



5 July 2019

## Submission to the Medical Council of New Zealand

### Cultural Competence, Partnership and Health Equity – Consultation on Revised Documents

The New Zealand College of Public Health Medicine would like to thank the Medical Council of New Zealand (the Council) for the opportunity to provide feedback on the revised statements *Statement on cultural competence and the provision of culturally-safe care* and *Achieving best health outcomes for Māori: a resource*.

The New Zealand College of Public Health Medicine (the College) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 222 members, all of whom are medical doctors, including 185 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.

Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM partners to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

#### Background

The College recognises that compelling health inequities exist in New Zealand between Māori and non-Māori New Zealanders.<sup>1</sup> These inequities are large, pervasive, and persist across the lifespan and over time. Maori also experience a differential level of healthcare which contributes to already poor health outcomes in these groups.<sup>2,3,4</sup> The College is committed to a vision of a fair and just society where Māori and non-Māori have equitable health outcomes.<sup>5</sup>

We therefore support the Council in its mahi to strengthen the standards for doctors regarding the provision of culturally safe care.

#### General Comments

The College agrees with the Council that concepts evolve over time, and that a review of the Council's *Statement on cultural competence* is appropriate at this time.

We strongly support the adoption of a definition of cultural competence that focuses on critical consciousness, self-reflection and self-awareness, rather than on acquisition of knowledge about other cultures.

We consider that the Council could go further in embracing the concept and nomenclature of 'cultural safety': to the extent that the concept of cultural safety surpasses and incorporates that of cultural competence, we can see no reason why the specific use of the term 'cultural competence' in the Health Practitioners Competence Assurance Act (2003) should prevent the Council adopting the more suitable term.

We commend the Council for including a section on health equity in the revised Statement. We suggest

that the document could go further in specifying the need to attain health equity as a primary rationale for cultural competence / safety requirements.

## Consultation Questions

### **Draft Statement on cultural competence and the provision of culturally-safe care**

**1. Do you agree with the proposed definition of cultural competence (in paragraph 14 of the draft revised statement)? Do you have any suggestions on how the draft definition could be improved?**

Traditional understandings of cultural competence have taken a narrow approach in encouraging health professionals to learn about the cultural practices, beliefs and values of other ethnic groups.<sup>6</sup> The College recognises that there are dangers in adopting this simplistic approach: these include stereotyping and ‘othering’, and ignoring power differentials.<sup>6,7</sup>

The College supports the incorporation of the concept of cultural safety in the proposed definition. This extends beyond simply learning about cultural mores and requires ‘safe service’ to be defined by those who receive it. It is underpinned by the concept of critical consciousness, requiring doctors to reflect on their own assumptions, biases and values, shifting the gaze from self to others and to injustice in the world.<sup>6,8</sup> This reflexive analysis should acknowledge diversity in worldviews and include an understanding of how culture, values, norms and behaviours may affect interactions with others. Cultural safety also requires providers to undertake an analysis of the institutional and personal power relations operating in the context, and to negotiate power imbalances to ensure patients receive equitable and acceptable care.<sup>6</sup>

We note that the first line of the definition reads “*The requirement for doctors to examine the potential impact of their and their patients’ culture on clinical interactions and healthcare service delivery*”. We suggest that this line could be strengthened to include the requirement for doctors to ‘*examine the potential impact of their own culture, including biases, attitudes and assumptions, on healthcare and service delivery*’.

We note that the proposed definition has a strong focus on the practice of individual doctors. This is understandable in terms of Council’s role in regulating individual practice. However, since healthcare organisations play a key role in determining the systems and structures which either promote or prevent inequities in health outcomes, we suggest the inclusion of a responsibility for doctors to contribute towards the development of culturally-safe organisations.<sup>9</sup>

**2. Paragraph 15 of the statement specifically outlines the cultural competence standards Council expects of doctors. Do you agree with the proposed standards? What changes (if any) do you suggest could improve these draft standards?**

The College agrees with the proposed wording changes and amendments in paragraph 15. We support the use of strengthened language to describe the Council’s expectations with regard to the provision of culturally safe care.

In particular, we strongly support the proposal to replace the following words/phrases:

- 15. a. i. *willingness* with *responsibility*
- 15. a. iii. *preparedness* with *commitment*
- 15. a. iv. *willingness* with *responsibility*

15. b. ii. *awareness with acknowledgement*

15. b. iv. *understanding with respect*

15. c. i. *rapport with connections*

15. c. ii. *cultural issues with cultural factors important to the patient*

15. c. iii. *Use cultural information when making a diagnosis with Use cultural information and cultural differences when developing a diagnosis and formulating a treatment plan that responds to both the cultural preferences of the patient and the best clinical pathway*

**3. Please provide any feedback about the draft Statement on cultural competence and the provision of culturally-safe care that you think Council should consider.**

The College strongly support the inclusion of an equity rationale in the Statement and supports the Council's use of the Ministry of Health's definition of equity.<sup>10</sup> We further strongly support the acknowledgement of the principles of te Tiriti o Waitangi and recognition of the indigenous rights of Māori as key drivers behind the *Statement on cultural competence and the provision of culturally-safe care*.

The College considers the health equity rationale for cultural competency and culturally-safe care should refer also to Pacific peoples. In New Zealand, Pacific peoples are over-represented in poor health outcomes and health inequities<sup>11, 12</sup> and like Māori, receive a differential level of healthcare to non-Māori and non-Pacific people.<sup>13, 14</sup> There is compelling evidence that although Pacific people access the health system, have high enrolment rates with Primary Health Organisations, and have high attendance rates with General Practitioners, they do not achieve the same health outcomes as other groups.<sup>15</sup> As a Pacific nation, New Zealand has a responsibility to its region and to all Pacific peoples living in New Zealand. We suggest that, in the section on health equity, the Council also recognises this responsibility and the need to address inequities in health outcomes for Pacific peoples.

We note that the Statement provides standards for doctors in providing culturally-safe care to patients and their families/whānau. We suggest that these standards should apply also to doctors in their other professional roles: as leaders, managers, teachers and advocates.

**Draft Achieving Best Health Outcomes for Māori: a Resource**

**4. Paragraph 27 outlines how doctors and healthcare organisations can support the achievement of best health outcomes for Māori. Do you think this adequately captures the key points that should be included? What changes (if any) do you suggest could improve this guidance? and**

**5. Please provide any other feedback about the draft Achieving best health outcomes for Māori: a Resource that you think Council should consider.**

The College supports the revisions to the document previously titled *Statement on best practices when providing care to Māori patients and their whānau*. The new *Achieving best health outcomes for Māori: a resource* is consistent with the new *Statement on cultural competence and the provision of culturally-safe care* in taking the focus off cultural differences, and placing it onto critical consciousness, self-reflection and self-awareness.

We support the arguments set out for the rationale for addressing Māori health. The College is committed to a vision of a fair and just society where Māori and non-Māori have equitable health outcomes, and recognises that Māori, as the indigenous people of Aotearoa New Zealand, have unique rights under te Tiriti o Waitangi (the Treaty of Waitangi) and the United Nations Declaration on the Rights of Indigenous Peoples.<sup>4</sup>

The College supports the suggestions included in the section on *Guidance for doctors and healthcare organisations to support achieving Māori health equity* as providing useful information that can help doctors and their healthcare organisations in critical self-reflection processes. We note this is in paragraph 24 of the draft Resource document (not paragraph 27, which we cannot find), which states:

**“Guidance for doctors and healthcare organisations to support achieving Māori health equity**

24. Doctors and their associated healthcare organisations can support Māori health equity by:

- a. Demonstrating an awareness of Māori indigenous rights and current issues in relation to health and health equity.
- b. Responding to the Treaty-based requirement to deliver effective healthcare to Māori.
- c. Supporting healthcare organisations to formally identify and address structures and processes that limit Māori health development.
- d. Proactively develop policies to improve Māori participation and success at all levels.
- e. Engaging in, and showing evidence of transformation with respect to, culturally-safe practice that aligns to the Council’s Statement on Cultural competence and the provision of culturally-safe care.”

However, we suggest that 24.a. could be better framed as two points:

- Demonstrating a commitment to Māori indigenous rights and te Tiriti o Waitangi obligations; and
- Demonstrating a thorough awareness of issues in relation to health inequities in general, and specifically with regard to health inequities in the area of the doctor or health organisation’s practice.

Furthermore, the College considers that the medical profession can better support Māori health equity by also engaging Māori health organisations, governance groups and representative committees when inputting into public policy changes/development that may affect Māori; and (where welcome) by supporting Māori health organisations, governance groups and representative committee’s own efforts into policy input. This extends beyond individual practitioners and healthcare organisations, to include wider professional bodies – giving a clear role for Colleges, the Council and other organisations. In this context, the wording “healthcare organisations” would be better as “health organisations”.

We therefore recommend the wording for paragraph 24 be amended to (with changes in ~~strikethrough~~ and **yellow highlights**):

**Guidance for doctors and healthcare organisations to support achieving Māori health equity**

24. Doctors and their associated **professional bodies** and healthcare organisations can support Māori health equity by: ....

~~a. Demonstrating an awareness of Māori indigenous rights and current issues in relation to health and health equity.~~

**a. Demonstrating a commitment to Māori indigenous rights and te Tiriti o Waitangi obligations.**

**[new]. b. Demonstrating a thorough awareness of issues in relation to health inequalities in general, and specifically with regard to health inequities in the area of the doctor or health organisation’s practice.**

**[renumbered] c. Responding to the Treaty-based requirement to deliver effective healthcare to Māori.**

**[renumbered] d. Supporting healthcare organisations to formally identify and address structures and processes that limit Māori health development.**

**[renumbered] e. Proactively develop policies to improve Māori participation and success at all levels.**

[renumbered] f. Engaging in, and showing evidence of transformation with respect to, culturally-safe practice that aligns ~~to~~with the Council's *Statement on cultural competence and the provision of culturally-safe care*.

[new] g. Engaging Māori health organisations, governance groups and representative committees for input into public policy changes and development that may affect Māori.

[new] h. Supporting, as appropriate and asked for, Māori health organisations', governance groups' and representative committees' own efforts with public policy development that may affect Māori.

We also recommend tidying the references in this document, for example, with reference 1, World Health Organisation should be spelt with a 'z' as World Health Organization; with reference 13, "U. Nations, Editor" should be "United Nations".

Thank you for the opportunity for the NZCPHM to submit on the revised statements for consultation; *Statement on cultural competence and the provision of culturally-safe care* and *Achieving best health outcomes for Māori: a resource*. We hope our feedback is helpful and are happy to provide further clarification on matter covered in this submission.

Sincerely,



Dr Felicity Dumble, President, NZCPHM

## References

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