

# Culturally competent health care

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## ABSTRACT

New Zealand has an increasingly diverse community containing many cultures, each with a unique worldview that shapes the collective identity and individual behaviours. This worldview may differ significantly from that of the prevailing Pakeha culture. The New Zealand health care system is grounded in the prevailing Western culture. The lack of cultural understanding between the prevailing\* health care system and many Maori or Pacific patients is reflected in the health disparities between Maori or Pacific people†, and Pakeha New Zealanders. In order to deliver high quality, effective health care to the diverse communities of New Zealand, the cultural competence of providers needs to be developed. For Maori and Pacific groups cultural competence is just as important as the clinical competence of providers. Guidance for developing cultural competence is presented in this paper.

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New Zealand is becoming an increasingly diverse country and this is readily apparent in the greater Auckland area, where a significant portion of New Zealand's Maori, Pacific, and Asian populations reside within the regional boundary. For example Maori now comprise some 18% and Pacific peoples some

17% of Counties Manukau residents. These growing communities have an impact on the wider society at the same time that other demographic changes are taking place. These include changes to birth rates, the ageing of European populations, greater participation of women in all aspects of society and growing numbers of immigrants and refugees.

Each of the many cultures represented in New Zealand has a unique perspective or worldview, which forms the basis of both collective and individual identity or behaviour.

Culture has been described as the learned and shared patterns of information that a group uses to generate meaning among its members. These patterns encompass language, non-verbal communications, relationships with other people, beliefs and material goods. Within cultures the members share a be-

lief in certain rules, roles, behaviours, and values. Concepts such as 'family', 'community', 'wellness', and 'illness' are different for various cultures and the meanings of these are contained within the language and customs of each culture. Culture shapes the individual's worldview and influences interaction with others, such as 'help-

seeking' behaviours and attitudes toward health care providers.

This definition also applies to the medical culture, which shapes the pattern of interaction between health care providers and patients from the majority cultures, as well as the interactions with other diverse cultures in our communities.

Both health providers and patients bring their respective cultural backgrounds and expectations to the health care setting. These cultural differences can present barriers to appropriate care. Illnesses can be categorised in strictly biological terms by Western medicine, but

many Maori and Pacific people carry cultural assumptions that may influence the presentation of symptoms or the response to diagnosis and treatment. A patient whose culture does not have a model for chronic diseases that fits with

the prevailing Western model of illness may perceive little benefit in a programme of lifestyle change and medicines to manage asymptomatic disease today against a potential advantage some time in the future.

The burden of chronic disease on Maori and Pacific populations has been well described, but is only ex-

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\* In this paper we use the term *prevailing* rather than *mainstream* to contrast health systems that are predominantly Pakeha directed with health care systems that are *sponsored by* Maori or other groups.

† The term 'Pacific peoples' does not refer to a single ethnicity, nationality or culture. The term is one of convenience used to encompass a diverse range of peoples from the South Pacific region and is used in this document to include those who self identify as a Pacific nation ethnicity.

plained in part by poverty. For example, Sporle et al<sup>1</sup> in their review of mortality rates of Maori and non-Maori men concluded that *'the poor state of Maori health cannot be solely explained by relative socio-economic disadvantage'* and also that *'the health system is still not nearly meeting health needs of many Maori.'*

### Culturally competent health care

The need to deliver culturally competent care to Maori, Pacific and other disadvantaged communities is brought into sharp relief when we consider that for almost all chronic diseases Maori and Pacific peoples have a greater burden of illness,<sup>2,3</sup> compared to non-Maori, non-Pacific peoples.<sup>4</sup> This paper presents guidance on cultural competence for Maori and Pacific patients, and has been developed as part of the Counties Manukau DHB plan for chronic care management. The draft paper was reviewed by Maori and Pacific groups including health workers.

Culturally competent health care has been defined as:

*A set of academic, experiential and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on the values, traditions, and customs of other cultural groups, and to work with knowledgeable persons from other cultures in developing targeted interventions, communications, and other supports.*<sup>6,10</sup>

While initiatives to increase the numbers of Maori and Pacific providers are underway,<sup>5</sup> there remains a need to increase the cultural competency of all providers, in order to improve access and health outcomes for Maori and Pacific people.<sup>4,8,9,12,13</sup>

Having a health care provider that is both understanding and understandable to<sup>6</sup> the patient has consistently been shown to predict patient satisfaction and the acceptability of treatment.<sup>7,8</sup> This is also true of Maori<sup>9</sup>

and Pacific people, but the lack of cultural concordance<sup>7,10</sup> between Maori or Pacific patients and predominantly Pakeha health providers suggests that a key factor in improving access to care,<sup>11</sup> adherence to treatment<sup>12</sup> and outcomes<sup>1</sup> is to develop the cultural competence of health care providers.

For example, Maori and Pacific patients are less likely to question treatment plans than Pakeha. In large part this is because Pakeha health professionals are seen to have a position of authority that should not be questioned, as that would be disrespectful. Clinicians therefore need to check on the understanding of Maori and Pacific patients in different ways, such as through indirect questioning, the use of family members, and by using Maori or Pacific health workers, and trained interpreters when necessary.

Culturally competent care begins with community involvement. This will mean that Maori and Pacific (or other ethnic groups) are to be included at all stages of service development, including staff training, policies and resource materials development, complaints processes, assessments of patient satisfaction, relationships with Maori and Pacific providers, and also with evaluations and planning for service improvements. Assistance with these matters can also be sought from the Maori and Pacific community, Maori and Pacific health professional groups, qualified Maori and Pacific consultants, Maori and Pacific patient advocacy groups, Maori and Pacific staff of hospitals, DHBs, the MOH, Te Kete Hauora and others. Consideration will need to be given to appropriately recompense and support these groups.

### Ethnicity data

All of these activities are underpinned by collection of information on ethnicity. Services must ensure that the self-identified ethnicity is included in the patient information management systems, as well as any

## Key Points

- New Zealand has an increasingly diverse community.
- Within our community there are many unique cultures.
- Culture is largely responsible for the behaviours and identity of individuals.
- The prevailing health care system is based on a dominant culture.
- Lack of cultural understanding is reflected in the health disparities between European/Pakeha New Zealanders and Maori or Pacific peoples.
- Cultural competence is the basis upon which effective, high quality care can be provided to individuals in our diverse communities in New Zealand.

patient records used by provider staff. This data is to be collected in an approved and consistent manner, so that individual patients can be offered care in a manner relevant to their cultural expectations, and also to evaluate outcomes for ethnic groups. Collecting and reporting demographic, epidemiological and clinical outcome data by ethnicity is the first step to making improvements to services for Maori, Pacific and other disadvantaged groups.

### Maori views of cultural competence

The Maori worldview places greater emphasis on group consensus than Pakeha culture, and the Maori view of health incorporates a steady-state where personal well-being is integrated with spiritual, family, community, social, and mental well-being. Key to this integrated sense of well-being are concepts such as *whakapapa* – an understanding of the past and community connections; and the concepts of *tapu* and *noa* – a balance between the profane and the ordinary that guides daily living.

Maori have a unique place in New Zealand society being an indigenous minority that has special needs due to a significant disparity in health status compared to the whole population. The Treaty of Waitangi and Crown objectives for the health of Maori provide a framework for planning and action to address these disparities. Maori comprise some 15% of the population currently but, like the Pacific population, have a greater rate of growth and a significantly lower health status compared to the remainder of the New Zealand population.<sup>13</sup>

Cultural competence for Maori requires that providers have a willingness and ability to draw on the values, traditions, and customs of Maori, and to work with kaumatua and other knowledgeable persons from Maori communities in developing targeted interventions, communications, and other supports for health.

### ***Skill requirements, needs and methodology***

#### *1. Values, staffing and training*

Ideally, Maori providers should be available to treat Maori patients. Alternatively providers with appropriate training and empathy for the cultural background of Maori patients can provide care. Providers should arrange for ongoing education and training for administrative, clinical, and support staff in culturally competent service delivery, including the dissemination of accurate information on the health needs and cultural practices of Maori.

Organisations should develop and implement a strategy to recruit, retain and promote qualified, culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of Maori communities. This will require innovative search and recruitment strategies.

#### *2. Community involvement*

Establish mechanisms for Maori involvement in the design and execution of service delivery, including

planning, policy making, operations, evaluation, training and treatment planning. A culturally competent service will build on relationships already established with Maori communities, kaumatua, and Maori health providers through attendance at hui, tangihanga, and other community events that celebrate the resilience of Maori.

#### *3. Language and resource materials*

Concepts of illness and health are encapsulated in Maori language and customs (te reo and tikanga). To enhance care, Maori should have access to bilingual staff or interpretation services. This will include the provision of oral and written notices, including translated signage at key points of contact, informing Maori of the availability of interpreter services. Translate into Maori (noting the importance of local dialect) signs and commonly used patient educational materials.

#### *4. Data collection*

Ensure that the client's self-identified ethnicity (including all iwi and hapu that are relevant to the individual) is included in patient information management systems, as well as any patient records used by staff. This data is to be collected in an approved and consistent manner. Collect, report and use accurate demographic, cultural, epidemiological and clinical outcome data for Maori.

#### *5. Complaints*

Develop structures and procedures to address complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services. Use complaints and critical incidents as learning opportunities for the organisation, including using them as a basis for discussion with kaumatua for analysis and for service improvements.

#### *6. Assessments and satisfaction*

Undertake ongoing organisational self-assessments of cultural competence. Where validated and cultur-

ally appropriate measures of access, satisfaction, quality, and outcomes for Maori and other ethnic groups are available, integrate these into organisational internal audits and performance improvement programmes.

#### *7. Relationships with Maori providers*

Maori providers can provide valuable linkages between communities, patients and providers in the prevailing health system. Even where the majority of Maori access providers from the prevailing system, the kaupapa Maori units of secondary care providers and the staff of Maori primary care providers have special expertise in the care of Maori patients. This should be utilised in the same way that expertise in clinical areas can be shared.

#### *8. Evaluation and improvements*

Complete and make available reports documenting the organisation's progress with implementing these criteria, including information on programme outcomes, performance indicators, staffing, complaints, training, and resources used.

### ***Discussion***

Cultural competence is to be regarded as a quality journey in which the results of all of the points noted above (from *Values* to *Evaluations*) are integrated into a cycle of continuous service improvement that will make culturally competent care available to Maori.

At some point each service/provider will be able to describe best practice in terms of clinical and cultural competence for Maori.

### ***Pacific views of cultural competence***

Terms to describe people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of ancestry or heritage vary considerably (e.g. Pacific Island, Pacific Nations person, Polynesian, Pacific Islander etc.). There is no officially sanctioned term to describe this group of people. Since 1994 the Min-

istry of Pacific Island Affairs has used the term 'Pacific peoples' to describe this group.

The term 'Pacific peoples' does not refer to a single ethnicity, nationality or culture. The term is one of convenience used to encompass a diverse range of peoples from the South Pacific region and is used in this document to include those who self identify as a Pacific nation ethnicity.<sup>14</sup>

Pacific peoples are culturally and ethnically diverse. It is estimated that Pacific peoples living in New Zealand represent over 20 Polynesian, Melanesian and Micronesian cultures, speaking an even greater number of languages.

Pacific peoples have been in New Zealand for over 100 years. In 1945 Pacific peoples comprised 0.1% of New Zealand's population. Pacific peoples are diverse in culture and languages, but share common migration and assimilation history in New Zealand. The migration of Pacific peoples increased rapidly in pace during the 1960s, a period of brisk economic growth and high demand for labour in New Zealand.

Today Pacific communities are no longer solely immigrant communities. Sixty per cent (60%) of Pacific peoples residing in New Zealand are New Zealand born, with a median age of 11.4 years.<sup>14</sup>

Pacific peoples in New Zealand have made changes to their lifestyles. Changes have sometimes meant total immersion in New Zealand lifestyles, while others have taken the best of traditional and modern lifestyles and some have endeavoured to retain solely traditional routines. There is an ongoing tension between adapting to change and retaining traditional values, lifestyles and attitudes.

Second and third generation New Zealand born Pacific peoples are often torn between the value systems

of the country they are born into and the traditional expectation placed on them by their immigrant parents, grandparents or communities.

Most Pacific cultures regard the extended family structure as central to the way of life and identity is often reinforced through family or kinship relationships, village and island.

Spirituality is a fundamental component to most Pacific cultures and is expressed in a Christian sense as well as in a traditional preservation and remembrance of ancestral ties and origins. The 'Church' remains an integral part of most New Zealand Pacific communities.

Non Church based Pacific organisations and networks have developed over many years and contribute to maintaining the 'connectedness' of each Pacific group and provide invaluable support to communities.

All of these factors shape the worldview of Pacific persons, including their view of health issues. In order to reduce health disparities, the prevailing health care system must take account of these issues when designing systems

of care. Service delivery gaps are more often due to a lack of information, training and skill development rather than an unwillingness to become more responsive. It is critical therefore to develop a systematic approach to supporting providers, to improve services that can deliver better outcomes.

### ***Skill requirements, needs and methodology***

Key components of a Pacific cultural competency approach will include:

#### ***1. Staffing and training***

Developing programmes that develop skills and an understanding of:

- Pacific peoples' cultures and the differences within each ethnic

group including an understanding of race, ethnicity and power.

- Pacific peoples' families, structure, inter-generational relationships, networks and how these relationships and networks influence health behaviours including 'New Zealand born' versus 'Pacific born' behaviours.
- Pacific peoples' views of health, well-being, healing, quality of life, utilisation of health care services and help seeking patterns.
- Historical factors which impact on the health of Pacific populations such as immigration patterns, racism, resettlement in New Zealand, citizenship rights, cultural adaptation and colonisation of Pacific nations.
- Psycho-social stressors experienced by different Pacific groups and sub-cultures within ethnic groups including 'culturally acceptable' behaviours of psychopathological characteristics.
- Traditional healing practices within each ethnic group.
- Role of religion, church and the church hierarchy and structures including the concepts of spirituality.
- Definitions of common Pacific values and concepts such as respect.
- Pacific peoples' health status and differences between ethnic groups.
- Priorities for Pacific peoples' health improvement.

Ongoing training and support for all staff to continue to build on experiences is critical both in a technical knowledge-based sense and also in an experiential process. An evaluation framework to monitor the effectiveness of the training and refine the programme is also useful.

Providers should endeavour to engage staff who reflect the diversity of the Pacific population served. Therefore recruitment, selection and retention of staff who value, respect and acknowledge a Pacific culture is a priority. Developing models and policies that include Pacific people and/or communities in these key

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processes often deliver more successful and sustainable outcomes than ad hoc approaches.

## 2. *Measuring cultural competency*

Developing standards and measures of cultural competency is an important step on the journey. It enables providers to recognise and reward staff who add value in this area and to measure effectiveness. It should be a key component in the performance management system of the organisation. This fills a significant gap within prevailing services where most quality improvement programmes have yet to incorporate the added value that cultural understanding can bring.

## 3. *Programme policies*

Strategic plans, goals, policies and procedures will identify key areas for implementation that will be measurable in improving health status and maximising health gain for Pacific peoples. This will involve identifying key individuals to take responsibility and drive cultural competency strategies. It will also identify key strategies to engage Pacific peoples in programme development, evaluation and performance measurement. In addition this provides a process that can validate programme design and delivery against health gain and the health needs of Pacific communities. Cultural processes and custom should be actively integrated wherever possible.

## 4. *Community engagement*

It has become clear that individual health is closely linked to community health; community health is profoundly affected by the collective behaviours, attitudes and beliefs of everyone who lives in the community. Partnerships can be an effective tool in improving health in Pacific communities. The complex nature of Pacific communities in Counties Manukau requires leadership approaches that are multi-faceted and culturally competent. Cultivating

leadership capacity is an indispensable strategy for engaging Pacific communities to reduce disparities in health status. Key points in working with Pacific communities will include:

- establishing and maintaining trust with Pacific communities and the Pacific health sector, particularly when there may be a history of adversarial relationships or distrust;
- effectively sharing resources with competing needs;
- sharing power and ensuring contributions are valued and respected; and
- using culturally competent communication modalities to provide Pacific partners with timely access to information.

The most fundamental principle to consider when engaging Pacific communities is the inherent ability of communities to recognise their own problems, including the health of its members and to intervene or develop solutions appropriately on their own behalf.

## 5. *Language and resource materials*

Language and custom are the cornerstones of maintaining cultural integrity. Therefore the support and promotion of 'first languages' is an important principle. The interpretation of cultural perspectives with regard to illness and health is also an integral component of diagnosis and treatment plans.

Providers ideally may have staff bilingual in key Pacific languages and will have access to accredited interpretation services. Patients and families will also have available key health information in translated format. The collection of 'first language' data as a routine part of clinical assessment will contribute to designing resources appropriate to the communities served.

Resource materials will be developed in partnership with Pacific communities that will consider cultural sensitivities and appropriateness both in design and use of messages.

## 6. *Data collection*

Data will be collected that will identify ethnicity. Ethnicity will be recorded in a consistent manner with NZ Statistics guidelines. Staff will be trained and supported to collect data and regular audits will be undertaken to ensure compliance. Data will be used to measure and review programme effectiveness, uptake of population groups and provide planning information.

## 7. *Complaints*

Providers will develop a complaints and feedback system and process that will support Pacific individuals, families and communities. A key principle will be the approach of utilising the complaints and feedback system as a quality improvement mechanism. Flexibility should be a key feature that will allow traditional Pacific custom to be applied where necessary, i.e. meeting with extended families, using key community members as advocates, following Pacific processes and protocols.

## 8. *Assessment and satisfaction*

Undertake ongoing organisational self-assessments of cultural competence. Where validated and culturally appropriate measures of access, satisfaction, quality, and outcomes for Pacific peoples are available, integrate these into organisational internal audits and performance improvement programmes. It is important to recognise the appropriateness of method, i.e. verbal versus written.

## 9. *Relationships with Pacific providers*

Pacific providers, churches and organisations can provide valuable linkages between communities, patients and mainstream providers. Pacific staff within mainstream organisations have expertise in managing relationships with Pacific families and may provide valuable assistance and support. Pacific providers are perceived as having a leadership role in the health sector

and therefore may be a valuable resource and the basis for collaborative arrangements.

### 10. Evaluation and improvements

Document the organisation's progress with implementing these criteria, including information on programme outcomes, performance indicators, staffing, complaints, training, and resources used.

Evaluation models must incorporate Pacific competency and utilise staff with particular skills in this area. In order to provide credible analysis, organisations undertaking evaluation will need to demonstrate a commitment to continuous improvement in cultural competency.

### Discussion

Pacific cultural competence is a process that will evolve over an extended period. Individuals and organisations are at various levels of awareness, knowledge and skills along the cultural competence continuum. Rapidly changing demographics ensure that the desire to adapt health delivery systems to meet the needs of growing Pacific populations will become more urgent. The sooner policy makers, funders and providers acknowledge and embark on this journey the sooner will Pacific communities fully participate as healthy segments of New Zealand society. It is hoped that this paper

will provide support for those already embarked on the journey and will provide inspiration for those contemplating change.

### Summary

The delivery of high-quality health care for Maori and Pacific peoples that is accessible, effective and cost efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live.

Knowledge of the cultural identity and of the preferences of individual patients is essential to treatment of that individual. For example, providers should not assume that all Maori or Pacific people have the same preferences for treatment, nor that an individual's choices will remain static over time. This is due to the diversity that exists within cultures as well as diversity between cultures, and the evolution of opinion that occurs in all cultures over time. For this reason consistent collection (and review) of ethnicity data in an approved manner underpins the delivery of culturally competent health care to individuals and communities.

Cultural competence requires a commitment to continuous improvement through continuing education, review and feedback in the same way that clinical competence does. Due to the emerging and developing nature of work in this area, this paper is to be considered a 'work in progress' rather than the definitive view of cultural competence. This paper is intended to provide guidance for organisations and individuals providing services to diverse

Maori and Pacific peoples. As with all professions the best advice comes from the person who is committed to understanding cultural differences in our community, and thus the unique individual qualities of the patient/client.

In health, as in

other professions, we should keep in mind the statement of Francis Bacon 400 years ago – '*science is not a finite body of knowledge – it is a debate in progress*'.

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