Dr David Jansen
General Practitioner
Auckland

Cultural Competency - Concurrent Workshop Repeated
Friday, 16 August 2013
Start 4:30pm
Start 5:35pm
Duration: 55mins
Duration: 55mins
Lounge 1
Lounge 1
Cultural Competence
Mauriora Associates Ltd:
Cultural Competency in the New Zealand Health Sector

Agenda

• Māori - health disparities
• Evidence from primary care and other health settings
• Consider possible causes
• Discuss what action can be taken
• Identify what resources are needed
Inequalities are not random.

In all countries socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards, and less access to quality health care than the more privileged.

Minister of Health
Pete Hodgson, 2008
Registration authorities must:

“set standards of **clinical competence**, **cultural competence**, and **ethical conduct** to be observed by health practitioners”

Section 118(i) HPCA Act
The purpose of cultural competence in health settings is to improve the quality of health care services and outcomes for patients.

- Culture affects the way patients:
  - access health care services,
  - comprehend health and illness,
  - respond to health care interventions.
Sustaining benefits

• Developing a trusting relationship with patients.
• Gaining increased information from patients.
• Improving communication with patients.
• Helping negotiate differences.
• Increasing compliance with treatment.
• Increased patient satisfaction.
• Improved efficiencies & cost-effectiveness of health care.
• Ensuring better patient outcomes.
Terminology

Disparities
a great difference, unequal

Inequalities
comparisons between

Inequity
fairness, impartiality
“Of real concern is the persistence of large, underlying health disparities for Māori and Pacific peoples compared with everyone else in New Zealand...

In our society, these are neither fair nor acceptable... ALL sectors of government and the community need to work towards greater health equity..”

Pete Hodgson
Minister of Health, 2008
Life-expectancy

- Non-Māori Male
- Non-Māori Female
- Māori Male
- Māori Female

YEARS OF LIFE


THREE-YEAR PERIOD
NatMedCa 2006

- Nationally representative sample
- Data direct from GPs
- Over 6300 visits by Māori recorded

Doctors reported a lower level of rapport with Māori compared with non-Māori

<table>
<thead>
<tr>
<th></th>
<th>Māori</th>
<th>Non-Māori</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests &amp; investigations</td>
<td>21.0%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Prescription</td>
<td>69.6%</td>
<td>65.9%</td>
</tr>
<tr>
<td>Mean length of consultation</td>
<td>13.7 minutes</td>
<td>15.1 minutes</td>
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</table>
Real PHO

Dietitians Road Show 2012
Real PHO Attendance Rate 0 – 3 yrs of Age

Utilisation Rate (per capita)

- M?ori
- Pacific
- Other
Real PHO
2 yr old Immunisation Rate

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Immunisation Rate (%)</th>
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<tbody>
<tr>
<td>Jul-07</td>
<td>92%</td>
</tr>
<tr>
<td>Aug-07</td>
<td>90%</td>
</tr>
<tr>
<td>Sep-07</td>
<td>88%</td>
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<tr>
<td>Oct-07</td>
<td>86%</td>
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<td>Nov-07</td>
<td>84%</td>
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<td>Dec-07</td>
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<td>Jan-08</td>
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<tr>
<td>Nov-08</td>
<td>60%</td>
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<tr>
<td>Dec-08</td>
<td>58%</td>
</tr>
<tr>
<td>Jan-09</td>
<td>56%</td>
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</tbody>
</table>

- M?ori
- Pacific
- Other
• Māori children are going at least as often to their GP as non-Māori

• Age-appropriate immunisation rates for Māori persistently lag behind non Māori

• Similar disparities exist for cervical and breast screening rates

• Māori attend primary care as often as others, but have less access to important public health programmes.
Māori Health Disparities
Māori health disparities

Disparities in access and outcomes:

- Preventive care
- Primary care
- Hospital services
- Mental health services
- Injury services
- Home help
- Income support
- Complaints
- Compensation for medical error

Māori consistently get MORE of the bad
LESS of the good
Māori have the greatest levels of health disparities and inequality, in measures of mortality and morbidity compared to non-Māori in New Zealand.
Causes of disparities?

- **Patient or population level**
  - Risk factors and behaviours
  - Adherence / attendance
  - Distrust, preferences etc

- **Provider level**
  - Availability, costs
  - Distrust, preferences etc

- **System level**
  - Policies, funding, ...
OECD report 2009
“Evidence of cherry picking” by GPs

• GPs provide differing levels of care to different groups of patients even when the patient is from a group known to have greater health care needs

• Lesser quality & intensity of service for Māori
Literature Review

• persistence of racial/ethnic disparities in
  ➢ access to needed health care
  ➢ unequal outcomes

• led to strategies for change
  ➢ developing cultural competence standards for providers and for health care organisations
  ➢ increased workforce diversity
  ➢ staff training in cultural competence.

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Literature Review

• widespread assumption in clinical literature that improving practitioner skills, knowledge and attitudes in the cultural competence domain will lead to improvements in health outcomes for culturally diverse groups including cultural minority or indigenous minority populations.

• evidence of improvements in undergraduate learner and practitioner knowledge, skills, attitudes and behaviors from a range of learning opportunities.

• However there is little or no evaluation of patient outcomes reported in the literature to date.
Literature Review

• research evidence on implementation of cultural competence
  ➢ many descriptive reports on programmes/trials
  ➢ training interventions for clinicians and other health care workers.

• Published evaluations of training programmes demonstrate increased knowledge and increased confidence amongst participants, an effect shown to persist for months and years.
Literature Review

• improved knowledge and self-reported willingness amongst trainees to alter future practice, little evidence for improved health outcomes as yet from cultural competence training.

• this aligns with what is known to be successful - improvement science/quality improvement
  ➢ peer review and feedback / Shewhart cycles
  ➢ clinical audit / educational needs analysis
  ➢ clinically-led collaboratives
  ➢ run charting analysis of variation
Psychiatrist stereotypes

- "Medication is the answer, but they just don't take their pills. If cannabis was prescribed, I'd bet they'd bloody take that."

- More than 11% of the 247 surveyed believe that Māori are biologically or genetically more predisposed to mental illness, “particularly psychosis”

Nil evidence for these statement
European GPs reported that Māori:

- Present late,
- Do not attend regularly or sufficiently frequently,
- Do not take their medication,
- Don’t know what medications they have taken or why
- Do not follow prescribed regimens of treatment,
- Do not embrace preventive medicine
- Do not arrange for repeats
- Do not know their personal medical history,
- Expect a quick-fix solution in a crisis

Authors conclude that these repertoires “either blame Māori for their plight or justify existing [unequal] service provision”

Communications and relationships are key to effective care, but Providers selective in application of communication style

Lesser communications and care with .... People unlike me

Greater satisfaction, Adherence to care and enablement

Reduced satisfaction, decreased adherence Lack of follow-up, reduced access

Providers communicate best with... People like me

Non-concordant relationship

Concordant relationship

Success Exemplar: BreastScreen South
• Māori have less contact with screening & greater mortality after diagnosis of breast cancer

• BreastScreen South became first breast screening provider in the world to attain coverage of over 70% of eligible women within an indigenous population,

AND

• Equal coverage for all ethnic groups
Equitable screening was an organisational goal

- Achieved through a targeted intervention:
  - personalised invitations
  - close relationship with local providers
  - marae-based screening
  - korowai (cloaks) for the women
  - trust building
Health literacy

• Patient ability to read, comprehend, and act on medical instructions.

• Health literacy is worse among ethnic minorities, the elderly, and patients with long term conditions, particularly in public-sector settings.
Nutritional advice

- Complex ideas incorporated in advice
- Guidance developed for literate, dominant populations – e.g. educated Europeans
- Confusing for others and not inclusive of non-dominant views

Impact of low health literacy

• Type 2 diabetes - inadequate health literacy associated with worse glycemic control and higher rates of retinopathy.

Schillinger et al
Association of Health Literacy With Diabetes Outcomes
JAMA. 2002
Dietary counselling is vital but access to advice is worse for men, workers and those with long-standing diabetes.

Robson et al Factors affecting the use of dietetic services by patients with diabetes mellitus. Diabetes Med. 2001
“Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.”

Right 1(3) Code of Rights
Cultural competence and APCs

Registration authority must not issue annual practising certificate unless “satisfied that the applicant meets the required standard of competence.”

Section 29 HPCA Act
Communications

Dietitians Road Show 2012
• A positive patient-centred approach results in greater patient satisfaction, greater enablement, lesser burden of symptoms and lower rates of referral

• Mostly related to communications skills and relationship development (partnership with patient)
Improved communications

• Tools for improved communications such as shared decision making and risk communication can be taught

• However, many practitioners are selective about who they use these with.

• Based on practitioner perceptions of consumer preferences for involvement


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"They just don't listen!"
What will I do next week?

1. Review cultural competence standards

2. Do they intersect/ complement your clinical & ethical standards?

3. Review process and outcomes of your care for Māori
   - Peer review, audit, reflective practice, self assessment
   - Patient experiences – what do patients think / understand?

4. Reflect on what other training is needed

5. Seek accredited training programmes that incorporate culturally competent content

6. Review current policies, plans and resources: do these take into account a Māori point of view?
Building on today's work

- Online awareness and knowledge
- MoH funded a **foundation** course
  - Includes health literacy as a topic
  - Treaty of Waitangi and Māori cultural competence
- Free to **all** RHPs

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