Building health equity and cultural safety in Aotearoa / New Zealand

Study Guide

Module 1 – Health equity in practice

Module 2 – Cultural safety in healthcare practice

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Modules covered by this Study Guide: Module 1 – Health equity in practice and Module 2 – Cultural safety in healthcare practice

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UNE Partnerships Pty Ltd.

The Education & Training Company of the University of New England

PO Box U199, University of New England NSW 2351

Telephone: (02) 6773 0000

ABN 74 003 099 125

Contents

Module 1: Health equity in practice

Welcome to Health equity in practice. This Module is tailored to practice managers and staff across the healthcare practice landscape, for example general practice, specialist practices, allied health, and dentistry. Practice managers are key stakeholders in the practice culture and leadership team, and have responsibility and influence in ensuring the practice is accessible and culturally safe for disadvantaged population groups. This Module supports staff in understanding health equity and how to achieve it for your community.

On completion of this Module, students will understand equity in healthcare, including the contributing factors and barriers to achieving equity in health outcomes for disadvantaged groups. Students will understand the strategic context of health equity, and will be introduced to specific tools to define, measure and implement effective strategies to support equity in your practice.

Outcomes

On completion of this Module, you will be able to:

- ✓ Understand equity, and how inequity contributes to different health outcomes for different population groups
- ✓ Understand implicit bias and be able to reflect on your implicit biases
- ✓ Understand the importance of good quality data to analyse and inform equity initiatives in your practice
- ✓ Understand how leadership improves health equity for your community.

Structure

This course is divided into the following Lessons:

- Lesson 1: Understanding equity

- Lesson 2: Understanding and managing bias
- Lesson 3: Equity: The big picture
- Lesson 4: Using data to achieve equity
- Lesson 5: Leadership to achieve equity.

Activities

Throughout this Study Guide you will notice a range of activities. These are intended to contribute to your learning by encouraging you to be active and involved. None are compulsory. They are intended to help you to learn but are not part of your formal assessment.

Activities with an online interactive version are identified with a mouse icon at the start.

Common activity types included in study guides are included below.

- Knowledge check or Reflection: These encourage you to confirm or explore your understanding as you progress.
- Reading: These may be uploaded to my.unep or provided as links to readings or websites to expand on the content of the Lesson .
- Video or Link: These provide alternative perspectives and give visual and audio alternatives to your text. Please do not feel you are required to watch all videos or read through all the links provided in this Study Guide.
- Find out more: In some Lesson s we provide support for additional reading or activities that go beyond what is required in the unit covered in this course or provide a refresher for underpinning concepts that support the knowledge and skills for this unit.
- Case study or Example: There are a range of case studies and examples provided throughout this Study Guide, to support your understanding and to provide a resource for some activities.

The end of an activity is identified with a band, like the one below and the text 'End of activity'. This indicates the normal Study Guide text will resume.

End of activity

Common Terms: You will notice that throughout this Study Guide we use the term 'patients' to refer to the people your team provides services or support to. In your workplace, you might use other terms such as patient, client, staff, employees, volunteers, or stakeholders.

We use the term 'medical receptionist' or receptionist to refer to the administrative staff in your team. In your workplace, you might use the term secretary, front desk staff, administrative assistant, or another term. Additionally, you may be a receptionist in a

different type of practice, such as general practice, specialist practice, allied health, psychology, or mixed practice.

We use the term ‘practitioner’ to refer to the clinical team working in the healthcare practice. This could include general practitioners, specialists, allied health practitioners, psychologists, or other health professionals working within or referring to your practice.

Lesson 1: Understanding equity

Equity, equality, and diversity are terms commonly used in healthcare today. While the ambition of 'equal access for all' can be conceptually understood as the right thing to do, it can be difficult to measure, implement and evaluate at a practice level because you are measuring the people who are not attending your practice, but who should be. As a practice manager, it is important to understand equity and the barriers to equal health outcomes, including those outside of your control. This Lesson introduces the concept of equity and the relevance to practice managers.

1.1 Defining equity

Some people face greater barriers than others to experiencing a healthy life. Although both life expectancy and *healthy* life expectancy have increased globally, life expectancy is unequal between the rich and poor. There is a persistent and sometimes widening gap between those with the best and worst health and well-being. This is occurring not just in poor countries, but within rich countries such as Aotearoa / New Zealand (NZ) and Australia.

So, what is health equity, and how is it measured? The NZ Ministry of Health uses the following definition:

Health equity: In NZ, people have differences in health that are not only unfair and unjust but avoidable. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes[1].

The graphic below illustrates the difference between equality and equity. To achieve equity in health outcomes, we must first ensure everyone has the basics needed to be healthy. Thinking the same approach to health will work universally, is like expecting everyone to be able to ride the same bike. In this analogy, everyone getting the same bike will lead to different outcomes for different groups of people. Likewise, a one-size-fits-all approach to healthcare results in different health outcomes for different groups of people, because the healthcare provided may not be suitable for all of the different population groups.

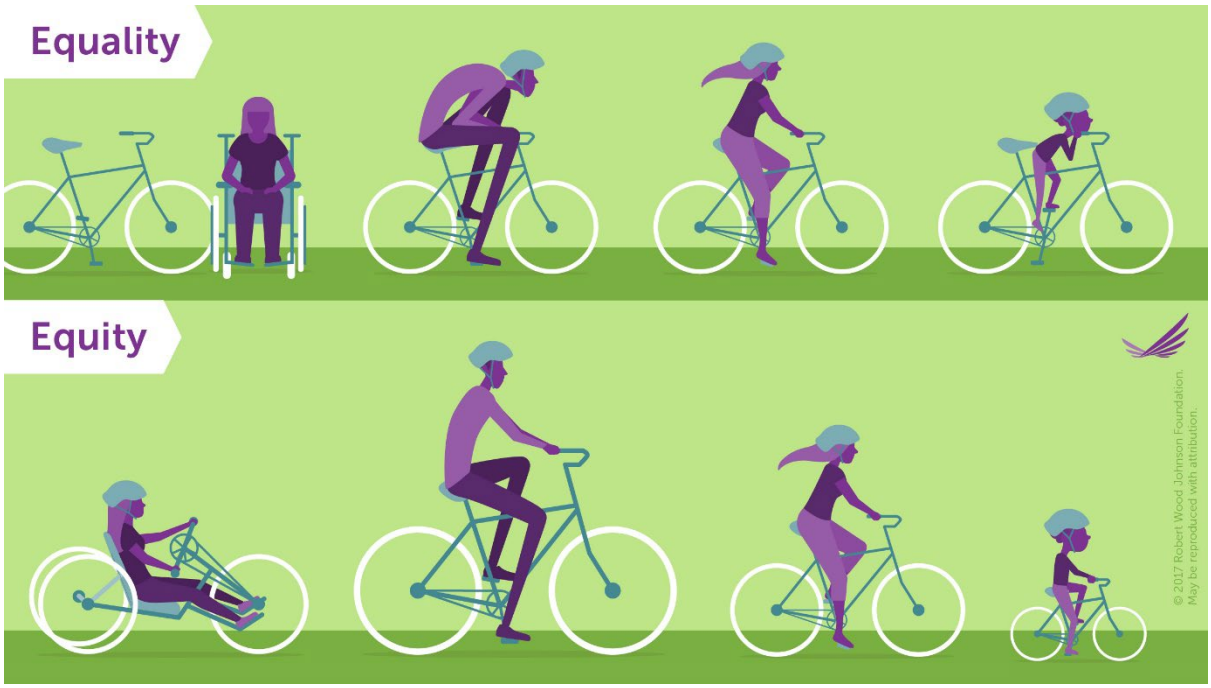


Figure 1: Equality and equity[2]

Equality involves everyone getting the same resources, even though one group may need more or different resources, such as information in a different language, a different (culturally safe) approach, or physically different resources such as wheelchair accessibility. Equity, on the other hand, requires

[1] Ministry of Health, 2021. *Achieving equity*, URL: https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity Retrieved 1 November 2021

[2] Robert Wood Johnson Foundation, 2017. *Visualizing Health Equity: One Size Does Not Fit All Infographic*, URL: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html Retrieved 1 November 2021

more, and possibly different, resources to support disadvantaged groups to ensure everyone has access to the basic requirements that are needed to be healthy. Imagine that you manage the following practices:

- Practice 1: a practice in a middle-class city suburb with predominantly well-off people who have good jobs and a high level of education.
- Practice 2: a practice that is in a rural, low-income area where people have a lower level of health literacy, and it is difficult to recruit and retain staff.

Would these two practices be able to fairly serve their communities with the same resources and the same approach? Probably not. Instead of sharing resources equally, those practices need a different portion of the available resources and a targeted approach to fairly serve their communities. This is equity.

Who is disadvantaged?

Poorer populations systematically experience worse health than richer populations[3]. The make-up of disadvantaged, poorer population groups will differ in different countries, and within different geographical areas of a country. Consider the following contextual differences that could influence the health outcomes for different groups of people.

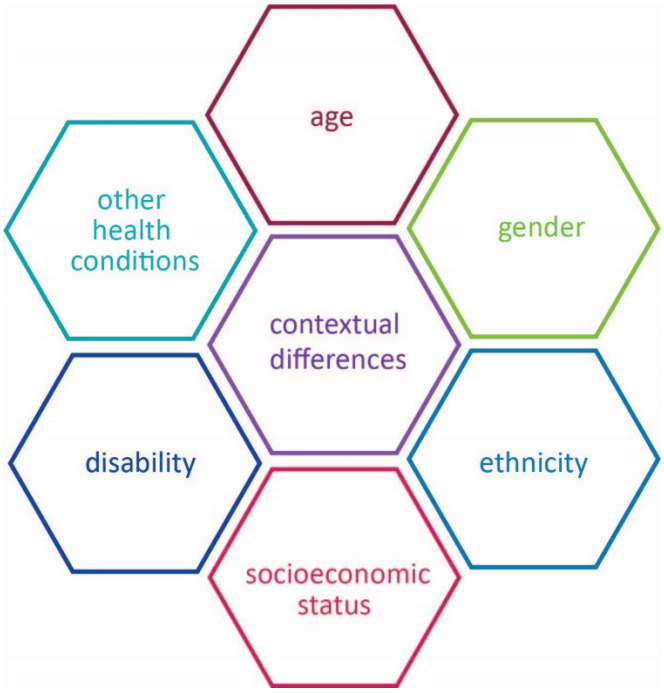


Figure 2: Influences on health outcomes

To have a positive impact on equity, your practice needs to really understand:

1. the population groups with the greatest healthcare needs in your community
2. the disadvantaged groups that have barriers to accessing your practice.

[3] World Health Organisation, 2021. *Social determinants of health*, URL: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 Retrieved 1 November 2021

These may be groups defined by any of the above contextual factors such as age, ethnicity, gender, or disability. To accurately define these groups, you need data. Some data will already be available in your practice, most likely through the practice management software. Other data will need to be collected. Once you have defined the problem and measured it using data, the practice is able to design a quality improvement initiative that targets the disadvantaged population groups. This concept will be further explored later in this Module.

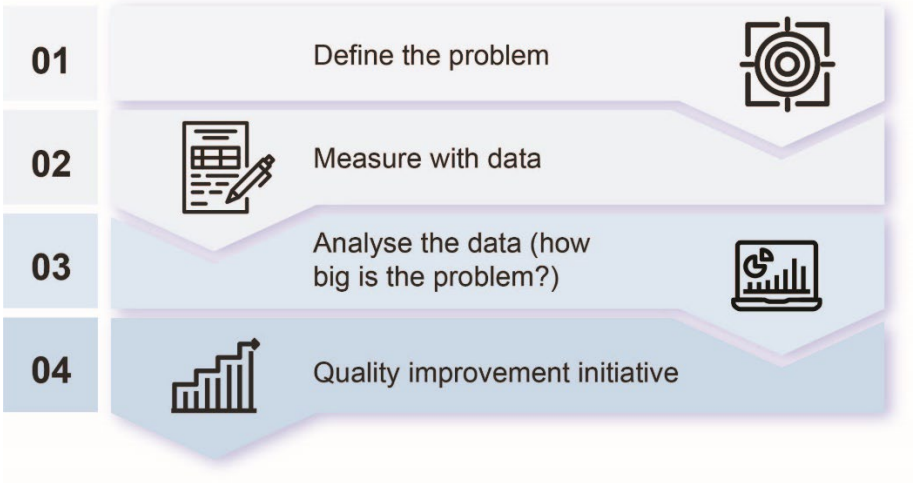


Figure 3: Defining the quality improvement initiative

The diagram above outlines the initial steps you take to define the quality improvement initiative required in your practice. This then forms part of quality improvement cycle, where the outcome is measured and continues to inform the quality improvement initiative as it evolves. If you are not familiar with quality improvement in a healthcare practice, the short course: Fundamentals of Practice Management covers this topic.

Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health.

Disadvantaged groups need more resources and a different approach.

We will now look more closely at the factors that influence health outcomes.

1.2 The social determinants of health

The social determinants of health are the non-medical factors that influence health outcomes for disadvantaged groups of people. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include social, political, and economic policies and systems, as well as social norms and culture.

The social determinants of health significantly influence the health outcomes of population groups, with health and illness following the same trend in all countries. Often, the lower the socioeconomic position, the worse the health outcomes. As such, disadvantaged groups within the population, such as different ethnic groups, have overall worse health outcomes compared to advantaged sections of the population, as they tend to also have poorer access to education, job security, secure housing, and food security.

The World Health Organisation provides examples of the social determinants of health, which can influence health equity in positive and negative ways; these are set out in the diagram below.

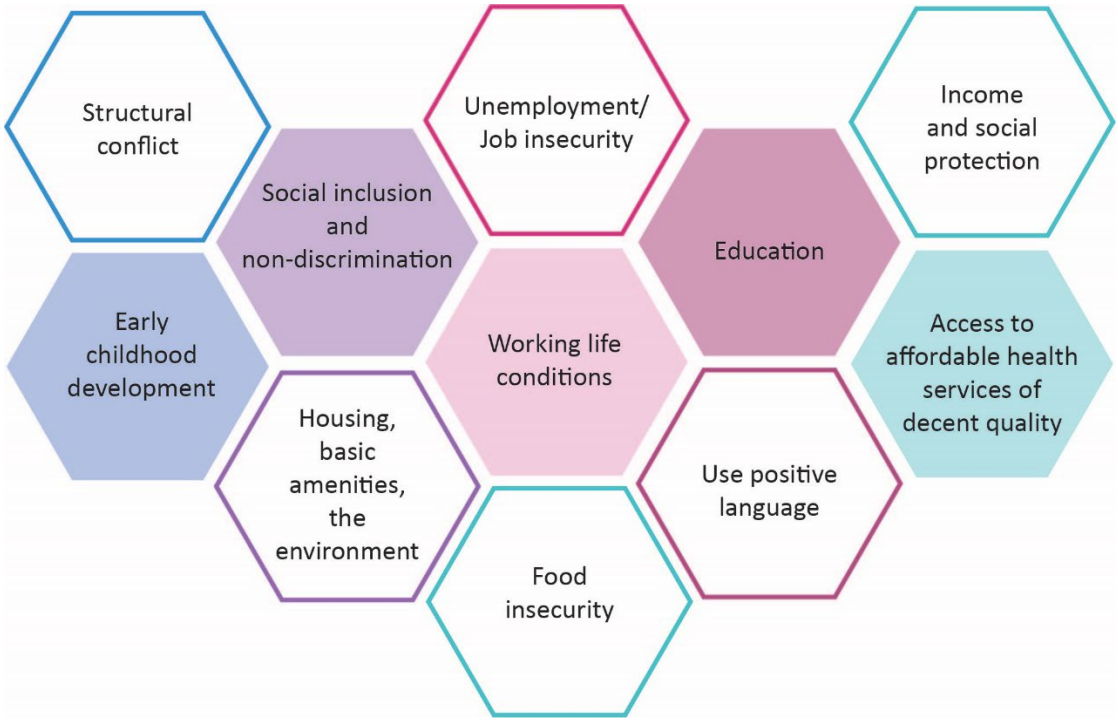


Figure 4:Social determinants of health

Research shows that the social determinants of health can have more influence over health outcomes than healthcare or lifestyle choices[4]. As such, the health system alone will not achieve health equity for disadvantaged groups, and governments and not-for-profits have a significant role in addressing the social determinants of health to achieve health equity for disadvantaged groups.

Activity 1: Case study – Māori health disparities

In NZ, Māori people have the worst health inequity of any group. Māori are sicker and die sooner than our Pākehā counterparts. We use Hone as a case study.

Hone was born into a Māori Whānau as the fifth of six children. Neither of his parents finished high school, and both parents worked full-time in low-income jobs. His father experienced periods of unemployment and had ongoing issues with alcohol addiction. Hone's extended family and community looked after the children when his parents worked.

Hone's family lived in a small home with his extended whānau and experienced overcrowding at home. Hone's grandparents provided much of his early childhood care. They had experienced discrimination in the health system in their past, and therefore were reluctant to access health services. As such, none of the children were vaccinated or received regular healthcare growing up.

[4] World Health Organisation, 2021. *Social determinants of health*, URL: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 Retrieved 1 November 2021

As an adult, Hone had difficulty accessing and engaging with health services due to a lack of experience, generational distrust due to discrimination, and poor health literacy. Hone has several risk factors for chronic disease and has general poor health, including smoking, excess alcohol consumption, obesity, and non-compliance with the medication he was prescribed for high blood pressure.

The health system is not providing Hone with equity of access to healthcare services, and therefore he is more likely to be sicker and to die sooner. He requires different resources, and a different approach.

End of activity

While changing key social determinants of health for your community may be outside your level of influence, it is important to understand why people from particular groups are disadvantaged. Everyone has a history that has shaped the way they engage with your practice and staff. Equally, every staff member has a history with experiences that have shaped the way they engage with disadvantaged groups. These experiences create bias, and bias is an important concept to understand when considering equity.

Summary

In NZ, people have differences in health that are not only avoidable but may be unfair and unjust. Equity recognises that people with different levels of advantage require different approaches and resources to get equitable health outcomes[5]. Disadvantaged groups could be identified by their ethnicity, age, gender, geographical location, sexuality, religion or other contextual factor.

Achieving equity in health outcomes is increasingly a priority for governments, with a focus on multifactorial government approaches. Multifactorial approaches are critical when you consider the complexities of the social determinants of health including housing, education, disability, food security, conflict and other factors. While a healthcare practice cannot change the social determinants of health for their population, the practice can support people from disadvantaged groups to access healthcare.

[5] Ministry of Health, 2021. *Achieving equity*, URL: https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity Retrieved 1 November 2021

Lesson 2: Understanding and managing bias

To provide a culturally safe healthcare environment that improves access and therefore equity in health outcomes, staff need to treat all individuals with dignity and respect. Everyone has different life experiences, and these life experiences create both conscious and unconscious thoughts and behaviours. These thoughts occur instantaneously, and you may not be aware of them. This Lesson introduces the concept of bias, and how it naturally occurs to help your brain make sense of the information it receives.

People of ethnic groups—particularly high needs population communities, often experience high levels of disadvantage and health inequity. However, this Lesson is not specifically about race or ethnicity because implicit bias can occur towards any population group such as disability, age, gender, religion, geographically isolated, sexual orientation or identity. Rather, in this Lesson we focus on the concept of bias that can be applied to any disadvantaged population group, including Māori.

2.1 Understanding bias

Bias is classified as implicit (unconscious) or explicit (conscious).

Implicit bias: attitudes and beliefs that occur outside of our conscious awareness and control.

Explicit bias: biases we are aware of on a conscious level.

In this Module we focus on ***implicit bias*** because once you are aware of a bias and it is explicit (or it is in your conscious level), you can take steps to manage it differently. This is the first step towards change.

Implicit bias

Implicit bias is a natural way for the brain to instantaneously make sense of the huge quantity of information presented to it every moment. Without an internal prioritisation and filing system, we would be overwhelmed with too much information for our brain to process, resulting in the brain not processing information well or even at all. We therefore use stereotypes instantaneously and unconsciously to make sense of, and 'sort', the world.

Consider the following scenarios where internal bias may unconsciously provide you with a particular stereotype, and therefore influence your thoughts and actions.

Activity 2: Reflection – Stereotypes

Scenario 1

You are in the reception area of your practice, and there is a person who is loud, obnoxious, and shouting at reception staff. Do you think you would have a different reaction and therefore action if:

- ☐ The person is dressed in a suit, is well-presented, and articulate?
- ☐ The person has an obvious disability?

Scenario 2

You are walking to the bus stop in the evening, and it is dark. You see a person sitting at the bus stop, and they don't look well – they are leaning against the bus stop wall, with their eyes closed and mouth wide open. Do you think you would have a different reaction and therefore action if:

- ☐ The person is of a minority ethnic group?
- ☐ The person is elderly, with a walking frame next to them?

End of activity

Unconscious stereotypes, such as implicit biases, are common. Individuals naturally have an affinity for people who are like themselves. The similar group could be related to ethnicity, age, gender or identity, and the group will change depending on the situation. Stereotypes exist in society, and we internalise the stereotypes without really being consciously aware of them. These distorted perceptions lead to behaviours that can cause discrimination, which in turn impact health outcomes for different groups of people.

Figure 5: Discrimination impact on health outcomes

Activity 3: Videos – Understanding bias

The following videos offer great information on understanding bias to complement your learning.

The Health Quality and Safety Commission of New Zealand (HQSCNZ) has created three videos in a series about bias. Watch videos 1 and 3 (video 2 is included as viewing in Module 2).

Video 1: Understanding and addressing implicit bias

The video provides examples of healthcare professionals reflecting on their own implicit bias, provides an explanation of implicit bias, and strategies for change.

- Understanding bias – Vimeo
- Understanding Bias

Video 3: Experiences of bias

In this video you will hear people talking about their experiences of bias in a health setting, and their suggestions for practical tips to ensure you don't make the same mistakes.

- Experiencing bias

End of activity

2.2 Self-reflection

As you now understand, implicit bias naturally occurs for the brain to sort and group a huge amount of information very quickly. As such, everyone has implicit biases. The very nature of implicit bias is that it is unconscious, meaning you are not aware of it. The following activity allows you to test yourself for implicit biases, as the first step towards change is awareness.

Activity 4: Self-reflection – Project implicit

Project Implicit allows you to take a free test to assess your implicit biases in areas such as disability, ethnicity, age and sexuality. It can be confronting but valuable to test yourself for implicit biases around the groups of people in your practice's community.

Completing this test(s) is for your own understanding and personal reflection only. There is no need to share your results.

- Project implicit

End of activity

Summary

To cope with the huge quantity of information the human brain is required to process every moment, we have an internal prioritisation and filing system that works instantaneously. We naturally use stereotypes to sort this information out and categorise it, unconsciously. This is implicit, or unconscious, bias.

Understanding your personal implicit bias requires you to reflect on your unconscious stereotypes. Shifting implicit bias to the conscious part of your brain is required as a step towards positive change.

Lesson 3: The equity context

Understanding and being committed to health equity is one thing; achieving it is quite another. Closing the gap on health outcomes (i.e., achieving equity) can be considered a 'wicked' problem in its size and complexity, requiring government and inter-organisational solutions to address the many social determinants of health.

However, if each practice and provider of health services aims to achieve health equity for their community, it is another step in the right direction. This Lesson provides background context on the government strategy in NZ, particularly in relation to equity in health outcomes for Māori.

It is important to understand how your practice fits within the big picture as there are legal and ethical obligations with which you must demonstrate compliance. These are explored further in Module 2.

3.1 The context

In NZ, there have been some notable successes in closing the gap between Māori and non-Māori health outcomes. One example is childhood vaccinations rates. Creation of a national health target has been successful in raising the overall proportion of age-appropriate fully immunised two-year-old children from 67% in 2007 to 93.5% in 2016[6,7]. As a result, longstanding ethnic inequity in immunisation rates has all but been eliminated.

There are, however, persistent gaps in the provision of health services and health outcomes between Māori and non-Māori, and other advantaged / disadvantaged groups. The Health Quality and Safety Commission (HQSC) of NZ [8] describes some of these inequities, including:

- Amenable mortality for Māori and Pacific peoples aged 0–74 years is twice that of 'other' ethnic groups.
- People living in deprived areas are 1.5 times more likely to report unmet need for primary healthcare than those living in non-deprived areas.
- Women were dispensed 26 percent more strong opioids than men.
- Māori consumers are consistently and significantly less likely to always feel staff treated them with respect and dignity while they were in the hospital.
- A maternal mortality rate for Māori that is nearly three time(s) that of New Zealand Europeans.
- There is an inequitable burden of sudden unexplained death in infancy (SUDI) for Māori and Pacific infants, and infants of young mothers.
- For people with rectal cancer, there was wide geographical variation in the use of short course radiotherapy in public hospitals.

To ensure sustained attention is provided to practices to address inequity, Primary Health Organisations (PHO's) provide health targets and data to practices. The data needs to be captured and produced by the Practice Management Software (PMS) and is vital in setting the practices clinical targets and reducing inequalities.

3.2 High level strategy

When you understand how the social determinants of health contribute to inequity in health outcomes, it can be easy to feel overwhelmed and ineffective by such a wicked problem. Government has a key role in creating health equity by addressing social determinants of health across different departments. It is important to understand the strategies and action plans of your government because the policies will influence how your practice needs to act, including incentives for funding, restructures of service providers, and to ensure your practice meets its compliance obligations.

The following documents are important reading.

[6] Ministry of Health, 2016. *Annual Report for the Year Ended 30 June 2016*, Ministry of Health, Wellington, NZ
[7] Health Quality & Safety Commission, 2016. *Health quality and safety indicators*, Wellington, NZ
[8] Poynter, M., et al, 2017. *Quality improvement: no quality without equity*, [pdf], URL: https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf Retrieved 1 November 2021

He Korowai Oranga

As NZ's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori.

The He Korowai Oranga framework is a living, web-based document outlining the components of the framework in an interactive pyramid.

Implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector, including your practice.

Activity 5: Reading – He Korowai Oranga

Ensure you have a good understanding of the framework by exploring the interactive pyramid found here:

- He Korowai Oranga

Reflect on which components of the He Korowai Oranga framework you relate to most strongly. They may be components you have seen change during your career, or your practice does well, or perhaps you have personal experience to draw from. List your top three components here.

Now reflect on which components of the He Korowai Oranga framework you find most foreign. These could be opportunities to upskill yourself, your practice staff, or to implement a quality improvement project. Write down your top three components here.

End of activity

Whakamaua: Māori Health Action Plan 2020–2025

Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for He Korowai Oranga. It sets the government's direction for Māori health advancement over the next five years, thereby helping to achieve better health outcomes for Māori.

Whakamaua is underpinned by the Ministry's Te Tiriti o Waitangi Framework, which provides a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

Whakamaua outlines a suite of actions that will help to achieve four high-level outcomes. These are:

- Iwi, Hapū, Whānau and Māori communities exercising their authority to improve their health and wellbeing
- ensuring the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori
- addressing racism and discrimination in all its forms
- protecting Mātauranga Māori throughout the health and disability system.

Activity 6: Reading – Whakamaua: Māori Health Action Plan 2020–2025

Read more about Whakamaua here:

- Whakamaua mental health action plan

End of activity

Te Tiriti o Waitangi

Te Tiriti o Waitangi is explored in more detail in *Module 2: Cultural Safety*. However, it is important to understand the link between Te Tiriti o Waitangi, He Korowai Oranga, and Whakamaua: Māori Health Action Plan 2020-2025.

Activity 7: Reading – Te Tiriti o Waitangi framework

Review the following graphics developed by the Ministry of Health, to further your understanding of the Te Tiriti o Waitangi framework.

- Te Tiriti o Waitangi framework

End of activity

Summary

It is important to understand the strategic context and government priorities that impact the healthcare sector. In NZ, people working in the healthcare system need to have read and understood the following government documents:

1. NZ ’s Māori Health Strategy, *He Korowai Oranga*, which sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori.
2. *Whakamaua: Māori Health Action Plan 2020-2025* is the implementation plan for He Korowai Oranga. It sets the government’s direction for Māori health advancement over the next five years, thereby helping to achieve better health outcomes for Māori.
3. *Te Tiriti o Waitangi*

Module 2 covers the obligations and implications of government strategy on practice managers.

Lesson 4: Using data to achieve equity

Over the past few decades, health has shifted to a data-driven environment. The systemisation of practices has allowed data to be collected and used to identify opportunities for quality improvement, including identifying cohorts of patients and targeting care towards them. For example, in the COVID-19 environment, patients of a particular demographic were identified and targeted for priority vaccination; using information technology and data to inform equity in your practice is no different. This Lesson provides guidance on how to collect and use data to drive equity in your practice.

4.1 Data and audit

In the contemporary healthcare environment, data drives the provision of safe and quality healthcare. Data is used to identify opportunities for improvement, and then evaluate the effectiveness of the quality improvement projects. Government funding is increasingly linked to data, to the point that government uses data to incentivise practices in the government's priority areas such as equity.

Data is grouped into two categories, as explained below.

Table 1: Qualitative vs quantitative data

	Qualitative	Quantitative
Definition	Measures, types e.g., categories	Numeric variables e.g., how much, how many, how often
Examples	Ethnic self-identification Gender Age Postcode (geographic location) e.g., rural vs metropolitan Financial status (e.g., pension card)	% of patients who have received X health check % of Māori patients who are prescribed medication Y Infant mortality rate

As the practice manager, it is important that you understand the capabilities of your software systems, as the system will have data available for analysis if you know how to access it. But remember, the data output is only as good as the input, meaning that if patient information is incomplete, your data set will be incomplete. Train your staff on why it is important to enter the data correctly and completely into the system.

Qualitative and quantitative data is necessary to identify:

- existing inequalities
- effective interventions
- evaluation of interventions.

Figure 6:Use of data

If you do not have sufficient data to identify inequities in access or health outcomes, you may need to discuss with your practice team to see if there is existing data you can access and analyse, or a way to introduce new sources of data collection to analyse in the future. Perhaps your reception staff have not prioritised collecting and entering ethnicity because they don't understand how the data is used or the clinical outcomes that result from collection of this data. Education and support of reception staff to start collecting and / or entering accurate information may be necessary.

4.2 Ethnicity data

Ethnicity refers to a group of people who have the same cultural, national, or racial origins and can be the ethnic group or groups that individuals identify with or to whom they feel that they belong.

Ethnicity data is one form of demographic data that is used to inform service planning and quality improvement initiatives. Closing the gap in health outcomes for disadvantaged cultural groups, such as high needs population people, are a high priority for governments including those in NZ, Australia and Canada. While each government has different strategies, there is learning from international experience that should be shared.

The purpose of collecting ethnicity data includes:

- measuring and monitoring population health over time, which identifies which ethnic groups have inequity in health outcomes
- targeting funding and allocation of resources to the ethnic groups who experience inequity
- guiding clinicians on the implementation of individual care plans and interventions.

Figure 7: Purpose of collecting ethnicity data

The following activity introduces the Primary Care Ethnicity Data Audit Toolkit, which is a best practice audit tool in NZ.

Activity 8: Reading – Primary care ethnicity data audit toolkit

The Primary Care Ethnicity Data Audit Toolkit provides a resource for assessing the quality of ethnicity data in NZ primary healthcare settings and supporting quality improvement. While ethnicity data has been collected for several years, the quality and completeness of data is not always sufficient for data to be useful.

Best practice dictates the audit should be completed every three years and is aligned with Foundation Standards Certification.

Find out if / when your practice has completed an ethnicity data audit and if any areas were identified for improvement. Could this be a quality improvement project in your practice?

- Primary-care-ethnicity-data-audit-toolkit-v2.pdf

End of activity

4.3 Health Equity Assessment Tool (HEAT)

The Health Equity Assessment Tool (HEAT) aims to promote equity in health in NZ. It consists of a set of questions that enable assessment of policy, programme, or service interventions for their current or future impact on health inequities. The questions cover the following stages of policy, programme, or service development[9]:

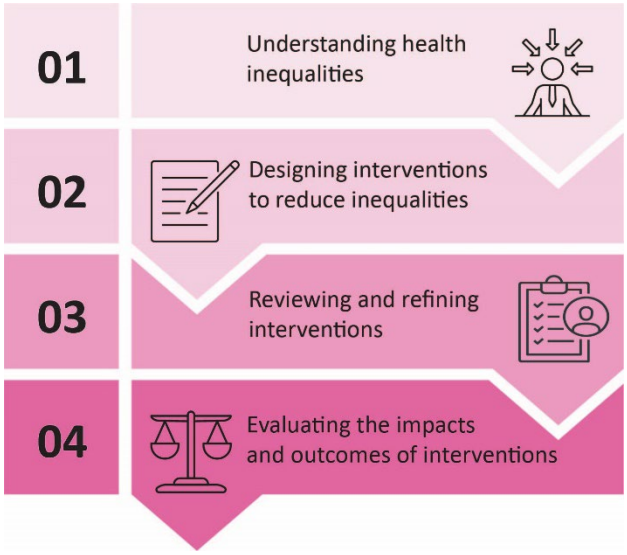


Figure 8: Practice use for the The Health Equity Assessment Tool (HEAT)

Activity 9: Read - Health Equity Assessment Tool: a user's guide

The Health Equity Assessment Tool (HEAT) includes a series of questions to consider (listed below) and challenges users to think broadly about equity issues. Further explanations and details of the questions can be found in the HEAT user's guide, which is recommended reading:

- health-equity-assessment-tool-guide.

End of activity

The Health Equity Assessment Tool (HEAT) provides valuable information. The following is a brief introduction to information contained in the HEAT.

Although the HEAT is designed to evaluate programs for their impact on Māori health outcomes, you could apply the questions to any disadvantaged group for which you are trying to improve equity.

[9] Signal, L., et al, 2008. *The Health Equity Assessment Tool: A user's guide*, Ministry of Health, Wellington, NZ

Test your suspicions by collecting and analysing data and applying the following questions from the HEAT[10].

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained, or increased?
4. Where / how will you intervene to tackle this issue?
5. How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

The HEAT is a flexible tool that can be used in its entirety or, alternatively, selected questions or groups of questions can be asked for specific purposes.

The HEAT questions can be used to provide a quick overview of potential issues and gaps in policies, services, and programmes. Alternatively, more in-depth responses to the HEAT questions can assist in developing an evidence base for policy, service, and programme development and / or evaluation.

Summary

Equity and related quality improvement projects require reliable data. As the practice manager, it is important that you understand the capabilities of your software systems, as the system will have data available for analysis if you know how to access it. However, the data output is only as good as the input, meaning that if patient information is incomplete your data set will be incomplete.

Qualitative and / or quantitative data is necessary to identify existing inequalities in access or outcomes and the evaluation of interventions. There are audit and evaluation tools that will assist you in evaluating equity issues, including the HEAT.

[10] Signal, L., et al, 2008. *The Health Equity Assessment Tool: A user's guide*, Ministry of Health, Wellington, NZ

Lesson 5: Leadership to support equity

At the healthcare practice level there are evidence-based initiatives you can implement to improve equity for your community. As with any quality improvement projects in a busy practice, sound leadership is critical, and the practice manager is well-positioned to lead the practice.

This Lesson introduces the importance of leadership in quality improvement initiatives, and how the typical standardisation required of quality improvement in healthcare can be counterproductive in achieving equity. Strategies for specific initiatives such as health literacy and patient-centred care are introduced.

5.1 Quality improvement and equity

Quality improvement in healthcare has gained significant traction in recent years and is linked to government funding. Patient and practitioner expectations are changing; high-quality healthcare is expected by consumers. Quality improvement initiatives in the health sector frequently focus on standardisation to reduce variation and improve the provision of evidence-based care, as this can improve overall efficiency, effectiveness, and safety of healthcare services.

Standardisation helps to achieve quality improvement by:

- increasing consistence
- reducing unwarranted variation.

Figure 9: Standardisation in quality improvement

However, consider what we have learnt in this Module regarding equity versus equality and then consider how standardisation impacts disadvantaged groups. Do you remember what happens when everyone gets the same bike? This will suit some people; however, others will not be able to ride the standardised bike because it doesn't meet their needs[11].

Standardisation requires everyone getting the same assessment and treatment with the same resources, or **equality.** Equity, on the other hand, clearly identifies disadvantaged groups with poorer health outcomes, and understands that they require different and perhaps more, resources.

So how do you reconcile equity with quality improvement? Some considerations are outlined below.

Ways of reconciling equity and quality improvement

- Initiatives need to be adaptable to local needs, considering the population has different needs and a standardised approach can fail to deliver to those most in need.
- Choose quality improvement projects that have a specific goal to improve access or equity for an identified disadvantaged group, using data to define the problem and measure your success.
- Understand how reliable your practice data is, particularly around ethnicity.
- Apply the 10 questions from the HEAT to your project, to encourage your team to think critically about the quality improvement projects you identify.
- Consider how increased workforce diversity will help the practice to collectively identify areas of need in your community.

[11] Robert Wood Johnson Foundation, 2017. *Visualizing Health Equity: One Size Does Not Fit All Infographic*, URL: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html Retrieved 1 November 2021

- Equity projects often require a long period of time to see results. Does your practice have the resources to sustain and grow the initiative?

5.2 Leading for equity

Inequitable access to healthcare has the effect of compounding inequity, as those most in need of healthcare have the least access to it. Barriers to accessing healthcare include issues with:

- health system literacy
- culturally safe health services
- patient and whānau-centred care.

These topics are all essential knowledge and are covered in detail in *Module 2: Cultural safety*.

Here are some practical suggestions to implement that will help your practice improve equity for your community.

Table 2: Practical steps to drive health equity

Driver of Health equity	Practical steps to take
Cultural safety	• Consider the artwork and signage in the practice. • Use bilingual signage. • Ensure staff can pronounce patients' names correctly. • Diversity in staffing creates diversity in views and life experience. Encourage and support a diverse workforce. • Engage representatives from the disadvantaged groups you are targeting to input into changes the practice could make. • Ensure all staff have received training in cultural safety, including clinical and non-clinical staff. • Encourage staff to understand implicit bias and become aware of their own implicit bias as this is a step towards change. • Critically review your practice for unintentional system issues that may be a barrier to access for disadvantaged groups. • See Module 2 for further information.
Patient-centred care	• Practices learn how to best meet the needs of their population groups by working with patients and whānau. • Partnership with patients and whānau aligns directly with Treaty of Waitangi principles of participation, partnership, and protection. • See Module 2 for further information.
Data and information technology	• Understand what data you have available and if you are using it effectively. • Understand the quality of the data inputs and improve the data collection and data entry if needed. • Focus quality improvement efforts and identify population groups that may need different care to achieve the same result based on reduced access or non-access.
Leadership	• Bold, innovative leadership disrupts the status quo. • Partner with patients and whānau to identify barriers and solutions. • Add standing agenda items to regular team meetings around the drivers of health equity, to ensure the whole team thinks of access and health equity .

Driver of Health equity	Practical steps to take
	• Introduce training requirements, such as cultural safety every two years. • Be prepared to shift the quality improvement focus from quick wins to long term changes. • Model cultural safety by ensuring the leadership team treats everyone (staff, patients, whānau) with dignity and respect. • Learn from other practice's that have successfully used tools such as HEAT, considering which parts of their projects you could replicate, and what lessons can be learnt
Health literacy	• Health literacy is a person's capacity to obtain, process and understand health information and services. • Assume all individuals have some degree of difficulty in negotiating health environments. • The practice is responsible for supplying appropriate information to every patient and their family. • Quality improvement initiatives can focus on removing health literacy as a barrier to access by looking at both the affected population and the practice. • See Module 2 for further information.

To have a positive impact on equity, quality improvement initiatives need to use data to understand the population groups with the greatest healthcare need. These could be groups defined by ethnicity, age, disability, geography, income levels, or something specific to your community. Quality improvement initiatives that provide the disadvantaged population groups with priority interventions to give them fair health outcomes are important in your practice.

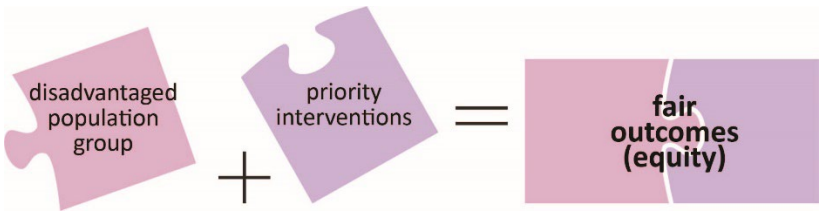


Figure 10: Quality improvement initiatives

The Health Quality and Safety Commission of NZ [12] suggests that when planning a quality improvement initiative, you should ask your team the following questions:

- Who are the individuals and groups in most need of this initiative?
- Is this service able to appropriately approach and be accepted by the individuals and groups most in need?
- Will this initiative be seen, sought, reached, and engaged with by those individuals and groups?
- What institutional and structural barriers prevent the benefits of the initiative reaching all who need them?
- What bias is brought via the design of the initiative and how can this bias be recognised, avoided, or mitigated?

[12] Poynter, M., et al, 2017. *Quality improvement: no quality without equity*, [pdf], URL: https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf Retrieved 1 November 2021

Activity 10: Find out more

The following article by Browne et al (2012) is optional reading if you would like more guidance on practical steps you can take to address inequity in your practice.

- Closing the health equity gap: evidence-based strategies for primary healthcare organisations

End of activity

Conclusion

In NZ, people have differences in healthcare that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes[13]. Disadvantaged groups could be identified by their ethnicity, age, gender, geographical location, sexuality, religion or other contextual factor.

Achieving equity in health outcomes is increasingly a priority for governments, with a focus on multifactorial government approaches. Multifactorial approaches are critical when you consider the complexities of the social determinants of health including housing, education, disability, food security, conflict and other factors. While a healthcare practice cannot change the social determinants of health for their population, the practice can support people from disadvantaged groups to access healthcare. Understanding the national strategic approach provides both the context of the bigger picture you are working within, and the legal obligations with which your practice must comply.

Equity and related quality improvement projects require reliable data. As the practice manager, it is important that you understand the capabilities of your software systems, as the system will have data available for analysis if you know how to access it. However, the data output is only as good as the input. Improving your equity data input may be your first quality improvement project.

From a practice perspective, the practice manager has a leadership responsibility to ensure the practice serves the community; using data and tools to identify target groups, design quality improvement initiatives and evaluate the outcomes. There are audit and evaluation tools that will assist you in evaluating equity issues, including the Health Equity Assessment Tool (HEAT) Guide. Some strategies to improve equity include understanding implicit bias, providing a culturally safe physical environment, support health literacy development, providing person and whanau-centred care. Every step you take to understand and address equity is crucial in supporting fair and just access to healthcare for disadvantaged groups.

Providing culturally safe services is a high priority strategy to achieving equity in healthcare and *Module 2: Cultural Safety* is dedicated to this topic.

[13] Ministry of Health, 2021. *Achieving equity*, URL: https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity Retrieved 1 November 2021

Module 2: Cultural safety in healthcare practice

Welcome to Cultural safety in healthcare practice. On completion of this Module, students will understand cultural safety as a high priority strategy to achieving equity in health outcomes for disadvantaged groups. While cultural safety for all groups is broadly covered, this Module has a specific focus on providing culturally safe healthcare environments for Māori, thereby meeting the practice's obligations under Te Tiriti o Waitangi.

The Module provides guidance on steps the practice and team can take to demonstrate their commitment to their obligations under Te Tiriti o Waitangi, including demonstrating an understanding of how supporting health literacy and person and whanau-centred care can contribute to a culturally safe healthcare practice.

Outcomes

On completion of this Module , you should be able to:

- ✓ Understand the needs-based and rights-based rationale underpinning Te Tiriti o Waitangi
- ✓ Understand practical steps the Practice and team can take to meet obligations under Te Tiriti o Waitangi
- ✓ Understand cultural safety as a high priority strategy in achieving equity of health outcomes for Māori
- ✓ Understand person and whānau-centred care as a key strategy for providing cultural safety
- ✓ Understand health literacy as a key strategy for supporting cultural safety and health equity.

Structure

This Module is divided into the following Lessons:

- Lesson 1: Te Tiriti o Waitangi

- Lesson 2: Cultural safety in practice
- Lesson 3: Person and whānau-centred care
- Lesson 4: Health literacy.

Activities

Throughout this Study Guide you will notice a range of activities. These are intended to contribute to your learning by encouraging you to be active and involved. None are compulsory. They are intended to help you to learn but are not part of your formal assessment.

Activities with an online interactive version are identified with a mouse icon at the start.

Common activity types included in study guides are included below.

- Knowledge check or Reflection: These encourage you to confirm or explore your understanding as you progress.
- Reading: These may be uploaded to my.unep or provided as links to readings or websites to expand on the content of the lesson.
- Video or Link: These provide alternative perspectives and give visual and audio alternatives to your text. Please do not feel you are required to watch all videos or read through all the links provided in this Study Guide.
- Find out more: In some lessons we provide support for additional reading or activities that go beyond what is required in the unit covered in this course or provide a refresher for underpinning concepts that support the knowledge and skills for this unit.
- Case study or Example: There are a range of case studies and examples provided throughout this Study Guide, to support your understanding and to provide a resource for some activities.

The end of an activity is identified with a band, like the one below and the text 'End of activity'. This indicates the normal Study Guide text will resume.

End of activity

Common Terms: You will notice that throughout this Study Guide we use the term 'patient' to refer to the people your team provides services or support to. In your workplace, you might use other terms such as patient, client, staff, employees, volunteers, or stakeholders.

We use the term 'medical receptionist' or receptionist to refer to the administrative staff in your team. In your workplace, you might use the term secretary, front desk staff, administrative assistant, or another term. Additionally, you may be a receptionist in a different type of practice, such as general practice, specialist practice, allied health, psychology, or mixed practice.

We use the term ‘practitioner’ to refer to the clinical team working in the healthcare practice. This could include general practitioners, specialists, allied health practitioners, psychologists, or other health professionals working within or referring to your practice.

Lesson 1: Te Tiriti o Waitangi

In Aotearoa / New Zealand (NZ), cultural safety is a high priority strategy in the attainment of equitable health outcomes for Māori. It is important to understand the context and history of Māori within NZ, and the local and international research on the rights and needs of culturally disadvantaged groups in the access to appropriate healthcare. This Lesson introduces Te Tiriti o Waitangi and the implications and obligations for healthcare practices.

1.1 Context

In NZ, Māori experience significant inequities in health compared to the non-high needs population. These inequities result in a significantly shorter life expectancy from non-Māori New Zealanders.

Table 1: 2017-2019 Life Expectancy at Birth for Māori Compared to Non-Māori

	Māori	Non- Māori
Females	77.1 years	84.4 years
Males	73.4 years	80.9 years

Due to the complex interactions of multiple social determinants of health (detailed in Module 1), Māori experience a high level of healthcare need. However, Māori receive less access to the full spectrum of healthcare services from preventative to tertiary care, and poorer care throughout this spectrum. Addressing Māori health inequity is a legislated high priority across NZ, based on both the needs and rights of Māori and reinforced by Te Tiriti o Waitangi also known as the Treaty of Waitangi[14].

1.2 Needs-based rationale

Māori have on average the poorest health status of any ethnic group in NZ. Māori health inequities are extensive and exist across multiple health indicators, culminating as poorer health outcomes and life expectancy for Māori as compared to non-Māori. The reasons for this inequity are broad and complex, including the social determinants of health, poor access to appropriate healthcare and the quality of care once it is accessed.

Māori have significantly worse health outcomes than non-Māori, including cardiovascular disease, heart failure mortality rate, lung cancer, diabetes and renal failure, infectious disease, mental health, suicide, interpersonal violence, oral health, infant health and unintentional injuries.

Although Māori experience a high level of healthcare need, they also receive less access to high-quality healthcare services. This demonstrates the needs-based rationale of health equity; Māori *need* better access to healthcare and high-quality care to achieve equity in health outcomes.

1.3 Rights-based rationale

High needs population people have a right to equity in health outcomes, and health services need to be delivered in a way that is accessible and provides high quality services for the user. Te Tiriti o Waitangi is the founding document of NZ. It establishes the basis for Māori rights to health equity, to be established through the principles of Partnership, Participation, and Protection.

[14] Curtis, E., et al, 2019. *Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition,* URL: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3 Retrieved 15 September 2021

Figure 11:The principles of Partnership, Participation, and Protection

The Te Aka Online Māori Dictionary[15] defines the following terms:

- Iwi - extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory.

Hapū - kinship group, clan, tribe, subtribe - section of a large kinship group and the primary political unit in traditional Māori society.

Whānau - extended family, family group, a familiar term of address to a number of people—the primary economic unit of traditional Māori society.

We'll now look at the principles of Te Tiriti o Waitangi and how these can be applied in your practice.

1.4 Te Tiriti o Waitangi principles

Te Tiriti o Waitangi places obligations on the Government of New Zealand which are interpreted into legislation, regulatory policy and advisory agreements. Health providers are in turn obliged to meet these obligations as advised by Government. Healthcare practices must demonstrate how they are meeting, or working towards meeting, their obligations under Te Tiriti o Waitangi.

In practice, this means the healthcare practice will have both an Equity Policy and Te Tiriti Policy embedded in their daily operations. It can be as simple as:

- learning to pronounce names correctly
- ensuring the practice allows for Māori customs when accessing healthcare such as supporting a meeting with the whole whānau to discuss health issues
- Māori used in the welcome
- bilingual signage.

[15] Moorfield, J. C., n.d. *Te Aka Online Māori Dictionary*, URL: https://maoridictionary.co.nz/dictionary-info Retrieved 15 September 2021

Equity and RNZCGPs quality programmes

Meeting the practices obligations to Te Tiriti o Waitangi and establishing an environment which promotes equity is central to the quality programmes. The Foundation Standard is about quality assurance and is mandatory for practices to receive government funding. An assessment occurs every three years to determine compliance and therefore funding.

Once practices have achieved the Foundation Standard, they are ready to begin the Cornerstone Modules which are focussed on quality improvement and include the Equity Module. The Equity Module enables practices to put the infrastructure in place to help them achieve equitable health outcomes for Māori as well as other underserved or marginalised groups.

Activity 1: Reading – The Foundation Standard

For further information on the Foundation Standard:

Indicator 3: Rights and health needs of Māori

For further information on the Cornerstone Equity Module:

- Equity module

End of activity

Te Tiriti o Waitangi outlines principles to deliver culturally competent care for Māori. This means that it is important to understand health and wellbeing from a Māori perspective and to understand and respect people's experiences of racism, discrimination, and marginalization. These experiences shape health, life opportunities, access to health care and quality of life. To provide a culturally safe healthcare environment, practices must demonstrate and support Te Tiriti o Waitangi principles, as follows.

Table 2:Practices must demonstrate and support Te Tiriti o Waitangi principles

Te Tiriti o Waitangi principles		
Principle 1	Kawanatanga	The right for the government to govern is qualified by the obligation to protect Māori Interests.
Principle 2	Tino Rangatiratanga	Māori have the right to exercise authority over their own affairs; an example of this is Iwi authority.
Principle 3	Te Orite	A provision which guarantees equity between Māori and other New Zealanders
Principle 4	Te Reitenga	A provision for the rites of Karakia, customs and spiritual beliefs

Activity 2: Reflection on Te Tiriti o Waitangi

As Health Workers, you need to be able to describe something that you do in your daily mahi / work that demonstrates how your workplace embraces and implements Te Tiriti o Waitangi. As a minimum, you can explain how you / your workplace is working towards this to reduce health inequities for Māori.

It is likely that you and the practice are actively working towards or implementing Te Tiriti o Waitaingi principles. Jot down your ideas or projects to help crystalise you're thinking.

Consider if you can formalise and document your ideas, as sometimes the documentation is not prioritised in the day-to-day business of a healthcare practice.

End of activity

Summary

Every healthcare practice in NZ has a legal and ethical obligation to achieve equity in health outcomes for Māori by providing a culturally competent and safe healthcare environment. Māori have both a need and a right to health equity, and Te Tiriti o Waitangi places obligations on the New Zealand government to achieve health equity for Māori. These obligations are interpreted into legislation, regulatory policy and advisory agreements, which healthcare providers are obliged to meet. It is important to understand the principles of Te Tiriti o Waitangi and document how the practice is achieving, or working towards, achieving their obligations.

Lesson 2: Cultural safety in practice

The contemporary view on providing culturally appropriate services has shifted from cultural competence to cultural safety. Historically, cultural competence involved learning a set of 'rules' about a particular culture which can have the unintended consequence of grouping everyone from that culture into the same stereotype, leading a person to 'other' the other person. Cultural safety, on the other hand, includes a requirement for staff to demonstrate both cultural competence and provide a culturally safe healthcare environment. This includes both the physical environment and the culture of the healthcare practice. This Lesson introduces you to cultural safety and steps to take to achieve it for Māori.

2.1 Cultural safety for health equity

In recent times, there has been a focus on staff being 'culturally competent' to ensure they are able to provide a culturally appropriate healthcare service to diverse groups. Cultural competence involves a person having the attitude, knowledge and skills that are needed to function respectfully and effectively to work with and treat people of different cultural backgrounds. Cultural competence can, however, be seen as a 'tick box' requirement, where practice staff are required to complete a course and thereby are deemed to be 'culturally competent'. Evidence shows that a competence-based approach alone will not deliver improvements in health equity, and this is where cultural safety plays an important role.

Cultural safety focuses on the patient experience to define and improve the quality of care. In a culturally safe environment, the patient will feel safe, connected to culture, and their identify will be respected.

Cultural safety can only be defined by those receiving the care.

For practice staff, providing a culturally safe healthcare environment requires the individual to self-reflect on their own attitudes, views, and biases, and how these may impact on the patient's experience and care. As you have learnt in *Module 1: Health equity in practice*, ongoing self-reflection is required, and people need to hold themselves accountable for providing a culturally safe environment.

Figure 12:The attainment of equitable health outcomes

In NZ, cultural safety is of particular importance in the attainment of equitable health outcomes for Māori. If a person does not feel respected and safe accessing a health service, they are less likely to attend, respect the healthcare provider and therefore less likely to develop a positive relationship with their healthcare team. This negatively impacts their health outcomes.

Providing a culturally safe practice environment requires everyone in the team to understand and demonstrate awareness and reflection so that cultural safety is embedded in the practice culture. The practice leadership team have a responsibility to provide consistency so that a culturally safe environment is accepted as 'just the way things are done here'. That way, new staff will quickly learn to be respectful and curious thereby supporting disadvantaged groups to access the practice safely and comfortably.

Activity 3: Video – Te Tiriti o Waitangi, colonisation and racism

Watch the video 'Te Tiriti o Waitangi, colonisation and racism' developed by the Health Quality and Safety Council of New Zealand (HQSCNZ). This is the second video in the series. You watched the first and third video in Module 1.

- Te Tiriti o Waitangi, colonisation and racism

Activity 4: Self-reflection – Culturally safe workspaces

As providing a culturally safe practice involves ongoing self-reflection, take this opportunity to reflect on your learning so far, including the Implicit Bias activity from Module 1.

Can you identify any opportunities for further:

1. personal development?
2. practice development, such as a quality improvement project to improve equity of access. For example, could the practice allow the entire whānau to attend appointments? Does the practice have the physical space in the consulting rooms? Enough chairs? Enough time? Will the whole whānau feel welcome and heard?

End of activities

2.2 Creating cultural safety in practice

Building a culture of values, consistency in behaviours and practices across the whole practice team is critical. The practice culture should be so consistent that providing a culturally safe and respectful practice "is just how we do things here". Achieving this practice culture requires strong leadership from the top, including the practice manager.

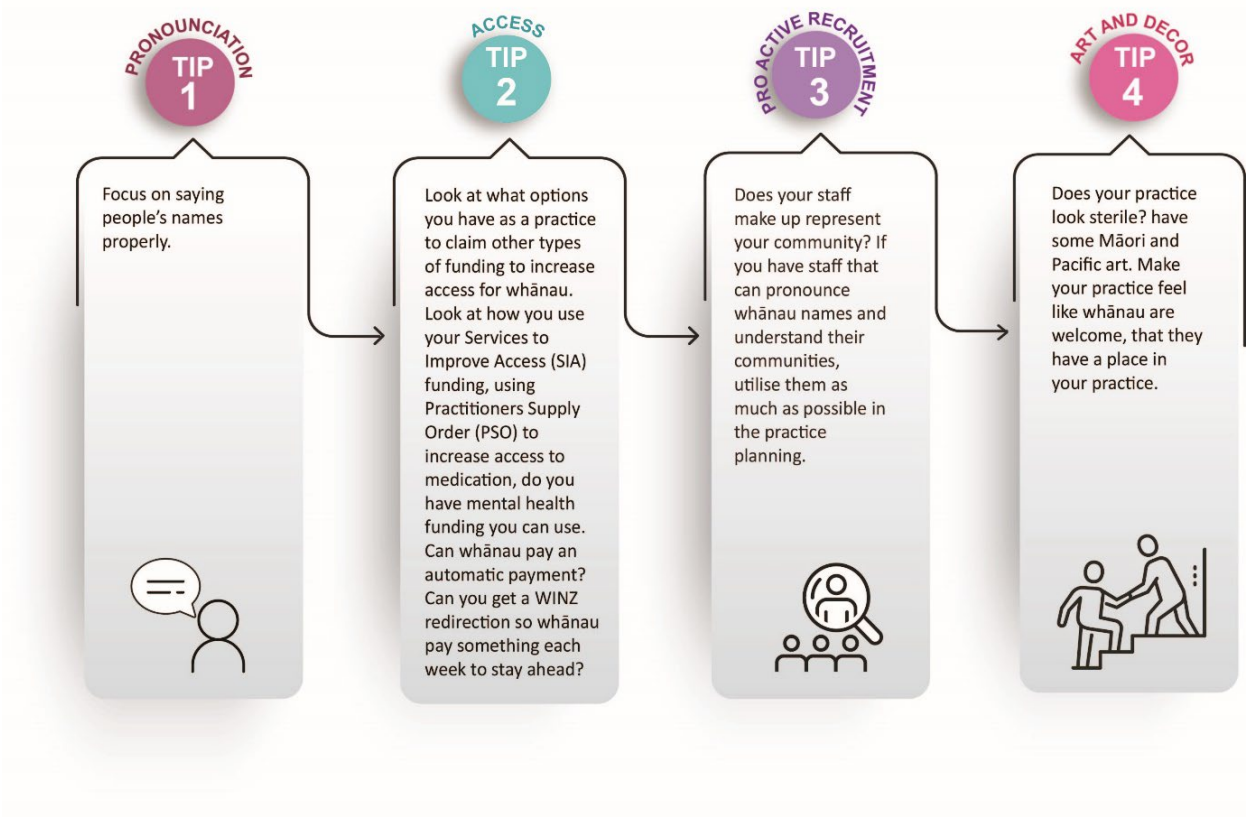
One important way to improve cultural safety within your practice is to consider the power differential between practice staff and patients from disadvantaged population groups. Examples of power differentials are shown in the following table.

Table 3: Power differentials

Workplace power differentials	
Front desk staff	The power to schedule the patient to see a doctor today or next week; the patient must argue their case successfully to get a priority appointment
Practice manager	Influences the culture of the practice through leadership and business operations. Is the physical environment welcoming to those from different cultures, and people who speak different languages? Is there enough space for whānau to join the patient?
Doctor	The power to diagnose, prescribe, and treat, and the power not to do these things
Practice nurse	The power to support collaborative care with patients by acknowledging their beliefs, culture, and values. Collaborative care will be unsuccessful if the patient feels disrespected or misunderstood and does not participate in collaborative care.

To provide a culturally safe environment in your practice, the team needs to identify ways to transfer power to the patient and their family through genuine patient-centred care and engagement with family and community groups, and to support patients in building their health literacy. These topics are covered in the next two Lessons.

The tips in the following diagram can be followed for achieving cultural safety[16]:



[16] Turuki Health Care. 2021. *Understanding and Developing Matekite - Turuki Health Care*, URL: https://turukihealthcare.org.nz/wellbeing/matekite Retrieved 2 November 2021

To engage your practice team in quality improvement initiatives that improve cultural safety for disadvantaged groups, you need to understand the current situation regarding where the practice strengths and weaknesses are. Data is critical to understand the current situation and also to measure any changes. It is important to understand the capabilities of the Practice Management Software, which collects demographic data that can be used effectively.

Summary

Achieving a culturally safe practice requires leadership and commitment from the practice managers and others in the leadership team. It is important the practice culture is one of cultural safety, including open and transparent reflection and self-awareness, ongoing learning and curiosity about individuals and their experiences and beliefs. Cultural safety can only be defined by those receiving the care.

Lesson 3: Person and whānau-centred care

Person and whānau-centred care involve collaborative healthcare focused on meeting the needs, values and desired outcomes of individuals and whānau. It is a model of care of treating each patient with respect and dignity and as a partner and collaborator in their healthcare. Rather than treating individuals with the stereotypes associated with their culture or other identity, it is necessary to treat everyone as a unique individual with unique experiences, beliefs and priorities. Providing person and whānau-centred care is a tool to provide a culturally safe practice environment.

3.1 Person and whānau-centred care

Groups of people are not homogenous, including those who belong to disadvantaged groups. As such, there is risk in learning 'knowledge' related to a particular group and applying it to everyone in that group. For example, some common stereotypes may include:

- Muslim women will only be seen by a female doctor.
- Māori will be less compliant taking medications.

In practice, this means that there is no tick box or prescribed 'correct' way to provide a culturally appropriate service. It means that every person who walks through the door is an individual, with unique beliefs, experiences, and relationships with their whānau. It is important to understand and have knowledge of their culture, but rather than creating more stereotypes based on someone's ethnicity or identity, your team can actively view each patient as an empowered and respected individual.

One way to avoid stereotypes is to ask questions with genuine curiosity and respect. If you have a belief that could be a stereotype, respectfully check with the patient to validate your assumptions. For example:

- Would you prefer a female doctor?
- What do you understand about your condition?
- Is it ok with you if I explain this to your spouse / mother / sister?
- What will help you to take this medication / come back for a check-up?
- What is stopping you from attending your appointments?
- Do you have any assistance at home?
- Do you have transport to get to your appointment?
- What language are you most comfortable speaking?

A model of care that ensures the person and their whānau are treated with respect and valued as individuals is key to providing a culturally safe environment at your practice. Person and whānau-centred care places the person at the centre of the healthcare environment, empowering them and their whānau to partner and collaborate with their healthcare providers. There are key values and behaviours required to provide person and whānau-centred care.

3.2 Values

In Māori culture, and many other cultures around the world, whānau is critical to the sense of self. Whānau connects the individual to the whakapapa, spiritually and to their whenua the land, as well as to each other.

Therefore, in NZ, person-centred care must be considered as person and whānau-centred care. You cannot treat the individual Māori in isolation from their whānau, and a healthy whānau is a fundamental element of a healthy person.

To achieve person and whānau-centred care, the values in the following diagram must be demonstrated to all Māori.

Figure 14: Values for achieving person and whānau-centred care

To demonstrate these values, everyone in the practice should be demonstrating the following in every interaction they have:

1. Recognise the inherent value and worth of every person and whānau.
2. Hold each individual and whānau in high regard, providing them with proper consideration, care, and attention.
3. Enable individuals and their whānau to take control of their own healthcare, building their health literacy and confidence in managing their own health with appropriate levels of support.
4. Ensure all team members are prepared to work with individuals and their whānau in a partnership, to achieve positive health outcomes.

To provide effective person and whānau-centred care, it is important to see the patient as a whole person. A patient is much more than the symptoms or illness that causes them to present at your practice and they have a lifetime worth of experiences and stories that are not understood by staff. To respect an individual, it is important to see them more broadly than their symptoms, including consideration of their whānau, abilities, social and cultural background, their preferences and beliefs, and holistic wellbeing. Everyone is impacted by the situational and cultural influences on their lives, for example, their social determinants of health such as employment, education, housing, food security and previous experiences. All these factors are unique and influence an individual and whānau's understanding of their health and ability to engage with health professionals.

It is important to remember that these influences change over the course of a person's life and will not be static over their lifetime. Someone who has previously declined a treatment may change their mind.

Activity 5: Reading – Healthcare Homes Collaborative

The Healthcare Homes (HCH) Collaborative provides further information and support regarding how to establish your practice in the Healthcare Homes model, and the resources can be utilised even if your practice is not accredited as a HCH practice. For example, one practice modelled their reception on the HCH model and now has a telephonist room and a main reception (without phones), so the main reception staff can provide uninterrupted meet and great services and health navigators.

There are significant benefits of becoming an accredited HCH practice, including the provision of culturally safe care to improve access for disadvantaged groups.

It is worth exploring the Healthcare Homes Collaborative website for resources.

- Healthcare Homes Collaborative

End of activity

To provide person and whānau-centred care to Māori, it is important to have cultural understanding and respect—cultural competence—to enable your team to achieve a culturally safe environment. Te whare tapa whā introduces understanding the dimensions of health and wellbeing for Māori.

3.3 Te whare tapa whā

For Māori, there are four cornerstones of health that must be taken care of to support their health and wellbeing, as defined by their elders at traditional tribal gatherings, and documented by Sir Mason Durie in 1984. This holistic model of health is called te whare tapa whā. The four cornerstones of health for Māori people are shown in the following diagram.

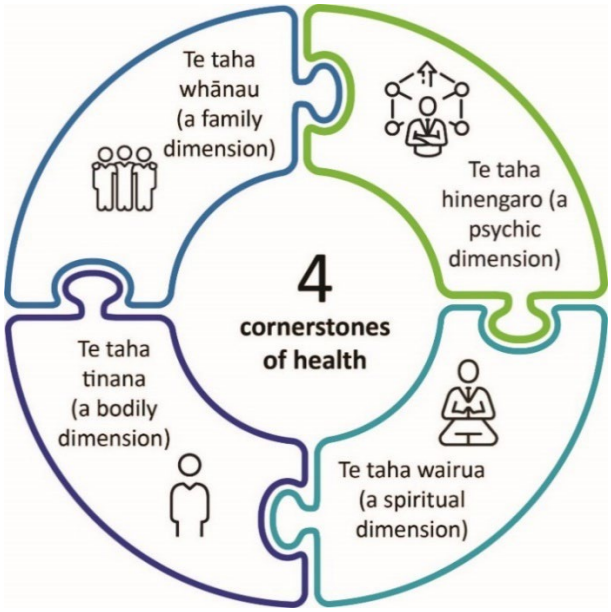


Figure 15: The four cornerstones of health for Māori people

The four dimensions are underpinned by connection with whenua (land). Whenua is the place of belonging and is a key element of identity for Māori. All five dimensions need to be nurtured and strengthened to support Māori health and wellbeing.

- **Taha tinana** is physical wellbeing. It is about how the body grows, feels, moves and how it is cared for. Achieving physical wellbeing by nourishing and strengthening it helps people to cope with the various ups and downs of life and be mentally well.
- **Taha hinengaro** is mind, heart, conscience, thoughts and feelings. It's about how people feel, communicate and think. When taha hinengaro is strong, people can better cope with life's challenges.
- **Taha wairua** is spiritual wellbeing. A spiritual essence is your life force—your mauri. This is who and what the person is, where they have come from and where they are going. Spiritual wellbeing is what someone believes and there is no right or wrong. Taha wairua provides a sense of meaning and purpose as well as experiencing a sense of connectedness to self, whānau, community, nature and the sacred.
- **Taha whānau** is family wellbeing. Whānau is about extended relationships including friends, hoamahi (colleagues), community and the people you care about. Everyone has a place and a role to fulfil within their whānau, and whānau contributes to your individual wellbeing and identity.

Activity 6: Video – HQSCNZ Improving cultural competence

To improve your knowledge and cultural competence for Māori, watch the videos developed by the Health Quality and Safety Commission of New Zealand and reflect on your own beliefs, experiences, and any bias you may have towards Māori.

- Communicating with Māori in a health setting
- Māori Cultural Practices

End of activity

3.4 Practical steps

In a healthcare practice, there are several strategies that can be implemented to provide a culturally safe environment for Māori, including providing person and whānau-centred care. Other steps your team could implement include:

1. everyone in the practice having an awareness of Māori rights and the issues they face in relation to equity of health outcomes
2. understanding and implementing the Treaty-based requirements in the provision of healthcare to Māori
3. reviewing practice policies and procedures to improve Māori participation and partnership
4. ensuring the practice provides a culturally safe environment, both physically and in all interactions with staff at the practice.

Summary

This Lesson introduces the person and whānau-centred care as a key strategy in providing a culturally safe healthcare environment. Each individual should be valued for their experiences and beliefs and be treated with dignity and respect. A respectful relationship enables the healthcare team and individual to work together in partnership, collaborating to achieve equitable health outcomes across all groups.

To meet the obligations of Te Tiriti o Waitangi and provide a culturally safe environment, it is important for all practice staff to demonstrate cultural competence, including an understanding that for Māori, there are four cornerstones of health that must be taken care of to support their health and wellbeing; this holistic model of health is called te whare tapa whā.

Lesson 4: Health literacy

Poor health literacy is a key contributing factor to inequitable health outcomes. People need to be able to understand and navigate both the health system and relevant health information to be able to make informed decisions regarding their healthcare. The provision of person and whānau-centred care relies on the individuals and their whānau having an appropriate level of health literacy to make informed decisions about their healthcare.

Your practice can help patients achieve equity in health outcomes by supporting them to improve their health literacy.

4.1 What is health literacy?

For a healthcare practice to be culturally safe, it must also be accessible to people from disadvantaged groups. A key component of improving access to healthcare is to improve the health literacy of target groups.

Health Literacy: the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions.[17]

The definition above should not be interpreted as a deficit of the patient. Rather, the health system, practices and health practitioners themselves all have a crucial role in health literacy. At a healthcare practice level, you have a responsibility to communicate information and deliver services. The practitioners themselves are responsible for providing information that makes sense to their patients and removing barriers the patient has in actioning the new health information they have received.

4.2 The importance of health literacy

The reason health literacy is so important is due to the strong link between health literacy and health status. Poor health literacy increases health inequities.

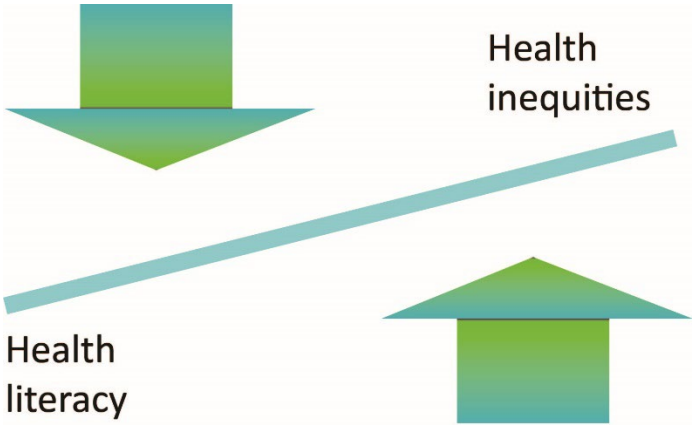


Figure 16: The relationship between health literacy and health inequities

Areas with the following factors are likely to have lower levels of health literacy:

- larger high needs populations
- larger population of older people
- communities with high levels of disadvantage and low general literacy levels
- areas with high turnover of health professionals and use of locums
- areas using high levels of overseas-trained doctors with English as a second language.

Individual health literacy is determined by a range of social, economic, cultural and health factors and, as such, it can change depending on the circumstances. Health literacy is influenced day-to-day by factors including:

- physical barriers such as transport, caring or other commitments, geography / remoteness

[17] Healthliteracynz, n.d. *What is health literacy?*, URL: https://www.healthliteracy.co.nz/page/about-health-literacy/ Retrieved 18 November 2021

- poor general literacy
- language barriers
- poor access to, or confidence using, digital technology
- workforce issues
- anxiety
- stigma (as perceived by the patient)
- poor health.

The shift towards patient and whānau-centred care gives the patient a greater degree of responsibility and ownership over their health. To successfully navigate the healthcare system and advocate for themselves and their families, consumers need to build their health and 'system' knowledge. By building their health literacy, consumers become more independent and less reliant on health professionals to access information and resources.

Improving health literacy is not just about using plain language and having handouts. The health system itself must change.

Activity 7: Video – Health literacy amongst Māori

Watch this video developed by the Health Quality and Safety Commission of New Zealand and reflect on your own beliefs, experiences, and bias you may have towards Māori and Pacific Islander groups.

- Health Literacy Amongst Māori

Reflect on other disadvantaged groups who attend your practice and consider the implications of poor health literacy, such as for older people.

Activity 8: Reading – Health literacy resources

The health literacy booklet is an excellent resource for practice staff on how to support your patients in building their health literacy.

- Health-literacy-booklet-3-steps
- About-health-literacy

End of activities

4.3 The practice manager's role

As a healthcare practice, everyone in the practice has a role in supporting people to improve their health literacy. This includes helping people to navigate the system, make informed decisions about their needs and access timely care.

Some examples to discuss with your team include:

1. Does a patient who has a newly acquired disability (e.g., a stroke, multiple sclerosis) and understand which Allied Health professionals can assist? Is a referral required, and what are the funding options available to them?
2. Fees should be discussed up front with all patients and whānau, including out-of-pocket expenses. If payment plans are available, raise this. This is called Informed Financial Consent.
3. services for new mothers/young families
4. interpreters.

There are steps everyone in the practice can take to improve health literacy for patients. The following table provides some examples.

Table 4: Improving health literacy

Practices which improve health literacy	
Front desk staff	Support patients who contact the practice to triage effectively. Give them time to explain their problem and the urgency they feel in seeing a doctor. Ensure all patients and whānau are treated kindly, with respect, even when the phone won't stop ringing and patients are lined up at the reception desk. If people feel rushed or like they are a burden, they are less likely to ask questions. Provide billing information at the time of booking the appointment, including any funding / payment options.
Practice manager	Be prepared to support staff in having time to spend with patients and whānau to explain both clinical information and navigating the system. Provide billing information at the time of booking the appointment, including any funding / payment options. Train staff in supporting health literacy. Talk to patients and whānau about healthcare options and funding models.
Doctor	Be prepared to spend the time asking questions to determine baseline knowledge and assumptions. Use plain English rather than jargon when talking to patients and ask them questions to confirm their understanding. Use diagrams / pictures in explanations.
Practice nurse	Review and potentially re-write the practice's letter template to be plain English / easy-to-understand, removing jargon, and having options for other languages. Use plain English rather than jargon when talking to patients and ask them questions to confirm their understanding. Use diagrams / pictures in explanations.

Summary

Supporting patients to improve their health literacy will make a significant impact on achieving equity in health outcomes. Oftentimes, health literacy support requires time: time to ask open ended questions of the patient and their whānau, time to gauge their understanding and experiences, time to talk through the options with them. When a patient feels uncomfortable and unknowledgeable, they are less likely to feel respected and ask questions. Unfortunately, a rushed, harried clinic with clear time pressure is not conducive to supporting patients in improving their health literacy.

Conclusion

This Module has introduced you to cultural safety in practice with a particular focus on Māori. It is important to understand the practice's obligations under Te Tiriti o Waitangi and demonstrate how the practice is meeting these obligations, including the four principles described in the following table.

Table 5: The four principles of cultural safety

Practice obligations under Te Tiriti o Waitangi	
Kawanatanga	The right for the government to govern is qualified by the obligation to protect Māori interests.
Tino Rangatiratanga	Māori have the right to exercise authority over their own affairs. An example of this is Iwi authority.
Te Orite	A provision which guarantees equity between Māori and other New Zealanders
Te Reitenga	A provision for the rites of Karakia, customs and spiritual beliefs

The practice also has ethical obligations in providing a culturally safe healthcare environment for disadvantaged groups, and strategies including engaging with and providing person and whānau-centred care. Supporting patients to improve their health literacy will ensure the practice provides a culturally safe healthcare environment for Māori and other disadvantaged population groups.