don't want to question anything for fear that you may be waiting longer in the queue'. • Families did not know whether they should be accessing health services - feel that they are a hassle, or over reacting. 'Is she sick enough to be admitted?' or 'child is sick enough' to take them to health services; issue of health literacy. Knowing what needs to be seen to. • Hesitated to access health services because of previous experiences that made them vulnerable.	• Māori are influenced by previous visits to the GP. • Unsure of whether 'child is sick enough' to take them to health services; issue of health literacy. Knowing what needs to be seen to. • Financial barriers.

Study	Focus	Sample/Data	Findings	Key questions
Wilson (2008): *The significance of appropriate health services for Indigenous Māori women.* Qualitative	Analysis of workforce competencies. Service effectiveness.	Māori Women.	• Whānau, spirituality, traditional and contemporary knowledge is important for health and wellbeing. • Nurses must engage in self-reflection on their own practice to increase their effectiveness. • Need to include the consumers of health care when measuring cultural competence. • Integrate culture into clinical practice.	Key questions to optimise culturally competent practice include: • How key beliefs of Māori women are determined. • How trust is promoted in the service and building on existing strengths of the patient.
Mead et al. (2008): *The General Practice Assessment Questionnaire (GPAQ) – development and psychometric characteristics.* Quantitative (postal questionnaire)	Quality standards.	Data from GP practices throughout United Kingdom.	• Scales of the GPAQ are internally reliable and that the items demonstrate an interpretable factor structure.	Key questions asked: • Ability to get an urgent (same day) appointment with a GP. • Ability to get a referral to a specialist when the patient felt it was necessary.
Crengle (2001): *The development of Māori primary care services.* Qualitative	Access and promotion of services.	Report on development of Māori primary care services over past decade.	• Barriers to care in Māori care services: financial, geographical, transport, lack of knowledge of health issues and how to access information, barriers within the health care system and cultural barriers.	• Supports previous findings on barriers to access including inability to receive care at the time needed, limited follow-up and failure to provide information in a way that is appropriate for Māori.
Ministry of Health (2004): *Māori Providers: Primary health care delivered by doctors and nurses: the National Primary Medical Care Survey (NatMedCa):2001/2002 Report 3.* Quantitative (survey)	Access and promotion of services. Service effectiveness.	Nationally representative, multi-stage sample of private GP's in New Zealand (28 practitioners at 14 Māori provider practices).	• Percentage of Māori patients was substantially higher in Māori providers (59%) compared with private GP's (12%) community governed non-profit (19%). • Two thirds of patients possessed a Community Services card (CSC). • 60% of visits involved writing of a prescription. • Three-month follow-up was recommended in 62% of visits, referrals made in 18% of visits and nearly two percent in an emergency referral. • Several key questions in the 'Practice Questionnaire'	Key questions: • Percentage of Māori staff and patients. • Identifying health services provided. • Site information: geographical location, including if located in rural area. • Financial: standard charge for patient including with CSC.

Source	Category	Method / Sample	Findings	Notes
Edwards & Merry (2002): *Disability Part 2: Access to dental services for disabled people: a questionnaire survey of dental practices in Merseyside.* Quantitative: Two-page postal questionnaire	Access and promotion of services.	157 general dentist practices in Merseyside, England (response rate 81%).	• Although dentists were willing to treat disabled patients, few dental practices were accessible at the time of the survey - only one third of practices reported having a fully accessible surgery. • Key issues: physical barriers, lack of time and lack of domiciliary equipment.	• Physical accessibility of the health care facility.
Edwards et al. (2002): *Disability Part 3: Improving access to dental practices in Merseyside.* Qualitative (audit)	Access and promotion of services.	Follow-up to the previous postal survey – audit of 27 general dentist practices in Merseyside, England.	• Disability awareness training can help in understanding of disabled people's needs and break down some barriers. • Attitudes are just as important as physical premises in improving access. • Provided simple changes for practices to improve access regarding attitudes of staff, health and safety issues, parking, ramps and handrails, reception, seating in the waiting room, hearing and visual impairment.	• Attitudes of practitioners. • Physical barriers: many practices had designated parking but did not have a disabled space, lack of ramps and handrails.
Casamassimo et al. (2004): *General dentists' perceptions of educational and treatment issues affecting access to care for children with special health care needs.* Qualitative (survey)	Access and promotion of services. Service effectiveness.	National survey in America of general dentists to determine overall care of children with special health care needs (CSHCN) (n=1251, response rate 24%).	• Dentists with hands-on educational experiences in dental schools with CSHCN were less likely to consider such factors as level of disability and patient behaviour as obstacles to care and were more likely to desire additional education in care of CSHCN. • Postgraduate education in general practice or advanced general dentistry residency had no effect on willingness to care for CSHCN.	• Need to ask providers if they provide care for disabled and if so, how often. • Barriers to willingness to treat also identified, e.g. level of disability, patient behaviour, funding.
Ministry of Health (2010): *Kōrero Mārama: Health Literacy and Māori – Results from the 2006 Adult Literacy and Life Skills Survey* Ministry of Health research report	Health literacy and information needs.	Māori consumers of health care.	• 4/5 Māori males and 3/4 Māori females have poor health literacy skills. • People with poor health literacy are less likely to access health services and more likely to be hospitalised or attain chronic conditions. • Building health literacy can be achieved through clearer communication from health professionals, providing plain language health information.	• How do you ensure that the information you provide to patients is clear and easy for patients with poor health literacy skills to understand?

Table 2: Responses to "yes/no" questions (n=29)

Questions	Yes	No	No Response
Does your organisation make home visits?	26 (90%)	3 (10%)	0 (0%)
Has your organisation ever included Māori in the development of services and/or policy review regarding Maori with disabilities?	11 (38%)	14 (48%)	4 (14%)

Amalgamated specific comments made:
- Not specifically at this level, as this is done at a national / central level.
- Have attempted to attract Māori on to the organisation's Trust but with little success.
- Our founding nurse specialist was Māori.
- I receive cultural supervision regularly whereby I discuss all Māori clients and the work I do with them.
- Have had advisory group in the past and a presently have a board member who is Māori.
- Room for improvement, pockets of resistance / lack of understanding, stigma of institutional racism.
- Intend to. Have been thinking about it; it has been mentioned to the new Board.
- Doing "cornerstones accreditation" therefore will have to.
- Not to a great extent. The rural education process is co-ordinated with the Māori warden process.

Do you ask clients to provide feedback regarding the services you provide?	17 (59%)	8 (27%)	4 (14%)

Amalgamated specific comments made:
- Comments/complaints form available, online and hard copy.
- All seem to be happy with level of service.
- Not specifically at this level, as this is done at a national / central level.
- Complaints mostly a lack of understanding from patients, worries around privacy.
- Asked about transport vouchers.
- Difficulty with whānau acceptance, gaining trust, letting Māori clients know that you care.
- Thinking of developing Māori specific survey.
- General comments via reception.

Does your organisation have someone who specifically addresses issues regarding Māori?	12 (41%)	13 (45%)	4 (14%)

Amalgamated specific comments made:
- Not specifically at this level, as this is done at a national / central level.
- We have a Māori representative who we can consult with.
- Māori health service.
- Number of Māori advocates.
- We ask someone external to our organisation to come in.
- A staff member whose husband is Māori.
- A cultural supervisor.

Does your organisation provide education to build understanding, awareness, Tikanga Māori and cultural sensitivity among staff to improve services to Māori with disabilities?	15 (52%)	9 (31%)	5 (17%)

Specific comments made:
- Cultural study days a requirement.
- Organisation does not provide but encourage staff to attend training sessions organised by others.
- I receive training in cultural awareness periodically when it is available.
- Part of training - all new workers.
- Bring in Maori liaison officer - about once a year or as required.

Does your organisation know how to access expertise to provide education to staff on Tikanga Māori / things Māori relevant to your service?	23 (79%)	2 (7%)	4 (14%)
Are you a "Māori provider"? (i.e. eligible for Māori provider funding)	5 (17%)	1 (3%)	No response = 3 (10%) Not Sure = 8 (28%)

Table 3: Collated answers to survey open ended questions

Please describe what is done well …. (No responses=3)	Please describe what needs improvement …. (No responses=6)
Service accessible to all (n=12).	Getting out to community and get to know Māori whānau (n=9).
Good relationship with local Māori health providers (n=5).	Get government departments to travel out to our area.
Employment of Māori in service (n=2).	Better systems of identifying Māori.
Engagement with whānau, making sure that they are seen and their wishes respected.	Workload does not support extended hours. Community needs assessment could identify if further services are required.
Governed by tikaka, Māori values of Te Ao Māori manakitanga whanaungatanga aroha.	Home visits would not be usual practice - only under special circumstances
Accept texting, offer text reminders, difficulties getting secondary disability, do not charge for 'no shows', try to see people quickly, aware of shearing work.	Improve patient access to transport.
Time, flexible, communication styles, good at building relations.	Improve communicate with clients.
	Improve education of clients.
Well educated cultural competencies, know community well, they know us, especially shearing community, medical Māori wardens available.	Having flexible hours for working e.g. hours suiting dairy, shearers and other rural workers.
Open door policy, Māori support person, onsite services, whānau orientated, talk "parent talk", plain language. Teach haka, Karanga, weaving, poi making, kapa haka, PolyFest, visit to Maraes, include Māori culture in staff development.	Improve follow-up of 'no shows' or instigate a drop-in service, better referral to Māori health providers, flexible time, set up Maori specific services.
See very few Māori.	

What does "Whānau Ora" mean to your organisation?	When treating Māori clients, how do you integrate their cultural beliefs and whānau into the treatment?
Integrated approach to health and social services empowering whānau to work together (n=3).	Acknowledgement and referral to te Korowai Hou Ora service at Southland Hospital.
Vague, something to do with - whānau / family / togetherness approach (n=14).	We deal with each client on a personal level.
Not sure at all (n=3).	Non- specific, respect their wishes.
	Asking - what / how they want treatment done, do they want a support person (n=8).
	Form a relationship, find common ground, courtesy, different pillows for head/feet, comfortable with practice.
	Reminders, contracting, dialogue, opportunistic communication with whānau.
	Areas of improvement, understanding Wairua and whānau/iwi/tribal.
	Respect cultural differences, consent to touch head/face, different pillows for heads.
	Māori elder will be contacted around death.
	Would engage the Te whare tapa wha model.
	Ensure you pronounce a client's name correctly.

Table 4: Identified small "good" practices or strategies known to enhance accessibility reported by organisations

- "no hesitation in referring client on"
- "very accessible during clinic hours"
- "offer a range of services"
- "within walking distance of bus routes"
- "easy parking; no steps"
- "use texting messaging to communication"
- "fax through scripts if client cannot get here"
- "discuss payment of account if problematic"

- "don't charge for 'no' shows'"
- "try to see people quickly"
- "onsite services"
- "advertising / communicating / networking"
- "open door policy"
- "time, flexible, communication styles, good
- at building relations"

Consistent with our mixed methods approach, the integrated survey and onsite interview findings are presented below as a thematic analytic narrative, illustrated by quotes from the interviews. To preserve the anonymity of our participant organisations, we have not identified the interviewee's name, position or health provider worked for. The integrated analysis resulted in four key themes: (1) general insights, (2) what organisations are doing well, (3) what some of the "issues" were, and (4) methods suggested by organisations for improving access.

General insights

Some organisations focused more on the 'Māori accessibility' perspective of the questions, as opposed to 'disability accessibility'. A frequent first response to our question was that the organisation did not specifically do much for Māori as they *"treated everyone equally"* and *"did not discriminate"*; they were *"colour blind"* ….. *"Um, well I mean I guess that they are treated like every other patient."* So then, when asked how accessible they thought their service was for hauā Māori, the general response was: *"I'd probably say good or very good …. because I don't think we discriminate."*

When asked if someone in the organisation specifically addressed issues regarding Māori, unless they were a Māori health provider or were part of a Ministry of Health related department, the answer was usually negative. One common response from providers was that they sensed that local Māori were not particularly involved in their culture: *"…so although I may see you know Māori, in terms of how they live, they're probably not very Māori and they don't tend to have, you know they're not strongly involved in marae or any of that …"*

Whānau involvement was considered, and some organisations had pamphlets that advocated for and invited whānau to accompany the person receiving the service. Providers stated this offer was largely taken up by whānau accompanying young people.

The process of going through the survey with organisations in an interview format did make some people actually think more about ways in which accessibility could be improved for hauā Māori, with responses such as *"You're right, it is thought provoking"* and *"Yes well, look, it's certainly awakened my ideas to actually go out there seeking …"*

Generally, unless the organisation was specifically a Māori health provider, the percentage of Māori clients seen was low (about 5%), as were the number of Māori staff employed (0 - 2 staff members). This said, a number of organisations only had one or two staff in total. The reasons why so few Māori accessed their service had either not been thought about by the organisation or was unknown: *"Well I don't think they access as much as, as the general population."* For example, one reason for why it was thought the shearing gangs were not accessing health services was their 'tough' nature, their resilience:

I know there's a lot of percentage of Māoris down here ... I don't know the [reason], it's a real community and a lot of the Māoris that work in rural communities, just tough shearers and ...... tough people that don't, don't wanna to come to treatment I suppose.

What were organisations doing well?

All organisations had adequate to good physical access; their premises were wheelchair accessible and disabled toilets were available. Most organisations were on the ground floor with good parking facilities and access via ramps. Those on the first or second floor had accessible lifts or facilities they could use on the ground floor for disabled clients. Signage, for some organisations, could be improved to promote accessibility, in that it was not easily seen and/or was only in English.

All organisations said that they did, or could, provide home visits as they considered that home visits increased accessibility, albeit frequently from the perspective that the person was too ill or incapacitated to come in, as opposed to the person's cultural choice to be seen in their home environment. For some organisations, providing home visits was not considered to be cost effective.

Most people who required a health professional were seen quickly, within a day or two, but it depended on the nature of their complaint or their location. Rurally-based people were likely to wait longer to see a health professional.

Most organisations said they collected ethnicity data. Some organisations asked clients on their first visit about their ethnicity: *"They are generally asked, you know how they identify, you know whether they identify as Māori or not, and we don't, you know, like, presume"*. Some organisations felt

awkward asking this question and so assumed ethnicity based on appearance or name: *"I don't always, um simply because it just doesn't feel right to ask …. I just see people as people…"*

"The Issues"

Lack of funding to provide a good accessible service was raised on a number of occasions: *"a lot of things that we could do, we can't 'cos we haven't got the resources, the people working on it."* Services said they were underfunded and this made them feel undervalued, and yet they were expected to do things differently, and have training to do this, with no extra financial compensation. The expectation was that they would *"work smarter"* and reduce duplication of services.

Access to funding for transport for disabled people to access service providers was problematic, especially in the rural areas, even though some funding, in the form of taxi vouchers was available via Accident Compensation Corporation and Primary Health Organisations: *"you know, like the transport, which has been an issue for like 30 years that I've been around, anyway."* In one rural area, St John's Ambulance service provided transport for a donation, mostly funded by a charitable organisation. Although considered a valuable service, the financial model was felt to be not really viable in the long-term.

One issue raised in small-town Murihiku/Southland, was the over-familiarity of people in the community with each other, and that this could result in people not thinking about accessing services when they probably should:

> *… it is a fairly tolerant community with all the disabilities which can be good and bad at the same time, good in fact that you know everybody can just sort of get around their business no matter what sort of disability now but um, being in the way that it can take quite a while for somebody to notify services if they sort of see something, because it is just like, "oh that is so and so .. they have always been like that.*

A disability advocate also referred to the *"over-familiarity"* issue:

> *…. particularly with those that are, have been, their whole lives have been managed by others and they haven't had much say in their own life and what's going on, it's an empowerment thing for them too to be able to actually say "hey I don't want to be doing this anymore, I would like to be doing this instead ….."*

Some organisations were doing an excellent job of being accessible for Māori and whānau, but had not really considered their accessibility (other than physical factors) for those experiencing disability, or even considered that they served people who had a disability:

> *Definitely our ability to articulate disability issues more fluidly. We never know whether we're talking with a person who has a disability or a disabled person who's blind, or, so our language needs to improve and probably the scope of the services.*

Suggested ways to improve accessibility

One provider summarised eloquently what was important to make their service accessible for Māori:

> *Well bricks and mortar aside, I think it's time, I think it's about having the time and taking the time. I think it's also about being flexible and nimble in your approach. I think it's about having very strong communication skills orally. Written and perhaps in a non-audio way as well …… But I think overall it's about taking time to build relationships.*

To many Māori, whānau is all-important, and for a service to be accessible it was considered fundamental that this be acknowledged: *"It is, it's just whānau always comes first."* Being *"whānau-centred"* and *"whānau-led"* ensures good accessibility.

> *Because a lot of whānau would say that they've never had an opportunity to do that necessarily in other agencies. We're very committed to taking our whānau with us. They help shape our services. For example, we would not be extending Mirimiri massage services, without whānau having told us that's what they wanted.*

Further, to enhance accessibility, knowing how to contact whānau was important: *"The thing that could help you provide, be more accessible to Māori experiencing disability would be to know where and how to contact Māori whānau?"* However, some providers expressed frustration with misunderstandings with the Privacy Act and accessing patients and whānau. Some organisations said that contacting whānau can be an issue in Murihiku/Southland, where due to the past itinerant-nature of many Māori living in Murihiku/Southland, there is often a lack of whānau for the older generation.

According to the organisations interviewed, a good place to start improving access for Māori was to build relationships with the Māori community: *"She told us that we need to form a relationship first, and she said you know find out about the person and get them to, tell them a little bit about themselves then tell them about yourself..."*

Interviewees felt it was difficult to maintain relationships with communities if you were not directly in them; a physical presence was considered important. Living in a small rural community was considered advantageous to building relationships: *"I think probably our best asset is that we know our community really well, and we know our Māori patients …. and they know us, so that they're accepting of us as treatment providers."*

Developing links with the local rūnaka (Māori sub-tribal council) was also thought to be a good practice: *"We have got the local rūnaka that we sort of link in with and the team long ago were welcomed on to the marae so we were considered family if you want to sort of call it that."*

Some interviewees said that to inclusively improve accessibility for hauā Māori and their whānau, an important strategy would be to ask the hauā Māori what they wanted and saw as important: *"Yeah…asking the community what do they want… or need."* It was felt that consultation hui to get feedback from disabled whānau as to what they see should be happening; having consumer advisory groups and gaining direct feedback from stakeholders was the best way to get information to improve access: *"Heard excellent things from whānau – as it is what they want – solution and responses are often a lot simpler than what the organisations think they should be."*

The most frequently cited suggestion by people interviewed was that service organisations should market what they offered to both the Māori community and Māori health providers:

I don't know whether it would be um, more awareness around our services. Because a lot of people think you know if you go to any of the societies not just [Name] but all those ones that it is all about support groups and we need to get away from the image because that is just, you know a sideline of what we do.

Interviewees felt that networking between organisations should be improved so that clients were appropriately referred and resources shared, especially in rural areas where resources were limited. Some providers had developed memoranda of understanding with each other to facilitate this process. Although many organisations did this, it was felt by some of those interviewed that improved communication would further assist the process:

Communication is always one that can be better, I mean um, we have these memorandums of understanding and we do liaise quite a lot but of course being rural services too we are short in resources and you know it [communication] is the last thing down on the priority list until it, something happens so to speak.

Some interviewees stated that fundamental to ensuring accessibility was to provide clients with choice, in particular choice about where they would like to be seen:

All about connecting whānau to resources, ideas, energy, the energy being staff, for wellbeing and independence, and with a philosophy like that, it's presumptuous to think that people then would have to come into your agency to do that. It's more about, for Māori, kaupapa driven Māori, is being where our people are, or where they say that they would like to receive the support …… we can do service in a home environment, or a community setting of a person's choice.

There were ambiguous responses to providing services on local marae (Māori meeting houses) in Murihiku/Southland. One provider said that:

We find that probably about 95% of our clients would prefer either to come here or we go to them, to their home, which shows that there is a lot of disconnect between Māori and marae based service delivery. And that's for lots of reasons. People have come here, moved to Invercargill, they're disconnected from their own manawhenua, or you know, grass roots if you like, flax roots. And so urban Māori are less likely, particularly if they're not from here, to be involved with a marae.

However, another Māori service provider thought that the marae was important to Māori; this provider suggested that although Māori in Murihiku/Southland had come from diverse areas and iwi, and although there might be slight differences, many of the processes, the tikaka (customary Māori practice), were similar on most marae and this made whānau feel at home. The marae can be a central point of wellness, even though the

person may not come from the area. This organisation was keen to encourage more activities at the marae, for example, health clinics and programmes for young people, and this may be more optimal then a home visit for some. This provider did acknowledge that it depended on individual preference, and that some Māori did not want to go to the marae.

According to many of those interviewed, the key to working with disabled Māori and whānau was flexibility, especially with regards to time:

…..but I think there are some things about accessibility that are for some um, that are around time and concepts of time…" ….."Yes I think you're right and so the way that we run our schedules, which is important because we need to, but unfortunately that doesn't work within a different cultural value…

An important cultural value was given to time: *"Cultural aspect of time which is a gift, when you're here gifting your time so time is about quality of time rather than being on time, yeah."* Cultural concepts of time led to a discussion around being flexible / tolerant with regards to appointment times: *"I mean sometimes people have difficulty coming because of their disability……or their life is sort of in chaos…"* The provider with whom this discussion was held said that she used a number of strategies in an attempt to be flexible, for example, being understanding, using texting to confirm appointments, not charging for 'no shows', and trying to see people after hours if necessary. As another provider summarised:

I think it's more important for our Māori whānau that we can be where they want us to be …. Because a number of our whānau who say they have a disability usually want more of our time than, I mean there is no way we would do 15 minute time slots on anything ….. they require more of our time and listening ear which is fine. It's absolutely fine.

Organisations said that important to improving accessibility is showing that the service really cares for their clients. One respondent told the following story to illustrate this point:

I think another thing that I, and I should've perhaps become more aware earlier, is that I think that sometimes I really need to show those Māori clients that I do care and I want them to come ….. I had one woman …. I was actually talking with someone and waiting for her to come and I didn't realise she'd come and she could hear that I was talking with someone, well she just left. Now this is a woman, was in her 50s, you know she was really just struck with her worthlessness and she left and said oh that's alright you know, and I think that sort of, I learnt from that that perhaps with those Māori clients, I have to go a little bit further so that perhaps if they don't turn up, then I do, I follow them up …. because otherwise they think they're just not important enough and they will just sign themselves out.

Some organisations talked of the unfortunate home environments, linked with racism, that some of their disabled Māori clients had experienced and had left these clients feeling disempowered. This was elaborated at length by one interviewee:

But I guess when you're abused and as children, you just grow up believing, and but absolutely they'll say, you know I'm nobody, I'm worthless, I'm not important … and that really gets in the way of them accessing services for them and that's where they need to, I think if they're treated by someone who says, well I think you're important, I don't care what you think but I think you're important and I think you should be here… cos I don't think people necessarily expect you to care and in a way you have to really go, you have to go the extra mile to let them know that you do actually care… and if you care, you will hang in there or you will continue to make a follow-up …. And if you don't do that, then you're just another Pākehā who doesn't care about me or about Māori.

The above quote also highlights the importance of following up Māori whānau, especially if they "no show", a strategy considered important to Māori in terms of accessibility and responsiveness to their concerns.

Many interviewees felt that the provision of information to clients could be improved. Whilst brochures were readily available in most services, and often in a number of languages, most of the information was provided in a written format. Most organisations however said they would prefer to use the brochures in a one-to-one session with the client, rather than just let the client take the brochure home to read, as this allowed the opportunity for questions to be asked and to ensure understanding of information provided. There appeared to be a need for more diverse forms of information, other than written forms. Some of the ways suggested by interviewees can be seen in Table 5. Although having brochures in different languages was considered a good idea, it was problematic when the person providing the information could not read the language of the brochure: *"I think we have brochures in about 25 different languages in a folder that we can access, I mean we can't read them but we can access them."*

Table 5: Interviewee suggestions of diverse ways to provide information

- Demonstrating information (e.g. teaching of exercises).
- Ask clients to repeat the information provided to check understanding.
- Having large print brochures available.
- Use of interpreters. Most organisations had access to a list of interpreters or would contact the citizen's advice bureau or the local hospital for more information.
- Contact other services organisations, such as the Blind Foundation or Deaf Aotearoa as necessary.
- Asking the caregiver or their family member to be an advocate.
- In-house training on sign language and interactive drawing techniques ("so people can draw their thoughts down if they can't talk them out loud").
- Ensure information is provided in plain language.
- Web-based information.
- Text messaging.
- Facebook.

Many organisations asked clients for written feedback but this was usually submitted anonymously and did not include ethnicity data, so no organisation could really recall receiving any Māori specific feedback or identify such feedback. One suggestion made was to develop and use with clients a Māori specific health feedback of services questionnaire.

One organisation felt however that it would be hard for Māori clients to give negative feedback and she would rather raise the issue directly with a client if she perceived there to be a problem:

I think that's really, you know it would be really hard for them to give me negative feedback … and so if I perceive it as an issue ….. yeah I'd raise it there. …… It is more a case of asking, yeah. It's not assuming anything.

Many of those interviewed referred to cultural competency. Most people did undertake some form of continuing education, and this had included sessions in cultural competence. A number of private practices (General Practices, Physiotherapists, Nurses) had in-service cultural training sessions and invited people in to provide these sessions, or they attended the local district health board, health trust, or their professional society training sessions.

With regards to cultural competence training, people mostly referred to specific culturally acceptable protocols, for example, using different pillows under heads and feet in physiotherapy practice or asking permission to touch. This narrowly framed perspective of cultural competence is illustrated by the following quote:

I used to always think, oh Māori culture, here we go again, you know but when they talk about you know the Māori sensitivities, nobody really actually said what they were …. And you are thinking right well what would be insensitive to them, nobody, you know all the workshops we went to nobody ever said or what the protocol is you know around, around funerals or being a patient in hospital, nobody had ever said you know.

This focused approach was different to the more encompassing approach taken by Māori service providers, summarised by one provider as:

No, very much…really around…our values…our Māori values. It's not just about tikaka…you know, tikaka's based on our values that were based around te reo Māori…so you know, whether it's whanaungatanga…manaakitanga…all of those good things…the principles …yeah…and aroha.

In general, when asked about being culturally competent, those interviewed said it was about asking the client what they would like: *"we do try and suss out any needs or if we're not sure, we ask." "Ah, basically if you just say what you're doing, is that OK, with you, and you give them the option."* Some organisations were more specific about this:

…. because everybody is still individual, and so we ask them. You know, are you open to Māori models of practice? Would you like to know more about Te Wheke, or Whare Tapa Wha … Checking how they want to be responded to, or engaged with, so, you know, but we are Māori. So you know, if they

want karakia, we'll do karakia, if they don't, we don't. If they want hello instead of kia ora, well that's fine. We're not about pushing something on somebody, but we do have assessment tools that are Māori flavoured, and you know, meet, greet, seek is all about whanangatanga, it's about making sure people feel comfortable. A lot of people are surprised that they get offered a hot drink or a cold drink, or, we just say that's part of our process, so yeah.

One suggestion made was for organisations to have a local cultural advisor, with whom they could regularly discuss and review Māori clients. The interviewee went on to say that a local cultural advisor would have local Māori knowledge, of whakapapa, which would help build relationships and trust with Māori, and this could be difficult for those who do not have such knowledge:

I think that the areas where I am perhaps not, you know is that sort of involvement of, or that awareness of whānau and spiritual things, I think that's where I would be inadequate ….. and I probably wouldn't know of the sort of, have a sense of where people's history of their iwi and that might be 'cos that doesn't, and I sort of, I don't, I guess in some ways I can't see the relevance of that, but that's because I'm not making those cultural links and I'm probably never going to…

Although all organisations were disability accessible in the physical sense, interviewees felt that much could still be done to make the accessibly inviting from a cultural perspective. One provider summarised the important aspects of this:

What people say they like about coming here, is the meet, greet and seek process. Is, often you know, the accessibility to myself, because I have my doors open, most of the time and I like to mingle with our.. our whānau that come in and the things that I listen for, they say oh it's really warm here, and I go are we talking about the heating? And they go no we're not, we're talking about something else. That I think is more important than a flyer on the wall. But the flyer on the wall needs to be there too. But moreover, more overly important is the relationships and taking the time and ensuring that we're understanding and having you know, a proper exchange of information. And that we are meeting their needs.

DISCUSSION

This study explored, in one region of Aotearoa New Zealand, hauā Māori access to health services from the perspectives of the services and organisations. We found that all organisations were disability accessible in the physical sense, but were much less accessible from a cultural perspective.

In the literature reviewed to develop our survey, one pertinent issue in analysing workforce competencies was the under-representation of Māori in the health professions leading to an often unfulfilled preference for Māori clinicians or providers (Bolitho & Huntington, 2006; Nikora et al., 2004; Ratima et al., 2007; Wiley, 2009; Wilson, 2008). The physiotherapy profession is no exception: of the 6,654 registered physiotherapists in 2017, only 4% were Māori (Physiotherapy Board of New Zealand, 2017). Our survey findings reflect this under-

representation. One implication of this is that non-Māori staff are less likely to understand Māori concepts of health (Cram et al., 2003). There is a need for culturally appropriate staff to be involved in the development of services or policy, to ensure tikaka Māori practices and to meet the obligations of the Treaty of Waitangi (Cram et al., 2003). Although this is vital to registration of most health professionals, including physiotherapists (Physiotherapy Board of New Zealand, 2015) in Aotearoa New Zealand and is embedded in health professional training (for example, Physiotherapy New Zealand have online cultural competence resources for members), whether the theoretical attainment of knowledge truly transfers into everyday practice is debatable. Further, cultural competency of staff extends beyond that of the health professional staff. Some organisations were attempting to address this issue by having Māori representation on their Boards or Trusts, by consulting with Māori wardens, or via practice accreditation processes, practices that physiotherapists could consider to enhance their accessibility to hauā Māori. Whilst organisations encouraged staff to attend cultural training sessions our survey did not explore whether this action actually increased cultural knowledge and sensitivity of staff; this issue would benefit from further research.

Funding was an issue, especially for the many rurally located services surveyed, and prevented services from being offered optimally; a finding not unlike those identified by Wiley in 2009. Wiley (2009) reported service providers' concerns of the challenges of raising awareness of and access to their services to hauā Māori living rurally. In terms of service effectiveness and reducing disparities, the inadequate timing and availability of services and appointment systems was a common theme from the literature review but these issues were not apparent in our survey results or interviews. Health information was generally available, and organisations said that staff had face-to-face interaction with patients to check their understanding. Many organisations asked clients for written feedback but this was usually submitted anonymously and did not include ethnicity data, so no organisation could accurately recall receiving any Māori specific feedback or identify such feedback. One suggestion made was to develop and use with clients a Māori specific health feedback of services survey.

Another suggestion arising from the survey was for organisations to have a local cultural advisor, with whom they can regularly discuss and review Māori clients. Further, a local cultural advisor should have local Māori knowledge, which would help build relationships and trust with Māori, as this can be difficult for those who do not have such knowledge. Although not a novel recommendation, it is one worth emphasising (Hickey and Wilson, 2017; Hollinsworth, 2013; King, Brough & Knox, 2014).

Many organisations appeared to not fully understand their Treaty of Waitangi obligations. There was a misunderstanding between what could be deemed a non-racial, human rights approach of respect for all people, no matter the ethnicity, and the importance of tikaka for services provided for Māori (Cram et al., 2003; Hickey and Wilson, 2017; Hollinsworth, 2013; King et al., 2014). "We treat everyone who walks through the door the same" seemed to be the policy applied. As we probed

during the interviews, we frequently saw the "light bulb" moments when our questions made organisations think about how they could perhaps improve accessibility and make services welcoming to all, especially hauā Māori.

Health and disability accreditation of a service was considered to be one way of ensuring organisations took their Treaty obligations seriously and were accessible to those experiencing disability. For those organisations subject to accreditation, cultural competency was compulsory for all staff. Appointing a quality assurance person to assist in disability access was also suggested. For Māori and governmental service organisations, tikaka (customary Māori practice) is explicit. Values governed by tikaka include aroha ki te tangata (respect for people), he kanohikitea (face-to-face communication), titiro, whakarongo kōrero (look, listen, speak), manāki ki te tangata (looking after people), kia tūpato (caution), kaua e takahia te mana o te tangata (do not trample on the spirit of people), kia ngakau mahaki (be humble) and whakawhānaungatanga (making connections) (Smith, 1999).

A strength of our study was the 58% response rate, considered good. A study which investigated response rates to surveys used in organisational research (n=1607 studies) reported that the average response rate was 35.7% (SD18.8%) (Baruch & Holtom, 2008). Furthermore, we had responses from a diverse range of services and locations. That said, in spite of our good response rate, a limitation may be that participating organisations inherently consider themselves to be more culturally responsive. We acknowledged that as our study focused on one region of Aotearoa New Zealand, the findings can be considered informative but not representative of Aotearoa New Zealand per se, especially as each region will most likely provide services in different ways and have in themselves nuanced cultural differences.

Recommendations

The survey provided valuable information that led to deeper exploration and probing of participants and organisations during the onsite interviews. The process of going through the survey with organisations in an interview format did make some people think more about their Treaty of Waitangi obligations and ways in which accessibility could be improved for hauā Māori. This methodology could be utilised in other organisations, such as physiotherapy practices and services, where indigenous peoples are being cared for, and international results would be interesting to compare.

To their credit, all organisations expressed interest in our study findings so they could learn how to better meet the needs of hauā Māori clients. Thus, it is possible that the process of this research itself sparked increased cultural awareness and a renewed interest in access issues among those surveyed and interviewed. In this case, a good place to start improving access for Māori would be to build relationships with the Māori community. Developing links with the local rūnaka would be considered good practice, as would asking the disabled community what they want. Physiotherapy practices might consider not only advertising their practice in the traditional way (e.g. website and newspaper presence), but actually going into the community and beginning dialogues as to what our

profession can offer and what it is that hauā Māori wish. Such community interactions truly give credence to Hickey and Wilson's (2017) proposition of Whānau Hauā, a model of health care that is holistic, relational, and collective in nature and encourages health professions to reach out into communities. To this end, a consultation hui to gain feedback from disabled whānau could be implemented, as well as having consumer advisory groups. User satisfaction evaluations which specifically target hauā Māori are recommended.

Networking between organisations should be improved so that clients are appropriately referred and resources shared, especially in rural areas where resources are limited. Some providers had developed memoranda of understanding with each other to facilitate this process. It was felt that improved communication would further assist current processes, and taking a larger step and appointing a local cultural advisor would demonstrate real commitment to developing greater responsiveness to hauā Māori utilising disability and health services.

Some organisations focused more on the 'Māori accessibility' perspective of the questions, as opposed to the 'disability accessibility'. A frequent first response to our question about accessibility was that they "treated everyone equally" and "did not discriminate". When asked if someone in the organisation specifically addressed issues regarding Māori, the answer was usually negative unless they were a Māori health provider or were part of a governmental department. One common response was that "local Māori were not particularly involved in their culture". For genuine progress to be made, such assumptions need to be challenged. For example, the attitude that the local marae was not important to Māori was not a view shared by survey respondents who were Māori, or who were representing Māori, and demonstrates a failure by mainstream services to recognise the importance of specific cultural traditions. King et al. (2014) emphasise the erroneous assumption that a "non-Indigenous experience is universal rather than culturally specific" (pp 747-748). Their qualitative findings quite clearly showed that their Indigenous participants, people experiencing disability, experienced their disability within the context of their culture. We strongly recommend that physiotherapists should always respectfully establish ethnicity and ask patients/clients what is important for them in terms of health care delivery, after all a behaviour explicitly itemised as an essential component of threshold competence for initial and continuing registration as a physiotherapist in Australia and Aotearoa New Zealand is "Consider each client as a whole, adopt client-centred and family/whānau focused (where relevant) approaches and prioritise cultural safety and cultural respect" (Physiotherapy Board of New Zealand, 2015, p. 7).

As physiotherapy services were included in our study and our research team were predominantly physiotherapists and thus potentially applied a physiotherapy lens to the study, we believe our findings would be of interest and potentially helpful to physiotherapy services (both in private and in the district health board) seeking ways to be more accessible to hauā Māori.

KEY POINTS

To improve access of health services for hauā Māori, health service organisations, including physiotherapy services:

1. Need to truly value the importance of tikaka and ensure it is integral to the services they provide.

2. Should consider having a local trusted cultural advisor with whom to regularly discuss and review hauā Māori clients.

3. Should regularly evaluate their service's accessibility and effectiveness, to whom they are promoting their service, and the health information they are providing, to ensure ongoing quality accessibility.

DISCLOSURES

PERMISSIONS

Ethical approval was gained from the University of Otago Human Ethics Committee (Ethics Committee's reference codes 12/028 and 12/175).

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