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Tēnā koe

MCNZ draft statements on Cultural Competency and Cultural Safety, and Hauora Māori.

About the College

Thank you for the opportunity to comment on the MCNZ draft statements on Cultural Competency and Cultural Safety, and Hauora Māori. The Royal New Zealand College of General Practitioners (RNZCGP) is committed to honouring Te Tiriti o Waitangi, achieving health equity for Māori, and strengthening culturally safe practice across our membership of 6,018 Specialist GPs who form 40 percent of the medical workforce. Our focus is on patient safety, a sustainable workforce, and equitable access to high quality primary care.

Summary

The draft statements on Cultural Competency and Cultural Safety, and, Hauora Māori are well-written and easy to understand. They rightfully assert the importance of cultural competence, cultural safety, and Hauora Māori in all aspects of medical practice.

Improvements however can be made to specific contents, particularly; making explicit mention of Te Tiriti o Waitangi and Māori health rights as the rationale for ensuring culturally safe and responsive practice for Māori, as well as referenced resources to help enable implementation of the documents' values at the practitioner level. Further suggestions, such as clearer separation of the concepts of cultural competency and cultural safety, additional definitions or concepts, and wording adjustments, are also included in our submission.

The College consents to any portion of our response being quoted.

The difference between cultural competence and cultural safety could be clearer

The separation of the terms cultural competence and cultural safety in the draft statement on Cultural Competence and Cultural Safety are an improvement from the 2019 Statement on Cultural Safety (1). However, there are instances in the draft where the two terms are conflated. For instance, both points in the section headed by the sub-title "*Be aware of your own cultural identities and worldviews*" better align with the concept of cultural safety, rather than cultural competence. Curtis et al. (2025) provide accurate, clear, and distinguished definitions for both cultural competence, and cultural safety in the Aotearoa New Zealand context (2) and should be considered for use in the draft statement.

Definitions for equity and cultural loading should be incorporated in both statements

Both draft statements provide clear definitions of terminology, with those of most importance helpfully highlighted from the outset. However, the addition of a definition for equity to the draft on Cultural Competence

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and Cultural safety, and a definition of cultural loading to the draft on Hauora Māori, would enhance these documents and provide clarification of the intersectoral nature of both equity and cultural loading across these statements

Discussing inequity and equity without defining these terms, limits the clarity of the draft statement on Cultural Competence and Cultural Safety and the importance of both concepts, particularly as cultural competence and cultural safety contribute to furthering equity in health, for example, through practitioner behaviour, communication, and acknowledgement of biases.

Additionally, while it is important that the clinician is guided by the patient and their whānau in how to interact and use their knowledge respectfully as identified in the draft statement on Hauora Māori, this should be done in a manner which does not place undue burden (i.e., cultural load) on the patient and their whānau, and should be highlighted in the statement.

Explicit mention of Te Tiriti o Waitangi and Māori health rights as understood within the health sector are missing from the documents

Although the draft statement on Hauora Māori is intended to support the existing MCNZ resource He Ara Hauora Māori: A Pathway to Māori Health Equity (3), Te Tiriti o Waitangi and Māori health rights, and how they relate to the health system and Hauora Māori specifically should be incorporated into the draft document. This includes articulation of:

- Kāwanatanga - the guarantee of good, just, and fair governance, as stipulated in Article 1 of Te Tiriti o Waitangi. In practice, this would be illustrated by the achievement of health equity for Māori.
- The right to maintain Tino Rangatiratanga and the right to safeguard all that is regarded as Taonga among Māori, as stipulated in Article 2 of Te Tiriti o Waitangi. Hauora is one such taonga for Māori and ill health and the burden of health need illustrates a failure to uphold Article 2.
- Ōritetanga - the guarantee of equity, both in health outcomes, and in access to resources (including those which *promote* good health), as identified in Article 3 of Te Tiriti o Waitangi. Ōritetanga, alongside kāwanatanga provide for the guarantee of culturally safe and culturally competent care, in recognition they are prerequisites to achieving health equity for Māori.
- The right for Māori to live and flourish as Māori in Aotearoa New Zealand, as stipulated in the oral article of Rītenga Māori. This in part, recognises the cultural safety, cultural competency and upholding Māori health rights enable Māori to live and flourish as Māori.

Similarly, the reassertion of Māori rights to Mana Motuhake, as articulated in He Whakaputanga o te Rangatiratanga o Nu Tireni (the Declaration of Independence of New Zealand) provides further justification of the need for culturally safe and culturally competent care.

Additionally, while the draft statement on Cultural Competency and Cultural Safety identifies that cultural competence necessitates specific knowledge and skills for providing adequate medical care in New Zealand, precisely what this information is within the New Zealand context, is not well-defined. For this purpose, further illustration of the health rights of Māori as tangata whenua should also be incorporated within the draft on Cultural Competence and Cultural Safety, similar to the 2019 document.

Finally, as the 2019 documentation has done, acknowledgement and recognition of the rights of Māori as protected under international law should be stipulated, specifically the United Nations' Declaration on the Rights of Indigenous Peoples (2007) (4).

These actions will better substantiate the points in both draft statements around indigenous, and specifically, Māori health rights, and will clearly signal a strong commitment to Māori health equity and culturally safe practice.

Further resources which practitioners can use for additional information, particularly on how to implement recommendations and measure success, should be referenced in the statements

Both draft statements clearly set expectations for doctors to provide culturally competent and culturally safe care and to understand Māori health rights in order to advance Hauora Māori. They also identify the importance of using data to measure and assess improvements in equity and quality of care. These points, alongside the identification of cultural competence and cultural safety as ongoing processes is welcome.

However, there is little guidance or resources for how practitioners can achieve the set expectations, and measure progress, and thus the draft statements are limited in enabling doctors to support equitable health outcomes and may lead to inconsistency in care and measurement due to variability in operationalising said expectations. Practical tools, frameworks, or resources for developing and measuring cultural competency, cultural safety, and implementing Te Tiriti o Waitangi and the WAI2575 principles in medical practice would strengthen both draft statements and make guidance more actionable and accessible.

The WAI2575 Hauora Report outlines how Te Tiriti o Waitangi principles could be meaningfully operationalised across the health system and would be a document worth identifying in both drafts, but particularly in the statement on Hauora Māori, as it details how unfair systems could be dismantled through governance structures, changes to funding models and institutional practices, and emphasises the need for measurable outcomes and clear accountability mechanisms (5). This would be a useful resource for assisting practitioners in their capability-building journey.

It would also be of great benefit to see further information on the historical, contemporary, and systemic factors which contribute to health disparities, including colonisation, and systemic racism. This information could be provided either in the draft statements themselves, or through further resources and would help enable practitioners to further understand the root causes of inequities and how they may contribute towards addressing them.

The commitment to pursuing and achieving health equity and cultural safety should be stronger

The draft statement on Hauora Māori identifies the importance of “advancing” health equity for Māori, and while this is true, a more appropriate aspiration is the achievement of Pae Ora (6). Furthermore, practitioners indeed “can” use their knowledge and positions to support Hauora Māori, however these actions indeed should be a required part of a practitioner’s actions.

Similarly, the draft statement on Cultural Competency and Cultural Safety defines cultural competence in part as the actions necessary to “achieve health outcomes for all cultural groups”. All patient populations deserve excellent health outcomes; however, the current wording does not necessarily suggest this.

Furthermore, unlike the 2019 Statement on Cultural Safety, the current draft statements do not identify the legal obligation of doctors to uphold rights identified in the Code of Health and Disability Services Consumers’ Rights (7).

In summary, the phrasing across the two documents could use strengthening to better illustrate the commitment to, and expectation, for providing culturally safe care, and achieving health equity.

The involvement of patients and their whānau in their own healthcare is minimal in both statements

Although the draft statement on Cultural Competence and Cultural Safety identifies the importance of practitioners adjusting their behaviour and practice according to patients’ cultures and worldviews there is a reduction in the emphasis on the importance of engaging patients in their own healthcare and decision-making compared to the 2019 statement and this element is completely missing from the statement on Hauora Māori.

This active participation and supporting of Tino Rangatiratanga for Māori is particularly pertinent to the draft statement on Hauora Māori, as it directly relates to treaty obligations and Māori health rights and is one way in which practitioners can uphold Te Tiriti principles through their practice and in order to protect Māori rights.

As mentioned previously, the provision of specific strategies or resources for how to engage patients and communities in developing, implementing, and evaluating culturally safe health care would be of benefit to both draft statements.

Specific concerns related to the Gender and Sex Data Protocol, and the MCNZ expectation that doctors adhere to it

The MCNZ statement on Cultural Safety (point 12) states: “you have an obligation to comply with national data protocols”.

We anticipate GPs will experience practical challenges in implementing this protocol. We suggest including specific comment on the national data protocols and how they will be operationalised in general practice settings.

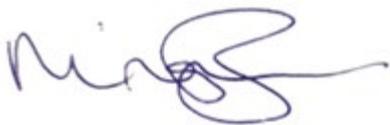
Recommendation

Our members recommend that MCNZ mandate two separate data fields (including in referrals): one for biological sex and one for gender identity. Gender identity could be optional. While this approach may not meet the needs of a transgender person who chooses to remain stealth, it would improve data accuracy and address existing safety issues that arise when a single field is used and the sex marker is changed.

Additional Notes

- Each draft statement should reference the other as a complementary document, as both are essential for pursuing health equity in New Zealand.
- The expansion of the definition of power, and how it may influence patient care is a welcome improvement from the 2019 statement on cultural safety, however the effect of the power-imbalance present between doctor and patient is not effectively conveyed in the current statements.

Nāku noa, nā



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