He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

ACC Access Report: What we know about access to the system and ACC

March 2025

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Analysis conducted: July 2022 to December 2024

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1. Overview

The Accident Compensation Corporation (ACC) provides injury prevention, cover and entitlements for people living in New Zealand and visiting New Zealand. People access[1] the Accident Compensation Scheme (the Scheme) by taking part in ACC's injury prevention initiatives and having claims lodged through the health system. Addressing inequities in access to the Scheme is a central goal of ACC's strategy, Huakina Te Rā.[2]

This report provides foundational evidence about barriers to accessing the health and social system[3] which the Scheme is part of, as well as the Scheme itself. It provides a summary of:

- What we know about access to the health and social system and the Scheme for Māori and identified populations, who are Pacific people, Asian people, and disabled people.
- What research tells us to consider when looking to improve equity of access to health and social services and to the Scheme.
- Existing operational activity ACC is undertaking to improve equity of access for Māori and identified populations.

The report draws on multiple sources of information, including quantitative and qualitative data from ACC's and other agencies' research, to inform the evidence base for decision-making on equity-related interventions.

1.1 Research over the last 20 years has shown that for various groups in New Zealand, access to the health and social system, and in turn the Scheme, is inequitable

ACC has conducted exploratory analysis[4] in the Stats NZ research database, the Integrated Data Infrastructure (IDI),[5] to identify populations that typically experience the greatest difficulty accessing

[1] Access for the purposes of this research summary refers to entry to the Scheme and access to services for all eligible injured persons.

[2] Huakina Te Rā sets out the strategic direction for ACC from 2023 to 2033. Our strategy | Huakina Te Rā (acc.co.nz)

[3] People primarily access the Scheme through the health system. So, we would expect those barriers to accessing the health system impact on access to the Scheme.

[4] See Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people. In ACC's access reporting work for populations identified by ethnicity, we are using the total ethnicity responses. This means that people can be assigned to more than one group.

[5] The Stats NZ research database contains linked government administrative datasets for the purposes of research. For more information see Data in the IDI | Stats NZ.

the Scheme.[6] In addition to Māori, we have identified Pacific people, Asian people[7] and disabled people (collectively referred to as identified populations) as having specific needs, including considering the intersectionality between disability and other identified populations (eg people living rurally, the LGBTQIA+ community), when accessing the Scheme.[8] These populations align with populations of interest in the Manatū Hauora | Health New Zealand Pae Ora Strategies.[9]

1.2 Māori, Pacific people, and Asian people have lower ACC claim rates[10] than non-Māori, non-Pacific people and non-Asian people[11]

Figure 1 shows the percentage of Māori, Pacific, and Asian people who had ACC claims, compared to people not of those ethnicities, per year, for the 10-year period 2013-2023.[12]

[6] This foundational work is available on the Access Reporting page on the ACC website.

[7] For our research purposes, the term "ethnic communities" comprises a diverse group representing over 200 ethnicities and speaking over 170 languages. The group includes people who identify as African, Asian, Continental European, Latin-American, Middle Eastern. Also included are former refugees, asylum seekers, new and temporary migrants, long-term settlers and multigeneration New Zealanders. ACC currently uses the 'Asian' ethnic identifier as a proxy for Ethnic Communities, because the ACC claims data for Asian people is more robust.

[8] These populations are referred to as 'identified populations' throughout this paper.

[9] The Pae Ora (Healthy Futures) Act 2022 Strategies identify Māori, Pacific people, disabled people, women and people living rurally. See New Zealand's Bold New Structural Health Reforms: The Pae Ora (Healthy Futures) Act 2022 - PubMed (nih.gov)

[10] The current rate of injury in the New Zealand population is unknown. We consider the number of ACC claims to be a proxy for the number of injuries, and as such, we consider lower claim rates to indicate poorer access to the Scheme within comparable populations. We recognise that the injury rates may differ between identified populations. See the Scheme Access Reporting page on the ACC website for more information about how we plan to measure injury prevalence in the New Zealand population.

[11] Accident Compensation Corporation. (2018). Annual Report. https://www.acc.co.nz/assets/corporate-documents/a85ddef227/ACC-Annual-Report-2018-ACC7919.pdf; Stats NZ. (2019). Ethnic group summaries reveal New Zealand's multicultural makeup. https://www.stats.govt.nz/news/ethnic-group-summaries-reveal-new-zealands-multicultural-make-up/

[12] Across all ethnicities, except for Asian people, claim rates dropped from 2020-2022, presumably due to the effects of the COVID-19 pandemic and associated restrictions on activity.

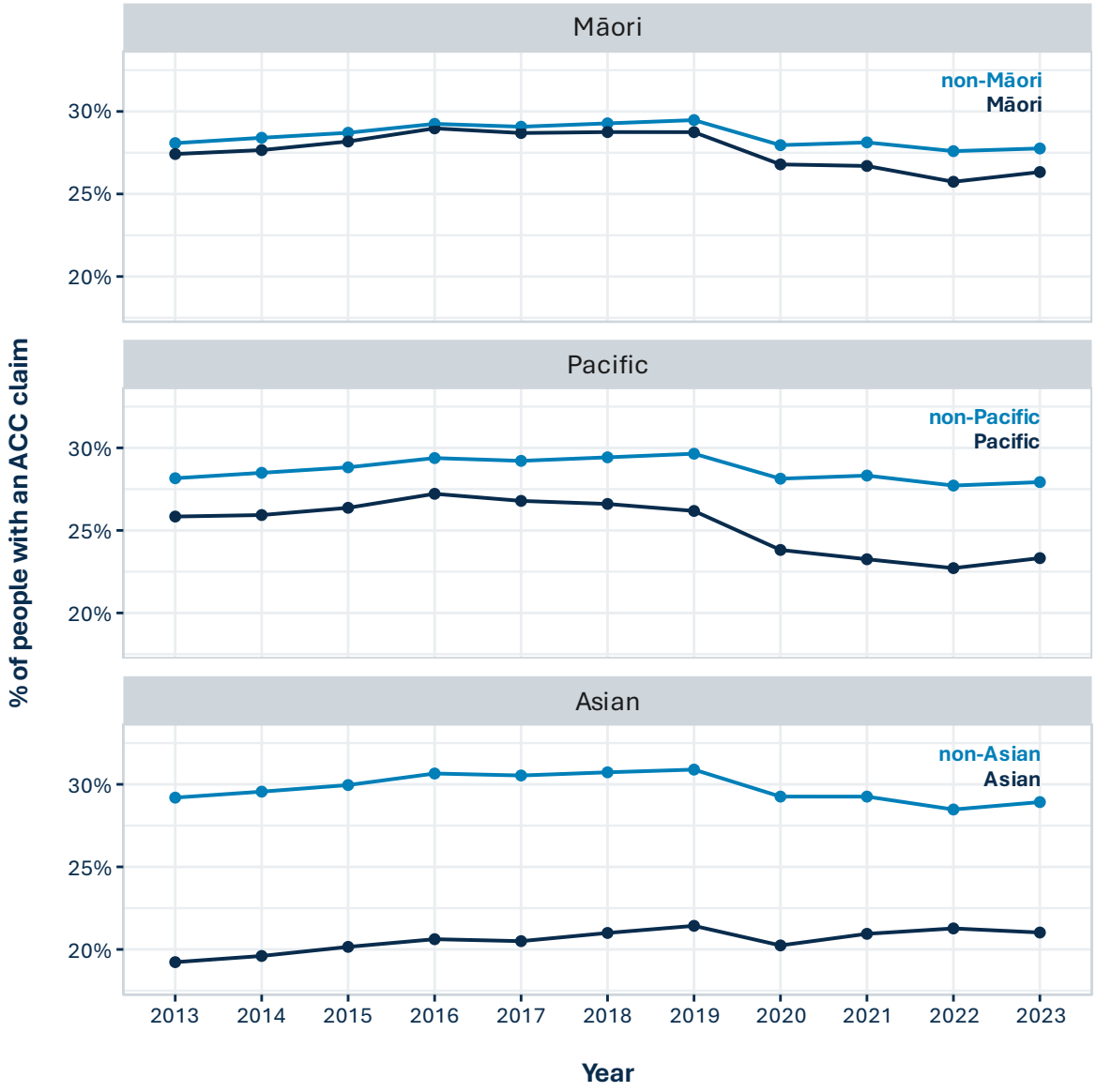

Figure 1: The percentage of each ethnic group who had an ACC claim, per year, for the 10-year period 2013-2023. A person was counted as having a claim if they had at least one accepted ACC claim with an injury date during the calendar year. Confidence intervals are not shown as they are very small and do not alter the findings.

For Māori, Pacific people and Asian people, systemic factors (such as lower socio-economic status, locality, language and education limitations, and structural factors such as bias and discrimination) inhibit access to health and social services. Limited partnership, and a lack of collaborative systems and service design approaches with Māori, Pacific People and Asian people, drives inequitable access.

Our exploratory analysis on claim rates in the IDI for disabled people (Figure 2 below) shows that disabled people's claim rates are strongly related to age, and claim rates increase for older groups.[13]

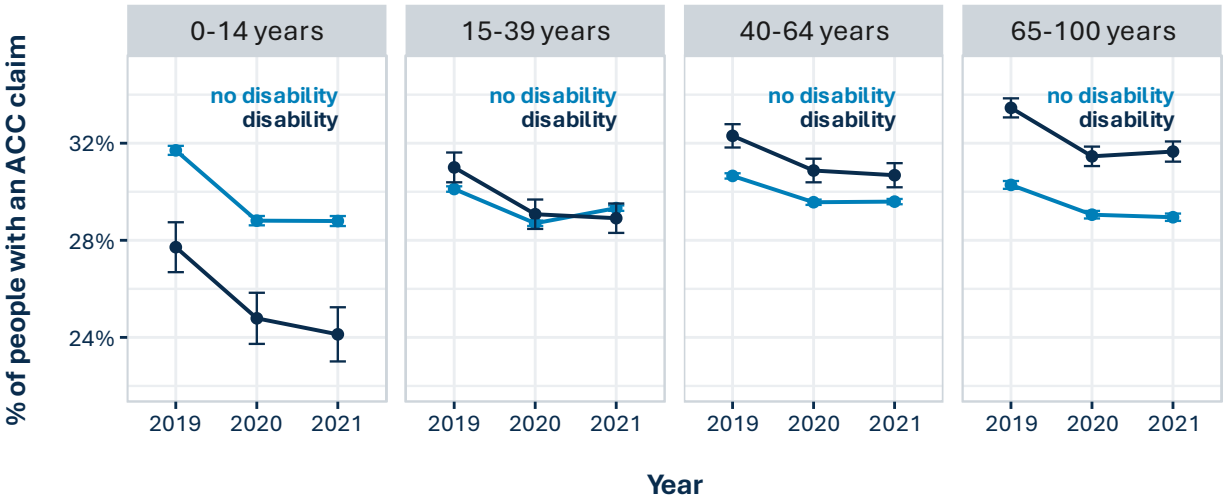

Figure 2: The percentage of people who had an ACC claim in 2019, 2020, and 2021, by age and by whether or not they reported a functional disability in the 2018 Census. Non-respondents to the 2018 Census question on disability are excluded from the analysis. A person was counted as having a claim if they had at least one accepted ACC claim with an injury date during the calendar year. Error bars represent 99% confidence intervals.

For disabled people,[14] systemic ableism and a lack of accessibility in service design and delivery result in poorer access to health and social services. Research shows that needs-based interventions are required to address these access inequities.[15]

1.3 What research shows ACC could consider to address inequitable access to the Scheme for Māori and identified populations

From the research, we know that Māori and identified populations have challenges accessing the Scheme, and that we can make improvements to make it more accessible for them:

- Cost, travel, and language barriers to accessing health providers impacts entry to the Scheme.[16]

[13] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people.

[14] For the purposes of this paper, we use the term 'disabled people' to talk about people with disabilities, in line with guidance from the Whaikaha | Ministry of Disabled People (until 2023, Office for Disability Issues) Disability Strategy and Action Plan. Some people may prefer other terms to identify themselves, including 'people with disabilities'.

[15] United Nations. (2019). New Zealand Disability Strategy 2016–2026 (2019) Disability Action Plan 2019–2023. Retrieved from https://www.odi.govt.nz/assets/Uploads/disability-action-plan-2019-1-page-printable-version.pdf.

[16] ACC. (2024). Annual Report, Wellington: ACC. ACC8695-Annual-Report-2024.pdf, p. 35.

- Māori are more likely to have their claim declined, and experience slower cover decisions.[17]
- More culturally responsive and appropriate approaches to service design and delivery are needed to ensure access needs are being met.

Through research and work done to support the development of ACC's strategy Huakina Te Rā, ACC has undertaken to:

- Work with health and social system partners to respond to discrimination, racism, and ableism, and other factors that cause barriers to accessing health and social services.
- Develop appropriate, culturally responsive interventions that target specific access barriers for Māori and identified populations.
- Continue to develop a strong evidence-base to inform decisions on needs-based interventions to address access inequities.[18]
- Monitor and evaluate existing ACC initiatives to understand their impact on Scheme access.[19]

1.4 We will continue to use the Stats NZ research database to help us identify barriers to accessing the Scheme and understand what works to improve access for Māori and identified populations

The Stats NZ research database provides more information about the New Zealand population. Investigating a broader range of factors that impact health and social system access, has helped us to identify the Scheme access needs of Māori and identified populations.

In our exploratory analysis, we analysed combinations of characteristics because we know that inequity has an exponential impact.[20] For example, a person who is disabled, identifies as Pacific, and is a woman, is likely to experience compounding barriers to accessing the health and social system. These barriers are exacerbated if that person also faces material hardship. This nuanced population-level analysis will help us identify specific cohorts of Māori and identified populations[21] that face difficulty accessing the Scheme, and then tailor interventions to meet the needs of these populations to help make the Scheme more accessible to them.

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[17] ACC. (205). Te Wero: Te Ara Kōmihana i ngā rātonga kaupapa Māori ki Te Ara Te Kaporeihana Āwhina Hunga Whara, The Challenge, pp. 7-8.

[18] ACC. (2024). Annual Report, Wellington: ACC. ACC8695-Annual-Report-2024.pdf, p. 35.

[19] ACC funds a range of interventions aimed at improving access and/or preventing injury among Māori and identified populations. More information about these can be found in ACC. (2024). Annual Report, Wellington: ACC. ACC8695-Annual-Report-2024.pdf, p. 35.

[20] Ministry of Health. (2019). Achieving Equity in Health Outcomes: Summary of a discovery process, Wellington: Ministry of Health.

[21] Following the passing of the Accident Compensation (Access Reporting and Other Matters) Amendment Act 2023 (the Amendment Act), ACC has obligations to report annually on levels of access to the Accident Compensation Scheme (the Scheme) for Māori and other people in the identified population groups. It is ACC's duty to select the identified populations it chooses to report on.

Furthermore, claim rates are indicative, as ACC does not know how ACC claim rates compare to actual rates of injury. We will develop a rate of injury for populations to compare to claim lodgement in the IDI. This will tell us about the characteristics of who is getting injured and has no associated claim, which will give us a better view of actual access disparities.[22]

2. How ACC understands equity of access

Equity of access moves ACC beyond an equality model, where people receive the same thing, to a model of access where people are provided with what they need to access our services, when they need those services, and how they might need those services.

Several strategic drivers require us to deepen our understanding of equity of access to the health[23] and social system and the Scheme:

- The ACC strategy Huakina Te Rā[24], which outlines our vision for a future where all people, whānau and communities thrive. Huakina Te Rā is a dual-framed approach that reflects ACC's obligations to Māori and non-Māori. The dual-framed goal that is most relevant to this report is Mana Taurite | Equity. This goal is described as:
    - 'Mana Taurite – equity of access, service experience and outcomes for Tangata Whenua.
    - Equity – the people we serve in Aotearoa New Zealand achieve equity of access and experience, and better outcomes.'
- The Accident Compensation (Access Reporting and Other Matters) Amendment Act 2023, that ensures the monitoring of access to the Scheme by Māori and identified populations to deliver targeted services in a manner that supports access to the Scheme by injured Māori and injured persons in those population groups.[25]
- Te Tauākiwhakamaunga Atu | ACC Statement of Intent 2023-2027,[26] describes equity as:
    - 'Equity is recognised as a critical health system response to inequitable differences in health outcomes for people living in Aotearoa New Zealand.'

[22] For more information about how we will measure the rate of injury in New Zealand, see the 'Equity of Access to ACC: Investigation of datasets and methods for ACC's reporting on Mana Taurite | Equity of Access' on the Access Reporting page of the ACC website.

[23] Ministry of Health. (2019). Achieving Equity in Health Outcomes: Summary of a discovery process, Wellington: Ministry of Health, p.7; PHARMAC. (2019). Achieving medicine access equity in Aotearoa New Zealand: towards a theory of change. Wellington: PHARMAC.

[24] Huakina Te Rā sets out the strategic direction for ACC from 2023 to 2033. Our strategy | Huakina Te Rā (acc.co.nz).

[25] See: Accident Compensation (Access Reporting and Other Matters) Amendment Act 2023 No 26, Public Act – New Zealand Legislation.

[26] ACC (2023). Te Tauākiwhakamaunga Atu | ACC Statement of Intent 2023-202, Wellington: ACC. statement-of-intent-2023-2027-acc8451.pdf, p.11.

- ‘Centring equity as a core pillar of the new health service will mean that people living in Aotearoa New Zealand will be able to access services and support when and where they need them, with their needs better reflected in the services they access.’

ACC has a commitment to use evidence to understand and meet injured people’s access needs.

In particular, ACC has set out to:

- Remedy unjust, unfair and unavoidable disparities for Māori and identified populations, and build an evidence base to understand the actions we should take and to measure improvement.
- Deliver improved outcomes for Māori and identified populations by identifying and responding to barriers to access and positive service experiences.
- Reduce disparities in access for Māori and identified populations.[27]

3. Access to the health and social system for Māori, Pacific people, Asian people and disabled people

We know from research that there is a range of factors that impact on people’s access to the health and social system. These include:

- Social determinants – The social determinants of health are conditions in which people are born, grow, work, live and age, and are the forces and systems that shape the conditions of daily life, for example, locality and socio-economic status. These have long been associated with individual health and well-being outcomes.[28]
- Systemic bias – Access to the health system for priority populations is inhibited by systemic factors, such as discrimination, racism[29] and ableism.[30] Evidence suggests that both ethnicity and culture influence how people interact with the health and social system. For Māori, Pacific people, and Asian people, the impact of these systemic factors results in poorer health outcomes.[31]

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[27] ACC. (2024). Annual Report, Wellington: ACC. ACC8695-Annual-Report-2024.pdf, p. 35.

[28] WHO. (2025). Social determinants of health; Saxe Zarden, L. D., (2024), Voting: The New Social Determinant of Health and a Long-Standing Concept for Social Work. Social work, Vol. 69, no. 4, pp.325 – 328.

[29] Comprised of policies and practices that exist within a society, systemic racism is a form of discrimination that results in a continued unfair advantage to some people and unfair or harmful treatment of others based on race.

[30] Disabled people comprise a diverse group with a wide range of physical, mental, intellectual or sensory difference. These differences become ‘disabling’ as a result of societal barriers to participation and inclusion. These barriers constitute ableism, defined as systemic, organisational, or interpersonal discrimination against disabled people.

[31] Harris, R.B., Stanley, J., & Cormack D. M., (2018). Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLoS ONE 13(5): e0196476. https://doi.org/10.1371/journal.pone.0196476.

Systemic ableism can also inhibit access to health services for disabled people.[32] Systemic ableism refers to policies and practices that result in bias, prejudice and discrimination against people with disabilities.

Research shows Māori,[33] Pacific people,[34] Asian people,[35] disabled people,[36] women,[37] children,[38]older people,[39] and the LGBTQIA+ community[40] currently access the health system inequitably and experience poorer health outcomes. Health outcomes are also impacted by locality (access to health services is impacted by availability, particularly in rural areas[41]) and socio-economic status.[42]

Through research and work to develop Huakina Te Rā, in addition to Māori, we have identified Pacific people, Asian people, and disabled people as groups for initial focus on improving equitable Scheme access, service experience, and rehabilitation and treatment outcomes. Research shows these populations are the people who have significant and longstanding access disparities.

In identifying these populations, we considered several factors relevant to ACC, including health and social care access and outcomes, known barriers to access, availability of ACC and agency data, reporting feasibility and methodological robustness.[43] We also looked at multiple aspects of identity (age, gender, location, amongst others) that impact on a person's access to health care and the

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[32] United Nations. (2019). New Zealand Disability Strategy 2016–2026 (2019) Disability Action Plan 2019–2023. Retrieved from https://www.odi.govt.nz/assets/Uploads/disability-action-plan-2019-1-page-printable-version.pdf; Beltran-Castillon, L. & McLeod, K. (2023). From Data to Dignity: Health and Wellbeing Indicators for New Zealanders with Intellectual Disability | Mar I te Raraunga ki te Rangatiratanga o te Noho: Ngā Tūtohu Hauora, Toiora Hoki mō Hunga Whai Kaha o Aotearoa. 6584cc68cbd28550e09d0397_Full_IDI report_final_web.pdf (website-files.com).

[33] Aide Memoire – ACC's delivery to priority populations: Part 2 – Māori.

[34] Accident Compensation Corporation. (2021). GOV-010518 ACC's Delivery to priority populations: Part 2- Pāsifika peoples; Ministry for Pacific Peoples. (2022). Pacific Wellbeing Strategy: Weaving All-Of-Government. Wellington: Ministry of Pacific Peoples.

[35] Aide Memoire – ACC's delivery to priority populations: Part 5 - Ethnic Communities; Ministry for Ethnic Communities. (2022). Former Refugees, Recent Migrants and Ethnic Communities Employment Action Plan; Health Navigator New Zealand. (2023). Asian Health Overview. Retrieved from https://www.healthnavigator.org.nz/health-a-z/a/asian-health-overview/.

[36] Aide Memoire – ACC's delivery to priority populations: Part 4 – disabled people.

[37] Aide Memoire – ACC's delivery to priority populations: Part 1 – women.

[38] Aide Memoire – ACC's delivery to priority populations: Part 6 – children and young people; Mills, C., Reid, P., & Vaithianathan, R. (2012). 12:384. The cost of child health inequalities in Aotearoa New Zealand: a preliminary scoping study. BMC Public Health. Vol. 12, Iss. 384. The cost of child health inequalities in Aotearoa New Zealand: a preliminary scoping study | BMC Public Health | Full Text.

[39] Aide Memoire – ACC's delivery to priority populations: Part 7 – older people.

[40] Tan, K. K., Carroll, R., Treharne, G. J., Byrne, J. L., & Veale, J. F. (2022). "I teach them. I have no choice": experiences of primary care among transgender people in Aotearoa New Zealand. The New Zealand Medical Journal (Online), 135(1559), 59-5. Adams, J., & Neville S. (2023) 'Rainbow Health in Aotearoa New Zealand – finally getting the attention it deserves?' Journal of Primary Health Care 2023; 15(2): 186–189. doi:10.1071/HC22152; Clark, T., Sutcliffe, K., Greaves, L., Roy, R., DaRocha, M., & Fleming, T. (2021), A Youth19 Brief: Rangatahi Māori with a disability or chronic condition. The Youth19 Research Group, Victoria University of Wellington and the University of Auckland, New Zealand.

[41] Eggleton, K. (2024). 'Reframing rural health inequities: a norm-critical approach.' Journal of Primary Health Care. Vol. 16, iss. 3. Pp. 230-231.

[42] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people. ACC: Wellington. Available here

[43] ACC. (2025). ACC Scheme Access Report: Year 1. ACC: Wellington.

Scheme.[44] What this means is that we are considering how demographic characteristics, such as age, gender, and location, and other factors such as education, health, and socio-economic status inter-relate when considering their influence on access to the Scheme. This will help us to understand specific barriers to accessing the Scheme.

We recognise that each population will have specific needs when it comes to addressing access to the health and social system, as cultural differences influence how people interact with the health and social system. This is particularly important to consider in light of New Zealand's culturally diverse society.[45] Acknowledging that the effects of demographic and socio-economic characteristics can vary between populations, will enable us to better target our disparity reduction efforts.

Further, examining multiple identity characteristics and other factors allows us the flexibility to adapt our groups of interest as new data is collected, and is consistent with ACC's commitment to use data and evidence to understand and meet client needs.

Research shows that addressing healthcare service uptake disparities requires interventions that address underlying social determinants and systemic factors.[46] These systemic factors compound vulnerabilities within population groups.[47] For example, Māori experience high levels of disadvantage because of systemic factors[48]. This disadvantage results in health inequities due to New Zealand's history of implementing of policies that result in either discriminatory or unfair outcomes to whānau Māori.[49] This is also the case for Pacific people, Asian people[50], and disabled people.

See the Table in Section 7 for a summary of the research on actions to address barriers to accessing the health and social system. The following four subsections of the paper outline examples drawn from health and social system research of how systemic factors can result in poorer outcomes for Māori, Pacific people, Asian people and disabled people.

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[44] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people.

[45] Chen, M. (2019). National Culture and its Impact on Workplace Health and Safety and Injury Prevention for Employers and Workers. Superdiversity Institute for Law, Policy and Business. superdiversity-acc-report-2019.pdf (maichen.nz).

[46] Lewycka, S., Dasgupta, K., Plum, A., Clark., Hedges, M., & Pacheco, G. (2023). Determinants of ethnic differences in the uptake of child healthcare services in New Zealand: A decomposition analysis. International Journal for Equity in Health. Iss. 22, vol. 13, pp. 1 – 15.

[47] Pinto, S. A., Mok, P., & Warn, V. (2023) Older people experience vulnerability and multiple disadvantage in New Zealand: A report on the needs of older people (65+) in health, housing, finance, social connection, and access. Report (msd.govt.nz)

[48] Waitangi Tribunal. (2020). Wai 2575 Health Services and Outcomes Kaupapa Inquiry. Retrieved from: https://www.health.govt.nz/our-work/populations/maori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry

[49] Wren, J., & Jansen, P. (2023). Brief of Expert Evidence: History of Maaori underutilisation ACC injury treatment and rehabilitation support services, the barriers to their utilisation, and what works to improve service delivery to Maaori. Waitangi Tribunal, Ministry of Justice. p. 20

[50] Yong. S., & Vosslomber, R. (2022). The Stigma of the Chinese Poll Tax in Colonial New Zealand. Journal of Accounting History. Vol. 28. Iss. 1. DOI: https://doi.org/10.1177/10323732221132562

3.1 Māori access to the health and social system

Māori experience inequitable access to health and social services because of systemic factors, including the ongoing impact of historically unjust policies and practices. For example, the Waitangi Tribunal in the Wai 2575 Health Services and Outcomes Kaupapa Inquiry[51] found:

- Ongoing persistent views within the health system that dismiss health inequities, as the Crown considers New Zealand's healthcare system to be comparatively strong by international standards.
- Concerns regarding the way the Crown reports on health sector performance and that mechanisms ensuring accountability were rarely used in relation to Māori health.
- Lack of Māori in influential leadership positions in the health system to inform better healthcare decisions for Māori.

On injury specifically, the rate for fatal injuries for Māori in 2018 was higher than the total population.[52] The national rates of unintentional injury for Māori are similar to non-Māori from age 65 onwards. This suggests once Māori transition out of work their rates of injury reflect those experienced by non-Māori.[53]

The barriers that Māori people face and the barriers that disabled people face are compounded for Tangata Whaikaha Māori.[54] The impacts of these barriers are exacerbated when other contributing social determinants and factors are at play, such as material hardship, living rurally and lack of actual physical access to service.[55]

[51] Wren, J., & Jansen, P. (2023). Brief of Expert Evidence: History of Maaori underutilisation ACC injury treatment and rehabilitation support services, the barriers to their utilisation, and what works to improve service delivery to Maaori. Waitangi Tribunal, Ministry of Justice. p. 20.

[52] StatsNZ (2023). Serious injury outcome indicators: 2000–2020 | Stats NZ

[53] Māori workplace injury claim rates are slightly higher than European counterparts, see Injury statistics – work-related claims: 2023 | Stats NZ.

[54] This strengths-based term is used to refer to Māori living with a disability and means 'people who are determined to do well, or is certainly a goal they reach for.' See Finding our name | Whaikaha - Ministry of Disabled People

[55] Clark, T., Sutcliffe, K., Greaves, L., Roy, R., DaRocha, M., & Fleming, T. (2021), A Youth19 Brief: Rangatahi Māori with a disability or chronic condition. The Youth19 Research Group, Victoria University of Wellington and the University of Auckland, New Zealand.

3.2 Pacific people's access to the health and social system

Historical policies and practices have resulted in unfair outcomes for Pacific people.[56] Pacific people tend to have lower socioeconomic status at a population level and poorer health outcomes. For example, work to inform the development of the Pacific Peoples' Wellbeing Strategy[57] found:

- Pacific people distrust the government due to poor experiences with the health and social system.
- Lack of culturally appropriate services designed to meet the diversity of need amongst Pacific people.
- Failure within health and social services to reflect Pacific people's lives, needs, and aspirations in service design and delivery.
- Lack of Pacific people representation in the design and delivery of health and social services.
- Lack of investment in raising Pacific cultural capability across the health and social system workforce.
- Lack of Pacific people's values, and narratives that reflect lived realities from across and within Pacific people's communities, in government.

3.3 Health and social system access for Asian people

Historically unjust policies and practices[58] have meant that Asian people experience poorer labour market outcomes and there are reports of discrimination in external, and internal recruitment processes.[59]

Health system research shows that there is a lack of culturally responsive services for Asian people, including:[60]

- A lack of knowledge about the New Zealand health and social service system and availability of services.
- Difficulty navigating the health and social system due to language barriers.
- Cultural discrimination, due to cultural practices and values that may differ from the dominant culture in New Zealand.

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[56] Ministry for Pacific Peoples. (2023). Dawn Raids Apology. Retrieved from: https://www.mpp.govt.nz/programmes/dawn-raids-apology/.

[57] Ministry for Pacific Peoples. (2022). Pacific Wellbeing Strategy: Weaving All-Of-Government. Wellington: Ministry of Pacific Peoples.

[58] Yong. S., & Vosslomber, R. (2022). The Stigma of the Chinese Poll Tax in Colonial New Zealand. Journal of Accounting History. Vol. 28. Iss. 1. DOI: https://doi.org/10.1177/10323732221132562

[59] Ministry for Ethnic Communities. (2022). Former Refugees, Recent Migrants and Ethnic Communities Employment Action Plan.

[60] Health Navigator New Zealand. (2023). Asian Health Overview. Retrieved from https://www.healthnavigator.org.nz/health-a-z/a/asian-health-overview/.

3.4 Disabled people's access to health and social services

In the 2013 disability survey,[61] one in four New Zealanders identified as disabled. Access to the health system for disabled people is impacted by systemic factors, including ableism. For example, Whaikaha - Ministry of Disabled People found:[62]

- A lack of acknowledgement and respect for the diversity within the disability community.
- A lack of representation of disabled people in influential leadership and governance positions.
- A lack of choice and control over the supports and services received.
- Information about health and social services not being in accessible language and formats for disabled people.
- Lack of access to quality peer support.

There is also a lack of access to culturally appropriate supports that have been designed for Tangata Whaikaha Māori,[63] and disabled people who are also Pacific people and Asian people.[64]

4. What works to address barriers to health and social system access

Research conducted on access to the health and social system shows that requirements for removing barriers for the different groups are:

- Relationship-based approaches.
- Organisational cultural competency.
- Providing information in multiple languages and accessible formats.
- Engaging with community groups and identified population representatives to design and deliver appropriate interventions, which meet a diversity of need.[65]

[61] Census 2023 data was not available at the time this research summary was conducted.

[62] Te Puna Aonui. (2022). Analysis - Disabled People. New Zealand: Te Puna Aonui, New Zealand Government. Retrieved from https://tepunaaonui.govt.nz/assets/National-strategy/Cohort-papers/Disabled-People-Analysis-Paper.pdf.

[63] Ingham, T.R., Jones, B., Perry, M., King, P.T., Baker, G., Hickey, H., Pouwhare, R., & Nikora, L.W. (2022). The Multidimensional Impacts of Inequities for Tangata Whaikaha Māori (Indigenous Māori with Lived Experience of Disability) in Aotearoa, New Zealand. International Journal of Environmental Research and Public Health, 19(20), 13558. https://doi.org/10.3390/ijerph192013558.

[64] Faasen, K., Martin, G., Potiki, M., & Jenkin, G. (2023). Evidence Brief: Primary Healthcare Needs of Disabled Children in Care and Protection. Wellington, New Zealand: Oranga Tamariki—Ministry for Children; University of Otago. (2011). Outcomes of Injury Study. Retrieved from: https://blogs.otago.ac.nz/ipru/files/2013/03/October-2011-POIS-Newsletter.pdf.

[65] Ministry of Health. (2019). Achieving Equity in Health Outcomes: Summary of a discovery process, Wellington: Ministry of Health.

5. Access to the Scheme for Māori, Pacific people, Asian people and disabled people

The purpose of the Scheme is to deliver injury prevention initiatives and no-fault personal injury cover for everyone in Aotearoa New Zealand. People access the Scheme through the health system. Given that the health equity literature tells us that Māori and identified populations currently access this system inequitably and experience poorer health outcomes, these poorer outcomes may be exacerbated through inequitable access to the Scheme.

ACC can play a key role working with system partners[66] to respond to systemic drivers of discrimination for Māori, Pacific people, Asian people, and disabled people. ACC can also look to undertake specific interventions for these populations. This is important because people view aspects of injury prevention, experience of injury (i.e., pain perception, expression and experience), and management of injury recovery through an ethnic and cultural lens.

We conducted exploratory analysis of claim rates (defined as the proportion of the population who made a claim) for Māori, Pacific people, Asian people and disabled people, using IDI data between 2013 and 2023.[67] This analysis investigated how claim rates changed over this period, how claim rates differed for Māori, Pacific people, Asian people and disabled people, compared to others, when other factors were statistically controlled for, and what factors may be associated with barriers to access for the identified groups. The research found:[68]

- Claim rates were lower for Māori and Pacific adults, much lower for Asian adults, and higher for disabled adults (and these differences remained even after controlling for other factors affecting access to the Scheme, such as socio-economic status, age and location).
- Claim rates were lower for Māori and disabled children, and much lower for Asian children (and remained so once other factors were controlled for).[69]

We have interpreted a lower likelihood of having an ACC claim as indicating a potential barrier to access, recognising that we have no information on injury prevalence between different groups to aid our interpretation of differences in claim rates. Work to explore these results further has been outlined in the ACC Access Report Year 1.[70]

[66] Ministry of Health. (2022). Mana Tangata in Aotearoa: What is our vision, what are we not there, and what can we do?

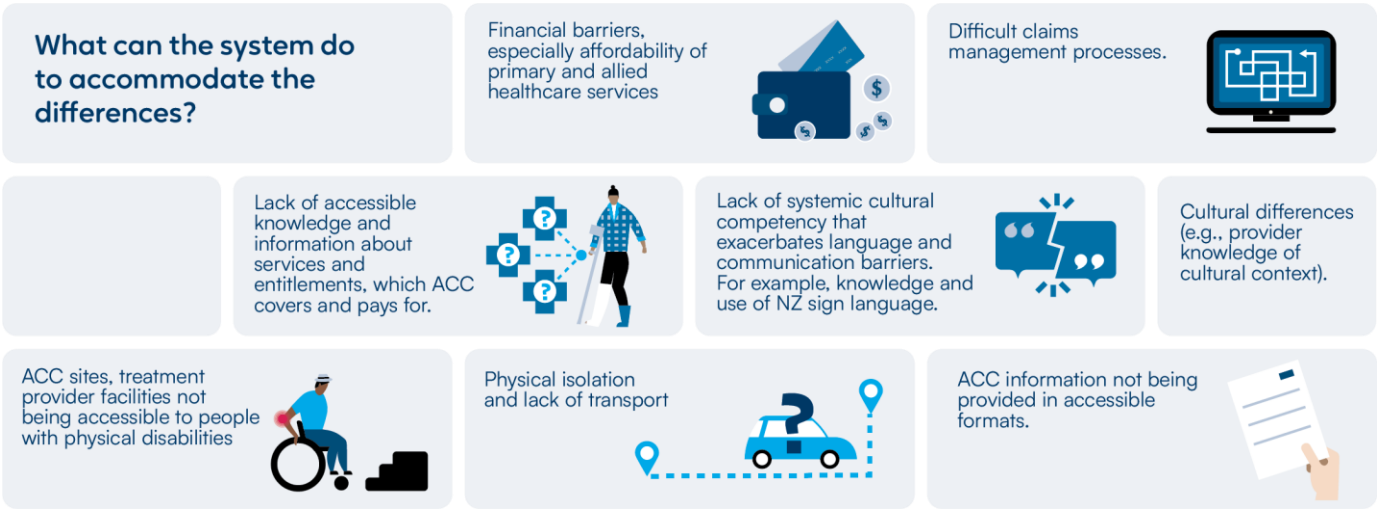
[67] Some of this analysis has been updated to include 2023 data.

[68] Our results are not official statistics. They have been created for research purposes from the IDI which is carefully managed by Stats NZ. For more information about the IDI please visit https://www.stats.govt.nz/integrated-data/

[69] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people.

[70] This report is available on the Scheme Access Reporting page of the ACC website.

See the Table in Section 7 of this report for a summary of the health and social system research and ACC research on access barriers and work to address these barriers. The following four subsections of the paper outline common barriers to access for Māori, Pacific people, Asian people and disabled people, and what we know from ACC research on barriers to access and actions to address these.



5.1 Analysis in the IDI showed that Māori claim rates were around half a percent lower than non-Māori claim rates from 2013 to 2019, and then dropped to around 1% lower from 2020 to 2022.[71]

Research suggests that, overall, Māori are less likely to lodge an ACC claim compared to non-Māori. Claim rates for Māori are higher in the Serious Injury and Sensitive Claims account when compared to non-Māori,[72] and increase as the level of deprivation increases (but they have lower average cost of claim).[73]

Approximately 5.3% of Māori claims were declined in 2017, compared to 3.8% of non-Māori claims.[74] Māori currently experience slightly slower cover decisions compared to non-Māori, which may reflect higher complexity of claims.

[71] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people, p.14.

[72] Aide Memoire – ACC's delivery to priority populations: Part 2 – Māori.

[73] ACC. (2020). Te Wero: Te Ara Kōmihana i ngā rātonga kaupapa Māori ki Te Ara Te Kaporeihana Āwhina Hunga Whara, The Challenge.

[74] ACC. (2020). Te Wero: Te Ara Kōmihana i ngā rātonga kaupapa Māori ki Te Ara Te Kaporeihana Āwhina Hunga Whara, The Challenge.

ACC has commissioned a suite of work to address inequity in Māori access, experience and outcomes.[75] This work will continue to be a focus under Huakina Te Rā and includes:

- Mana Taurite | Equity Action Plan: this work includes consolidating the evidence of equity research to help with commissioning targeted interventions to respond to equity barriers.
- Hāpai: ACC's Te Ao Māori approach to case management.[76]
- Rongoā Māori (traditional Māori healing):[77] an access option available to all, which also assists Māori to realise autonomy and choice.[78]
- Kaupapa Māori solutions: providing equitable funding for Māori treatment and rehabilitation services.[79]
- Kaupapa Māori Navigation Services:[80] organisations that can give free and independent advice to assist people to understand processes for a declined claim and how to navigate the Scheme.
- Te Whānau Māori me ō mahi:[81] guidance on Māori cultural competencies for suppliers and providers supporting Māori clients, whānau and communities.

Rongoā Māori and Hāpai are examples of culturally responsive interventions that provide relationship-based approaches and develop organisational cultural competency to improve access to ACC for Māori.

5.2 Our IDI analysis found that Pacific people's claim rates were 2 to 3% lower than non-Pacific claim rates from 2013 to 2019, and then 4-5% lower for 2020-2022[82]

Research conducted on claims in the financial year 2017/2018 found that while Pacific people comprised approximately 9% of the population of New Zealand, they accounted for approximately 6% of ACC claims lodged annually, and 5% of claims costs. Within this, however, there are significant sex

[75] For more information about these initiatives see ACC's 2024 Annual report pp. 34 – 35.

[76] Hāpai is an initiative providing kiritaki Māori (Māori clients) and their whānau with options in recovery support. Hāpai is grounded in tikanga Māori, Te Ao Māori principles to inform the way Kaimahi (ACC staff) manage the claims. It is currently available to kiritaki Māori who have experienced complex injuries. Hāpai (acc.co.nz)

[77] Rongoā Māori services (acc.co.nz)

[78] This covers various methodologies including, but not limited to: mirimiri (bodywork); whitiwhiti kōrero (support and advice); karakia (prayer). Rongoā Māori is a Kaupapa Māori service that is by Māori, with Māori, and for Māori. Rongoā Māori is available for all injured New Zealanders to help them rehabilitate from a covered injury.

[79] ACC. (2024). Annual report. ACC8695-Annual-Report-2024.pdf p. 34.

[80] Navigation Services (acc.co.nz).

[81] acc-te-whanau-maori-me-o-mahi-guidance.pdf.

[82] Knox. A, & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people, p.14.

differences; females comprise only 39% of total Pacific people's claims and 28% of costs. The highest incidence of injury claims among Pacific people is in the 15-19 age group.[83]

For Pacific people, during the financial year 2017/2018, new accepted claims comprised 6.8% of new claims volume. However, since then, the number of new accepted claims has decreased by 21%. This is a higher drop than any other population group.[84]

Pacific people tend to access programmes that have been designed with their specific cultural needs in mind.[85] Currently, ACC funds violence prevention programmes:

- Le Va: a Pacific led organisation that leads community-based programmes to help reduce family violence, sexual violence and suicidal behaviour among Pacific young people.[86]
- Atu-Mai: a national violence prevention programme for Pacific young people and their families.[87]
- Fathers Fono: a parenting workshop that brings Pacific fathers together to support each other to be fathers that provide a safe and supportive environment for their families through relationships, values and self-care. [88]

Similar to approaches for Māori, ACC could draw on evidence generated by the work being conducted in the IDI to support ACC's Access Reporting work,[89] insights from programme reviews[90] and findings from work done by other organisations to address other known barriers to access for Pacific people. For example, we know that the cost of co-payments and health services for Pacific people impact claim journeys.[91] ACC could look at ways to reduce costs associated with claim lodgement, treatment, and rehabilitation. This could also draw on work already done by the Ministry for Pacific Peoples on the Pacific Wellbeing Strategy.[92]

[83] ACC's delivery to priority populations. Part 2. Pāsifika peoples / Emma Powell, Chief Customer Officer, ACC. (natlib.govt.nz).

[84] A larger drop for Pacific people is also seen in claim rates from IDI analysis. See Knox. A, & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people. p.22.

[85] Thomsen, P., & Brown-Acton, P. (2021). Manalagi Talanoa A Community-Centred Approach to Research on the Health and Wellbeing of Pacific Rainbow LGBTIQA+ MVPFAFF Communities in Aotearoa New Zealand. Pacific Health Dialog, 21(7), 474-480.

[86] Le Va has a broad range of resources and programmes.

[87] Atu mai includes workshops and online training. https://atumai.nz/.

[88] https://www.leva.co.nz/resources/fathers-fono.

[89] See the Access Reporting page on the ACC website for more information.

[90] Ministry of Health. 2024. Government Policy Statement on Health 2024 – 2027. Wellington: Ministry of Health.

[91] Research New Zealand (2021). Co-payments survey 2021. Report_Std_RNZ (acc.co.nz)

[92] Ministry for Pacific Peoples. (2022). Pacific Wellbeing Strategy: Weaving All-Of-Government. Wellington: Ministry of Pacific Peoples.

5.3 Our IDI analysis showed that the most marked ethnic contrast is the difference between Asian and non-Asian claim rates with Asian people's claim rates 8-10% lower than non-Asian claim rates from 2013-2021[93]

While Asian people's claim rates dropped in 2020, their rates increased again in 2021 and 2022, so that the gap between Asian and non-Asian people's claim rates had reduced to 6.8% in 2022.

Generally, ACC data indicates that there are fewer claims lodged for Asian people, including serious injury claims, than for people of other ethnicities. Asian people account for 9% of new claims and comprise 15.3% of the population. However, claims lodged for Asian people follow a different trend to non-Asians. For example, claims spike between the ages of 20-49, indicating a higher incidence of claims for the working aged Asian population than the non-Asian population.[94]

Asians living in New Zealand experience several cultural, environmental and institutional barriers to accessing ACC services. There is a need for more culturally relevant information and injury-related services to assist Asian immigrants in overcoming these barriers.[95]

ACC evidence identifies wide variation in the experience of barriers across Asian communities,[96] particularly in attitudes to compliance, injury prevention[97] [1], and healthcare utilisation. English language proficiency varies greatly. For example, one study noted that Chinese-born respondents experienced more communication difficulties than those born in Hong Kong or Taiwan.[98]

ACC funds acupuncture (a traditional Chinese medicine practice) as an injury treatment pathway. ACC is also able to fund culturally appropriate restorative practices (for example, yoga and naturopathy) to assist with a client's rehabilitation and independence, provided it meets a set of criteria.[99]

ACC could also:

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[93] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people, p.14-15. This report is available on the ACC website.

[94] ACC. (2021). Aide Memoire – ACC's delivery to priority populations: Part 5 - Ethnic Communities

[95] Sobrun-Maharaj, A., Tse, S., & Hoque, A. (2010) Barriers experienced by Asians in access injury-related services and compensations. Journal of Primary Health Care. Vol. 2. Iss. 1, pp. 43-53. Barriers experienced by Asians in accessing injury-related services and compensations - PubMed (nih.gov)

[96] Hosking, J., Ameratunga, S., Exeter, D., & Stewart, J. (2013). Social and geographical differences in road traffic injury in the Auckland region. University of Auckland: p 17. Microsoft Word - RTI social geographical differences report FINAL.docx (at.govt.nz)

[97] Super Diversity Institute. (2019). National culture and its impact on workplace health and safety and injury prevention for employers and workers.

[98] Auckland University of Technology. (2005). Access issues for Chinese people in New Zealand.

[99] Criteria include: that the services are required as a direct result of a covered injury, they are necessary, appropriate and of the required quality to achieve its purpose, and they facilitate the restoration of the claimant's independence to the maximum practicable extent. In determining this, ACC needs to consider the nature and consequences of the claimant's injury, the achievement of rehabilitation outcomes, costs, cost-effectiveness, the availability of other forms of rehabilitation, and all other relevant factors.

- Engage with Asian community groups and representatives, through the Ministry for Ethnic Communities and other engagement channels, to advise on improvement in data collection and targeted interventions.
- Provide information about the Scheme specifically for Asian people in a range of languages and formats.
- Undertake co-design with Asian community groups and representatives to develop access interventions that will address Asian community members' needs and empower them to access the Scheme.
- Improve our demographic data collection on Asian people.

Progressing these actions could draw on work done by the Ministry for Ethnic Communities for the Ethnic Communities Employment Action Plan.

Similar to Māori and Pacific people, we can draw on evidence generated through the work being conducted in the IDI to support ACC's Access Reporting work,[100] and findings from work done by other organisations, such as the Ministry for Ethnic Communities and the Human Rights Commission, on what works to improve access to services for Asian people.

5.4 ACC has estimates of claim lodgement rates for disabled people from IDI research[101]

This research shows that disabled people's claim rates were higher than non-disabled people's claim rates, both before and after 2018.[102]

ACC is:

- Developing information about the Scheme for disabled people in accessible formats.
- Building on the work of pilots such as Living My Life[103] to continue to deliver bespoke services for disabled people.

Drawing on work done by the Human Rights Commission and Whaikaha - Ministry of Disabled People for the New Zealand Disability Strategy and Action Plan[2], ACC could work to design access interventions with disabled people, to empower them to access Scheme entitlements.

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[100] See the Access Reporting page on the ACC website.

[101] The rate of ACC claim lodgement for disabled people is not known from ACC data because ACC does not collect information about accepted claims for disabled people.

[102] Knox, A., & Morris, M. (2023). Exploratory Analysis of Claim Rates to Support Mana Taurite | Equity of Access: Analysis of IDI data for Māori, Pacific people, Asian people and disabled people, p.22. This report is available on the ACC website.

[103] ACC. (2022). Living my life Service: Operational Guidelines. Living my Life Operational Guidelines

Similar to approaches for Māori, Pacific people and Asian people, we can draw on evidence generated by the work being conducted in the IDI to support ACC's Access Reporting work,[104] and findings from work done by other organisations, such as Whaikaha - Ministry of Disabled People, on what works to improve access to services for disabled people.

6. We can use the Stats NZ research database to help us identify who is experiencing barriers to accessing the Scheme and understand what works to improve access for Māori and identified populations

Data analysis conducted at ACC has found:

- Inconsistencies between ACC's ethnicity data and other agency ethnicity data. ACC was 26% less likely to identify someone as Māori when compared to Health data.[105]
- Limited to no visibility on access to the Scheme for disabled people.

These issues prevent us from obtaining a more accurate view of Scheme access in our claims data. Our access reporting work aims to improve our data quality and address some of these issues. The Stats NZ research database, the IDI, provides more information about the New Zealand population. Investigating a broader range of factors that impact health and social system access will help us to identify the access needs of Māori and identified populations, when it comes to accessing the Scheme.

Furthermore, claim rates are indicative, as ACC does not know how ACC claim rates compare to actual rates of injury. We will develop a rate of injury for populations to compare to claim lodgement. This will tell us who is getting injured and has no associated claim, which will give us a better view of actual access disparities.[106]

[104] See the Access Reporting page on the ACC website.
[105] ACC. (2020). Te Wero: Te Ara Kōmihana i ngā rātonga kaupapa Māori ki Te Ara Te Kaporeihana Āwhina Hunga Whara, The Challenge.
[106] See the Access Reporting page on ACC's website for more information about how we will measure injury prevalence.

7. Summary of health and social system research and ACC research

The table below summarises the research on barriers to access, and actions that could be taken to addresses them. The table presents the summary by population: Māori, followed by Pacific people, Asian people, and disabled people.

Population	Barriers to access	Actions for consideration	References
Māori	**Health and social system:** • The Waitangi Tribunal expressed concerns that health and social services value transactional relationships that do not adequately reflect the Treaty of Waitangi[3] • Lack of value of Te Ao Māori and Matauranga Māori within service delivery • Low trust in the Crown, government, health and social system, because of historical exclusion of Te Ao Māori in policies and practices • Health and outcomes kaupapa inquiry results showing continued Treaty breaches	**System level:** • Consider Treaty obligations at all levels of the health and social system • Valuing Matauranga Māori and Te Ao Māori across the health system by using strengths-based approaches in developing strategies, policies, programmes, and interventions • Enabling partnerships with Māori at all levels of the health system • Co-designing interventions, policies and programmes with Māori whānau, hapu and iwi that specifically address social determinants of health barriers (eg low socio-economic status, locality)	**System research:** Te Puni Kōkiri: Future demographic trends for Māori [4] Whakamaua: Māori Health Action Plan [5] POIS-10 Māori: Outcomes & experiences following injury [6] Barriers to Māori utilisation of health services [7] Responding to the experiences of Whānau Māori affected by cancer[8] Disrupted mana and system abdication[9]

- Lack of accountability in performance measures and metrics
- The Waitangi Tribunal expressed concerns regarding the way the Crown reports on health sector performance and that mechanisms set in place ensuring accountability were rarely used in relation to Māori health
- Lack of Māori members on the boards of relevant health organisations to inform better healthcare decisions for Māori
- Ongoing persistent views that dismiss health inequities as the Crown considers New Zealand's healthcare system to be comparatively strong by international standards
- Racism, prejudice and bias are modifiable determinants that can impact mental and physical health and lead to poorer health outcomes for Māori
- Māori participation in the health and social system is conditional
- Developing agency partnerships, for example with Te Puni Kōkiri, the Iwi Leaders Group and Te Arawhiti, across the health system and working together to eliminate systemic discrimination
- Ensuring funding for interventions is ongoing and avoiding 'pilot fatigue'
- Ensuring that research and insights are used to make change and avoid 'research fatigue' with communities
- Provide professional development and training opportunities for Māori board members, eg MoH suggested this for Māori partnership boards to increase support in Māori participation in governance and management decision making

AC Scheme:

- Engaging with Māori at iwi, hapū and whānau levels, and building trust with Māori across different contexts

ACC research:

Research New Zealand. Co-payments survey 2021[10]

Aide Memoire (GOV-010263) ACC's delivery to priority populations. Part 2: Māori[11]

on them having to suppressing their own values

ACC level:

- Lower levels of trust and confidence due to poorer experiences with health social service providers
- Cost of consultations, prescriptions and travel impacts funds available for the whole family/whānau
- Caring for whānau, difficulty getting to appointments and calling back
- Missing work for appointments
- Lack of access to health and social services from rural locations
- Disparities in provision of certain treatments compared to non-Māori

- Clearly communicating with Māori about who ACC is and what it does in te reo Māori
- Partnering with Māori (where we have a clear mandate to partner) to collaborate on Māori-led solutions to address access barriers, and partnering with other agencies who work with Māori
- Providing access to Māori providers, or a provider that is iwi-based
- Ensuring that Rongoā Māori/traditional Māori healing practices are offered, where this meets client needs
- Acknowledging and enabling kanohi ki te kanohi and tikanga
- Lifting ACC's cultural competence, with providers and for clients' contact with ACC staff
- Improving ACC's visibility and presence with Māori providers and services

Pacific people	**Health and Social system:** • Distrust in the government due to poor experiences with the health and social system • Lack of culturally appropriate services designed to meet the diversity of need amongst Pacific people • Failure within health and social services to reflect Pacific people's lives, needs, and aspirations in service design and delivery • Lack of Pacific people's representation in design and delivery of health and social services • Lack of motivation within the health and social system to enhance Pacific cultural capability • A lack of Pacific people's values, and narratives that reflect lived realities from across and within Pacific communities, in government	**System level:** • Developing agency partnerships, for example with Ministry for Pacific Peoples, across the health and social system to work together to eliminate systemic racism, bias, and discrimination • Collaborating to build the government's understanding of what is important to Pacific people and communities • Co-designing interventions with Pacific people • Ensuring that research and insights generated across government are used to make change (such as addressing barriers associated with social determinants of health eg socio-economic issues, locality) and avoiding 'research fatigue' with communities • Accessibility for Pacific people across different forms of technology • Developing the Pacific health workforce and increasing the	**System Research:** Manalagi Talanoa[12] Ministry of Health Pacific Health and Wellbeing Action Plan[13] Pacific Wellbeing Strategy[14] Te Mana Ola: Pacific Health Strategy [15] Government Policy Statement on Health 2024-2027[16] **ACC research:** Research New Zealand. Co-payments survey 2021[17] Aide Memoire ACC's delivery to priority populations: Part 2 - Pāsifika peoples[18]

- Difficulty navigating the health and social system due to language barriers
- Lack of face-to-face health support; increased use of technology such as telehealth and online portals can alienate Pacific people, and diminishes confidence in receiving care

ACC level:

- Lack of awareness and information about ACC
- Lack of engagement with ACC
- Caring for dependants, difficulty getting to appointments or calling back
- Administrative and organisational barriers, including language barriers and cultural discrimination
- Co-payment cost of consultations

number of Pacific providers or Pacific-led options

AC Scheme:

- Emphasise and value relationships over transactional processes within ACC processes
- Improve claim management processes and encompass Pacific cultural ways within these processes
- Increase engagement with Pacific communities and providers, involving increased education about ACC
- Work with system partners to eliminate systemic discrimination
- Improve communications by framing these from Pacific people's perspectives and providing these in an accessible format
- Ensuring funding for Pacific people's interventions is ongoing and avoiding 'pilot fatigue'
- Take opportunities to be present and visible at the grassroots

		level for the Pacific community. For example, a promotional tent at Pacific people's events such as the Pasifika Festival and Polyfest	
Asian people	**Health and social system:** • A lack of knowledge about the New Zealand health and social service system and availability of services • Difficulty navigating the health and social system due to language barriers (including a lack of injury language competence or translation services) • Cultural discrimination, due to cultural practices and values that may differ from the dominant culture in New Zealand; high reported experience of racism compared to other groups, highest for those who are born overseas **ACC level:**	**System Level:** • Work with system partners and agencies, for example with the Ministry for Ethnic Communities and the Human Rights Commission, to eliminate systemic discrimination and develop interventions, policies and programmes with Asian communities that address barriers related to social determinants of health • Build relationships with providers and NGOs who have experience working with Asian people, including newly arrived migrants and those whose primary language is not English • Co-design culturally responsive approaches, including valuing traditional or herbal-based	**System Research:** Former Refugees, Recent Migrants and Ethnic Communities employment action plan[19] Summary of engagement on employment action plan[20] Ethnicity Matters[21] Health Navigator New Zealand – Asian Health overview[22] Recommendations on the health system for Asian and Ethnic communities in Aotearoa[23] Challenges for Asian Health and Asian health promotion in New Zealand[24] Utilisation of Health Care by Three Asian Ethnicities[25]

- May prefer to self-manage an injury using traditional or herbal-based remedies, which may not be known about, valued, or funded
- May prefer being treated for an injury by someone of their own ethnicity and may not have access to a provider of their ethnicity
- For migrants (both injured persons and health providers, such as overseas-trained GPs), there may be unfamiliarity with the Scheme, which may create additional barriers to access for cover and entitlements
- Cost of services and treatment
- Financial reasons for not making claims, such as the responsibility to financially support their families superseding their own health; concern that weekly compensation rates will not cover their current total expenses

remedies, where they meet an injury-related need
- Ensure a diversity in culture and practice of health and social service delivery and practice
- Ensure funding for interventions is ongoing and avoiding 'pilot fatigue'
- Ensure that research and insights are used to make change and avoiding 'research fatigue' with communities

AC Scheme:

- Provide ACC information and resources in a range of languages and alternate formats
- Ensure ACC staff are culturally competent, especially those in client-facing, policy, provider, and procurement roles
- Develop a clear view of equity issues for Asian people, including a clear understanding of who this population is
- Develop a deeper understanding of the unique health needs of subpopulations of ethnic

Barriers experienced by Asians in accessing injury-related services and compensations[26]

Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data[27]

ACC level

Aide Memoire – ACC's delivery to priority populations: Part 5 - Ethnic Communities[28]

	• Lack of knowledge and promotion about ACC, including that claiming is free, and misconceptions about eligibility • Fear of employment being affected by making a claim; difficulty taking time off work to seek out treatment; concern that employment will be jeopardised by having an ACC claim • Older Asian people may be less likely to access the health system and ACC due to fear of Western medicine or stigma around being seen as 'begging' • For some Asian men, seeking help when in pain is considered as showing weakness • Transport is a barrier for older people, or those who rely on their family to drive them	communities by conducting ethnic health research • Provide culturally appropriate services where required; for example, study participants of Asian backgrounds reported that health professionals who listened carefully and took more time during appointments increased trust and encouraged continued visits	
Disabled people	**Health and social system:** • A lack of acknowledgement and respect for the diversity within the disability community	**System:** • Developing agency partnerships, for example with Whaikaha - Ministry of Disabled People, across the health system to work	**System Research:** New Zealand Disability Strategy & action plan[29]

- A lack of representation of disabled people in leadership and governance positions
- A lack of choice and control over the supports and services received
- Information about health and social services not being in accessible language and formats for disabled people
- Lack of access to quality peer support
- Lack of access to culturally appropriate supports that have been designed for Whaikaha Māori, and disabled people who are also Pacific people and Asian people

ACC level:

- Lack of data means that we do not have a clear view of equity issues for disabled people in the provision of health services, and access to the Scheme
- Some non-working disabled people think they do not qualify for ACC or are uncertain about

together to eliminate systemic ableism and discrimination
- Include disabled people's voices in planning and strategy, and design policies and programmes with disabled people that address barriers to access which are related to social determinants of health
- Work to ensure disabled people have health literacy
- Enable pathways for good communication between service providers and disabled people to meet their diversity of need
- Incorporate indigenous and culturally responsive approaches in service design and delivery
- Work with NGOs that provide services to people with intellectual impairments to increase disabled people's understanding of, and access to the Scheme
- Ensuring that research and insights are used to make

Multidimensional impacts of inequities for Tangata Whaikaha Māori[30]

Te Puna Aonui – analysis disabled people[31]

Oranga Tamariki Disabled Children report[32]

Outcomes of Injury Study[33]

Government Policy Statement on Health 2024-2027[34]

ACC Research:

Living my life evaluation report[35]

Peer Support POC report[36]

Aide Memoire ACC's delivery to priority populations: Part 4 – Disabled people[37]

the impact of their disability on ACC entitlements
- Awareness of ACC entitlements can depend on carer(s) and/or medical professional(s) giving disabled people relevant information they can understand and knowing what questions to ask

change and avoid 'research fatigue' with disabled people
- Improve access to information and advice on health services, so that the system is easier to navigate; for example, by providing quality communication, translation and interpretation services

AC Scheme:

- Provide ACC information in a range of languages and alternate formats (such as easy-read and formats that are accessible for screen-readers)
- Produce plain-English, and other commonly spoken languages, picture-based, step-by-step resources suitable for people with intellectual impairments
- Build relationships with providers and NGOs who have experience working with disabled people to co-design interventions and programmes (for example, Living My Life).

- Work with health organisations, residential care facilities and vocational service providers to encourage injury reporting and the seeking of medical treatment and rehabilitation for injured people with intellectual impairments in their care
- Ensure all ACC staff are educated about disability, especially those in client-facing, policy, provider, and procurement roles
- Ensuring funding for interventions is ongoing and avoid 'pilot fatigue'

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