He Kaupare. He Manaaki.
He Whakaora.
prevention. care. recovery.

Te Whānau Māori me ō mahi

Guidance on Māori Cultural Competencies for Providers

Version 2
October 2023

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Contents

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] runs 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 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 after a literature review and expert advice on cultural safety and cultural competence. The draft was refined by a multi-disciplinary reference group of Māori clinicians, including experts in the fields of physiotherapy, public health, psychology and medicine.

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Foreword

ACC recognises that Te Tiriti o Waitangi / the Treaty of Waitangi is the government's founding document in Aotearoa New Zealand. Whāia Te Tika, ACC's Māori strategy, has the goal of creating better ACC experiences and outcomes for Māori through developing the capabilities of ACC kaimahi (staff) so they can provide a strong customer focus and enable better engagements and partnerships with hapori Māori (Māori communities).

Māori continue to be disadvantaged by a health system that is institutionally racist (Waitangi Tribunal, 2019). In light of the Waitangi Tribunal inquiry into health outcomes, ACC has undertaken reviews of Māori access to ACC-funded services and staff capabilities. Programmes have been launched to support ACC kaimahi to develop capabilities and awareness related to Māori and to provide guidance for providers and kaimahi in cultural competence and cultural safety.

The *ACC Guidelines for Māori Cultural Competencies for Providers*, initially published in 2005[2], were intended to assist healthcare providers in improving access and care for Māori clients. As noted in the guidelines, a single document cannot be comprehensive given the diversity of values and preferences in every community. It is, therefore, timely to revisit the guidelines as many provider groups have incorporated cultural safety into requirements for practitioners alongside cultural competence. ACC has also developed a policy for cultural safety outlining expectations of providers supporting Māori patients, whānau and communities.

Meeting the requirements of ACC's *Kawa Whakaruruhau (Cultural Safety) Policy* will assist providers in achieving goals relating to Māori health equity and their responsibilities for cultural competence and culturally safe practice within professional standards. The practical effect is that providers will ensure services are delivered equitably to Māori clients/whānau and in a manner that recognises and respects the values and beliefs of Māori clients.

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

Executive summary

There has been no improvement in measures of access to ACC support since the *ACC Guidelines for Māori Cultural Competencies for Providers* were first published in 2005. Māori continue to experience lesser access to primary health care, hospital care, and accident and disability support services[3]. This is inequitable given the known unmet health needs, and higher rate of serious injury, for Māori.

Given these persisting inequities and the shift toward cultural safety, the project team, Expert Reference Group and Critical Reviewers consider it is time to include cultural safety and anti-racism as strategies to eliminate these inequities.

Data presented to the Waitangi Tribunal shows that compared to non-Māori, non-Pacific residents[4]:

- 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.

For some years, we have discussed how our embedded views as practitioners may contain biases that lead to inequitable health outcomes for others, particularly Māori. A potential solution is to adopt cultural safety principles and make changes in practice that ensure safe and equitable care as **defined by the kiritaki (client), whānau and their communities.**

Cultural safety acknowledges differences between groups and addresses biases that impact Māori access to care and lead to inequitable outcomes for Māori. Cultural safety concerns ongoing critical self-reflection on the delivery of safe care, as **defined by the kiritaki, whānau and their communities.** This requires measurements of progress towards health equity and planned actions that eliminate bias and racism within their workplaces and in the provision of care. Improvements in the data available to monitor progress to equity and to identify the impact of systemic bias[5] against Māori will assist providers in measuring progress.

In keeping with these changes, ACC has developed its *Kawa Whakaruruhau (Cultural Safety) Policy 2023* to replace its Hauora Competencies. The *Kawa Whakaruruhau Policy* applies to all suppliers and treatment providers providing health services under an ACC contract or providers claiming for treatment under Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

3 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

4 https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/ (See also Appendix 1 of this document for data on injury to Māori and non-Māori)

5 Systemic bias (also called institutional bias) is seen when policies and practices result in certain groups being advantaged or favoured while other groups are disadvantaged.

Towards health equity

In 2005, the main aim of the ACC Guidelines for Māori Cultural Competencies for Providers was to influence and support the elimination of health inequities for kiritaki Māori (Māori clients) by focusing on cultural competence.

Cultural competence is about the acquisition of skills to achieve a better understanding of members of other cultures.[6]

Professor Durie notes that the goal of culturally competent care with Māori clients is to improve relationships and achieve "better clinical results."

The initial focus of Māori cultural competence was to support practitioners in learning about the history of Māori, the state of Māori health and the likely contributors to health disparities. It was anticipated that this would lead practitioners to continuously examine their practices and identify, then correct, barriers to care and recovery.

Cultural competence training also included information about Māori preferences and worldviews. It was acknowledged that by attempting to describe Māori preferences, it is possible to create or reinforce stereotypes. Diversity of preferences and experiences exists in every group, so to avoid reinforcing stereotypes, providers were reminded that Māori culture is dynamic, that Māori people are diverse, and that Māori cultural preferences vary by region and between individuals or may alter according to the setting.

Māori cultural competence training has given general guidance on cultural preferences and customs. While it is helpful to understand local tikanga, it is just as important to be aware of your cultural values and biases that get in the way of successful conversations with kiritaki or the adequate provision of valuable treatments.

A client and health care provider sharing the same ethnicity or language does not guarantee that the client will receive culturally safe care.

In the years since the 2005 guidelines and the delivery of cultural competence training to health practitioners, we have learned that supporting the development of cultural competencies alone will not deliver health equity (see the section below on the persistence of Māori health inequity). Practitioners also need to address the assumptions they are making about the situation and the person they are working with and take action to address inequities in their practices and the organisations they work within.[7]

To support the journey towards equity, cultural safety and anti-racism are increasingly being added as tools in a provider's kete (woven basket). Cultural safety requires critical self-reflection on delivering safe care, as defined by the kiritaki, whānau and their communities. This enquiry should lead to deliberate actions that eliminate bias and potential for racism.

6 Durie M. Cultural Competence and Medical Practice in New Zealand. Report to the Australian and New Zealand Boards and Council Conference, November 2001.

7 The evolving field of cultural competence has also identified pitfalls when providers or organisations desire a short course that provides a checklist for each cultural group with a focus on pronunciation and ceremonial welcomes or a course that fails to address biases or fail to examine inequities in access, treatment and outcomes. This superficial approach is insufficient if Māori are to achieve health equity. While being more aware of cultural differences is a positive step, it does not guarantee that a person will act in a culturally safe way. Cultural competence is not a checklist of items. Cultural competence requires a commitment to continuous improvement through continuing planning, education, training, review, supervision and feedback, in the same way that clinical competence does.

Cultural safety focuses on the experience of the kiritaki Māori and whānau and their involvement in decision-making about their care. As Whaea Irihapeti Ramsden states:[8]

Cultural safety is a mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. The word safety is deliberately chosen to give power to the consumer.

Cultural safety acknowledges the interpersonal power differences between practitioners and kiritaki and the impact of power differentials on health care access and outcomes. Breaking down these power differences through the collaborative development of health care can improve the health care experience of kiritaki and whānau and lead to better health outcomes. As Carlson asserts, cultural safety is a relational practice.[9]

From their review of cultural safety in medical training, the Council of Medical Colleges and Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)[10] made recommendations to incorporate cultural safety alongside cultural competence, specifically to:

- acknowledge systemic racism and privilege that exists in the health sector and 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)
- collect and use data for equity monitoring
- support providers to focus on self-reflection and culturally safe practice, including the privilege that Pākehā (European) receive in their health care.

The supporting concept of anti-racism is about educating health practitioners about how they may perpetuate racism in their everyday interactions with kiritaki and whānau and how their institutional culture may tacitly (or perhaps explicitly) endorse everyday racism. This includes identifying inaction or minimising responses to derogatory remarks, invalidations, and offensive behaviours towards Māori and training in initial responses that address racist microaggressions (insults).[11]

These concepts—cultural competence, cultural safety and anti-racism—require the ongoing commitment of individual health practitioners and their organisations to identify and eliminate biases and hold themselves and others accountable for achieving health equity.

This document has been developed to guide your exploration of the ideas highlighted throughout the following pages. You will also find an overview of health inequities (with more information in Appendix 2). The main aim is to change the narrative and practice of health care so that kiritaki Māori and their whānau are in the driving seat and can work collaboratively on their care with health practitioners.

8 Irihapeti Merenia Ramsden Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu (2002) Thesis submitted for degree of Doctor of Philosophy in Nursing, Victoria University of Wellington

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

10 Te Ohu Rata o Aotearoa., Council of Medical Colleges., & Allen, & Clarke. (2021). Cultural Safety Baseline Data Report Release and Recommendations.
Te Ohu Rata o Aotearoa., Council of Medical Colleges., & Allen, & Clarke. (2020). Cultural safety within vocational medical training. (2021).

11 Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (2019). Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. American Psychologist, 74(1), 128–142.

ACC Kawa whakaruruhau / Cultural safety requirements

Culture shapes the behaviours, attitudes and values of providers and their institutions. As both the provider and their kiritaki and whānau 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.[12] These patterns include language and non-verbal 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 professionals) often share beliefs in specific rules, roles, behaviours and values, which shape interactions with others.[13,14,15] Cultural safety challenges health professionals "to reflect on and re-examine our values, attitudes and behaviours, be prepared to receive critical and constructive feedback."[16]

Health professionals have biases reflecting their socio-cultural backgrounds, influencing their interactions with patients, whānau and colleagues. Concepts such as courtesy, kindness and respect may have specific expressions within health professions 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 health care settings. This can lead to an inappropriate expectation that every whānau should appoint a single spokesperson.

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

ACC's cultural safety policy *Kawa Whakaruruhau* applies to all providers and outlines expectations that providers must meet to address the needs of kiritaki Māori and whānau to achieve cultural safety.

Meeting the requirements of ACC's *Kawa Whakaruruhau Policy* will assist providers in achieving goals relating to Māori health equity and their responsibilities for cultural competence and cultural safety within professional standards. The expected outcome is that providers will ensure services are delivered equitably to kiritaki Māori and in a manner that recognises and respects the values and beliefs of kiritaki Māori.

Improving your competence in providing care attuned to the individual Māori values and preferences can improve access to care, enhance communications with kiritaki Māori and kaimahi Māori (Māori colleagues) and support a shared understanding of health or wellbeing concerns for kiritaki Māori and their whānau. This can lead to individual care plans co-designed with the kiritaki and their whānau and improved satisfaction.

12 Penn NE, Kar S, Kramer J, Skinner J, Zambrana RE. Ethnic minorities, health care systems, and behavior. Health Psychology 1995 December, 14(7), 641-646.

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

14 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.

15 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.

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

Cultural safety relates to the experience of the kiritaki and their whānau as receivers of ACC services and care. It is directed at empowering kiritaki to speak up about their care and actively participate in achieving positive health outcomes and experiences. Cultural safety acknowledges the barriers in accessing ACC services arising from the power imbalance between ACC, health practitioners and kiritaki and whānau.

To meet the requirements of kiritaki Māori effectively, health practitioners need to understand their cultural background and how this influences their interactions with kiritaki and whānau from various cultural groups. A key component of cultural safety is critical consciousness. This involves critically reflecting on the power structures that exist and challenging their own culture, biases, privilege and power relationships rather than attempting to become experts in the cultures of others.

ACC expectations for cultural safety require all providers to examine the impact of their own culture on the service they provide and to provide culturally safe care, as defined by their kiritaki and whānau and as measured through progress towards achieving health equity. The health practitioner who develops critical consciousness through reflection and ongoing examination of their beliefs and practice can become more aware of potential bias and more skilled in engaging with kiritaki and joint decision-making.

For many health practitioners and health provider organisations, a commitment to cultural safety will align with accreditation or certification requirements through continuous professional development.

To embed culturally safe practices, providers and suppliers need to:

- evidence cultural safety training and performance monitoring for all kaimahi
- evidence cultural safety activities incorporating personal self-reflection and self-awareness as part of kaimahi training and professional development
- evidence cultural safety as a requirement for accreditation and ongoing certification
- implement systematic monitoring and assessment of inequities in their health workforce and health outcomes for kiritaki and whānau.

ACC's commitment to health equity

Ethnicity data is now collected from 97% of new ACC claims, and this shows Māori entitlement claim rates are approximately 12.7% lower than for non-Māori. Māori also have lower average medical fees claims by approximately 16.5% when compared with non-Māori. By contrast, Māori continue to have higher rates of serious injury claims than non-Māori, approximately 47.5% higher for the 2022/23 year. For more information on injury to Māori and Māori utilisation of ACC services, see Appendix 2.

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, with claims concerning Māori with lived experience of disability heard in the years after 2020. Stage One of Wai 2575 concluded in March 2019 after inquiring into aspects of primary care. A range of commissioned research reports related to those hearings is available from the Waitangi Tribunal[17]. The Wai 2575 Māori Health Trends Report[18] notes limited improvements in Māori health over the years 1990–2015, such as in lung cancer mortality, low birthweight rates and infant mortality rates, but also in areas where inequity between non-Māori and Māori have increased. These areas of increasing inequity include smoking, hospitalisation and adult mortality in all types of cardiovascular disease.

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 patterns of lesser care for Māori and lesser access to care and treatments did not change from 2012 to 2022, which is inequitable[19].

Emergency department data between 2007–08 and 2016–17 shows Māori males and females had higher age-standardised emergency department attendance rates than non-Māori males and females. There is a similar pattern for public hospital discharges, with Māori males and females having higher age-standardised rates of publicly funded hospital discharges than non-Māori males and females.

Information on health care 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[20] and the Health Quality and Safety Commission.[21]

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

18 Ministry of Health. 2019. Wai 2575 Māori Health Trends Report. Wellington: Ministry of Health. See also https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-ratonga-hauora-kua-mahia-health-service-use/primary-health-care

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

20 https://www.health.govt.nz/system/files/documents/publications/equity-of-health-care-for-maori-a-framework-jun14.pdf

21 https://www.hqsc.govt.nz/our-work/leadership-and-capability/kaiawhina-workforce/health-literacy-equity-cultural-safety-and-competence/

Barriers to care

Literature on barriers to care for Māori has confirmed institutional biases acting against Māori. Baxter[22] reported on the impact of cultural appropriateness of care, broad structural barriers and the increased impact of socio-economic barriers on Māori. Crengle[23] 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.

As reported by Graham and Masters-Awatere:

For many Māori, the existing public health system is experienced as hostile and alienating.[24]

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 the way in which 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.[25]

Curtis et al.[26] reviewed the international development and interpretation of concepts of cultural competence and cultural safety. They confirmed that a narrow or limited understanding of cultural competency could have the unintended consequence of reinforcing stereotypes by focusing on individuals acquiring knowledge of 'other' cultures. The impact of power is seen at a societal level where dominant groups have greater access to power, resources, decision-makers, opportunity and social status resulting in privileged but largely hidden access to health care in all its forms.

22 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

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

24 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

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

26 Curtis E, Jones s, Tipene-Leach D, Walker C, Loring B, Paine SJ, &, Reid P (2019) Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. International Journal for Equity in Health 18:174

Many New Zealand studies have identified the adverse experiences of Māori within the health system.[27,28,29,30,31] 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:

... providers must find ways to ensure that Māori consistently experience positive, high-quality healthcare interactions that support Māori ways of being.

The impact of the culture of the health provider organisation

This section provides some useful guidance for organisations to develop their approach to cultural competence.

E kore e taka te parapara a ōna tūpuna, tukua iho ki a ia.

The qualities of his/her ancestors will not fail to be fulfilled; they descend through him/her (there are positive influences on each of us that come from our forebears).

The ACC Kawa Whakaruruhau Policy requires providers to meet the needs of kiritaki Māori effectively 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 considering if kiritaki Māori receive equitable access to care. Providers then need to achieve culturally safe and equitable outcomes from that care. Together the organisation and staff will be required to address inequitable outcomes by supporting kaimahi to adhere to professional requirements for cultural safety and cultural competence and by development of policies and plans that address:

- 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
- training for all kaimahi in cultural competence, Māori preferences and cultural safety
- delivery of culturally responsive and appropriate service delivery.

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 develop plans to address these. Comparisons can only be made if each service provider collects accurate ethnicity data.

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

28 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.

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

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

31 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

TRAINING AND PLANNING

Providers should develop a training plan for all kaimahi that covers the following areas:

- cultural safety training and supervision
- barriers to effective care
- communication skills with kiritaki Māori
- Māori health frameworks and models of health and rehabilitation
- ethnicity data collection
- linking with Māori providers and iwi/hapori Māori
- ACC Kawa Whakaruruhau Policy.

Providers may need to engage qualified trainers, institutions or wānanga with experience in developing training programmes for cultural safety. The training programmes should include regular updates for all kaimahi and may need to be repeated for new employees. Kaimahi with health or specialist qualifications and expertise may require more specific or expert training in line with certification and accreditation requirements. A comprehensive training plan should guide each workplace to improve access, care and rehabilitation for Māori.

REFLECTIONS ON STAFFING

- What is the role and position of kaimahi Māori within your organisation?
- Does their position support their ability to identify inequities, then influence and champion change?
- Have you asked for and/or reviewed the needs of the population you serve and made any changes to the location, timing, and availability of services to suit the preferences of kiritaki and whānau Māori?

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. Importantly, 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.[32]

Example 1: 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.

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

REFLECTIONS ON ETHNICITY DATA COLLECTION

- Do you provide explanations of why, how and when information is being collected and used? 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 make an assumption based on appearance or name?
- What has been your response to someone declining to answer this question or identifying multiple ethnicities?

Supporting kiritaki Māori – some considerations

The following matters are not a comprehensive list of key issues for kiritaki Māori but provide a starting point for providers and organisations to consider in planning regular training and support for their kaimahi.

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 is a means of social control, a normative system, an ethical system, a repository of Māori knowledge, and also 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.

Kia mau ki te kupu a tou matua.

Adhere to the advice of your parents and ancestors.

REFLECTIONS

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

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 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.[33]

REFLECTIONS

- How can providers and organisations support improved consultations with kiritaki and whānau?
- Do you 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 follow-up?

Kiritaki and whānau Māori constantly strive to overcome the barriers between themselves and their providers.[34, 35, 36] Providers, for their part, have a duty to achieve skilled performance[37] to remove these barriers.

Communication – a key issue

Studies from around the world confirm that kiritaki place the most significant emphasis on the communication skills of providers. Client satisfaction with care and the acceptability of treatment[6, 38, 39] is associated with the ability of providers to show they both understand their kiritaki and are understood by their kiritaki.[8] Kiritaki Māori also highly value the communication skills of providers.[40, 41] 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.

33 Personal communication from Former President of the Māori Women's Welfare League

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

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

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

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

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

39 A Survey of Determinants of Patient Satisfaction with GPs in Auckland. The Radford Group report to ProCare Health Ltd, 1996

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

41 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/

He tao rākau, e taea te karo; he tao ki, e kore e taea te karo.

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

The whakataukī (proverb) above reflects Māori feelings about the importance of the spoken word. Mispronunciation of Māori names and words is jarring to Māori ears 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 mis-pronounciation 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 (greenstone). The father and daughter left without further care but later presented to a hospital emergency department.

REFLECTIONS ON THE CONSULTATION

- What assumption/s 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 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[42] 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 give people the information they need in a way that works for that person, so they can make informed decisions and manage their health and wellbeing. 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[43], 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 a number of 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?" [44]

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?

42 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

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

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

WHĀNAU SUPPORT

Attendance of whānau at appointments to support kiritaki Māori should be encouraged to improve communication and enable mutual understanding. The Hui process has been supplemented with the Meihana model[45] showing how social and medical information collection can be extended to give a deeper understanding of kiritaki Māori.

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 need for the examination and seek 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 say karakia before a procedure or at times of heightened concern, such as before the administration of blood products, this should be supported. More examples are provided in the Tikanga Recommended Best Practice Policy produced by District Health Boards[46].

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 complaints 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).

However, people respond differently to pain because of social, cultural and psychological factors. Studies of pain behaviours across cultures emphasise the need to be wary of cultural or ethnic stereotypes.[47] While there are cultural differences, it is always important to assess each person individually.

Further information

- Information and resources on health equity and cultural safety from the Health Quality and Safety Commission: https://www.hqsc.govt.nz/our-work/leadership-and-capability/kaiawhina-workforce/health-literacy-equity-cultural-safety-and-competence/
- Tikanga Recommended Best Practice. Auckland District Health Board, March 2003
- Mead, Hirini Moko. Tikanga Māori, Living by Māori Values. Huia Publishers, 2003
- Tikanga Guidelines. Waikato District Health Board

ACC funded the development of these guidelines by Mauri Ora Associates. We thank the many individuals and organisations that contributed to this work.

45 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.
46 See for example https://baynav.bopdhb.govt.nz/media/1566/regional-Maori-health-services-tikanga-best-practice-document.pdf
47 Kleiman A. (eds). Pain As Human Experience: an anthropological perspective. University of California Press 1992:77-99

Appendix 1: Glossary of important terms

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
DISPARITY	A noticeable or significant difference
EQUITY	Equity is the absence of unfair, avoidable or remediable differences in health care access and health outcomes among groups of people
HAPORI MĀORI	Māori communities
HAPŪ	Sub-tribe, clan
HUI	Meeting – formal and informal
INEQUITY	Injustice or unfairness. In the context of health, this is the presence of avoidable differences in health care access and health outcomes between groups of people

KAIMAHI	Staff, work colleagues
KANOHI KI TE KANOHI	Face-to-face, a face-to-face meeting
KARAKIA	Prayer, incantations
KAUMĀTUA	An elder (generally male, but some apply the term kaumātua to both men and women)
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)
KOHA	A donation, freely given without expectation of any return
KUIA	An elder (female)
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

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	Māori welcome which takes place usually when going on to a marae
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
RANGATIRA	Chief, leader, esteemed person
TAMAITI	Child (singular)

TANGATA WHENUA	The indigenous people of Aotearoa
TANGIHANGA	Mourning and funeral rites. For Māori, these are the most important of all rituals and include 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 method of restoring 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 2023

MĀORI STATISTICS

As at 30 June 2023, Māori comprised 17.4% of the New Zealand resident population. Statistics New Zealand population projections through to 2043 show the average growth rate for Māori at 1.6% per annum, well in excess of that expected for the European/Other population (0.4% per annum).

On this basis Māori are expected to increase from 17.4% to 20.9% of the resident population by 2043, while European/Other will fall from 69.7% to 65.4%.

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 97% of new ACC claims, and this shows Māori entitlement claim rates are approximately 12.7% lower than for non-Māori. Māori also have lower average medical fees claims by approximately 16.5% when compared with non-Māori. By contrast, Māori continue to have higher rates of serious injury claims than non-Māori, approximately 47.5% higher for the 2022/23 year.

THE MĀORI POPULATION

As at 30 June 2023, Māori comprised 17.4% of the New Zealand resident population. Statistics New Zealand population projections through to 2043 show the average growth rate for Māori at 1.6% per annum, well in excess of that expected for the European/Other population (0.4% per annum).

On this basis Māori are expected to increase from 17.4% to 20.9% of the resident population by 2043 while European/Other will fall from 69.7% to 65.4% of the resident population.

INJURY TO MĀORI

The following graph and tables are sourced from information provided to ACC from clients. ACC collects ethnicity data from 97% of new claims. Analysis of this data shows that:

- Māori represent 17.4% of the resident population, but account for 15.1% of entitlement claims;
- Overall, Māori have lower claim rates than non-Māori (all other ethnic groups combined). Māori entitlement claim rates are approximately 12.7% 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 35.4% lower than that for non-Māori (c.f. 6.0% disparity for earners) (see Tables 3 and 4);
- Māori continue to have higher rates of serious injury claims than non-Māori. Māori are twice as likely to sustain a serious injury compared to non-Māori. (see Table 5);
- Māori are just over 43% less likely to claim ACC compensation for a treatment injury than non-Māori (see Table 6);
- The average cost of med fee only claims is consistently lower for Māori than for non-Māori by approximately 16.5% (see Table 7).

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%	68.9%	8.8%	17.9%
Total North Island Regions	19.3%	64.2%	10.4%	20.1%
Total South Island Regions	10.9%	84.7%	3.3%	10.6%
Northland Region	37.3%	73.9%	4.9%	4.9%
Auckland Region	11.8%	50.6%	16.2%	32.6%
Waikato Region	25.0%	74.1%	5.2%	11.7%
Bay of Plenty Region	30.3%	73.7%	4.0%	8.7%
Gisborne Region	57.4%	56.6%	5.1%	3.5%
Hawke's Bay Region	29.1%	74.4%	6.5%	6.4%
Taranaki Region	21.7%	85.4%	2.6%	5.7%
Manawatū-Whanganui Region	24.6%	79.6%	5.0%	7.9%
Wellington Region	15.1%	74.3%	8.8%	15.3%
Tasman Region	9.2%	94.1%	2.0%	3.4%
Nelson Region	11.5%	86.3%	2.7%	9.1%
Marlborough Region	14.5%	89.0%	3.8%	5.0%
West Coast Region	13.0%	91.7%	1.8%	4.6%
Canterbury Region	10.2%	82.0%	3.6%	13.3%
Otago Region	9.3%	87.2%	3.1%	8.5%
Southland Region	16.9%	85.4%	3.1%	7.7%

GRAPH 1: NEW ENTITLEMENT CLAIM RATES PER 100,000 POPULATION BY GENDER AND AGE GROUP 2022/23 – ACC ANALYTICS & REPORTING & STATISTICS NEW ZEALAND 2023 POPULATION PROJECTIONS

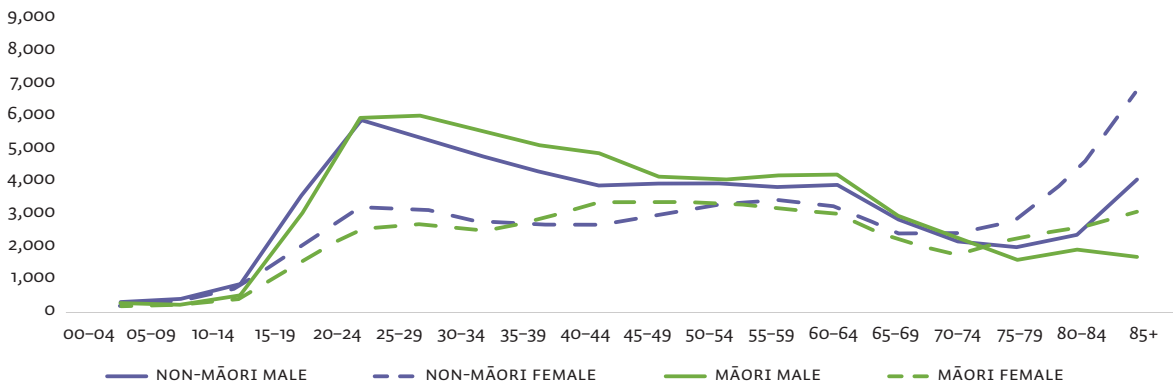

TABLE 2: RATE OF NEW ENTITLEMENT CLAIMS PER 100,000, MĀORI VERSUS NON-MĀORI (ALL FUNDS) – ACC, ANALYTICS & REPORTING

LODGEMENT FINANCIAL YEAR	MĀORI	NON-MĀORI
2017/18	2,450.3	3,060.0
2018/19	2,486.9	3,130.0
2019/20	2,225.2	2,890.9
2020/21	2,651.2	3,417.6
2021/22	2,372.3	2,922.8
2022/23	2,603.0	2,982.4

TABLE 3: RATE OF NEW ENTITLEMENT CLAIMS PER 100,000, MĀORI VERSUS NON-MĀORI (EARNERS ONLY) – ACC, ANALYTICS & REPORTING

LODGEMENT FINANCIAL YEAR	MĀORI	NON-MĀORI
2017/18	1,999.9	2,261.8
2018/19	2,024.6	2,313.6
2019/20	1,798.2	2,119.4
2020/21	2,116.0	2,519.0
2021/22	1,938.5	2,191.8
2022/23	2,163.4	2,300.7

TABLE 4: RATE OF NEW ENTITLEMENT CLAIMS PER 100,000, MĀORI VERSUS NON-MĀORI (NON EARNERS ONLY) – ACC, ANALYTICS & REPORTING

LODGEMENT FINANCIAL YEAR	MĀORI	NON-MĀORI
2017/18	454.0	802.0
2018/19	465.3	819.5
2019/20	429.6	774.3
2020/21	538.4	902.1
2021/22	437.1	735.4
2022/23	443.8	687.4

TABLE 5: RATE OF NEW SERIOUS INJURY CLAIMS PER 100,000, MĀORI VERSUS NON-MĀORI – ACC, ANALYTICS & REPORTING

LODGEMENT FINANCIAL YEAR	MĀORI	NON-MĀORI
2017/18	9.1	5.2
2018/19	10.7	5.4
2019/20	8.2	4.3
2020/21	9.7	5.1
2021/22	8.7	4.1
2022/23	4.3	2.3

TABLE 6: RATE OF NEW TREATMENT INJURY CLAIMS PER 100,000, MĀORI VERSUS NON-MĀORI– ACC, ANALYTICS & REPORTING

LODGEMENT FINANCIAL YEAR	MĀORI	NON-MĀORI
2017/18	120.9	217.5
2018/19	127.9	226.1
2019/20	132.2	222.6
2020/21	146.0	245.3
2021/22	139.9	242.8
2022/23	147.9	261.2

TABLE 7: AVERAGE COST OF MED FEE CLAIMS, MĀORI VERSUS NON-MĀORI – ACC, ANALYTICS & REPORTING

LODGEMENT FINANCIAL YEAR	MĀORI	NON-MĀORI
2017/18	$259	$321
2018/19	$279	$339
2019/20	$299	$353
2020/21	$301	$363
2021/22	$302	$360
2022/23	$281	$337

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 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 97% of ACC clients with a claim in 2022/23 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 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: Identify 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 or blindness).

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