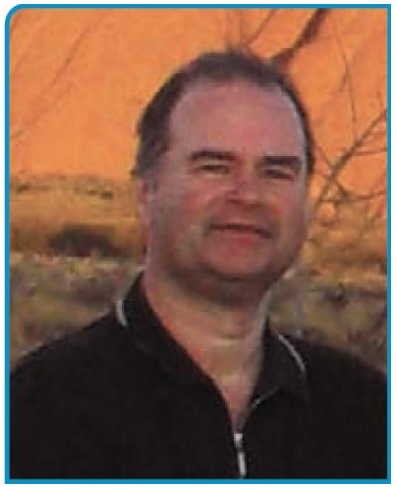

Dr David Jansen

General Practitioner

Auckland

Cultural Competency - Concurrent Workshop Repeated

Friday, 16 August 2013	Start 4:30pm	Duration: 55mins	Lounge 1
	Start 5:35pm	Duration: 55mins	Lounge 1

MAURIORA HEALTH EDUCATION RESEARCH

Cultural Competence

Cultural Competency

Mauriora Associates Ltd :

Cultural Competency in the New Zealand Health Sector

http://www.mauriora.co.nz/web/index.php/courses/courses-list/62-foundation-course-in-cultural-competency

Agenda

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- 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

The challenge

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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

A response

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

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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

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- 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

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Disparities

a great difference, unequal

Inequalities

comparisons between

Inequity

fairness, impartiality

NZ Health disparities

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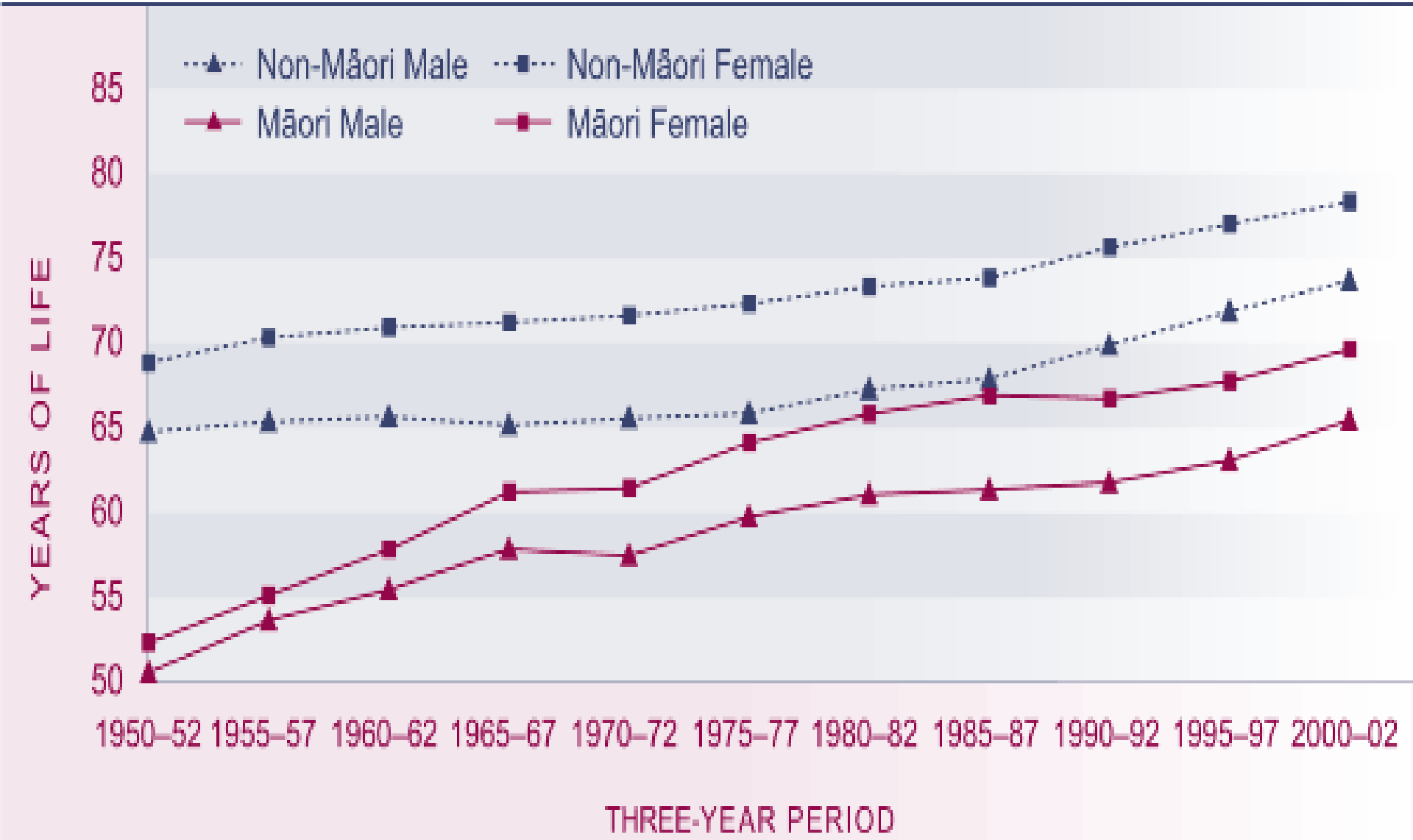
"Of real concern is the persistence of large, underlying health disparities for Māori and Pacific peoples compared with everyone else in New Zealand…

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



NatMedCa 2006

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

Crengle S, Lay-Yee R, Davis P, Pearson J. *A Comparison of Māori and Non Māori Patient Visits to Doctors:* ***The National Primary Medical Care Survey (NatMedCa)****: 2001/02. Report 6,* 2006. Available from www.moh.govt.nz

NatMedCa 2006

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

	Māori	Non-Māori
Tests & investigations	21.0%	25.4%
Prescription	69.6%	65.9%
Mean length of consultation	13.7 minutes	15.1 minutes

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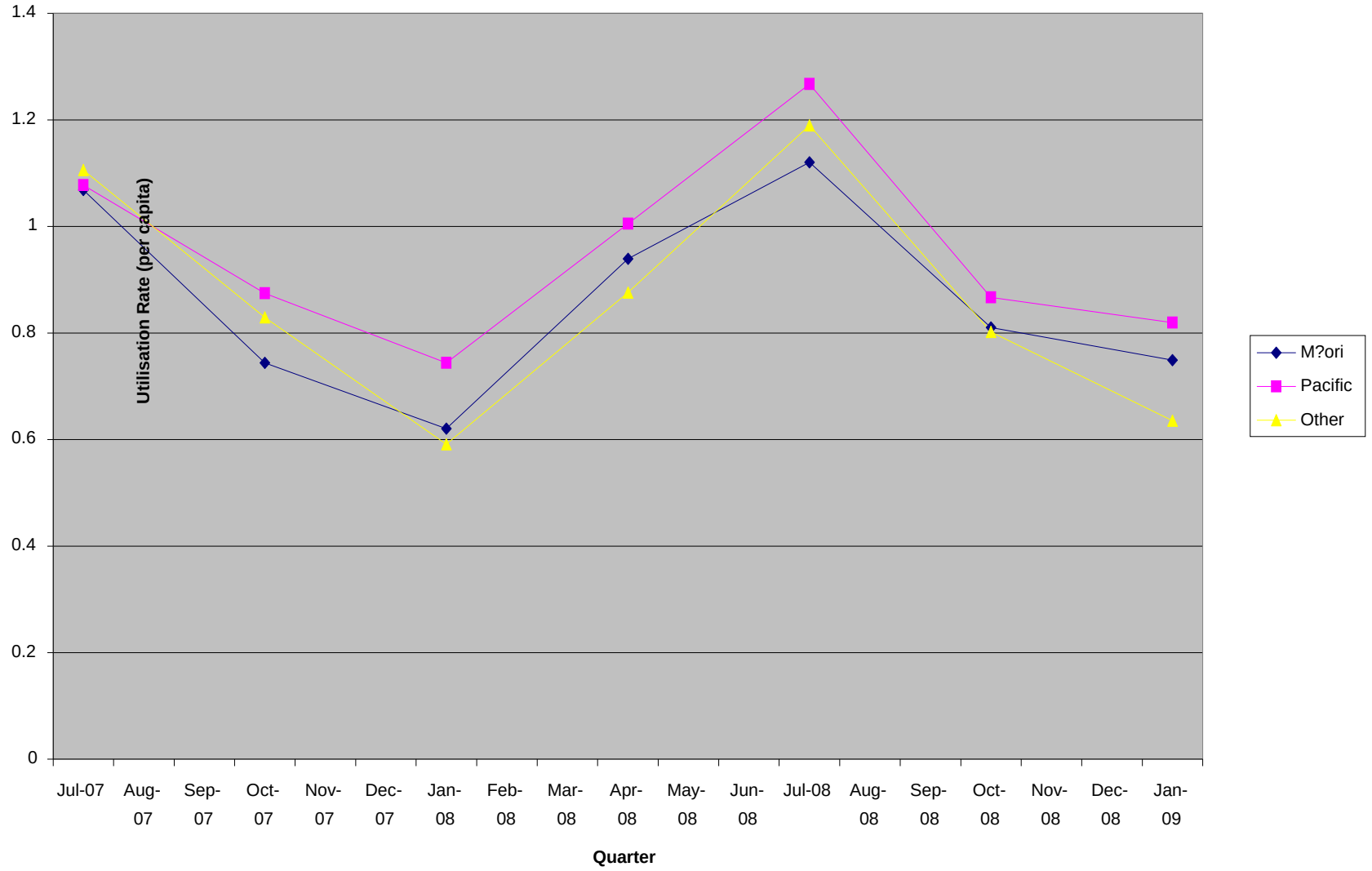
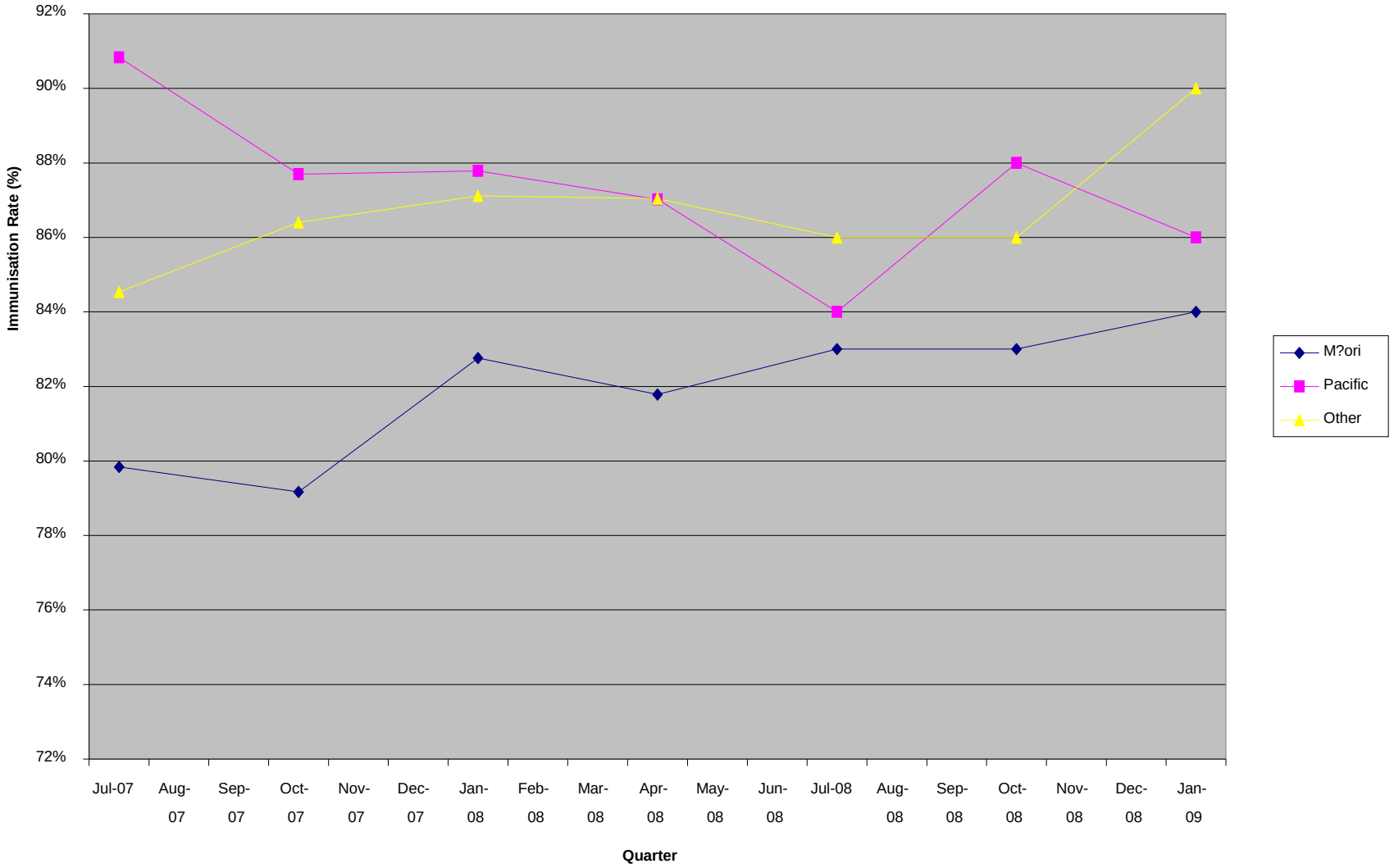
Real PHO

Dietitians Road Show 2012

Real PHO Attendance Rate 0 – 3 yrs of Age



Real PHO
2 yr old Immunisation Rate



Real PHO

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- 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.

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Māori Health Disparities

Dietitians Road Show 2012

Māori health disparities

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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

Summary

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?

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- **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

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- 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.

Literature Review

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- 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

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- 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

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- 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

Australian and New Zealand Journal of Psychiatry 2000
Johnstone and Read 34(1) 135-145

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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

NZMJ 2002

McCreanor and Nairn

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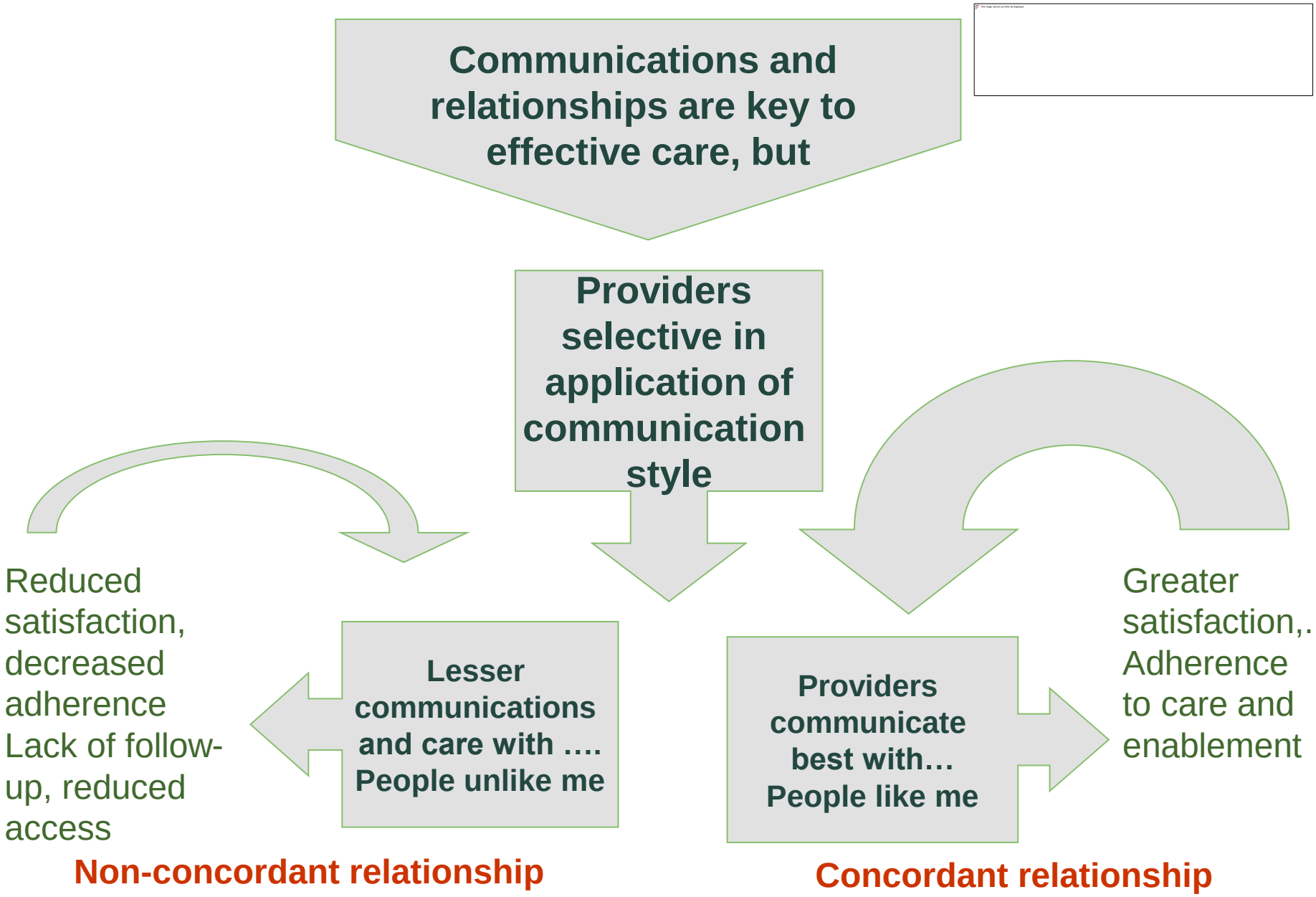
- European GPs reported that Māori:
  - Present late,
  - Do not attend regularly or sufficiently frequently,
  - Do not take their medication,
  - Don't know what medications they have taken or why
  - Do not follow prescribed regimens of treatment,
  - Do not embrace preventive medicine
  - Do not 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"*

http://www.nzma.org.nz/journal/115-1167/272/



Jansen P, Smith K, *Māori experiences of primary health care: Breaking down the barriers*. NZFP Oct 2006;33:5(298-300).

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Success Exemplar: BreastScreen South

BreastScreen South

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- 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

BreastScreen South

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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

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Health Literacy

Dietitians Road Show 2012

Health literacy

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- 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

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- 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

Geiger, *Communicating dietary guidelines for Americans: room for improvement* , J Am Diet Assoc, 2001.

Stein*, Cultural literacy in health care.*J Am Diet Assoc, 2004.

Grant et al, *Nutrition and Indigenous health in New Zealand*. J Paed Child Health.

Signal et al, Perceptions of NZ nutrition labels by Māori, Pacific and low-income shoppers. Public Health Nutrition, 2008.

Impact of low health literacy

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- 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

Diabetic access to advice

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- 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

HDC

"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

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Communications

Dietitians Road Show 2012

BMJ 2001

Little *et al*;323:908-11 Observational study in 3 practices

- 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

Edwards *et al,* BRJGenPract 2005 ;55(510):6-13

"They just don't listen!"

What will I do next week?

MAURIORA HEALTH EDUCATION RESEARCH

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

MAURIORA HEALTH EDUCATION RESEARCH

- 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

www.mauriora.co.nz