

Barriers and facilitators for Māori in accessing hospital services in Aotearoa New Zealand

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ABSTRACT

AIM: This paper reports the findings of a literature review to answer the research question, “What are the barriers and facilitators of access to hospital services for Māori?”

METHOD: MEDLINE (Ovid) and PsycINFO were searched using keywords to identify relevant literature published between 2000 and 2020. The data analysis was informed by a Kaupapa Māori positioning and the CONSIDER statement on reporting of health research involving Indigenous peoples.

RESULTS: Twenty-three papers met the inclusion criteria. We identified five themes that captured the barriers for Māori accessing hospital services (practical barriers, poor communication, hostile healthcare environment, primary care barriers and racism) and five facilitatory themes were identified (practical facilitators, whakawhanaungatanga, whānau, manaakitanga and cultural safety).

CONCLUSION: This article confirms existing knowledge about practical barriers and facilitators to healthcare access for Māori and contributes to an emerging body of evidence about the impact of racism and culturally unsafe services in preventing Māori from accessing healthcare services. The facilitators identified provide a potential roadmap for the redesign of services so they are accessible and effective for Māori. Improving services in this way would support district health boards, the Ministry of Health and professional organisations to comply with their commitments to providing culturally safe services and health professionals.

Māori health inequities result from systematic failures in the provision of healthcare by the public health system and historical structural failures that have led to the inequitable distribution of the social determinants of wellbeing for Māori compared to non-Māori.¹⁻⁹ Māori have greater need for health services but experience more barriers to accessing services compared with non-Māori.^{1,2} Māori are less likely to have health practitioners explain medical information in a way that is understood, and health practitioners spend less time with Māori patients compared with non-Māori.³ Māori are more likely to live in environments with reduced access to healthy food and opportunities for exercise and recreation in the built environment, to live closer to fast food, tobacco and low cost alcohol retailers and to experience barriers to influencing local government

and regulatory bodies to modify these social determinants of wellbeing compared with non-Māori.⁴⁻⁶

Non-communicable diseases, suicide and motor vehicle accidents are the leading causes of death for Māori.⁷ Each of these can require frequent hospital-based care. Outpatient appointments and hospital service utilisation can either facilitate or provide a barrier to care for acute and chronic conditions. Therefore, the contribution of hospital-based care on Māori health is significant.⁸ Cancer care for Māori illustrates disparities in the provision of population-level prevention efforts, as well as reduced access for Māori to timely screening, diagnosis and treatment in the hospital setting compared with non-Māori.⁹ Facilitating meaningful action towards health equity for Māori requires all aspects of the health system to be interrogated.

Given this context, it is timely to investigate evidence on the interplay between personal and system factors as key drivers for Māori inequities in hospital services.

Methods

This literature review incorporates an Indigenous Kaupapa Māori Research positioning. This included Māori leadership of the research agenda and Māori research supervision (including supervisors with expertise in Kaupapa Māori theory and research experience). This approach specifically rejects cultural deficit or victim-blaming analyses as valid explanations of Māori health inequities.¹⁰

A literature search was undertaken to identify experiences of whānau Māori in accessing hospital care. The research question asked, “What are the barriers and facilitators of access to hospital services for Māori?” A systematic search strategy of MEDLINE (Ovid) and PsycINFO databases was conducted to identify published peer-reviewed journal articles. Keyword search terms were: Māori; barriers; enablers; facilitators; services; outpatient; experience; attendance. All articles identified from the initial database search were imported into Covidence, a systematic review software for managing the screening and selection process.¹¹

Inclusion and exclusion criteria are presented in Table 1. This literature review excluded studies that were solely descriptive (ie, studies that may have documented outcomes such as disparities in access but did not discuss or critically analyse the inequities in Māori access to hospital services). Grey literature was also excluded as it was outside of the scope of the study timeframe and resources.

All included articles were critiqued from a Kaupapa Māori positioning that promotes Māori/non-Māori analyses within research as important for the examination of non-Māori privilege and racism as causal factors for Māori/non-Māori health service inequities. The analysis was broadly guided by the CONSIDER statement and Kaupapa Māori epidemiological principles,^{12,13} including quality of ethnicity data collection, benefit of research to Māori, level of Māori research leadership or control, use of

mātauranga Māori and avoidance of deficit/victim-blaming analyses. The literature was examined for statements on researcher positionality as this is acknowledged as an important influence on how researchers interpret Indigenous data.¹⁴ Quantitative studies were reviewed to determine how the analytical approach informed a systems level view of Māori/non-Māori health inequities. All articles were reviewed from a structural determinants approach, which included an acceptance of diverse Māori realities and rejection of cultural essentialism.¹⁵

Results

During the initial search, 391 papers were identified. Duplicate articles were removed (n=50) and the abstracts of the remaining articles were reviewed using inclusion and exclusion criteria, resulting in 23 articles for study inclusion following full article review (Table 2).

Of these, four papers were published prior to 2010 and 19 were published between 2010 and July 2020. Thirteen articles involved Māori participants only. The study settings included acute hospital services, outpatient clinics, community services and primary care. We excluded studies solely looking at the experience of Māori in primary care. However, the majority of articles included findings from Māori in primary and community care.

The Kaupapa Māori analysis found that, although most authors avoided deficit framing and included a social determinants-based analysis of the findings, very few reported on the quality of ethnicity data beyond “self-identified” (n=9) or “not stated” (n=9). Researcher positionality was stated explicitly in just under half of the articles (n=11). Some articles that claimed to use Kaupapa Māori methods did not explicitly state researcher positionality or address governance issues (n=2). Barriers to access (n=22) and facilitators of access (n=20) were discussed similarly across the included articles.

Overall, five themes captured the barriers experienced by whānau Māori:

- Poor communication
- Hostile healthcare environment
- Primary care barriers

- Racism
- Practical barriers

Five themes identified facilitators to accessing healthcare services by Māori:

- Practical facilitators
- Whakawhanaungatanga
- Whānau
- Manaakitanga
- Cultural safety

Barriers to accessing hospital services

Poor communication was a feature of Māori participants' experiences with main-stream hospital and outpatient services. Māori were not given appropriate, or enough, information;^{16–18} information provided was poorly written or illegible; terminology used was obtuse; and healthcare providers were described as “not proactive” in offering information.^{17,19}

Studies reported participant confusion about the appropriate use of services leading to delays in diagnosis and treatment (eg emergency department use).^{17,20} Healthcare interactions where Māori felt rushed or where interactions occurred with unfamiliar health professionals who had not properly introduced themselves led to whānau feeling disempowered and misinformed about how to best take care of their wellbeing.^{21,22} Māori feel reluctant to complain and powerless, and as if they are “a nuisance” when asking questions from healthcare practitioners.²³

Hostile healthcare environment. The literature demonstrates how Māori experience the healthcare environment as hostile, disempowering and alienating. Māori are aware of previous negative experiences (both personal and vicarious via whānau), including media reporting on racism in health, which diminishes trust in the health system and social services

Table 1: Literature search inclusion and exclusion criteria.

Inclusion	Exclusion
Language: English language	Language: non-English
Dates: 2000–2020	Dates: prior to 2000 or published after July 2020, as analysis was undertaken in September 2020
Population: Māori adults defined as 18 years of age + with or without non-Māori participants, which includes parents accessing care for their children	Population: children and non-Māori adults 18+
Geographic: Aotearoa New Zealand	Geographic: International
Setting: hospital and outpatient	Setting: primary and community care
Study type: peer-reviewed, qualitative and quantitative	Study type: case reports, letters, books, dissertations and editorials
Intervention: attendance at hospital and outpatient services and factors associated	Intervention: does not review attendance at hospital and outpatient services and factors associated
Outcome: must not be descriptive only; must have some critical thinking to elucidate drivers of experience	Outcome: descriptive only; no critical thinking to elucidate outcomes

Table 2: Literature analysed.

Lead author, date	Title	% Māori participants	Barriers y/n	Facilitators y/n	Methods
Anderson, A. 2017	Whānau perceptions and experiences of acute rheumatic fever diagnosis for Māori in Northland, New Zealand	100%	y	y	Kaupapa Māori, qualitative
Anderson, A. 2019	Mismatches between health service delivery and community expectations in the provision of secondary prophylaxis for rheumatic fever in New Zealand	51.00%	y	y	Kaupapa Māori, Talanga, Kalaka (other Indigenous research methods)
Barker, C. 2016	Pathways to ambulatory sensitive hospitalisations for Māori in the Auckland and Waitemata regions	100%	y	y	Telephone surveys
Bolitho, S. 2006	Experiences of Māori families accessing health care for their unwell children: a pilot study	100%	y	y	Qualitative
Makowharemahihi, C. 2019	Initiation of maternity care for young Māori women under 20 years of age	100%	y	y	Kaupapa Māori, qualitative
Corbett, S. 2014	Barriers to early initiation of antenatal care in a multi-ethnic sample in South Auckland, New Zealand.	20%	y	n	Questionnaire (postal)
Cram, F. 2003	Mapping the themes of Maori talk about health	100%	y	y	Kaupapa Māori, qualitative
Dew, K. 2015	Dissonant roles: The experience of Māori in cancer care.	77.00%	y	y	Qualitative
Dhunna, S. 2018	An Affront to Her Mana: Young Māori Mothers' Experiences of Intimate Partner Violence	100%	y	y	Kaupapa Māori, qualitative
Ellison-Loschmann, L. 2015	Barriers to and delays in accessing breast cancer care among New Zealand women: disparities by ethnicity.	17%	y	n	Questionnaire, option of written or in person
Frey, R. 2013	"Where do I go from here"? A cultural perspective on challenges to the use of hospice services	12.00%	y	n	Qualitative
Hutchinson, P. 2015	Factors Influencing Outpatient Cardiac Rehabilitation Attendance	9%	y	y	Questionnaire (postal)

Table 2: Literature analysed (continued).

Lead author, date	Title	% Māori participants	Barriers y/n	Facilitators y/n	Methods
Kerr, S. 2010	Kaupapa Maori Action Research to improve heart disease services in Aotearoa, New Zealand	100%	y	y	Kaupapa Māori, qualitative
Lovell, S. 2007	Sociocultural barriers to cervical screening in South Auckland, New Zealand	15.00%	y	y	Qualitative
Masters-Awatere, B. 2019	Whānau Māori explain how the Harti Hauora Tool assists with better access to health services	100%	y	y	Kaupapa Māori, mixed methods RCT
Pitama, S. 2003	Exploring Maori health worker perspectives on colorectal cancer and screening	100%	y	y	Kaupapa Māori, qualitative
Rahiri, J.-L. 2020	Enhancing responsiveness to Māori in a publicly funded bariatric service in Aotearoa New Zealand	100%	n	y	Kaupapa Māori, qualitative
Reid, J. 2016	The significance of socially-assigned ethnicity for self-identified Māori accessing and engaging with primary healthcare in New Zealand. Health	100%	y	y	Kaupapa Māori, qualitative
Stokes, T. 2019	Improving access to health care for people with severe chronic obstructive pulmonary disease (COPD) in Southern New Zealand: qualitative study of the views of health professional stakeholders and patients	8.33%	y	y	Qualitative
Walker, R.C. 2019	Patients' Experiences of Community House Haemodialysis: A Qualitative Study	40.00%	y	y	Qualitative
Walker, T. 2008	The road we travel: Māori experience of cancer	100%	y	y	Qualitative
Wilson, D. 2012	Indigenous hospital experiences: a New Zealand case study	100%	y	y	Qualitative
Wright, T. 2018	Patient experience of a psychiatric Mother Baby Unit	20%	y	y	Qualitative, with Te Whare Tapa Whā

generally.^{24–28} Māori find the system hard to navigate, feel uncomfortable and isolated as inpatients, disrespected by healthcare staff who mispronounce names and discriminated against by being “badgered” about health-risk behaviours like smoking.²¹ A study by Wilson et al (2012) found that these factors led to Māori seeking an early discharge from hospital at higher rates than non-Māori. Makowharemahihi et al (2019) found that Māori would not seek care from providers who were perceived as having negative views towards Māori or had provided negative experiences in the past.

Transition from primary care to hospital services. Although we excluded papers solely focused on primary care or community services, a small number of articles commented on the experience of Māori in community and primary care and the impact on hospital service access. Common primary care barriers included poor relationships with general practitioners (GPs), no available GPs, not being registered with a GP, no access to a GP known as “culturally safe” and difficulty accessing screening in primary care.^{18,26} Barker et al, who looked into the factors impacting on Māori presenting to hospitals with conditions that could have been managed by a GP, found that an inability to get an appointment within 24 hours, a lack of transport and finance, the inability to pay for prescriptions and pre-existing debt with GPs were common reasons to seek healthcare at hospitals rather than general practice.

Racism featured in the literature, both in the experiences of whānau and in the feedback from health practitioners. Providers did not account for Māori cultural beliefs, which was particularly noticeable within breast or cervical cancer screening and prostate exams.^{21,28} Māori describe how being identified as Māori is negatively received in a predominantly Pākehā health system and find that socially assigned ethnicity, based on phenotypic markers of skin colour or facial features, was understood and experienced as discrimination.²⁹ Some providers recounted their experiences with Māori patients in such a way that highlighted providers’ focus on clinical risk factors (rather than social determinants) and their use of a victim-

blaming positioning, suggesting that Māori patients obfuscated and wasted their time.²² A study exploring Māori health worker perspectives of colorectal screening participants described Māori as being actively discouraged from attending screening by non-Māori health workers despite qualifying for screening.²¹

Practical barriers included financial barriers, lack of access to transport to attend appointments, lack of sick leave or support from employers to attend appointments and lack of childcare.^{16,20,26,27,30}

Facilitators

Whakawhanaungatanga represents the importance of relational interactions and relationship building with healthcare providers. It is an important facilitator to accessing healthcare services for Māori. More than rapport, whakawhanaungatanga implies a reciprocal relationship, exemplified in the health setting as mutual sharing to create a relationship built on trust. In the literature this was described variously as rapport, the ability to communicate and the ability to be included. Whakawhanaungatanga was found in friendly interactions and the provision of information that was readily available, appropriate and understood.^{21,24,26,27,31} Established relationships across the healthcare pathway that allowed seamless integration for Māori moving between multiple services were positive.^{18,24} Pitama et al (2003) found that a trusted relationship with a GP facilitated access to primary care services, increased perceived advocacy, reduced anxiety about health issues and supported access into other health services like cancer screening.

Whānau involvement was seen positively by most Māori participants. However, whānau often felt like a “nuisance” in hospital environments and generally reported feeling unwelcome. Having whānau present in hospital allowed family members to provide a care role in what felt like a hostile environment.^{18,23} This included personal cares such as bathing and supporting whānau with toileting. Whānau also talked about the need to advocate for their family members by pushing nurses and doctors for more information about diagnosis, treatment and procedures,

as well as encouraging patients to seek healthcare.^{22,23} Māori providers were praised for “being available” to patients and their whānau in ways that were not reported as frequently for mainstream providers.^{24,25}

Manaakitanga was an important facilitator for Māori to access hospital services. It includes personal attributes of staff with caring attitudes seen as more important than clinical skills, and health professionals who made themselves available to answer questions were rated highly.³³ Māori valued providers who had the knowledge to provide a good service, to take appropriate action to treat whānau and genuinely cared for their wellbeing as Māori.^{21,32} Peer support was an important facilitator, especially for Māori with chronic and incurable conditions. Community treatment options were strongly preferred over hospital-based treatment, where appropriate.³⁴

Ethnic concordance between healthcare providers and patients was important. Māori consistently reported positive experiences with Māori providers who were able to understand and interpret the complex issues that affect whānau Māori.^{24,25} The Māori workforce in general (including Māori providers) was seen as an important facilitator to access services.^{21,25} In Rahiri et al, a Māori participant offering suggestions for how to improve bariatric surgery services for Māori said, “You know if you speak to a Māori doctor or a Māori nurse, you get to be whānau and it’s a better feeling.”³⁵ Māori models of health and tikanga-based frameworks were acknowledged as key facilitators by several studies.^{21,27,35} In one study, Māori recognised that mimicking norms associated with whiteness, such as presenting to the doctor in tidy clothes, facilitated access to services, and that social assignment as Pākehā (for fair-skinned Māori) aided in gaining positive and less-judgemental interactions with health practitioners.³⁶ Similarly, Pitama et al (2012) found that Māori health workers who possess high health literacy (defined as knowledge of the public health system, a Western model of healthcare and service delivery) were most effectively able to support whānau to access timely and appropriate care.²¹

Practical facilitators were found to originate predominantly, though not exclusively,

from the involvement of Māori providers. This included transport to appointments, delivery of prescriptions, having an ambulance alarm connected in the house after an admission to hospital, provision of car seats and navigators aiding with the identification of appropriate healthcare services and access to tikanga Māori services.^{19,25,32} Practical facilitators arising from non-Māori provider input included flexible payment options in primary care and flexible community integrated models of care.^{20,33}

Discussion

This literature review summarises evidence on access to hospital services for Māori via ten themes including barriers experienced by whānau Māori (poor communication, hostile healthcare environment, primary care barriers, racism and practical barriers) and facilitatory factors (practical facilitators, whakawhanaungatanga, whānau, manaakitanga and cultural safety). The studies included are diverse in methodology and subject matter. They were selected because they identified barriers and facilitators of access to hospital services for Māori and critically analysed these experiences.

The literature reinforces evidence that there are barriers for Māori to outpatient service attendance. Although this is well known in the literature, only a small number of articles look critically at the barriers to accessing hospital services specifically for whānau Māori. Of concern, this review found that Māori whānau experience a healthcare environment that is hostile towards them as Māori. This aligns with the findings of a recent review into the experience of Māori in the public health system by Graham and Masters-Awatere.³⁷ This experience of hostility has been picked up by other authors who have found that Māori interpreted health practitioners’ targeting of Māori for lifestyle discussions (such as smoking) as racial stereotyping.³⁶

Despite a growing body of evidence of racism in healthcare, some individuals and organisations struggle to accept racism as a causal factor that can be both structurally and personally mediated.^{38–40} It is generally accepted that individuals can hold and act on racist views, but it has been difficult

to engage policymakers, politicians and health leaders to understand and act on the causes of, manifestations of and solutions to structural racism. As a result, surface-level interventions, such as addressing transport barriers, are often supported, whereas the more complex fundamental interventions required to identify, monitor and eliminate racism within healthcare service delivery are not. To put it simply, there is no point solving someone's transport barrier by giving them a taxi chit if the taxi drives them towards a racist health service. Therefore, it is imperative to mitigate problems of access, in addition the problems of quality and cultural safety in the healthcare services being provided.³ Whānau have been shown to innovate within this system. Barker et al (2016) found that Māori sometimes responded to practical barriers to accessing primary care by utilising emergency departments, because they perceived that hospital-based care was better quality, incurred lower costs to whānau and mitigated a lack of convenient appointments with their GP. However, this remains concerning, as it highlights an unacceptable issue with healthcare access. Attention must be paid to the fundamental environmental and structural drivers of ethnic health inequities in both primary and secondary care if inequities for Māori are to be comprehensively addressed.

These concerns were also found in Māori experiences of culturally unsafe healthcare, despite a commitment to culturally safe care being present in district health board (DHB) operating guidelines, code of conduct agreements for health professionals, competency frameworks from professional guidelines and Medical Council of New Zealand (MCNZ) requirements.^{41–43} If New Zealand continues to operate healthcare services that are culturally unsafe, DHBs will be unlikely to achieve equity within their services, and health practitioners will fail to meet the standards set by their professional organisations.

Systems that privilege one group over another (eg, by attending to their cultural norms while ignoring those of other groups) are shown here to contribute to inequities in healthcare access, which can be extrapolated as contributing to Māori health

inequities.^{27,28} In addition, Māori experiences of feeling targeted for issues like smoking and weight loss show that Māori can perceive health practitioners as having an agenda and interpret these discriminatory experiences as barriers to be overcome to receive necessary healthcare. These experiences may act cumulatively and be shared among communities so that one person's negative experience of healthcare becomes magnified among whānau and friends. Prior negative experiences in healthcare were a key factor in the literature that prevented Māori from accessing healthcare services when in need.^{21,23}

Facilitators are important to understand in tandem with barriers. The literature identified reciprocal relationships (whanaungatanga) and care for patients as Māori (manaakitanga) as facilitatory factors for hospital service access. This is consistent with Māori-led interventions such as the Hui Process designed for healthcare settings and taught at medical schools in New Zealand as a way of bringing whanaungatanga into the clinical setting.⁴⁴ This is a tool that has been developed for utilisation by any healthcare professional irrespective of whether they are Māori or non-Māori and may offer tangible solutions for individuals and healthcare organisations aiming for pro-equity, culturally-safe healthcare delivery.

The literature promotes manaakitanga as an important facilitator of access for Māori, with ethnic concordance between Māori health practitioners and patients providing a positive impact. The importance of supporting and maintaining a pipeline of Māori health professionals remains paramount. This starts at high school with outreach programmes in schools and continues through to the social justice/equity admission processes of health professional training and the commitment of specialty training colleges to increasing the numbers of Māori trainees.⁴⁵ It is also important to see the growth of the Māori clinical workforce mirrored in the appointment of Māori to senior executive and governance roles within the health system.

The strengths of this study lie in the Kaupapa Māori positioning and the methods of analysis and the focus on Māori

experiences in the public healthcare system within hospital settings. By employing a Kaupapa Māori critical analysis, we were able to interrogate the literature in a way that is meaningful for Māori. This is important to enable correct and meaningful identification of inequities, barriers and facilitators.

Study limitations include the narrow inclusion criteria. Our focus was specifically on Māori and the New Zealand health system. We acknowledge that we may have excluded a broader literature base (including grey literature) that is still relevant, but it was outside the scope of this literature review. Therefore, these findings may not be generalisable to other populations. However, we expect the findings to be broadly relevant to other Indigenous populations who face similar structural barriers.

Conclusion

This literature review identifies common barriers to and facilitators of access to hospital services for Māori. It confirms what is well known about practical barriers and facilitators to access and contributes to an emerging body of evidence about how racism and culturally unsafe services prevent Māori from accessing health services. The facilitators identified provide a potential roadmap for the redesign of services so they are accessible and effective for Māori. If the barriers identified within this literature review are addressed and the facilitators identified are used to guide service delivery, it may be possible for the Ministry of Health, DHBs and professional organisations to meet their commitment to provide healthcare services that are compliant with the Treaty of Waitangi, pro-equity, anti-racist and culturally safe for Māori.

Competing interests:

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