Te Whānau Māori me ō mahi

Guidance on Māori cultural competencies for providers

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He whakataukī

Hūtia te rito o te harakeke, kei whea te kōmako e kō?

Ka rere ki uta, ka rere ki tai. Kī mai koe ki ahau, he aha te mea nui o te ao?

Māku e kī atu, he tangata! He tangata! He tangata!

This whakataukī (proverb) originates from Te Aupōuri, an iwi in Te Tai Tokerau (Northland). Metge and Jones note that a close translation of this whakataukī [1] is as follows:

If you pluck out the flax shoot, where will the bellbird sing? It will fly inland; it will fly seawards. If you ask me, what is the most important thing in the world? I will reply, People! People! People!

Northern kaumātua attribute this saying to a wahine rangatira (woman of high ranking) whose relatives promised her to another iwi to form an alliance and enable peace. The saying is part lament, part warning.

This whakataukī begins by referring to the pā harakeke (flax bush), something all New Zealanders are familiar with. Each pā harakeke has many swordlike blades. Rito (new shoots) emerge between the two centre blades in each fan. Māori identify each rito as the tamaiti (a child), and the two blades on either side as ngā mātua (the parents). As flax fans grow together in a clump, their roots are so intertwined that they stand or fall together. The rito is the growing point of the fan and the centre of the whole bush. The flax bush is a favourite Māori metaphor for the parent-child relationship and the larger whānau (family) group.

Weavers cutting flax always take the outer leaves of a fan. To remove the rito is to destroy the whole fan. If the bush stops growing and fails to put out flower stalks, there will be no flowers full of nectar to attract the bellbird (kōmako, korimako) and give it cause to sing. Instead, it will fly distractedly between land and sea, searching for somewhere to perch and feed. This resonates with whānau, who, through protecting the next generation, can ensure the whole whānau can thrive.

The whakataukī concludes with the most robust possible affirmation of the value of people and the whānau who produce and nurture them.

What is the most important thing in the world?
I will reply, People! People! People!

1 Metge J and Jones S. *He taonga Tuku Iho nō Ngā Tūpuna — Māori proverbial sayings — a literary treasure*. New Zealand Studies July 1995, p.3

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This guidance has been updated following a literature review, meetings with ACC staff, ACC suppliers, and advice on cultural safety and cultural competence from the Expert Reference Group. The update was informed by a multidisciplinary reference group, including Māori clinicians and researchers, as well as a nominee from the New Zealand branch of the Australasian College of Health Service Managers.

This document draws on refined definitions and practical guidance from Curtis et al. (2025), Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand, to ensure alignment with contemporary understandings and expectations across Aotearoa's health context.

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Summary

This document offers practical guidance to support providers and suppliers to deliver culturally safe care to ACC kiritaki and enable equitable outcomes. It is a tool to help them to meet the requirements of ACC's Kawa Whakaruruhau (Cultural Safety) policy and is in line with relevant professional and national health standards.

Māori continue to experience less access to primary healthcare, hospital care, and accident and disability support services.[2] This inequity persists despite the well documented unmet health needs of Māori.

Data presented to the Waitangi Tribunal shows that, compared to non-Māori and non-Pacific residents[3]:

- Māori live shorter lives
- Māori have a relatively greater proportion of life with injury and disability
- Māori have the highest rate of disparities in access to care and health outcomes
- Māori experience lower access to health, ACC and disability support services.

ACC is responsible for ensuring people are able to lodge a claim following an injury, and then receive the necessary and appropriate treatment, rehabilitation, and support they require. However, information on claims and access to support shows Māori are still less likely than non-Māori to lodge an ACC claim, but more likely to suffer a serious injury, less likely to receive needed care and support, and more likely to have poorer long-term injury outcomes.

ACC is working to improve access to the Accident Compensation (AC) Scheme and outcomes for Māori, including the provision of programmes to support ACC kaimahi (staff) in developing capabilities and awareness related to Māori health needs.

Guidelines on Māori Cultural Competencies for Providers, initially published in 2005[4] were intended to assist healthcare providers in improving access and care for Māori clients. An update in 2022 introduced cultural safety concepts alongside cultural competence in keeping with many of the evolving requirements for health workers and their organisations, including health professionals.

In addition, ACC developed a policy for cultural safety that outlines expectations of providers supporting Māori clients, whānau, and communities, ensuring they meet the unique needs of Māori, and all New Zealanders. The ACC **Kawa Whakaruruhau (Cultural Safety) policy** applies to all suppliers and treatment providers delivering health services under an ACC contract.

Meeting the requirements of ACC's **Kawa Whakaruruhau (Cultural Safety) policy** will support all staff — including health workers, managers, leaders, administrators, and clinicians — to advance Māori health equity and fulfil their responsibilities for cultural competence and culturally safe practice. In doing so, contribute to achieve equitable health outcomes for all clients, specifically Māori and identified population groups experiencing significant health disparities.

Since 2022, hospital (public and private), residential, and disability services certified under the Health and Disability Services (Safety) Act 2001 and the Human Assisted Reproductive Technologies Act 2004 are required to meet the Ngā Paerewa Health and Disability Services Standard. Other services not required to be certified are encouraged to adopt these standards. Cultural safety considerations are woven throughout Ngā Paerewa, including accountabilities for supporting cultural safety commitments, workforce development and patient rights in keeping with the Code of

2 Graham, R and Masters-Awatere B, Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research Aust NZ J Public Health. 2020; 44:193-200

3 https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/

4 Te Tūroro Māori me o mahi. The Māori patient in your practice. Guidelines on Māori Cultural Competence for providers. ACC 1625.

Health and Disability Services Consumers' Rights (the Code) published by the Health and Disability Commissioner.[5]

This document, Te Whānau Māori me ō mahi, supports managers, administrators, and health workers (kaimahi) in meeting ACC cultural safety requirements, and may also be helpful in meeting the Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021) and the Code of Health and Disabilty Services Consumers' Rights. This document was updated in 2025 and was informed by a review of published literature on how healthcare managers can support the implementation of cultural safety. The findings of the literature review were compared against the Ngā Paerewa Health and Disability Standards[6] to develop advice for provider organisations, managers and health workers. It was also developed with the support of an Expert Reference Group, who considered the literature review and the cultural safety requirements of relevant professional or regulatory bodies and national standards.

As a result, the Expert Reference Group recommends that all providers undertake regular planned training for their staff, supported by regular reviews of access, experience, and outcomes for Māori and identified priority populations. Analysis of the results of regular training, as well as measures of access, experience, and outcomes, should be shared with community representatives and staff to assist in developing plans to eliminate any inequities that are identified. Staff training and organisational policies should be aligned with cultural safety principles to ensure safe and equitable care as defined by the kiritaki (client), whānau and their communities.

5 Available at https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

6 Ngā Paerewa Health and Disability Standard, 2001 (NZS 8134:2021)

Background

In 2005, the main aim of the **Guidelines on Māori Cultural Competencies** was to reduce health inequities for kiritaki Māori (Māori clients) by focusing health professionals on the history of Māori, the state of Māori health and the likely contributors to health disparities. Cultural competence training also included general guidance on Māori customs, preferences and worldviews. To avoid reinforcing stereotypes, providers were reminded that Māori perspectives, customs, or cultural preferences vary by region and between individuals, or may alter according to the setting. Over the past two decades, it has become clear that developing cultural competencies alone will not achieve health equity. Staff must also be aware of their own biases, as well as those embedded within their organisation, which can lead to reduced access to health services and fewer quality treatment options for Māori. Provider organisations and their staff also need to measure access and outcomes and take action to address any inequities.

Regular staff training must be accompanied by regular measurement and reporting of access and outcomes for Māori and other priority populations, with a commitment to addressing any inequities that are uncovered.

More recently, the health sector has turned its attention to cultural safety and a focus on the experiences of kiritaki Māori and their whānau, as well as their involvement in decision-making about their care. This requires staff and organisations to collect, monitor and report access and outcomes data, alongside self-reported experience data from kiritaki Māori and whānau.

Planned measurement of access and outcomes of care, followed by analysis and reflection on delivering safe care as defined by the kiritaki, whānau, and their communities, should lead to deliberate actions that eliminate bias and provide high-quality care to all people.

The relationship between cultural safety and cultural competency

The Health Practitioners Competence Assurance Act (2003) consolidated regulations for 13 health professions and included a requirement for governing authorities to set standards of cultural competence alongside standards for clinical competence and ethical conduct. Under this framework, the focus on cultural competence has been on developing the knowledge and skills of practitioners by supporting them to learn about the history of Māori, the state of Māori health, and the likely contributors to health disparities.

Cultural competence refers to a set of knowledge about culture(s), along with the associated skills and behaviours that health professionals require, to deliver high quality health care and achieve equitable health outcomes for all groups.[7]

Separately, nursing educator Irihapeti Ramsden led the development of cultural safety, which focuses on the experience of the service user and their whānau. Since its inception, the concept has been taken up and further developed to reflect contemporary health contexts. Curtis et al. offers an updated definition of cultural safety, stating:

Cultural Safety requires health professionals to examine themselves and the potential impact of their own identities and culture on their practice. Culturally safe health professionals acknowledge and address their own power, privilege, biases, attitudes, assumptions, stereotypes, prejudices, and characteristics that may affect the quality of care provided. Cultural safety requires a critical consciousness where health professionals engage in ongoing self-reflection and hold themselves accountable for culturally-safe practice, as defined by patients and their communities, and as measured through progress towards achieving health equity. Culturally-safe health professionals influence healthcare to reduce bias and achieve equity within the workforce and working environment. Cultural safety benefits all patients and communities. This may include communities based on Indigenous status, age or generation, gender, sexual orientation socioeconomic status, ethnicity, religious or spiritual belief and disability.[8]

Cultural safety acknowledges the interpersonal power differences between practitioners and kiritaki and the impact of power differentials on healthcare access and outcomes.[9] Curtis et al notes that to achieve culturally safe and unbiased practice, health

7 Curtis, E., Loring, B., Jones, R., Tipene-Leach, D., Walker, C., Paine, S-J., & Reid, P. (2025). Refining the definitions of cultural safety, cultural competency and Indigenous health: Lessons from Aotearoa New Zealand. International Journal for Equity in Health, 24(130) https://doi.org/10.1186/s12939-025-02478-3.

8 Curtis, E., Loring, B., Jones, R., Tipene-Leach, D., Walker, C., Paine, S-J., & Reid, P. (2025). Refining the definitions of cultural safety, cultural competency and Indigenous health: Lessons from Aotearoa New Zealand. International Journal for Equity in Health, 24(130)

9 Carlson, T. (2019). Mana motuhake o Ngāti Porou: Decolonising health literacy. Journal of Social Anthropology and Cultural Studies, 16(2), pages 89, 90, 94, 95

workers need to undertake regular critical self-reflection, assessments and critiques of their cultural safety, with a commitment to improvement.[10]

It is important to note that despite the overlap between cultural safety and cultural competency, the two concepts should be treated as distinct components. This approach is essential to acknowledge and understand the critical competencies within both, and advance health equity.

From their review of cultural safety in medical training, the Council of Medical Colleges and Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)[11] made recommendations to incorporate cultural safety alongside cultural competence, specifically to:

- acknowledge systemic racism and privilege that exists in the health sector, which impacts engagement with health providers
- address structural barriers that exist in the health system
- understand the kiritaki and their context so that interactions can be tailored
- encourage partnering with Māori, including Māori representation in governance, as an expression of Te Tiriti o Waitangi (Treaty of Waitangi)
- promote the collection and use of data for equity monitoring
- support providers to focus on self-reflection and culturally safe practice, including understanding how health system structures can privilege Pākehā (Europeans).

Achieving equity requires the ongoing commitment of individual health workers and their leaders to identify and eliminate biases and hold themselves accountable for achieving health equity.

Curtis et al. have identified the following key attributes of health professionals (and organisations) that support safe and competent care for indigenous peoples:

1. Understand that Indigenous peoples have Indigenous rights to health (above and beyond any extra health need).
2. Understand that Indigenous peoples often have higher unmet health needs (independent of other factors e.g. socioeconomic status).
3. Have a critical understanding of the determinants of Indigenous health inequities, including the role of health professionals in creating, maintaining or eliminating inequities.
4. Recognise that there are diverse and dynamic ways of being Indigenous and Indigenous peoples live in a variety of geographic, cultural and socioeconomic contexts.
5. Have knowledge of key aspects of traditional and contemporary Indigenous values and cultural practices, and the implications of these for your practice.
6. Assess the equity of your practice for Indigenous peoples, and implement measures to address any inequities you identify.
7. Show evidence of skill development with respect to cultural safety and cultural competency, and demonstrate how you are using this to benefit Indigenous peoples through your practice.[12]

10 Curtis, E., Loring, B., Jones, R. et al. (2025) Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand. Int J Equity Health 24, 130 (2025). https://doi.org/10.1186/s12939-025-02478-3

11 Te Ohu Rata o Aotearoa., Council of Medical Colleges., & Allen, & Clarke. (2021). Cultural Safety Baseline Data Report Release and Recommendations.

12 Curtis, E., Loring, B., Jones, R., Tipene-Leach, D., Walker, C., Paine, S-J., & Reid, P. (2025). *Refining the definitions of cultural safety, cultural competency and Indigenous health: Lessons from Aotearoa New Zealand. International Journal for Equity in Health*, 24(130)

Kawa Whakaruruhau – ACC's cultural safety requirements

Culture shapes the behaviours, attitudes and values of providers and their institutions. As the provider, kiritaki and whānau all bring their respective cultural backgrounds and expectations to the service encounter, there are many opportunities for confusion. Culture has been described as the learned and shared patterns of information that a group uses to generate meaning among its members.[13] These patterns encompass language and nonverbal communications, beliefs and spiritual associations, relationships with others, and possessions. Concepts such as 'wellness' and 'illness' have meanings within each culture's language and customs.

Members of a cultural group (including health workers and registered health professionals) often share beliefs in specific rules, roles, behaviours and values, which shape interactions with others.[14] [15] [16] Cultural safety challenges health workers to reflect on and re-examine their values, attitudes, and behaviours, and be prepared to receive critical and constructive feedback.[17]

Concepts such as courtesy, kindness and respect may have specific expressions in healthcare settings and effectively be taught or modelled (in the formal or informal curriculum). For example, it is common to see a hierarchy of authority for decision-making within hospitals. This can lead to an inappropriate expectation that this will be matched by whānau with the appointment of a single spokesperson.

Cultural competence is having the attitudes, skills and knowledge needed to achieve cultural safety.

The ACC Kawa Whakaruruhau (Cultural Safety) Policy applies to all contracted providers, including workers who have direct contact with kiritaki Māori and those in supporting roles such as managers or administrators and leaders. Kawa Whakaruruhau outlines expectations that providers must meet to address the needs of kiritaki Māori and whānau to achieve cultural safety.

ACC expects providers to examine the impact of their own culture on the service they provide and to deliver culturally safe care, as defined by kiritaki and whānau and as measured through progress towards achieving health equity. Analysis of existing beliefs coupled with reviews of access to services and outcomes of care can reduce bias and support the development of skills to engage with kiritaki in joint decision making.

To meet the needs of kiritaki Māori and other community groups effectively, health practitioners and other workers need to understand their own cultural background and how this influences their interactions with kiritaki and whānau from various cultural groups. This includes critiquing the power structures that exist and challenging their own culture, biases, privilege and power relationships rather than attempting to become fully competent in the cultures of others.

For many health workers and health provider organisations, a commitment to cultural safety will

13 Penn NE, Kar S, Kramer J, Skinner J, Zambrana RE. Ethnic minorities, health care systems, and behaviour. Health Psychology, 1995, December, 14(7): 11 -646.

14 Jansen P, Sorrensen D. Culturally competent health care. NZFamPhys 2002 October, 27(3)

15 Cross T, Brabazon B, Dennis K, Isaacs M. Towards a Culturally Competent System of Care, volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1989

16 Isaacs M, Benjamin M. Towards a Culturally Competent System of Care, volume II, programs which utilize culturally competent principles. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1991

17 Malpas NZMJ 30 March 2012, Vol 125 No 1352; ISSN 1175 8716 Page 98 http://journal.nzma.org.nz/journal/125-1352/5124/

align with accreditation or certification requirements through workforce development and continuous professional development (CPD).

Under the ACC Kawa Whakaruruhau (Cultural Safety) policy, providers and suppliers are required to embed culturally safe principles across their workplace. Providers and suppliers can evidence this in the following ways:

- evidence regular cultural safety training and performance monitoring for all kaimahi
- evidence cultural safety activities incorporating personal self-reflection as part of kaimahi training and CPD and other workforce development activities
- evidence cultural safety as required for accreditation or certification
- implement regular monitoring of services and assessment of potential inequities in health outcomes for kiritaki and whānau
- provide guidance to managers and administrative staff of their roles in implementing cultural safety and supporting kaimahi to participate in training and review activities.

Literature review

To inform this update, a review of recently published literature on management support for cultural safety was undertaken with the backing of Allen + Clarke.

Cultural safety is for everyone

Baseline assumptions for this review are that:

- while the prior guidelines have a focus on cultural competency and safety for Māori, the specifications in Ngā Paerewa include Pacific peoples and other cultures
- where the reviewed studies provide advice on providing culturally safe care for indigenous populations, the lessons are likely to apply to all groups, and cultural safety applies to interactions between staff and between providers.

The review included an assessment of the 2021 Ngā Paerewa standards which incorporate cultural safety considerations throughout. These considerations are also contained in the Code of Health and Disability Services Consumers' Rights and can be summarised as:

Patients/clients have a right to have their own culture and identity respected:

a. indigenous or other cultural worldviews considered in service provision

b. upholding cultural safety and respect for identity and worldviews.

Resourcing the workplace and workforce to be more culturally safe:

a. workforce development and cultural competency/safety training

b. structural mechanisms for ensuring cultural safety

c. partnering with cultural and community experts.

Accountability for having cultural safety commitments in place:

a. governance accountability for cultural safety

b. monitoring and reporting on cultural safety commitments.

Themes identified from the literature review[18] support the Ngā Paerewa standards on matters of cultural competence and cultural safety. The themes have been summarised as:

- leadership and accountability: sustained resourcing of strategies, demonstrated commitment to cultural safety, establishing policies to address bias and monitoring results
- partnerships and community engagement: engaging Māori throughout the process of implementing cultural safety and involving community feedback and participation in strategy development
- ongoing education and training for all staff: addressing biases through different training and reflection exercises

18 Drost, J. L. (2019). Developing the alliances to expand traditional Indigenous healing practices within Alberta Health Services. *The journal of alternative and complementary medicine*, 25(S1), S69-S77.
Guinaran, R. C., Alupias, E. B., & Gilson, L. (2020). The practice of power by regional managers in the implementation of an indigenous peoples health policy in the Philippines. *International Journal of Health Policy and Management, 10*(7), 402.
Hickey, S., Couchman, K., Stapleton, H., Roe, Y., & Kildea, S. (2019). Experiences of health service providers establishing an Aboriginal-Mainstream partnership to improve maternity care for Aboriginal and Torres Strait Islander families in an urban setting. *Evaluation and Program Planning, 77*, 101705.
Lauzière, J., Fletcher, C., & Gaboury, I. (2021). Factors influencing the provision of care for Inuit in a mainstream residential addiction rehabilitation centre in Southern Canada, an instrumental case study into cultural safety. *Substance Abuse Treatment, Prevention, and Policy, 16*(1), 55.
Parter, C., Gwynn, J., Wilson, S., Skinner, J. C., Rix, E., & Hartz, D. (2023). Putting Indigenous cultures and Indigenous knowledges front and centre to clinical practice: Katherine hospital case example. *International journal of environmental research and public health, 21*(1), 3.
Silver, H., Corman-François, M., Kapellas, S., Lemire, P., Pepin, J., Sarmiento, I., & Andersson, N. (2024). Co-designing Culturally Safe Indigenous Birth in High-Risk Obstetrics: Implementing Joyce's Principle with Inuit and Cree Families and Their Medical Providers. *Journal of Transcultural Nursing*, 10436596241292042.

- addressing systemic barriers: measures to improve service delivery, address power imbalances and solve resourcing problems
- workforce development: indigenous representation and retention, as well as overall staff cultural competence
- context-specific implementation: aligning efforts with national initiatives and frameworks and developing context-specific strategies for implementing cultural safety.

The literature review identified that sustained training in cultural competence or cultural safety improves the knowledge and skills of participants and may improve patient care.[19] The referenced studies include healthcare, social work, and educational settings.

The themes that emerged from the literature review and incorporated in the Ngā Paerewa standards are supported by systematic reviews in the Cochrane Library.[20] There is good evidence in Cochrane reviews of methods to improve healthcare practices, that:

- feedback to health workers on the patient-reported outcome measures improves communication with patients, diagnosis and record keeping[21]
- local opinion leaders, alone or in combination with other interventions, increase the use of best practice[22]
- health professionals (and other healthcare workers) can improve their practice when given data showing that their practice is inconsistent with a desirable target.[23]

Collection and analysis of data that compares current practice versus a standard or best practice is known as clinical audit among health professionals and is often used in conjunction with other interventions, such as peer review or the use of opinion leaders, to improve effectiveness. Key components of this approach that can be used in developing culturally safe care for all patients include:

- leadership by local champion(s) that have existing relationships to staff
- a range of channels, such as verbal, written, or graphical
- focusing on measures where there is substantial room for improvement
- measuring individual practice as well as the team and organisation as a whole
- comparing performance to peers
- facilitating an actionable plan with specific advice for improvement.

19 Hardy, B. J., Filipenko, S., Smylie, D., Ziegler, C., & Smylie, J. (2023). Systematic review of Indigenous cultural safety training interventions for healthcare professionals in Australia, Canada, New Zealand and the United States. BMJ open, 13(10), e073320.
MacLean, T. L., Qiang, J. R., Henderson, L., Bowra, A., Howard, L., Pringle, V., ... & Mashford-Pringle, A. (2023). Indigenous cultural safety training for applied health, social work, and education professionals: A PRISMA scoping review. International Journal of Environmental Research and Public Health, 20(6), 5217.
Moloney, A., Stuart, L., Chen, Y., & Lin, F. (2023). Healthcare professionals' cultural safety practices for indigenous peoples in the acute care setting—a scoping review. Contemporary Nurse, 59(4-5), 272-293
Rissel, C., Liddle, L., Ryder, C., Wilson, A., Richards, B., & Bower, M. (2022). Improving cultural competence of healthcare workers in First Nations communities: a narrative review of implemented educational interventions in 2015—20. Australian Journal of Primary Health, 29(2), 101-116.

20 The Cochrane Library (ISSN 1465-1858) is a collection of databases that contain high-quality, independent evidence to inform healthcare decision-making. See https://www.cochranelibrary.com

21 Gibbons C, Porter I, Gonçalves-Bradley DC, Stoilov S, Ricci-Cabello I, Tsangaris E, Gangannagaripalli J, Davey A, Gibbons EJ, Kotzeva A, Evans J, van der Wees PJ, Kontopantelis E, Greenhalgh J, Bower P, Alonso J, Valderas JM. Routine provision of feedback from patient-reported outcome measurements to healthcare providers and patients in clinical practice. Cochrane Database of Systematic Reviews 2021, Issue 10. Art. No.: CD011589. DOI: 10.1002/14651858.CD011589.pub2.

22 Flodgren G, O'Brien MA, Parmelli E, Grimshaw JM. Local opinion leaders: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2019, Issue 6. Art. No.: CD000125. DOI: 10.1002/14651858.CD000125.pub5

23 Ivers N, Yogasingam S, Lacroix M, Brown KA, Antony J, Soobiah C, Simeoni M, Willis TA, Crawshaw J, Antonopoulou V, Meyer C, Solbak NM, Murray BJ, Butler E-A, Lepage S, Giltenane M, Carter MD, Fontaine G, Sykes M, Halasy M, Bazazo A, Seaton S, Canavan T, Alderson S, Reis C, Linklater S, Lalor A, Fletcher A, Gearon E, Jenkins H, Wallis JA, Grobler L, Beccaria L, Cyril S, Rozbroj T, Han JX, Xu AXT, Wu K, Rouleau G, Shah M, Konnyu K, Colquhoun H, Presseau J, O'Connor D, Lorencatto F, Grimshaw JM. Audit and feedback: effects on professional practice. Cochrane Database of Systematic Reviews 2025, Issue 3. Art. No.: CD000259. DOI: 10.1002/14651858.CD000259.pub4.

ACC and health equity

ACC claims data consistently shows that Māori experience a higher risk of a serious injury but are overall less likely to lodge a claim than non-Māori.[24] Māori who lodge a claim are less likely to receive appropriate care such as high-tech imaging, elective surgery and clinical services. For example, research shows that Māori were 37% less likely to have an initial CT scan following a traumatic injury than non-Māori.

Commencing in 2017, the Health Services and Outcomes Inquiry at the Waitangi Tribunal (Wai 2575) heard claims concerning health services and outcomes of national significance. Claims concerning Māori with lived experience of disability were heard in the years following 2020. Stage One of Wai 2575 concluded in March 2019, following an inquiry into aspects of primary care. A range of commissioned research reports related to those hearings is available from the Waitangi Tribunal.[25]

Concerning primary care, the report notes (page 226) that Māori adults were:

- more likely than non-Māori to have a usual medical centre
- less likely than non-Māori to see a GP or to visit an after-hours clinic
- more likely than non-Māori to see a practice nurse without seeing a GP
- more likely than non-Māori to have unmet needs and unfilled prescriptions.

These inequitable patterns, where Māori have reduced access to services and treatment, and lesser care, did not change in the 10 years from 2012 to 2022.[26] In 2023, the Accident Compensation Act was amended, requiring ACC to report on access to services by Māori and other identified population groups. This amendment provides more tools for ACC to understand how to address these inequities.

Information for providers on ACC's cultural safety policy and supporting resources is available on the ACC website.[27]

Information on healthcare equity for Māori, including a framework to guide individuals and organisations in developing knowledge about equity and influence their workplaces and actions to support health equity, is available from the Ministry of Health[28] and the Health Quality and Safety Commission.[29]

24 Aide memoire to Minister for ACC available at https://www.documentcloud.org/documents/20893046-2-gov-010263-accs-delivery-to-priority-populations-part-2-maori-reda/

25 See https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_195476216/Hauora%202023%20W.pdf

26 Health inequities are systematic differences in the health status of different population groups that arise from unfair distribution of resources.

27 See https://www.acc.co.nz/for-providers/provide-services/cultural-safety-and-competencies

28 See https://www.health.govt.nz/publications/equity-of-health-care-for-maori-a-framework

29 See https://www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/health-literacy/

The causes of inequity for Māori

Research on barriers to care for Māori has consistently shown the presence of systemic and institutional biases that disadvantage Māori. Baxter[30] reported on the impact of cultural appropriateness of care, broad structural barriers and the increased impact of the socio-economic obstacles on Māori. Crengle[31] further identified structural barriers to Māori engaging with care, such as:

- the location, timing and availability of services to suit Māori preferences
- financial barriers, which are more likely to impact Māori due to lower socio-economic status than non-Māori
- systematic bias by providers who privilege Pākehā rather than treating those in greatest need
- cultural barriers, including the acceptability of services to Māori and the provision of appropriate information to Māori.

Many New Zealand studies have identified the adverse experiences of Māori within the health system.[32 33 34 35 36] The authors of these studies have identified that repeated negative experiences of Māori have an impact on the acceptability of care and likelihood of future use. Making a positive change to this requires persistent effort by providers. As Graham and Masters-Awatere state:

For many Māori, the existing public health system is experienced as hostile and alienating.[37]

The importance of culturally safe services has also been highlighted by Durie (and called culturally appropriate) as a significant aspect of access to care:

The degree of comfort individuals feel with seeking health services impacts on their use of services and, in turn, health outcomes. Comfort is a product of both individual attitudes and how services are delivered. The delivery of care in a culturally appropriate manner is an important element in determining the willingness of people to access services and the success of any treatment or care delivered.[38]

30 Baxter J, Barriers to Health Care for Maori with Known Diabetes. New Zealand National Working Group on Diabetes and Te Roopu Rangahau Hauora a Ngai Tahu, September 2002

31 Crengle S. The development of Maori primary care services. Pacifi c Health Dialog 2000, 7(1): 48-53

32 Jansen P, Bacal K, Crengle S. He Ritenga Whakaaro: Māori Experiences of Health Services. Auckland (NZ): Mauri Ora Associates; 2009.

33 Anderson A, Mills C, Eggleton K. Whānau perceptions and experiences of acute rheumatic fever diagnosis for Māori in Northland, New Zealand. NZMJ. 2017;130(1465):80-9..

34 Westbrooke I, Baxter J, Hogan J. Are Māori under-served for cardiac interventions? NZMJ. 2001;114:484-7

35 McKinny C. Māori Experiences of Hospital Care in Auckland. Auckland (NZ): University of Auckland; 2006

36 Palmer, S.C., Gray, H., Huria, T. et al. Reported Māori consumer experiences of health systems and programs in qualitative research: a systematic review with meta-synthesis. Int J Equity Health 18, 163 (2019). https://doi.org/10.1186/s12939-019-1057-4

37 Graham, R and Masters-Awatere B, Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research Aust NZ J Public Health. 2020; 44:193-200

38 Durie M. Mauri Ora: the Dynamics of Māori Health. Auckland: Oxford University Press, 2001

The impact of organisational culture

This section offers guidance to leaders on developing a systematic approach to cultural competence and cultural safety.

Mā te mōhio, ka mārama

From knowledge comes understanding

Achieving health equity through culturally safe practice requires a plan: just as effective organisations undertake regular planning to define objectives and outline plans and resources to achieve them, then put the plans into action while monitoring progress before assessing performance and making necessary adjustments.

The **ACC Kawa Whakaruruhau (Cultural Safety) policy** requires providers to ensure cultural safety is embedded in their services and maintain records demonstrating compliance with the policy. To achieve this, providers will need committed leadership to make changes that are necessary for cultural safety to be effective. The provider organisation and staff are responsible for identifying and removing barriers to care for ACC kiritaki and their whānau. Together the organisation and staff will be required to address inequitable outcomes by supporting kaimahi to adhere to requirements for cultural safety and cultural competence and by developing appropriate policies and plans. These may consider:

- how the provider will consult iwi/Māori
- the effective collection of ethnicity data and the appropriate use of that data
- the identification and reduction of inequalities between Māori and other New Zealanders
- workforce development for kaimahi Māori (Māori staff)
- training for all kaimahi in cultural competence, Māori preferences and cultural safety
- delivery of culturally responsive and appropriate service delivery.

The role of leaders, managers and administrators in supporting equity:

- **set the scene** for needed changes and anticipate challenges
- **understand barriers** to effective care
- ensure ethnicity data is collected for measures of performance
- establish **community engagement** to review strategies, performance and insights
- coordinate the development of **plans** for
  - > appropriate staffing
  - > training and development for all staff using qualified trainers and a variety of methods
  - > data collection of current performance from internal and external sources
  - > analysis of measures and insights
  - > performance review and feedback
  - > reporting of results to stakeholders
- ensure there are **adequate resources** to implement plans and monitor performance.

Leaders (including members of any governance board), managers and support staff have a central role in shaping and reshaping organisational culture. A key component of improving care for Māori is reviewing data on access to treatment and outcomes between Māori and non-Māori. If inequities in access or outcomes for Māori compared with need (or compared with non-Māori) are found, providers can work with staff and Māori and community representatives to develop plans to address these.

Reflections on staffing:

- As the provider, do you have staff positions with responsibility for community engagement and data collection to support cultural safety plans?
- What is the role and position of kaimahi Māori within your organisation?

Collection of ethnicity data

Health equity is evidenced through the accurate and consistent collection of ethnicity data. This data should be used to plan improvements to services for Māori. This includes comparing access to services and outcomes of care for Māori and non-Māori. Without this information, suppliers and providers cannot measure the effectiveness of their services and any existing disparities would likely continue.[39]

Example

In a seminar on Māori health, a GP reported difficulties collecting ethnicity data. The GP resorted to apologising to patients for asking the question and adding that the information was required for government statistical purposes. Other GPs in the area had greater success in collecting ethnicity data and told of their experiences, which included:

- explaining that the purpose of collecting ethnicity data and other demographic information on all patients was to ensure each patient and their whānau were receiving care appropriate to their needs
- ensuring the whole practice team adopted a consistent approach
- providing training and feedback on ethnicity data collection to the practice team.

Reflections on ethnicity data collection:

- How do you explain to kiritaki the reasons for the collection and use of information?
- Have you advised kiritaki when and why information may be shared with others?
- Have you and your team sought ethnicity information directly from kiritaki and whānau? If not, did you guess or assume details based on their appearance or name?
- What has been your response to someone declining to answer this question or identifying multiple ethnicities?

39 Reid P, Robson B, Jones CP. Disparities in health: common myths and uncommon truths. Pacific Health Dialog 2000, 7 (1):38-47

Overcoming inequity – planned surgery

Reports of the Perioperative Mortality Review Committee (POMC) of the Health Quality and Safety Commission (HQSC) from 2015 to 2019 highlighted that Māori have higher rates of death after surgery in public hospitals compared with non-Māori, even after adjusting for age, gender, deprivation and the presence of other illnesses (co-morbidities). Reasons for this persistent inequality, highlighted by the Māori Caucus of HQSC, included differences in care before and after surgery.

Gurney et al[40] reported on mortality rates for New Zealand residents having surgery under general anaesthesia using the National Minimum Dataset (NMDS). This dataset includes all public hospitals and some private hospitals. While adjusted 30-day mortality had decreased for the overall population between 2005 and 2017, Māori had a 30% higher mortality rate than Europeans. The authors stated that this "*... is in part due to institutionalised racism in the healthcare system*", noting financial and cultural or access barriers.

Input to the POMC included consumers and the Māori Caucus (convened by HQSC) with advice on better data analysis and a recommendation to focus on remediable barriers to care.[41]

Teamwork can eliminate inequality

The Perioperative Mortality Review Committee made recommendations to hospitals on improving outcomes for Māori, then worked with professional groups, surgical teams, and managers to regularly review data, understand the issues and develop action plans.

In 2024, 210,500 planned surgeries were performed with no difference in 30-day mortality between ethnic groups. The disparity for Māori seen in previous years had been eliminated.

Attention now turns to the persistent disparity in 30-day mortality after emergency surgery for Māori (1.4%) and Pacific peoples (1.6%) compared to European (0.9%) and Asian (0.9%) New Zealanders.[42]

40 Gurney JK, McLeod M, Stanley J, et al. 2020. Postoperative mortality in New Zealand following general anaesthetic: demographic patterns and temporal trends. BMJ Open 10: e036451. DOI: 10.1136/bmjopen-2019-036451

41 See https://www.hqsc.govt.nz/resources/resource-library/summary-of-perioperative-mortality-review-committee-pomrc-reports

42 See https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/POMRC/Publications-resources/Surgery-and-Risk-in-Aotearoa-Infographic-2024.pdf

Practical guidance

The following practical guidance is designed to support providers in implementing the expectations of the **ACC Kawa Whakaruruhau (Cultural Safety) policy** and relevant professional standards. It has been adapted from Curtis et al (2025), which considers the following to be core components of cultural safety and cultural competency.

Cultural safety:

1. Recognise and respect diverse understandings of health, cultural practices, family structures and social supports.
2. Recognise how marginalisation and privilege shape access to, delivery of, and outcomes from health care.
3. Eliminate bias and discrimination within health care practice, teaching, research, workforce development, leadership and data use.
4. Follow national protocols for the accurate collection, classification and analysis of ethnicity data, and assess the effectiveness of professional practice by ethnicity.
5. Demonstrate evidence of continuous improvement through ongoing critical self-reflection, peer and community feedback, and measurable progress towards equity.

Cultural competency:

1. Understand that culture influences health beliefs, behaviours and outcomes, and that culture itself is dynamic.
2. Reflect on one's own cultural identity, values, assumptions and their influence on practice.
3. Recognise and respect the cultural worldviews and preferences of patients, colleagues and communities, avoiding stereotyping or cultural appropriation.
4. Develop and maintain cultural knowledge and skills through continuing education, supervision and partnership with cultural experts.
5. Regularly evaluate cultural competence, identify learning needs, and seek guidance or cultural expertise when appropriate.

Frontline or back office: What's my role?

The table outlines the roles of staff in ensuring high-quality and equitable care is provided to all kiritaki, from a combination of Ngā Paerewa standards, ACC's Kawa Whakaruruhau, and professional requirements, with reference to the systematic reviews and other relevant papers identified in the literature review section.

	Managers and administrators	Registered health professionals	Other health workers with direct contact with kiritaki	Governance boards and leaders
Community engagement	Co-lead with the community	Participate when requested	Participate when requested	Set expectations, review performance
Identifying inequity	Co-lead	Co-lead	Co-lead	Review and approve plans
Setting the scene: a strategy to achieve health equity	Lead and influence	Participate	Participate	Review and approve plans
Plans (training, data collection, performance, staffing)	Accountable	Provide input	Provide input	Set expectations, review and approve plans
Resource allocation	Lead	Provide input	Provide input	Have oversight
Workforce development	Ensure resources are available and staff meet requirements		Participate/meet requirements	Review and approve plans
Professional development	Ensure resources are available and staff meet requirements	Participate/meet requirements		Review and approve plans
Providing high quality, culturally safe care to all	Ensure resources are available. Review outcomes	Lead	Lead	Review outcomes and seek insights
Review of access, experience and outcome measures	Lead	Actively participate. Offer reflections	Actively participate. Offer reflections	Review and seek insights

Supporting kiritaki Māori

The following examples are provided as additional context to support understanding of kiritaki experiences. It is not a comprehensive list, but it provides a starting point for providers and organisations to consider when reviewing services and planning regular training for kaimahi on Māori preferences.

The impact of prior experiences

All patients, including kiritaki Māori, will have expectations and perceptions of care that are formed form their own experiences and the experiences of whānau.[43, 44, 45] Past and current experiences may also influence decisions on whether to seek assistance, follow care recommendations, or provide feedback on healthcare interactions.

In a study exploring Māori perceptions of healthcare services, Mauri Ora Associates completed 10 hui to gather information on positive and negative experiences of care from community-based providers, general practices, hospitals and ACC, using this information to inform a survey that was completed by 651 kiritaki Māori.[46] Findings were that while most reported good service, a sizable number of kiritaki Māori stated a reluctance to seek healthcare in the future due to negative attitudes and barriers they have experienced.

Kiritaki Māori participating in the hui expressed the view that care will be provided to them at a lesser quality than non-Māori, by people who are either disrespectful, or do not understand Māori perspectives and cannot provide understandable information to kiritaki Māori. The hui also highlighted a complex interplay between barriers and expectations of care.

Example: Identifying then removing barriers

Regular surveys of patient experiences for a multi-disciplinary community service showed a persistent issue for kiritaki Māori perceiving lesser respect and challenges accessing care.

Community consultation identified hours of operation for kiritaki Māori requiring time off work or obtaining substitute caregivers in order to attend appointments as a barrier.

These matters were raised in staff meetings and a change in hours and staff rostering was agreed to extend hours of operation to accommodate workers and those with caregiver responsibilities. These changes were communicated widely with a plan to monitor the impact.

Reflections on support for kiritaki Māori:

- Do kiritaki Māori access your services in proportion to population in your region? Do kiritaki Māori access your services in proportion to injury rates and need for treatment/support?
- What sources of information do you have on Māori experiences of care in your service or similar services? How can providers and organisations support improved consultations with kiritaki and whānau?

The Health Quality and Safety Commission conducts national patient experience surveys to regularly collect, measure and use patient experience feedback for quality improvement. These surveys include hospital inpatients and outpatients, general practice attendees and home and community support services.

43 Bryant S, Campbell S. 1996. Final Evaluation of Te Mammography Pilot Project for Māori Women in the Waikato Waiora Region, Te Awamutu: Te Karere Matauranga Māori Research and Development Consultancy.

44 Cram F, Smith L & Johnstone W. 2003. 'Mapping Themes of Māori Talk About Health'. NZMJ 116, no. 1170

45 Health Waikato. 2001. He Whakawhaititanga O Ngā Ratonga Mate Huka Integrated Diabetes Project: A Cultural Stocktake of Health Waikato Diabetes Service Investigating Māori Preferences for Service Delivery.

46 Jansen P, Bacal K, Crengle S. He Ritenga Whakaaro: Māori experiences of health services. Auckland, Mauri Ora Associates 2008

Background information and results of patient experience surveys are available from the HQSC searchable data available at www.hqsc.govt.nz/our-data/patient-reported-measures/patient-experience/

The HQSC also has materials to assist health workers and organisations understand bias in healthcare. See www.hqsc.govt.nz/resources/resource-library/learning-and-education-modules-on-understanding-bias-in-health-care/

Reflections on bias and assumptions:

- What are the assumptions and values that guide your activities? For example, interactions with whānau and friends, when buying and selling goods or services, attending school, sports and employment (paid or unpaid).
- What are the sources of those assumptions and values, and are they accurate for this person on this day?

Tikanga Māori

The customs and protocols that have guided Māori over generations collectively form what is known as tikanga or tikanga Māori. As Hirini Moko Mead notes (Tikanga Māori: Living with Māori Values, 2003), tikanga Māori serves as a means of social control, a normative system, an ethical framework, a repository of Māori knowledge, and a body of customary lore. At a time of heightened concern because of injury, tikanga Māori may guide interactions with health and rehabilitation providers, **just as prior experiences have shaped expectations for the provider and kiritaki Māori**.

Ko te kai a te rangatira, he kōrero

The food of a leader is conversation

Example: Miscommunication and different interpretations

The whānau of Mrs K is very reluctant to go to the hospital or see medical specialists because "they do not believe what you tell them, and they treat Māori badly". This came about after the referral of their kuia (female elder) to a specialist for assessment following a fall — causing injury. During talks with whānau members, the specialist asked if the kuia was taking any medications. The whānau was clear that their kuia was not on any medicines, so they were very upset when the correspondence from the specialist stated that "the family/whānau denies the patient is on any medication". The whānau took this to mean that the specialist thought their kuia was taking medicines and did not believe what the whānau said. In this case, a common clinical phrase was at odds with the language used by the whānau. This impacted their perception of, and future engagement with, clinical kaimahi.

Reflections on communication preferences:

- How can providers and organisations support improved consultations with kiritaki and whānau?
- Do you review and assess the advice given to kiritaki and whānau for clarity and understanding?
- Have you asked kiritaki and whānau about their preferences for receiving information within the consultation and as a follow-up?

Kiritaki and whānau Māori constantly strive to overcome the barriers between themselves and their providers.[47, 48, 49] Providers, for their part, have a duty to achieve skilled performance[50] to remove these barriers.

47 Durie M. Maori attitudes to sickness, doctors and hospitals. NZMJ 1977, 86: 483-485

48 Tipene-Leach D. Māori — our feelings about the medical profession. Community Forum November 1978

49 Gribben B (for Auckland UniServices) Integrated Care Evaluation 2000-2001 — Primary Options for Acute Care. Counties Manukau District Health Board, December 2001

50 Competencies are those areas of skilled practice that are expected of healthcare providers

Communication – a key issue

Studies from around the world confirm that kiritaki place the most importance on providers' communication skills. Client satisfaction with care and the acceptability of treatment[51, 52] is associated with the ability of providers to demonstrate that they both understand their kiritaki and are understood by them. Kiritaki Māori also highly value the communication skills of providers.[53, 54] It is kiritaki and whānau that determine the success of the interaction when they feel satisfied that issues were addressed in accordance with their needs and expectations.

He tao huata ka taea te karo he tao kupu e kore e taea te karo

A wooden spear shaft can be parried, but a verbal spear cannot be parried

The whakataukī above reflects Māori feelings about the importance of the spoken word. Mispronunciation of Māori names and words can be jarring to Māori and, if continued without self-correction, implies a lack of respect for Māori.

This is the opposite of the English saying, *'Sticks and stones will break my bones. However, words will never hurt me'*, which promotes resilience in the face of verbal aggression.

Reflections on communication:

- What assumptions guide the English proverb that advises people to ignore name-calling?
- How would you respond to persistently having your name or title pronounced incorrectly?
- When might kiritaki and whānau consider persistent mispronunciation to be disrespectful?

Example: Seek help with pronunciation

Mr Ngawharau took his daughter, Pounamu, to a busy accident and medical clinic. He was asked to fill out various forms and sit in the waiting room. The clinic triage nurse explained that she found it hard to pronounce their name and suggested calling the injured child Jade, as that was much easier for her. Jade is the English equivalent of pounamu, also known as greenstone. The father and daughter left without further care but later presented to a hospital emergency department.

Reflections on communication:

- What assumptions was the triage nurse making when Mr Ngawharau and Pounamu completed the enrolment form?
- What could have been done differently in this situation?
- How will you record the preferences of kiritaki and whānau on pronunciation and use of their names?

Supporting the preferences of whānau Māori

The following sections provide general advice. Please refer to the readings at the end of this section for more information.

Initial contact

- The appropriate use of space and time is important at first contact to give time for kiritaki Māori and their whānau to get to know the provider.
- All providers or kaimahi should introduce themselves and explain their role to the kiritaki and their whānau.
- It is very important to pronounce Māori names correctly or ask when unsure. For many people, names are connections to the past

51 Fortin AH. Communication skills to improve patient satisfaction and quality of care. Acad Med. 2000 November, 75(11):1071-1080

52 A Survey of Determinants of Patient Satisfaction with GPs in Auckland. Radford Group report to ProCare, 1996

53 Jansen P, Improving consultations with Māori clients, NZFamPhys 1998 April, 25(2)

54 Cram F, Smith L, Johnstone W. Mapping themes of Māori talk about health. NZMJ 2003 March, 116 (1170) http://www.nzma.org.nz.info/journal/116-1170/357/

and the present, so getting this right is a mark of respect.

- Rushing the first meeting or not allowing sufficient time for kanohi ki te kanohi (face-to-face) interaction can negatively impact relationships and, therefore, the joint understanding of treatment plans between the provider and kiritaki.
- Lacey and colleagues[55] from the University of Otago reported on a framework for clinician-to-kiritaki consultations that utilises the concepts of pōwhiri — formal and informal meetings. *The Hui* process they describe includes mihimihi (initial greeting engagement), whakawhanaungatanga (making a connection), kaupapa (attending to the main purpose of the encounter) and poroporoaki/whakamutunga (closing the session).

Collecting or imparting information

To be effective, providers must provide people with the information they need in a way that works for them, enabling them to make informed decisions and manage their health and well-being. This has been described as meeting health literacy needs. In the past, the issue of health literacy was presented as a problem residing with the consumer. The reality is that the health system is complex, and how health conditions or treatments are explained needs to match the preferences of the kiritaki.

As each person has different preferences for receiving information[56] providers need to:

- use plain language
- identify what people know or do not know so that new information builds on prior knowledge
- carefully explain referrals to unfamiliar health services
- offer information in several ways to ensure that understanding is achieved
- be aware that for many Māori, the preferred method of exchanging information is kanohi ki te kanohi, supplemented with written materials and diagrams
- check that kiritaki and whānau have been given sufficient information that makes sense to them before leaving the consultation. For example, you could ask, "I want to be sure that I have given you all the information you need. Can you tell me what you understand will happen to you, from what I have said today?"[57]

Reflections on the consultation:

- Have you allowed enough time to introduce yourself to the kiritaki and their whānau?
- Do you let the kiritaki set the scene for the consultation?
- In your observations of non-verbal communications, did you understand the context and check on the meaning?
- Have you checked that the kiritaki and whānau understand the matters discussed and the treatment plan?

Whānau support

The attendance of whānau at appointments to support kiritaki Māori should be encouraged to enhance communication and facilitate mutual understanding. *The Hui* process has been supplemented with the Meihana model [58] showing how social and medical information collection can be extended to give a deeper understanding of kiritaki Māori.

55 Lacey, C Huria T, Beckert L, Gilles M, Pitama S. The Hui Process: a framework to enhance the doctor— patient relationship with Māori NZMJ 16 December 2011, Vol 124 No 1347

56 See https://www.hqsc.govt.nz/resources/resource-library/teach-back-training-toolkit-march-2014/

57 See for example https://www.healthnavigator.org.nz/clinicians/h/health-literacy/

58 Pitama S, Robertson P, Cram F, et al. Meihana Model: A Clinical Assessment Framework. New Zealand Journal of Psychology. 2007;36(No. 3):118-125.

The head

In many cultures, the head has special significance. Before examining or touching another person's body (including the head), providers must explain the purpose of the examination and obtain permission.

Eye contact

For Māori, making direct eye contact can be a sign of disrespect, especially when directed toward authority figures. During a consult with kiritaki and whānau Māori, it may be appropriate to avoid prolonged eye contact and to look at a neutral point in the room as a sign of respect.

Karakia (blessings/prayer)

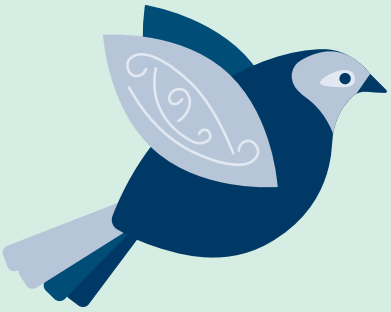
If kiritaki Māori or their whānau want to recite karakia before a procedure or at times of heightened concern, such as before the administration of blood products, this should be supported.

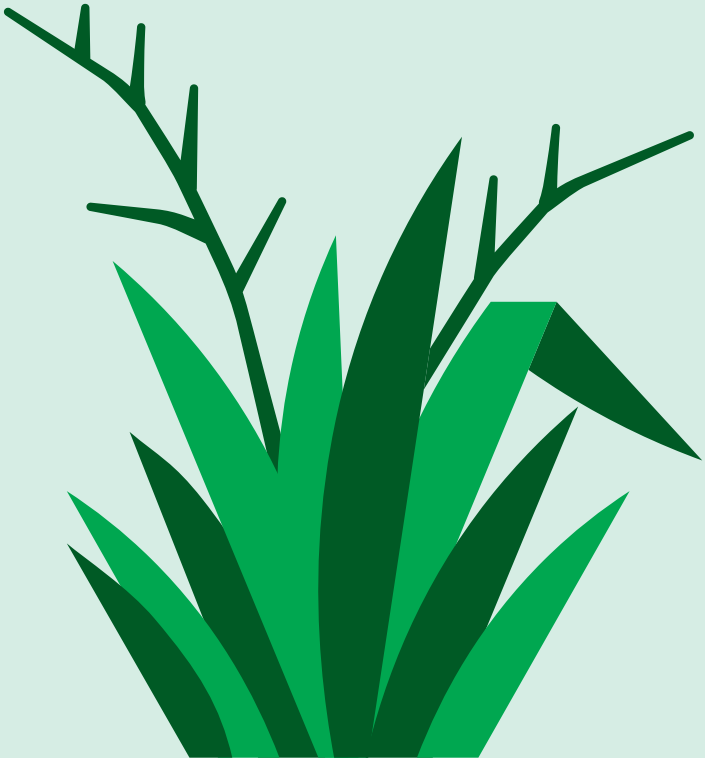
Support for kiritaki

Ask kiritaki Māori and their whānau if they have any particular cultural, spiritual, language or other needs, and document these. Provide verbal and written information and support regarding the complaint procedures.

Pain

Pain is one of the most common symptoms encountered by treatment and rehabilitation providers. Pain may also be associated with diagnosis (injections, acupuncture), treatment (operations) and rehabilitation (physical therapies). Studies of pain behaviours emphasise the need to be wary of cultural or ethnic stereotypes.[59] While there may be cultural differences, it is always important to assess each person individually.





59 Kleiman A, Brodwin P, Good B, Good M. Pain as human experience: an introduction. In Good M, Brodwin P, Good B, Kleiman A. (eds). Pain as Human Experience: An Anthropological Perspective. University of California Press 1992:77-99

Further information

- https://www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/health-literacy/
- Mead, Hirini Moko. *Tikanga Māori, Living by Māori Values*. Huia Publishers, 2003

Appendix 1: Glossary of important terms

Equity	Equity is the absence of unfair, avoidable or remediable differences in healthcare access and health outcomes among groups of people
Inequity	Injustice or unfairness. In the context of health, this is the presence of avoidable differences in healthcare access and health outcomes between groups of people
Disparity	A noticeable or significant difference
Racism	The systemic oppression of a racial group to their disadvantage compared to other groups — **OR** — the systemic privileging of a racial group to receive an advantage over other groups
Critical consciousness	To identify and resist the unconscious biases and hidden curriculum (unspoken values and rules) that privilege some and exclude others
Cultural competence	The acquisition of attitudes, skills, and knowledge to function effectively and respectfully when working with and treating people from a range of cultural backgrounds

Cultural safety	Providers and organisations engage in ongoing reflection, holding themselves accountable for providing culturally safe care, as defined by the patient and communities
Hapori Māori	Māori communities
Hapū	Sub-tribe, clan
Hui	Meeting — formal and informal
Kaimahi	Staff, work colleagues
Kanohi ki te kanohi	Face-to-face, a face-to-face meeting
Karakia	Prayer, blessings, incantations
Kaumatua	An elder (generally male, but some apply the term kaumatua to both men and women). Plural is kaumātua
Kaupapa	A policy, plan, theme, purpose, scheme, proposal, or similar
Kirimate	Reference to the immediate family of the deceased
Kiritaki	Client. This document refers to injured persons who are ACC clients
Kiritaki Māori	Māori client(s)
Kuia	An elder (female)
Koha	A donation, freely given without expectation of any return
Mana	A supernatural force in a person, place or object. Prestige, authority, control, power, influence, status, spiritual power, charisma. Mana belongs to an individual and the tribe. Mana is acquired through lineage, but more importantly, through recognition of performance and service to others, wisdom and humility. For more information, see Te Aka Māori Dictionary (maoridictionary.co.nz)
Manuhiri	The visitors or guests
Mātua	Parents (also ngā mātua)

Māuiui	Malaise (feeling unwell)
Mauri	The life force that exists in all things, both alive and inanimate
Mihimihi	Initial greeting engagement
"Ngā wā o mua"	It means "the times in front of me". However, because the Māori worldview sees the past as visible but the future as unknown (behind us), this phrase refers to times gone by
Pākehā	Non-Māori New Zealanders — primarily people of European descent
Poroporoaki	Closing a session (also whakamutunga)
Pōwhiri	The Māori welcome, which takes place when going onto a marae
Rangatira	Chief, leader, esteemed person
Tangata whenua	The indigenous people of Aotearoa
Tamaiti	Child (singular)
Tangihanga	Mourning and funeral rites. For Māori, these are the most important of all rituals and include the sharing of grief, takahi kāinga (literally, the trampling of the home), kawe mate (taking the memory around), and hura kōhatu (unveiling funerary stones). The mourning processes often take a year to complete. During the initial days of mourning, friends and relatives gather for the tangi and make a point of getting there on time to "look upon the face" of the tūpāpaku (the body of the deceased) and to express emotions openly and unashamedly
Te reo Māori	The Māori language, to speak Māori
Tika	A principle to do what is proper
Tikanga	Customs
Tohunga	A generic term for an expert recognised by the people. Today, tohunga can assist in dealing with sickness that has a mental or social component. Tohunga are available through kaumātua and Māori clergy

Tūpāpaku	The body of a deceased person
Tūroro	A person who is sick
Waiata	A chant that accompanies a speech
Wairua	The spiritual force within people
Whakapapa	Genealogy, the origins of people and their connection with others
Whakatau	To restore balance through acknowledgement. All things have equal amounts of noa (unrestricted) and tapu (sacred, restricted, protected). When someone is sick or injured, the environment affects that balance. The use of karakia to whakatau is one way to restore that balance.
Whakataukī	Proverb
Whakawhanaunga-tanga	Establishing a relationship, relating well to others
Whānau	Immediate and extended family
Whanaungatanga	Establishing a sense of family/whānau connection or friendships

Appendix 2: ACC data report on Māori claims and entitlements

Updated for year ended June 2025

Māori statistics

As at 30 June 2025, Māori comprised 17.4% of the New Zealand resident population. Statistics New Zealand population projections through to 2045 show the average growth rate for Māori at 1.5% per annum, well in excess of that expected for the European/Other population (-0.1% per annum).

On this basis Māori are expected to increase from 17.4% to 19.7% of the resident population by 2045, while European/Other will fall from 65.3% to 54.0%.

While most Māori live in the North Island, every region has a Māori population of at least 9.2% (Tasman). The largest Māori population in the North Island is the Gisborne region at 57.4% and in the South Island, Southland has the largest percentage of the Māori population at 16.9%.

Injury to Māori

Ethnicity data is now collected from 96% of new ACC claims, and this shows Māori entitlement claim rates are approximately 17.4% lower than for non-Māori. Māori also have lower average medical fees claims by approximately 15.1% when compared with non-Māori. By contrast, Māori continue to have higher rates of serious injury claims than non-Māori, approximately 43.0% higher for the 2024/25 year.

The following graph and tables are sourced from information provided to ACC from clients. ACC collects ethnicity data from 96% of new claims. Analysis of this data shows that:

- Māori represent 17.4% of the resident population, but account for 14.3% of entitlement claims
- overall, Māori have lower claim rates than non-Māori (all other ethnic groups combined). Māori entitlement claim rates are approximately 17.4% lower than for non-Māori (see Table 2)
- while the lower entitlement claim rates are apparent for both Māori earners and non-earners the disparity is far greater for non-earners where the Māori rate is 24.0% lower than that for non-Māori (compared with 15.1% disparity for earners) (see Tables 4 and 5)
- Māori continue to have higher rates of serious injury claims than non-Māori, approximately 43.0% higher for the 2024/25 years (see Table 6)
- Māori are 39% less likely to claim ACC compensation for a treatment injury than non-Māori (see Table 7)
- the average cost of medical fee only claims is consistently lower for Māori than for non-Māori by approximately 15.1% (see Table 8).

Table 1: Percentage of ethnic groups by region — Statistics New Zealand 2023 population projections

As at 30 June 2023	Māori	European / Other	Pacific	Asian
Total NZ	17.4%	69%	9%	18%
Total North Island Regions	19%	64%	10%	20%
Total South Island Regions	11%	85%	3%	11%
Northland Region	37%	74%	5%	5%
Auckland Region	12%	51%	16%	33%
Waikato Region	25%	74%	5%	12%
Bay of Plenty Region	30%	74%	4%	9%
Gisborne Region	57.4%	57%	5%	3%
Hawke's Bay Region	29%	74%	7%	6%
Taranaki Region	22%	85%	3%	6%
Manawatū-Whanganui Region	25%	80%	5%	8%
Wellington Region	15%	74%	9%	15%
Tasman Region	9.2%	94%	2%	3%
Nelson Region	12%	86%	3%	9%
Marlborough Region	14%	89%	4%	5%
West Coast Region	13%	92%	2%	5%
Canterbury Region	10%	82%	4%	13%
Otago Region	9.3%	87%	3%	9%
Southland Region	16.9%	85%	3%	8%

Table 2: New entitlement claim rates per 100,000 population by gender and age group 2024/25 — ACC Analytics & Reporting & Statistics New Zealand 2025 population projections

Age Group	Māori Female	Māori Male	Non-Māori Female	Non-Māori Male
00-04	202.9	252.3	208.7	322.8
05-09	263.0	348.9	432.0	464.1
10-14	574.4	718.6	972.1	1,097.7
15-19	1,498.9	2,814.5	2,161.3	3,435.3
20-24	2,767.6	5,670.2	3,347.6	5,763.5
25-29	2,857.6	5,826.6	3,502.9	5,542.0
30-34	3,143.3	5,271.6	3,307.9	5,109.9
35-39	3,257.3	4,958.6	3,138.1	4,599.9
40-44	3,426.9	4,595.0	2,991.5	4,143.2
45-49	3,622.4	4,340.7	3,091.7	4,065.0
50-54	3,575.4	4,248.9	3,662.0	4,237.9
55-59	3,722.5	4,023.4	3,893.3	4,437.9
60-64	3,679.2	4,362.2	3,837.7	4,466.3
65-69	2,754.6	3,479.5	3,044.1	3,482.6
70-74	2,743.1	2,621.1	2,918.1	2,602.0
75-79	2,500.0	2,280.7	3,509.4	2,382.6
80-84	3,171.4	2,607.1	5,003.3	3,116.6
85+	3,400.0	3,562.5	7,810.9	5,018.3

Graph 2: New entitlement claim rates per 100,000 population by gender and age group — ACC, Analytics & Reporting & Statistics New Zealand 2025 population projections

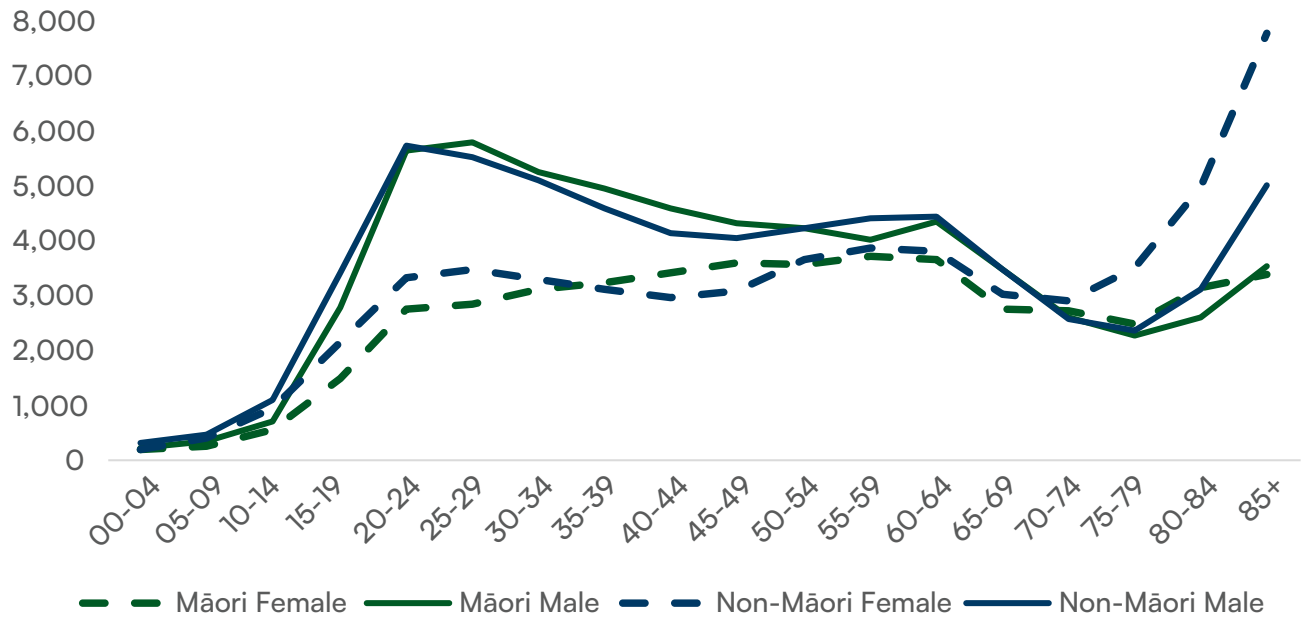


Table 3: Rate of new entitlement claims per 100,000, Māori versus non-Māori (all funds) — ACC, Analytics & Reporting

Lodgement Financial Year	Māori	Non-Māori	Pacific	Asian	European / Other
2019/20	2,285.4	2,925.9	1,936.7	1,231.6	3,120.2
2020/21	2,762.4	3,500.0	2,438.9	1,773.2	3,619.9
2021/22	2,530.3	3,070.4	2,095.2	1,604.7	3,149.3
2022/23	2,910.9	3,347.5	2,546.1	1,685.6	3,488.4
2023/24	2,883.4	3,397.4	2,540.7	1,755.1	3,564.3
2024/25	2,762.7	3,346.0	2,493.3	1,865.8	3,474.1

Table 4: Rate of new entitlement claims per 100,000, Māori versus non-Māori (earners only) — ACC, Analytics & Reporting

Lodgement Financial Year	Māori	Non-Māori	Pacific	Asian	European / Other
2019/20	1,834.4	2,140.8	1,591.2	988.1	2,248.8
2020/21	2,190.4	2,578.8	2,032.9	1,453.8	2,610.8
2021/22	2,049.0	2,302.6	1,772.0	1,369.7	2,303.0
2022/23	2,340.4	2,529.2	2,194.3	1,435.9	2,564.6
2023/24	2,263.0	2,537.1	2,152.2	1,501.7	2,579.7
2024/25	2,096.7	2,469.8	2,066.9	1,605.6	2,468.0

Table 5: Rate of new entitlement claims per 100,000, Māori versus non-Māori (non-earners only) — ACC, Analytics & Reporting

Lodgement Financial Year	Māori	Non-Māori	Pacific	Asian	European / Other
2019/20	451.1	784.9	345.4	243.5	871.2
2020/21	571.9	921.0	405.7	319.4	1,008.9
2021/22	480.4	767.7	323.0	234.8	846.1
2022/23	570.2	818.1	351.8	249.8	923.6
2023/24	620.4	860.1	388.5	253.4	984.4
2024/25	665.8	876.1	426.2	260.3	1,006.1

Table 6: Rate of new serious injury claims per 100,000, Māori versus non-Māori — ACC, Analytics & Reporting

Lodgement Financial Year	Māori	Non-Māori	Pacific	Asian	European / Other
2019/20	8.3	4.4	3.9	1.9	4.5
2020/21	10.3	5.4	6.2	2.5	5.6
2021/22	9.2	4.7	5.0	2.8	4.7
2022/23	8.1	4.9	5.4	1.5	5.2
2023/24	4.8	4.0	4.8	1.7	4.0
2024/25	3.2	1.8	2.3	1.1	1.7

Table 7: Rate of new treatment injury claims per 100,000, Māori versus non-Māori — ACC, Analytics & Reporting

Lodgement Financial Year	Māori	Non-Māori
2019/20	133.7	222.8
2020/21	148.8	246.7
2021/22	142.9	244.7
2022/23	157.8	272.8
2023/24	181.3	302.0
2024/25	201.0	332.0

Table 8: Average cost of med fee claims, Māori versus non-Māori — ACC, Analytics & Reporting

Lodgement Financial Year	Māori	Non-Māori	Pacific	Asian	European / Other
2019/20	$356	$380	$291	$409	$385
2020/21	$347	$393	$304	$417	$398
2021/22	$354	$395	$300	$389	$405
2022/23	$375	$418	$316	$412	$428
2023/24	$378	$440	$332	$436	$449
2024/25	$360	$424	$327	$436	$430

Data quality and caveats

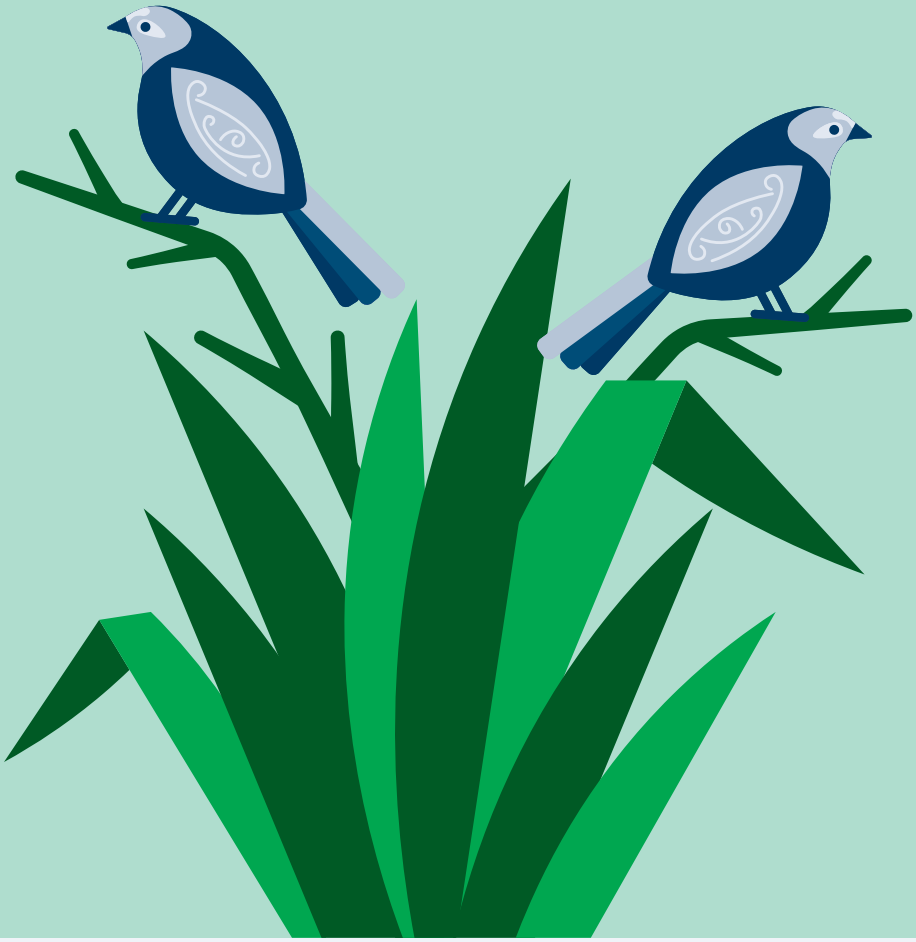
- All included claims are accepted for cover.
- Claims may be lodged immediately following an accident or at any later stage.
- Data are based on population projections from Statistics New Zealand and the most recent ACC data available. Please note that subnational population projections are only available for 2023 — national population projections are provided for 2025.
- Please note that European/Other is a Statistics New Zealand ethnicity grouping that excludes Pacific Peoples and Asian ethnicities as well as Māori.
- Ethnicity data is recorded for 96% of ACC clients with a claim in 2024/25 year.

Definitions

- Entitlement claim (moderate to serious): An entitlement claim is a claim that does not consist of only medical fees but has also received additional support such as weekly compensation or rehabilitation at some point in its case history. These types of payment are called entitlement payments.
- New claims: A claim is new in the year in which it is lodged with ACC.
- Earners: Earner claims are defined as claims where the earner status is employed or self-employed or, where the status is other or unknown, the claim is paid from the earners or work fund.
- Non-earners: Non-earner claims are defined as claims where the earner status is non-earner or unemployed or, where the status is other or unknown, the claim is paid from the non-earners fund.
- Treatment injury: A treatment injury is an injury that occurs when a person is seeking or receiving treatment from one or more registered health professionals. By 'treatment' we mean diagnosis, monitoring, investigation, advice, and actual treatment received.
- Med fee only: These are claims where ACC has paid a health professional for medical treatment or service. A high percentage of all claims are in this category and these claims often involve only a few visits to one or a few health professionals. The client generally has no direct dealings with ACC. A claim

is deemed to be a medical fee only / treatment only claim if ACC is only purchasing medical, dental treatment or counselling. These claims are sometimes referred to as minor claims.

- Serious injury: If a person has an injury that results in a significant impairment or loss of functions (often permanent), ACC classifies that person's claim as a serious injury claim. Injuries must meet a set of clinical criteria to be classified as 'serious injury', but in general consist of the following types of injury:
  - moderate to severe traumatic brain injury.
  - spinal cord injury.
  - other catastrophic injury (e.g., multiple amputations, burns to over 50% of the body, blindness).



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