



Te Kaunihera Rata  
o Aotearoa  
**Medical Council  
of New Zealand**



**23 October 2020**

## **Cultural Safety Baseline Data Report Release and Recommendations**

*Tēnā koutou katoa - kua takoto te manuka, ka mau te wero*

The Medical Council of New Zealand, in partnership with Te Ohu Rata O Aotearoa (Te ORA), is pleased to release an independent report outlining findings of the current state of cultural safety and health equity delivered by doctors practicing in Aotearoa New Zealand and experienced by patients and whānau.

Māori patients' experiences are the focus of the report, however many of the challenges and solutions will be applicable to other ethnic groups and populations who experience inequitable healthcare.

The report forms the baseline from which a wider evaluation will be undertaken on a range of initiatives in a joint work programme between the Council and Te ORA. The programme aims to contribute to achieving equity in healthcare through developing the practise of doctors and improving how patients experience their care.

The initiatives look at how to embed practices such as self-reflection, create an understanding of a doctor's own conscious and unconscious biases, and consider how these impact on the doctor-patient relationship. Other initiatives include increasing the number of, and support for, Māori doctors, and ensuring Māori are in governance and decision-making roles in health organisations. The aim is to transform the workforce and the profession, as well as the systems we work within, to contribute to achieving health equity.

While this report offers an insight into current practice, it is only the first step on this long journey. It sets a baseline for ourselves and other health organisations to use when developing programmes, strategy and policy that supports the aim of achieving health equity.

We strongly encourage those working across the health and disability sector to draw on the following general suggestions, gathered from the key themes in the report's findings, for their own journey of change and improvement.

### **Findings and Recommendations:**

#### **Acknowledging systemic racism**

It is important to firstly acknowledge that systemic racism and privilege exists in the health sector in order to meaningfully address this problem. The report found that while most doctors were aware of the health context for Māori, including colonisation and how it impacted on health outcomes, some described difficulty in addressing this in their practice and the system they worked in. Doctors who worked in settings where they dealt with large numbers of Māori patients living in high deprivation were particularly aware of the impacts of colonisation and described an awareness of the deep-seated nature of inequity, its complexity and how this may impact patient choices.

Some doctors had an awareness that patients may come from a context that does not help them to engage with health professionals or with the treatment prescribed, and that there were systemic issues underpinning this.

Thought must be given as to what needs to change and how this can be supported across organisations and within communities. Doctors can reflect on their own cultural views and biases as a first step, then work to influence and support the places they work in and those they interact with, to make positive change.

### **Structural barriers exist in the medical system**

There is a need to reconsider short consultation and appointment times, and the focus on only the immediate presenting needs, which limits the ability to build relationships and partner with Māori and can create situations where biases are more likely to be expressed. This results in a relationship which is largely transactional and does not incorporate principles of whanaungatanga, te whare tapa whā and whānau ora.

### **Getting to know the person and their context**

Many whānau feel disempowered, that their knowledge is underestimated and that they are not involved in decision making. This leads to whānau feeling distanced from both the doctor and healthcare and distanced from their own health. Tailoring the consultation to the individual can help, while also ensuring their input is respected and valued.

### **Including wairuatanga in health care**

It was strongly expressed that health care providers need to consider the specific practices, values and beliefs associated with an individual's connection to people and place, and include this in the caring of whānau Māori.

### **Recognise the additional cultural loading on doctors who identify as Māori**

The report confirms that many Māori doctors experience additional cultural demands on top of their day to day work, as well as responsibilities from their own whānau, hapū or iwi or advisory roles in the wider community. There is little evidence of cultural activities and training of others being acknowledged and recognised in job descriptions or as a key element of professional development.

### **Workforce recruitment strategies**

Recruitment strategies in some District Health Boards and Primary Healthcare Organisations aim to increase the number of Māori doctors, many with set targets to achieve parity with their local population. Some DHBs have specific strategies to ensure that Māori values are at the centre of the recruitment process. This is encouraged across the health sector.

### **Partnerships with Māori**

Low Māori representation in governance requires those in governance to be bold and courageous about highlighting issues for Māori. There have been some successes, but these require considerable effort and assertiveness on the part of individuals, and risks Māori perspectives being overlooked and ignored. There was a strong feeling of the need for strengthening Māori participation in decision making, and in support of such partnerships as an expression of the Treaty of Waitangi.

### **Collection and use of robust ethnicity data for equity monitoring**

Organisations and individual practitioners need accurate data to identify inequities and address the structures and processes that limit Māori health development. We recommend that the collection of these data are prioritised and available to doctors and health organisations responsible for service provision.

### **Prompting doctors to focus on self-reflection and culturally-safe practice**

The extent to which doctors engage in self-reflection, consider how their own cultural view and biases impact on how their patients receive their care, and then adjust their practice, depends heavily on doctor self-motivation to make change. Initiatives to embed cultural safety into all aspects of practice, professional development activities, policies and processes are essential.

### **Support your team to acknowledge the privilege Pākehā receive in their healthcare and consider what they can do to address underprivilege for Māori as vital to achieve health equity**

On almost all indicators, non-Māori (predominantly Pākehā) experience significantly better health outcomes than Māori. Achieving equity of health outcomes in Aotearoa New Zealand requires first that we acknowledge that current inequities are not acceptable, that we understand better what is contributing to that inequity, and the health and disability system becomes more determined to operate differently so that inequities are addressed.

It is a professional obligation to deliver health care equitably to all. We encourage you and your organisation to use these recommendations as a basis for achieving long term, positive change for the benefit of all patients and whānau.

Heoi te kupu,  
Noho ora mai rā tātou,



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# Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives

**FINAL REPORT**

**23 OCTOBER 2020**



Te Kaunihera  
Rata o  
Aotearoa

**Medical  
Council of  
New Zealand**



ALLEN+CLARKE

## IDI Disclaimer

The results in this report are not official statistics. They have been created for research purposes from the Integrated Data Infrastructure (IDI), managed by Statistics New Zealand. The opinions, findings, recommendations, and conclusions expressed in this report are those of the authors, not Statistics NZ or the Medical Council of New Zealand. Access to the anonymised data used in this study was provided by Statistics NZ under the security and confidentiality provisions of the Statistics Act 1975. Only people authorised by the Statistics Act 1975 are allowed to see data about a particular person, household, business, or organisation, and the results in this report, have been confidentialised to protect these groups from identification and to keep their data safe. Careful consideration has been given to the privacy, security, and confidentiality issues associated with using administrative and survey data in the IDI. Further detail can be found in the Privacy impact assessment for the Integrated Data Infrastructure available from [www.stats.govt.nz](http://www.stats.govt.nz).

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## EXECUTIVE SUMMARY

This report provides findings from research undertaken to capture a baseline of the current state of cultural safety in the practice of doctors in Aotearoa New Zealand (Aotearoa), and the cultural safety of patients – specifically those who identify as Māori – receiving health services from those doctors. The key findings are as follows.

### ***Undergraduate medical education is performing well in teaching doctors the fundamentals of culturally safe practice***

Providers of undergraduate medical education in Aotearoa have made efforts to ensure that their undergraduate medical education programme equips doctors to practice in a culturally safe way. Students are taught hauora Māori, tikanga, and te reo through immersed, integrated, and independent learning. The curriculum at both schools is designed to teach students to be aware of power dynamics and embed a culture of ongoing self-reflection and practice development.

Graduates are familiar with Māori models engagement, including the Hui Process and Meihana Model, and have been provided opportunities to practice these. Doctors that had recently graduated reported that these components of medical education had provided a solid theoretical grounding in the foundation of hauora Māori, tikanga Māori, and te reo Māori.

### ***Prevocational and vocational training programmes vary in the extent to which they focus on cultural safety***

While providers of these training programme (DHBs and Medical Colleges) are accredited by the Medical Council as meeting set standards, in practice the extent to which their programmes focus on cultural safety is variable. This variability is due to the extent to which senior supervising doctors recognise the importance of culturally safe practice, level of exposure to practice with ethnically diverse populations, and pressures to focus on clinical competencies. Training is often delivered in time-pressured work environments that leave little time for critical reflection.

Prevocational and vocational training processes do not currently include mechanisms to support doctors to enhance their skills and knowledge in hauora Māori, tikanga Māori, and te reo Māori.

### ***Recertification processes do not include adequate mechanisms to prompt doctors to focus on culturally safe practice***

Recertification providers have attempted to mandate or incentivise doctors to undertake CME in cultural safety, by mandating the completion of points in cultural safety or assigning higher credits to relevant CME modules. Despite this, the extent to which doctors engage in the training and change practice depends heavily on self-motivation. It is possible to meet recertification requirements with little genuine change in practice related to cultural safety.

### ***While doctors are trained to undertake critical reflection on their practice, the onus is on the doctor to focus on cultural safety***

Many doctors reported that they choose to focus their reflections on clinical or technical aspects of their practice. Those that did undertake critical reflection on cultural safety valued peer group discussion related to their engagement with patients, reflecting on what had gone well and what could have gone better.

### ***Workplaces are offering a range of training, but uptake from doctors is low***

Most DHBs and PHOs that participated in the research offered training in Te Tiriti o Waitangi and/or engaging with Māori. Despite this training being compulsory at some entities, uptake of these courses by doctors is low – often around 30% of the doctor workforce. This was mainly due to the time pressures of clinical work, but also a lack of recognition amongst some doctors about the value of this training.

### ***Most doctors can speak basic greetings in te reo Māori and have an understanding of tikanga***

The majority of doctors have the ability to speak basic reo greetings and have some awareness of tikanga Māori and models of health. However, only about half of these doctors reported that they regularly use reo when consulting with Māori patients. Nearly all doctors had awareness of tapu, such as ensuring that they ask first before touching the head and explaining why they need to do so. Most were also familiar with tapu around bodily fluids, and tikanga related to death.

### ***Structural barriers in the Western medical system limit doctor ability to build relationships and partner with Māori in their healthcare***

Doctors struggled to develop a relationship with whānau Māori due to the short consultation times, pressures to focus on clinical outcomes, and practice models that worked on a ‘first doctor available’ model. Even doctors that have a strong understanding of Māori models of health and were attempting to provide care that aligned with this described a tendency of focus on the physical aspects of health as these were the immediate presenting needs. Doctors interviewed for this research typically had a theoretical understanding of power dynamics, but most did not have any specific strategies to address power dynamics during consultations and struggled to move beyond a relationship which was largely transactional.

### ***Recruitment and retention of Māori doctors requires a strategic approach***

In recent years, both Otago and Auckland universities have achieved proportionality of approximately 15-16% of medical graduates who identify as Māori. However, DHBs and PHOs struggle to recruit and retain Māori doctors. Strategies such as the Pūkawakawa programme in Northland have had some success in increasing Māori doctor participation in the workforce.

### ***Māori doctors experience cultural loading in the workplace***

Māori doctors reported facing demands from responsibilities in their own whānau, hapū, or iwi, or advisory roles in the wider community, as well as being seen as the ‘go to’ expert in Māori culture in their workplace. This combination of assumed responsibilities and pressures, both internal and external to the place of work, places a considerable cultural load on Māori doctors. Peer support networks are important to provide a safe space for Māori doctors to air concerns and find solutions to their own experiences.

### ***Changes are needed to make workplaces to be culturally inclusive for Māori doctors***

This could include simple changes, such as the use of reo in handover meetings, to foster cultural inclusivity. More substantial changes are needed to attenuate the competitive environment in some specialisations, that anecdotally is deterring some Māori doctors from entering these professions.

It was felt that open acknowledgement of systemic racism is required, that it is important to acknowledge this as a truth and start believing it in order to meaningfully address the problem.

Participants described the need to build strong legislation that directs efforts and resources into addressing the outcomes.

### ***Whānau do not have adequate opportunities for whakawhanaungatanga with their doctors***

Many whānau interviewed for this research feel like they get pushed through the system and get a different doctor every time who doesn't know who they are or anything about the whānau. This leads to whānau feeling distanced from both the doctor and healthcare and distanced from their own health. Doctors often talk to the patient indirectly, which can feel like the doctor is talking 'through' them instead of to them. Whānau who attended a Māori provider had a more positive experience, with time taken to connect with patients who feel listened to and generally much happier with their healthcare.

### ***Whānau had experiences of feeling side-lined in their healthcare and their knowledge underestimated***

The nature of a consultation is largely dependent on the individual doctor. Whānau related that some will listen to a certain degree, but sometimes they just focus on the immediate symptoms and not what else is going on, so "listening, but not really."

Many whānau feel disempowered: that they are not involved in decision making around their health; and that they are more 'told' by the doctor of what they should do. They are simply provided with the solution, and it is not always a solution to the cause, just to the symptoms.

Patients often feel that their own 'gut feeling' of what is right for themselves or their tamariki has not been heard, and then experience further frustration when their gut feelings proved correct after all.

### ***Patients mostly felt that whānau were welcomed into consultations***

Whānau particularly felt welcomed in primary care, although there were also positive examples from the secondary and tertiary sectors. Patients have taken tamariki along to consults and felt they were welcomed, with toys and activities provided to keep them entertained. The psychiatrist that one patient visits always offers to include other whānau. Another participant described being in hospital with her son around the clock and feeling very supported by staff and very involved in her child's care.

### ***Whānau considered that the system follows a biomedical model of health***

Whānau felt that the Māori worldview does not come into consultations, that there is still a very individual focus, whereas many Māori think and operate as a collective, as a whānau. There is no time for anything other than the immediate issue for presentation, and no investigation by medical professionals into aspects other than physical symptoms.

The need to include wairuatanga in health care was strongly expressed, and that medical practitioners need to consider the specific practices, values, and beliefs associated with an individual's connection to people and place; and include this in the caring of whānau Māori.

### ***Non-Māori experience Ambulatory Sensitive Hospitalisations, adverse perioperative outcomes, and death from all causes at lower rates than Māori***

Our analysis of health equity data shows that non-Māori experience health privilege. ASH rates for non-Māori are approximately two thirds of the rate of Māori. On average, the death rate for non-Māori within 30 days of major surgery is 40% lower than for Māori. For all-cause mortality, non-Māori group died at approximately half the rate of Māori during the period of analysis.

There was little difference observed between the non-Māori and Māori groups in any dispensing of urate-lowering therapy for gout. However, continuous long-term therapy is essential for efficacy of treatment, and non-Māori are more likely than Māori to be regularly dispensed urate-lowering therapy over the course of a year.

Non-Māori have lower rates of both hospital admissions and repeat hospitalisations for asthma than Māori. Rates of asthma medication dispensing following hospitalisation were low for both Māori and non-Māori. Non-Māori were more likely than Māori to receive an influenza vaccine as part of their preventative care.<sup>1</sup>

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<sup>1</sup> <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/asthma/>

## **1. BACKGROUND TO THE RESEARCH**

This report presents findings of research undertaken to capture a baseline of the current state of cultural safety in the practice of doctors in Aotearoa New Zealand (Aotearoa), and the cultural safety of patients – specifically those who identify as Māori – receiving health services from those doctors.

### **1.1. The Cultural Safety, Partnership and Health Equity Initiatives**

The Medical Council of New Zealand (Medical Council) and Te Ohu Rata o Aotearoa (Te ORA) have embarked on the Cultural Safety, Partnership and Health Equity Initiatives, a programme aimed at reducing the health disparities and inequities that exist between Māori and Pākehā in Aotearoa. The initiatives have multiple aims.

- Improved understanding for doctors of how to imbed cultural safety into everyday practice.
- Improved clarity (for doctors, medical colleges, and employers) on the required standards of cultural safety and mechanisms for assessment.
- Improved cultural safety for patients.
- Improved understanding of the outcomes of care and the causes of health inequities.
- Increased number of Māori doctors entering and completing vocational training (the long-term goal is, at a minimum, demographic proportionality).
- Increased Māori participation, and visibility of that participation, in governance and decision making.
- Increased recognition and support for Māori doctors who experience additional demands as a result of their cultural identity.
- Improved cultural safety at undergraduate level through coordination with the universities.

Overall, the programme is aimed at supporting the improvement of health outcomes for Māori.

### **1.2. Research purpose**

To understand the effectiveness of the initiatives, the Medical Council and Te ORA are evaluating the Cultural Safety, Partnership and Health Equity work programme.

Phase 1 of the evaluation (this research) is intended to document the current state or baseline of cultural safety in the practice of doctors in Aotearoa, as well as the cultural safety of whānau Māori receiving health services from those doctors.

The purpose of this research is to capture, analyse, and report data to establish:

1. the current status of cultural safety of patients receiving healthcare services in Aotearoa, and
2. the current status of doctors' ability, attitudes, approaches and practices related to cultural safety in healthcare in Aotearoa.

The research is intended to inform Phase 2 of the evaluation, under which the analyses can be re-run to assess the effectiveness of the Cultural Safety, Partnership and Health Equity work programme in enhancing cultural safety in doctors' practice.

## 2. DEFINITION OF CULTURAL SAFETY

The research has used the Medical Council's definition of cultural safety, as provided in the Statement on cultural safety (2019):

*The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.*

*The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.*

*The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.*

This definition has framed the development of the research team's description and conclusions related to the current status of doctor contribution to an environment of cultural safety in healthcare in Aotearoa.

## 3. METHODOLOGY

### 3.1. Mahi tahi

The research team's approach to the capture of baseline data was informed by the principle of mahi tahi. Mahi tahi denotes meaningful collaboration and togetherness in any project or endeavour and is based on the bicultural partnership established between Māori, as tangata whenua, and the Crown, in 1840.

In implementing the research, the mahi tahi approach meant that the team was co-led by Māori and Pākehā researchers. The research indicator framework, all data collection tools, and this report have been developed collaboratively, with the co-leads taking responsibility for ensuring the integrity of mahi tahi is retained.

The team has worked in a participatory way with the Medical Council and Te ORA, collaborating to develop the research framework and holding a 'sense making session' to discuss the emerging findings.

The team also convened a whānau reference group of Māori health consumers, that the team met with at two key points: firstly to test the appropriateness of the proposed data collection methods and tools; and secondly to 'reality check' the team's interpretation of the research findings.

This report has been written to prioritise the voices of whānau Māori, and to uphold the validity and integrity of their experiences.

### 3.2. Ngā mātāpono – values and philosophies

The project is underpinned by the following key values. These values have informed the development of the indicators and measures framework (see Appendix A) and have guided the collection and analysis of data during the research. The findings reported under each research question have also been considered and summarised in terms of their alignment with ngā mātāpono.

- **Tino rangatiratanga** refers to Māori self-determination over health, acknowledging that Māori are experts on their own health and wellbeing and allowing for Māori patients and whānau appropriate decision-making power in consultations, throughout their health journey, and also that Māori have decision-making representation in the health system.
- **Manaakitanga** refers to the care, protection, and support of Māori patients and whānau, and of Māori doctors in the health system. It requires that doctors are culturally competent and equipped to provide culturally safe care to Māori. Manaakitanga promotes behaviour that acknowledges that the mana of others is equal to or greater than one's own, therefore interactions with Māori patients and whānau must be mana-enhancing.
- **Pūkengatanga** refers to the pursuit of excellence with regards to the skills, expertise and knowledge of the doctor and commitment to deep self-reflection, ongoing development of critical consciousness, and lifelong learning, particularly with regards to cultural safety, hauora Māori, reo, and tikanga.
- **Whanaungatanga** refers to the development and maintenance of respectful, reciprocal relationships with Māori patients and whānau, and Māori communities. Whanaungatanga is also required for interactions within the medical profession, and the development of effective intersectoral and community relationships.
- **Ōritetanga** refers to Crown obligations of health equity, as expressed in Te Tiriti o Waitangi (Article 3 in particular), and specifically equitable access to appropriate, timely health care for Māori as Treaty partners.
- **Wairuatanga** refers to whānau Māori prioritising connectedness to people, place, and tupuna, and the recognition that this is integral to the understanding of whānau wellbeing. The values, beliefs and practices of wairuatanga are an essential element of health and wellbeing for Māori patients.

### 3.3. Key research questions

The research sought to answer five key questions.

1. What is the current status of doctor contribution to an environment of cultural safety in healthcare in Aotearoa?
2. What is the current status of doctor contribution to an environment of cultural safety for Māori patients and whānau in Aotearoa?
3. What is the current status of Māori doctors' experiences of cultural safety amongst their non-Māori colleagues?
4. What is the current experience of cultural safety amongst Māori receiving health care from doctors?
5. What is the current status of Māori health equity, that is, the current status of health outcomes for Māori compared with non-Māori?

### 3.4. Framework of indicators and measures

The research was framed by collecting data against a series of indicators and measures which sought to identify what cultural safety 'looks like' in the context of doctor practice and patient care for the purposes of this project. The indicators and measures included in the framework were informed by a document and literature review.

The framework of indicators and measures is provided in Appendix A, which also includes core value(s)/mātāpono associated with each indicator, the data source, data collection method, and any notes on relevant contextual factors.

### 3.5. Methods used for the research

A summary of the data collection methods used in the research is provided below. The research team has completed the following activities.

- A **review of 28 works of academic and grey literature** on the definition and measurement of cultural safety in the health sector. The review prioritised literature from Aotearoa, but also considered literature from other relevant jurisdictions including Australia, Canada, and the USA.
- **Context-setting interviews** with 14 representatives from relevant national organisations including MCNZ, Health Workforce New Zealand, the Health Quality and Safety Commission, the Council of Medical Colleges, Otago Medical School and Auckland University School of Medicine.
- An **email survey of DHBs** to obtain information on the representation of Māori on governance groups and committees, requirements for cultural safety training, and organisational policies to support cultural safety. The survey achieved a response rate of 70%.
- **Qualitative semi-structured interviews** in four DHBs: Northland, Counties Manukau, Bay of Plenty and Canterbury. These DHBs were selected to include regions with high Māori populations, urban and rural populations, and a South Island region. Research participants included:
  - DHB and PHO representatives (n=22)
  - Doctors (n=29)
  - Whānau Māori (n=34)
  - Other (including practice managers, equity leads) (n=5)
- A **poster installation** at sites such as whare wānanga, marae, libraries and community centres. Whānau were invited to write or draw responses to questions on how they experience going to the doctor.
- **Analysis of risk-adjusted patient outcomes** comparing non-Māori and Māori. Analysis was carried out in the Integrated Data Infrastructure (IDI) with the intention that future evaluators will be able to easily replicate this work with additional years of data in order to evaluate the impact of the Medical Council's cultural safety initiatives. The report presents analyses of three key indicators of health equity (ambulatory sensitive hospitalisations, all-cause mortality, and access to pharmaceuticals). Additional detailed analyses relating to key mortality and hospitalisation sub-categories are provided in Appendix B.

### 3.6. Reporting of doctor views on cultural safety

Given that the intent of the research is to document the current status of doctor contribution to an environment of cultural safety in healthcare in Aotearoa, the findings provided in section 4 have been written descriptively. This aims to capture the voice of those who participated in the research without comment or critique. This means that some of the quotes and reported perceptions from doctors may

be inflammatory or offensive to some readers. The research team does not endorse these views; the intent is to reflect the full spectrum of doctors' views as accurately as possible.

### 3.7. Strengths and limitations

The following key strengths of the evaluation approach and methodology have been identified.

- Our co-leadership approach, through mahi tahi, ensures that data collection, analysis and interpretation incorporate both Māori and Pākehā perspectives. This is particularly important given the project's focus.
- Our approach uses evidence and feedback from a variety of sources, particularly emphasising context-rich, qualitative information from a range of stakeholders at the national level and regional levels, and from those delivering and receiving care, allowing for contrasting of perspectives.
- The measures framework (Appendix A) has allowed the research team to identify, define, and justify indicators of cultural safety. The framework has provided a basis against which the responses of different stakeholders has been compared and upon which the team has built conclusions about the current state of doctor provision of culturally safe care and whānau experience of cultural safety.
- Having a whānau reference group ensured both the way the research was conducted, and the findings we identified, are framed and grounded within the experience of end-users of the health system.

The following limitations of the evaluation approach have been identified.

- The measures of health equity (research question 5) are useful for providing a baseline of the current state of Māori and non-Māori health outcomes but will have limited use in terms of showing the impact of the Medical Council's cultural safety initiatives over time. Multiple complex factors contribute to inequities, and it will not be possible to attribute any difference to changes in the cultural safety of patients. The time lag required for any improvements in cultural safety means changes are unlikely to be reflected in statistical data on inequities within the timeframe of the evaluation.
- The findings from the qualitative interviews with doctors and patients provide data only on the perspectives of those interviewees: the findings are not generalisable to the entire population of doctors and Māori users of the health system. Those interviewed were selected to represent a range of characteristics (e.g., ethnicity, location). This strengthens the relevance of the findings, but nonetheless those engaged are only a very small portion of these populations.
- Qualitative data collection is limited in its ability to act as a 'baseline', as post-initiative measurement is unlikely to engage with the same people. However, subsequent fieldwork visits to the same DHB regions may be able to document broad changes in perspective from participant groups.
- Some participants, particularly doctors, are likely to have an interest in presenting themselves as culturally competent. Self-reported data is vulnerable to biases such as social desirability bias. An unbiased perspective will be difficult to capture from engagement with doctors almost by definition. In the conclusion section, the data from doctors has been compared with data from patients, to provide a more balanced perspective.



## 4. RESEARCH FINDINGS

### 4.1. Question 1: What is the current status of doctor contribution to an environment of cultural safety in healthcare in Aotearoa?

*Research question 1 was underpinned by the following values.*

- *Manaakitanga: doctors deliver culturally safe care and validate the cultural context in which patients operate in relation to their health, including their beliefs, values and experiences. Doctors are supported to provide culturally safe practice through education, training, appropriate resourcing and ongoing professional development.*
- *Pūkengatanga: Doctors develop a critical consciousness through ongoing reflection and improvement on their own attitudes, values, biases, preferences, and power dynamics in patient interactions.*

#### 4.1.1. Undergraduate medical education

##### ***Undergraduate medical education has a strong focus on teaching cultural safety***

The University of Auckland School of Medicine and the University of Otago Medical School have made deliberate efforts to ensure that their undergraduate medical education programmes equip doctors to practice in a culturally safe way. The curriculum at both schools includes a specific focus on patient engagement, the development of critical consciousness, a commitment to ongoing reflection, and an awareness of power dynamics.

Representatives from Auckland and Otago Medical Schools stated that there was a deliberate move away teaching cultural competence as a specific set of skills that can be ‘learned’ (which research shows does not contribute to making people more adept at working with people from varied backgrounds), to building a culture of ongoing self-reflection and practice development. As such, the bulk of undergraduate education in culturally safe practice is integrated into the curriculum. For example, students are taught how to apply models of care which reduce power imbalance within clinical interactions, such as when taking a patient history or conducting a physical examination. In the latter years of their undergraduate education (years 5 and 6), doctors are taught skills to undertake independent learning and development. For example, University of Auckland medical students are expected to develop a ‘personal learning plan’ which encourages them to reflect on their learning and professional practice, identify areas for development, and create a plan to fill these gaps. This is intended as a precursor to their professional development plan.

##### ***Recently graduated doctors considered their undergraduate education provided a solid grounding in culturally safe practice***

Interviews with doctors that had graduated from New Zealand medical schools suggested that the effectiveness of cultural safety education had improved over time. Doctors that had completed their undergraduate medical education prior to 1990 reported that their education had included very little or no cultural safety components (or that they could not recall any).

Those that had graduated from 1990 to 2005 typically reported that they had experienced some exposure to the concept of cultural competence, and that aspects of cultural safety were embedded into modules such as communication skills. This was generally described as a ‘light touch’ or ‘add on’ rather than a core component of undergraduate education.

Doctors that had recently graduated (since 2005) reported a much more comprehensive and integrated focus on cultural safety. Doctors stated that they had received a theoretical grounding in the foundations of culturally safe practice and opportunity to practice these skills.

*I started [medical school] with the idea that being a good doctor was all about the clinical aspects of practice. What I've learned is that all those other aspects, like how you communicate and your biases... that's what makes an effective doctor.*

- Doctor, graduated 2016 (Pākehā)

Doctors that had trained in overseas medical schools reported a variable focus on cultural safety. About half of these doctors stated that they had received very little or no training related to cultural safety as part of their undergraduate medical education. Others stated that they had received some education on topics such as communicating across cultures and holistic healthcare models. Many of the overseas-trained doctors interviewed for this research were educated in the United Kingdom (UK) and noted that discussions of cultural safety focused on multiculturalism. It came as a surprise to many that culturally safe practice in the Aotearoa context was mainly focused on practice with Māori.

#### **4.1.2. Prevocational training**

##### ***Cultural safety is embedded in the prevocational training curriculum***

In Aotearoa prevocational training requires graduate doctors to obtain a position at a DHB that has been accredited by the Medical Council as a training provider. The training programme is two years and includes a series of clinical attachments, developing and executing a professional development plan, and achieving the learning outcomes in the New Zealand Curriculum Framework for Prevocational Medical Training (NZCF).

The NZCF includes a focus on cultural safety under two of its five domains: Professionalism, and Communication. Broadly, the Professionalism domain includes requirements for students to demonstrate awareness of the beliefs and knowledge of commonly encountered cultural groups, communicate effectively with these groups, and be aware of their own cultural values. The curriculum currently refers to these skills as aspects of 'cultural competence' but representatives from the Medical Council stated that this will be amended to 'cultural safety' during the next curriculum review. The Professionalism domain of the NZCF also includes a set of competencies related to engaging with Māori patients and their whānau. This is discussed under section 4.2.2.

The Communication domain also includes aspects of doctor practice that are integral to the provision of culturally safe care, including ensuring that whānau are included in decision making, and providing information in a way that patients and whānau understand.

In addition, Medical Council representatives stated an expectation that the training programme will include an immersed focus on culturally safe practice across all curriculum areas.

##### ***Prevocational training providers vary in the extent to which they focus on cultural safety***

While DHBs are accredited by the Medical Council to deliver the NZCF, the research found that variability in the extent to which prevocational training programmes focus on cultural safety. Representatives from the Medical Council, DHB and PHO personnel, and registered and intern doctors all noted that some DHBs are performing strongly in preparing doctors to deliver culturally safe care, whereas others place less emphasis on the cultural safety aspects of the training programme.

Interviews with intern doctors, those that had recently completed prevocational training, and DHB personnel suggest that this variability is due to the following inconsistencies.

- The extent to which key DHB personnel, including the Director of Clinical Training (or similar) and doctors acting as Prevocational Educational Supervisors (who oversee and mentor prevocational doctors) recognise the importance of culturally safe practice. Prevocational doctors reported that senior doctors often place greater emphasis on the development of clinical competencies and consequently, prevocational doctors felt pressure to make this the focus of their learning.
- The extent to which DHB prevocational training programmes are developed and delivered in conjunction with Māori and Pasifika health units or teams. This is discussed further in section 4.2.2.
- The extent to which trainees gain exposure to community health settings. Interviewees noted that some DHBs have a greater focus on supporting intern doctors to undertake community-based learning at sites that expose them to health and social issues such as poverty. Intern and recently graduated doctors who had undertaken prevocational training in DHBs in predominantly Pākehā communities stated that they had very little exposure to other population groups during their training.
- The extent to which prevocational doctors are provided time to engage in critical reflections. Two out of the four DHBs visited during this research have established mechanisms to support intern doctors to undertake reflection, such as peer group meetings at which issues such as bias and patient engagement are discussed. Doctors in the other two DHBs reported that their training took place in time-pressured work environments that left little time for critical reflection.

This variability meant that the doctors interviewed reported mixed experiences regarding the extent to which their prevocational training had equipped them to practice in a culturally safe way. About one third of the doctors interviewed stated that they considered their prevocational training provided adequate formal teaching and opportunities for independent learning related to cultural safety. The other two thirds considered that their prevocational training did not have as much focus on cultural safety as they would have liked, and that it was given less emphasis than during their undergraduate education.

*Cultural competence was a big focus at med school but seemed more like a standalone module in PG1 and 2. Kind of like 'that's done, now back to the clinical stuff'.*

- Doctor, completed prevocational training in 2015 (Pākehā)

#### **4.1.3. Vocational training**

##### ***Vocational training curricula current do not have a strong focus on cultural safety***

Vocational training for doctors is the mandate of Medical Colleges, which have the ability to confer specialist status on medical graduates. As with prevocational training, while the Colleges are accredited by the Medical Council to provide training, how they implement the training and the extent to which this focuses on cultural safety is variable.

Examination of a sample of vocational training curriculum documents from five Colleges found that all curricula include at least some competencies or standards related to cultural competence or cultural

safety. These are typically listed under domains such as Professionalism, Communication, and Ethics as skills or competencies that trainees must demonstrate.

Of the five vocational training curricula reviewed, the RNZCGP general practitioner curriculum included the most explicit focus on cultural safety. Culturally competent practice is enshrined as one of its core overarching curriculum principles. Cultural competence is embedded throughout each of its six domains (for example, the Professionalism domain includes a requirement to ‘demonstrate culturally competent behaviours in all aspects of practice’).

***The vocational training programme contains few mechanisms to ensure that doctors develop culturally safe practice skills***

Doctors interviewed for this research stated that in most specialisations there was little formal training on culturally safe practice. Doctors reported that courses, work-based assessments, and examinations tend to focus on clinical skills, and that content related to cultural safety is minimal.

*[Cultural safety] feels like an ‘add-on’ thing. If you’re motivated you can incorporate it, but it’d be pretty easy to get through the entire training with only a very surface touch on cultural competence.*

- Intern doctor, currently undertaking vocational training (Pākehā)

Doctors also noted that many of the Colleges cover Australasia and that cultural safety materials are not always relevant or specific to the Aotearoa context. Doctors would like to see the cultural safety aspects of their vocational training strengthened and expanded.

In particular, Māori doctors interviewed expressed disappointment that prevocational training did not align with the extent to which their undergraduate training had embedded cultural safety.

*It was pretty poor to be honest... I felt that the content of training was of lesser quality and depth than what we learned at undergraduate level.*

- Doctor, completed vocational training in 2017 (Māori)

Doctors reported that they found placements/rotations in hospitals or community practice posts useful as these offered the opportunity to interact with people from a range of cultures, ethnicities, and demographic groups. Learning was consolidated through reflective practice discussions with peers and mentors. However, doctors noted that there was a need for self-motivation and a desire to develop a culturally safe practice – the vocational training programme in and of itself does not contain adequate mechanisms to ensure that doctors develop this aspect of their practice.

The Council of Medical Colleges reported that the Colleges are becoming more aware of the need to provide training and support to doctors to practice in a culturally safe way. The Colleges have invested resource to enhance their capacity and capability to provide guidance and training in culturally safe practice. For example, most Colleges either have an equity plan or are in the process of developing one, although the stage of development is reported to be variable.

#### **4.1.4. Recertification processes**

***Recertification programmes have attempted to mandate or incentivise doctors to undertake CME in cultural safety***

Medical Colleges are responsible for the delivery of continuing professional development and recertification programmes for specialist medical practitioners. The Colleges have made efforts to better embed cultural safety into recertification processes. The Colleges have increased their offering of tools and resources to support doctors to upskill in cultural safety, including tools for practice review that focus on professionalism and ensure cultural safety is embedded, and online learning resources.

At present, the primary mechanism used by Colleges to enhance doctor cultural safety is through CME requirements. The research team examined CME requirements for five Colleges, of which one (the RNZCGPs) had made CME on cultural safety mandatory, implementing an annual requirement to undertake a minimum of two hours CME addressing cultural competence. Discussion with representatives from the Council of Medical Colleges noted that there was a reluctance in most Colleges to make CME on cultural safety mandatory. Some had assigned higher credits to relevant CME modules to incentivise uptake.

***Doctors consider that CME cultural safety training is of variable quality, and in itself not likely to change practice***

Doctors interviewed for this research noted that, while they were required or incentivised to undertake CME related to cultural safety, the extent to which this impacted or changed their practice relied on the motivation of the individual doctor.

*I see the full spectrum of doctors, some who have no interest or awareness in cultural competency, and then others who are heavily invested. You can focus your CME according to your interest... which is nil, for some docs.*

- DHB Māori Health Unit personnel

Some doctors described that CME process as 'box ticking', noting that, for example, credits can be gained through online courses with multichoice assessments that are relatively easy to pass. It was noted that it is possible to gain the prescribed CME points without changing practice.

Doctors also reported that a wide range of training opportunities were accredited as counting towards CME requirements, but that these were of variable quality.

*I went to a conference which had a session on cultural competence – it was okay, but not great. It didn't make me change anything. But this can tick off the CME requirements.*

- Doctor (Pākehā)

Some CME providers have made a deliberate effort to embed cultural safety across the training they deliver. For example, Pegasus PHO, which delivers CME to General Practitioners in the Canterbury region, has developed courses which apply an equity and cultural safety lens to every topic. The research team reviewed course materials for an upcoming course on Ageing Well, which included strands on the Māori and Pasifika perspective of ageing, and information on the impact of colonisation on ageing for Māori. Doctors who had attended these courses stated that they found the embedding of cultural safety into a range of CME topics useful.

Other aspects of the recertification process, including practice audits, peer or 360° reviews, structured conversations, and the development of a professional practice plan offer opportunities for doctors to reflect on and develop their practice in relation to cultural safety. However, doctors reported that the extent to which they focus on cultural safety as part of recertification relied heavily on their own motivation.

Doctors noted that if they were self-motivated to enhance their practice in this area, mechanisms such as the Regular Practice Review (RPR) provided a structured way of identifying areas to develop in their practice.

*I do find the audit review process useful as a prompt to think about how I am doing in terms of equity. It's actually been quite eye opening – I wasn't doing as well as I'd assumed.*

- Doctor (Pākehā)

#### **A substantial proportion of doctors reported that they focus CME on other aspects of practice**

About half the doctors interviewed for this research were sceptical about the value of focusing their continuing professional development on cultural safety and preferred to focus on other aspects of practice such as clinical competencies.

The research team notes that the Medical Council has recently reviewed its recertification requirements for vocationally registered doctors in Aotearoa. The recertification programme minimum requirements are now underpinned by cultural safety and a focus on health equity. Colleges have until 1 July 2022 to implement the new requirements.

#### **4.1.5. Mechanisms to prompt doctor critical reflection**

##### **Doctors undertake critical reflection on their practice, but this does not necessarily focus on cultural safety**

Doctors are trained to undertake critical reflection on their practice during their medical education, as part of their professional skills learning domain. As students progress through their degree they are encouraged to reflect on colonisation, power, inequity, and how they might be complicit in reproducing these inequities.

Once qualified, they are prompted to undertake critical reflection as part of the recertification process, through mechanisms such as their PDP, CPD and collegial practice visits. There are also periodic events run by parties such as the Health Quality and Safety Commission (HQSC), whose Patient Safety Week 2019 focused on implicit bias and was supported by online learning modules to support practitioner reflection on their practice.

Nearly all doctors interviewed stated that they undertake critical reflection, but this was not necessarily focused on cultural safety. The onus is on the doctor to choose to focus on aspects related to cultural safety, with many choosing to focus their reflections on clinical or technical aspects of their practice.

*I'm time poor and I find that [reflecting on culturally safe practice] doesn't add anything to being a good GP. I tend to focus reflections and development on my clinical skills.*

- Doctor (Pākehā)

##### **Peer group sessions and informal discussions with colleagues are valued as a way to reflect on cultural safety and bias**

Those that did undertake critical reflection on cultural safety typically did this through peer group discussion related to their engagement with patients, reflecting on what had gone well and what could have gone better. For example, an emergency department doctor stated that a colleague has created a CPD dinner at which doctors at all levels talk about topics such as bias. The dinner was described as

effective due to its face-to-face, comfortable environment, and being run by fellow doctors. A general practice conducts weekly peer group sessions at which doctors discuss situations they have faced, opportunities, things that could have done differently – and offers a chance to listen to others and help them. Doctors also highlighted the importance of informal discussions with other doctors (for example, tearoom discussions during breaks) as an opportunity to have reflective discussions with colleagues.

Doctors' critical reflection often focused on identifying their own biases and how this had impacted their practice. Some doctors used tools such as implicit bias tests to help identify biases and work to address these.

***Barriers to critical reflection on bias include discomfort with the topic and a lack of time***

Several doctors interviewed noted the discomfort and reluctance of some of their colleagues to discuss bias. A senior Māori doctor, who also held a teaching role, considered that the system does not adequately prompt doctors to confront bias.

*Sadly, it's very easy to get away with not being aware of bias. Some of the older doctors, from a certain generation, would be quite comfortable with never addressing their bias. People have to be open to the idea that they are not treating everyone the same, and some won't engage in that – many doctors are like that unfortunately.*

- Doctor (Māori)

Other barriers to critical reflection on cultural safety included a lack of time (critical reflection was described by one doctor as a 'luxury item') and, for some, a small number of patients from diverse cultural backgrounds, which meant that doctors don't necessarily see this as important.

It was noted that doctors can be prompted to engage in critical reflection on bias by focusing on the clinical implications of bias, and the potential to be more clinically impactful if bias is confronted. Those in teaching or mentoring roles also noted the importance of providing examples of their own biases.

*I emphasise self-reflection and give examples of my own. I can talk about my biases and describe this is how I nearly made a mistake – people can start discussing their bias out in the open. Many doctors are receptive to that kind of kōrero.*

- Doctor (Māori)

A small number of doctors described the uncomfortable realisation that they had been perpetuating bias and developing strategies to mitigate this.

*I do pre-judge people. If I ever catch myself treating patients differently, I think what would I do if this patient was a white judge from Howick.*

- Doctor (Pākehā)

Doctors that undertook critical reflection in relation to cultural safety in their practice described taking steps to strengthen their practice. This included using informal tools such as podcasts, and conversations with colleagues, patients, and community members, as well as formal learning resources, such as courses. For example, one UK-trained doctor described having a 'light bulb moment' when they had thought that they were inclusive to everyone – but realised actually it is not appropriate to treat everybody the same, and in doing so was not always connecting well with Māori patients. The doctor undertook some online research and later did a tikanga Māori course. This had

created awareness of how colonisation is a barrier to seeking medical attention and the doctor made an effort to engage with Māori in line with tikanga.

Other doctors stated that they considered that there was a lack of available and accessible resources to assist them to develop cultural safety skills, and that enabled them to undertake learning in a way that suited busy practice environments. The online courses run by Mauriora Associates were highlighted by several doctors as a particularly useful resource.

#### 4.2. Question 2: What is the current status of doctor contribution to an environment of cultural safety for Māori patients and whānau in Aotearoa?

*Research question 2 was underpinned by the following values.*

- *Pūkengatanga: medical education supports doctors in achieving cultural safety in care for Māori through inclusion and assessment of reo, tikanga, and hauora Māori in the curriculum, employers provide for ongoing skills development in these areas, and doctors undertake lifelong learning in reo, tikanga and hauora Māori.*
- *Manaakitanga: employers encourage and support cultural safety in practice with Māori. Doctors engage and communicate effectively with whānau Māori, apply an appropriate model of hauora, and draw on their own skills in reo, tikanga and hauora Māori in order to deliver culturally safe care to Māori patients and whānau.*

##### 4.2.1. Hauora Māori, tikanga Māori, and te reo Māori in undergraduate medical education

***Undergraduate medical education is equipping students with an understanding of the foundations of Māori models of health***

Auckland and Otago Medical Schools have included an explicit focus on hauora Māori in the curriculum. At both schools this is based on the '3 I' model, which incorporates:

- **immersed** learning - time that is designated for hauora Māori such as noho marae and classroom-based teaching on topics such as Treaty of Waitangi, Māori health models, and te reo Māori,
- **integrated** learning, in which hauora Māori is actively integrated into other parts of the curriculum, for example by teaching Māori perspectives on topics such as mental health, and
- **independent** learning, whereby students are supported to engage in self-directed learning and reflection related to hauora Māori.

The curriculum draws from a range of models include Te Whare Tapa Whā, the Meihana Model, and the Hui process. Students are taught the theoretic foundations of these models and how to apply these in a practice setting and are given opportunities to practice their application through role play and also in clinical placements. This includes learning opportunities within local Māori communities.

Learning also includes a focus on the context and determinants of Māori health, including the impacts of colonisation and racism, deconstruction of discourses about Māori health, and doctors' role in supporting Māori health advancement. Interviews with personnel from Otago and Auckland Medical Schools emphasised that the discussion is framed around equity and is carefully constructed to avoid deficit-based framing of Māori health.

*We emphasise that being Māori is not a risk factor to poor health, but a mark of exposure to risk factors.*

- *Medical school representative*

Both medical schools reported that students are taught te reo Māori and that this is tied to specific learning outcomes, such as the ability to give their pepeha and correctly pronounce te reo Māori words

that are common in a health context. Otago University has developed a mobile application, Aki Hauora, to support students to interactively learn health-focused reo.

Representatives from Auckland and Otago Universities reported that tikanga Māori is not taught as a specific course or module, but rather is woven through the curriculum and university processes. For example, tikanga is embedded into clinical practice sessions, in which students are expected to follow tikanga practices related to tapu of the body. Both universities also incorporate practices intended to normalise tikanga, such as having kaumātua attend to whakanoa cadavers, and laboratory coats (that may have touched bodily fluids) are cleaned onsite so that students don't need to take them home in their bag and risk them touching kai.

Both schools include hauora Māori, reo, and tikanga competencies as part of the student assessment process. This includes written assessments and practice examinations such as demonstrating the Hui process and Meihana model while undertaking patient history and a physical examination.

***Doctors are graduating medical school with an understanding of hauora Māori and a commitment to culturally safe practice with whānau***

Similar to the findings described in section 4.1.1, doctors that had graduated more recently reported that their undergraduate education had a stronger focus on hauora Māori, tikanga, and reo. Doctors that had graduated prior to 2005 typically reported that there was very minimal inclusion of hauora Māori, tikanga, and reo in their training, and that what they had received was tokenistic, not particularly useful, or deficit framed.

Interviews with doctors that had recently graduated reported a much more comprehensive and integrated focus on hauora Māori, tikanga, and reo. Doctors stated that they had received a theoretical grounding in the foundations of hauora Māori, colonisation and its impact on Māori health outcomes; hauora Māori models including an introduction to Te Whare Tapa Whā and the Meihana Model; and engaging effectively with Māori, particularly using the Hui process.

Several doctors highlighted marae visits as particularly useful for gaining exposure to tikanga Māori.

*One thing that sticks out, that we enjoyed, was the overnight marae visit. We had a powhiri and got a whole lot of education on Māori culture. It was an eye-opener for those of us who hadn't had much exposure [to tikanga] before... it sparked the desire to learn more.*

- Doctor (Pākehā, graduated in 2011)

Representatives from DHB Māori Health Units and PHO Hauora Māori staff also noted that they have seen improvements over time in the cultural awareness of newly graduated doctors.

*It has been good to watch how recent graduates come out with their reo and tikanga knowledge, and to see the huge change in the attitudes of medical doctors. I'm seeing a big difference and it gives me great hope for the future.*

- PHO hauora Māori advisor

***Medical schools are ensuring that Māori medical students are not experiencing cultural loading***

Māori doctors' views on the effectiveness of the curriculum also shifted depending on when they had graduated. Older Māori doctors tended to describe the provision of information as very Eurocentric and coming from a biomedical model, and that hauora Māori models with a more holistic view of health were presented as the 'other'. They also considered that health equity discussions were framed through a deficit lens.

*We were shown data presented by ethnicity, and repeatedly told that Māori had poorer health, but there was no structured plan about what to do about. I felt it was victim-blaming and it didn't do anything to make us feel confident that the non-Māori in our class were upskilled.*

- Doctor, graduated 1997 (Māori)

In contrast, Māori doctors who had graduated since 2005 reported that the curriculum discussed topics such as health equity, hauora Māori, and tikanga Māori in an informed and appropriate way, and that they did not feel pressure to be an expert or advocate of 'things Māori' (i.e. they did not experience cultural loading).

*I felt that tikanga was normalised and incorporated into the way that we were taught. It was a relief not to have to be the Māori voice in the room.*

- Doctor, graduated 2012 (Māori)

However, Māori doctors noted that while medical education had made positive strides in incorporating hauora Māori models of care, overall undergraduate education was delivered through a biomedical model which prioritises physical health and did not align well with Māori concepts of health and wellbeing.

#### **4.2.2. Hauora Māori, tikanga Māori, and te reo Māori in prevocational training**

##### ***The extent to which prevocational training providers emphasise hauora Māori and involve their Māori Health Unit staff in the programme is variable***

Learning outcomes for prevocational students related to culturally safe practice with Māori patients and their whānau are outlined in the Professionalism domain of the NZCF. Prevocational doctors are expected to be able to ask patients about their ethnic background, develop a rapport with Māori patients, demonstrate an awareness of the general beliefs, values, behaviours, and health practices of Māori, involve whānau, and be aware of health disparities that exist in Māori communities and their origins.

As was outlined in section 4.1.2, there is variability in the extent to which the DHBs which provide training emphasise the importance of training and assessing student doctor knowledge and practice of hauora Māori.

Some of the DHBs that participated in this research had developed and delivered their prevocational training programmes in partnership with their Māori Health Units or teams. For example, MidCentral DHB's prevocational teaching programme includes at least four formal teaching sessions focusing on a range of topics relevant to hauora Māori, cultural competency, bias in healthcare and equity, and te reo-focused activities during Te Wiki o te Reo Māori. Other DHBs offer periodic workshops on hauora Māori, community placements in areas with a high Māori population, and marae visits. Canterbury DHB has developed a pilot programme, tested in 2019, to run a series of practical workshops with intern doctors intended to provide tools to engage with Māori. The workshops focus on practical skills to better engage with Māori, for example encouraging use of te reo Māori greetings, focusing on

correct pronunciation, and an overview of tikanga in the hospital setting. The programme will be rolled out to all intern doctors at the DHB in 2020.

In other DHBs, Māori Health Unit personnel reported that the prevocational training programme was run largely without their involvement, and they described challenges in seeking to ensure a focus on hauora Māori.

*I haven't yet managed to crack it yet. I found who the coordinator was, and I have asked them about what they have in terms of cultural safety training but haven't actually had that info back from them.*

- DHB Māori Health Unit representative

***Intern doctors considered the prevocational training programme was limited in its focus on hauora Māori, tikanga and reo***

Several doctors commented that the formal training on hauora Māori through mechanisms such as workshops was often at a more basic level than they had received at undergraduate level.

Doctors reported that the most valuable aspect of prevocational training was the opportunity to interact with Māori patients and whānau in a clinical setting and put into practice their undergraduate learnings on Māori models of care (such as the Hui process and Meihana model). However, a barrier was that the intern doctors stated that they often had a greater knowledge of hauora Māori than the senior doctors they were working with, and in some cases felt reluctant to 'show up' senior doctors by questioning their practices with whānau Māori.

**4.2.3. Hauora Māori, tikanga Māori, and te reo Māori in vocational training**

***There is little in vocational training curricula that specifically focuses on cultural safety with Māori***

Interviews with Council of Medical College representatives and examination of a sample of vocational training curricula found that while there is some focus on cultural safety in general (as discussed in section 4.1.3) there is very little in the written curricula that specifically focuses on cultural safety with Māori. The exception is the RNZCGPs' curriculum, which includes recognition of the status of Te Tiriti o Waitangi and highlights the importance of culturally competent practice with Māori and reducing Māori and non-Māori disparities in health outcomes.

There is evidence that some Colleges have established structures to support their trainees to develop cultural safety with Māori. The Royal Australasian College of Physicians has a Māori Health Committee, established in 2007, whose functions include "assisting in the education and training of physicians and paediatricians in facilitating their understanding, knowledge and skills when dealing with Māori patients" (RACP Māori Health Committee terms of reference).

The College of Emergency Medicine launched its Manaaki Mana strategy in 2019, which includes action points to create a kete of resources for all emergency medicine trainees, provide trainees with regular te reo and tikanga training, and ensure the College's training programme has robust mechanisms in place to assess the cultural competence of trainees. Doctors that practiced emergency medicine were positive about the potential impact of this strategy but noted that it was in its early stages of implementation and that little change to the vocational training programme had happened to date.

***Doctors considered that interacting with Māori patients and staff was useful in developing their practice with whānau***

Current trainees and those who had recently completed vocational training stated that the most valuable means of enhancing their ability to practice in a culturally safe way with whānau Māori was through doing placements in hospitals or practices with Māori patients and staff.

*Interacting directly with Māori patients and getting to know the Māori staff was way more valuable than the formal education. It taught me to be aware of Māori history and how to build relationships. It definitely influenced my practice.*

- Doctor, completed vocational training 2011 (Pākehā)

#### **4.2.4. DHB/PHO training to support culturally safe practice with Māori**

##### ***DHBs and PHOs offer training in Te Tiriti o Waitangi and Engaging with Māori***

There is variability regarding DHB and PHO expectations regarding the type and duration of training that doctors are expected to undertake related to cultural safety with Māori. Most DHBs and PHOs that participated in the research offered training in Te Tiriti o Waitangi and/or Engaging with Māori. Typically, this is through a half-day or one-day workshop covering topics such as local iwi, colonisation and impacts on Māori health, hauora Māori models, and site-specific tikanga.

This training was compulsory for all staff (including doctors) in about half of the DHBs that participated in this research, generally as part of the induction process. The remaining DHBs reported that the training was optional.

The most comprehensive DHB training identified by this research was Whanagau DHB's Hāpai te Hoe programme. This two-day programme is compulsory for all new staff prior to commencing work. The programme is framed in Māori concepts, values and beliefs, and includes learning objectives on tikanga, Te Tiriti o Waitangi, the WDHB Waka Model of Care, the concept of whānau-centred care, improving equity in health outcomes for Māori, and practical skills in working with Māori patients and whānau.

Most of the PHOs that the research engaged with required doctors employed in their practices to attend Te Tiriti o Waitangi training and to repeat the course periodically (every 3-5 years).

It was noted that cultural training expenses often comes out of the Hauora Māori budget, placing the responsibility and cost on the Māori group in the workplace. This serves to redirect much needed resource away from a focus on hauora Māori. Some of the training courses were reported to have considerable cost per participant as they require a registration for each person, so that they can undertake the programme and access the resources. It was felt that both the responsibility and the budget should be centralised in the organisation, and that the lack of dedicated investment at a teaching level ultimately manifests in the negative responses from the whānau.

There was some evidence of cultural training workshops diminishing in allocated time, and therefore perceived importance (one workshop went from two days, to one, then to a 3hr session over the space of two years). The need for more workshops on decolonisation and implicit bias was articulated.

##### ***Doctor uptake of training opportunities is low***

DHB and PHO personnel reported that, even when made mandatory, uptake of these courses by doctors is low – often around 30% of the doctor workforce. This was primarily due to the time pressures of clinical work, but also a lack of recognition amongst some doctors about the value of this training.

There was mixed feedback from doctors about the quality and usefulness of the training they received. Some considered that it provided a useful introduction or refresher and included useful elements such

as local tikanga practices. Others stated that they had attended reluctantly and were not convinced about its relevance to their profession. A small number of doctors stated that they had found the training contentious.

*I did a one-day Treaty of Waitangi training when I came to New Zealand. That was eye opening. The style was very combative, and the content seemed opinion based. This made some people feel alienated.*

- Doctor (Pākehā)

DHB and PHO personnel also noted that it is challenging to measure the effectiveness of the training; while it may be well received by staff, there is little evidence as to whether it is resulting in more culturally safe care for Māori.

In addition to Te Tiriti of Waitangi and Engaging with Māori training, outlined above, DHB and PHO personnel described a range of other optional training opportunities that are available for doctors. About half the DHBs that participated in this research offer te reo Māori and/or tikanga Māori courses for their staff, either onsite or through paying for staff to attend externally run courses. Several DHBs provide kaumātua-led sessions on waiata. Again, uptake of these opportunities by doctors was reported to be low.

Most DHBs and PHOs also offered ad-hoc opportunities for the various departments and practices to receive training or support from Māori Health Unit/Hauora Māori personnel to upskill staff on topics such as whānau ora, skills to enhance engagement with whānau, and te reo pronunciation.

#### 4.2.5. Doctor engagement with whānau Māori

##### ***Most doctors can speak basic greetings in te reo Māori, but some are reluctant to use these with whānau***

The majority of doctors interviewed for this research were able to speak a few phrases in te reo Māori, such as greetings. However, only about half of these doctors reported that they regularly use reo when consulting with Māori patients. This generally involved using 'kia ora' to greet the patients, and reo for body parts (such as using 'puku', especially with children). Most doctors also acknowledged the importance of pronouncing Māori names correctly and made efforts to seek advice on correct pronunciation.

Half of the doctors interviewed were reluctant to incorporate te reo into their consultations with whānau Māori. Many of these doctors described lack of confidence in their own ability as a barrier.

*I want to do better at speaking Māori in consultations but I'm worried that I'll do more harm than good. I know my pronunciation needs work and it seems safer to just speak English.*

- Doctor (Pākehā)

Other doctors were reluctant to use te reo due to the perceived risk of embarrassing a patient if they are not a fluent speaker themselves. A small number of doctors who were able to speak fluent te reo Māori had addressed this concern by 'mirroring' the patients. For example, one doctor described beginning the consultation with common 'safe' Māori words, and continuing to speak reo until the patient spoke English.

##### ***Using te reo Māori helps doctors to engage effectively with whānau***

Doctors who use te reo Māori with Māori patients described the positive impact this has had on whānau engagement in the consultation.

*Small things, like saying 'kia ora' or 'mōrena' make a big difference. A few words [in te reo] indicates that you are respecting their culture.*

- Doctor (Pākehā)

*Te reo is so powerful because the minute you start using it... you can feel the air change.*

- Doctor (Māori)

The research team also found a small number of examples of doctors conducting full consultations in te reo Māori. Doctors noted that doing so can change the consultation environment for the patient. For example, a doctor described a consultation with a kuia which felt difficult until he started speaking te reo Māori with her.

*I had a few minutes of speaking and she said to me – it really warms my heart to hear you speak te reo here. After that she was much more willing to engage with me.*

- Doctor (Māori)

Some of the doctors interviewed had recognised that a lack of te reo as a gap in their skillset and had made a concerted effort to enhance their te reo skills, by taking te reo Māori courses through local community education providers, where wānanga, or their employer.

### **Nearly all doctors made an effort to follow tikanga of the body**

Nearly all doctors had awareness of tapu, such as ensuring that they ask first before touching the head and explaining why they need to do so. Most were also familiar with tapu around bodily fluids and ensuring that food was kept separate from anything that comes into contact with the body.

Most doctors were also aware of tikanga related to death, highlighting the importance of whānau being with the deceased at all times, and getting the body released quickly. Doctors also reported that they offered whānau the opportunity to take home genetic material, such as the products of a miscarriage.

A small number of doctors offered karakia as part of their practice. Several of those interviewed noted that incorporating karakia had met with resistance or discomfort from some doctors.

*At one time there was a push to invite karakia from whānau, but some doctors don't like doing karakia with patients. I'd like to more, especially when patients are critically unwell.*

- Doctor (Māori)

Those working in at hauora Māori primary care practices highlighted the value of working in a tikanga infused environment, where providing care in a kaupapa way is taken as a given.

*[At the hauora] tikanga Māori is normal. We can be as Māori as we can, and don't have to explain it. The strong tikanga values inform everything we do, and it makes us and our patients feel safe.*

- Doctor (Māori)

Doctors who worked in hauora noted the benefits of practicing in line with tikanga Māori for themselves and their patients. These included recognition of the time to whakawhanaungatanga with patients, a shared understanding of tapu and noa, and a whānau-centred approach to healthcare.

The need to gain a better understanding of tikanga was identified by many doctors as a gap in their knowledge. However, doctors had little awareness of what resources were available to them to enhance their knowledge.

*I did a te reo course but there doesn't seem to be anything around related to tikanga.*

- Doctor (Pākehā)

**Most doctors are aware of the health context for Māori, including colonisation and how it impacts on health outcomes**

For many doctors this is an uncomfortable topic. Several doctors described attending education sessions which had included discussion on colonisation and its impact on Māori health equity, which they had found confronting. Some doctors appreciated the challenge being put in front of them, and others considered it 'off putting'.

Doctors that worked in settings where they dealt with large numbers of Māori patients living in high deprivation were particularly aware of the impacts of colonisation.

*It's pretty stark in [location]. We see poverty, poor housing, high rates of smoking and obesity. The social determinants of health are in your face.*

- Doctor (Māori)

Some doctors also described an awareness of the deep-seated nature of inequity, its complexity and how this may impact patient choices. Some doctors had an awareness that patients may come from a context that does not help them to engage with health professionals or with the treatment prescribed, and that this was a systemic issue rather than an individual fault.

*When it's busy and you've got a Māori patient who is not doing exactly what you want, it's easy to discount them and subconsciously blame the patient for not being compliant. It's only when you really think about it, you realise that non-compliance comes from a background of barriers stemming from colonisation.*

- Doctor (Pākehā)

Other doctors noted that Māori appear to be tolerant of a level of unwellness that non-Māori would not. For example, one doctor described a Māori woman who had severe asthma but continued to work due to the need to support her whānau. The doctor reflected on the need to be aware of underpinning values which prioritised the needs of the whānau over individual health needs, and that it was necessary to work with patients to incorporate their values into a treatment plan.

Several doctors also reflected that Pākehā patients tend to be more willing to challenge doctors, seek a second opinion, and advocate for their health needs. One general practitioner, who worked in an area with a high Māori population described a practice of suggesting to junior doctors that they spend some time working in a practice that services a largely Pākehā population, to see the extent to which Pākehā are willing to demand what they want, and noted that as doctors their job is to provide patients what they don't know to ask for.

*We are gatekeepers, and if people don't know what the gates are, it's up to us to let them know.*

- Doctor (Māori)

***Some practices and individual doctors have taken steps to reduce barriers for Māori***

Steps to reduce barriers were particularly made by doctors working in primary care practices serving high Māori populations. Some practices had tried to acknowledge the wider context for Māori by making access as easy as possible, by being flexible with appointment times, seeing people who were late for appointments, and offering walk-in clinics. However, the majority of the general practices visited for this research did not have flexible appointment policies. Although they acknowledged that this may be an attendance barrier for some patients, they considered that efficient practice management meant that set appointment times were required.

There was also recognition in some practices that whānau Māori valued the ability to build a relationship with a specific doctor and had made an effort to ensure whānau were consistently seen by the same doctor.

*This is really critical, especially for those with chronic conditions. Having someone that knows your story as much as possible means that you will get healthcare that is tailored to your needs.*

- Doctor (Māori)

It was noted that this is easier in hauora and traditional GP-owned models of primary care, which tend to have more consistency in the doctor workforce and assign a 'family doctor' to patients. The corporate ownership model of primary care, under which doctors are employees, tend to deliver care through allowing patients to see the next available doctor, meaning it is more difficult to build a doctor-patient relationship.

Doctors also described being more active in following up for patients whom they knew had contextual challenges that made it difficult to access healthcare.

*I routinely tell patients not to trust the system. We still use letters [to confirm appointments] which is no good for whānau who move a lot. I always follow up on results and referrals myself.*

- Doctor (Māori)

***Very few doctors used a specific model of Māori health in their practice***

More recently graduated doctors typically had an awareness of Te Whare Tapa Whā and the Meihana Model but stated that they struggled to apply the principles in a meaningful way in work environments that are time pressured and output focused. Even doctors that have a strong understanding of Māori models of health and were attempting to provide care that aligned with this described a tendency of focus on the physical aspects of health as these were the immediate presenting needs. This was particularly challenging in specialisations such as emergency medicine.

*This is something we are grappling with – how do we use Te Whare Tapa Whā model in an ED timeframe. To some extent in ED, there just has to be a focus on the physical. Sometimes it's obvious – if there's a big whānau there, you include them.*

- Doctor (Māori)

A large number of doctors identified a lack of knowledge of Māori models of health as something that they would like to know more about but were not sure where or how to access this information.

*I'm fully aware that I don't fully understand enough about Māori cultural and health models. I need to learn more in that regard. There is so little that we can access to improve our understanding.*

- Doctor (Pākehā)

A small number of doctors mentioned that they ask patients about whether they use rongoā or other traditional healing models, but this was not common practice for most doctors.

Doctors at hauora Māori practices were more confident that they were delivering a Māori-centred model of care. For example, one hauora is moving to a model intended to deliver holistic care. Under this model, whānau are assigned a doctor who acts as their care lead. The intent is to enable development of an ongoing relationship that support the ability to feel comfortable talking about a range of health issues. The hauora is also attempting to incorporate a holistic model of wellness, offering wānanga on a range of health topics, and incorporating kaupapa Māori concepts such as maramataka/Māori lunar calendar into the model of care.

### **Most doctors did not have any specific strategies to address power dynamics**

Doctors interviewed for this research typically had a theoretic understanding of power dynamics but reported that they did not consciously think about this when engaging with patients.

Several doctors reflected on the impact that the power imbalance had on their ability to provide effective healthcare to their patients, noting that some Māori were reserved and respectful, and that it could be difficult to get them to be open about their health needs.

*There are a particular group of Māori guys, they actually call me 'mam'. They look at me as an authority figure and it's been a huge challenge to get beyond that and get them to let me know what they need and how I can help them.*

- Doctor (Pākehā)

The majority of doctors did not have any specific strategies to address power dynamics during consultations and struggled to move beyond a relationship which was largely transactional. Again, this was exacerbated by the time limitations of a short consultation.

A small number of doctors described attempting to minimise power imbalance by being aware of their own biases, being respectful, allowing time for whānau to talk through their needs, and being mindful of microaggressions and the tone of voice used.

*I have a constant dialogue with myself about how I am being perceived. There is no magic way to reduce power dynamics... it's just about tuning in to their background or experience or what might make them comfortable.*

- Doctor (Pākehā)

### **Structural barriers in the Western model of healthcare limit opportunities for whakawhanaungatanga**

The majority of doctors spoken to noted that it was challenging to build ongoing relationships with patients (including Māori) in the context of their working environment. Doctors in primary care are limited to a 15-minute consultation with the patient, and doctors in secondary and tertiary care stated

that they generally have limited time with a patient, who may or may not be able to communicate. This meant that doctors across all specialisations stated that they typically struggled to find the time to engage with patients in a way that enabled them to get to know their wider context.

Some general practices had found ways to get around this. One practice held group consults for patients with chronic disease, for example having six people in a 90-minute session. This enabled building relationships between doctors and patients as well as providing a support network amongst patients.

A small number of doctors in traditional consulting environments made an effort to get to know a person's whānau, and home and work contexts. This was mainly doctors who worked as GPs in small practices that saw the same patient over multiple consultations. A very small portion of these doctors stated that they use the Hui process. Others described using relationship building techniques such as telling the patient about where they are from and their family and asking the patient about their family. Several doctors mentioned the importance of looking for commonalities and areas of connection.

*If I know whānau members, I'll mention this – make a common connection, so that removes the barrier of 'you are the patient' and 'I am the doctor'.*

*-Doctor (Pākehā)*

Māori doctors in particular emphasised the importance of getting to know the person and their context, and asking where they are from, their maunga and awa. Doctors gave examples of how this had enhanced their ability to provide care. For example, one doctor was struggling to engage with an older patient, who was wearing a Māori Battalion shirt. When the doctor asked him about this, they were able to establish that both their grandfathers had fought in the Battalion, and "after a five-minute kōrero we were mates." The doctor was then able to get the patient to be much more open about his health needs.

Several Māori doctors also described challenges in encouraging their Pākehā colleagues to undertake a similar approach.

*I think that process is something that non-Māori doctors are not comfortable with. Pākehā say to me 'that's none of my business! All that personal stuff'.*

*- Doctor (Māori)*

### ***Doctors struggled to provide genuine whānau involvement in decision making***

The majority of doctors spoken to were conversant of the need to include patients and whānau in the decision-making process. However, they noted that the practice model had some limitations in providing for patient involvement in the decision-making process, including pressures for doctors to achieve best clinical outcomes (which incentivises the provision of medication/treatment).

Those doctors that did provide for patient involvement in decision making typically aimed for a 'directed choice' model, under which they presented options, with the doctor providing advice on what the clinically optimal course of action would be.

*It's not my job to coerce patients into a course of action. But it is my job to very clearly show them what the best course is.*

*- Doctor (Pākehā)*

Several doctors highlighted personal challenges in accepting that patients may choose not to undertake treatment. As one doctor explained, Western medicine tends to assume that people will

always choose to have treatment, which is seen as the ‘gold standard’. However, for Māori patients accepting treatment is not necessarily a given.

*I’m constantly amazed that people with chronic or terminal illness don’t always want to go down the treatment line. I still find it really difficult to accept ‘failure’ – that people won’t take your advice sometimes – but I’ve accepted the need to hand over decisions to patients and whānau.*

- Doctor (Pākehā)

### **Doctors reported that they included whānau in the patient health journey**

Nearly all doctors stated that they welcomed whānau, if the patient wanted this. Some doctors also noted the importance of not only allowing whānau to be physically present, but actively include them in the discussion by introducing him/herself to everyone, checking who is the whānau spokesperson, and keeping the whānau updated about patient progress.

*Yes, we’re pretty good at that, whānau turn up, we’re good at allowing them to be with the whānau. It can be helpful on both sides – support for the patient, and it helps us too. The more ears, the more understanding.*

- Doctor (Māori)

Some doctors pointed out that the physical environment does not always support the inclusion of whānau. For example, consulting rooms are often small and cramped, and whānau rooms at secondary/tertiary facilities may not be particularly welcoming or large enough. A recently opened general practice that serves a high Māori population stated that they had purposely designed a larger consultation room to allow the whole whānau to attend in the consult space.

#### 4.3. Question 3: What is the current status of Māori doctors' experiences of cultural safety amongst their non-Māori colleagues?

*Research question 3 was underpinned by the following values.*

- *Ōritetanga: the medical workforce reflects the population it serves. This requires appropriate representation of Māori in medical training and in the health workforce.*
- *Manaakitanga: Māori students are supported into and through medical training and in the workforce, acknowledging and providing the appropriate support and development for the additional cultural responsibilities often placed on them, and ensuring their workplace is a culturally safe environment.*

##### 4.3.1. Māori participation in the doctor workforce

***At undergraduate level, achieving population proportionality of Māori medical students is a key focus***

One of the challenges reported by medical schools is the limited potential pool of Māori students coming through secondary schools, foundation programmes or other pathways, and low participation of Māori in sciences at secondary school level. There are also geographical challenges in some areas such as in Northland where Whangārei is the only location all three sciences are taught, requiring students to move to the city if they wish to study science at secondary school.

Kia Ora Hauora, the national initiative to support Māori into health careers, works closely with secondary schools, tertiary institutions, communities, and providers to promote medicine and other health sciences, and to support Māori students into and through their study and towards careers in health.

Considerable effort has gone into increasing the pool of undergraduate students in both Auckland and Otago Medical Schools, particularly in the last two decades. At Otago, 'Te Ara Hauora'<sup>2</sup> provides a suite of outreach programmes that focus on increasing science engagement for Māori, and the 'Tū Kahika programme' in foundation year prepares students academically, guarantees a place in a residential college, and provides financial assistance. A focus on supporting students in the first year of Health Sciences is important.

*There is a vicious culling process at the end of year one, which deters many Māori students.*

- *Medical school representative*

The 'Te Whakapuāwai' programme at Otago provides students with ongoing information, one-on-one guidance, and opportunities for whanaungatanga with others undertaking study. Students are further supported on their journey into professional training with the 'Tū Taurira' Hauora programme.

At Auckland University, the Vision 20:20<sup>3</sup> initiative contains three components; the 'Whakapiki Ake Project' which actively engages with Māori in secondary schools, 'Hikitia te Ora'; a one-year foundation programme to prepare Māori and Pacific students for tertiary study in health, and the 'Māori and Pacific Admission Scheme' (MAPAS) which provides academic support such as tutorials, workshops and

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<sup>2</sup> <https://www.otago.ac.nz/mhwdu/tearahauora/index.html>

<sup>3</sup> <https://cdn.auckland.ac.nz/assets/auckland/fmhs/study-with-us/docs/Vision%202020%20Handbook.pdf>

wānanga, study spaces, and tracking of academic progress. Pastoral care is also provided through access to a student support advisor, a range of services, and cultural development.

In recent years, both Otago and Auckland Universities have achieved proportionality of approximately 15-16% of medical graduates who identify as Māori.

***Māori student retention is enhanced through support networks and ensuing no ‘cultural loading’ obligations***

Students who came through MAPAS in Auckland reported favourably on the various hui organised to help facilitate relationships, support, and whanaungatanga. They reported it was helpful even just knowing there was “a place to go and have a cup of tea and a biscuit.”

Recently Auckland University has contended with issues of discrimination and harassment experienced on campus. Māori and Pacific students in Auckland have reported experiences of everyday racism in the institution, promoting a campaign in 2015 entitled ‘I, too, am Auckland’. University representatives spoke of how these experiences take their toll on students and present a challenge to retention.

Māori students at the University of Otago attribute good retention rates to the high quality of the curriculum, positive study experiences, and good relationships. The hauora Māori content in the medical curriculum ensures no, or limited, cultural loading of Māori students to ‘teach’ their peers. There is an expectation on lecturers to be up to speed and take the responsibility of the teaching load. Otago continues to implement practices that normalise tikanga. The whakawātea practice undertaken in year two is attended by approximately 90% of students, both Māori and non-Māori.

Otago University personnel reported that the pass rate of Māori medical students is equivalent to that of non-Māori. Very few Māori students drop out of the course, and if they do it is usually due to health or personal issues rather than academic challenges.

Medical school can be a challenge to those who enter with a strong reo and tikanga background, to find that the institution and other Māori colleagues don’t have the same prioritisation of reo. These students can find themselves in a support role for others who are learning the language, and also find that the reo teaching in the curriculum doesn’t challenge or extend their own knowledge.

In general, the stronger inclusion of reo in the medical curriculum in recent years has been favourably received with largely positive feedback from students, patients, and whānau.

***It is a challenge to support Māori doctors through internship and on to employment***

The specialisations that are reportedly attracting a higher portion of trainees are: Psychiatry, Emergency Medicine, General Practice, and Surgery. Respondents commented that strong Māori individuals, and general acceptance of ‘things Māori’ contribute to the higher intake of Māori into some specialist areas. For example, Psychiatry and Mental Health and Addictions are viewed as an area where a focus on cultural safety is generally accepted and normalised.

Several Colleges have developed specific Māori health strategies. Māori doctors noted that these strategies have the potential to make these specialisations more attractive to Māori. For example, The Australasian College for Emergency Medicine’s *Manaaki Mana* strategy aims to provide “excellent, culturally safe care to Māori, in an environment where Māori patients, whānau and staff feel valued and where leaders actively seek to eliminate inequalities.”<sup>4</sup>

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<sup>4</sup> <https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand>

The Royal New Zealand College of General Practitioners launched a strategy in 2017, *He Ihu Waka, He Ihu Whenua, He Ihu Tangata*, with its aim of achieving health equity for Māori. It challenges the College to ensure that “Māori health equity becomes ingrained throughout the Colleges ethos and work programmes.”<sup>5</sup>

The Royal Australasian College of Surgeons has a Māori Health Action Plan<sup>6</sup> and an Indigenous Health Position statement, which covers the indigenous populations of both Australia and New Zealand.<sup>7</sup> Some interviewees noted that as most colleges are Australasian, and span both countries, this reduces the focus on tangata whenua in Aotearoa. When there is a shared commonality, the context is changed, and it is important to remain authentic to Aotearoa.

The Colleges were encouraged by a range of participants in this research to consider their admittance criteria into vocational training to ensure Māori students are not unfairly disadvantaged.

### ***Recruitment and retention of Māori doctors is difficult***

Recruitment strategies in some DHBs and PHOs aim to increase the number of Māori doctors, many with targets to achieve parity with their local population. DHB representatives noted the importance of robust ethnicity data for equity monitoring, and that ethnicity data of both employees and patients is not always well captured, with variations in quality across DHBs and health organisations.

The research team identified some examples of successful programmes that have increased Māori doctor participation in the workforce. The Pūkawakawa programme in Northland is a partnership with the DHB and Auckland University, established 12 years ago, and stated to be the first of its kind. It takes undergraduate doctors through an orientation process and includes a visit to Waitangi and rural clinics throughout the year in order to experience the realities of Northland which helps inform their practice. Pūkawakawa students are in turn used to help promote, advocate and encourage high school students. Reportedly, the number of Māori in this programme has increased over the years, from one student in the beginning, to approximately 25% now, and also including some speakers of te reo. Students report the positive impact of this programme and that it has been “life-changing.”

Some DHBs have specific strategies to ensure that Māori values are at the centre of the recruitment process. For example, Bay of Plenty DHB has a values-based recruitment strategy which assesses the extent to which a candidate aligns with a set of values centred on manaakitanga. Recruitment interviews for leadership positions regularly include Māori on the assessment panel, although not necessarily at the lower levels of employment positions.

Recruiting general practitioners in general is difficult, and PHO personnel reported that practices “hit the jackpot” if they can get a Māori doctor; there might be two or three across a PHO region. Some iwi providers have been successful in attracting Māori doctors, by providing a kaupapa Māori environment which supports doctors to practice ‘as Māori’. These iwi providers also work hard to ensure other doctors in the practice are culturally competent.

Retention of Māori doctors is a challenge as they are in high demand. Some practices have made specific efforts to retain Māori doctors. For example, one general practice allowed a lot of autonomy, flexible working arrangements, and focused on the needs of the doctor’s whānau as a whole. Another practice supported attendance at health sector governance hui and established a position for the Māori doctor as cultural advisor to the practice.

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<sup>5</sup> [https://www.rnzcgp.org.nz/RNZCGP/Advocacy/M%C4%81ori\\_health\\_strategy.aspx](https://www.rnzcgp.org.nz/RNZCGP/Advocacy/M%C4%81ori_health_strategy.aspx)

<sup>6</sup> [https://umbraco.surgeons.org/media/2388/maori-health-action-plan-2016-18\\_final\\_29-february.pdf](https://umbraco.surgeons.org/media/2388/maori-health-action-plan-2016-18_final_29-february.pdf)

<sup>7</sup> <https://www.surgeons.org/resources/interest-groups-sections/indigenous-health/racs-indigenous-health-position>

### ***Māori doctors experience additional cultural demands while in employment***

These additional demands arise from community expectations and pressures, such as responsibilities in their own whānau, hapū or iwi, or advisory roles in the wider community. Māori doctors are often in demand on committees as Māori representatives, and there was report of being “spread pretty thin”, and the need to resign from some committees because of time pressures. There is often limited or no recognition by the employer of these added responsibilities.

In addition to this, Māori doctors report that many of their colleagues assume they are also an expert in Māori culture, and are therefore seen as the ‘go to’ person for questions and advice, which can be overwhelming.

Māori doctors report that their colleagues are accepting and appreciative of their cultural skills – not validating them as such, but appreciative. Some Māori doctors reported that there was a pressure on Māori doctors to be better than their Pākehā contemporaries (clinically) or “people aren’t going to give us the appropriate level of respect.” Māori doctors spoke of the need to make allies and alliances with other likeminded people in order to feel supported.

### ***Māori doctors experience cultural loading in the workplace***

A combination of assumed responsibilities and pressures, both internal and external to the place of work, places a considerable cultural load on Māori doctors. Cultural supervision and support are viewed as important in this respect, in order to reduce the burden on Māori doctors, and ensure they can practice safely in a cultural sense. As one respondent stated; “cultural supervision and support, this is the taha wairua, it’s not articulated as that but for me that’s what it is ... it’s intangible, but as Māori we feel it, sense it, it’s around connectedness.”

Most Māori doctors feel they are supported in their work in general, but that they receive little or no particular training or support ‘as Māori’, with the view that “we are all equal under the roof of the hospital.”

There was little evidence of cultural activities and training being built into the job descriptions or professional development plans of doctors. Some reported using non-clinical time to do cultural activities, time which might otherwise be used for teaching, feedback and research. One doctor commented that their employer has become more accepting of, for example, taking time out of work to meet cultural demands outside the hospital, but also that this has required a level of assertiveness from the Māori doctor over time in the role. In general, Māori doctors found their requests to attend Māori health conferences and training courses were readily approved. One DHB is planning to launch a Māori leadership training initiative under which all Māori staff, including doctors will have the opportunity to access leadership training wānanga.

### ***Peer support networks are important to provide a safe space for Māori doctors***

There was evidence of varied peer support networks for Māori doctors within DHBs and PHOs, with instances of doctors establishing their own systems.

One DHB hosts a hui for all Māori staff every two months where they gather, share kai and waiata, and “be Māori in the DHB.” While the desire was expressed for more frequent hui, this is limited by doctors’ busy schedules, and also the requirement of junior doctors to be present in the practice at all times, prohibiting their release for these gatherings.

Some support networks have a focus on racism, bias, and privilege in the workplace and in the system, and provide a safe space for Māori doctors to air these concerns and find solutions to their own

experiences. Doctors report the peer groups are enjoyable and provide valuable opportunity for learning from one another.

### ***DHBs and PHOs have made efforts to create a culturally safe workplace***

There are strategies in place in DHBs and PHOs that serve as cultural frameworks for the workplace and guides for training doctors. Examples include *Te Hononga*<sup>8</sup> in Northland which provides a suite of cultural competency and equity training resources, and the recently launched Bay of Plenty DHB strategy *Te Toi Ahorangi*,<sup>9</sup> developed by Te Rūnanga Hauora o te Moana a Toi and founded on tikanga Māori principles.

Many employers have initiatives to foster culturally inclusive workplaces. For example, several practices reported that they try to ensure they retain and keep diversity within their staff. Approximately half of the workforce are Pākehā in one workplace, but it reportedly still “feels like a kaupapa environment”, based on whanaungatanga. In one DHB there is an equity group that is planning changes to the physical and social environment in the form of artworks and murals, waiting room layout, promoting the use of reo.

Considerable effort has been put into cultural competency training in recent years. These workshops were spoken about favourably and appreciated by Māori and non-Māori staff alike. However, the importance of providing the opportunity for immersed cultural experience, such as marae and community visits, in order to complement workshops was emphasised. Place-based context provides people with a level of confidence to implement tikanga practices, reo, and other initiatives in the workplace. Knowing about Māori in Aotearoa is a skill that doctors must possess, “as much as holding a scalpel or writing a script.” ‘Exposure’ and ‘discomfort’ were described as two things needed to promote learning and understanding and it was felt that health professionals would benefit from going into a Māori space, such as the marae or community, in order to experience te ao Māori.

*What better way to learn about the environment than to be in the environment?*

- Doctor (Māori)

The view was also held that there needed to be more space for community voice at conferences and in ongoing professional development programmes in order to bridge the gap between the clinical or academic world, and the lives of whānau Māori.

### ***Māori doctors consider that changes are needed to make workplaces culturally inclusive***

Māori doctors noted that simple changes, such as the use of reo in handover meetings, fosters cultural inclusivity. Competent reo speakers in a team means the team itself is more open to speaking the language. Some doctors feel that te reo and tikanga efforts in their workplace are somewhat tokenistic. For example, one doctor noted that while the workplace has signage in te reo Māori, there is not much spoken reo. Another doctor stated that karakia at the start of hui feels like something that ‘should’ be done rather than a genuine effort.

Despite (in places), high numbers of Māori staff and/or staff members competent in te reo, a large number of doctors interviewed considered that the hospital can never be an overtly Māori environment. There is a fear of how others will react, that it feels like introducing “something alien”, and fear of the “eye-rollers” and those that “don’t want this rammed down their throat.” Doctors described instances of resistance to tikanga and reo training from doctors who are trained overseas

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<sup>8</sup> <https://www.tttpho.co.nz/your-community/te-hononga/>

<sup>9</sup> <https://www.bopdhb.govt.nz/m%C4%81ori-health/m%C4%81ori-health/>

and hold a different worldview, although in contrast to this, many foreign doctors trained in Aotearoa have reportedly been open and accommodating in this respect.

Despite the threat of resistance, some staff have decided they're "just going to do it" and will deal with adverse reactions when they come to it. One Māori doctor described their ultimate goal would be to walk into a hospital that is:

*an overtly Māori environment, with signage, big brash Māori name, staff engaging with patients in a whanaungatanga way, for all patients – this would change medicine if this could be done.*

- Doctor (Māori)

Within a DHB there can be variation across different departments. Some with higher numbers of Māori staff have incorporated tikanga into their operations in a more organic way. Other departments can be a very "Pākehā environment", and doctors are reported to be competitive and arrogant. It is felt that a sense of entitlement is strongly embedded in the medical profession and that doctors are put on a pedestal.

*We literally on the first day of med school are told that we are the cream of the crop.*

- Doctor (Pākehā)

The hospital setting was described as a hostile place to be a Māori doctor, and those that remain in the hospital environment "have a sharp edge to them" and are required to adapt to the cut and thrust of hospital work. Anecdotally, the majority of young doctors will seek a low conflict environment and go into community-based medicine.

It was also commented that as there are very few new Māori doctors coming through some professions in particular, making it difficult to see the culture and environment changing in the immediate future.

### ***Systemic structures impact on Māori doctor experiences in the workplace***

Māori doctors that participated in this research described challenges in working in the wider system, which many interviewees described as inherently biased. While inequities are evident and acknowledged, the fundamental problem is the system underneath it. The system is viewed as racist, having been developed as a colonial structure, and it was felt that deep down there is resentment about focusing on Māori inequities, with many doctors sharing that belief.

*How do you change the hearts and minds of people, let alone doctors?*

- DHB Māori Health Unit personnel

It was felt that open acknowledgement of systemic racism is required, that it is important to acknowledge this as a truth and start believing it in order to meaningfully address the problem. Sometimes the system doesn't like to hear the truth and "if they don't want to hear what you've got to say – they won't ask you." However, racism is a health issue. It can be a challenge to confront, especially if there is limited understanding of the mechanisms of colonialism, racism, implicit bias, and privilege. Self-reflection and peer support are very important in this regard, as doctors need permission to talk about it in a non-judgemental space.

Participants described the need to build strong legislation that entails directing efforts and resources into addressing the outcomes. Appropriately directed resources can go a long way to addressing

inequity, although there was an awareness that tagging resources to ethnicity is a politically fraught action and it was commented that most politicians do not have the courage to do this.

The Wai2575 claim found that superficial things are done well in the health system, but the system doesn't address the things it says it is going to address. Several Māori doctors expressed hope that the claim will be effective in driving change. They were also hopeful that there will be generational shift, as the younger cohort coming through is noticeably more accepting of diversity and aware of the need for justice and equity. However, it was acknowledged that the 'here and now' remains unaddressed. Being a doctor is to be a part of the system, and Māori doctors felt a responsibility for systemic inaction and inertia.

*I work on behalf of the system, I expect Māori patients to trust me, but can they trust the system? Can I trust the system?*

- Doctor (Māori)

### ***Māori representation in decision making structures in the health system is minimal***

Across the DHBs and PHOs that contributed to this research there is a consciousness of the need to appropriately include hapū and iwi of the region in decision making. However, the mechanisms by which this happens varies. Some have an iwi partnership board as well as a cultural advisory group such as a kaunihera kaumatua who sits at the level of the DHB and provides cultural expertise (not necessarily also health expertise).

DHBs are required under the Public Health and Disability Act 2000 to have Māori membership proportional to the population of Māori in the DHB, with a minimum of two of the seven board members who identify as Māori. If Māori members are not elected into these positions, they can be appointed by the Health Minister. The number of Māori representatives in DHBs that participated in this research varied. Canterbury DHB has two Māori representatives who are reportedly always ministerial appointees as the majority of people in the region who vote and run for the DHB are Pākehā, and they tend to vote for Pākehā representatives. Hutt Valley DHB has two elected Māori members with one appointed by the Minister. Counties Manukau DHB comprises 11 members, two of whom are Māori. Whanganui and Midcentral each have three Māori board members.

Some DHBs are currently undergoing restructure or merger. The Māori partnership board for Northland DHB, Te Kahu o Taonui, is moving towards a collective Māori relationship Board that works across Auckland DHB, Waitematā, and Northland. Hawkes Bay DHB has undergone changes and have a newly appointed chairperson who is Ngāti Kahungunu and have a total of four Ngāti Kahungunu Board members.

There is also a legislated obligation to provide mechanisms that enable Māori contribution to decision-making. Again, the nature of these groups and the process for establishing them differs across the DHBs. Canterbury Clinical Network has a system-wide Māori health reference group, Te Kāhui o Papaki kā Tai, which includes health system leaders, representatives from all three PHOs, DHB Funding and Planning, DHB Māori Health, NGO reps, and Mana Whenua ki Waitaha. Bay of Plenty DHB has a rūnanga of 17 iwi that have a two-way relationship with the Board. While it is not quite co-governance, there are aspects of co-governance. This system has been in place for 19 years. There is also a panel of kuia and kaumatua who provide advice. Counties Manukau DHB has a Memorandum of Understanding with Ngā Manawhenua o Tamaki Makaurau, which is a collective of eight entities which are recognised as mana whenua in the greater Auckland region.

PHOs also have structures that differ in different regions. Mahitahi PHE in Northland have 50% Māori representation. An independent group leads the recruitment for the Board. The five main iwi in

Northland mandate who their representatives are. Eastern Bay of Plenty PHA has a board with three Māori (iwi) seats, three community seats and three GP seats. They are voted in for a three-year term. They are currently merging with Western Bay of Plenty PHO, with delays due to differing perspectives on the number of Māori seats required. As a PHO that is going through a change, a priority is to ensure that values are distributed through the new entity.

***The representative model has not always been effective for Māori in the decision-making process***

Low Māori representation in governance groups requires of the representatives to be bold and courageous about key issues for Māori. There have been some successes in addressing issues, but these require considerable effort and assertiveness on the part of individual members and the challenge is that the Māori voice gets overlooked and ignored.

As an example, in Canterbury DHB only two out of the eleven representatives are Māori. Implementing changes are a challenge as the other nine members tend not to have the same view. However, there has been some successes in getting key Māori issues considered at governance level. For example, data for immunisation revealed that 25% of Māori were not immunised, so a nurse team was arranged to undertake these immunisations, and when the 2019 measles outbreak occurred there was no inequity in the Canterbury region.

Canterbury Clinical Network has a service level alliance comprised of pharmacy, doctors, nurses etc and with one Māori representative at each table. While this is viewed as positive, in practice the Māori voice can get ignored or drowned out, and issues have been “dropped off” meeting minutes. There is recognition that this system is not working, and current discussions include the possibility of setting up a Māori co-design group as well as a general group to ensure voices are heard. There was a strong feeling of the need for strengthening Māori voice at the decision-making table, and for a Treaty relationship structure. As one study participant stated:

*I want to see mana whenua voice in everything, co-design, co-develop, co-everything.*

- PHO Hauora Māori representative

#### 4.4. Question 4: What is the current experience of cultural safety amongst Māori receiving health care from doctors?

*Research question 4 was underpinned by the following values.*

- *Tino Rangatiratanga: Māori patients and whānau are informed, engaged, and participate in decisions that affect them. Māori are appropriately represented in decision-making structures in the health system.*
- *Whanaungatanga: respectful, reciprocal relationships with Māori patients and whānau and Māori communities are developed and maintained.*
- *Manaakitanga: Māori patients and whānau receive care and services in a manner that serves to enhance their mana. This requires that doctors are culturally competent and equipped to provide culturally safe care to Māori. Manaakitanga promotes behaviour that acknowledges that the mana of others is equal to or greater than one's own.*
- *Wairuatanga: connectedness to people, place and tūpuna is integral to the understanding of whānau wellbeing. The values, beliefs and practices of wairuatanga are an essential element of health and wellbeing journeys.*

##### 4.4.1. Whānau relationship with their doctors

###### ***Whānau often do not have adequate opportunities for whakawhanaungatanga with their doctors***

Developing a relationship over time is important. Many whānau interviewed for this research feel like they get pushed through the system and see a different doctor every time who does not know who they are or anything about their whānau. There is no actual conversation, no personal connection.

*It feels like there's a script that they adhere to, and then they'll categorise you in with what the script says, then decide on your medication from there.*

- Whānau

Whānau feel distanced from both the doctor and healthcare and distanced from their own health. Doctors often talk to the patient indirectly, which can feel like the doctor is talking 'through' them instead of to them.

One patient described the long-standing relationship with her GP: how they were on a first name basis; how the doctor had delivered all her children; and she was always able to see that doctor when required. However, when the doctor retired, and the practice came under a corporate health organisation, the patient saw different doctors each visit and felt there was no ability to build a relationship with them. It was commented several times that this service model allows no time for whakawhanaungatanga or to build a relationship of trust or rapport with the doctor. Seeing a different doctor every visit was described as feeling like "sharing personal information with a complete stranger." There is often no introduction, no names given, and this leads to great discomfort. One respondent stated that they felt like "just a number" and not a person, leaving them feeling belittled.

Whānau who attended a Māori provider generally found this a more positive experience, because time was taken to connect with patients, who then feel listened to and generally much happier with their healthcare. These doctors are also members of the community, so patients might encounter them at the marae or other community events and venues where they will ask about the health of the patient. This can make the patient feel cared for.

Smaller providers often have a small number of doctors, so patients will get “one or the other” and they are familiar with both. One whānau spoke positively of their GP practice, that they were accommodating and made space for them especially when seeking appointments for a baby. They had never had problems with their GP, or with reception staff, and even locums who cover their regular GP seem to follow a certain standard. It was felt that a positive culture had been deliberately cultivated in this particular practice.

Other whānau also spoke favourably of their doctor visits. The sentiment was expressed that they were “lucky” to have had good experiences, and comment was also made by those who felt they were fortunate to have a Māori GP. Whānau typically described interactions with younger doctors more positively.

Whānau stated that ‘good’ doctors are those who appear genuinely keen to know both what is wrong, and about who you are as a person, and take time to get to know you. Whānau feel respected, acknowledged and appreciated. Communication is easy. Some doctors simplified explanations of diagnoses, stepped away from the computer, asked for permission to touch the patient and pronounced names correctly. Comment was made that; “that’s all it took.”

#### 4.4.2. Provision of information

##### ***Māori patients considered that their doctors often provided inadequate explanations, used jargon and underestimated whānau knowledge***

Sometimes explanations provided to patients and whānau are inadequate. For example, patients are told how to take the medication, but not what it is for and why it is needed. On such occasions, it feels like the doctor assumes the patient is not competent or does not know how to articulate themselves properly. Some whānau reported they just get a “scribble on a paper”, written in haste by the doctor. The sentiment expressed was that if patients and whānau were told about the treatments they were getting then they would feel more validated and empowered.

Some whānau reported that there was an expectation to know all the jargon the doctor was using. Whānau reported negative experiences with regard to this, particularly when a patient had multiple medications, and explanations weren’t provided for each of them.

Some whānau were grateful for their own health knowledge through their training as nurses or experience in the health sector, that lent a familiarity to medical terminology. Comment was made that it would be considerably harder for whānau without this knowledge.

One interviewee stated that doctors often make the assumption that something is common knowledge because they have been doing it so long themselves and forget that the patient might not be familiar with a certain medical situation. To counter this requires doctors to change their expectations around a patient’s response, and not react to an unexpected question from the patient. Additional time is required for thorough explanations and checking understanding.

One respondent related a time when she took her child to the doctor with an eczema flare up. The doctor was surprised that the parent knew what lymph nodes were and the parent described the doctor’s manner as condescending; “yes, yes, they are lymph nodes! Well done!”. It was infuriating: she felt it was because of his perception of that she fit the stereotype of a young Māori sole parent, “I felt I had to prove myself.”

A number of whānau report instances of being patronised and feeling like they did not have a voice. Whānau intelligence should not be underestimated.

*We know how to come up with the solutions ourselves ... don't say that we don't know.*

- Whānau

On the other hand, several whānau reported positively that their doctor explained things so that they are understandable and that jargon and anything that is too technical or clinical is avoided. Some whānau stated they have never felt talked down to. One patient reported an experience with a doctor in hospital who sat down with her and her daughter and explained exactly what she was experiencing, the reason for her symptoms, what the options were for next steps, and answered all questions. It took approximately half an hour, but she stated she never felt like they were being rushed.

#### ***At times whānau feel like they have been bombarded with information***

Some of the information packs provided to patients have been described as useful and informative, however, most information was described as quite “Pākehā”. It is seen as generic and not relatable for whānau Māori, which leads to them not being used. Comment was made that the information brochures coming out of DHBs and primary care practices in the past couple of years have been more relatable, but most are still outdated.

Conversely, some whānau described the lack of information resources, and that if they are given out it is usually at the pharmacy when medications are collected rather than provided by the doctor. Many describe turning to the internet to get information on a health condition and highlighted the importance of adhering to known and reputable health websites. Plunket and Healthline freephone have also been accessed in order to get information and asking other parents or adults who are experiencing something similar is also considered to be informative and helpful.

Some whānau described not receiving either written or verbal information unless it was specifically asked for, and whānau have noted the importance of having to be active and assertive in order to ask the doctor to explain things. It was felt that the doctors seem busy and unable to take the time out to ensure understanding and very clinical information is given. Whānau often feel that the doctor is talking to them from the computer screen, and the lack of information and the knowledge divide can exacerbate the feeling of being “talked down to”, by not explaining a medication or treatment plan in enough depth.

#### **4.4.3. Involvement in decision making**

##### ***Māori patients' and whānau had variable experiences related to involvement in decision-making***

Many whānau feel disempowered and that they are not involved in decision making around their health and are more ‘told’ by the doctor of what they should do. They are simply provided with the solution, and it is not always a solution to the cause, just to the symptoms. Whānau would like more involvement in decision making and a focus on finding explanations for the underlying cause of the health issue, so that prevention of recurrence is possible. A patient of a practice that was taken over by a corporate health care provider reported little partnership in decision making with the doctors. The engagement with the doctor seemed impersonal and rushed.

*They take time to read the notes, then speak for two minutes to ask what I was there for, then write a prescription.*

- Whānau

There was no discussion of other needs, or holistic health and it was described as feeling like being on a “conveyor belt.”

Whānau who attended a hauora practice described their experience as more holistic and receiving a full “warrant of fitness” check. One patient expressed that this felt wonderful, feeling that they were really being cared for. The doctors worked in partnership with the patient, involving her closely in her health plan and made statements such as “we can improve your health, but you need to be a party to this. We can give you pills, but you also need to get enough sleep.” This approach meant that the patient was, to some extent, involved in her own healthcare and the advice was more readily taken.

Several patients interviewed stated they do feel like they are involved in decision making processes and feel that there is space created within consultations to enable their input as a whānau. They are given information about options and can talk it over with other family or friends, then bring it back to the doctor to support the decision.

***Whānau are required to be strong and assertive in order to make needs and preferences of whānau heard and implemented***

Some patients described having other whānau members as advocates, or being strong advocates themselves, but were also aware that not everyone has this level of support or comfort with the health system.

*It depends on what level of assertiveness you are prepared to go to with your doctors to ensure your needs are met.*

- Whānau

This power imbalance was referred to several times by whānau during interviews. Many whānau do not know their rights as health consumers, or do not have the confidence to speak up about what is right for their whānau, such as requesting a second opinion or further information.

Depending on the seriousness of the issue, some whānau will question the certainty of the doctor’s decision or ask if there are other alternatives rather than simply say ‘yes’ to anything the doctor suggests. Some stated that they felt comfortable enough to request further information, and also to inform their doctor when something works, and they want to continue with that particular treatment. However, if the issue was serious, they felt they needed to trust the doctor’s decisions without question.

Time pressures put constraints on consultations. One respondent stated she never feels comfortable voicing more than one health issue per visit and that it feels as though once they have sorted your immediate problem, there is no time left for anything else. Many Māori patients attend a doctor’s appointment with multiple health needs. It can be difficult for some to enter the institution of health services, particularly for those with mental health challenges, and there is an opportunity lost if only one health issue is attended to. Patients feel that the doctor is under pressure to finish the consult within time, “it feels like the doctor is right on the clock.”

The structure of the appointment system also does not fit the needs of many whānau. There is often more than one person sick at one time in the family, and the logistics of potentially requiring more than one appointment can place an additional burden on families.

*I’ve been told off for taking in more than one child at one time ... kids fall like flies, if one gets sick, the other gets sick.*

- Whānau

In contrast to this, a patient who attended a hauora service said she felt empowered to share her opinions. She always sees one of the same two doctors, so they know her history and take a holistic approach. This builds trust and allows her to voice her needs and views.

### ***Whānau reported that doctors did not listen to them and their knowledge was underestimated***

Patients feel that their own 'gut feeling' of what is right for their tamariki has not been heard, and then experience further frustration when their gut feelings proved correct. Several examples were given:

- One incident where the doctors were wanting to conduct a lumbar puncture on a daughter. The whānau felt that this wasn't necessary, but the doctor continued despite their protests. Test results arrived just before the procedure to confirm that the puncture was not needed.
- Another incident where a mother telephoned for a repeat prescription for specialised infant formula for her daughter with allergies, to be told that her doctor had left, and the new doctor would not be giving the formula any longer. She felt this was extremely inappropriate, the doctor was not familiar with the patient or whānau, and there could have at least been a weaning period with consultation. The mother made an appointment to see another doctor in order to get the formula.
- Another participant described taking her son to the doctor who ran tests and stated there was nothing wrong with him. Subsequent tests at his kura picked up a partial deafness. An earlier diagnosis would have hastened their journey in understanding his health needs by one year.

*I didn't follow up on it or put in a complaint. You have to pick your battles.*

- Whānau

- Another instance in which an IV line had been incorrectly inserted, and despite the whānau informing the doctor that it didn't look correct, and that their child was in pain, the doctor insisted it was fine. A nurse subsequently confirmed that it was incorrect.
- One mother described how once her son was prescribed medication, there was the perception that he didn't need further care. They had to fight to get acknowledged and it was found he was never meant to be taken off the books. They received an apology, but "still, it was six months." She felt that her own confidence and awareness of rights and entitlements helped in this situation.

*If something doesn't feel right, you just keep asking and asking and asking.*

- Whānau

The nature of a consultation is largely dependent on the individual doctor. Whānau related that some will listen to a certain degree, but sometimes they just focus on the immediate symptoms and not what else is going on, so "listening, but not really."

Some doctors, including non-Māori doctors, were described as "awesome" as they appear genuinely keen to know both what is wrong, and about you as a person. A few respondents felt that in general they were listened to when they visited the doctor.

#### **4.4.4. Inclusion of whānau**

##### ***Patients mostly felt that whānau were welcomed into consultations***

This was particularly prevalent at general practices. Patients have taken tamariki along to appointments and felt they are welcomed, with toys and activities provided to keep them entertained. The psychiatrist that one patient visits always offers to include other whānau. Another participant described being in hospital with her son almost around the clock and feeling very supported by staff and very involved in her child's care.

The level to which whānau are welcomed depends on the practice. In some instances, interviewees stated that while it was okay to bring whānau along ‘in theory’, the consultation rooms are small, and the doctor does not always acknowledge whānau presence. This makes whānau feel unwelcome. In other practices the doctor will ask partner and kids’ names and talk in an inclusive way about options for care. This makes a real difference.

Some stated they had only ever been to a GP appointment alone and were fine with this. One study participant noted that the option of bringing their whānau had never been offered, and also that it would depend on the purpose of the visit, as it may not always be necessary or appropriate to bring whānau.

Study participants stated that it is more difficult to involve whānau in hospital. Set hours for visiting times and the inability to stay overnight proved a constraint. Partners are not permitted to stay in the hospital with young babies. One participant reported the difficulty in being isolated from whānau with a sick baby and being heavily pregnant and how overwhelming this was.

#### 4.4.5. Inclusion of hauora Māori models of health

##### ***Whānau considered that the system still very much follows a biomedical model of health***

Whānau reported that in appointments there is no time for anything other than the immediate issue for presentation, and no investigation by medical professionals into aspects other than physical symptoms.

*When we identify an issue, [we] start with wairua; immeasurable, intangible, unsee-able – there’s no place for this in a doctor’s clinic.*

- Whānau

There is the need to enhance the cultural responsiveness when working with whānau Māori: the model that doctors come from is a “real biomedical one instead of a psychosocial one – a real barrier.” The need to include wairuatanga in health care was strongly expressed and that medical practitioners need to consider the specific practices, values and beliefs associated with an individual’s connection to people and place and include this in the caring of whānau Māori.

Whānau felt that the Māori worldview does not come into consultations, that there is still a very individual focus, whereas many Māori think and operate as a collective, as a whānau.

*That’s what we do, we’re thinking about others consistently, knowing that our tamariki are okay makes us feel better, we put their health needs above our own.*

- Whānau

Experiences at Māori health providers were described as an exception. Māori health providers followed a wider perspective of hauora, are founded on tikanga Māori values and focus on whanaungatanga and genuine engagement with whānau Māori. Most DHB employees interviewed stated either that they didn’t know if there was a Hauora Model of health in place, or that if there was, it was poorly implemented and not generally well known.

#### 4.4.6. Tikanga Māori and te reo Māori

##### ***Experiences with regards to tikanga in health care ranged greatly***

Several whānau reported that no tikanga Māori practices were observed or allowed for in their consultations with doctors, and that it didn’t really come into play in a consultation. Some felt that ‘being Māori’ is often disregarded by their doctors and underscored the importance of doctors

knowing the local people, their histories and their struggles. It was stated that some doctors are just not aware of tikanga around the body, and an instance was described where a doctor reached out to touch the head and then responded angrily when the kuia tried to move away from him. This could have been mitigated if the appropriate respect was shown by asking permission first. Others described having to proactively explain these cultural preferences to the doctors in the hospital, and there wasn't the expectation amongst whānau that doctors would already know.

Another whānau described an experience where a tissue sample was required, it was very important to them that appropriate protocol was observed. However, the doctor saw this as "just skin." One participant noted that even the 'small' cultural practices like kanohi-ki-te-kanohi are not observed, with doctors mostly looking at their screens or somewhere else.

It was found that levels of understanding and engagement in te ao Māori varied between cities and rural areas – with doctors in the rural areas often noted to be more in touch with their communities and possessing a closer understanding of local people and their tikanga. It was also noted that some new doctors are more culturally aware than older doctors, and that this might reflect more modern training initiatives.

Some doctors have good awareness of tikanga and how this interacts with health. One patient reported that their doctor understands the need to attend tangi, and the processes and obligations involved, and importantly, the implications of attending tangi, returning to the marae and meeting wider whānau obligations for the health of the patient and whānau. Another spoke of very positive experiences with a non-Māori midwife who encouraged and ensured there was a space for karakia during and after childbirth. One English doctor was described who undertook te reo classes, attended noho marae and really tried to immerse himself, and this made a difference.

Some whānau described themselves as being unafraid to speak their mind with regards to values and tikanga practices that are important for them and are happy to speak up or question when they are concerned. It was appreciated when space was left for this input during consultations, rather than assumptions being made either way.

### ***Whānau appreciate doctors making an effort to speak te reo Māori***

With regards to doctors speaking te reo during consultations, the comment was made that "I would love it if they did." And even if the doctor didn't know much reo, it was felt they could still do a mihi, and that would contribute to a feeling of a safe environment for patients and whānau. It was felt that this would make the whole visit a lot more personal.

Others reported that both Māori and non-Māori staff at their practice use te reo greetings, and that this feels welcoming. Hauora Māori practices were generally seen as places where te reo was normalised, even among non-Māori staff. Some described doctors' efforts to use the Māori language with whānau and dropping "little gems of reo" in sentences during consultations, such as when asking a child to breathe in, the doctor counted in te reo. These efforts were appreciated, particularly in interactions with tamariki who respond positively and more openly.

Correct pronunciation of names is particularly important. It was noted again that these efforts seemed to be from the younger generation and/or those recently moved to Aotearoa from overseas. In general, there was the feeling that more te reo in the health environment would be welcomed.

This is balanced out by a word of caution from one of the te reo-speaking doctors interviewed, of the need to take care with use of te reo as many experience whakamā.

*While we need to make provision for the opportunity to engage, we need to be careful as many people have real whakamā (shame) about not having the reo, it is a sensitive area for many.*

- Doctor (Māori)

Doctors reported that best practice is to take guidance from the patients and whānau themselves as to the appropriate level to use during a consult; “people will speak when they are ready.”

The converse of this the mispronunciation of te reo, even common words such as whānau. There was general consensus that this was an issue, that te reo must be correctly pronounced, and that efforts of te reo inclusion but with poor pronunciation, were viewed by whānau as tokenistic.

*At minimum pronounce names correctly, it’s manaakitanga, even pronouncing English names right.*

- Whānau

#### 4.5. Question 5: What is the current status of Māori health equity, that is, the current status of health outcomes for Māori compared with non-Māori?

*Research question 5 was underpinned by the following values.*

- *Ōritetanga: equitable health outcomes for Māori and non-Māori across a range of health indicators.*
- *Rangatiratanga: kaupapa Māori principles are applied in the analysis of quantitative data.*

##### 4.5.1. Methodology

A kaupapa Māori approach has been taken in the equity analysis of health data. In recognition of the two partners in Te Tiriti o Waitangi, we have defined the groups for comparison as those who self-identify as Māori; and those who do not (non-Māori).

The analysis focuses on aspects of health that are widely accepted as being amenable to doctor practice – that is, enhanced cultural safety in doctor practice could result in better care for Māori patients, and over time could contribute to better health for Māori. Three indicators are included.

- Cases of patients being hospitalised for reasons that could have been avoided if they had received care earlier (Ambulatory Sensitive Hospitalisation (ASH) rates).
- Deaths from a range of diseases, acute and chronic conditions, accidents and suicide (all-cause mortality).
- The extent to which patients are getting the medication they need. We focused on asthma medication (dispensing of inhaled cortico-steroids after hospitalisation) and gout medication (any and regular dispensing of urate-lowering therapy) as these conditions particularly affects Māori.

Our analysis compares the non-Māori group to the Māori group in the calculation of rate ratios, rather than the more traditionally reported comparison of Māori vs non-Māori. This takes a non-deficit standpoint by framing the analysis to show the health privilege experienced by non-Māori. This kaupapa Māori method and approach has been implemented in a recent study (see Huria et al 2018<sup>10</sup>).

A rate ratio allows us to directly compare how frequently the non-Māori group experience each health outcome compared to Māori. A rate ratio of 1.0 (or with a confidence interval that includes 1.0) indicates there is no difference between these two groups for that particular equity indicator. A ratio below 1.0 indicates that non-Māori experience that particular health outcome at a lower rate than Māori (for example, non-Māori are hospitalised at a less frequent rate than Māori). A ratio of above 1.0 indicates that non-Māori experience that outcome at a higher rate than Māori (for example, non-Māori are more likely to be dispensed certain medications). The rate ratio of 1.0 is presented as a reference point in each ratio graph.

The Māori population has a very youthful age profile, which differs from that of the non-Māori group. To make robust comparisons between the two groups, standardising for age is required in order to remove age structure as a potential explanatory factor for any differences observed.

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<sup>10</sup> Huria T, Palmer S, Beckert L, Williman J and Pitama S (2018) Inequity in dialysis related practices and outcomes in Aotearoa/New Zealand: A Kaupapa Māori analysis. International Journal for Equity in Health, 17(17) <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-018-0737-9>

In keeping with kaupapa Māori philosophy, data has been standardised to the Census 2001 Māori population, which has been used as a standard in many other Māori health datasets,<sup>11</sup> and has also been a preferred standard for the Ministry of Health in Māori health analytics since 2006.<sup>12</sup> This standard is favoured for application to Māori health data as it more closely reflects the demographic circumstances of the Māori population.<sup>13</sup>

#### 4.5.2. Analysis methods

Data to inform the analyses were drawn from Statistics New Zealand's Integrated Data Infrastructure (IDI). This is a large research database that holds microdata from government agencies, Statistics NZ surveys, and non-government organisations. The data is linked together, or integrated, to form the IDI.

Calculation of hospitalisation and mortality rates uses data collected on those that experienced either death or hospitalisation (the numerator), and compares these numbers to the total number of people that could have been at risk of either death or hospitalisation in that particular time period (the denominator). These are presented as a rate per 100,000. For example, out of every 100,000 people in Aotearoa, how many experienced preventable hospitalisations?

Numerator data for hospitalisation and mortality analyses were drawn from the Ministry of Health public hospitalisation tables (events and diagnoses) and the mortality table.

The Statistics NZ's Estimated Residential Population (ERP)<sup>14</sup> has been used as the denominator. The ERP represents the best estimate of New Zealand's residential population available in the IDI.

Demographic information on age, sex, and ethnicity for individuals appearing in both the denominators and numerators were drawn from the 'personal details' table available within the IDI. This table draws on multiple sources (Ministry of Health, Inland Revenue etc.) and represents the 'best guess' regarding each individual's sex and birth date. Ethnicity in the personal details table is an 'ever' measure, meaning that if a person is ever recorded as Māori in any of the source datasets, during the time period of data analysis, then they appear as Māori in our dataset. This method addresses the undercounting of Māori in various datasets.

Analyses of post-hospitalisation pharmaceutical dispensing use unique denominators. The denominator for cortico-steroid dispensing in the year after asthma hospitalisation is all people who were hospitalised for asthma at that time.

Trend analyses were undertaken to assess changes in rates and ratios over time.

#### 4.5.3. Ambulatory Sensitive Hospitalisations (ASH)

***Non-Māori experience potentially avoidable hospitalisations at a consistently lower rate than Māori***

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<sup>11</sup> Such as Tatau Kahukura: Māori Health Chartbook, Tatau Kura Tangata: Health of Older Māori Chartbook, and Hauora Māori Standards of Health IV: a study of the years 2000-2005.

<sup>12</sup> [https://www.health.govt.nz/system/files/documents/publications/position-paper-maori-health-analytics-age-standardisation-nov18\\_0.pdf](https://www.health.govt.nz/system/files/documents/publications/position-paper-maori-health-analytics-age-standardisation-nov18_0.pdf)

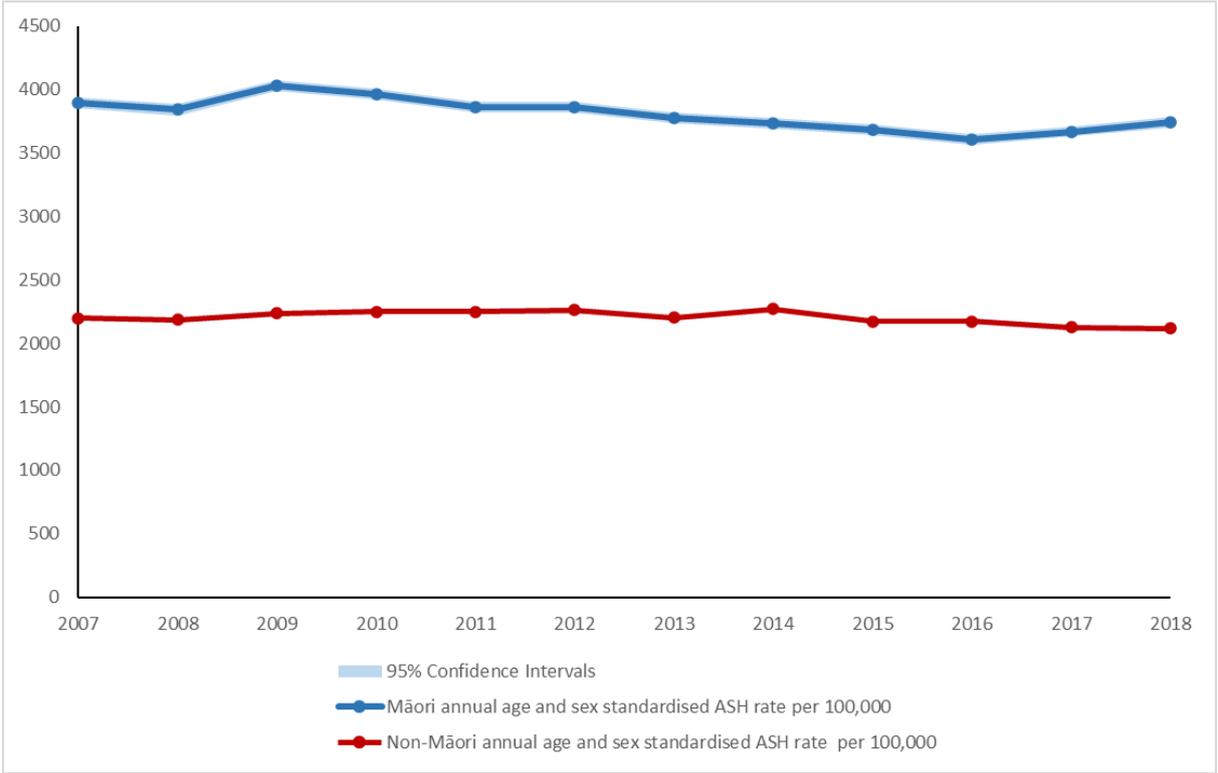
<sup>13</sup> This is described in Robson B, Purdie G, Cram F and Simmonds S (2007) Age standardisation – an indigenous Standard? Emerging Themes in Epidemiology, 4:3

<sup>14</sup> The ERP contains all individuals aged 5 and over who are in the IDI spine and who appear in ACC, IRD, MoH or education datasets in the previous 12 months. All children under 5 are included if they are part of the spine. The ERP accounts for deaths and migration. Further details are available here:

<https://www.stats.govt.nz/assets/Research/Identifying-the-New-Zealand-resident-population-in-the-Integrated-Data-Infrastructure/identifying-nz-resident-population-in-idi.pdf>

Ambulatory sensitive hospitalisations (ASH) are hospital admissions that are mostly acute (i.e. urgent) and are considered either preventable or reducible if the patient had received interventions in primary care. High ASH admission rates can indicate difficulty in accessing timely care, poor coordination or care continuity, barriers to primary care, or other structural constraints such as limited provider capacity and the availability of primary care workers. ASH rates are often considered a proxy marker for primary care access and quality.

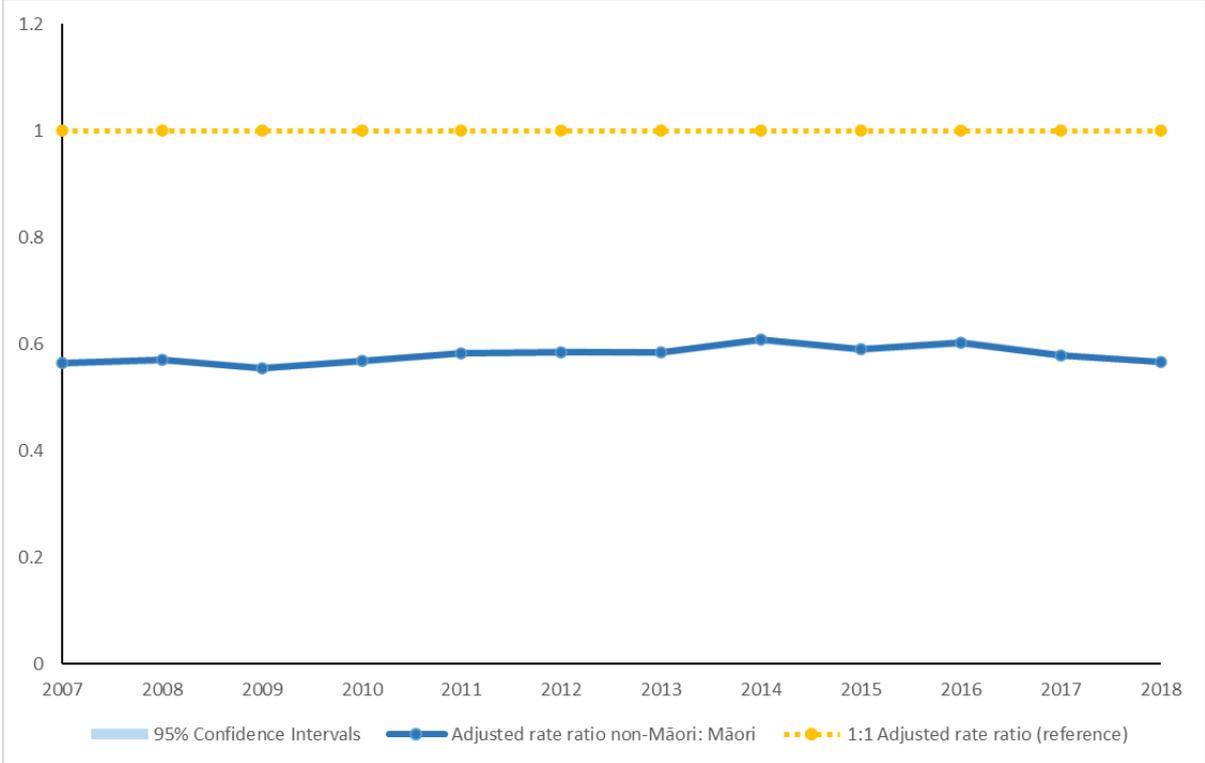
Our analysis of ASH rates shows consistently lower rates for non-Māori over the time period 2007-2018 (Figure 1).<sup>15</sup> This means that non-Māori were hospitalised for potentially avoidable reasons less frequently than Māori. In the five-year period from 2014 to 2018, the average age-standardised yearly rate for the non-Māori group was 2,171 per 100,000, and for non-Māori was 3,686 per 100,000.



**Figure 1: Total ASH rates by ethnicity (age-sex standardised using 2001 Māori Census population) per 100,000 people 2007-2018**

<sup>15</sup> Please note that for Figures 1 and 2, the confidence intervals are very tight. Consequently, they may be difficult to discern in the graphs.

Figure 2 shows that between 2007 and 2018, non-Māori experienced ambulatory sensitive hospitalisations, on average, 42% less than Māori (average rate ratio 0.58). During this time, the rate ratio was relatively consistent indicating no change in the disparity between non-Māori and Māori.



**Figure 2: ASH adjusted rate ratio (non-Māori vs. Māori) 2007-2018**

A more detailed examination of data from the most recent five years, from 2014 to 2018, shows that differences in ASH rates were typically less for non-Māori women compared to Māori women than for non-Māori men compared to Māori men, which indicates a greater inequity in males. In terms of age, differences in rates were greatest for non-Māori aged 45-64 compared with Māori aged 45-64.

***There is substantial inequity in hospitalisation for congestive heart failure. The inequities remain constant over the twelve-year time period from 2007 to 2018***

ASH rates were also examined by different causes of hospitalisation (Appendix B1). This showed that there is substantial inequity in hospitalisation for congestive heart failure, with the non-Māori group being hospitalised for congestive heart failure at a quarter of the rate of Māori. Non-Māori were also hospitalised much less frequently for asthma, cellulitis and diabetes. Detailed data on ASH rates for different causes of hospitalisation are discussed in Appendix B1.

For all ASH indicators in the twelve-year period from 2007 to 2018, the age-standardised rate ratios remained relatively constant, indicating no change in the inequity between non-Māori and Māori during this time.

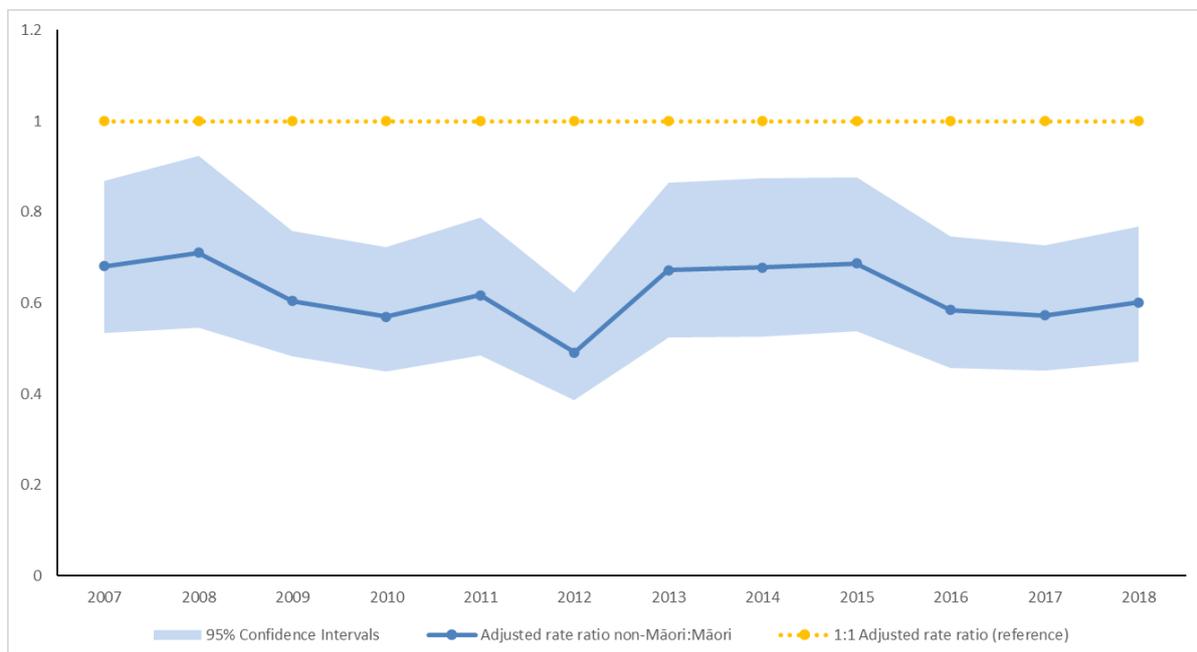
#### 4.5.4. Perioperative outcomes

Perioperative outcomes refer to the health status of a person after they have undergone surgery. Our analysis looked at outcomes for non-Māori and Māori following surgery involving general anaesthetic, which is considered to be 'major surgery'.

Prior work undertaken by the HQSC's Perioperative Mortality Review Committee has shown that there are significant disparities in perioperative outcomes for Māori.<sup>16</sup> The Committee notes that research indicates that at every step in a care pathway, Māori are more likely than non-Māori to experience delays or complications.

##### ***Non-Māori deaths within 30 days of surgery were at a consistently lower rate than Māori***

Between 2007 and 2018, mortality rates within 30 days of undergoing surgery were consistently lower for non-Māori (Figure 3). Rates of death for the non-Māori group ranged between 30-50% lower than Māori throughout this 12-year time period. The average age sex standardised rate ratio was 0.62.



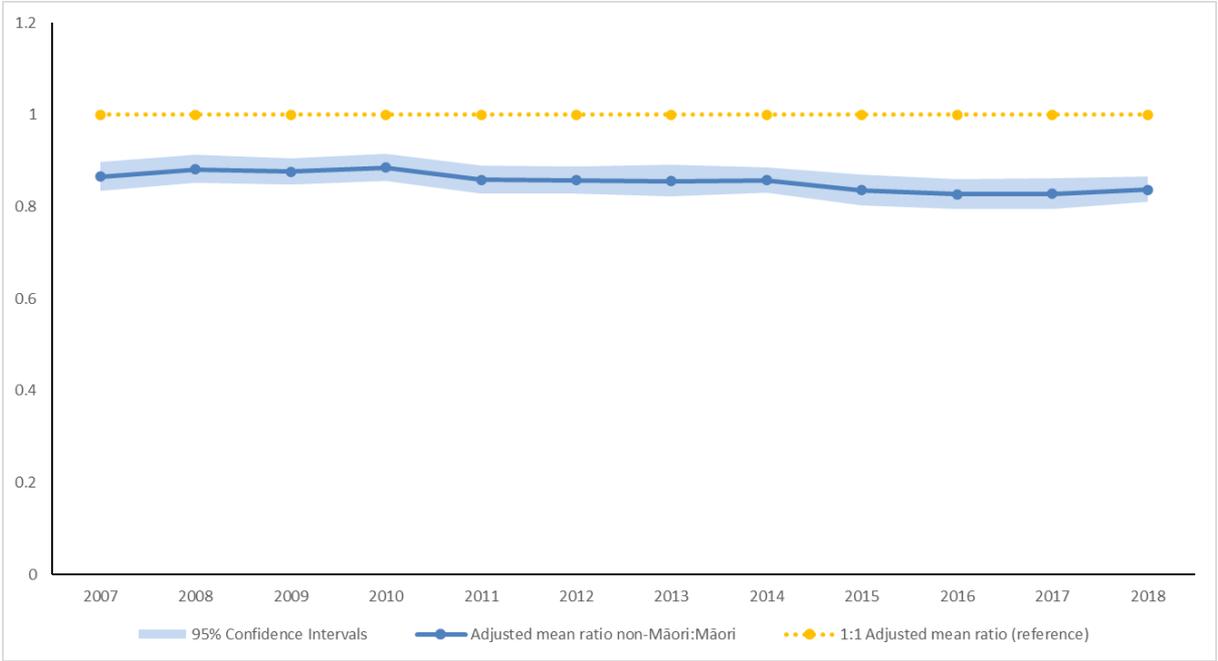
**Figure 3: Mortality within 30 days of surgery, adjusted rate ratio (non-Māori vs. Māori), 2007-2018**

Confidence intervals are wide because post-operative mortality rates for both Māori and non-Māori are low, however, the difference is still statistically significant in all years.

<sup>16</sup> POMRC. 2015. *Perioperative Mortality in New Zealand: Fourth report of the Perioperative Mortality Review Committee*. Wellington: Health Quality & Safety Commission 2015.

**Length of hospital stay following surgery is consistently shorter for non-Māori**

The length of time taken to recover from surgery is also an indicator of inequity. Data for 2007-2018 indicates that, on average, the length of time non-Māori remain in hospital following surgery with anaesthesia is 11-17% less than Māori (Figure 4). This pattern was consistent over the 12-year time period. The average age sex standardised rate ratio was 0.86.

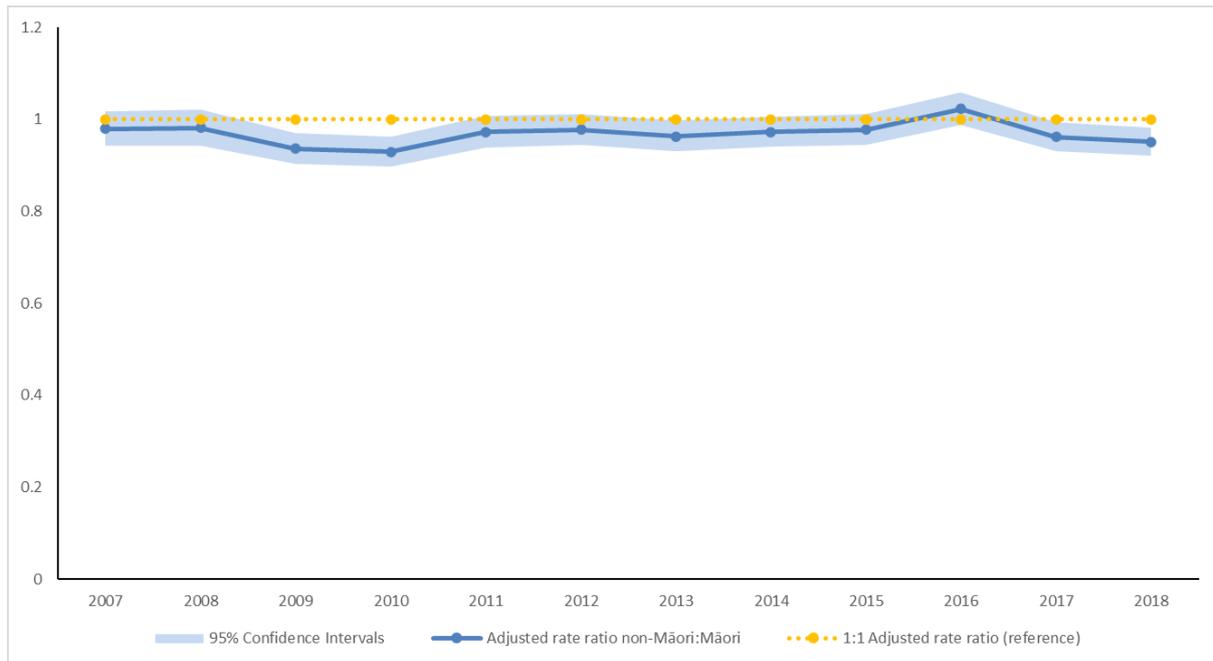


**Figure 4: Length of hospital stay following surgery involving general anaesthesia, adjusted ratio of means (non-Māori vs. Māori) 2007-2018**

**Rates of readmission were slightly lower for non-Māori in some years**

Unplanned readmissions to hospital following surgery are associated with poor patient outcomes, and often considered preventable. As a quality indicator, readmission rates reflect the impact of hospital care on a patient’s illness, and the coordination of care following discharge.

Between 2007 and 2018, the rate of readmission to hospital within 30 days of surgery showed no statistically significant difference between Māori and non-Māori in most years (Figure 5). Data for 2009-10 and 2017-18 indicated a slightly lower rate for non-Māori. The average age sex standardised rate ratio was 0.97.



**Figure 5: Readmission within 30 days of surgery, adjusted rate ratio (non-Māori vs. Māori), 2007-2018**

#### 4.5.5. Dispensing of selected pharmaceuticals

Dispensing of prescription medication can be impacted by aspects of doctor practice related to their ability to address a person’s needs (e.g. cultural safety, health literacy, knowledge and skills, adherence).<sup>17</sup> The analysis compared dispensing of medications for gout and asthma to non-Māori and Māori patients, as these are highlighted in the HQCS’s New Zealand Atlas of Health as conditions that particularly affect Māori people.

***Non-Māori were slightly more likely than Māori to be dispensed urate-lowering therapy for gout, and were statistically more likely to receive it regularly***

There is inequity in the prevalence of gout between Māori and non-Māori. Data reported by the HQSC shows that the prevalence of gout for the non-Māori, non-Pacific population aged 20–44 is four times lower than that of Māori.<sup>18</sup> The non-Māori, non-Pacific group also have later onset of gout and fewer hospital admissions than Māori.<sup>19</sup>

Urate-lowering therapy is recommended as a treatment for gout. The benefits of this therapy are realised when it is used continuously long-term.

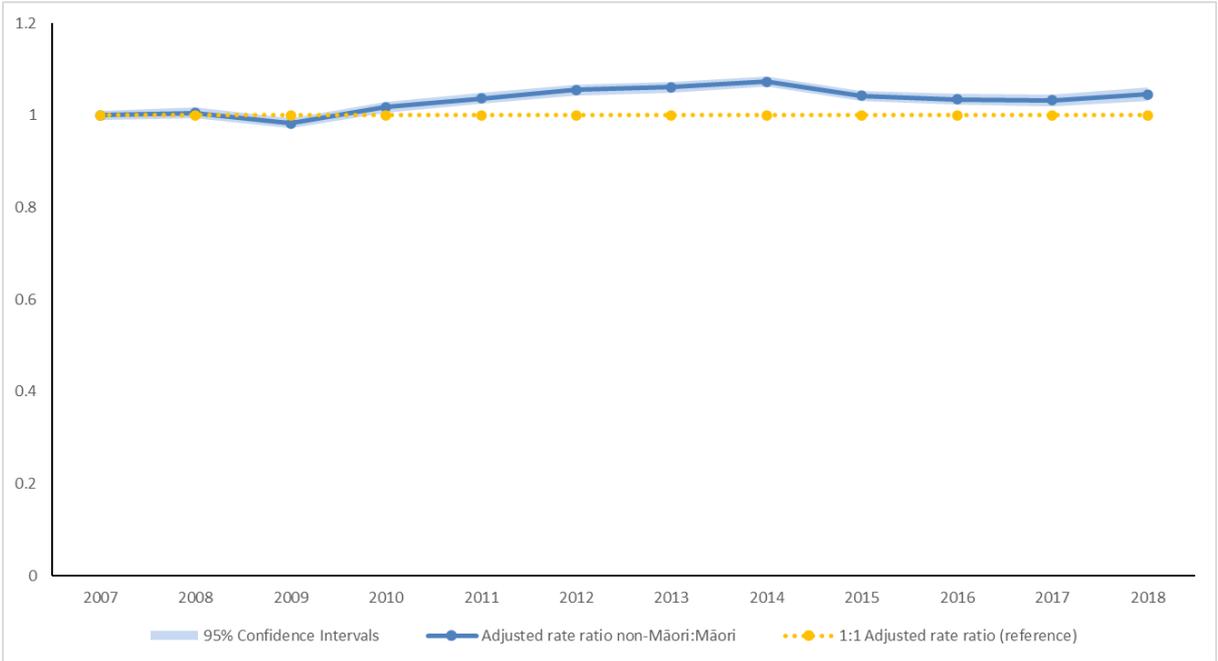
Our analysis first investigated any dispensing of urate-lowering therapy, defined by the New Zealand Atlas of Health as people dispensed medicine in one quarter in a year. Differences in dispensing patterns were small as, overall, both Māori and non-Māori gout patients were very likely to be dispensed urate-lowering therapy. However, the non-Māori group were slightly more likely to be

<sup>17</sup> PHARMAC. (2019). *Achieving medicine access equity in Aotearoa New Zealand: towards a theory of change*. Available at: <https://www.pharmac.govt.nz/assets/achieving-medicine-access-equity-in-aotearoa-new-zealand-towards-a-theory-of-change.pdf>

<sup>18</sup> <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/gout/>

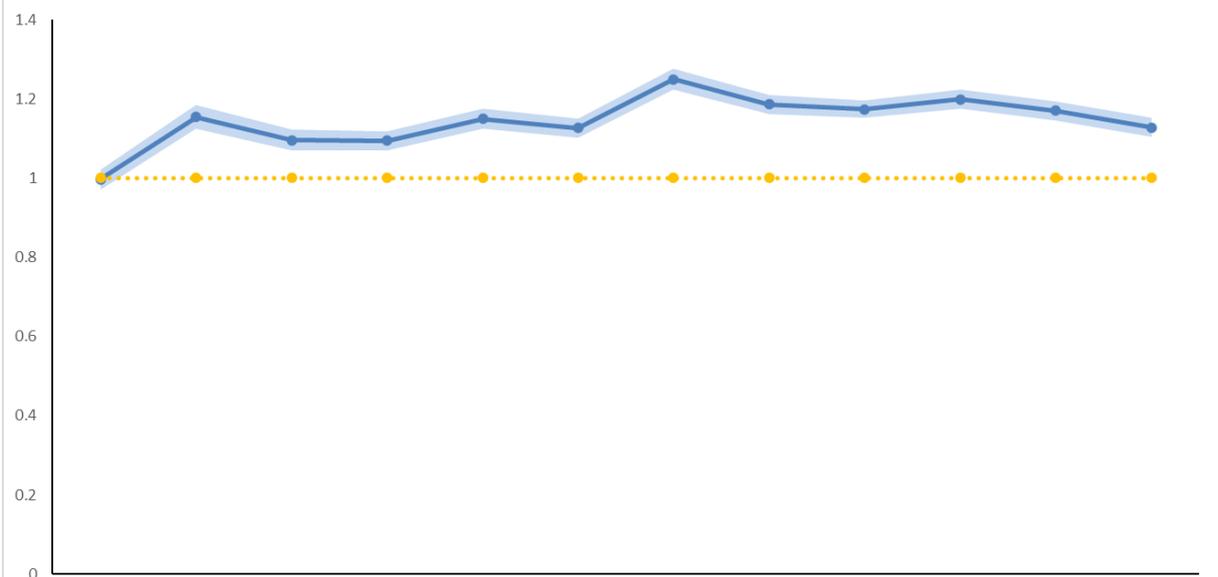
<sup>19</sup> Ibid

dispensed urate-lowering medication (Figure 6). This gap between non-Māori and Māori increased from 2009 to 2013, then remained constant through to 2018.<sup>20</sup>



**Figure 6: Any dispensing of urate lowering therapy for gout, adjusted rate ratio (non-Māori vs. Māori), 2007-2018**

It is important that urate-lowering therapy is used regularly. Intermittent use can lead to ongoing gout flares, joint damage, and disability. ‘Regular use’ is defined in the New Zealand Atlas of Health as dispensing for three or four quarters in a year. Analysis of regular dispensing shows that non-Māori were more likely to be regularly dispensed urate-lowering therapy than Māori. This indicates that gout



**Figure 7: Regular dispensing of urate lowering therapy for gout, adjusted rate ratio (non-Māori vs. Māori), 2007-2018**

<sup>20</sup> Please note that gout diagnosis information is only available up to 2015, so there are no newly diagnosed cases in the 2016-2018 samples.

medicine is more available to non-Māori over the year. The average age sex standardised rate ratio was 1.14.

***Overall rates of asthma medication dispensing following hospitalisation were low***

Evidence shows that non-Māori, non-Pacific people experience lower asthma severity than Māori, as indicated by lower rates of hospital admissions. In 2018, non-Māori, non-Pacific children aged 5-14 were about half as likely to be hospitalised for asthma as Māori children of the same age. Non-Māori, non-Pacific adults aged 15-49 years were about three times less likely to be hospitalised than Māori.<sup>21</sup> Non-Māori, non-Pacific were also less likely to be re-hospitalised for asthma during the year following their first admission.<sup>22</sup>

Our analysis explored dispensing of asthma medication following an asthma hospitalisation. Use of inhaled cortico-steroids (ICS) in the year following an asthma hospitalisation is an indicator for ongoing asthma management. ICS use following hospital discharge can reduce readmissions. The HQSC has defined appropriate ICS dispensing as at least one community dispensing of an ICS during two or more 3-month periods in the year following discharge from hospital for an asthma event. The overall rate of ICS dispensing in the year following hospitalisation is low. On average, 40% of people aged 5–49 years admitted to hospital with a primary diagnosis of asthma did not receive an ICS in two or more quarters in the year after admission.<sup>23</sup>

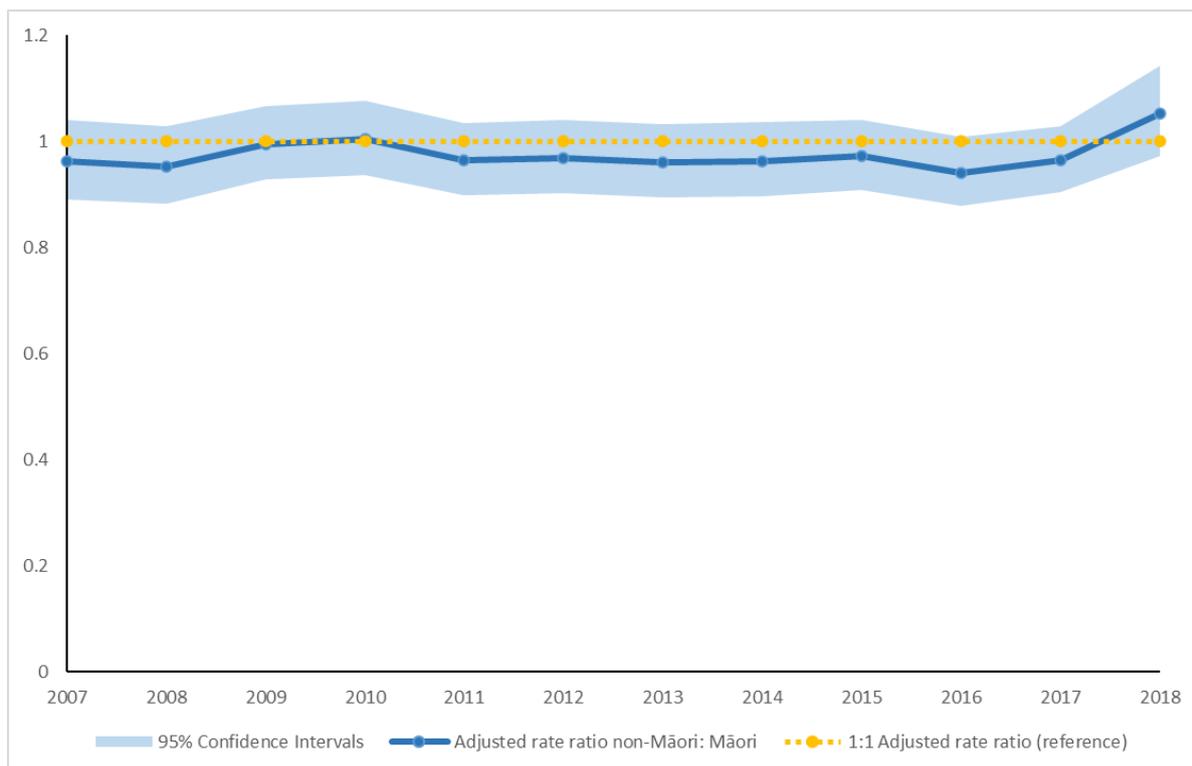
Rates of ICS dispensing were analysed for the period 2007-2018. During this time, no statistically significant difference was found between the non-Māori and Māori group in dispensing of ICS in the year following an asthma hospitalisation. The rate ratio remained relatively constant during this time, at around 1.0 (Figure 8). A more detailed analysis of data from the most recent five years (2013-2017) showed no clear differences between non-Māori and Māori by either sex or age group.

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<sup>21</sup> <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/asthma/>

<sup>22</sup> Ibid

<sup>23</sup> Ibid



**Figure 8: ICS dispensing for individuals hospitalised with asthma adjusted rate ratio (non-Māori vs. non-Māori) 2007-2017**

The HQSC notes that people who have been hospitalised for asthma are recommended to receive an influenza vaccine in the year after admission, as part of their preventive care. Overall rates of uptake are low. In 2018, only 15% of people aged 0-49 received a funded influenza vaccine in the year after admission. There is evidence of inequity in relation to vaccine uptake; in 2018, 17% of non-Māori, non-Pacific people received an influenza vaccine in the year after admission compared to 13% of Māori.<sup>24</sup>

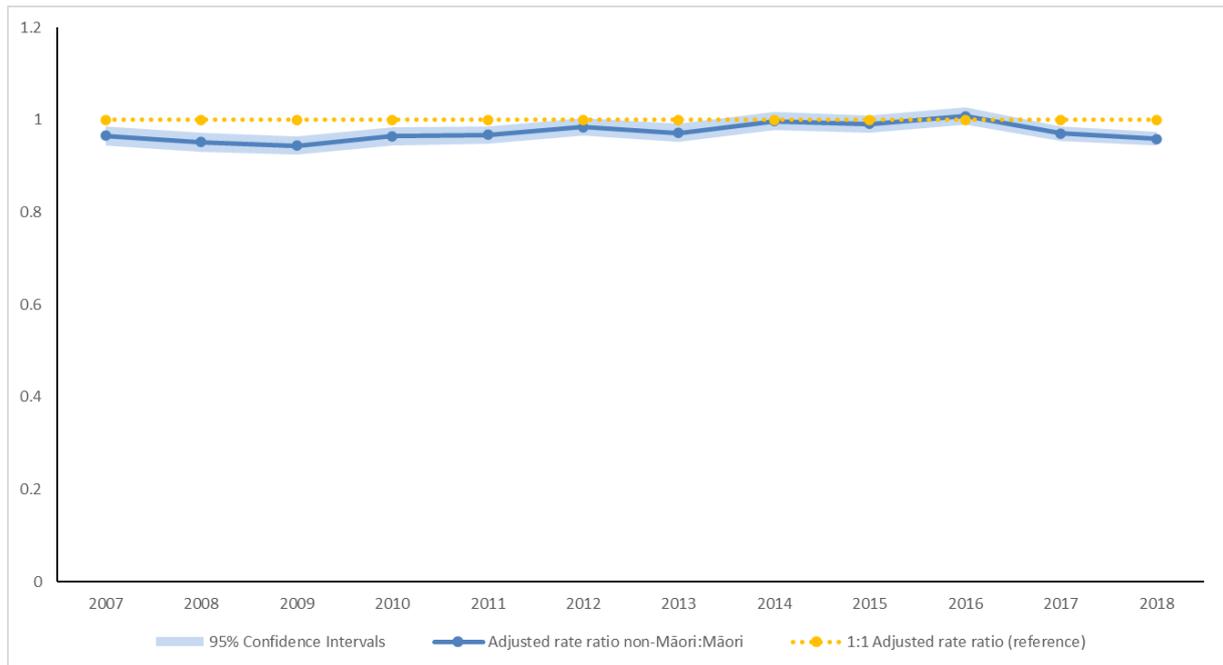
***Non-Māori were slightly less likely than Māori to be dispensed only reliever medications for asthma***

Appropriate medications for management of asthma include both preventative medication for regular use and reliever medication for use during exacerbations of this health condition. Use of reliever only may not provide adequate management of asthma.

During the 12-year time period of analysis, of those diagnosed with asthma, the non-Māori group were slightly less likely to be dispensed only reliever medications (Figure 9). This indicates they were more likely to receive both preventer and reliever than Māori with asthma.

This gap decreased between 2009 and 2016, and there was little difference between Māori and non-Māori in 2014-2016 but the gap increased again in 2017-2018.

<sup>24</sup> <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/asthma/>



**Figure 9: People dispensed reliever medication for asthma who were not dispensed preventers (inhaled corticosteroids), adjusted rate ratio (non-Māori vs. Māori), 2007-2018**

4.5.6. All-cause mortality

**Mortality rates are consistently lower for non-Māori; rates for both non-Māori and Māori are decreasing**

All-cause mortality presents data for overall deaths. It includes a wide range of diseases, acute and chronic conditions, as well as accidents and suicide. An examination of all-cause mortality data provides an overall view of inequity in deaths between Māori and non-Māori, whereas data by cause of death (provided in Appendix B2) provides a more detailed analysis on equity indicators that may be amenable or potentially avoidable with effective and timely care.

An examination of all-cause mortality data from 2007 to 2016 shows the non-Māori group experienced consistently lower rates of death compared to Māori (Figure 10). Although death rates decreased somewhat for both Māori and non-Māori during this time, the rate of decrease is similar, therefore the inequity between the two groups remained relatively constant.

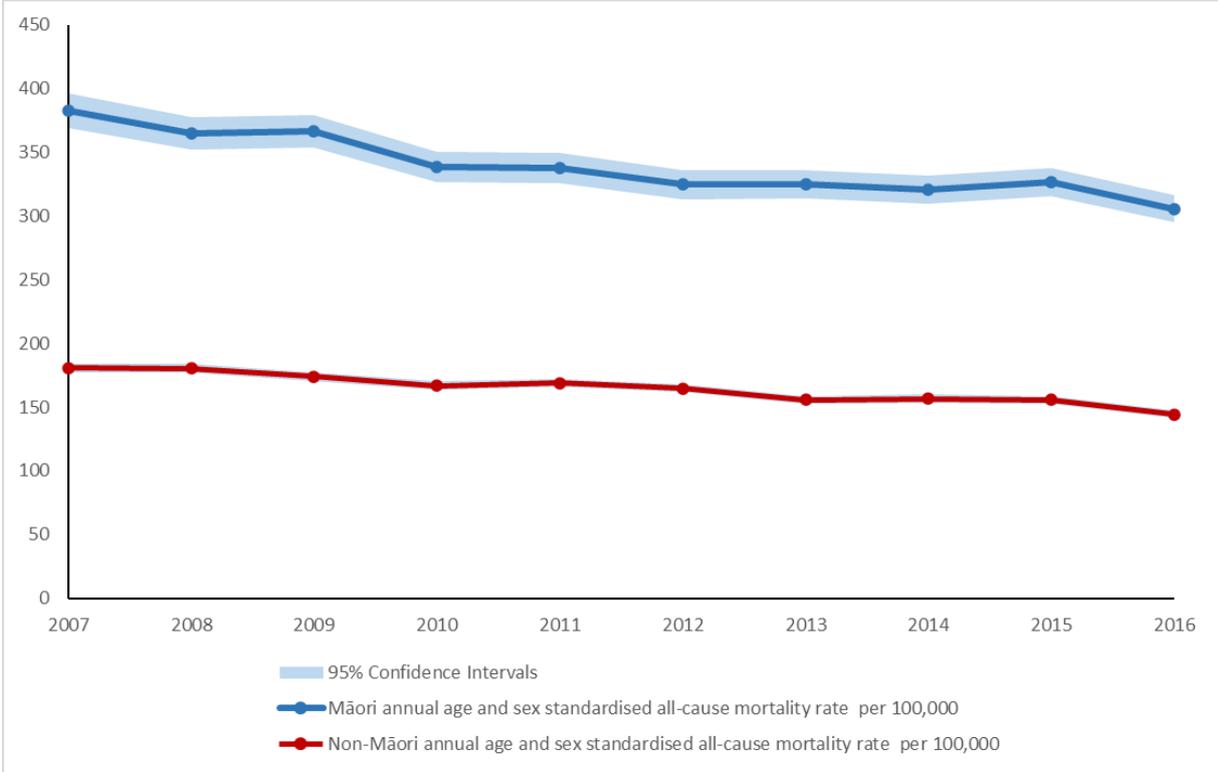
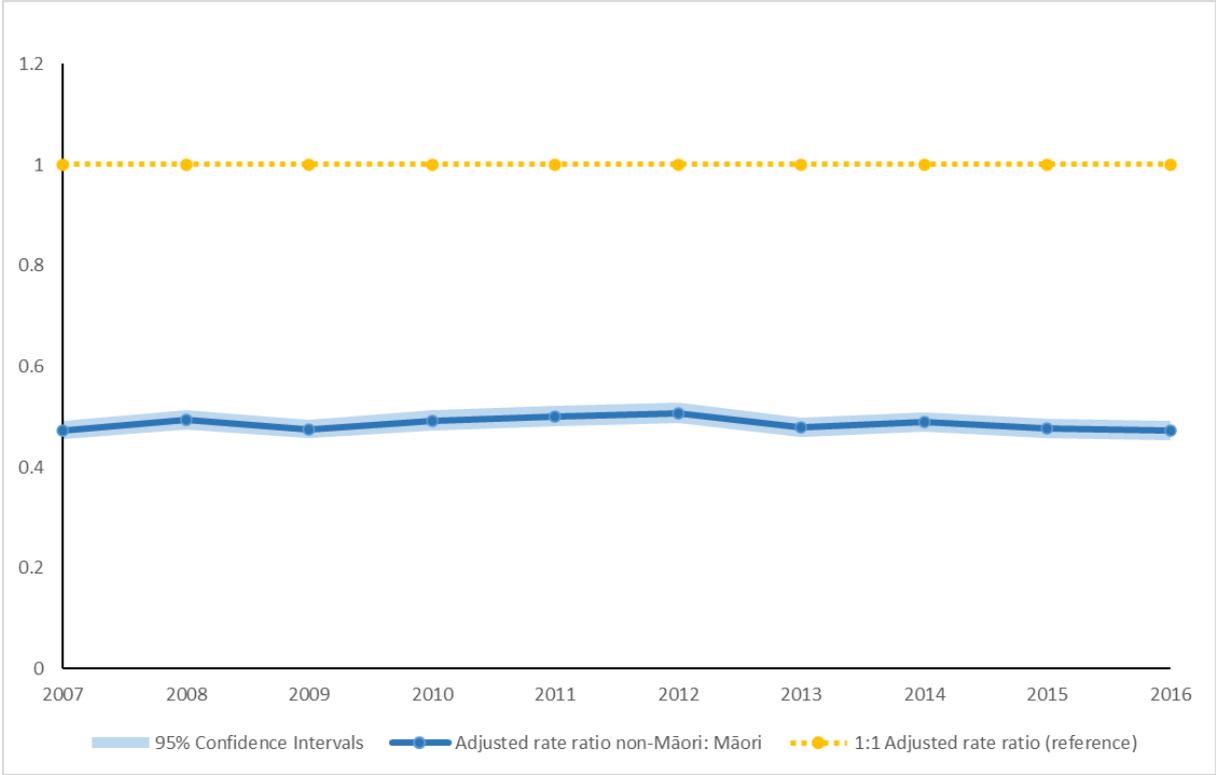


Figure 10: Age sex standardised (using 2001 Māori census population) all-cause mortality rates per 100,000 people 2007-2016

**Non-Māori deaths from all causes are approximately half the rate of Māori**

Comparing the non-Māori group to Māori indicates that the non-Māori group die at approximately half the rate of Māori during this period of analysis (Figure 11). The average age sex standardised rate ratio was 0.48.



**Figure 11: All-cause mortality adjusted rate ratio (non-Māori vs. Māori) 2007-2016**

A more detailed analysis of data from the most recent five years (2012-2016) showed no clear pattern by sex in terms of non-Māori compared to Māori rate ratios. In terms of age, differences in rates were greatest for non-Māori aged 25-44 compared to Māori aged 25-44, and non-Māori aged 45-64 compared to Māori aged 45-64.

**There is substantial and entrenched inequity in death from diabetes, circulatory and respiratory conditions**

Mortality rates were examined by different cause of death. The greatest disparity was observed in deaths from diabetes, where the non-Māori group dying five times less frequently than Māori (average rate ratio 0.19). There were also substantial inequities observed in deaths from circulatory and respiratory conditions with non-Māori dying at approximately 40% the rate of Māori (average rate ratios 0.42 and 0.38 respectively). For both cancer and suicide, an average rate ratio of approximately 0.56 was observed during this time. These data are presented in Appendix B2.

For all mortality data, the disparity remained relatively constant over the twelve-year period of analysis, showing no change during this time.

## 5. CONCLUSION

This section sets out the overall conclusions related to each of the key research questions.

### **What is the current status of doctor contribution to an environment of cultural safety in healthcare in Aotearoa?**

Doctors in Aotearoa are being well prepared for culturally safe practice through their undergraduate education, in which aspects of cultural safety are embedded into student learning. There is a deliberate move away from teaching ‘cultural competence’ to the foundations of cultural safety, including awareness of bias, power dynamics, patient engagement models, and the development of critical consciousness.

This is resulting in a cohort of new graduate doctors who are conversant in the principles of culturally safe practice, motivated to address inequity and equipped with tools to support ongoing self-reflection and practice development.

However, from the point of completing undergraduate medical education, it is largely up to the motivation of the individual doctor to continue to enhance their practice in relation to cultural safety. Once medical school graduates enter prevocational and vocational training, cultural safety becomes less of an educational focus. Students enter work environments and a senior medical workforce that often privileges clinical outcomes. While the curriculum for prevocational training, and some vocational curricula, include learning outcomes related to cultural safety/competence, this in and of itself is not adequate to ensure that doctors develop culturally safe practice. Similarly, although some Colleges have heavily incentivised or mandated completion of CME modules related to cultural safety, doctors noted that it is possible to complete recertification requirements without changing practice.

The current doctor workforce includes a group of doctors who consider that they ‘treat everybody the same’ and do not need to change or adapt their processes to accommodate a range of cultural groups. This cohort is typically, but not exclusively, of Pākehā ethnicity and completed training prior to 2000. These doctors expressed discomfort with the idea that they may be biased and expressed that they did not see value in attending education sessions or undertaking reflective practice activities focused on cultural safety. These doctors did not respond to the current suite of mechanisms embedded in the system to prompt them to enhance the cultural safety of their practice and present a challenge for efforts to develop an environment of culturally safe care.

On the other hand, a growing portion of the doctor workforce (predominantly younger doctors, and those of Māori or Pasifika ethnicity) who see the importance of culturally safe practice, are committed to health equity, and are motivated to continuously develop their practice. As this cohort grows in numbers it may provide impetus for the rest of the workforce to change their practice.

### **What is the current status of doctor contribution to an environment of cultural safety for Māori patients and whānau in Aotearoa?**

Formal medical education’s role in preparing doctors to provide culturally safe care for Māori patients and whānau is in line with the findings outlined above. Undergraduate medical education has evolved to the point where it now places substantial emphasis on providing students with a strong foundation in hauora Māori, and some ability and knowledge of reo and tikanga. Prevocational training, vocational training, and recertification are acting as a system bottleneck, at which point doctors can choose to continue culturally safe practice development or can meet system requirements with little genuine engagement.

Once in employment, doctors have a range of training opportunities that they can access to enhance their practice with Māori, but uptake very much depends on the motivation of the individual doctor. Currently, funding for this training often comes from the Hauora Māori budget, which both places the responsibility on the Māori Health group in the workplace and redirects resource away from hauora Māori.

The majority of doctors engaged for this research were reluctant to place themselves in uncomfortable situations, despite being aware that small accommodations would enhance the patient experience. For example, while most doctors could speak a few words of te reo Māori, few made efforts to do so. Doctors also reported being aware that Māori may experience barriers to accessing healthcare but were not willing to make changes to established structures such as strict adherence to appointment times.

There were some positive aspects of doctor practice. Most doctors were conversant with tikanga related to health and made efforts to practice in line with tapu. Those working in hauora environments (including doctors of both Māori and non-Māori ethnicity) typically worked from a more holistic model of care, which doctors and whānau reported had positive impacts on Māori engagement in health.

Doctor perceptions of the extent to which they care for Māori in a culturally safe way contrasts on some aspects of how whānau themselves perceived their interactions. A large cohort of doctors considered that they were welcoming to all and were adequately building relationships with whānau in order to deliver appropriate care. This contrasts with the views of whānau, who often saw the relationship as transactional and ineffective at meeting their health needs.

### **Question 3: What is the current status of Māori doctors' experiences of cultural safety amongst their non-Māori colleagues?**

In the last two decades there has been concerted effort put into increasing the recruitment and retention of Māori students in medicine. This includes dedicated support programmes in both medical schools, and innovative collaborations between schools, health providers, communities, universities and Kia Ora Hauora that have effectively increased the intake and improved the experience of Māori students. The success of these efforts is reflected in the achievement of population parity in recent years, and through the experiences of both Māori patients and staff who see a new generation of doctors coming through.

Inclusion of reo and tikanga in medical curricula reduces the cultural loading on Māori students, however there is evidence of additional responsibilities placed on Māori doctors in employment, with little recognition of these, and further added to by community demands on doctors' time and energies. Māori doctors seek to mitigate the impact of these added challenges through the establishment of peer group networks, and by limiting the number of committees they are involved in, however further support from employers and work environments would be beneficial.

Considerable changes to work environments would contribute to a culturally safe environment for Māori; many DHBs have strategies that have been developed in consultation with community and are founded on tikanga Māori principles. At present, there is a hesitation to implementing reo and tikanga practices in some workplaces, for fear of the 'eye-rollers'. Māori doctors describe an inherently biased system that underlies their workplace and workplace experiences. It requires confronting the mechanisms of colonialism, racism, bias and privilege in order to build legislation, appropriately direct resources, and ultimately contribute to a culturally safe environment for Māori in the medical profession.

Māori decision-making representation on boards of DHBs and PHOs is varied and minimal and requires considerable courage and assertiveness of individual members in order to have their voice heard. A co-design model with equitable decision-making power is a preferred structure.

**Question 4: What is the current experience of cultural safety amongst Māori receiving health care from doctors?**

The feeling of being patronised by doctors, being talked *at*, or *down to*, has been normalised for some by many years of this experience and has become an intergenerational expectation. Māori patients and whānau feel like they are not listened to, have little input into decisions on their health, and feel that they are processed through the health system on a conveyor belt. Time and appointment constraints mean a focus on the immediate concern, with no opportunity for a holistic assessment of health, to attend to multiple ailments, or to see multiple family members in the one consultation slot. Wait times and the inability to see the doctor of choice were also described as barriers, serving to distance patients and whānau from the health system, and from their own health.

There is little opportunity to develop relationships with doctors, and communication is often poor and inadequate, with doctors often making assumptions on the health literacy level of patients and whānau. Power imbalances in consultations leave whānau feeling disempowered in decision-making and frustrated at being unheard. A knowledge of the health jargon, patient rights, and a level of assertiveness and persistence were seen as essential for navigating the health system.

Some whānau did report positive experiences, and it seemed to depend very much on the individual doctor. Most doctors were respectful of basic tikanga practices and some included a level of reo in their consultations, the most appropriate approach is to gauge the level preferred by individuals and whānau. Strengthening doctor knowledge of tikanga and reo was viewed as important for authentic inclusion in consultations and wider health services.

Experiences at Māori health services were invariably reported as positive, whānau described a sense of whanaungatanga with their doctors, involvement in their own health journeys, and the feeling that they could connect with their doctor on a personal level, and felt genuinely cared for.

**Question 5: What is the current status of Māori health equity, that is, the current status of health outcomes for Māori compared with non-Māori?**

Non-Māori experience better health outcomes than Māori in potentially preventable hospitalisations, recovery after major surgery, and in death from a range of causes. This indicates health inequity between the two groups.

There is substantial difference in the rates at which non-Māori and Māori are hospitalised for avoidable reasons. Non-Māori were hospitalised 42% less than Māori over a ten-year period, with an even greater inequity in hospitalisation for congestive heart failure, asthma, cellulitis and diabetes.

The analysis also shows severe inequity in outcomes for Māori and non-Māori after undergoing surgery. On average, the death rate for non-Māori within 30 days of major surgery was 40% lower than for Māori during the ten-year time period. Non-Māori also recover from surgery more quickly, staying in hospital for a shorter time period following their operation.

Similarly, non-Māori have substantial health privilege in outcomes related to mortality. Data for all causes of death shows that non-Māori died at approximately half the rate of Māori during the period of analysis. When the data is looked at by cause of death, there is considerable disparity in indicators that may be amenable or potentially avoidable with effective and timely care. Non-Māori died five

times less frequently than Māori from diabetes, and less than half as frequently from both circulatory and respiratory conditions.

Non-Māori experience later onset, lower prevalence, and fewer hospitalisations for gout than Māori. While any dispensing of gout medication is slightly higher for non-Māori, data on appropriate dispensing (i.e. allowing for continuous therapy) shows that non-Māori are more likely to be regularly dispensed urate-lowering therapy.

Non-Māori experience health privilege in terms of having lower rates of hospital admissions and lower rates of repeat hospitalisations for asthma. Overall rates of asthma medication dispensing following hospitalisation were low, and non-Māori were more likely to receive an influenza vaccine as preventive treatment.

An important finding across these analyses is that the observed inequities are entrenched, with little or no change to the extent of disparity over the period of analysis.

More positively, the data shows that non-Māori and Māori had relatively equitable rates of readmission to hospital within 30 days of surgery. The rate ratio for this indicator showed no statistically significant difference between non-Māori and Māori.

## APPENDIX A: FRAMEWORK OF INDICATORS AND MEASURES

The indicators and measures provided in the following framework seek to identify what cultural safety “looks like” in the context of doctor practice and patient care for the purposes of this project. The framework also includes core value(s)/mātāpono associated with each indicator, the data source, data collection method, and any notes on relevant contextual factors.

**Research question 1: What is the current status of doctor contribution to an environment of cultural safety in healthcare in Aotearoa?**

Indicator	Measure(s)	Data source	Data collection method
Medical education supports cultural safety in doctors' practice  MANAAKITANGA	Medical education, prevocational, and vocational training requirements related to cultural safety in doctors' practice	Medical schools Medical colleges	Examine content of curriculum Interviews with medical school and medical college representatives
	Certification and recertification requirements related to cultural safety in doctors' practice	Medical colleges	Examine requirements Interviews with medical college representatives
	Doctor perceptions of the value and usefulness of the cultural safety education and training they receive	Doctor self-reporting	Interviews with doctors
	Employer requirements for participation in ongoing training related to cultural safety, and type and frequency of training	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
Entities that employ doctors encourage culturally safe practice  MANAAKITANGA	Employers have policies, guidelines, implementation frameworks, and workforce development plans to support cultural safety in doctors' practice	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
	Employers have key performance indicators and/or standards for cultural safety in doctors' practice	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel

Indicator	Measure(s)	Data source	Data collection method
	Entities that employ doctors allocate resources to initiatives to support cultural safety in doctors' practice	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
Doctors develop a critical consciousness with regards to providing culturally safe care	Doctors report that they engage in critical reflection on their own attitudes, values, biases, and preferences	Doctor self-reporting	Interviews with doctors
PŪKENGATANGA	Doctors identify areas of weakness in their practice and commit to acquiring new skills and knowledge to address the gap(s)	Doctor self-reporting	Interviews with doctors
	System mechanisms are in place to encourage critical reflection and acquisition of new skills and knowledge to address identified gaps	Medical colleges	Interviews with medical college representatives
	Doctors recognise the power dynamics in their relationships with patients, including imbalances in health care interactions	Doctor self-reporting	Interviews with doctors
Doctors deliver culturally safe care	Doctors acknowledge and validate the cultural context in which patients operate in relation to their health, including their beliefs, values and experiences	Doctor self-reporting	Interviews with doctors
MANAAKITANGA	Doctors deliver care in ways which balance the power relationships in interactions with patients	Doctor self-reporting	Interviews with doctors
	Patient views on the extent to which they feel culturally safe in their interactions with doctor(s)	Engagement with patients	Interviews with patients; poster installation

**Research question 2: What is the current status of doctor contribution to an environment of cultural safety for Māori patients and whānau in Aotearoa?**

<b>Indicator</b>	<b>Measure(s)</b>	<b>Data source</b>	<b>Data collection method</b>
Medical education supports doctors in achieving cultural safety in care for Māori  PŪKENGATANGA	Portion of medical school curriculum (ELM and ALM) dedicated to hauora Māori in the three categories: immersed, integrated and independent	Medical school curricula	Examine content of curriculum Interviews with medical school representatives and experts in hauora Māori education
	Inclusion of and assessment of te reo Māori in curriculum	Medical school curricula	Examine content of curriculum Interviews with medical school representatives
	Inclusion of and assessment of tikanga Māori in curriculum	Medical school curricula	Examine content of curriculum Interviews with medical school representatives
Doctors are supported to achieve cultural safety in care for Māori through vocational training and practice  PŪKENGATANGA	Requirements for prevocational training related to cultural safety with Māori	Medical colleges	Interviews with medical college representatives
	Requirements for vocational training related to cultural safety with Māori	Medical colleges	Interviews with medical college representatives
	Requirements for certification and recertification related to cultural safety with Māori	Medical colleges	Interviews with medical college representatives
	Requirements related to cultural safety with Māori in continual professional development (CPD), professional development plans (PDP), regular practice reviews (RPR), and other competency assurance mechanisms.	Medical colleges	Interviews with medical college representatives
Entities that employ doctors encourage cultural safety in practice with Māori  PŪKENGATANGA	Employers have policies, guidelines, strategies and implementation frameworks that promote ongoing development to achieve cultural safety in	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel

Indicator	Measure(s)	Data source	Data collection method
	practice with Māori, and for tikanga and reo		
	Employers have key performance indicators and/or standards for cultural safety in practice with Māori, and for tikanga and reo	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
	Employers allocate resources to initiatives that support cultural safety in practice with Māori, and for tikanga and reo	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
Doctors develop a critical consciousness with regards to cultural safety in care to Māori  PŪKENGATANGA	Doctors acknowledge the wider context of health for Māori including the impacts of privilege, racism and social determinants and how these contribute to health inequities; and their role in addressing these.	Doctor self-reporting	Interviews with doctors
	Doctors identify areas of improvement in their practice with regards to tikanga and reo, and commit to strengthening their skills and knowledge in these areas	Doctor self-reporting	Interviews with doctors
Doctors have relevant skills and knowledge regarding cultural safety in practice with Māori  PŪKENGATANGA	Doctors demonstrate knowledge of te reo Māori	Doctor self-reporting	Interviews with doctors
	Doctors demonstrate knowledge of tikanga Māori	Doctor self-reporting	Interviews with doctors
	Doctors demonstrate knowledge of key Māori concepts and how they apply to the delivery of health care	Doctor self-reporting	Interviews with doctors
Doctors achieve cultural safety in care to Māori patients and whānau	When engaging with Māori patients and whānau, doctors apply appropriate relationship-	Doctor self-reporting; Māori patients and whānau	Interviews with doctors; interviews with Māori patients and whānau; poster installation

Indicator	Measure(s)	Data source	Data collection method
MANAAKITANGA	building skills that recognise power dynamics		
	Doctors validate the cultural context for Māori regarding health, make provision for this in their treatment plan as required, and acknowledge the diversity of Māori patients and whānau within this context	Doctor self-reporting; Māori patients and whānau	Interviews with doctors; interviews with Māori patients and whānau; poster installation
	Doctors apply an appropriate model of hauora during clinical assessment that situates the health journey of Māori in its historical, socio-political context	Doctor self-reporting; Māori patients and whānau	Interviews with doctors; interviews with Māori patients and whānau; poster installation
	Doctors demonstrate appropriate communication with Māori patients and whānau, ensure understanding and provide adequate information to guide shared decision-making	Doctor self-reporting; Māori patients and whānau	Interviews with doctors; interviews with Māori patients and whānau; poster installation
	Doctors allow for the involvement and inclusion of whānau in the health journey of a Māori patient	Doctor self-reporting; Māori patients and whānau	Interviews with doctors; interviews with Māori patients and whānau; poster installation

**Research question 3: What is the current status of Māori doctors' experiences of cultural safety amongst their non-Māori colleagues?**

Indicator	Measure(s)	Data source	Data collection method
Māori doctors participate in the doctor workforce	Proportion of Māori trainees entering Medical School	MCNZ Workforce Survey	Analysis of MCNZ Workforce Survey
MANAAKITANGA	Proportion of Māori doctors that graduate Medical School	MCNZ Workforce Survey	Analysis of MCNZ Workforce Survey

Indicator	Measure(s)	Data source	Data collection method
	Proportion of Māori doctors that enter postgraduate vocational training	Medical colleges	Interviews with representatives of medical colleges
	Proportion of Māori doctors that complete vocational training	Medical colleges	Interviews with representatives of medical colleges
	Proportion of Māori doctors in medical specialisations	Medical colleges	Interviews with representatives of medical colleges
	Retention rates of Māori doctors in the workforce	MCNZ Workforce Survey	Analysis of MCNZ Workforce Survey
Entities that employ doctors support Māori doctors during their employment MANAAKITANGA	Employers have reo, tikanga, and hauora Māori strategies, and a commitment to the Treaty of Waitangi	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
	Employers make provision for, and adequately resource ongoing reo, tikanga, and hauora Māori training for Māori doctors that are appropriate to their needs	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
	Entities that employ doctors implement initiatives to foster culturally inclusive workplaces	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
	Employers offer recognition and support for Māori doctors who experience additional demands as a result of their cultural identity	Entities that employ doctors	DHB survey Interviews with DHB and PHO personnel
Māori doctors work in a culturally safe environment MANAAKITANGA	Māori doctors report that interpersonal interactions with their non-Māori colleagues uphold and validate their beliefs, values and experiences	Māori doctors	Interviews with Māori doctors

Indicator	Measure(s)	Data source	Data collection method
	Māori doctors report that their workplace environment supports them as Māori	Māori doctors	Interviews with Māori doctors

**Research question 4: What is the current experience of cultural safety amongst Māori receiving health services from doctors?**

Indicator	Measure(s)	Data source	Data collection method
Māori patients and their whānau are informed, engaged, and participate in decisions that affect them  RANGATIRATANGA	Māori patients report that they feel listened to by their doctors	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
	Māori patients report that their doctors explain things in a way that is easy to understand	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
	Māori patients report that they have as much involvement as they want in decisions that affect them	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
	Māori patients report that they feel empowered to voice their opinions, health aspirations, and needs	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
	Māori patients report that they are provided with appropriate, timely, and comprehensive information that supports their decision-making	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
Māori patients receive care/services in a mana-enhancing manner  MANAAKITANGA	Māori patients report that their doctors treat them with kindness, understanding and respect	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
	Māori patients report that whānau presence and inclusion is welcomed in medical settings (as desired)	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation

Indicator	Measure(s)	Data source	Data collection method
	Māori patients report that their doctors uphold and validate their beliefs, values, and experiences	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
	Māori patients report that provision is made for appropriate reo and tikanga (as required)	Māori patients and whānau	Interviews with Māori patients and whānau; poster installation
Māori are represented in decision making structures in the health system	Representation of Māori on health facility governance groups and committees	DHB and PHOs	DHB survey Interviews with DHB and PHO personnel
RANGATIRATANGA	Māori members of governance groups report that they are adequately supported in their role	Governance group members	Interview/survey
	Māori members of governance groups report that their views and opinions are valued, and they are empowered to contribute in the decision-making process	Governance group members	Interview/survey

**Research question 5: What is the current status of Māori health equity, that is, the current status of health outcomes for Māori compared with non-Māori?**

Indicator	Measure(s)	Data source	Data collection method
Māori patients' rates of ambulatory sensitive hospitalisation compared to non-Māori patients	Total ASH rates (modified ASH and standard ASH)	National Minimum Dataset	Extraction and analysis of data from IDI
ŌRITETANGA	Rates for hospitalisations (modified ASH and standard ASH) for: angina/chest pain, asthma, cellulitis/skin infections, congestive heart failure, epilepsy, gastroenteritis, and pneumonia.	National Minimum Dataset	Extraction and analysis of data from IDI
Māori patients' perioperative outcomes compared to non-Māori patients	Mortality rates from any cause of death in the 30 days after surgery involving general anaesthetic	National Minimum Dataset and mortality data	Extraction and analysis of data from IDI

Indicator	Measure(s)	Data source	Data collection method
ŌRITETANGA	Number of days in hospital post-surgery	National Minimum Dataset and mortality data	Extraction and analysis of data from IDI
	Rates of re-admission post-surgery	National Minimum Dataset and mortality data	Extraction and analysis of data from IDI
Māori patients' access to selected pharmaceuticals compared to non-Māori patients ŌRITETANGA	Rates of dispensing of urate lowering therapy (gout)	Pharmaceutical Collection	Extraction and analysis of data from IDI
	Proportion of people hospitalised for asthma who were not regularly dispensed an inhaled corticosteroid (ICS) in the year after admission	Pharmaceutical Collection	Extraction and analysis of data from IDI
	Proportion of people aged 0-49 with asthma who have ever been dispensed an inhaled steroid and then only dispensed relievers	Pharmaceutical Collection	Extraction and analysis of data from IDI
Māori patients' mortality rates compared to non-Māori patients ŌRITETANGA	Overall mortality rates from any cause of death	Mortality data	Extraction and analysis of data from IDI
	Mortality rates from specific causes (circulatory system diseases; endocrine, nutritional and metabolic diseases; respiratory diseases)	Mortality data	Extraction and analysis of data from IDI

APPENDIX B: DETAILED ANALYSIS OF HEALTH EQUITY DATA

B1 Appendix Ambulatory Sensitive Hospitalisations (ASH)

B1.1 ASH Congestive heart failure

Non-Māori experienced ASH for congestive heart failure at approximately a quarter of the rate of Māori. The average rate ratio was 0.25 in the twelve-year time period. This inequity remained consistent over the time period analysed (Figure 12).

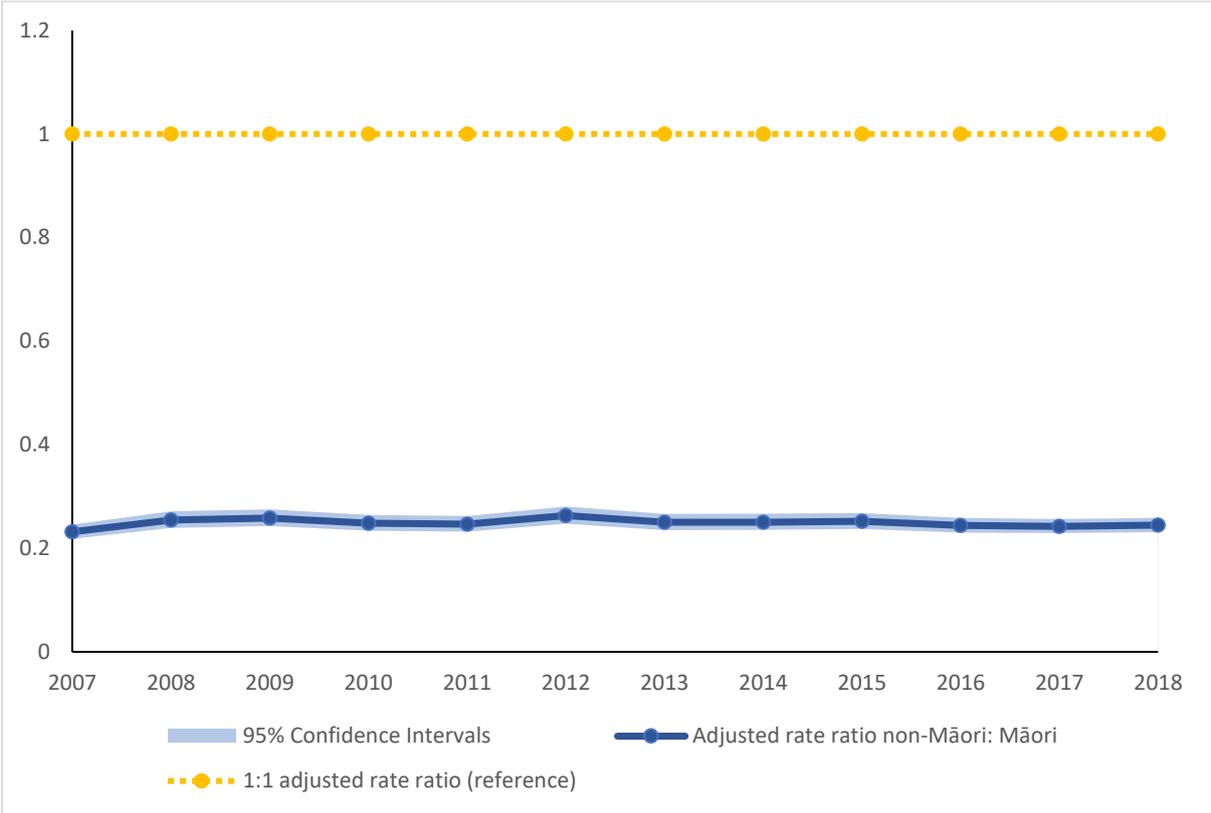
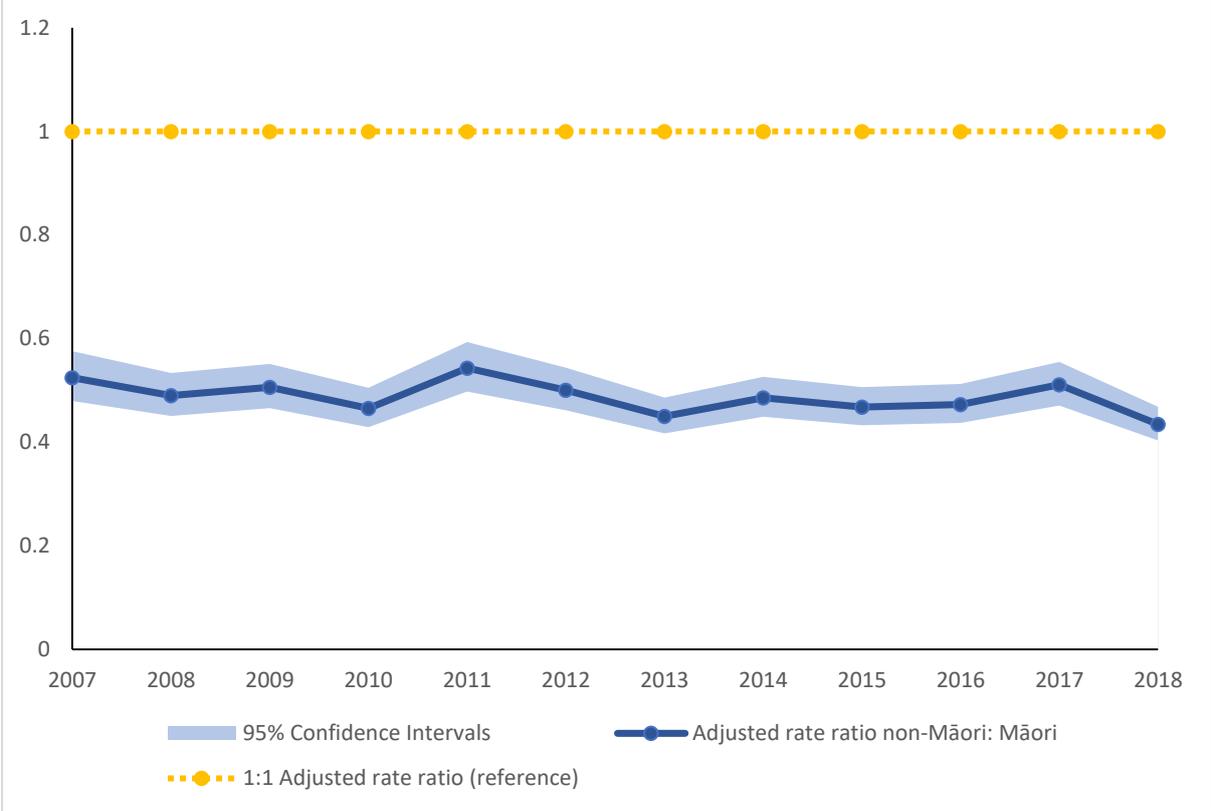


Figure 12: Age-standardised rate ratio non-Māori: Māori, ASH congestive heart failure, 2007-2018

**B1.2 ASH Epilepsy**

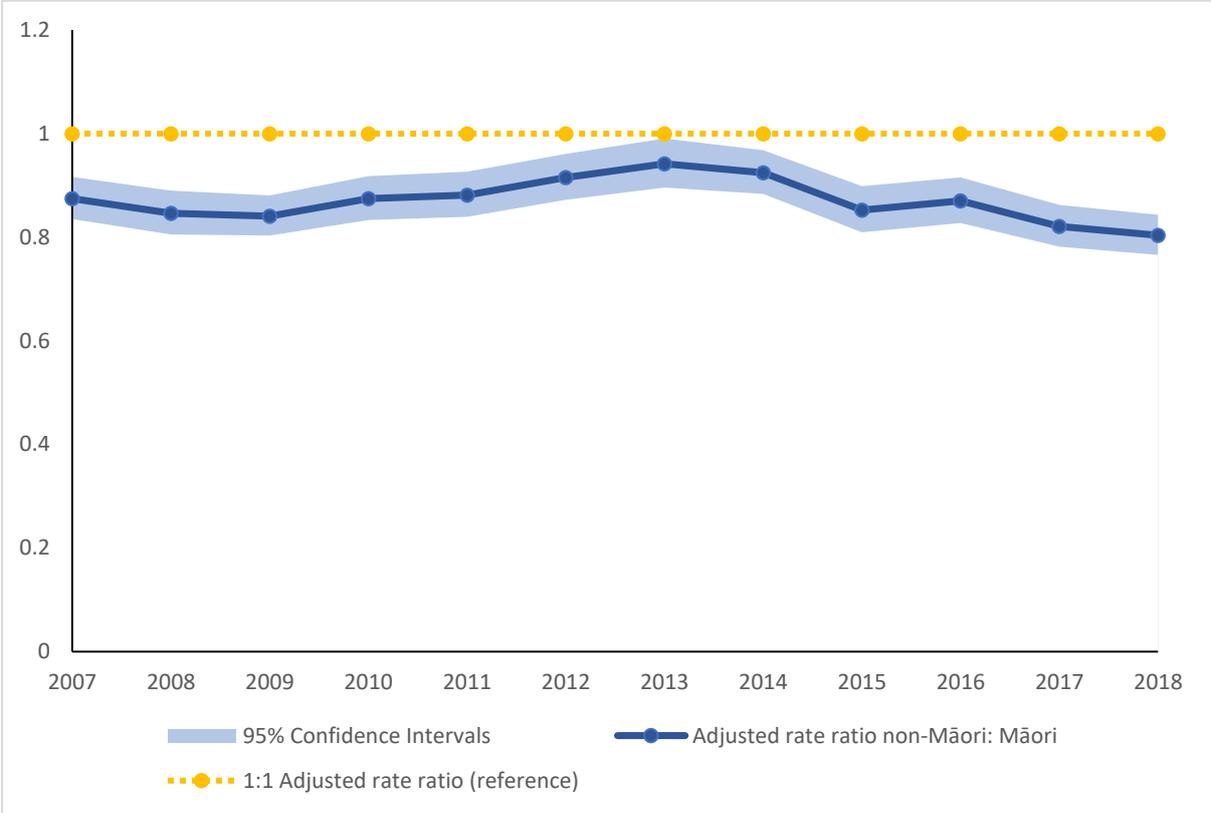
Non-Māori experienced ASH for epilepsy at approximately half the rate of Māori. The average rate ratio was 0.49 over the twelve-year period of analysis. The inequity remained consistent throughout this time (Figure 13).



**Figure 13: Age-standardised rate ratio non-Māori: Māori, ASH epilepsy, 2007-2018**

**B1.3 ASH Gastroenteritis/dehydration**

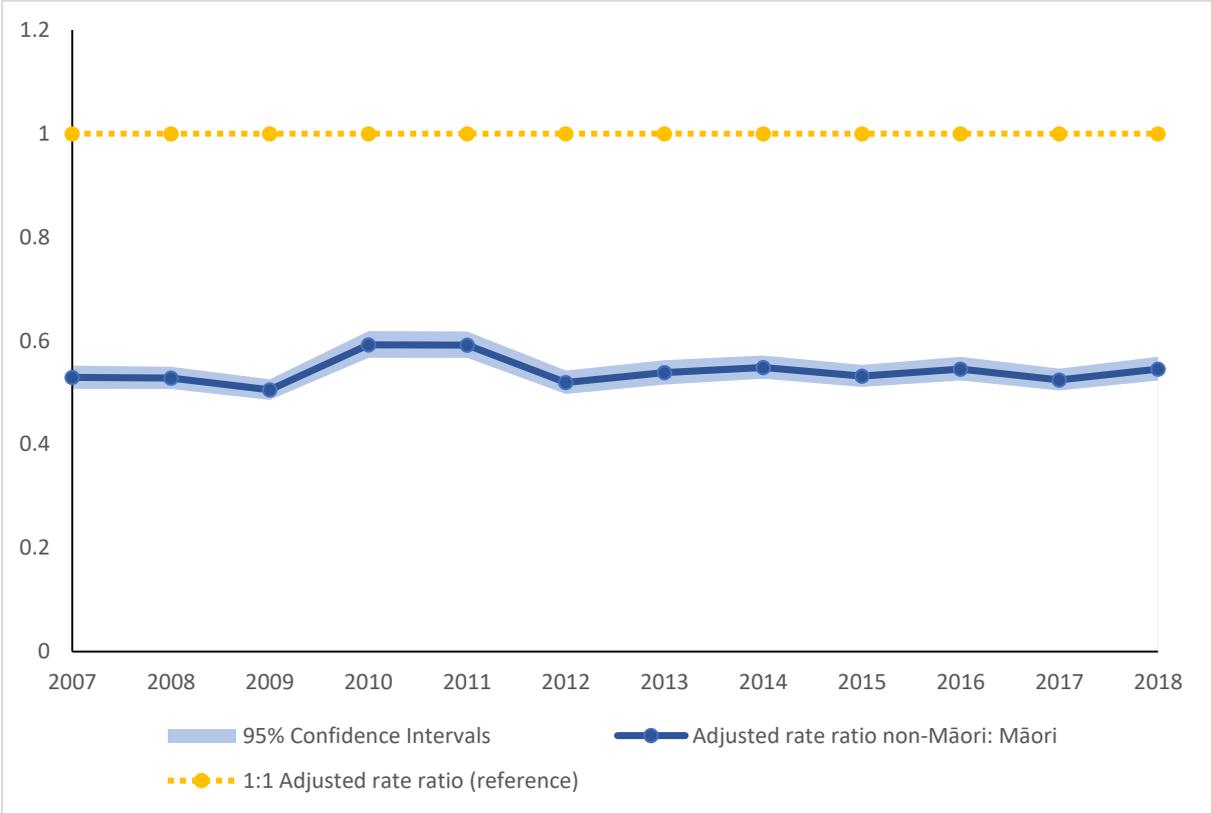
The non-Māori group experienced ASH for gastroenteritis and dehydration at a slightly lower rate than Māori throughout the twelve-year time period. The average rate ratio was 0.87 during this time. The inequity was relatively consistent (Figure 14).



**Figure 14: Age-standardised rate ratio non-Māori: Māori, ASH gastroenteritis/dehydration, 2007-2018**

**B1.4 ASH Pneumonia**

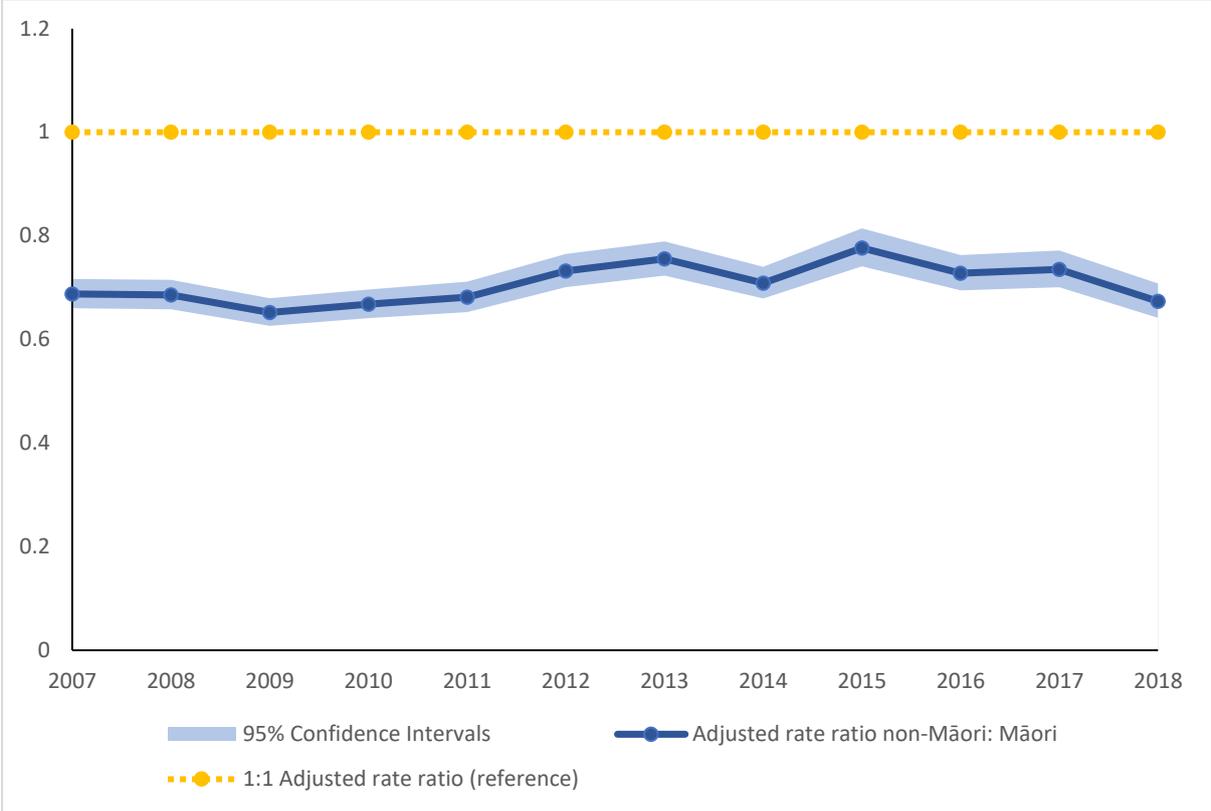
The non-Māori group experienced ambulatory sensitive hospitalisations for pneumonia at approximately half the rate of Māori in the period from 2007 to 2018. The average age-standardised rate was 0.54. The inequity was consistent throughout the period of analysis (Figure 15).



**Figure 15: Age-standardised rate ratio non-Māori: Māori, ASH pneumonia, 2007-2018**

**B1.5 ASH Angina and chest pain**

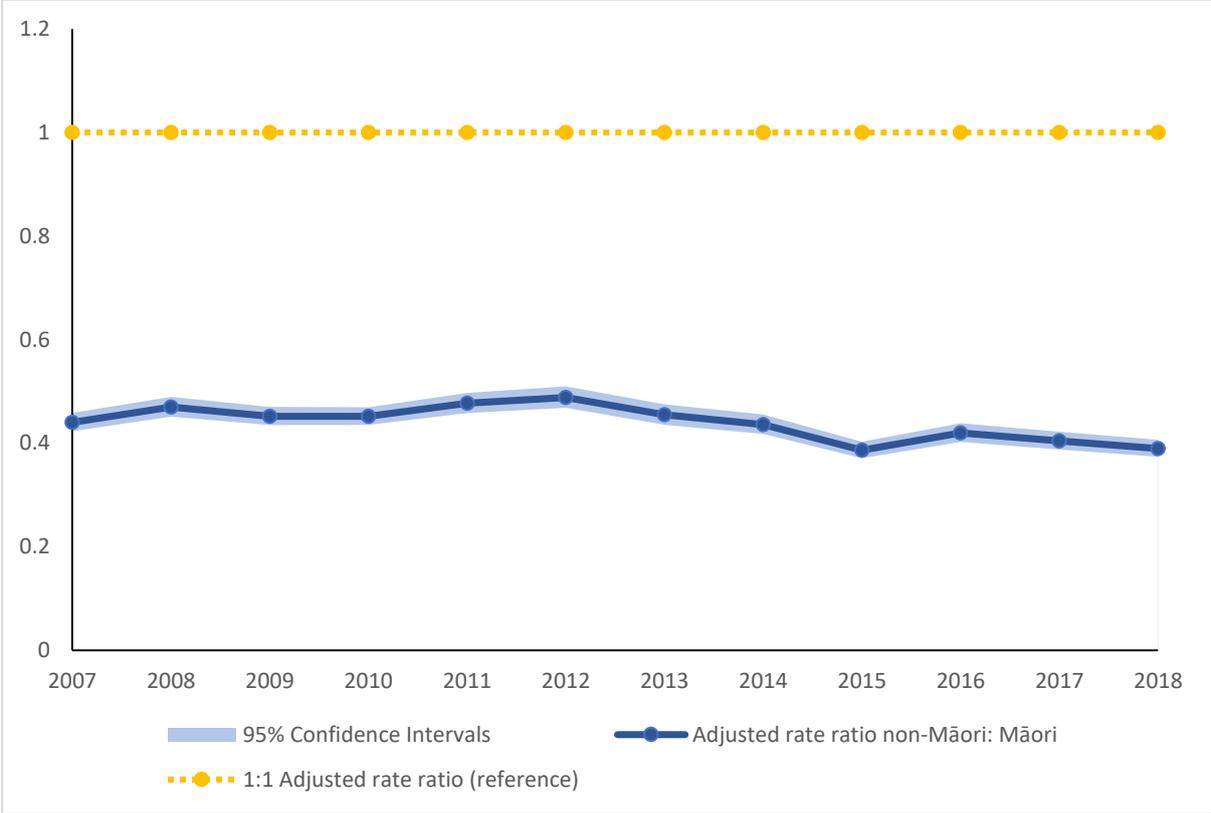
The non-Māori group experienced ambulatory sensitive hospitalisations for angina and chest pain at approximately 70% of the rate of Māori over the period 2007 to 2018. The average standardised rate ratio was 0.70. The inequity was relatively consistent throughout this time, with minor fluctuations (Figure 16).



**Figure 16: Age-standardised rate ratio non-Māori: Māori, ASH angina and chest pain, 2007-2018**

**B1.6 ASH Asthma**

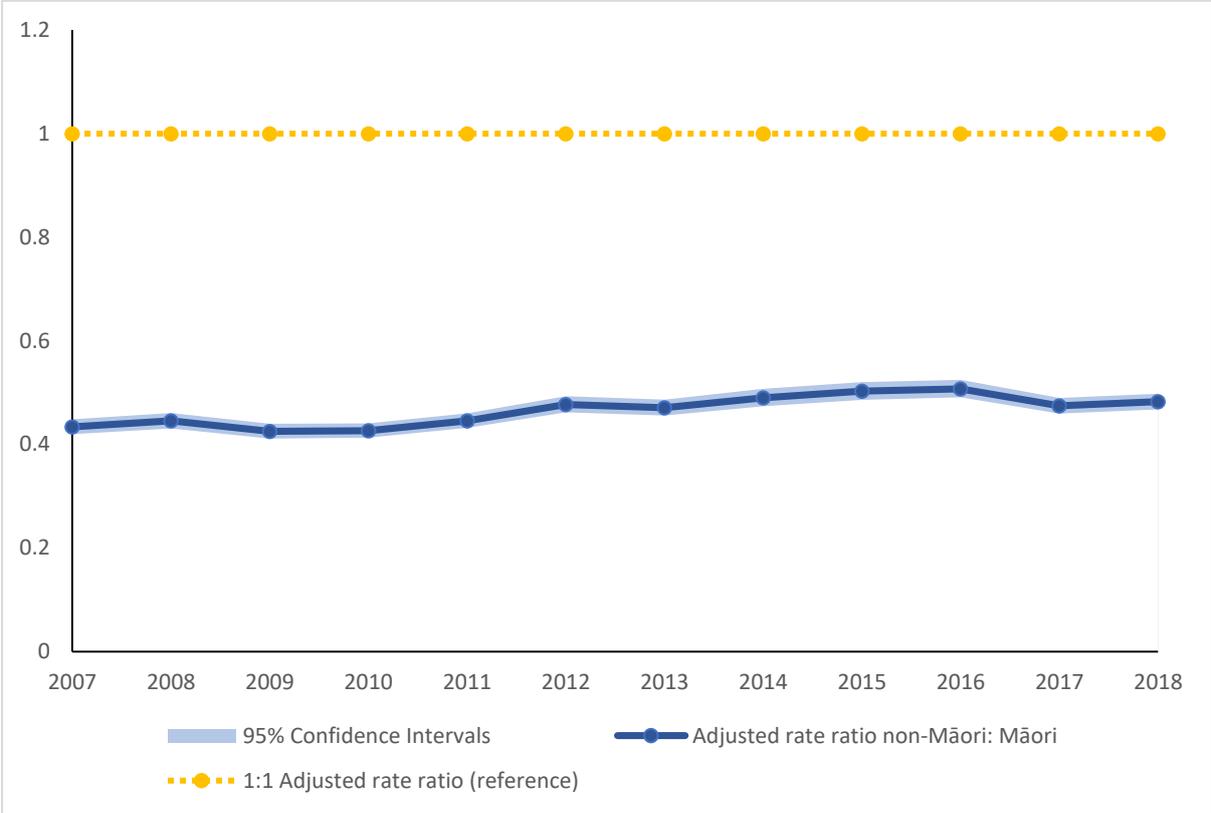
The non-Māori group experienced ASH for asthma at a substantially lower rate than Māori during the period 2007 to 2018. The average standardised rate ratio during this time was 0.44. The inequity was consistent over time (Figure 17).



**Figure 17: Age-standardised rate ratio non-Māori: Māori, ASH asthma, 2007-2018**

**B1.7 ASH Cellulitis**

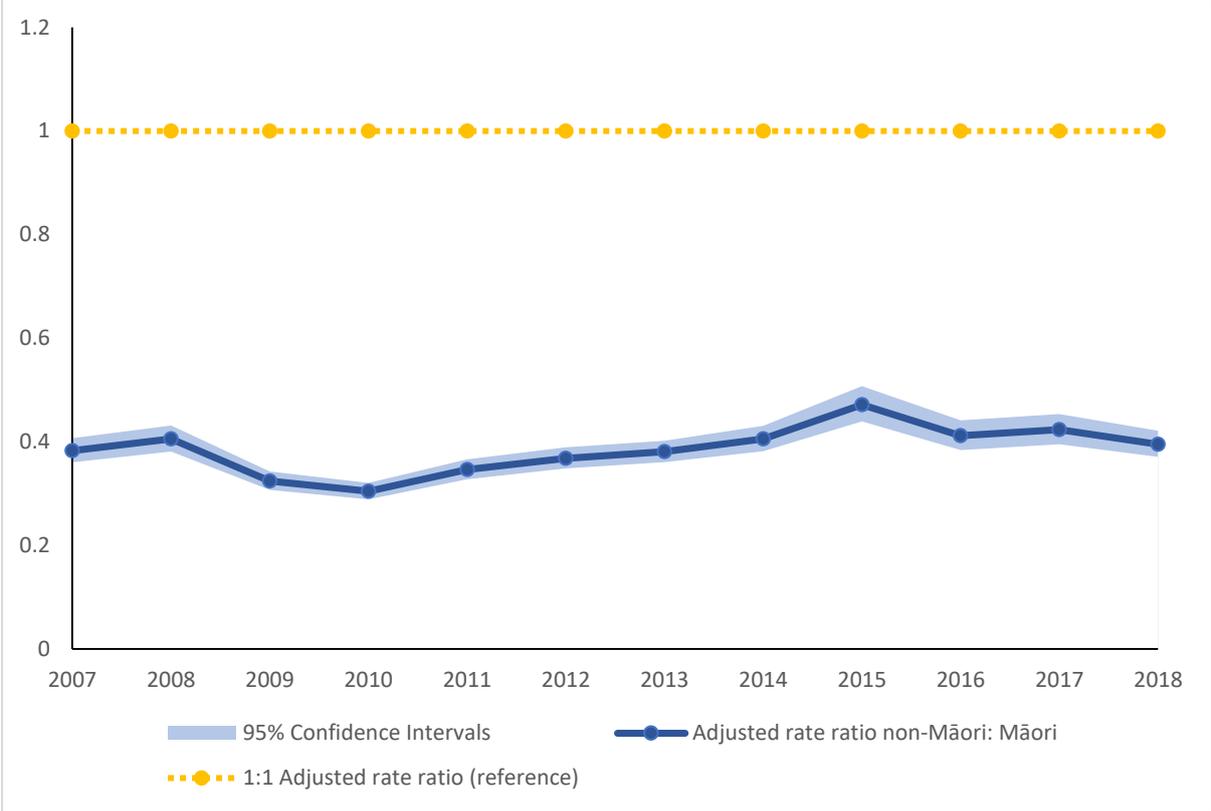
The non-Māori group experienced ASH for cellulitis at approximately half the rate of Māori over the period 2007 to 2018. The average standardised rate ratio during this time was 0.47. The rate ratio was relatively consistent throughout this time period (Figure 18).



**Figure 18: Age-standardised rate ratio non-Māori: Māori, ASH cellulitis, 2007-2018**

**B1.7 ASH Diabetes**

The non-Māori group experience ASH for diabetes mellitus at approximately 40% of the rate of Māori during the period 2007 to 2018. During this time, the average age-standardised rate was 0.38. The rate ratio was relatively consistent over time, with some variation, but no evidence of overall increase or decrease (Figure 19).

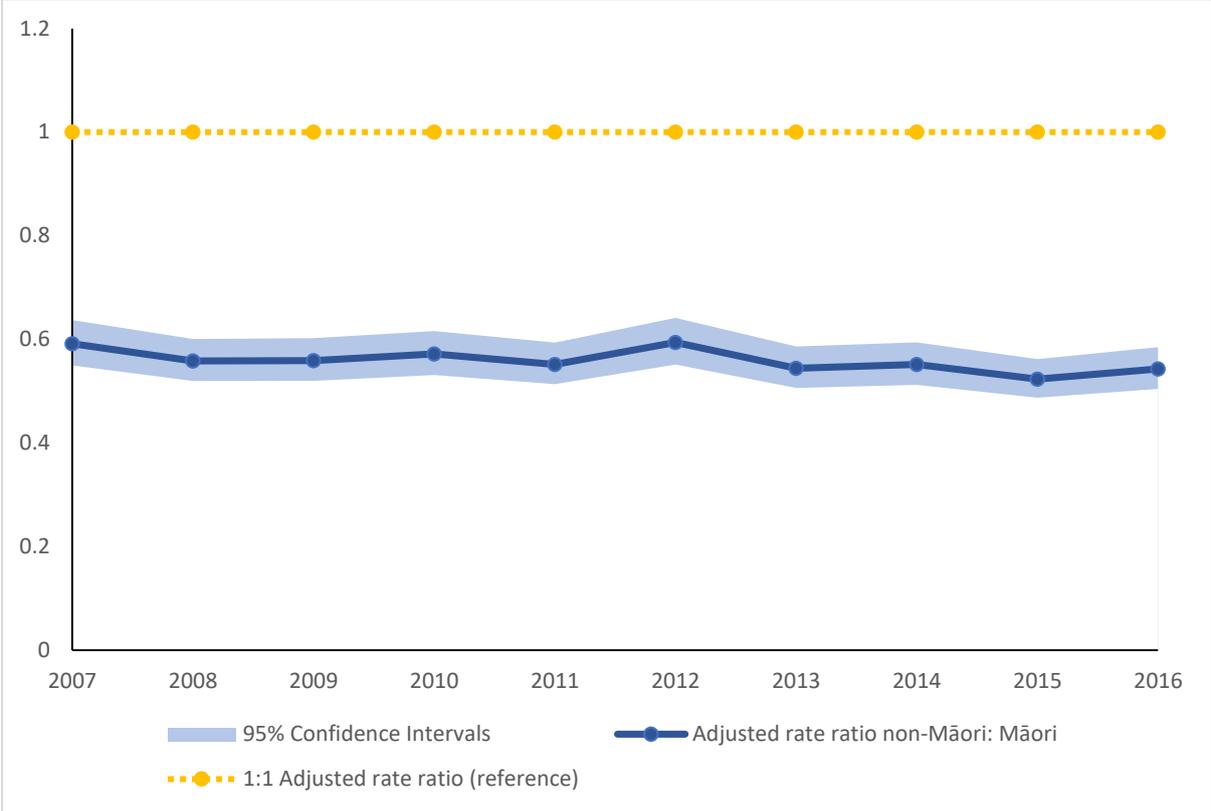


**Figure 19: Age-standardised rate ratio non-Māori: Māori, ASH diabetes, 2007-2018**

**B2 Mortality**

**B2.1 Cancer mortality**

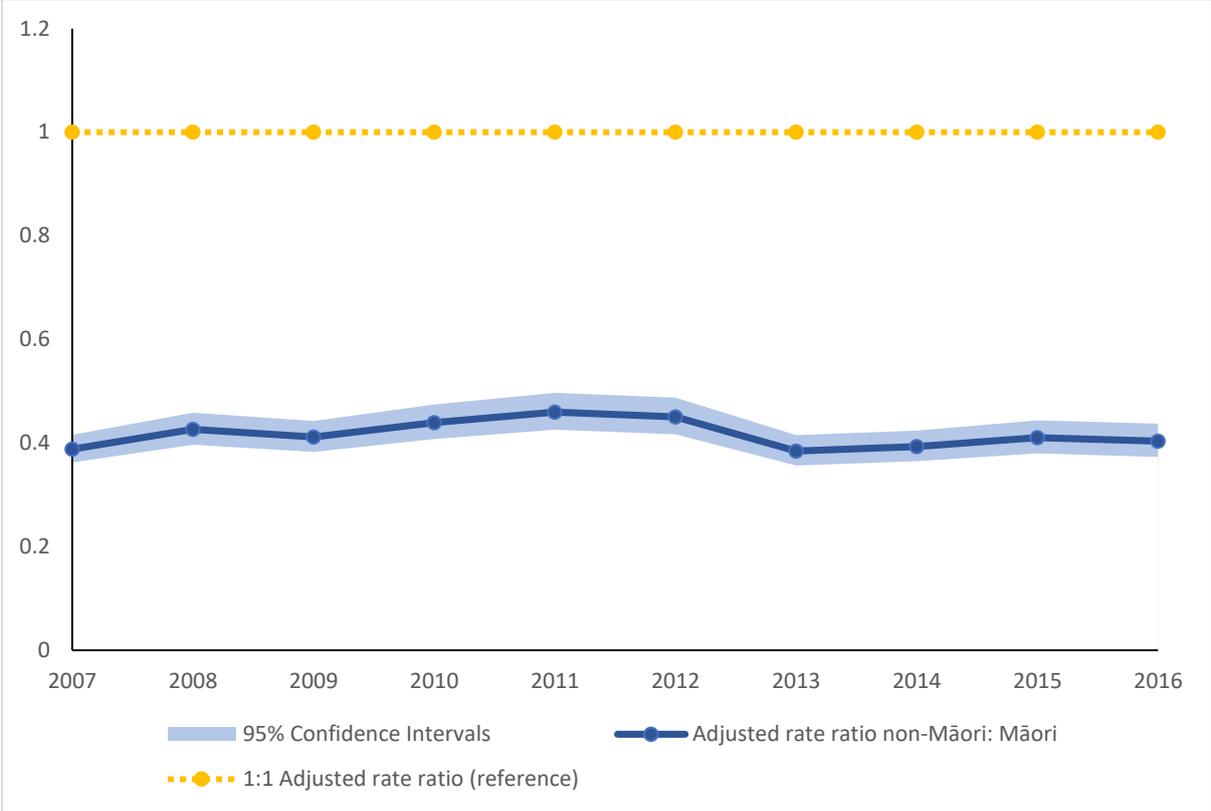
The non-Māori group died from cancer at over half the rate of Māori throughout the ten-year time period 2007 to 2016. The average age-standardised rate ratio during this time was 0.56. The disparity was consistent during this time (Figure 20).



**Figure 20: Age-standardised rate ratios, non-Māori: Māori, cancer mortality, 2007-2016**

**B2.2 Cardiovascular disease mortality**

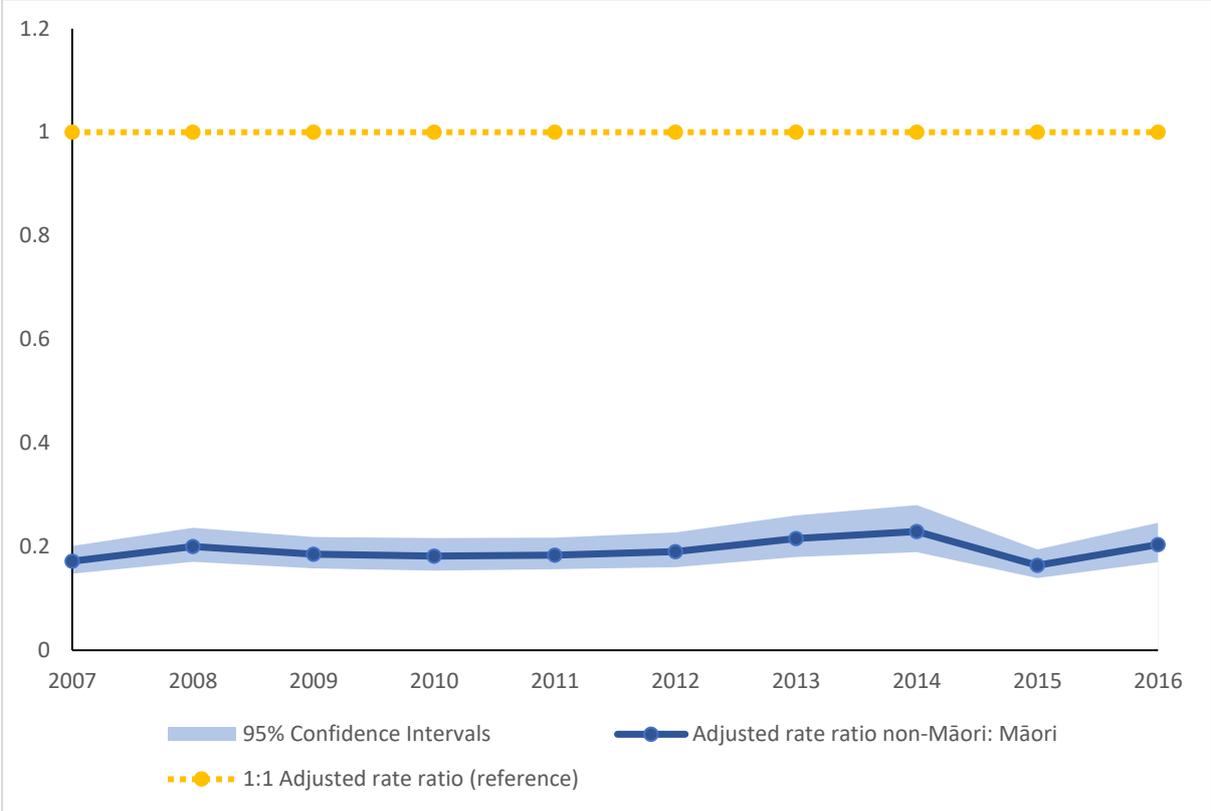
The non-Māori group experienced death from cardiovascular disease at approximately 40% of the rate of Māori during the ten-year time period 2007 to 2016. The average age-standardised rate ratio during this time was 0.42. The disparity was consistent over the time period observed, with minor fluctuations (Figure 21).



**Figure 21: Age-standardised rate ratios, non-Māori: Māori, cardiovascular disease mortality, 2007-2016**

**B2.3 Diabetes mellitus mortality**

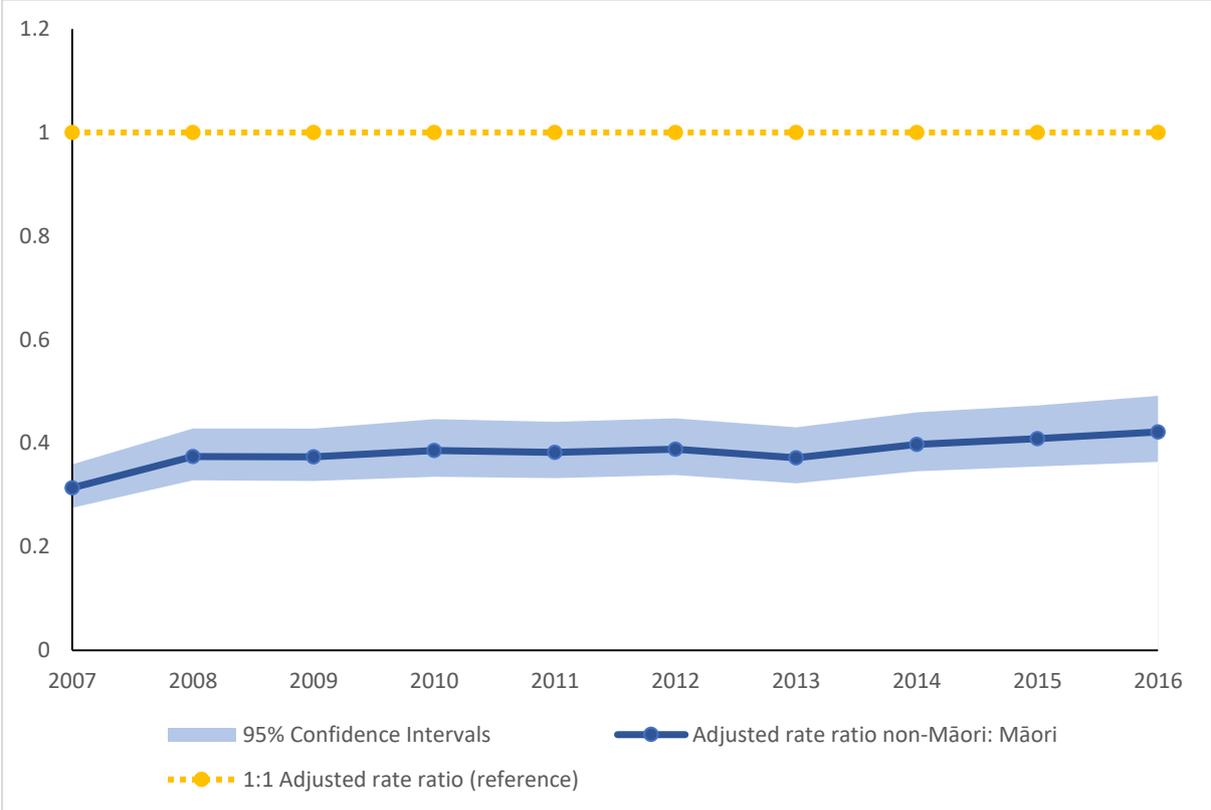
The non-Māori group experienced death from diabetes mellitus at 20% of the rate for Māori. The average age-standardised rate ratio during the ten-year time period 2007 to 2016 was 0.19. The disparity was consistent over this time (Figure 22). This was one of the greater disparities observed in this dataset.



**Figure 22: Age-standardised rate ratios, non-Māori: Māori, diabetes mellitus mortality, 2007-2016**

**B2.4 Respiratory mortality**

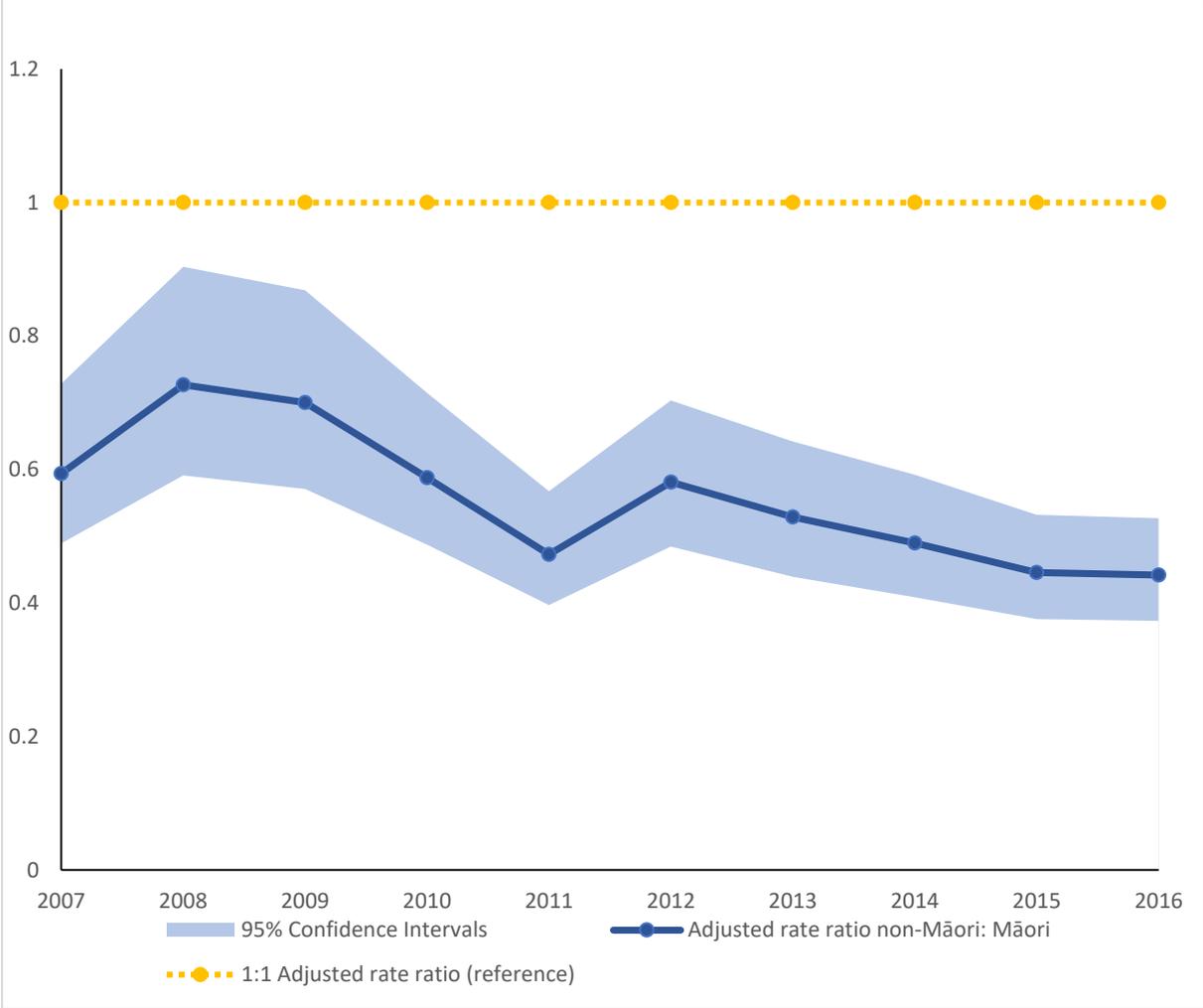
The non-Māori group experienced death from respiratory illness at approximately 40% of the rate of Māori during the ten-year time period 2007 to 2016. The average age-standardised rate during this time was 0.38. The inequity was consistent over the time observed (Figure 23).



**Figure 23: Age-standardised rate ratios, non-Māori: Māori, respiratory mortality, 2007-2016**

**B2.5 Suicide**

The non-Māori group experienced death by suicide at a considerably lower rate than Māori during the ten-year time period 2007 to 2016. During this time the age-standardised rate-ratio ranged from 0.44-0.72. While the ratio fluctuated somewhat over this time, there is no evidence of change in inequity over the time period of analysis (Figure 24).



**Figure 24; Age-standardised rate ratios, non-Māori: Māori, suicide, 2007-2016**