Libraries and Learning Services

University of Auckland Research Repository, ResearchSpace

Copyright Statement

The digital copy of this thesis is protected by the Copyright Act 1994 (New Zealand).

This thesis may be consulted by you, provided you comply with the provisions of the Act and the following conditions of use:

- Any use you make of these documents or images must be for research or private study purposes only, and you may not make them available to any other person.
- Authors control the copyright of their thesis. You will recognize the author's right to be identified as the author of this thesis, and due acknowledgement will be made to the author where appropriate.
- You will obtain the author's permission before publishing any material from their thesis.

General copyright and disclaimer

In addition to the above conditions, authors give their consent for the digital copy of their work to be used subject to the conditions specified on the Library Thesis Consent Form and Deposit Licence.

Cultural competence in ethnically diverse healthcare: A case of a district health board in New Zealand

Xiaowei (Cindy) Luo

Institute of Innovation and Improvement (i3), Waitematā District Health Board

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Bioscience Enterprise
The University of Auckland, 2019

Abstract

With increasing migration taking place globally, there has been a corresponding increase in cultural diversity among populations in receiving societies worldwide. Health services which are not responsive to the needs of culturally diverse populations have led to health disparities between ethnically diverse groups and the dominant population groups. This study investigated how health disparities can be reduced by determining the components of cultural competence which are needed in healthcare organisations which serve increasingly multicultural populations. This is a mixed-methods qualitative case study consisting of a two-stage sequential research design that took place at Waitematā District Health Board (WDHB), one of the twenty DHBs in New Zealand that plan, fund and deliver health services to the population in its region. The first stage of data collection was the preunderstanding stage, which consisted of having informal conversations with industry members in addition to secondary data collection. The second stage of data collection consisted of conducting semi-structured interviews with fourteen staff of WDHB. Various barriers in accessing adequate health services faced by culturally diverse population groups were conveyed in this study. Eight components of cultural competence have been proposed along with focus areas within each one, for where action can be taken by healthcare organisations as part of an attempt in moving along the cultural competence continuum. The eight cultural competence components are cultural awareness, cultural competence education, models of care, cultural representation, workforce capability, primary health organisation enrolment and health literacy, interpreting services and ethnicity-based data collection. The findings of this study can be used as a preliminary guide for healthcare organisations in New Zealand to better meet the health needs of an increasingly ethnically diverse population via appropriately responding to the obstacles conveyed in the study. This can consist of developing indicators and quantifiable baseline targets and values specific to the health needs of their population. The study has also highlighted the importance of the Treaty of Waitangi, where further exploration is required to determine how the unique position of the indigenous Māori population can be acknowledged in healthcare organisations' attempt in moving along the cultural competence continuum.

Acknowledgements

To my industry supervisors, Sue Lim and Jarrard (Jay) O'Brien, thank you for all your support and encouragement from the start to finish. Annette Mortensen, I'd also like to thank you for your input and support. You are all very much appreciated, and this would not have been possible without your assistance.

To my academic supervisor, Dr Carlos Diaz Ruiz, thank you for your guidance throughout this process and for all your effort since the beginning. I have enjoyed the journey and will cherish the ups and downs of this learning experience.

To my interview participants, thank you for your time and valuable contribution to this study. I have enjoyed speaking to you all and deepening my understanding of cultural competence and the exciting things happening at Waitematā District Health Board. Your support is much appreciated.

To the team at i3, thank you for providing such a great experience for me as an intern. It has been a fantastic learning opportunity for me, and I've enjoyed getting to know everyone. A special shout out to Cam and the other kids at i3 who added in that extra sparkle of fun.

To my Bioscience Enterprise classmates, it has been a great journey of growth and learning over the past 2 years and I'm glad to have shared it with every one of you. Wishing you all the best for your future endeavours!

To all my friends who have supported and cheered me on throughout this process, your encouragement is much appreciated.

Finally, to my family, thank you for being there for me throughout these past few years of my studies. I would not have achieved any of this without your unconditional love, constant encouragement and belief in me.

Table of Contents

Abstract……………………………………………………………………………………………..ii

Acknowledgment……………………………………………………………………………...iii

Chapter 1: Introduction……………………………………………………………………..1

1.1 Ethnic diversity in healthcare………………………………………………………………1

1.1.1 Cultural competence……………………………………………………………………..1

1.1.2 Culture and ethnicity……………………………………………………………………..2

1.1.3 Role of cultural competence in healthcare…………………………………………….3

1.2 Increasing ethnic diversity in New Zealand………………………………………………....4

1.2.1 Role of the Treaty of Waitangi in healthcare…………………………………………..5

1.2.2 Structure of the New Zealand health system…………………………………………6

1.2.3 Case study at Waitematā District Health Board………………………………………7

1.3 Research objectives and contribution…………………………………………………..7

1.4 Methodology……………………………………………………………………………….8

1.5 Thesis structure…………………………………………………………………………...8

Chapter 2: Literature Review…………………………………………………………………..10

2.1 Cultural competence continuum………………………………………………………….10

2.2 Cultural competence at different levels of the health system…………………………….11

2.2.1 Individual level cultural competence……………………………………………………11

2.2.1.1 Cultural Awareness……………………………………………………………….11

2.2.1.2 Cultural competence education……………………………………………………11

2.2.1.3 Explanatory models in health………………………………………………………15

2.2.2 Organisational level cultural competence………………………………………………16

2.2.2.1 Cultural representation…………………………………………………………...16

2.2.2.2 Culturally competent leaders and role models……………………………………17

2.2.2.3 Whole organisation effort……………………………………………………………..18

2.2.3 Systemic level cultural competence…………………………………………………..18

2.2.3.1 Health literacy…………………………………………………………………..18

2.2.3.2 Interpreting services………………………………………………………………20

2.2.3.3 Ethnic monitoring……………………………………………………………….20

2.3 Chapter summary……………………………………………………………………..21

Chapter 3: Methodology…………………………………………………………………….23

3.1 Research design………………………………………………………………………23

3.2 Data collection……………………………………………………………………………...25

3.2.1 Preunderstanding phase…………………………………………………………………..25

3.2.1.1 Informal conversations…………………………………………………………….25

3.2.1.2 Secondary data collection………………………………………………………….25

3.2.2 Primary data collection…..………………………………………………………….....26

3.2.2.1 Procedure for semi-structured interviews………………………………………….26

3.3 Data Analysis……………………………………………………………………………….27

3.4 Significance of the proposed research……………………………………………………………..28
3.5 Reliability and Validity…………………………………………………………………………..28
3.5.1 Reliability………………………………………………………………………………………28
3.5.2 Validity…………………………………………………………………………………………29
3.6 Ethical considerations……………………………………………………………………………..30
Chapter 4: Findings………………………………………………………………………………..31
4.1 Cultural competence at the individual level……………………………………………………..31
4.1.1 Cultural awareness……………………………………………………………………………..31
4.1.2 Cultural education at Waitematā District Health Board ……………………………………..32
4.2 Cultural competence at the organisational level………………………………………………..38
4.2.1 Cultural representation………………………………………………………………………38
4.2.2 Leadership influence…………………………………………………………………………40
4.2.3 Culturally competent and capable workforce…………………………………………...…40
4.3 Cultural competence at the systemic level………………………………………………………43
4.3.1 One size does not fit all………………………………………………………………………...43
4.3.2 PHO enrolment and health literacy…………………………………………………………44
4.3.3 Interpreting services…………………………………………………………………………..46
4.3.4 Ethnicity-based reporting……………………………………………………………………47
4.3.5 Resource allocation…………………………………………………………………………..48
4.4 Process of cultural competence…………………………………………………………………..49
4.4.1 Level of approach……………………………………………………………………………..49
4.4.2 Continuous process…………………………………………………………………………..51
4.5 Māori equity; the role of the Treaty of Waitangi...52
Chapter 5: Discussion……………………………………………………………………………..55
5.1 Cultural competence components and reducing health disparities……………………………..55
5.1.1 Cultural awareness and attitude……………………………………………………………55
5.1.2 Cultural education……………………………………………………………………………56
5.1.3 Models of care…………………………………………………………………………………..59
5.1.4 Cultural representation………………………………………………………………………60
5.1.5 Workforce capability…………………………………………………………………………..62
5.1.6 PHO enrolment and health literacy…………………………………………………………63
5.1.7 Interpreting services…………………………………………………………………………..64
5.1.8 Ethnicity based data collection……………………………………………………………...65
5.2 Approaching cultural competence………………………………………………………………..65
5.2.1 Cultural competence is a continuous process……………………………………………..66
5.3 Māori equity; the role of the Treaty of Waitangi………………………………………………...67
Chapter 6: Conclusions and Implications………………………………………………………..68
6.1 Overall conclusion…………………………………………………………………………………..68
6.2 Implications…………………………………………………………………………………………70
6.2.1 Academic……………………………………………………………………………………..70

6.2.2 Industry……………………………………………………………………………………..70
6.3 Limitations…………………………………………………………………………………………..71
6.4 Future research………………………………………………………………………………….71
Appendices……………………………………………………………………………………………73
Appendix 1: Research findings- categories and themes from thematic analysis…...………………73
Appendix 2: Quotes from primary data collection……………………………………………..…….74
Appendix 3: Interplay of cultural competence components………………………………………......98
Appendix 4: Cultural competence components with focus areas……………………………………99
References…………………………………………………………………………………………100

Chapter 1: Introduction

1.1 Ethnic diversity in healthcare

The number of international migrants worldwide has continued to increase over the past decade, growing from 173 million in 2000 to 220 million in 2010 and reaching a staggering 258 million in 2017 (United Nations, 2017). As a result of mass international migration occurring at a global scale, many modern societies have experienced drastic changes in their ethnic composition in the past few decades (Demireva & McNeil, 2016; Meissner & Vertovec, 2015). Consequently, health disparities can arise when the healthcare system is incapable of meeting the needs of the ethnically diverse population groups it serves (Ballard, 2003; Betancourt, Green, Carrillo & Park, 2005; Kreitler, 2005; Wheeler & Bryant, 2017). Studies have consistently demonstrated that patients of ethnic minority backgrounds experience poorer quality healthcare and worse health outcomes compared to those of the majority population as a result of the lack of tools available and consensus on the best approach to providing culturally competent healthcare services for the increasingly diverse population groups served (Nelson, 2002; Poker, Hubbard & Sharp, 2004; Saha, Beach & Cooper, 2008; Vega, 2005). For this research, 'health' has been defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946, p. 1). It is important that efforts are made to address health disparities since the right to health is the "enjoyment of the highest attainable standard of health" and is a "fundamental [right] of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 1946, p. 1). For the purpose of this research, 'health disparities' have been interpreted as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (Developing Healthy People 2020, 2008, p. 2).

1.1.1 Cultural competence

The term 'cultural competence' first appeared in literature in the field of social work and counselling/psychology, following the demand for human services providers to better meet the needs of the growing multicultural population in the United States (US) in the early 1980s (Aragon de Valdez, Gallegos & Green; Green, 1982; Pedersen & Marsella, 1982; Sue et al., 1982). Immigrant groups from non-English speaking backgrounds who were unfamiliar with Western approaches to health care and service delivery were initially the target group of cultural competence interventions (Saha et al., 2008). Similarly, there was increasing cultural diversity in the health populations being served from the 1980s to the 1990s in the US.

Initially as a concept designed to cater to the needs primarily of immigrants, the term 'cultural competence' now refers to the health needs of all minority groups with a particular focus on those that experience the most health disparities. In addition to being small in size, minority groups may also consist of culturally and linguistically diverse (CALD) people and/or migrants and refugees (Giger et al., 2007).

In the early 21st century, the need to address cultural competence in other human service disciplines such as education have also been raised in the literature (Betancourt et al., 2003). In the healthcare sector, significantly poorer health outcomes are observed among ethnic minority groups compared to the dominant population (Betancourt et al., 2003; Brach & Fraser, 2002).

Although the concept of cultural competence in healthcare has been interpreted in various ways in the literature, this thesis will adopt one of the earliest and most often cited definitions, which describes cultural competence in the healthcare setting as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis & Isaacs, 1989, p. 13). Cross et al. (1989) goes further to convey that "a culturally competent system of care acknowledges and incorporates- at all levels- the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaption of services to meet culturally unique needs", where 'competence' is "having the capacity to function effectively" (Cross et al., 1989, p. 13). As previously discussed, the scope of this research will just focus on the ethnic component of culture.

A range of terms have been used to date to encapsulate and describe notions analogous to cultural competency in a healthcare setting, such as cultural responsiveness, cultural sensitivity, cultural effectiveness and cultural humility (Betancourt, Corbett & Bondaryk, 2014; Hlavac, Beagley & Zucchi, 2018; Majumdar, Browne, Roberts & Carpio, 2004; Richmond & McCroskey, 1997; Tervalon & Murray-Garcia, 1998). Due to the scope of this research, the study will adopt the widely recognised term 'cultural competence', with the assumption that a similar interpretation is captured by the other synonymous terms described.

1.1.2 Culture and ethnicity

Cross et al. (1989, p. 13) have used the term 'culture' to imply the "integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group." Likewise, Pachter (1994, p. 690) has defined a "cultural group" as a "collective of individuals that share common beliefs, ideas, experiences, knowledge, attitudes, and behaviours." All these interpretations suggest that culture is composed of the behaviours and beliefs that one has embraced and developed, which then go on to modify the way in which we interpret and experience our surroundings and everyday social encounters, including the patient-physician encounter (Robins, Fantone, Hermann, Alexander & Zweifler, 1998). While one's culture is composed of a range of socio-cultural parameters, such as the individual's gender, age, geographic location and socioeconomic status, this research will principally focus on the ethnic component of culture. Ethnicity is a concept that has been explained as "cultural practices and attitudes that characterise a given group of people and distinguish it from other groups. People within a group have certain background characteristics

such as language, religion, ancestry and other shared cultural practices which provide them with a distinctive identity…[it] involves a system of shared meanings developed in a social and economic context with a particular historical and political background” (Watt & Norton, 2004, p. 38). For the purpose and scope of this research, the terms ‘ethnicity’ and ‘culture’ are assumed to be the same and will be used interchangeably.

1.1.3 Role of cultural competence in healthcare

A culturally incompetent healthcare system can affect patients’ threshold for seeking care, patients’ understanding in recognizing clinical symptoms, while having misaligned expectations and perceptions of care and treatment (Betancourt et al., 2003; Gornick, 2000). A variety of unfavourable effects have been observed to result from factors that result in health disparities for ethnic minority patients. These can include a greater number of medical errors, more adverse clinical consequences, prolonged length of hospital stay, avoidable readmissions and hospitalisations, overutilisation and underutilisation of treatments and procedures (Barker, 1992; Divi, Koss, Schmaltz & Loeb, 2007; Eisenberg et al., 1993; Flores & Ngui, 2006; Jha, Orav, Zheng & Epstein, 2008; Jiang, Andrews, Stryer & Friedman, 2005; Pachter, 1994; Schyve, 2007). Poor adherence to health promotion, disease prevention interventions and medication can result as a consequence of linguistic/cultural barriers in the clinical encounter (Betancourt, Carrillo & Green, 1999; Brach & Fraserirector, 2000; Crane, 1997; Hornberger, Itakura & Wilson, 1997; Langer, 1999; Meyers, 2007). Stereotyping, which impacts on decision-making and behaviour, can also result when cultural and social factors are not taken into consideration by providers (Van Ryn & Burke, 2000). Discriminatory or biased treatment of patients based on their culture, language proficiency, social status and/or ethnicity are some of the other unfavourable outcomes (Schulman et al., 1999; Van Ryn & Burke, 2000).

In healthcare organisations that have taken into consideration the health needs of minority groups, numerous benefits are often observed. Some of the major benefits of delivering culturally competent healthcare services are improved health literacy among patients and better communication (Betancourt et al., 2003; Stewart, 2006), which can cut down on delays in seeking healthcare and treatment. This could be due to the resulting effect of patients obtaining a greater knowledge of their health condition, the health system and better approaches to receiving care from service providers. Better communication between health service providers and users can also result in the optimum understanding, communication and trust between service providers and service users, leading to increased adherence with treatment interventions, better attendance of ‘follow-up’ appointments, less ambiguity, clearer expectations, reduced medication errors, adverse effects and preventable hospitalisation rates (Betancourt et al., 2003; Smedley, Stith & Nelson, 2003; Stewart, 2006). A large body of research has hence suggested that patient adherence, satisfaction and health outcomes are directly correlated to the provider-patient interaction (Orth, Stiles, Scherwitz, Hennrikus & Vallbona, 1987; Stanton,1987; Stiles, Putnam, Wolf & James, 1979). A more culturally competent health care system can, therefore, result in

greater health care access and equity for all ethnic groups in national health populations (Stewart, 2006).

1.2 Increasing ethnic diversity in New Zealand

New Zealand is a country located in the southwestern Pacific Ocean with a population of over 4.78 million people, where 86.1% of the population is urban ("New Zealand Population", 2019). In 2013, English was the language predominantly spoken, by 96.1% of the population ("Statistics New Zealand", 2018). New Zealand has experienced relatively constant net migration, ranging from 12,483 to 14,881 per year since 2010 ("New Zealand Population", 2019). Auckland has been growing consistently over the past decade and has been the most populated region out of all 16 regions in New Zealand over the past decade, consisting of 32.4%, 33.4% and 35% of the total New Zealand population in 2006, 2013 and 2017, respectively ("Statistics New Zealand", 2018). As the fastest growing region in New Zealand, Auckland is becoming the main destination for migrants, where it is expected to be home to even greater numbers of people of Asian and Pacific backgrounds in the next few decades ("Statistics New Zealand", 2018).

Based on the latest available Census data from 2013, 46,953 people identified with at least 1 Middle Eastern, Latin American or African (MELAA) ethnicity, though making up only 1.0% of the total New Zealand population in that year, it was a 35.0% increase from that of 2006 ("Statistics New Zealand", 2018). Similarly, for the number of people who identified with at least one Asian ethnicity, there was a significant increase of 33.0% from 2006, making up 11.8% of the total New Zealand population in 2013 (Statistics New Zealand, 2014). Likewise, there was also a 6% and 11% increase from 2006 in the number of people identifying with at least one Māori and Pacific ethnicity respectively (Statistics New Zealand, 2014). New Zealand has hence become increasingly ethnically diverse over the past decade, where it has also been estimated that it will continue progressing in that direction for the next two decades. New Zealand's official data agency Stats New Zealand Tatauranga Aotearoa (Stats New Zealand) has made projections (90% chance likelihood) of New Zealand's population growth for up to 2038 ("National ethnic population projections: 2013(base)–2038 (update)", 2017). With the exception of the European/Other group, all other ethnic groups are expected to experience an increase in its share of the proportion of the total New Zealand population from both migration and natural increase ("National ethnic population projections: 2013(base)–2038 (update)", 2017).

For the Asian and MELAA population residing in New Zealand, it has been found that cultural and language issues are two of the most prominent barriers when accessing health services (Mehta, 2012). Additionally, a lack of familiarity with the New Zealand health and disability sector and lack of knowledge on the available health services further hinders access to the appropriate healthcare for these population groups (Mehta, 2012).

The indigenous population of New Zealand, Māori, have one of the poorest health outcomes of all ethnic groups in New Zealand, as based on the mortality rates in New Zealand from 2012-2014, the gap in the average life expectancy at birth between Māori and non-Māori was 7.1years during those years ("New Zealand Period Life Tables: 2012–14", 2015). The Pacific population similarly experiences a lower life expectancy at birth compared to the total New Zealand population. These population groups hence comprise a large component of the ethnic minority groups that are faced with health disparities in New Zealand. For this research, life expectancy is defined as "the expected number of remaining years of life spent in good health from a particular age" (Stiefel, Perla & Zell, 2010, p. 32) and is considered to correlate to one's health outcome.

Along with the increasing ethnic diversity that New Zealand has been experiencing over recent years and is likely to continue encountering for at least another decade, there will be a corresponding increase in diverse health needs from different cultural groups. Providing culturally competent services to diverse groups will require the development and implementation of strategic initiatives by the New Zealand health and disability system. However, there is currently a lack of systemic initiatives and tools available to define and assess cultural competence in the healthcare setting.

1.2.1 Role of the Treaty of Waitangi in healthcare

Te Tiriti o Waitangi, or the Treaty of Waitangi (hereafter the Treaty) which was signed in 1840 between over 500 indigenous Māori chiefs and a British Crown representative, is the founding document of New Zealand's government, representing the relationship between iwi (tribe), and hapu (sub-tribe), and the Crown (Auckland and Waitematā District Health Boards, 2017; Herbert, 2002). Part of the agreement as outlined by the Treaty is a partnership between the two parties, in addition to the rights of Māori for protection for their forestry and fishery resources and all taonga (treasures) essential for Māori self-determination under British governance (Kawharu, 1989). Te Tiriti o Waitangi is the signed (and hence legal) document from which an English version was created, where arguments about the 'translation' are still common (Orange, 2015). Three Articles are presented in the Treaty, describing kawanatanga (governance), tino rangatiratanga (sovereignty) and oritetanga (citizenship). In relation to health, Article I describes the responsibility of the New Zealand government to implement policies that enable Māori to effectively access good health services and to be able to make appropriate health decisions (Bridgman, 1993). The essence of self-regulation and determination for iwi and hapu is described in Article II (Bridgman, 1993). Article III outlines equal citizenship for Māori with their non-Māori counterparts, with the key proposition of giving Māori the right to vote (Herbert, 2002). Māori is hence guaranteed a leading role in decision making in the healthcare sector at a national, regional and individual level, as encapsulated in the Articles of the Treaty. Although other population groups are taken into consideration, the Māori population is the most explicitly prioritised group in national health care policies in New Zealand due to their unique indigenous status as reflected in the Treaty (Anderson, Binney & Harris, 2014; Durie, 1998; Ellison-

Loschmann & Pearce, 2006; King, 2001). The responsibility of advancing Māori health is emphasised further with the establishment of the New Zealand Public Health and Disability Act 2000 (New Zealand Public Health and Disability Act 2000, 2018), which holds District Health Boards (DHBs) accountable to engage in activities with the purpose of enhancing Māori health gains. Therefore, in addition to addressing the needs of a multicultural society, the New Zealand health system also faces the unique duty to respect the rights and carry out its duties for Māori, its indigenous population (Durie, 1998; Clifford, McCalman, Bainbridge & Tsey, 2015; Ward & Liu, 2012). This change in the population composition hence brings new dynamics between meeting treaty obligations for the health needs of the indigenous Māori population while also addressing the health needs of the newer migrant communities.

1.2.2 Structure of the New Zealand health system

The New Zealand health and disability system (hereafter New Zealand health system) is led by the Ministry of Health (MoH), who is responsible for the overall development and management of the system (Ministry of Health, 2018). The MoH is the principal advisor to the Minister of Health (hereafter the Minister), who is also advised by the strategic prioritisation function, other ministerial advisory committees and the Health Workforce New Zealand (Ministry of Health, 2018). Policies for the health system are developed with the input of the Minister along with Cabinet and the government, where the role of the Minister is outlined in the New Zealand Public Health and Disability Act 2000 (New Zealand Public Health and Disability Act 2000, 2018).

Most of the funding for the New Zealand health system comes from general taxation, though there are also other sources such as Accident Compensation Corporation (ACC), local governments, other government agencies and private sources (Ministry of Health, 2018). 'Vote Health' is the amount of public fund that the government allocates to the health and disability sector, where three-quarters of this public funding is allocated to DHBs ("Funding", 2016).

DHBs were created via the implementation of the New Zealand Public Health and Disability Act 2000, which outlines the roles and objectives of these Crown agencies ("District health boards", 2018). There are a total of 20 DHBs in the country, where each DHB has the responsibility to plan, manage, provide and purchase health services for the population within their district or catchment area ("District health boards", 2018; Sheridan et al., 2011). DHBs can fund for primary care, public health services, hospital services, aged care services, in addition to services provided by private and non-governmental organisation (NGO) providers such as Māori and Pacific providers (Ministry of Health, 2018). With the goal of enabling efficient and effective access to health services for all New Zealanders, DHBs hence comprise most of the day-to-day business in the health system ("District health boards", 2018; Sheridan et al., 2011).

Primary health organisations (PHOs) are NGOs that fund primary health providers and are local structures that co-ordinate and deliver primary health care services by subsidising a range of

health services with funding from the government (Ministry of Health, 2018). PHOs which generally consist of nurses and doctors in addition to other health professionals, are established by DHBs via working with providers and local communities and are utilised by the government to carry out its objectives in the communities (Barnett, Smith & Cumming, 2009; "Primary health organisations", 2011; Ministry of Health, 2018). Enrolments with PHOs are voluntary despite it being a major source of access to the New Zealand health system (Ministry of Health, 2018).

1.2.3 Case study at Waitematā District Health Board

With a total population greater than 630,000 people within its catchment, composed of 10% Māori, 10% Pacific people, 18% Asian, and 60% Other (including European/NZ), WDHB is the largest DHB in the country by population ("About DHBs", 2018). With more than 6800 employees, WDHB provides community and secondary hospital services through 30 community sites in addition to North Shore Hospital and Waitakere Hospital ("About DHBs", 2018). Significant population increase is expected to take place in the future, where the population has been projected to reach 788,000 by 2036/37 (Waitematā District Health Board, 2017). The Māori population is expected to grow by at least 49%, the Pacific population by at least 46% and the Asian population by at least 83% (Waitematā District Health Board, 2017). It is therefore essential for WDHB to plan and develop services that can meet the needs of these ethnically diverse population (Waitematā District Health Board, 2017). According to Waitematā District Health Board (2017), a large proportion (37%) of the current WDHB residents were migrants, people who are born overseas. Migrants consist of 81% of the Asian population, 43% of the Pacific population and 29% of European/Other population; 20% of the migrants have lived in New Zealand for under 5 years in the year of 2017 (Waitematā District Health Board, 2017).

Both the large population size and the increasing ethnic diversity at WDHB qualifies it as a state-of-the-art multicultural healthcare setting. WDHB is hence used as a case study in this research to explore the components of cultural competence in an increasingly ethnically diverse healthcare environment.

1.3 Research objectives and contribution

Research purpose: Cultural competence in ethnically diverse healthcare; a case of a DHB in New Zealand.

The research questions are:

(1) What are the components of cultural competence in an ethnically diverse healthcare setting?

(2) How to reduce health disparities in an increasingly diverse ethnic population in New Zealand?

Contribution

While the concept of cultural competence in the healthcare setting has been addressed frequently in the literature, there is a lack of research exploring the components of cultural competence for healthcare organisations. Furthermore, there is a paucity of research focusing on how health disparities in a rapidly growing multicultural population can be minimised. This research found components of cultural competence in healthcare and focus areas under each component in which healthcare organisations with a rapidly growing multicultural population can engage in to reduce health disparities for minority groups. In determining the components of cultural competence in healthcare, this study also explored the conceptualisation of cultural competence and the process in which healthcare organisations can progress towards becoming more culturally competent.

Practical implications

The cultural competency components and the corresponding focus areas described in this study can be used by healthcare organisations to meet the health needs of ethnically diverse population groups. Consequently, this can reduce health disparities among affected groups.

By regularly assessing and monitoring their efforts in addressing an ethnically diverse population against the focus areas presented in the study, healthcare organisations in New Zealand can move towards reducing health disparities for diverse population groups by improving access to healthcare and the quality of care. The findings of this research can also be used in policy, funding and planning to inform strategies and actions related to cultural competence or to inform further study and development.

1.4 Methodology

This is a mixed-methods qualitative study consisting of a two-stage sequential research design, using a DHB in New Zealand as a case study. The first stage of data collection was the preunderstanding stage, which involved informal conversations with industry members in addition to secondary data collection. This was followed by primary data collection in the form of semi-structured interviews, where the interview questions and participant selection were informed by the findings from the preunderstanding stage. Triangulation was utilised in the process of data collection, where complementary data for the same phenomenon was obtained.

1.5 Thesis Structure

Chapter 1 of this research introduces the context of New Zealand and WDHB as the case study used to explore the concept of cultural competence in an ethnically diverse healthcare system. The research objectives, research contributions, methodology, scope and thesis structure are also outlined.

Chapter 2 explores the current knowledge in the literature on the conceptualisation of cultural competence in healthcare. The components of cultural competence in an ethnically diverse health care setting is also explored.

Chapter 3 provides the rationale for the methodology used in this research, including the research design, research data, data collection and analysis, in addition to the significance, reliability, validity and ethical considerations of the research.

Chapter 4 integrates and presents the findings from the secondary data collection and semi-structured interviews.

Chapter 5 answers the research questions by discussing the findings from chapter 4 with the current literature on cultural competence components in ethnically diverse healthcare. The chapter also explores how health disparities can be reduced in New Zealand with consideration of the unique position of Māori.

Chapter 6 concludes the study findings with respect to the research question and gaps in the literature. Both the academic and industry implications of the research, the limitations and area of recommendation for future research are all addressed.

Chapter 2: Literature Review

This chapter starts by exploring how cultural competence in an ethnically diverse healthcare setting is conceptualised. It then explores the current knowledge in the literature on components of cultural competence in an ethnically diverse healthcare setting, which was found to exist in three major levels in the healthcare organisation; individual, organisational and systemic. Due to the scope of this study, only the most important components were explored, as determined by the number of citations in the literature.

2.1 Cultural competence continuum

Cultural competence in healthcare has been commonly been conceptualised to be a continuous and dynamic process without a destination or endpoint (Campinha-Bacote, Yahle & Langenkamp, 1996; Cross et al., 1989). One of the most recognised cultural competence models described it as a process in which a healthcare professional and the healthcare organisation transfigures through various stages of cultural competence ranging from being destructive/unaware to proficient, as shown in figure 1 (Cross et al., 1989). Six stages have been conveyed to make up the cultural competence continuum; cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and cultural proficiency, where each stage is defined by a set of characteristics that are exhibited (Cross et al., 1989). The most incompetent end of the continuum is the cultural destructiveness stage, which consists of attitudes, practices and policies that are destructive to cultures and individuals identifying with that culture. This can be observed in the form of subjugation and forced assimilation in addition to privileges and rights reserved exclusively for the dominant group (Cross et al., 1989). The other end of this spectrum is the cultural proficiency stage, which is characterised by the health organisation holding culture in high regards, and research is conducted to add to the system on providing culturally competent practices. An effort is also put into shaping approaches of care and improving relations between cultures (Cross et al., 1989).

Cross et al. (1989) and Campinha-Bacote et al. (1996) have also rejected the idea of cultural competence existing as an end goal, proposing that health professionals should continuously strive to work within the cultural context of the patient as part of the process of meeting the health needs of ethnically diverse population groups. However, unlike Cross et al. (1989) who has presented six stages for a cultural competence continuum, Campinha-Bacote et al. (1996) does not define points in the process, and instead proposes five components of cultural competence that are to be present at all levels of the health system; cultural awareness, cultural knowledge, cultural skill, cultural encounters and culture desire. The crossing of these five elements is said to signify the process of becoming culturally competent, where the greater the intersection between the elements, the greater the competence of the health care system.

Contrary to Campinha-Bacote et al. (1996) and Cross et al. (1989), other groups such as Carballeira (1997), Leininger (1993), and Davidhizar and Giger (1998) have interpreted cultural competence as an obtainable endpoint reached when certain sets of skills are gained.

Figure 1. Cultural competence continuum. Adapted from Cross et al. (1989)

2.2 Cultural competence at different levels of the health system

While cultural competence in the healthcare organisation has been explored in a variety of ways, it has frequently been described at three levels in the healthcare organisation for where cultural competence can be established in; individual, organisational and systemic (Betancourt et al., 2003; DeSouza, 2008; McCalman, Jongen & Bainbridge, 2017; Tiatia, 2008). Cultural competence at the individual level refers to enhancing the patient-clinician encounter, which focuses on increasing health professionals' cultural awareness, consequently improving their interaction with patients from differing cultural backgrounds. At the organisational level, cultural competence focuses on creating and developing a culturally-aware workforce. Systemic cultural competence focuses on implementing the appropriate structures and processes in addressing an ethnically diverse population (Betancourt et al., 2003; DeSouza, 2008; McCalman, Jongen & Bainbridge, 2017). The following sections discuss aspects that healthcare organisations should focus on to reduce health disparities within an ethnically diverse population at these three levels.

2.2.1 Individual level cultural competence

The quality of the patient and health provider encounter largely affects patient satisfaction, adherence to treatment and health outcomes (figure 2). Individual level cultural competence attempts to improve health outcomes by enhancing the quality of this interaction.

2.2.1.1 Cultural awareness

A key aspect of cultural competence at the individual level is having awareness or knowledge and acceptance of cultural differences, where awareness or knowledge in this context refers to the clinicians' understanding of cultural differences and its impact in healthcare (Betancourt et al., 2003; Lister, 1999; Pachter, 1994). The appropriate attitude should be adopted by the health practitioner in dealing with cross-cultural interactions in the clinical setting, which can consist of having a mindset that enables respect for cultural differences (Campinha-Bacote, 2002; Lister, 1999; The Lewin Group, 2001). A culturally aware health practitioner can easily build trust and understanding in the patient-clinician encounter, which can go on to affect the communication between the health practitioner and patient, consequently affecting the health outcome of patients

(Campinha-Bacote, 2002; Carballeira, 1997; Eisenberg, 1979). When sociocultural differences between the provider and the patient are not deliberated, effective provider-patient communication cannot be established, which may, in turn, result in non-adherence, poorer health outcomes and patient dissatisfaction (Betancourt et al., 2003; Smedley et al., 2003; Stewart et al., 1999). The establishment of a good relationship between the patient and the health provider is hence a major aspect of cultural competence at the individual level, as it correlates to good health outcomes (Cross et al., 1989; Smedley et al., 2003).

2.2.1.2 Cultural competence education

Cultural competence education (hereafter cultural education) for health professionals can be considered an attempt to provide effective and equitable healthcare to all population groups, especially those from a CALD background (Horvat, Horey, Romios & Kis-Rigo, 2014). This consists of increasing health providers' knowledge of the relationship between health beliefs and behaviours and sociocultural factors, and to supply providers with the skills and tools to navigate these factors with the goal of quality health care delivery (Betancourt et al., 2003; Carrillo et al.,1999; Culhane-Pera, Reif, Egli, Baker & Kassekert, 1997; Like, Steiner & Rubel, 1996; Tervalon & Murray-Garcia, 1998).

Cultural education or 'cross-cultural' education programmes for health providers have been developed since 1996 after the importance of sociocultural factors in the clinical encounter was recognised, and have incorporated a range of approaches (Like et al., 1996). These have included a focus on the non-technical skills of health professionals via developing openness, kindness and empathy towards ethnic minority populations, general guide to communicating with patients from differing backgrounds, in addition to learning aspects of specific cultural backgrounds (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003; Brach & Fraserirector, 2000; Campinha-Bacote, 2002; Dauvrin & Lorant, 2015; Seeleman, Suurmond & Stronks, 2009; Wells, 2000). The approach that cross-cultural education has taken hence varies from a 'categorical' or approach to a more "cross-cultural approach". The focus in the categorical approach consists of clinicians having awareness of the relevant attitudes, values, behaviours and beliefs of specific cultural groups (Betancourt et al., 2003; Paniagua, 2013). Focusing on certain cultural groups that health providers see most often in their community can be effective as the skills taught are more directly applicable (Betancourt et al., 2014; Lee & Farrell, 2006). However, this can lead to the oversimplification of the complexity of culture, as differences can exist even among people of the same ethnic groups due to various sociocultural factors such as age, acculturation and social status (Betancourt et al., 2014; Lee & Farrell, 2006). Additionally, stereotyping may also result from the application of the categorical approach in cross-cultural education (Lee & Farrell, 2006).

In contrast to the categorical approach, cultural education can also take a broader focus by teaching health practitioners how to interact with patients of differing backgrounds in general (Betancourt et al., 2003; Culhane-Pera et al., 1997). This may involve recognising and navigating

aspects such as styles of communication, decision-making preferences, familial roles in addition to the influence of gender issues, racism, prejudice and mistrust (Kleinman, Eisenberg & Good, 1978). This approach focuses on developing crucial skills and attitudes of providers by focusing on the individual patient as the teacher. Kleinman & Benson (2006) proposes that the most important aspect in practising culturally competent care is to habitually ask patients what they value the most in their experience of illness and treatment, where the findings can then be incorporated into treatment decisions and negotiations with patients. The culture that patients may identify with is interlinked to many other aspects of their life, ranging from their political, economic, psychological, religious and biological experiences (Moerman, 2002; Sahlins, 1978). Due to differences in age, cohort, class, political association, religion, ethnicity and personality, variations of cultural identity can be found among individuals of the same ethnic group (Kleinman & Benson, 2006). Kleinman (2007) hence emphasises that learning about what matters to the patient is not a technical skill, but an interpersonal skill that can go on to become an important element of the health practitioner's cultural competence.

Health professionals who are in direct contact with patients, such as physicians, nurses and psychiatrists, are often the target population of cultural competency training, as their personal level of cultural awareness directly impacts on patients' healthcare experience (Jirwe, Gerrish, Keeney & Emami, 2009; Kreuter, Lukwago, Bucholtz, Clark & Sanders-Thompson, 2003; Mostow et al., 2010; Perloff, Bonder, Ray, Ray & Siminoff, 2006; Purnell, 2002; Qureshi, Collazos, Ramos & Casas, 2008).

Many groups have found strong evidence in an improvement in health care professionals' knowledge, understanding and skills when working with patients from CALD backgrounds after receiving cultural education (Gallagher & Polanin, 2015; Like, 2011; Truong, Paradies & Priest, 2014). In contrast, a variety of studies have also questioned the effectiveness of cultural education and if any observable difference is made (Betancourt & Green, 2010; Renzaho, Romios, Crock & Sønderlund, 2013). Betancourt and Green (2010) and Dauvrin and Lorant (2015) also questioned the sustainability of the effects of cultural education in the long term, implying that the application of cultural training by health professionals tends to decrease over time, especially when no objective measures, such as patient outcome and quality of care received by patients, are in place to assess its effects. As most cultural competency pieces of training consist of one-off sessions, there may, in fact, be inadequate evidence of the advantageous effects of cultural competence training on patient adherence and health outcomes in the long term (Beach et al., 2005; Dauvrin and Lorant, 2015). Green and Race (2006) has argued that making staff attend cultural competency training does not guarantee any behaviour or attitude change, nor application of the knowledge in practice, especially in cases where attending cultural competency training has been made mandatory by the organisation or other governing bodies, where staff may do the course just for the sake of doing it.
A cultural competency training/intervention review conducted by the Cochrane Collaboration is one of the few large-scale reviews that have been done on the effects of cultural education based

on factors including patient health outcomes (Horvat et al., 2014). This study assessed the effects of "educational interventions for health professionals working in health settings that aimed to improve: health outcomes of patients/consumers of minority cultural and linguistic backgrounds; knowledge, skills and attitudes of health professionals in delivering culturally competent care; and healthcare organisation performance in culturally competent care" (Horvat et al., 2014, p. 1). The review included a total of five randomised control trials, consisting of a total of 8400 patients where at least 3463 (41%) were from CALD backgrounds, in addition to 337 healthcare professionals. The control group are health professionals with no training, while the intervention group were those who received training. The studies were based in the US, Canada and the Netherlands, which are all regions with comparable political, social and economic climate to New Zealand. The main findings observed consisted of improvement in attendance for the patients of health professionals in the intervention group compared to the control group (Horvat et al., 2014). Patient-reported quality of care was mixed, where no effect was found among the intervention group for two of the five studies. Overall, the review obtained positive evidence, but of low quality, on the effects of cultural competency courses. Although the review does not provide any statistically significant conclusion with the low sample size and low quality of evidence from the diverse range of studies, it still provides support for the effectiveness of cultural education for health professionals.

Figure 2. Linking communication to health outcomes. Adapted from Betancourt et al. (2003).

2.2.1.3 Explanatory models in health

Pachter (1994, p. 690) has interpreted explanatory models in health as "the way an individual conceptualizes a sickness episode. It includes beliefs and behaviours concerning aetiology, course and timing of symptoms, reasons for becoming sick, diagnosis, methods of treatment, and roles and expectations of the sick individual."

Patients' cultural beliefs largely shape the manner in which symptoms are interpreted and health problems are conveyed, in addition to their decision to seek treatment, to whom an individual goes to, the length of time one remains in care and their evaluation of the care received (Angel & Thoits, 1987; Kleinman et al., 1978). This is consistent with the idea that one's decision to seek aid and treatment is not objective but instead is a socially conditioned selective process, just like the differing level of pain experienced by different individuals or groups of individuals with the same extent of pathological injury (Angel & Thoits, 1987; Zola, 1966).

Kleinman et al. (1978) have proposed that the personal awareness of a change in body feeling is the first part of the illness process, which is often followed by recognizing the sufferer as being "ill", either by the sufferer themselves or their family. Action is often then taken by the sufferer or their family in an attempt to recover, which can consist of consultation with the extended family, community and/or practitioners. Eisenberg (2009, p. 3) has defined "illness" as "experiences of discontinuities in states of being and perceived role performances", whereas "disease" was described "in the scientific paradigm of modern medicine, are abnormalities in the function and/or structure of body organs and systems". Unlike modern medicine, traditional healers often focus on the illness by attempting to provide a meaningful explanation for the illness and to address the community, family and personal factors impacting on the illness (Horton, 1967; Kleinman et al., 1978). Conversely, biomedicine in modern healthcare often disregards the human experience of illness and solely focuses on the identification and treatment of the disease (Green, Carrillo & Betancourt, 2002; Kleinman et al., 1978). This is concordant with Fabrega Jr's (1972) description, who proposed that in the Western paradigm, 'disease' is the maladaptation or malfunctioning of biological or psychological mechanisms in an individual, whereas 'illness' is dependent on cultural factors that influence the explanation and perception of any discomfort experienced. Illness is therefore characterised by personal, interpersonal and cultural responses to disease; a discordant occurs when a patient suffers from an 'illness' but the physician is treating the disease (Engel, 1977; Green et al., 2002).

A variety of health beliefs, medical practices and attitudes toward medical care may exist, resulting in differing degrees of concordance and trust between patients and doctors in the healthcare system (Betancourt et al., 2003). The sociocultural backgrounds of patient and physician are often one of the major determining factors for the level of understanding established in the interaction (Berger, 1998; Betancourt et al., 2003). Davis (1968), Francis, Korsch and Morris (1969), Haefner and Kirscht (1970) and Stimson (1974) have all proposed that patient nonadherence, dissatisfaction with health care and lack of access to quality health care is often partially due to this systemic negligence of the illness experience. Only when the mutual understanding of one another's health belief is achieved between patients and health care providers can there be a high likelihood for the proper utilisation of health services, adherence with treatments and good health outcomes for patients (Pachter, 1994; Patel, 1995; Rich, Patashnick & Chalfen, 2002; Salimbene, 1999). The interaction between patients and doctors can

hence be described as “transactions” between the explanatory model of the patient and the clinician, which can consist of “major discrepancies in cognitive content as well as therapeutic values, expectations, and goals” (Kleinman et al., 1978, p. 254). Therefore, to provide culturally competent services that meet the health needs and interpretation of diverse population groups, clinicians need to be able to effectively navigate differences in explanatory models (Carrillo et al., 1999; Saha et al., 2008).

2.2.2 Organisational level cultural competence

2.2.2.1 Cultural representation

Initiatives that optimise diversity in the workforce and cater to aspects such as workforce development and leadership are all contributors to organisational cultural competence (Betancourt et al., 2003). As part of meeting the health needs of diverse population groups, strategies should be put in place to recruit and retain staff from various cultural backgrounds at all levels of the healthcare organisation (Betancourt et al., 2003). Organisational cultural competence initiatives can consist of efforts to ensure that enough diversity exists in the leadership and workforce of a healthcare organisation so that its patient population is well represented (Betancourt et al., 2003; Dozier, Beach, Gutzmer & Yagade, 2017). With research suggesting the existence of a correlation between one’s ethnicity and their quality of health care, the paucity of cultural representation often found in the health care workforce has been proposed to be a significant barrier to good health outcomes for ethnic minority patients (DeSouza, 2008; Dozier et al., 2017; Tolmac & Hodes, 2004). In a study where patients were given the choice to select their choice of physician, respondents in each ethnic group were observed to be more likely to select someone of the same ethnic group as themselves (LaVeist & Nuru-Jeter, 2002; Saha, Taggart, Komaromy & Bindman, 2000). Racial concordance between the physician and patient is correlated with higher self-rated quality of care and greater patient satisfaction for minority patient groups when patients and physicians shared similar cultural backgrounds compared to those that did not (LaVeist & Nuru-Jeter, 2002; Saha, Komaromy, Koepsell & Bindman, 1999). One of the most acknowledged explanations for such phenomenon links to the idea of a greater level of trust and understanding being established in cases where the same values and beliefs are held by the clinician and patient, where one’s culture is often an influential factor (Betancourt et al., 2003). Furthermore, a shared style of conversing as a result of belonging to similar ethnic and cultural backgrounds are also suggested to contribute to more effective communication and greater understanding between the patient and clinician, all of which can lead to greater health outcomes (Sullivan, 2004).

In addition to cultural representation in the general workforce, Betancourt et al. (2003) also propose that the degree to which a nation’s health care leadership matches the ethnic composition of the population that it serves should also strongly affect the availability and acceptability of health care for minority ethnic populations. Having cultural diversity at the senior

decision-making level can introduce a cultural perspective in the strategic design of the healthcare organisation, where the culturally diverse leaders can also act as representatives for the needs of ethnic minority community groups (Betancourt et al., 2003; DeSouza, 2008).

2.2.2.2 Culturally competent leaders and role models

Cope and Kalantzis (1997) further argues that just having cultural representation or culturally competent individuals in the general workforce of healthcare organisations is unlikely to result in any substantial long term organisational cultural awareness, in the absence of culturally competent champions among senior members. Hobby (2008) and Yamada and Brekke (2008) similarly suggests that in addition to having culturally competent clinicians, it is as equally important to have leaders who excel in ethnically diverse healthcare settings, as competent leaders can create an organisational context in which cultural competence is implemented, encouraged and emphasised (Chrisman, 2007). These senior leaders in healthcare organisations can largely influence and shape the structures and processes of the organisation (Betancourt et al., 2003). Structural policies, procedures, and delivery systems improperly created or poorly adapted to serve diverse patient populations have often been suggested to be attributed to a lack of cultural competence among the leaders of healthcare organisations (Betancourt et al., 2003; Chrisman, 2007). Friedkin (2001) and Dauvrin and Lorant (2015) also suggests that the most influential individuals can make cultural competence the norm among healthcare professionals with their role modelling position. Therefore, whether negative or positive behavioural and attitudinal norms are disseminated among the general healthcare workforce will depend on the implicit cultural competence norms determined by the attitude of the leaders (DiMaggio & Garip, 2012; Yamada & Brekke, 2008). Warhurst (2011) similarly suggests that soft skills that cannot be taught, such as respectful attitude towards patients, professionalism and empathy, are all best developed through role-modelling as opposed to formal training. Interestingly, Dauvrin and Lorant (2015) suggest that the most influential individuals may not necessarily be those in formal leadership roles. A network effect is conveyed to exist, where the champion for cultural competence may just be the most sociable or popular individual among a group environment as part of a social hierarchy, as shown in figure 3 (Dauvrin & Lorant, 2015; Valente, 2010; Zwarenstein, Goldman & Reeves, 2009).

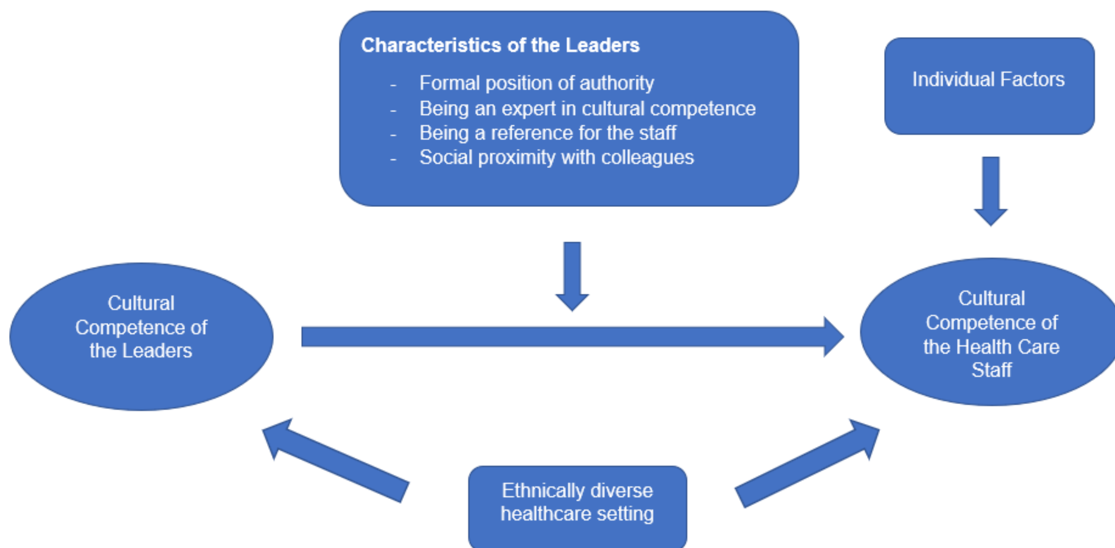


Figure 3. Leadership model of cultural competence**.** Adapted from Dauvrin and Lorant (2015).

2.2.2.3 Whole organisation effort

The importance of integrating cultural competence into the workplace is often not addressed in cultural competence training programmes (Betancourt & Green, 2010). Difficulties arise in the practical application of cultural competence training when cultural competency skills are not valued and prioritised in the work environment (Dauvrin & Lorant, 2015). The better an organisational environment formally and informally encourages and supports culturally competent service delivery and assessment, the greater the likelihood that health professionals will be culturally competent (Dauvrin & Lorant, 2015). In contrast, a lack of appreciation for cultural diversity and cultural competence can result in negative cultural competence norms within the organisation. Furthermore, Taylor et al. (2011) convey that the quality of care received by patients isn't dependent on the exertion of a few individual health professionals, but is based on the efforts of an entire team. Therefore, while individual health professionals can utilise their own expertise to care for patients, positive health outcomes for patients can only be achieved via the collective complementary health competencies of many health professionals. When cultural competence is not recognised and valued by the general workforce, sole culturally competent healthcare workers may struggle to provide culturally competent services (Fuller, Hester, Barnett & Relyea, 2006; Taylor et al., 2011).

2.2.3 Systemic level cultural competence

2.2.3.1 Health literacy

The World Health Organization has defined health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" ("Health Promotion", 2019, para.1).

This suggests that health literacy consists of more than just having the required linguistic abilities, but also understanding the health system from which the patient receives health care services. Poorer health outcomes, which contribute to health disparities, have often been associated with low health literacy (Bennett, Chen, Soroui & White, 2009; Berkman, Sheridan, Donahue, Halpern & Crotty, 2011; Davis & Wolf, 2004). Independent of other factors such as age and gender, a variety of lifestyle habits correlated to poor health outcomes have been proposed to result from a lack of health literacy, such as a lack of physical activity, poor diet and smoking, all of which are known to contribute to a reduction in life expectancy (Roberts, 2015). Gilson, Doherty, Loewenson and Francis (2007) also state that health literacy is a more accurate predictor of one's health outcomes relative to other factors such as education level, age or income. Minority ethnic groups and migrants have often been found to have lower health literacy compared to the general population, which has been correlated with their lower access to health care (Diaz & Kumar, 2014; Gimeno-Feliu, Magallón-Botaya, Macipe-Costa, Luzón-Oliver & Lasheras-Barrio, 2013; Maxwell, Crespi, Antonio & Lu, 2010; Norredam, Nielsen & Krasnik, 2009; Zuvekas & Taliaferro, 2003). It is suggested that this is due to a lack of familiarity with the Western health system, which can considerably differ from that of migrants' home countries (Murray, Hagey, Willms, Shillington, & Desjardins, 2008; Ng & Omariba, 2014). A lack of language proficiency has also been suggested to contribute to difficulties in understanding and navigating the healthcare system (Murray et al., 2008; Ng & Omariba, 2014).

In comparison with these observations, other researchers have found that ethnic minority groups utilise health services more frequently, including visits to GP, hospitalisation and emergency services compared to the general population (Bennett et al., 2009; Berkman et al., 2011; Uiters, Devillé, Foets, Spreeuwenberg & Groenewegen, 2009). In the Netherlands for example, ethnic minority groups have been found to have accessed their general practice (GP) 1.5 times more frequently than the indigenous Dutch population (Uiters et al., 2009). While there is no definite explanation for this, it has been suggested that groups with lower health literacy may be more likely to misunderstand minor symptoms, resulting in greater use of primary care services (Rau, Sakarya & Abel, 2014; Uiters et al., 2009). Despite these observations, there is still a large consensus in the literature that minority ethnic groups have lower access to healthcare services (Diaz & Kumar, 2014; Gimeno-Feliu et al., 2013; Maxwell et al., 2010; Zuvekas & Taliaferro, 2003).

As part of an attempt to improve health outcomes for ethnic minority populations in receiving societies, effort should be made to enhance the health literacy of these disadvantaged groups, by enhancing their ability to understand and navigate the health system, in addition to making informed health decisions (Chang & Fortier, 1998; Jacobson et al., 1999). This can be in the form of culturally appropriate health education materials that improve patients' knowledge and understanding of the health system and their health condition (Chang & Fortier, 1998; Jacobson et al., 1999). Andrulis and Brach (2007) have pointed out that health information presented in

plain English can be easier for population groups with limited English language abilities to understand and comprehend. Additionally, the use of jargon should also be reduced, and diagrams and pictures included where possible. Health champions or trained community workers have also been suggested to be effective in relaying health messages to diverse ethnic groups, as those populations may be less likely to seek out information related to health from formal sources (Atkinson & Mason, 2014; Eakin, Bull, Glasgow & Mason, 2002). Similarly, family and community involvement can also be an effective way to disseminate important health information and to engage ethnically diverse groups in health-related discussions (Atkinson & Mason, 2014; Eakin et al., 2002).

2.2.3.2 Interpreting services

Studies have conveyed that in the presence of systemic barriers such as language barriers, patients of minority ethnic groups experience the greatest disparities with referrals to specialists and continuity of care compared to those of the majority cultural group (Betancourt et al., 2003; Collins, Hall & Neuhaus, 1999). One of the commonly observed barriers is the lack of linguistically appropriate services, such as interpreting services available (Carrasquillo, Orav, Brennan & Burstin, 1999; Diamond, Schenker, Curry, Bradley & Fernandez, 2009; Hornberger et al., 1997; Seijo, Gomez & Freidenberg, 1991). Even the existence of the slightest language barrier has been suggested to significantly impede effective patient-clinician interaction while also impacting on patients' health care experience and health outcomes (Angelelli, 2008; Pérez-Stable, Napoles-Springer & Miramontes, 1997). Being able to communicate with a sufficient level of language proficiency is crucial to be able to effectively access health care services (Diamond et al., 2009; DeSouza & Garrett, 2005). A variety of approaches could be put into place to minimise the disadvantageous effects in accessing quality health care services for those without an adequate level of English proficiency. These could consist of hiring bilingual staff and/or providing interpreting services (Betancourt et al., 2003). While family members and other untrained staff are often utilised as interpreters, a substantially higher quality of patient-physician interaction is reported when trained interpreters are used instead (Angelelli, 2008; Baker, Hayes & Fortier, 1998). This may be due to the personal connection that the patient has with the interpreter, which can consequently lead to biases and inaccuracies during the interpretation process. Healthcare organisations should hence provide interpreting services as part of addressing the health needs of an ethnically diverse population.

2.2.3.3 Ethnic monitoring

The patient pathways in the health system and their health outcomes are all aspects that should be monitored in healthcare organisations (Cormack, 2007; Iqbal et al., 2012). Through ethnicity-based data collection, healthcare organisations can obtain a more comprehensive understanding of patients' health experience and health outcome and get a better grasp on if they are providing culturally responsive healthcare services for all ethnic groups (Cormack, 2007; Hasnain-Wynia & Baker, 2006; Hasnain-Wynia, Pierce & Pittman, 2004; Iqbal et al., 2012). As a process that should

be based on self-identification, ethnicity-based data collection has been proposed to be an effective way to assist in the planning of service improvements of health organisations (DeSouza, 2008; Hasnain-Wynia et al., 2004). Findings from ethnicity-based data collection can assist in the strategic planning and structuring of the healthcare organisation to address gaps in access to health care and health outcomes for minority groups, where strategies put in place to address these gaps can consequently result in greater health outcomes for disadvantaged ethnic groups and reduce health disparities (Cormack, 2007; DeSouza, 2008).

2.3 Chapter summary

This chapter explored the different ways that cultural competence in healthcare has been commonly conceptualised in the literature. Cultural competence has commonly been perceived to be a dynamic ongoing process, where health organisations move along the different stages of the continuum (Cross et al., 1989). However, other groups have also interpreted cultural competence to be an obtainable end goal once certain expertise is gained through training and development (Carballeira, 1997; Leininger, 1993; Davidhizar and Giger, 1998). The chapter also identified cultural competency components that healthcare organisations can focus on in addressing and meeting the health needs of an ethnically diverse population. These components have been proposed to exist at three major levels of the healthcare system; the individual level, organisational level and systemic level. The cultural competence components identified at the individual level consists of having awareness of cultural diversity and its role in healthcare, providing cultural education to health professionals and the effectiveness of cultural competency courses. Furthermore, the importance of understanding and navigating through the differing explanatory models of health was also determined. The cultural competence components identified at the organisational level of the health delivery system consists of cultural representation, culturally competent leaders and role-models, in addition to the importance of it being a whole organisational effort. The cultural competence components identified at the systemic level of the health delivery system can consist of the importance of providing interpreting services, enhancing the health literacy of minority groups and collecting health data by ethnicity.

The findings from the literature review suggest that there is an interplay between the cultural competence components at the three different levels of the healthcare system. Cultural competence at each level is intricately linked to that of another level (figure 4).

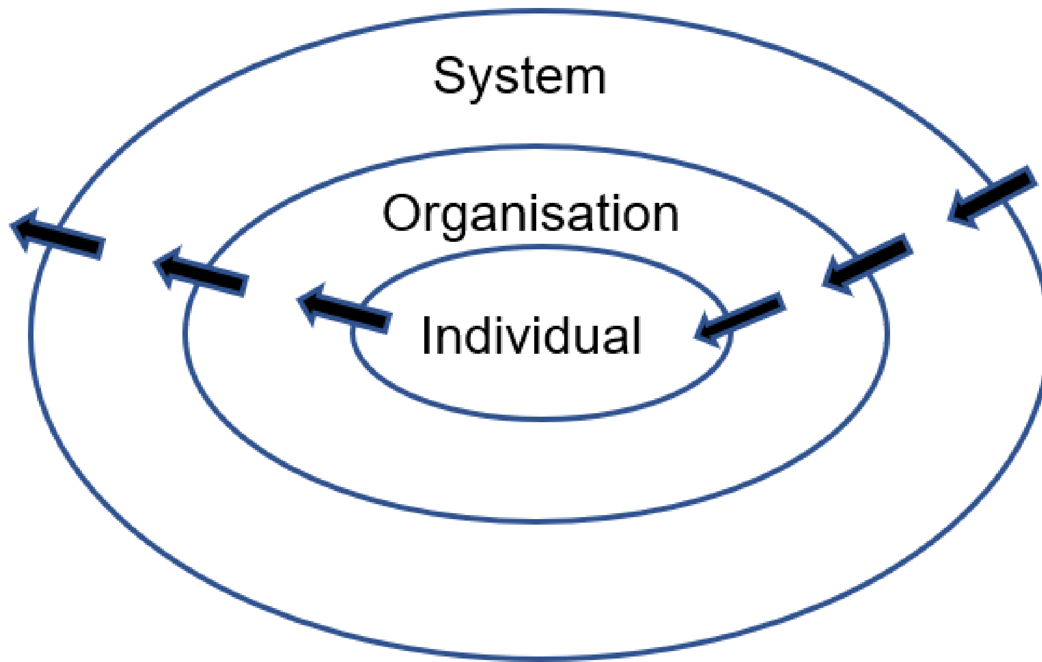


Figure 4. Three levels for which cultural competence exists in the health care sector; the individual level influences the organisational level which go on to influence the systemic level of cultural competence, and vice versa. Cultural competence at each level both depends and influences that of another. Adapted from the National Health and Medical Research Council (2005).

Chapter 3: Methodology

This chapter explains and justifies the rationale for the methodology of the research design, data collection and analysis, significance, reliability and validity of the research. Additionally, ethical considerations will also be addressed.

Research purpose: Cultural competence in ethnically diverse healthcare; a case of a district health board (DHB) in New Zealand.

The research questions are:

(1) What are the components of cultural competence in an ethnically diverse healthcare setting?
(2) How to reduce health disparities in an increasingly diverse ethnic population in New Zealand?

3.1 Research design

This a mixed methods research study with a two-stage sequential design using WDHB in New Zealand as a case study, with the purpose of identifying the components of cultural competence in an ethnically diverse healthcare setting and focus areas for reducing health disparities. WDHB is considered an appropriate case study for this research as it is one of the 20 Crown agencies in New Zealand that plan, fund and delivers healthcare services ("About DHBs", 2018). WDHB also has the greatest resident population with an increasingly diverse multicultural population as explained in chapter 1 ("About DHBs", 2018).

Data collection consisted of two stages (figure 5). The first stage of data collection was the pre-understanding phase, which consisted of secondary data collection and having informal conversations with industry members. The second stage of data collection was primary data collection; semi-structured interviews were conducted with WDHB employees, where the interview questions were informed by the findings from the first pre-understanding stage. Triangulation was hence utilised in this research, as both quantitative and qualitative methods of data collection were used for data collection to obtain complementary data in addressing the same research phenomenon.

The semi-structured interviews took an inductive interpretive approach, where reality is assumed to be subjective and based on individual experiences and perceptions. This form of questioning is believed to be appropriate for this inductive study as it gives the interviewer the opportunity to direct the flow of conversation depending on the interviewees’ responses, allowing the interview to take on different trajectories (Cohen & Crabtree, 2006; Eriksson & Kovalainen, 2008).

While there is no single explanation of what a case study is, it has commonly been interpreted as a method that “explores a real-life, contemporary bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information… and reports a case description and case themes” (Creswell, 2013, p. 97). A case study is hence suited to generating in-depth and complex knowledge (Flyvbjerg, 2006; Yin, 2009). A single case study, as opposed to a multiple case study, is believed to be an appropriate methodology for this research since they enable the researcher to obtain a deeper understanding of the subject studied, are inexpensive and can be conducted within a limited timeframe (Gustafsson, 2017). Dyer Jr and Wilkins (1991) and Siggelkow (2007) similarly proposes that the existence of a phenomenon can be described in more depth with single case studies.

Thematic analysis was used to analyse the results, an approach that emphasises on the holistic meaning of the data (Eriksson & Kovalainen, 2008).

Strategies of inquiry: Two-stage sequential mixed methods design

1) **Preunderstanding phase:**
   - ➔ Secondary data collection
   - ➔ Informal conversations
2) **Semi-structured interviews**

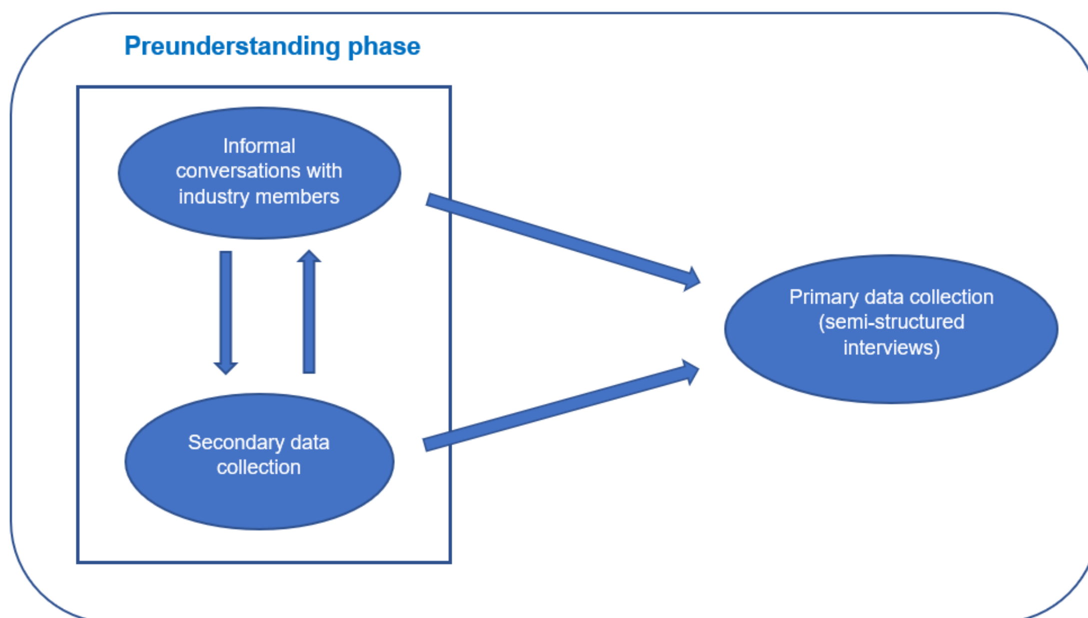


Figure 5. Sequential explanatory mixed methods design. The findings of the preunderstanding stage informed the interview design of the second stage, enabling triangulation to take place.

3.2 Data Collection

3.2.1 Preunderstanding phase

3.2.1.1 Informal conversations

The researcher interned at the Institute for Innovation & Improvement (i3) for a period of 10 months from March 2018 to December 2018. i3 is WDHB's innovation hub that hosts a variety of activities ranging from care redesign, health leadership, research and innovation to digital technology and data design, all with the purpose of producing good health outcomes and good patient experience. Being immersed in such an environment, the researcher was able to observe the range of tasks taking place while engaging with personnel from various backgrounds on their takes to cultural competence in the organisation. The researcher's two industry supervisors are also experienced in the New Zealand health sector and were able to continuously inform and update the researcher on the policies, procedures and processes taking place in the organisation of relevance to cultural competence. The researcher's industry supervisors also helped to facilitate meetups for the researcher with key stakeholders in the arena of cultural competence in the organisation. Furthermore, the researcher also partook in a research project with relevance to cultural competence during the internship. Therefore, through this component of the preunderstanding phase, the researcher gained the opportunity to become more acquainted with the scene of cultural competence in the New Zealand healthcare setting. The insight gained from this pre-understanding phase also helped to define the scope of the search for the secondary data collection in addition to informing the researcher on the design of the semi-structured interview questions.

3.2.1.2 Secondary data collection

Secondary data was collected in the preunderstanding phase of the data collection and took place simultaneously with the informal conversations. Secondary data on the initiatives in place at WDHB of relevance to cultural competence was collected via conducting searches on Google, the MoH website and WDHB website. The data found was used to inform the study design of the second phase of the research.

3.2.2 Primary data collection

Semi-structured interviews consisted of the second stage of data collection and were used for primary data collection to gain insight into key stakeholders' knowledge and perspectives on relevant policies/standards/procedures/guidelines and programmes/courses currently in place and how cultural competence in WDHB can be best addressed in New Zealand's bicultural legislative context by identifying components of cultural competence. This method of data collection was

used as it gave participants the flexibility and opportunity to emphasise on what they understood as important, enabling the exploration of concepts not covered in the topic guide and that may not have been anticipated by the researcher. The researcher also has leeway to follow up and clarify any new aspects raised in the interview believed to be relevant, where the topic guide can be used to help facilitate data analysis (Bell, Bryman & Harley, 2018).

3.2.2.1 Procedure for semi-structured interviews

This study used the purposive (judgement) sampling method, a non-probability sampling technique typically found in qualitative studies where subjective methods are required to determine which participant is appropriate for the study purpose based on the qualities they have (Baxter & Jack, 2008; Bell et al., 2018; Etikan, Musa, & Alkassim, 2016). This form of nonprobability sampling is believed to enable the best utilization of the time and resources available as it will allow the researcher to focus specifically on participants that will be of relevance for the research purpose (Etikan et al., 2016; Silverman, 2013). With help from the researcher's industry supervisors, WDHB employees in relevant positions and with the applicable experience and knowledge to the study were identified, where the information provided by each participant was expected to be unique and of value (Bernard, 2017; Creswell & Plano Clark, 2011). Participants were chosen either due to their senior position in WDHB or the relevance of their role to cultural diversity. Secondary data collection and informal conversations with industry members that took place prior to this stage also helped the researcher to identify the appropriate participants. Initial contact with participants was made in the form of an email sent by one of the industry supervisors, where any further contact made with those who were available and willing to participate was done directly with the researcher. The snowballing effect was also used during the sampling process when participants recommended other individuals who they believed were also appropriate for the study (Byrne, 2001; Noy, 2008). A set number of participants was not predetermined at the start of the study, which was common in the purposive sampling method, though the attempt was made to conduct at least 12 interviews, at which point 92% saturation should be reached (Guest, Bunce & Johnson, 2006; Miles & Huberman, 1994). Sampling continued until the researcher believed it was close to reaching the point of saturation, a point at which more data collected will not produce new themes and/or changes to the codebook (Fusch & Ness, 2015; Guest et al., 2006).

Eventually, 14 participants were interviewed, consisting of 3 members representing the executive leadership team (ELT), 2 from the senior management team (SMT), with 2-3 participants representing the views of each of the health needs of each of the 3 cultural groups (Māori, Pacific, and Asian) at WDHB (figure 6). The remaining 2 participants are also in leadership positions with extensive knowledge and experience in the increasingly diverse culturally diverse scene at WDHB.

While an attempt was made to align the semi-structured interview questions to the objectives of the research, a personalised interview transcript was used for each interview and tailored to the participant's role at WDHB. Findings from the literature review and the preunderstanding stage (informal conversations with industry members and secondary data collection) all informed the researcher in the design of the interview questions. The semi-structured interview questions were assessed by industry and academic supervisors for validity and reliability.

One-on-one semi-structured interviews were conducted in a designated location at the North Shore Hospital campus, where the responses are expected to help the researcher determine the components of cultural competence in ethnically diverse healthcare. The interviews were all audiology recorded and manually transcribed by the researcher.

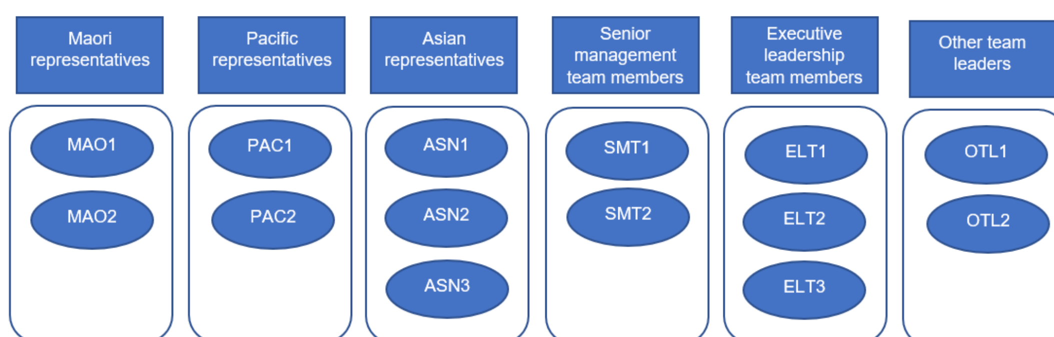


Figure 6. Interview participant groups

3.3 Data Analysis

Recorded interviews were manually transcribed into written text format by the researcher via the method of intelligent verbatim. This method strives to capture the content from the interview as opposed to how it was delivered by eliminating repetitions and fillers that are irrelevant to the research. This type of transcription also results in more coherent transcripts while also staying true to the intention of the participants.

Transcripts were then sent to participants for review, where participants were given two weeks from when the transcript was made available to them for the opportunity to review the transcript and make edits/changes or to withdraw from the study.

The finalised transcripts were analysed along with the secondary data collected. Thematic analysis was used to analyse the results, which is a technique that involves determining, analysing, organising, interpreting and reporting themes obtained within a data set (Braun & Clarke, 2006; Saldaña, 2015). This is a data analysis method widely used in qualitative research to produce trustworthy and insightful findings (Braun & Clarke, 2006; Nowell, Norris, White &

Moules, 2017). The entire process was carried out manually by the researcher and recorded in Microsoft Word.

Lumper or holistic coding, a “broad brush- stroke” approach where the holistic meaning of an excerpt is represented by a single code, was used during data analysis (Saldaña, 2015, p. 23). This type of coding is conveyed to be appropriate as it “gets to the essence of categorizing a phenomenon” (Saldaña, 2015, p. 24). Prior to data analysis, deductive coding based on the literature presented in chapter 2 was utilised to create an existing set of codes. New inductive codes were then added as the secondary and primary data were analysed (Saldaña, 2015). Several cycles of coding took place as each transcript was read multiple times and codes were regrouped upon the detection of new codes from the analysis of more transcripts. This iterative process allowed the identification of the most optimum group of codes, categories and overarching themes in relation to the research objective.

3.4 Significance of the proposed research

The findings of this research which explored the components of cultural competence in a culturally diverse healthcare context and how health disparities can be reduced, can be used by various sectors such as policymakers, funders, providers or researchers involved or interested in cultural competence to inform strategies and actions relating to cultural competence or as a scheme for further study and development. This is significant as it contributes to reducing health outcomes for ethnic minority groups in the health sector.

3.5 Reliability and Validity

Member checking, also known as participant or respondent validation, is often utilised in qualitative studies to establish the credibility and trustworthiness of the data (Birt, Scott, Cavers, Campbell & Walter, 2016; Creswell & Miller, 2000). This validation technique was utilised in this study, where interview transcripts were sent back to participants who expressed an interest to review their transcripts during the interview.

Triangulation of the results collected would have contributed to increasing the validity and reliability of the study while strengthening research findings (Miles & Huberman, 1994).

3.5.1 Reliability

The reliability of research describes the precision, accuracy and reproducibility of the study processes and results (Collis & Hussey, 2013; Leung, 2015). While the data generated from methods such as semi-structured interviews are often difficult to reproduce, an attempt has been made to increase the reliability where possible. The use of topic guides was a means to enhance the consistency of the concepts covered in the interviews and the flow of questioning. Similarly,

having a single researcher to collect and analyse the results also helped to maximise consistency in the data collection and analysis stage, contributing to the overall consistency of the research. The reliability of this study is likely to be strong since all the participants have been in the healthcare sector for a significant period. It is hence unlikely for the understanding and perceptions of the participants on cultural competence to take any drastic changes within a few months' time from the interview.

3.5.2 Validity

Validity refers to the extent to which the study captures what we are trying to measure and if the data collected represent the true concept (Collis & Hussey, 2013; Leung, 2015).

While WDHB is the largest DHB in New Zealand by population, the specific nature of the bicultural legislative context for which the case exists in and its increase in cultural diversity as a recent phenomenon at WDHB could make it hard to generalise the findings of this research to other culturally diverse healthcare settings.

Biases are easy to develop in the subjective nature of such qualitative studies. One aspect of the study that could have been affected by bias is the interviewer/researcher forming preconceived ideas prior to going into the interview, consequently affecting the conduct of the interview and hence the responses of the participants. Sampling bias may have also affected the selection of participants in the study as participants were selected through a non-randomized purposive sampling process (Byrne, 2001). This may have also affected the results to some degree.

Triangulation was utilised in this research, where findings from the preunderstanding stage helped to inform the design of research questions for the semi-structured interviews. The application of triangulation in data collection enabled complementary and converging results to be determined for the same phenomenon. The application of multiple methods in this research hence enhances the reliability and the validity of the findings for the theory it seeks to analyse (Yin, 2009).

Unlike deductive research, in qualitative inductive research methods, researchers are intrinsically part of the research process, where interpretations of the research findings are influenced by the researcher's own bias and presumptions and shaped by their own experiences, culture and expectations (Eriksson, & Kovalainen, 2008). Therefore, with the growth and development of the researcher's knowledge on the subject matter, there is a corresponding adjustment in the researcher's interpretation of their prior knowledge and the role of the researcher in the data collection process of qualitative research hence cannot be disregarded. An attempt has been made to engage in the process of reflexivity in this research by relating each point of the research process to the previous one, where the process is also believed to contribute to the validity of the study.

3.6 Ethical considerations

The study was approved by the University of Auckland Human Participants Ethics Committee (UAHPEC), on the 11th of September 2018 for three years, where a full review application was submitted. Locality approval and Māori responsiveness were also obtained with the Research & Knowledge centre at WDHB.

Many procedures have been taken to maintain the ethicality of the research. While the industry supervisors had a role in guiding the researcher through the research process via the utilisation of their networks and industry expertise, the research itself was developed by the researcher and their academic supervisor. This was an attempt to eliminate any conflict of interest in the research findings.

In the initial contact made with participants, a consent form, participant information sheet and a general interview guide were all made available to the participant to ensure that participants are well-informed of their decision to participate. Participants were also assured that their decision to participate or not participate in the research is entirely voluntary and will have no effect on their employment or relationship with WDHB. They were also made aware of their rights to withdraw from participating in the study at any time during the interview, in addition to withdrawing any data traceable to the participant up to 14 days after the interview transcript is made available to them, without the need to provide a reason.

To ensure the confidentiality and privacy of participants, the collection and analysis of all data were done by the researcher, where only the researcher and researcher's academic supervisor had access to the raw data. Measures have also been taken to protect the identity of participants by replacing their names with a general description of their role at WDHB in relation to the research and no identifying information has been published.

Chapter 4: Findings

This chapter presents and integrates the findings from the secondary data collection in addition to the primary data collection (semi-structured interviews), to answer the research objectives outlined in chapter 1. The coded categories and themes of the findings are displayed in appendix 1. Furthermore, only a selection of the quotes has been presented in this chapter, for the full range of quotes, please see appendix 2.

Research questions:

1) What are the components of cultural competence in an ethnically diverse healthcare setting?

2) How to reduce health disparities in an increasingly diverse ethnic population in New Zealand?

4.1 Cultural competence at the individual level

4.1.1 Cultural awareness

One concept that was addressed by six participants was the role of clinicians' thought processes in becoming culturally competent. The course of becoming culturally competent consists of understanding the existence of cultural differences in addition to having the awareness of the importance of the role of culture in one's health journey and health outcome. It is hence fundamental that health professions have the right attitude and intentions to start with; one must care about addressing the needs of different patient population groups and value its effects before efforts can be made to provide culturally competent services.

"I think it needs to incorporate things like attitude change…"- **PAC2**

"…it's about people accepting the fact that this is a diverse population, in terms of culture, and many other things."- **ASN2**

Obtaining the required attitude and intention to be culturally competent can consist of the practice of self-awareness and self-reflection. One consistent finding from the semi-structured interviews was the importance of WDHB employees learning about their own culture before they can reflect on their own values and beliefs and the impact it has on the care that they provide.

Cultural education was conveyed to be a potential means of producing the needed mindset change, as they can help clinicians to learn aspects of both their own culture and that of others and become more aware of each of its roles in the clinician-patient encounter.

"…when you learn about cultural competence, one of the most important things is understanding your own cultural paradigm. Being able to do that, then you are able to understand someone else's because you then have that empathy and that ability to be able to reflect…"- **ELT1**

Being able to understand the dissimilarities of different cultural paradigms can also help to reduce institutional racism, as health professionals become more aware and accepting of cultural differences.

"…organisational development is really key in terms of looking at our own systems and processes and undoing institutional racism in our organisation…if you wanted to do away with institutional racism, cultural competence would be critical to that because part of it is about understanding yourself, your own culture and your similarities and differences from other people, and that difference is okay. Racism is essentially that difference is not okay."- **OTL1**

A barrier to increasing individual cultural competence conveyed by a participant was people feeling apprehensive of engaging in a conversation on cultural differences and its impact on health. As it is a topic that may be foreign to some, clinicians may be concerned with coming off as oblivious or offensive. This inability to have the required conversation regarding culture can impede and hinder one's progress with becoming culturally competent.

"…one of the barriers is people feeling really nervous about talking about it. Because they don't want to be offensive by appearing that they are ignorant about cultural competence…" **- ELT1**

A large aspect of cultural competence at the individual level consists of having an awareness for the different understanding of the concept of health, illness and treatment for different patient groups. An individual's belief on what is health and illness and consequently what their expectations for treatment is are all largely influenced by their ethnic background. Both a Pacific and an Asian representative have expressed the importance of understanding patients' health belief and explanatory model as part of being culturally competent. Misalignment can occur when clinicians and patients from differing cultural groups have discrepancies in the understanding of health and wellbeing that is not addressed.

"If you ask a sick patient in the ward how they are feeling, they may say they are 'well' even though there may be a mismatch with their physical condition, but if the family is well and thriving and they've met all of their cultural responsibilities, and if we know that those are dealt with, then actually we're really well and we're really blessed…"- **PAC2**

"*…I think understanding that maybe it's how we prefer to be treated, and finding solutions that better equate to that, that definitely improves people's desire to visit a doctor or someone for your health."*- **PAC2**

"…may have her own thinking about what wellbeing is."- **ASN2**

"…link with people in the right way right upfront in terms of meeting not just their cultural needs but the things they expect from us in health service and having that conversation right upfront about what we can do and can't do and how we keep the gap closer…"- **ELT2**

4.1.2 Cultural education at Waitematā District Health Board

For this research, the terms 'cultural training' and 'cultural courses' have all been used interchangeably with 'cultural education'.

When participants were asked about their knowledge of any cultural education courses at WDHB, while a few courses were mentioned by some participants, the eCALD cultural competence courses provided by WDHB eCALD Services was extensively mentioned and described by all 14

participants, where it was regarded as "the flagship of the education that the organisation provides". Therefore, a large component of participants' experience and perspective on cultural competence training at WDHB expressed in the interviews were based on the eCALD cultural competence courses.

WDHB eCALD Services

WDHB eCALD Services (hereafter eCALD) has been developing face-to-face cultural competency training for the health workforce in the Auckland region since 2009. Having expanded to also providing e-learning, the eCALD cultural competence courses are now available to the entire New Zealand health workforce and is currently fully funded by the Ministry of Health ("Enhancing CALD Cultural Competence", 2019).

With the main mission of improving the quality of cross-cultural interactions and understanding between culturally diverse population groups and healthcare practitioners, the courses which eCALD provide teach healthcare professionals how to work with CALD patients in addition to working in a culturally diverse environment ("Enhancing CALD Cultural Competence", 2019).

Registration bodies in New Zealand have been required to create standards for clinical and cultural competence, as outlined in the Health Practitioners Competence Assurance Act (HPCAA) (Health Practitioners Competence Assurance Act 2003, 2017). As part of meeting the cultural competency standards, a variety of registration bodies have made at least module 1 of the eCALD courses mandatory for their members to take, included is the New Zealand Medical Council, through the Royal College of General Practitioners, as outlined in the Foundation Standards and Cornerstone Standards (Royal New Zealand College of General Practitioners, 2016). Representing the legal, professional, and regulatory requirements for general practice, the Foundation Standard for General Practice was first developed in 2013 with the aim of ensuring the safety of its patients (Royal New Zealand College of General Practitioners, 2016). Additionally, other groups such as the Public Health Physicians, the Nursing Council of New Zealand, the Psychologists Board, the Pharmacy Council and the Royal Australian College of Surgeons have all made the completion of module 1 of eCALD courses mandatory ("Enhancing CALD Cultural Competence", 2019).

While registration bodies and accreditation groups have acknowledged cultural competence by incorporating it into their standards, there is currently no overarching policy at WDHB that has mandated any cultural education. Instead, whether a staff member engages in cultural training of some kind is dependent on their profession and the service group they're in.

Mandating cultural education

When asked if cultural competency training should be made mandatory or if staff should be given the option to choose, differing opinions were found from the semi-structured interviews. While some participants believed that cultural competence courses should be made mandatory, others also questioned the effectiveness of doing so.

Participants have argued that mandating cultural courses may have the opposite effect as it may make people become less engaged when it is perceived by health practitioners as being given a lack of autonomy. In such cases, the "extrinsic motivation" to take the courses may in fact "turn people off", cause them to be less "engaged" and is hence only done as a "tick box" approach. The effectiveness of cultural competence has also been questioned; even when cultural courses are made mandatory and staff are required to attend, there is no guarantee that the information is absorbed by the participant in a way that will make a difference to health practitioners' cultural competence.

"Part of being a health professional is learning and having this thirst for knowledge and learning. So I think that it should just be mandatory, and I think that with the right approach, people will embrace it."- **ELT1**

"I don't think mandating it in terms of 'you must attend that course' will do anything for it. In fact, I think it will probably turn people off."- **ELT2**

"…making it mandatory means that… everyone will be exposed to cultural competency training. And they may or may not absorb it, if they're less engaged, they may not retain so much knowledge. And so obviously, the downside of that is that again, that's extrinsic motivation. So people haven't chosen to be there, and so potentially will not engage so well."- **OTL1**

"…in principle, making it mandatory is good. There are logistical issues in putting this into practice and just making it mandatory will not make [cultural competence] happen."- **PAC1**

However, even in cases where health practitioners unwillingly take up the cultural courses due to it being mandated, attitudinal/behavioural change can still take place. In some cases, participants may not be aware that they needed cultural competency training until after they have taken the course. Similarly, cultural competency training may not always produce immediate changes in learners' attitude and behaviour, but instead may come to use in the future when the learner recognises the importance of cultural competency and becomes more self-aware.

"I have feedback from people who joined the course or took up the course because it is a mandatory requirement by their professional bodies, and given feedback showing a change of attitudes and behaviours…'I'm taken by surprise by what I have learnt from the course and I am going to implement changes in my practice"- **OTL2**

"Even if the person doesn't use those skills immediately, they may start using it in the future when they do realise it is something important to address…"- **ASN2**

Determining the effectiveness of eCALD courses

As previously described, there is the possibility that employees who are not interested nor engaged with cultural courses are only taking it due to it being mandated. Therefore, whether if any substantial effect has been made to health practitioners who have taken cultural courses in such cases will require further exploration.

In terms of measuring the effectiveness of the eCALD cultural courses, an evaluation study has been done to determine any changes in learners' attitudes and behaviours when working with patients (and their family members) of culturally diverse backgrounds, in addition to changes in patient experience (Mortensen, Lim & Puddle, 2018). The study consisted of a pre and post self-assessment, where the post-evaluation was done by a selected group of participants three

months after the completion of the course; learners assessed the impact of the course via self-reflection (Mortensen et al., 2018). These learners who have taken the course were asked to assess their attitude and behaviour changes; their views about the usefulness and relevance of the course(s) they have undertaken; their views on systemic or other barriers that impact on the provision of culturally appropriate services; and their views about improvement of patient experience (Mortensen, Lim & Puddle, 2018). From findings of the study suggests than in addition to a perceived increase in the patient experience, there was also an improvement in learners' behaviour and attitude when working with culturally diverse patients (Mortensen et al., 2018).

Supporting the findings of this evaluation, another study (independent) also emphasised the effectiveness of the eCALD training as determined by an increase in participants' knowledge regarding cultural differences, such as on values, health beliefs, religious beliefs and customs, enhanced understanding in their interaction with patients in addition to having a more positive attitude and increased sensitivity towards CALD patients (University of Auckland, 2012). The positive impact of the eCALD courses as conveyed by participants in the self-assessment was similarly conveyed in this study, where it was suggested that greater awareness and understanding of learners' own culture and its impact on patients' health care journey was obtained (University of Auckland, 2012).

Despite the positive impact that learners believe they have experienced after taking the eCALD courses, the self-reporting element of the study is still largely subjective in nature, as it is based on health practitioners' own perceptions. Objectively determining if any behavioural/attitudinal change has been made to learners via taking the cultural competence courses can only be achieved via measuring the effect of the courses based on patient health outcomes and their health journey, which can be difficult to implement.

"…feedback from people who joined the course or took up the course because it is a mandatory requirement by their professional bodies, and given feedback showing a change of attitudes and behaviours."- **OTL2**

"…eCALD has been a massive important national piece of work. And I think that's given a lot of awareness to diversity into how you respond to a whole range of patient needs and be able to have those conversations and I think that's been an incredible investment and labour of love from Sue and the team."- **SMT1**

"…the eCALD programme, which is the flagship of the education that the organisation provides."- **ELT3**

"…that is an absolute gold standard, there's nothing of it in the world that I know of."- **OTL1**

"*…cultural competence is judged by the patient's experience of health care."-* **PAC1**

"…eCALD has a before and after self-evaluation…good feedback from learners. However, it's not consumer (patient) feedback…"- **ASN1**

"The course is there and sometimes as a tick box people do it, we know how many people have done the course, but we don't know what impact it has had on the other end…how do we measure what difference training has made when a staff member interacts with patients?… Do they fall back on their default unconscious bias?"- **ASN3**

"…they're wholly subjective so it's just people reporting before and after the training, whether they would change their behaviour or not, right, so what we haven't yet done is actually gone and observed behaviour change…So I think that's the bit that's missing. We haven't 100% proved that it changes behaviour, but we know with absolute confidence that people report it does."- **OTL1**

Expanding to other target populations

The current target population of eCALD Services are the health professionals in the New Zealand health workforce that work directly with CALD patients. Two participants from the study have expressed the potential to expand the target population to those in the senior management levels; "Board members" or "policymakers" in the MoH. The implications of this would be to establish a culturally competent perspective in the decision-making process at the strategic level. The supposed outcome would be to implement culturally competent initiatives from a decision-making and policy level which would put the relevant infrastructures in place to enable a culturally competent organisation. Furthermore, this is expected to accelerate the rate in which the ideal outcome is reached, via having the right frameworks in place.

"There is very limited cultural competence training available for staff, nothing in place particularly for management, never been done for Board members."- **PAC1**

"I think it's time for the eCALD team to move on or try targeting the policy level as a higher priority because we have already had some great success at different levels, we have some policies in place at the DHB level or even nationwide. So I think it would be a great idea to promote that at a national platform because with that, the change would be quicker."- **ASN2**

Situational/disease-specific cultural competence training

There is also usefulness with cultural competency courses that are tailored to a specific service, situation and/or disease. The content addressed in these courses is more likely to be directly applicable to the situation that health professionals are inclined to be faced with. This is something that has been touched on by eCALD already as described previously ("Enhancing CALD Cultural Competence", 2019). Similarly, WDHB's Asian Health Services also provides workshops designed for specific services upon request. This consists of teaching staff on how to work with CALD patients, where issues that cannot be resolved from online training alone are addressed ("Asian Health Services", n.d.).

"…the next level is disease-specific."- **PAC1**

On Māori and Pacific courses: *"…not as comprehensive as eCALD, its' sort of a singular online training module about how to engage with Pacific, as with Māori, a singular thing about a little bit of insight into Māori worldviews and protocols and Treaty responsibilities, as opposed to eCALD, which has gone into situational training."*- **OTL1**

Face to face, experiential, interactive learning

Five participants have conveyed the effectiveness of interactive, face-to-face and/or experiential learning such as ones that address "narratives and stories and experiences". Teaching cultural competence in a physical setting such as a workshop instead of getting learners to do an online course can enable better engagement and deeper discussions to be made. Furthermore, physically experiencing the taught materials can also produce a deeper understanding of concepts while

making it more memorable. Similarly, incorporating narratives such as patient stories and conversations around personal experiences via an interactive setting can also facilitate a deeper level of self-reflection and self-awareness.

"I personally think face-to-face workshops normally provide more opportunity for learners to think deeper through their discussions during the sessions."- **ASN1**

"A few years ago I had done this Treaty of Waitangi training and we also had a Marae visit, understanding some of the protocols there, so those kinds of training could be helpful."- **ASN2**

"…we find the face to face one quite good interaction across the team; you can go through narratives and stories and experiences better in a face to face environment…"- **SMT1**

"…I think most of the time, it's through those patient stories that people identify more effectively with…"- **SMT2**

Accessing cultural competency training- Too busy; Training as part of work; Responsibility of the organisation

When participants were asked about the barriers that may prevent staff from attending cultural competence training, participants expressed that finding time to attend from the busyness of work was a common issue they were aware of. Due to the high demand workload that health professionals are often faced with, scheduling staff to attend cultural competency training can be difficult to implement. Others also mentioned the problem of staff having to apply for annual leave or doing the courses/training in their own time, depending on which service they are in. Many participants have hence argued that it is the responsibility of WDHB to enable their staff to attend cultural competency courses, by giving them the "protected time" to go during work hours or in lieu, instead of having to apply for annual leave, since "anything that is training about your ability just to perform your role to the best of your capabilities should be considered working." Providing staff with the opportunity to attend cultural competency training will also help them feel "valued", which can consequently motivate staff's desire to attend in addition to acknowledging cultural competence as a priority for the organisation.

"So staff leaving to attend the cultural competency programmes is an issue, we're depending on managers releasing staff since they are faced with minimum hour study leave backfill that they have to organise when their staff goes."- **PAC2**

"…access to training and development opportunities is one of the biggest things we can do to make people feel valued, and people don't have protected time to go to take advantage of those opportunities…clinical practice takes precedence."- **OTL1**

"…what I hear from clinicians often is 'I'm too busy, I'm just too busy for that, that's an add-on to make myself go to training too. And also that 'feeling like it's not really me."- **SMT1**

"…as an organisation there is an obligation on the organisation to make sure staff can go; make them available during their work time…"- **ELT1**

On being released for cultural training: *"It shouldn't have to be a battle."*- **ELT2**

One participant has also expressed that health workers being unaware of the existence of cultural competency courses as another barrier that can preclude staff from attending. Therefore, this further suggests that cultural courses should be made mandatory as discussed previously.

"So it's up to them to see it, or someone actually offer it to them or enrol them or whatever, for them to actually know more about it. So they're there if you're looking, but what's the carrot to make you look, what's the carrot to make you go? And if there is no carrot, should we make it mandatory?"- **SMT2**

4.2 Cultural competence at the organisational level

4.2.1 Cultural representation

The concept of cultural representation was explored extensively in the semi-structured interviews, where a variety of opinions regarding its effects are conveyed. In relation to this, the ethnic composition of WDHB was also addressed.

Cultural representation among the senior level

On the senior management level, there is a lack of cultural representation for all 3 main minority ethnic population groups (Māori, Pacific and Asian) at WDHB. There are 10 positions on the ELT level, with a position for a Māori chief executive officer (CEO) and a Chief Advisor Tikanga role ("Waitematā DHB Leadership", n.d.). The SMT contains 21 members, including the role of a general manager for Māori health and general manager for Pacific health ("Waitematā DHB Leadership", n.d.).

Participants have similarly noted that there is a lack of cultural representation in the ethnic composition of employees on the SMT, ELT and board level, which is not reflective of the ethnic distribution of the WDHB residence population.

"…mostly non-Māori exists in our senior management, executive leadership and governance level, and poorly on the board level. So in my view, that is not enough."- **MAO1**

"There is no Pacific presence at Board level, or at Board sub-committee levels, there is a Pacific general manager which is Tier 2 and Pacific planning/funding manager which is Tier 3."- **PAC1**

"…the diversity within our leadership teams are quite limited. So how as a health board can we be seen to progress, to be culturally competent if the representation within our current senior management team is quite limited."- **SMT2**

"…if I think about the executive, we could definitely do with more diversity."- **ELT2**

"…one thing that I do find interesting is that we have a general manager for Pacific health, General Manager for Māori Health and no general manager for Asian health. So Asian health services sit under our director of patient experience, whereas the other two are departments in their own right, have a place on the senior management team…I think it's historical…"- **OTL1**

"At Board, ELT and SMT levels there is no Asian or Middle Eastern or African representation."- **OTL2**

"Asian representation in decision making, since there's currently nobody advocating in the decision-making area. We have a 26% Asian workforce in the WDHB in 2018, but none of the senior management team members is Asian. This is something we need to address."- **ASN1**

"Māori and Pasifika have representation on the SMT, whereas the Asian services don't."- **SMT2**

Cultural representation among the frontline staff

In addition to a lack of cultural representation at the senior leadership level, Māori and Pacific populations also experience a lack of cultural representation among the frontline staff at WDHB. In contrast, there is an adequate amount of cultural representation among the frontline staff for the Asian population. For the purpose of this research, frontline staff encompasses all staff that directly interact with patients, including but not limited to: doctors, nurses, social workers, occupational therapists and physiotherapists, psychologists, paramedics, pastoral care workers, pharmacists, dieticians and speech pathologists:

"…poorly at a frontline staff level; we don't have many Māori staff here at all."- **MAO1**

"The workforce population within WDHB for Asian is overrepresented."- **ASN3**

"Asian workforce is adequately represented at the frontline level."- **OTL2**

Semi-structured interview findings suggest the presence of a positive impact on patients' health outcome when adequate cultural representation is present in a healthcare organisation. When patients have the opportunity to interact with someone of a similar cultural background to themselves, greater clinician-patient engagement is achieved as a result of the deeper understanding and trust established. Various explanations have been given by participants for this phenomenon, such as patients having a "natural affinity" to people that look like themselves and/or have similar values and beliefs. Participants have also suggested that ethnically diverse staff can act as champions for initiatives that address the needs of ethnically diverse populations.

"The system tends to favour the people that work within the system or the ethnic groups that work within the system, so we have a largely non-Māori workforce. So 92% of the New Zealand health system is non-Māori, so it's not surprising that the system works well for non-Māori people since there is a similarity and strong commitment to the health and wellbeing of non-Māori people within our community."- **MAO1**

"…as any ethnicity, you just have a natural affinity, it's just a different sort of engagement type."- **MAO2**

"…increasing the proportion of Māori working within the DHB as well as other ethnicities obviously is going to support some of these culturally orientated kinds of questions. We are not only preaching to the converted but within services, we do have champions who understand it and get it."- **MAO2**

"…people respond better to health workers who look like them, who identify with the same issues, not necessarily physically look like them but have similar values and beliefs."- **PAC2**

While cultural representation has been widely described to contribute to the cultural competence of an organisation, there are also difficulties in its implementation due to a large number of ethnicities found within the WDHB catchment. Therefore, while cultural representation should be considered where possible, it should not be prioritised over the importance of having the right skills for the job. Alternatively, WDHB can consider just applying cultural representation to specific services in the organisation, where there is a high demand for specific cultural or linguistic needs.

Furthermore, the underlying proposition of cultural representation is that it assumes the clinician's culture, values and norms based on just their ethnicity. Discordance can arise when health

professionals do not have adequate cultural knowledge or language skills expected of their ethnicity.

"…assumes that Māori and Pacific people are homogenous groups…Pacific people are made up of the hundreds of different islands and subcultures as is Māori …not a singular group of people as there are multiple iwi, hapu etc…."- **OTL1**

"…just employing Māori staff doesn't mean that those Māori staff are going to be perfect for our Māori population, they still need to be able to build rapport and understand where people are coming from…"- **OTL1**

"With the diversity of cultures, languages and dialects spoken by clients it is impossible to provide language matched health professionals for all groups."- **OTL2**

4.2.2 Leadership influence

Culturally competent staff in leadership positions at WDHB has been conveyed to be influential in bringing cultural competence to the rest of the organisation. Having a culturally sensitive perspective at senior levels can directly influence initiatives related to cultural diversity within WDHB. As **PAC2** pointed out, when cultural competence is incorporated into processes at the executive level, there is also better acceptance by the rest of the organisation. Three participants, therefore, suggested that ensuring a culturally competent healthcare organisation starts from having culturally aware leaders who can be champions for addressing the health needs of culturally diverse populations.

"…that would lead by example, they would have a good understanding of cultural competency themselves. So their ability to make decisions would be more effective around what sort of services we develop, and what we fund and what we don't fund, etc"- **SMT2**

Racism: *"…the leadership needs to take leadership, so at the top, and we've seen some of the effects with institutional racism too. When it is taken up by the executive, it seems to be better accepted by the rest of the organisation."*- **PAC2**

"I think our leaders need to be culturally competent to role model and to influence, and it trickles down to the rest of the organisation. I think if you tried the bottom-up approach, there would be some influence but overall the decision-makers are the ones that day to day make the decisions for the organisation of where the funding goes. It's really important, I'd say the leadership group has effective cultural competence."- **SMT2**

Both Māori representatives from the study have also suggested the need to have more Māori leadership roles in WDHB. This concept also relates to that of cultural representation as previously discussed.

"…in terms of developing more Māori and leadership roles in this organisation and the Auckland DHB, there's a lot of work still to do in that space as well."- **MAO1**

"…within services we do have champions who understand it and get it. So that would be amazing if we had Māori cardiac rehabilitation nurses to champion the new prototype on our behalf. They can support it at that kind of cold-face level where the clinicians are…"- **MAO2**

4.2.3 Culturally competent and capable workforce

A major contributor to cultural competence at the organisational level is creating a workforce of culturally competent and capable people, an aspect that can be taken into consideration during

recruitment in addition to making efforts to retain skilled and competent staff. Opportunities for training and career development have also been suggested by participants to support the creation of this ideal workforce for a culturally diverse population.

While capability in health care is often perceived as one's ability to carry out the clinical aspect of one's role, a Māori representative has emphasised that cultural competence is part of this clinical competence as opposed to being an extra aspect that staff should strive for. As cultural awareness helps clinicians to communicate and engage effectively with patients, having the required cultural competence is fundamental in staff's ability to carry out their role as a clinician. Another participant has also emphasised that knowing the importance of and having the desire to become culturally competent are all mindsets that staff should have intrinsically. Only when staff has the right attitude to begin with, can a culturally competent workforce be created. These are all facets that need to be considered in building a culturally competent and capable workforce.

Cultural competence is clinical competence*: "It's seen as something that's different to clinical competence, but clinical competent and cultural competence is one and the same thing, you can't be one without the other."*- **MAO1**

"…to build a strong competent workforce, so building that capacity and capability of a Pacific culturally competent strong workforce, since that is an enabler for good health outcomes."- **PAC2**

On being culturally competent: *"…I would hope that people who enter these kinds of professions have enough insight into their own practice to know that it is something they should be doing anyway…It shouldn't be something that we wag a stick at people and be like this is something you must do. People should recognise the importance of doing that themselves already."*- **ELT2**

Semi-structured interview findings emphasised that an essential part of creating a culturally competent workforce at WDHB is dependent on the recruitment stage, which consists of the utilisation of the appropriate employment methods in bringing the right people into the workforce. If the organisation valued cultural competence, then having cultural awareness would spontaneously be considered an essential requirement in the recruitment of staff at WDHB.

In addition to accounting for appropriate cultural perspectives and attitudes in the recruitment process, participants have also emphasised the importance of putting efforts into retaining the right staff as part of contributing to creating a capable and competent workforce.

"…we should be having the expectation that everybody who comes to work with us should come with a level of competence. We shouldn't be employing people who don't have the capability to do the job."- **MAO1**

"…keeping the pipeline open, employing the right people and keeping the right people here…"- **ELT2**

"...it's important to ensure that cultural competence is applied from everything you do, in terms of how you attract and recruit people and the experience you give them as a student, to the experience you give them as part of the onboarding process."- **ELT3**

A lack of capability in meeting the health needs of the Māori population at WDHB is expressed by both Māori representatives in this study. It has been conveyed that part of addressing the health needs of Māori is recruiting culturally competent and capable staff that can work effectively with

Māori patients. To create a workforce consisting of such competent and capable staff, the organisation needs to begin by having a commitment and dedication to making a difference for the Māori population. Efforts to recruit and retain Māori staff as part of ensuring adequate representation is an important aspect of cultural competency. Another Māori representative has also emphasised the importance of having the right capabilities in teams involved in work around the Māori health and equity space, which currently appears to be lacking in clinical expertise. This has also been suggested to be related to the lack of funding available.

"Where we will get our biggest amount of bang is to ensure that we've got a capable and competent workforce who is committed to making a difference for our Māori population…If we just change tomorrow, to stop employing people who aren't culturally competent, then automatically, that shows we have a value for that now, and therefore people will value becoming more culturally competent."- **MAO1**

"…we've got a long way to go as a workforce, we've got some awesome people working within our organisation, but we've also got some work to do to develop their capability and competence to work with the Māori community…"- **MAO1**

"…it's a priority for the DHB to increase our Māori workforce, and we're currently looking at how we can attract more Māori in our workforce and retain more Māori in our workforce."- **MAO1**

"…data analysis people that don't have experience, background or education in health…don't have any clinical expertise within [the] team"- **MAO2**

"…quite a significant issue in addressing Māori health equity, it does require investment and resources…Ideally, we'll have enough resource to work with other teams, work more collaboratively internally and externally, develop more programmes of work, have different skillsets etc. Because of resourcing, this hasn't been the case…"- **MAO2**

An aspect that participants suggested to be a contribution to the cultural competence of WDHB consists of providing opportunities for personal and professional development. This can be in the form of cultural education as discussed previously, in addition to career development opportunities that can support staff of ethnically diverse backgrounds to further their career within the healthcare organisation, which can also contribute to cultural representation at the senior management level. One participant has also conveyed that a potential barrier for staff wanting to develop their cultural competence is a lack of resources in the form of subject matter expertise. It is difficult for staff to get hold of people such as kuia and kaumātua, Māori elderlies recognised for their experience and guidance (Higgins & Meredith, 2011), in order to obtain the necessary support and information to advance their ability to meet the health needs of Māori patients.

"…we're not doing enough of is that we're not giving enough training opportunities for people to understand other cultures."- **PAC1**

"…*part of it is about how we develop people, so we need to think really carefully in thinking about leadership development opportunities, how are we working with different cultural groups to develop them as leaders in a way where they can interact that level."*- **OTL1**

"…in terms of having the subject matter experts that people can go to and ask. Kuia and kaumātua are very tight on the ground, and for us, they cover two DHBs; we share them with Auckland, which makes them even more stretched so that resource is really hard to get hold of."- **ELT2**

"The conundrum for me is how do we continue to grow our cultural competence when the resources are so dire…people are really keen to do it. They see the need and they see the

benefit, and they're really interested in learning and growing in that space and they get completely frustrated when they can't find someone to sit down and have a conversation with about it. So that's a real problem from my perspective, is access to support around cultural competency, and growing in that space. You can do a lot of stuff online and that's great, but sometimes you need an expert in front of you."- **ELT2**

The study findings further suggest that addressing the health needs of diverse population groups is the responsibility of the entire organisation, where instead of just relying on cultural staff, it should be made into "everybody's business". In catering to the cultural needs of Māori, WDHB can incorporate Māori protocols and practices "into business as usual".

"…how do we make Pacific health everybody's business?"- **PAC2**

"…one of the things in terms of what more we might do for cultural competence is to shift the responsibility from those cultural health teams to the rest of the organisation…if we take the Māori health team, they don't necessarily have to be the keepers of everything Māori. So one of the things that they would like to see is tikanga, so Māori protocol and practices just woven into business as usual…So how do we just weave those things in so that it's okay for members outside of the Māori Health Team to initiate those practices because it should just be business as usual…educate the rest of the organisation, how to take responsibility for some of that stuff."- **OTL1**

4.3 Cultural competence at the systemic level

4.3.1 One size does not fit all

Participants have conveyed when it comes to the model of care, 'one size fits all' does not work, this is especially the case for "Māori and Pacific" patients, who may benefit more from a more holistic model of care. To design a model of care that can effectively meet the health needs of patients, WDHB must incorporate the "cultural, social and religious needs" of all its patient groups. One Māori representative has conveyed that while the current model of care is not entirely ineffective, it is too clinically focused, imposing limitations in its ability to meet the health needs of Māori and whānau. While three health models have been proposed for Māori by the MoH, there are no standards in place to measure its utilisation nor effectiveness. The three health models are Te Whare Tapa Whā, Te Wheke and Te Pae Mahutonga ("Māori health models", n.d.).

As patient experience is qualitative in nature, another participant has also emphasised the need for WDHB to conduct more social and qualitative research to better understand the health needs of patients.

"…the things that Māori have identified as being important to their wellness are spirituality, Te Reo Māori and connection back to their whānau, community or traditional places of meeting such as the marae. But as an organisation, the health system doesn't do well for people tending to their spirituality…"- **MAO1**

"…the model that worked for a lot of other people simply didn't work for Māori and Pacific people."- **MAO2**

"…one size fits all is the thought process that some of our staff go through, but no, it's not the case. We need to understand what's important for each individual patient, particularly those from different cultural backgrounds to make sure we provide the care and support that they need and value these patients."- **SMT2**

"…if we're looking at our diverse population and the facilities and models of care that we are providing, that we are including the cultural, social and religious needs into that model of care."- **ELT3**

"…based on research…a more holistic comprehensive model of care will achieve better health outcomes with Māori than what your standard models of care provide."- **MAO2**

"*So when a Māori person comes into the organisation…they don't go on to a hauroa pathway or paeora pathway of care. That is problematic because our pathway of care is clinically based…and the clinical way of caring for people is too limited in my view when trying to care for the needs of whānau and Māori who utilise our services…they don't work for our people, if you look at the performance metric, the traditional way of care does not work for our people to the same level. I'm not saying they are totally ineffective, of course they are, but in terms of access to timely intervention, in terms of what the feedback is from whānau, we still got a lot of improvement to do."*- **MAO1**

"I think the other challenge that we have is that the thinking in our system is very clinically based and it is not adapting, immersing itself in strong Māori intelligence. The way it defines health is very clinically focused. The acts upon it are very limited in its ability to respond to the health or hauora needs of its Māori people."- **MAO1**

"…I'd love to see much more ethnographic research being done with our different communities so that the DHB actually understands people's worldviews and can start to think what does that mean for how we provide health care to that group of people?"- **OTL1**

4.3.2 PHO enrolment and health literacy

General practitioners are often patients' first point of contact when unwell, where enrolling with a PHO can significantly influence one's access to quality health services and health outcomes. The PHO enrolment rate can hence act as an indicator of access to healthcare for WDHB's population. In comparison to the 4% of overall WDHB residents not enrolled with a PHO, Māori and Asians WDHB residents have much lower PHO enrolment rates, with approximately 9% and 17% respectively not enrolled (Waitematā District Health Board, 2017). One of the barriers that have been suggested to correspond to the low PHO enrolment rate among Asian is the lack of familiarity with the New Zealand health system, which can often be very different to patients' country of origin. Similarly, a significant contributor to low PHO enrolments for these groups is a lack of understanding of the role of PHOs in accessing healthcare services in New Zealand.

"Where we have better access rates, that would be a measure of the DHB doing well"- **PAC2**

"…to provide similar services for Asians, migrants and refugees. Many new migrants don't know what a GP is, and the New Zealand health system may work quite differently from their country of origin."- **ASN1**

"…the real focus [is] on improving primary care enrolment, and so realising primary care is the doorway to being able to access the full range of health care services and preventative services."- **SMT1**

"…so that's been our focus; is making sure that people are aware that in New Zealand that primary care is the healthcare home because that's not necessarily what people are used to in [their] home countries"- **SMT1**

Increasing the health literacy of WDHB residents and particularly patients who are not familiar with the New Zealand health system can be an effective aspect of increasing PHO enrolments among diverse ethnic groups. The Ministry of Health New Zealand has defined 'health literacy' as

"the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing" (Ministry of Health, 2015, p. 1). Patients' ability to make informed health decisions is based on their ability to acquire, process and understand basic health information and the health system (Ministry of Health, 2015). Challenges arising from inadequate health literacy skills can be reduced when the effort is put into developing the health literacy of people accessing the services. This can consist of providing services that are easy to navigate and access, while also providing understandable and useful health information to help New Zealanders to adequately manage their own health (Ministry of Health, 2015). A participant has further emphasised that health literacy is not just limited to language or knowing how to navigate the New Zealand health system, but it is also about having the right attitude towards health and treatment.

"…with the right education, people do things that they never did in their original country, and they do acquire the attitude that is necessary to actually use these preventative services like the screening programmes."- **PAC1**

"It requires a conversation. We are required to give them a lot of information so that they can see the decision to change."- **PAC1**

"…heath literacy…is a key barrier that we are working towards, but that is a long-term thing instead of a quick fix. So health literacy is about all kinds of language, not just verbal language, but understanding symptoms etc…So in my mind it's all of that, so I think when people talk about health literacy, we tend to think about the understanding of symptoms, treatments and those kinds of things, but also I think it needs to incorporate things like attitude change, and increasing understanding not just the English language or the English verbal language, but about understanding the whole system…The health system itself is very complex in the hospital. People need to understand what services they need to access, why, and how to get there, and who they need to see. There needs to be a lot more understanding of that kind of things."- **PAC2**

One participant has also raised the need for WDHB to utilise popular non-English media platforms as a way of communicating health messages to that population. WeChat, a Chinese messaging and social media application widely used among the Chinese-speaking community, is an example of a potential platform that WDHB can employ in an attempt to reach the Chinese community, which consists of the largest proportion of non-English speakers at WDHB (Waitematā District Health Board, 2017).

"…improving Asian patients' health journey in the DHB, because they face a lot of difficulties due to language and cultural barriers."- **ASN1**

"…others who are more recent migrants and have got English as their second or third language, for them, of course it's a big [issue]."- **ASN3**

"I believe the language barrier is a huge barrier impacting on access and communication between health providers and service users and the effect on health diagnosis and treatment. For non-English speakers, communicating without an interpreter impacts on the accuracy of assessments and on appropriate and timely care-planning, and subsequently on the quality of care received by the service user and their family."- **OTL2**

"…about communication. The DHBs have been doing a lot of communication now on Twitter, Facebook, but it may not reach the ethnic population, because, for example, a lot of Chinese population are using social media Wechat instead. It's a big and very successful platform. The NGOs have been using it already, and they use that for communication and for promotion as well…but the DHBs have not yet taken advantage of that, so we are just relying on the traditional

media platforms like Facebook and the print media, such as the New Zealand Chinese Herald or the radio. That's all fine, but we do need to look at a more efficient way of engaging with the Asian communities."- **ASN2**

The Pacific population in New Zealand is largely religious, where 73% of Pacific people in New Zealand were reported to be Christians in 2013 (Macpherson, 2018; Pasefika Proud, 2016). In New Zealand, churches act in the place of villages, a place where a sense of community is established and plays a vital role in the religious and social lives of many Pacific families (Macpherson, 2018). Therefore, WDHB can utilise this network to promote health care services and programmes to the Pacific population via working with churches and community groups. Similarly, for the Māori population, participants of the study have suggested the effectiveness of working with Māori communities and enabling opportunities for family members to be involved in the patients' decision-making process. This is believed to lead to a better connection and understanding between clinicians and patients, which can result in a greater health journey and health outcome for patients.

Engaging with the community and the primary sector: *"…Pacific patients are really in hospital for a short time, but actually, they're within their communities. So if we're looking at making a difference to the health outcomes for patients, it often involves linking in with the families in the communities, primary services, linking with primary health care, linking with even Pacific agencies in the community that are more community-based. So the whole primary health sector, we work very closely with."*- **PAC2**

Patient and Family participation/involvement: *"…if your service is responding to you as a person and considering your belief system and your feelings and your kind of cultural frame, then that's going to make you feel included in your care, which is one of our priorities. It's also going to ensure that there is a possibility for your family to participate in your care as well. I think it probably speaks to our overall priorities around better patient outcome and experience. If people are feeling involved in their care, and they're in an environment that is inclusive and welcoming to them, that then results in better connections between clinicians and patients, and hopefully greater outcomes and greater experiences."*- **ELT3**

4.3.3 Interpreting services

Patients who are migrants with limited English linguistic abilities can face difficulties in accessing healthcare services due to communication barriers. In the absence of a skilled interpreter, misunderstandings can arise, and assessments can be inaccurate. It is hence crucial that adequate interpreting services are in place to remove such barriers and increase the access to health care and the health outcome of these patients.

WATIS (originally called 'Waitematā Translation & Interpreting Service') Interpreting Service is an interpreting service managed and provided by Asian Health Services of WDHB ("Asian Health Support Services", 2019; "WATIS Interpreting Service", 2019). Contracting more than 200 interpreters and covering over 90 languages and dialects, WATIS covers both for WDHB's hospital and community-based services ("WATIS Interpreting Service", 2019).

4.3.4 Ethnicity-based reporting

Participants of this study have acknowledged the existence of diversity among people of the same culture or ethnicity. Heterogeneity among groups can be in the form of differences in socioeconomic factors, amount of experience with the New Zealand health system and/or individual health beliefs. Meeting the health needs of subgroups among minority groups will hence require culturally sensitive data collection; this is especially the case for the Asian group.

"…you've got people from different iwi, Māori who live here, but not from the area, you've got young Māori, old Māori, Māori who are wealthy and well off and others who are unemployed and in a dark space."- **MAO2**

"There is diversity in Pacific as well, so [there is] the need for Pacific ethnic-specific language and having access to that kind of knowledge and understanding around the diverse Pacific ethnicities."- **PAC2**

"When we look at the Asian population overall, they do really well. But when you try to look at the subgroups, there are health disparities."- **ASN3**

"…Asian is such a broad group, the same as Pacific, which is also such a broad group, there's heterogeneity in that group in terms of length of time in New Zealand, and in terms of the health system that people come from, and familiarity with the New Zealand health system and those kind of things."- **SMT1**

In New Zealand, the MoH has standardised the procedure of ethnicity data collection, recording and usage of people receiving service from the New Zealand health and disability sector via the publication of HISO 10001:2017 Ethnicity Data Protocols (Ministry of Health, 2017). The Ethnicity Data Protocols outlines the standard processes for collecting, recording and using the ethnicity data of people receiving care from the New Zealand health and disability sector such as DHBs. The findings of the ethnicity-based reporting can go on to aid in the research and development of ethnicity-specific services and treatments. The protocols for collecting and recording ethnicity data which have been created with contribution from a diverse range of government groups and sectors, and are in accordance with Stats New Zealand's Statistical Standard for Ethnicity (Ministry of Health, 2017). There are 4 levels of ethnicity data collection, with level 4 being the most detailed level of classification. WDHB is only required to collect ethnicity data for patients up to level 1, as shown in figure 7 (Ministry of Health, 2017). This level of ethnicity data collection has been suggested to be inadequate and insensitive, especially for the Asian population, which contains many subgroups with differing health needs (Thackrah & Thompson, 2013). Information on specific health outcomes and health needs of patients of certain subgroups and ethnicities is hence difficult to identify.

While there is MoH standardised ethnicity-based data collection for patients, the same requirements do not exist for the ethnicity of staff at WDHB, as the current system in the organisation does not provide for the option to capture multiple ethnicities in a codified format such as 'priority coding'.

Level 1- alphabetical order	
Code	**Descriptor**
4	Asian
1	European
2	Māori
5	Middle Eastern/Latin American/African
6	Other Ethnicity
3	Pacific Peoples
9	Residual Categories

Figure 7. Level 1 is the top fundamental level of the Stats New Zealand numbering hierarchy. All codes at the more detailed levels are derived from the level 1 codes. Adapted from HISO 10001:2017 Ethnicity Data Protocols (Ministry of Health, 2017).

"National data used to be categorised into Māori and non-Māori, which then improved to Māori, Pacific and Other [and] no Asian data included. That might be why we are not directly included in the DHB level…We hope Level 4 ethnicity break down data is implemented in the future as statistics are currently unavailable. This will allow us to have a more in-depth break down of ethnic data available. It means we can utilise our health budget to target specific ethnic groups."- **ASN1**

"…sometimes it's quite challenging to just call it Asian as an umbrella term, but we certainly know under Asian, they're all different, so we have been trying very hard to provide more subgroup level data so that we can really do good work to meet the needs of all our population from a cultural or language perspective."- **ASN2**

"So in order to get improvement, you need to know where you are failing and where you are doing well. So a fundamental marker and improvement is ethnicity-based reporting, if you are not using ethnicity-based reporting of all the metrics in the system, then how do you know where you are doing well or not? So the thing is, if you want to look at improvement, then you've got to report all your metrics by ethnicity. Otherwise, you are operating blind, how would you know where to put your effort? How do you know where the good learnings are?...we do have some reporting by ethnicity, but the question is how do we choose those areas?"- **MAO1**

4.3.5 Resource allocation

A lack of funding and resource allocation for the area of work in WDHB involved in addressing the health needs of the culturally diverse population groups (Māori health, Pacific health and Asian health) have been conveyed by participants. This can be observed in the form of a lack of employees in service provision roles or a lack of resources to implement initiatives relating to the needs of ethnically diverse patient groups. One Asian representative from the study suggested that the increase in the Asian population has subsequently led to increased demand on resourcing, such as interpreters, where there appears to be a shortfall of.

"…if you are committed to system's excellence, then resourcing will never be an issue since you want to invest in things that will achieve system's excellence."- **MAO1**

"…we don't have enough FTEs to cover all…so it's focusing on achieving more with less."- **MAO2**

"…we constantly experience the funding to be less than what we would like in order to respond to needs, and that is the biggest challenge…"- **PAC1**

"The demand has increased and the Asian population at WDHB has also been increasing over the last few years. So the demand for interpreting services has increased but they have been - unable to keep up with the demand because of the funding shortfall."- **ASN3**

"…we've got our Māori partners and Pacific partners, and we could probably do a whole lot more resources in those spaces. They're tiny wee teams…"- **ELT2**

4.4 Process of cultural competence

As discussed in previous sections, there are various cultural competency components that healthcare organisations can address in meeting the health needs of an ethnically diverse population, ranging from the individual level to the systemic level. This section looks at participants' opinion on how WDHB should make progress in cultural competence. There is currently a lack of consensus regarding which level of cultural competence is most important or which level of cultural competence WDHB should start addressing.

4.4.1 Level of approach

Eight participants expressed that all levels of cultural competence in the organisation are equally important, and efforts made to progress cultural competence at WDHB should not be limited to a single level even as the starting point since barriers related to cultural competency are also multi-levelled.

Participants conveyed that cultural competence among the frontline staff can directly impact on the clinician-patient encounter, which in turn can enhance the level of understanding and communication between the patient and clinician. Not only does this improve patient experience in the health sector, but can also increase the likelihood of patients adhering with treatments administered and hence obtaining better health outcomes.

While cultural competence at the systemic or strategic level does not directly impact on patient experience in the same way as clinical cultural competence, the implementation of the appropriate cultural competence strategies can create the required structure to support clinical cultural competence. An Asian representative has also noted that "*a top-down approach for any strategic direction or action plan might take a shorter time to implement, as the bottom-up approach requires more time for people's voices to reach the decision-makers".*

"…it could go both ways, in reality, that is probably how it works."- **MAO2**

"*It has to be done at all the…levels."*- **PAC1**

"…in a hierarchal organisation like this, it needs to be at all levels."- **PAC2**

"…both approaches are equally important. It is very important for frontline staff members to have cultural competency, as it will impact patient care directly…However, a top-down approach for any strategic direction or action plan might take a shorter time to implement, as the bottom-up approach requires more time for people's voices to reach the decision-makers..."- **ASN1**

"It has to come from the top-down and bottom-up."- **ASN3**

"…you have to do a bit of all of it, it's got to be multi-level because they're multi-level issues."- **SMT1**

"…the top-down is about removing barriers and embedding things like cultural competence in the strategy and direction of the organisation. And the bottom up is about how you would drive behaviour change at a personal level."- **OTL1**

Two ELT participants have conveyed that efforts to address cultural competence at WDHB should start at the clinician level since change can only take place when intrinsic motivation is present among the individual staff members. A workforce made up of many culturally competent individuals in an organisation can collectively result in whole organisational cultural competence. Systemic cultural competence is hence believed to emerge spontaneously in such cases.

ELT2 has further emphasised that while the presence of cultural awareness at the senior management level and the implementation of initiatives can help to support and advance staff's intrinsic motivation, it should not be regarded as the main driving force for change. Furthermore, ELT2 has expressed that in the absence of cultural competence at the individual level, relevant strategic initiatives will just be perceived as "tick-box" tasks to be carried out.

"…I think change comes from within. Ultimately when you learn about cultural competence, one of the most important things is understanding your own cultural paradigm. Being able to do that, then you are able to understand someone else's because you then have that empathy and that ability to be able to reflect."- **ELT1**

"…change is driven within the system by individuals…So if you focus on the individual, they will naturally cluster into teams and naturally motivate themselves for organisational competence to happen, then you will get systemic [cultural competence]"- **ELT1**

"Top-down never works, that's just enforcing stuff, and then we get people doing it because it's a tick box; I think it's both, probably."- **ELT2**

"Bottom-up is always better since there is that natural growth. Top-down is important in terms of saying this is what we need to do and this is the right way to do it, and mandating people to be released so that they don't feel that they have to take annual leave or a day off to attend courses."-**ELT2**

As mentioned earlier, there is currently a lack of initiatives in place at the strategic and policy level at WDHB to address cultural competence, which has also been communicated by three participants in the semi-structured interviews. The absence of any framework or assessment tools to ensure or assess the organisational cultural competence can be considered a reflection of the low prioritisation that the organisation places on cultural competence.

In the absence of strategies at the organisational policy level to address the culturally diverse population at WDHB, achieving cultural competence will need to depend on individual culturally competent champions to drive the change.

OTL2 has also conveyed that the "bottom-up approach is slower to achieve the results needed". Focusing on developing cultural competence at the individual level can create champions or cultural competence, but as discussed previously, without the adequate support structures in place, it may be difficult for culturally competent individuals to bring about any long-lasting changes. Establishing cultural competence at WDHB will hence consist of the "buy-in" of culturally aware leaders who have the power to effect change at the strategic level. This is considered an

effective means of addressing cultural competence as it allows the appropriate initiatives can be put into place.

"…I think to have some fundamental change, it's the policy level, system level and the environment level that will play a very important role to change the culture…"- **ASN2**

"…cultural competency is not really accounted for at a strategic level just means it's always going to sort of be up to individuals to promote it…"- **OTL1**

"…not having it weaved into our strategic direction, it means that people don't have to find it important, to think that it's low in priority for them."- **OTL1**

"There is no organisational policy or framework that addresses cultural competency at organisational, systemic, professional and personal levels."- **OTL2**

"The top-down approach is more effective, because, with policy and management buy-in, cultural education will be made mandatory, budget will be allocated for interpreting service, cultural support services will be resourced and adequately provided where the needs are identified, workforce recruitment policy will look at addressing cultural representation or employing bilingual or multilingual staff to meet the needs of the client groups; equity framework will include cultural competency training for educating health providers; etc…The bottom-up approach is slower to achieve the results needed, for example, providing cultural education can only help create champions for culturally competent practice and culturally competent individuals can only try to advocate for culturally responsive services and support clients who have complex cultural needs. It may be difficult to achieve change without resourcing and funding. In order for resourcing and funding to be made available, there is a need for management buy-in, policy [change] or [for it to be] a government priority"- **OTL2**

4.4.2 Continuous process

The idea of cultural competence being "an ongoing" and continuous process was conveyed by five participants in the study. The participants acknowledged that cultural competence exists on a continuum and "it doesn't stop" as it is not an endpoint destination to be reached. Cultural competence is largely an experience consisting of many stages that healthcare organisations can move through. At the individual level, clinicians' cultural awareness can be enhanced by education, but they don't automatically become competent, instead, it is a skill that needs to be developed through everyday encounters and practices. Similarly, the same concept is expected to apply to any of the other levels of the healthcare organisation in becoming culturally competent. Likewise, one participant has also communicated that barriers for moving along the cultural competence continuum can arise in the form of resistance, as "change in any sort will be difficult to deal with especially for those who are comfortable in the current context". Existence of "institutionally racist systems, procedures and infrastructure" have also been suggested to contribute to difficulties in implementing the necessary change towards cultural proficiency.

"It is not doing it online or attending workshops, it is continuous. This is not a one-off event, so can't be a tick-box task."- **PAC1**

"…I don't know if we would reach it, it's not a destination…"- **PAC2**

"…cultural change will take some time, we can't just expect it to happen overnight."- **ASN2**

"cultural competence…[is] an ongoing thing that happens all the time, and you get better at it, but you don't finish…"- **SMT1**

"…it's an evolution, it's a process, it's a continuous process, it's not something where you suddenly become culturally competent, so I think we've got to change the way that people think about it."- **ELT1**

"The fundamental barrier is that change in any sort will be difficult to deal with especially for those who are comfortable in the current context. Change in particular, since we live in a colonised society where the colonised population want to do things differently is even harder to make a change since there is going to be resistance, and some of that is just embedded through institutionally racist systems, procedures and infrastructure."- **MAO1**

One of the obstacles to addressing the ethnically diverse population within the healthcare organisation was the presence of institutional racism, also known as systemic racism. This has been described as an organisation's collective failure to implement professional and suitable services to people due to differences such as one's culture, colour or ethnic origin, and is a form of racism that can be observed in processes, behaviour and/or attitudes of a health care organisation; prejudice and stereotyping can emerge as a result, putting people of ethnic minority groups in the disadvantage (Macpherson, 1999). The eradication of institutional racism is likely to be a time-consuming process.

"…obstacle is that whether we like to admit it or not, we still have a level of institutional racism and unconscious bias in our system."- **MAO1**

"…there are a lot of issues in the hospitals about racism, lack of cultural competency. What I'd like to say is have you offered these people good training? Because if you haven't, then you can't blame them for being culturally unaware." - **PAC1**

"It's covert, but we're calling it institutional racism."- **PAC2**

"…also probably to do with institutional racism…Māori and Pacific people are less likely to be shortlisted for jobs, that's proven."- **OTL1**

4.5 Māori equity; the role of the Treaty of Waitangi

The Treaty of Waitangi, which is the founding document of New Zealand's government, plays an essential part in New Zealand, and similarly in its health sector. This will hence need to be taken into consideration when addressing the health needs of other diverse ethnic groups and that of Māori. The DHB's unique responsibility to Māori health outcomes as represented by the partnership established in the Treaty was acknowledged by all participants of this study. Regarding whether WDHB has taken a bicultural or multicultural approach, a range of viewpoints was conveyed, from a strong bicultural approach to an entirely multicultural approach. Five participants, however, agreed that both biculturalism and multiculturalism could and should function in parallel at WDHB. For the scope of this study, multiculturalism is interpreted as scenarios where all the different cultural or racial groups in society have equal rights and opportunities, while biculturalism refers to the construct of rights in New Zealand as Māori and non-Māori (Sullivan, 1993; Ward & Liu, 2012).

Only one participant believes that more of a multicultural approach has been taken, though acknowledges that there has been an inclination towards biculturalism:

"…they've probably taken a more multicultural approach, but we nod to biculturalism."- **OTL1**

Participants have also expressed that a bicultural approach is currently been taken in respect to the Treaty, but acknowledges the importance of multiculturalism:

"I think the approach by the Ministry is very bicultural, perhaps due to the Treaty, but at the service level, we have a very multicultural environment."- **ASN1**

"We know New Zealand is becoming a more and more diverse and multicultural society and we need to acknowledge that."- **ASN3**

"…multiculturalism is really important because that's about making everyone well, everyone has equal opportunity to live well." **– OLT1**

Other participants have expressed that a bicultural approach has been taken by WDHB, with mention of the position of the Chief of Tikanga on the executive leadership team of Waitematā and Auckland DHBs. The main purpose of the role is to guide the DHBs in carrying out their obligations to the Treaty by facilitating relationships with mana whenua and Mātā Waka ("Executive Leadership Team", 2016). Participants similarly emphasised the focus on Māori for the plans and strategies have been taking place at WDHB so far:

"…bicultural is priority…You can see that in the structure, where the Chief of Tikanga is positioned in the structure."- **PAC2**

"More and more of our plans and strategies that we're being asked to think about is through an equity lens, and it's fairly focused on Māori health outcomes."- **SMT2**

"…given the KPIs it has, it probably is more bicultural than it is multicultural."- **SMT2**

Participants conveyed that while WDHB functions in a bicultural environment, there has been evidence of attention on multiculturalism:

"I think the organisation does take a bicultural approach, but when I look at the activities, it's clear to me that there are multicultural activities also occurring."- **ELT3**

"…bicultural approach is very strong…I've seen the shift to cultural diversity and multiculturalism…So I think that we do operate at a level of multiculturalism."- **PAC2**

"I think it's more starting to shift into a multicultural approach when working, so it is trying to respond to the different ethnic groups that are becoming prominent in the utilisation of our services, which have high needs in our community…"- **MAO1**

"…we have always taken a bicultural approach, but I have seen the last few years with the growing culturally and linguistically diverse population, while the organisation placed importance with the bicultural approach they are recognising the importance of working with a multicultural population."- **OTL2**

In respect to the Treaty and the growing diversity at WDHB, five participants have expressed that both a bicultural and multicultural approach can take place in "parallel" as they are "not mutually exclusive":

"…we have to understand that Māori have a Treaty, so they've got kind of legal rights to being represented at the governance level, they've got a legal right to participate in decision level making at the DHB, and that's kind of guaranteed in the Treaty of Waitangi, and that's not to say that other groups can't be given that right, it's just to say that with Māori, the Treaty right is already there…other groups should also participate, but their rights come from needs, so the DHB's approach and response are a bit different within the different communities that they engage with. I've never thought of it as an us-or-them mentality, we're all in this together, so what is best for them is best for everyone…"- **MAO2**

"Both approaches are in place in the DHBs and that is how it should be."- ***PAC1***

"We have a treaty responsibility that's under the legislation, so that's just the rules, and we have a responsibility to the population we serve, so it's both, and those things we can often do in parallel."- **SMT1**

"There's a bicultural approach in which there are Treaty partners, and in the Crown side of Treaty partners you can have multicultural approaches within, but they are not mutually exclusive."- **SMT1**

"I don't think they are mutually exclusive."- **ELT1**

"I'd say both."- **ELT2**

Māori population's unique position in New Zealand as the indigenous people are also reflected in the Treaty, which is something that will need to be acknowledged in the activities of WDHB:

"The bicultural approach is specific for Māori as indigenous people with a Treaty agreement with the Crown."- **PAC1**

"The indigenous people of New Zealand is a culture but they cannot be reduced to just another culture like the other cultures in New Zealand. As indigenous people, they have specific rights as recognised by international entities such as the United Nations and defined specifically in the Treaty of Waitangi."- **PAC1**

"…we need to do more bicultural thinking, and because we have a legislative responsibility to act in accordance with the principles of the Treaty of Waitangi"- **OTL1**

In addressing the multicultural population at WDHB, a Māori representative has expressed the importance of the Treaty in the multicultural context, and any multicultural approaches that do take place should come under the Crown side of the partnership. Similarly, attempts to address a culturally diverse population at WDHB should not detract from its efforts on meeting the health needs of Māori.

"I think the DHB is definitely trying to be more multicultural. Politically, it is an issue from the Treaty perspective because it needs to prioritise its indigenous population in the first instance and get it right for its indigenous Māori population"- **MAO1**

"There are only two partners in the Treaty relationship, and that's Māori and the Crown, and the Crown represents everybody else and Māori sit alone on their side of the Treaty. What happens sometimes is the DHB tries to shift other ethnic groups into the Māori side, but no, they need to stay on the non-Māori side, and it's not because they are not important, it's just that it is the Treaty relationship."- **MAO1**

"…it should not confuse its Treaty obligations to Māori with biculturalism and/or multiculturalism. So it can do whatever it likes in relation to multiculturalism, but not at the expense of Māori, its indigenous population."- **MAO1**

One participant has raised the concern that without any acknowledgement of the unique position of Māori, the effect of colonisation on Māori are downplayed. Therefore, the purpose of having a bicultural approach can help to mitigate the ongoing effects of such historical events.

"…the risk of only focusing on multiculturalism is that it denigrates Māori status as tangata whenua and the huge implications of colonisation, and those are ongoing. So I think we can't underestimate the impact to Māori of the process of colonisation, the impacts of which still go on today. So biculturalism is important to help put in place systems and structures that undo the negative impact of colonisation."- **OTL1**

Chapter 5: Discussion

This chapter will discuss the study findings with the current literature on cultural competence in culturally diverse healthcare, to answer the research questions. A visual representation of the cultural competency components and focus areas discussed below is found in appendix 3 and 4.

The research questions are:

(1) What are the components of cultural competence in ethnically diverse healthcare?

(2) How to reduce health disparities in an increasingly diverse ethnic population in New Zealand?

5.1 Cultural competence components and reducing health disparities

Eight components of cultural competence are proposed in this section, where focus areas for healthcare organisations in New Zealand have also been described under each of the components in order to reduce health disparities in an increasingly multicultural environment.

5.1.1 Cultural awareness and attitude

One component of cultural competence obtained from the research findings and supported by the literature is for health professionals to have an awareness of the existence of cultural diversity and its role in the patient-clinician encounter. This understanding is crucial since cultural differences between the patient and clinician can greatly influence the quality of patient-clinician interaction, which is underpinned by the trust and mutual understanding established. The literature adds to the findings by conveying that a major contributor to establishing a sense of understanding between the patient and clinician is having an awareness of each other's explanatory models, which is influenced largely by one's culture. The explanatory model in health has been described in the literature as the way an individual interprets their health condition, subsequently affecting their decision to seek care and their treatment expectations. Patients from differing ethnic backgrounds may take a more holistic approach to health and wellbeing that go beyond the physical body, such as by also incorporating spiritual needs which may differ greatly from how health and illness are defined in the Western biomedical paradigm of mainstream medicine. However, this was not explored extensively in the findings of this research. The literature goes on to further imply that when the clinician lacks cultural awareness, varying perspectives on health and illness cannot be explored properly between the patient and clinician, and mutual understanding and trust becomes difficult to obtain. This can lead to a lowered experience of care, which can also result in negative downstream effects such as non-adherence to treatments and non-attendance to follow-ups, all of which will affect patient health outcomes and contribute to health disparities. The research findings complement the literature by further implying that to effectively understand the beliefs and values of patients and the role of cultural diversity in the healthcare setting, practitioners need to first become familiar with their own

culture. Only when they are aware of their own values and beliefs and its impacts in the process of healthcare can they progress towards being culturally aware. Contributing further to the literature, participants have emphasised the importance for health practitioners to have appropriate attitudes towards cultural diversity and the desire to become more culturally competent. The research findings further convey the practice of self-reflection as a contributor in developing cultural awareness. Engaging in conversations about cultural differences and their implications for health can help increase the cultural awareness of health practitioners. The research further complements the literature by pointing out that a potential barrier that may hinder conversations around culture and its implications in health is staff feeling hesitant about having such conversations due to their unfamiliarity with the topic and the fear of offending others. Healthcare organisations can, therefore, encourage staff to have conversations about cultural practices with patients by developing policies and best practice guidelines to facilitate better practice. A good example of creating a supportive environment for those topics is to ensure that the health workforce has access to cultural education programmes. Similarly, healthcare organisations can also incorporate differing explanatory models into their models of care and encourage health practitioners to have the conversation with patients around their health beliefs and expectations, both of which can deepen health practitioners' cultural understanding. Focusing on these areas can result in more culturally aware health practitioners, enhance the patient-clinician encounter, improve health outcomes and reduce health disparities for ethnically minority patients. Cultural education and models of care are discussed in further detail in the following sections.

5.1.2 Cultural education

Both the literature and the research findings have described health education as an appropriate initiative to develop the cultural awareness of staff in healthcare by helping staff understand cultural diversity and its impact on the patient-clinician encounter. As previously described, they provide opportunities for staff to comfortably explore a topic they may not be familiar with. Providing cultural education for staff is hence an enabler of cultural competence as they contribute towards equipping health care providers with the tools, knowledge and skills to better manage and understand fundamental cultural factors that play a role in the clinical encounter. Furthermore, both the literature and the research findings are in concordance that it is the responsibility of healthcare organisations to help their staff become more culturally aware by providing them with adequate cultural education. Additionally, the research findings have stressed that providing cultural training to help staff understand and work with ethnically diverse population groups also reflects the organisation's priority to address the health needs of ethnically diverse population groups.

The literature suggests that the focus and nature of cultural education in healthcare can take two approaches. The first approach teaches staff how to interact with patients of diverse cultural backgrounds in a general sense via focusing on developing skills such as openness, kindness and empathy towards those groups. The second approach to cultural education is categorical, which can consist of the exploration of the values, beliefs and customs, in addition to the historical

and demographic experience of specific cultural groups. The literature further conveys that a potential disadvantage with focusing on engaging with patients of specific ethnic groups is the underlying assumption that all members from the same ethnic group hold similar values and beliefs. This may not always be the case since members from the same cultural backgrounds may have different health beliefs and expectations due to differences in other factors such as acculturation or socioeconomic status. Furthermore, culture is not static but is a process, where people's cultural understanding of their health needs and beliefs may change over time, even within an ethnic group. The potential for differences to exist within ethnic groups have also been acknowledged by participants in the research findings. Likewise, the cultural education described in the finding has also taken a general approach by teaching health professionals how to recognise and understand the dissimilarities of different cultural paradigms in healthcare. While the literature acknowledges that teaching staff to work with patients from cultural groups that they see most often may be more directly applicable, this can be difficult to implement due to a large number of cultural groups that would need to be covered in increasingly multicultural regions. Furthermore, as mentioned in the literature, stereotyping may result when a categorical approach is taken. It is hence best for cultural education to take a general approach by enhancing health professionals' ability to understand and work with patients from differing backgrounds with differing health beliefs.

For the format of cultural education, the findings of this research conveyed that cultural education in healthcare can be presented as an online activity for staff to do themselves in their own time or in the form of an interactive workshop. While online modules are easier for staff to access and for the provider to implement, interactive face to face workshops has been described by participants to better engage staff members than online courses. This is especially the case when personal experiences are explored through narratives, facilitating conversations around cultural differences that can encourage the practice of self-reflection, all of which can result in greater cultural awareness. Healthcare organisations should, therefore, consider providing cultural training to staff via workshops in addition to online courses. The most effective format of providing cultural education is an aspect that requires further exploration in the literature.

The target audience of the cultural education provided by the healthcare organisation described in this research has been predominantly health professionals who work directly with CALD patients. Likewise, the literature has also focused solely on health professionals as the main stakeholder group for cultural education when addressing ethnically diverse populations in healthcare. However, participants in this study have also pointed out the potential effectiveness of targeting cultural education to individuals at more senior levels of the healthcare organisations and systems, such as those who are involved with the implementing/overseeing of strategies and operations. Developing the cultural competence of these groups can contribute to the implementation of processes and structures that take into consideration the health needs of culturally diverse population groups. Therefore, developing culturally competent individuals at the

decision-making level of the healthcare organisation or health system can contribute to the cultural competence at the organisational and systemic levels.

The effectiveness of cultural education in making the necessary changes in the attitude and behaviour of learners has been questioned by participants of this study. For the eCALD courses described in this study, there is currently a lack of objective measures in place to determine its influence on learners. The only measure is a pre and post self-assessment evaluation, which is largely subjective due to its self-reporting nature. However, participants in this study have reported positive feedback and have observed a positive effect on practice from staff who have undertaken the eCALD training. The effectiveness of cultural courses on the cultural awareness of health professionals determined by more objective measures has also been proposed in the literature. The review by the Cochrane Collaboration which looked at the effectiveness of cultural education by patient feedback supports the idea that a positive impact is made from cultural education for health professionals (Horvat et al., 2014). This is also consistent with the findings of an independent study on the effectiveness of eCALD courses conducted by the University of Auckland (2012) as described in the findings of this study. Despite the consensus in the literature and the study findings on the effectiveness of cultural education, the study findings have also questioned the sustainability of the effect of cultural training and the possibility for it to subside over time. The long-term effect of cultural training is hence an aspect that can be further explored by the literature.

The findings of this research also add varying perspectives to the literature on whether participation in cultural education should be mandatory or remain voluntary. The study findings show that mandating cultural education courses can expose all staff to cultural education, which is useful as it engages those who are not aware of its significance in healthcare or who would not otherwise have been aware of the courses available. However, there are drawbacks to making cultural education courses mandatory, which was also conveyed in the research findings; learners who are uninterested may view the training as a tick box activity, resulting in a lack of effective engagement. Similarly, participants have suggested there is a lack of autonomy for staff when the courses are mandatory, which may, in fact, be counterproductive. Despite the potential issues with mandating cultural education, the study findings suggest there is still a greater gain when staff are required to participate in cultural education courses.

In addition to providing cultural education, it is equally as important to make them accessible to staff, which can consist of having structures and process in place that both encourage and enable staff to attend. Findings from this research conveyed that barriers to receiving cultural education included having to apply for annual leave or a lack of staffing that may prevent staff from being released during work hours. To overcome these barriers, healthcare organisations should, therefore, strive to have protected hours for cultural training or provide the option for staff to do the course with time in lieu instead of having to apply for annual leave. Not only does this increase the access of health practitioners to cultural education, but it also signifies the value and importance of addressing the health needs of diverse population groups from the organisation.

Overall, increasing the cultural awareness of healthcare professionals via cultural education can improve the quality of the patient-clinician encounter for culturally diverse population groups, which correlates with improved health outcomes and reduced health disparities for the affected groups. It is hence important to expose all staff in healthcare organisations that serve an increasingly ethnically diverse population to cultural education, which can be achieved by mandating cultural courses. In New Zealand, instead of relying on registration bodies of specific health professions, healthcare organisations such as DHBs should have the responsibility to ensure that staff receives the relevant cultural education. This can be achieved via developing and integrating appropriate standards into organisational policies. Furthermore, to enable greater access to cultural education, it should be made available to staff to take as part of work, where staff should also be given the option to take it with time in lieu instead. The content of cultural courses should take a general approach by teaching healthcare professionals to understand cultural differences and their effect on the clinical encounter. In acknowledgement of the obligations and responsibilities of health care organisations to the Treaty of Waitangi, healthcare organisations should provide courses that educate staff on the role of the Treaty in healthcare in New Zealand, in addition to understanding the basic customs and protocols for working with Māori patients. In addition to providing online training, face to face workshops should also be available. Furthermore, instead of just focusing on enhancing the patient-clinician encounter, healthcare organisations should also target cultural education to health planners and funders, managers and clinical leaders in healthcare organisations to introduce cultural awareness into executive levels of the healthcare organisation. Objective measures should also be developed to measure the effectiveness of cultural education, where changes in the attitude and behaviour of staff are determined by patient experience and patient feedback.

5.1.3 Models of care

Incorporating the appropriate models of care for both indigenous and increasingly ethnically diverse populations into healthcare services has been proposed by the research findings to be a component of cultural competence. Patients from differing cultural backgrounds can have differing explanatory models which govern their explanations and understandings of illness, their health-seeking behaviour and expectations of treatment. The importance of adjusting models of care to different cultural groups and health beliefs has been acknowledged in the study findings, an aspect that has not been emphasised in the literature.

In New Zealand, cultural groups such as Māori and Pacific may adopt a more holistic perspective on health and wellbeing with a spiritual dimension compared to the more physiologically focused biomedical health model vastly utilised by the New Zealand healthcare sector. In respect to their obligation to meeting the health needs of Māori, the MoH has proposed three Māori health models; Te Whare Tapa Whā, Te Wheke and Te Pae Mahutonga ("Māori health models", n.d.). However, to ensure the Māori health models are effectively utilised in healthcare organisations,

standards need to be put in place to regularly assess the utilisation and effect of these Māori health models.

Acknowledging that one size does not fit all and developing culturally sensitive models of care to meet the needs of different population groups is an important component of cultural competence. In the absence of an appropriate model of care for diverse population groups, the health needs of those groups may not be met. The appropriate models of care can be incorporated into a variety of areas in the healthcare organisation. At the level of patient-clinician encounter, understanding a patient's model of care can help clinicians to make suitable treatment decisions in accordance with the patients' beliefs and understandings around health.

The fundamental basis for patients' decision-making process may consist of the interplay of many factors, including community and cultural beliefs, family attitudes and personal experiences. The research findings have suggested that conducting more qualitative research such as ethnographic studies with communities can enable healthcare organisations to gain a better understanding of the worldview of different cultural groups. While both the study findings and the literature have conveyed that one size does not fit all, there needs to be more investigation in the literature on how healthcare organisations can explore and determine the health beliefs of their differing cultural groups to develop more appropriate models of care that meet the health needs of all their population groups. Therefore, part of meeting the health needs of diverse patient populations consists of understanding the worldview for those groups and identifying what their values and beliefs are around health.

5.1.4 Cultural representation

The importance of the workforce of healthcare organisations to reflect the ethnicity of the population that it serves have been explored extensively in the literature in addition to being conveyed by the participants of this research. Cultural representation of diverse ethnic groups is suggested to be essential in all levels of the healthcare organisation as a component of cultural competence.

The research findings propose that greater clinician-patient engagement is achieved when patients are served by someone of the same cultural background as themselves, where a deeper level of understanding and trust can be established due to shared values and beliefs. This is also consistent with the literature which shows that when provided with the option of choosing their clinician, patients are more likely to choose someone of the same ethnic background as themselves. In accordance with these observations, participants in the study have described the existence of a natural affinity that patients have towards clinicians from a similar cultural background. This is with the underlying assumption that a common set of health-related values and beliefs are shared, which is usually dependent on one's culture. Cultural representation among the frontline staff can, therefore, contribute to improving the engagement and quality of the patient-clinician encounter. Due to the deeper level of understanding and an enhanced quality of communication obtained, patients are also more likely to adhere to treatment and to attend follow up appointments, all of which contributes to better health outcomes.

In addition to cultural representation among the frontline staff, participants of this research also communicated the importance of cultural representation at the senior management level. This is supported by the literature which emphasises that senior members from ethnic minority groups can act as representatives for the health needs of the cultural group that they identify with. They can introduce a culturally sensitive perspective into structures and processes implemented at the systemic level of the healthcare organisation. The effects of cultural representation at the senior level of healthcare organisations can be considered analogous to the effect of having culturally competent staff at senior levels, which can be achieved through cultural education, as previously discussed. In both scenarios, it can contribute to the cultural competence of the systemic level of the healthcare organisation, which can consequently affect access to healthcare services and the quality of care experienced by culturally diverse populations.

The study findings have highlighted issues with the concept and implementation of cultural representation that is not addressed in the literature. One major flaw in the concept of cultural representation is the underlying assumption that the values and beliefs of all those belonging to the same ethnic group are the same, which is not always the case as previously discussed. Furthermore, while a workforce with an ethnic composition which reflects that of the population it serves is ideal, difficulties can arise in practice where there is a diverse range of ethnic groups to be represented. This is also a potential barrier for a healthcare organisation's ability to embrace the concept of cultural representation. Additionally, although an attempt should be made during recruitment to create an ethnically diverse workforce, issues can arise when it is done at the expense of choosing the most skilled candidate for the job. More investigation is hence needed in the literature on the barriers and disadvantages of the concept of cultural representation.

Both the literature and study findings have implied that culturally competent leaders can take on the role of champions for cultural awareness. While the study findings have limited the role of champions to those in leadership positions, the literature has further proposed the existence of a social network effect at play. This phenomenon conveys that the most influential individual may, in fact, be the most popular and sociable person in a group setting, as opposed to someone in a formal leadership position. Likewise, the literature has suggested that role modelling via influential individuals may be more effective in cultivating attitudes associated with cultural awareness among staff than the impact provided by formal cultural education.

From the complementary perspectives on the effect of cultural representation in an ethnically diverse healthcare environment expressed in the literature and the study findings, it is evident that cultural representation contributes to meeting the health needs of ethnically diverse populations. As a result, greater health outcomes can be obtained and health disparities in quality of care and healthcare experience can be reduced for these populations. The study findings have also emphasised that ensuring cultural representation in the workforce can reflect the organisational values and priorities in addressing the health needs of a culturally diverse population. While an attempt should be made by healthcare organisations in New Zealand to achieve cultural representation for all major minority ethnic groups, cultural representation for the Māori population

should be made a priority. This is due to Māori being one of the population groups with the poorest health outcomes in New Zealand in addition to being the indigenous people of New Zealand and Treaty partners. Part of ensuring cultural representation for diverse population groups among the healthcare organisation can consist of targeted recruitment and retention of staff; both aspects will need to be addressed at the strategic level of the healthcare organisation.

5.1.5 Workforce capability

The literature explored for this study has described cultural awareness as an additional skill and knowledge that staff should strive to obtain once they are recruited into the healthcare organisation. However, findings from this research suggest that cultural competence is part of clinical competence- they are one and the same. Therefore, cultural competence should be a prerequisite to being employed into the organisation as opposed to an additional skill or ability that is to be developed. The findings of the study further indicate that having a basic level of cultural awareness should be made an essential criterion in recruitment. In cases where staff are not already culturally aware, they should at least demonstrate an understanding of cultural diversity in healthcare and a desire to become culturally competent. Incorporating such standards into the recruitment process can contribute to creating a culturally and clinically competent workforce that can better meet the health needs of an ethnically diverse population.

The study findings contribute further to the literature by stressing that in addition to focusing on hiring culturally aware staff, efforts should also be made by the healthcare organisation to retain staff that are already competent and capable as they are assets to a culturally competent workforce. This can consist of providing training and development opportunities for staff, such as cultural education, as previously mentioned. One potential barrier that may be present for staff to advance their cultural competence and capabilities is a lack of resources and opportunities available in the healthcare organisation. In addition to cultural education, healthcare organisations should also provide resources in the form of subject matter expertise for staff who want to develop their cultural skills and abilities. To better meet the health needs of the Māori population, Māori expertise such as kaumātua (elders in Māori society who are held in high esteem) should be made readily available and accessible to the workforce. The role of subject matter expertise as part of developing a culturally competent workforce requires further investigation in the literature.

The literature has further conveyed cultural competence to be a whole organisation effort, where a large collective body of culturally competent individuals is required to result in overall organisational cultural competence. The efforts of just a few culturally competent individuals can be diluted in the workforce when it is not valued and practised by the entire organisation. This is also supported by the findings of this study, which suggested that progressing along the cultural competence continuum should be the responsibility of the entire organisation as opposed to relying on the efforts of certain cultural staff members or teams in the organisation. The efforts of culturally competent individuals in the organisation are ineffective in meeting the long-term health

needs of ethnically diverse population groups in the absence of positive cultural norms being integrated into the organisation and practised by the entire workforce.

Creating a workforce of culturally competent and capable staff is a component of cultural competence. Only when the large body of the workforce in the healthcare organisation is culturally competent can they effectively meet the health needs of different population groups. This can then result in better health outcomes in the long term and reduced health disparities for minority cultural groups.

5.1.6 PHO enrolment and health literacy

Both the findings of this study and the literature conveys that there is lower health literacy among ethnic minority groups compared to the majority population group. This can result from a lack of familiarity with the health system due to differences between patients' country of origin and/or a lack of English language skills to navigate the health system and make informed health decisions. The literature further conveys that one's health literacy is an indicator of one's health outcome, where greater health literacy correlates to better health outcomes. Attempts to improve the health literacy of culturally diverse population groups is hence a component of cultural competence which healthcare organisations should address.

The literature has suggested that providing health education materials written in simple English for those population groups with limited English language ability is an effective way of helping those groups to understand health-related information. The study findings further contribute to the literature by suggesting the utilisation of local cultural community media platforms as an effective method to relay health promotional messages to ethnically diverse groups. This is especially effective for population groups with low English literacy skills. As mentioned already, more than 87,000 people in New Zealand was reported to not speak English from 2013 Census, where 68.3% of this group identified with one Asian ethnicity ("Statistics New Zealand", 2018). These population groups are hence unlikely to use the conventional news channels and social media platforms utilised by the dominant English-speaking population in New Zealand. Therefore, healthcare organisations in New Zealand should consider relaying promotional health messages via platforms commonly used by these cultural community groups in their language. This can increase the chance of the message being received and understood, hence increasing the health literacy of those minority groups with limited English abilities. The effectiveness of using media platforms commonly accessed by non-English speaking groups to convey health messages is something that requires further exploration in the literature.

The findings of this study further suggest that enrolment with a PHO, which provides primary health care services, can be considered an indicator of one's access to health services. In New Zealand, there is a greater proportion of people from the Māori and Asian population who are not enrolled with a PHO compared to that of the general New Zealand population, as described in the study findings. The low PHO enrolment rate among the Asian population has been correlated to a

lack of familiarity with the New Zealand health system. Part of reducing this health disparity can consists of regularly monitoring the PHO enrolment rate for these population groups, while also implementing the appropriate initiatives to increase the enrolment rate. For the Asian population, healthcare organisations can utilise Asian media platforms (ie radio channels, newspapers) commonly utilised by those within the Asian community to educate them on the New Zealand health system and importance of enrolling with a PHO.

The findings of this study have also proposed the effectiveness of engaging with ethnically diverse population groups via linking with community cultural groups in settings such as churches and Marae for the Pacific and Māori population respectively. The effectiveness of community engagement is supported by the literature, which has also proposed that communicating health messages to diverse ethnic population groups through trained community workers can facilitate better engagement, discussions and dissemination of health information. This is due to the family-orientated and community-orientated nature of these cultural groups.

Effectively implementing these initiatives can improve the health literacy and PHO enrolment rates of the otherwise disadvantaged ethnic population groups. By improving their ability to navigate the healthcare system and the ability to make more informed health decisions, a greater health outcome is likely to result, which can reduce the health disparities experienced by these populations.

5.1.7 Interpreting services

Both the literature and the study findings have acknowledged the importance of addressing language barriers in the clinical encounter. The literature further conveys that poor patient comprehension, ineffective quality of care and patient dissatisfaction can all be experienced by ethnic minority groups when accessing health care in the presence of language barriers. It has been emphasised that even in the presence of the slightest communication barrier, the effects on the clinical encounter can still be significant. While family members and friends of patients are often used as the interpreter, the literature has conveyed that this is not as effective as using a trained and skilled interpreter. It is hence essential for healthcare organisations to provide interpreters to meet the linguistic needs of patients as part of being a culturally component organisation. Findings from this research further suggest that the range of languages covered by interpreting services should include all the major languages spoken by non-English speakers within the region that the healthcare organisation serves. An adequate amount of staff covering these major languages should also be readily available, while interpreters for minor languages or dialects that are not required on a frequent basis can be hired on a casual contract. The minor and major languages required will depend on the region that the healthcare organisation caters to, which can vary largely in its ethnic composition. Providing interpreting services is a fundamental component of cultural competence when addressing an increasingly ethnically diverse population, since reducing linguistic barriers for minority patient groups can result in

greater access to healthcare in addition to greater health outcomes and reduced health disparities.

5.1.8 Ethnicity based data collection

The practice of ethnicity-based data collection in healthcare organisations has been conveyed in both the literature and the study findings to be an essential component of cultural competence. The literature has suggested that the practice of collecting health data by ethnicity can help healthcare organisations to determine where health disparities are experienced by ethnically diverse populations. These gaps in access to health care and health outcomes for minority groups can then be addressed by the appropriate ethnicity-based strategic planning. While the literature on ethnicity-based data collection has only touched on the importance of collecting ethnicity data, the findings of this study further convey the importance of the sensitivity of the ethnicity data collected. Due to the large amount of diversity that can exist within certain ethnic groups, disparities among subgroups may be present.

Healthcare organisations in New Zealand such as DHBs should hence be required to collect ethnicity data beyond level 1 of the Ethnicity Data Protocols. This will ensure that disparities within large ethnic groups coded at level 1 are captured. Consistent with the literature, the research findings further suggest that ethnicity-based reporting should be incorporated into all areas of health metrics in the healthcare organisation so that the health of all ethnic groups in every aspect of the healthcare is adequately reflected and addressed. Incorporating ethnicity-based health data into strategic planning can result in service improvements that meet the health needs of all cultural groups. Ethnicity-based data collection is especially important in an increasingly ethnically diverse setting such as Auckland, New Zealand in contributing towards reducing health disparities.

5.2 Approaching cultural competence

While a variety of opinions regarding how healthcare organisations should approach cultural competence are obtained from the semi-structured interviews, there is a consensus among the participants that healthcare organisations should ensure cultural awareness at the individual level in addition to introducing cultural competence into the structure and processes at the systemic level of the organisation.

From the cultural competency components and focus areas described above, it is evident that the quality of the patient-clinician encounter is the point for which many of the cultural competence components proposed are relayed through. Similarly, ensuring the presence of cultural awareness among individuals at the systemic level of the healthcare organisation has also been proposed to help incorporate culturally sensitive perspectives in the strategic planning and structuring of the healthcare organisation. Therefore, there is an interplay between the different components of cultural competence at the different levels of the healthcare organisation, as discussed throughout this chapter (appendix 3). This finding supports the literature (figure 4)

which has conveyed that ensuring cultural competence at each of the three levels of the healthcare organisation is intricately linked to the cultural competence at the other levels of the organisation. Both the literature and study findings hence imply that addressing an increasingly diverse population will require culturally competent actions to be taken at all levels of the healthcare organisation simultaneously.

5.2.1 Cultural competence is a continuous process

Varying perspectives on the conceptualisation of cultural competence in healthcare are presented in the literature, with some proposing that this is an obtainable goal via training and development, while others describing it as a dynamic process existing on a continuum without an end destination (figure 1). The findings of this research support the conceptualisation of cultural competence as a dynamic process, one that involves continuous progress and advancement to be made in all levels of the health care system. At the individual level of the healthcare organisation, clinicians can enhance their level of cultural competence through cultural education. However, this one-off event does not automatically result in culturally competent individuals, as it is a skill that requires constant development and progress through time and experience. The same concept applies to cultural competence at the organisational and systemic level of the healthcare system; creating a culturally sensitive workforce with the adequate structures and processes to address an ethnically diverse population is a continuous process that will require time and effort.

The findings of the study further contribute to the literature by emphasising potential barriers that may arise in the process of moving along the cultural competence continuum. Since responding to the health needs of different cultural groups can require a change in the current manner of working, resistance may come from those who are comfortable with the healthcare organisation as it currently is. Institutional racism is another potential barrier in the healthcare organisation's attempt to reduce health disparities for ethnically minority health groups. As conveyed by the study findings, these are deeply rooted issues that will require time to be overcome.

Funding and resource allocation towards areas of work in healthcare organisations that address the needs of a multicultural population is also crucial to effectively meeting the health needs of those patient groups. Funding allocated towards improving access to health care and quality health services for minority ethnic groups can be invested into a range of areas in the healthcare organisation. All the components of cultural competence described above require an adequate amount of resourcing for it to be carried out effectively. In the absence of a sufficient amount of funding in the area of ensuring culturally competent services, difficulties may arise in reducing health disparities for ethnic minority groups. The amount of resourcing that an organisation sets aside for work in cultural spaces can also be an indication of the value that the organisation puts on cultural competence. Furthermore, ensuring cultural competence at the strategic level of healthcare organisations such as DHBs in New Zealand can contribute towards effectively scaling

allocated funding across the organisation in a way that the health needs of diverse ethnic groups are also met.

The potential barriers in progressing along the cultural competence continuum require further investigation in the literature.

5.3 Māori equity; the role of the Treaty of Waitangi

As the indigenous population, Māori has a unique status in New Zealand. The partnership between Māori and the Crown as described in the Treaty continues to play a role even today, affecting all national care policies. Likewise, any approaches to address a growing multicultural population will need to take this into consideration. The role of Māori and the Treaty in healthcare has been acknowledged by all participants of this study. However, there is still controversy around the implication of the Treaty in practice. While participants of the study all recognise the growing cultural diversity in New Zealand and especially Auckland, and the need to address the health needs of those groups, there is a lack of consensus in how the matter should be approached. Majority of the participants agreed that both the health needs of the Māori population and that of other ethnic groups in New Zealand can be and should be prioritised and addressed at the same time. However, participants have stressed that addressing the health needs of the other diverse ethnic groups must not subtract from efforts put into addressing Māori health needs by the healthcare organisation.

The cultural competence components discovered and discussed in this study have been done so with acknowledgement given to the indigenous status of Māori.

Chapter 6: Conclusions and Implications

This chapter concludes the key findings from this research with respect to the two research questions and current knowledge in the literature. Recommendations for both the industry and the academic field of study are presented, and the limitations and suggestions for focus areas for future research are addressed. The research questions which this study address are:

1) What are the components of cultural competence in ethnically diverse healthcare?

2) How to reduce health disparities in an increasingly diverse ethnic population in New Zealand?

6.1 Overall conclusion

Eight components of cultural competence were discovered from this research. Focus areas have been proposed under each of the components for healthcare organisations to engage in as part of reducing health disparities for an increasingly multicultural population. The eight cultural competence components are: ensuring cultural awareness among staff; providing cultural education; developing models of care; ensuring cultural representation; reducing disparities in PHO enrolment and health literacy; providing interpreting services; ensuring a culturally competent and capable workforce; and utilising ethnicity-based monitoring**.**

The first component of cultural competence is ensuring all staff within the healthcare organisation have an awareness of cultural diversity and its role in healthcare. Understanding patients' explanatory models and health beliefs can enhance the quality of the patient-clinician encounter, which can result in better health outcomes for the patient, where part of obtaining an awareness of other cultures is having an understanding of one's own culture. This can be achieved through practitioners self-reflecting on their own beliefs and practices and engaging in conversations around cultural practices with patients and their families.

Providing cultural education is an essential component of cultural competence for healthcare organisations, and should be provided by healthcare organisations and made mandatory for staff at all levels within the organisation. This can contribute to an enhanced quality of interaction in the patient-clinician encounter in addition to ensuring cultural competence at the strategic level. The content of cultural courses should take a generic approach and teach staff to work with patients of diverse cultural groups in general. Courses on Māori customs and protocols in addition to the role of the Treaty of Waitangi should also be provided by the healthcare organisation and made mandatory for healthcare workers to take, where cultural education should be delivered via online courses in addition to workshops. As part of removing potential access barriers, staff should be provided with the opportunity to participate in cultural education during working hours instead of having to apply for annual leave or have the option to take cultural courses with time in lieu.

Objective measures also need to be developed to measure the effectiveness and long-term effects of cultural education.

Developing appropriate models of care to meet the explanatory models and health needs of diverse population groups is another cultural competency component. Part of developing models of care for diverse population groups consists of carrying out qualitative research to obtain a better understanding of the worldview and health beliefs of different population groups. Furthermore, standards need to be put in place to measure the use and effectiveness of the Māori health models that have been proposed by the MoH.

Ensuring minority ethnic populations are represented at all levels of the workforce is another component of a culturally competent healthcare organisation. Cultural representation among the frontline staff who directly interact with patients can enhance the patient-clinician encounter. Cultural representation at the systemic level can add culturally sensitive perspectives into the strategic planning and delivery of services, contributing to cultural competence at the systemic level. Ensuring cultural representation, therefore, helps healthcare organisations to better meet the health needs of diverse population groups, which in turn can contribute to greater health outcomes and reduced health disparities. Targeted recruitment strategies can be used to improve Māori representation at all levels of the healthcare organisation.

Creating a culturally competent and capable workforce is a component of cultural competence as it contributes to organisational cultural competence. Focus areas can consist of implementing standards for recruitment so that staff who demonstrate cultural awareness or a desire to become culturally aware are preferred candidates. Opportunities to progress staff's cultural awareness should also be made available. In addition to cultural education, healthcare organisations should also make roles such as kaumatua, who are expertise in Māori customs and practices, readily available to staff who would like to advance their knowledge in Māori culture and to incorporate awareness into their work.

Efforts to increase the PHO enrolment rate and health literacy of ethnic minority population groups are a component of cultural competence, since enrolling with a PHO correlates to one's access to healthcare services while health literacy determines one's health outcomes. The utilisation of ethnic media platforms can contribute to improving PHO enrolment. Furthermore, health literacy can also be improved by working with community groups in settings such as churches and marae.

Interpreting services should be provided by healthcare organisations to remove language barriers and hence barriers in accessing healthcare services, hence contributing towards a reduction in health disparities for affected minority population groups. The languages covered should depend on the linguistic needs of the population which the healthcare organisation serves. For major languages utilised by a large number of ethnically minority groups, an adequate number of interpreters should be readily available, whereas, for minor languages, contract interpreters can be employed.

Ethnicity-based data collection should be utilised in all health metrics to capture gaps in access to health services and health outcomes between different cultural groups, where the appropriate initiatives are to be taken to respond to the different health needs. In New Zealand, ethnicity data should be coded beyond level 1 of the Ethnicity Data Protocols due to a large number of subgroups that can exist among groups coded at level 1.

The process of cultural competence is a dynamic process, where healthcare organisations move towards the cultural proficiency end of the continuum as it meets the health needs of diverse cultural groups. For healthcare organisations to progress along the cultural competence continuum, action is required in all 3 levels of the healthcare organisation, ranging from the individual level to the organisational level. This is due to an interplay of the cultural competency components.

While resistance to change may be a potential barrier for healthcare organisations to progress along the cultural competence continuum, inadequate funding may also impede the organisation's ability in becoming more culturally competent and reducing health disparities among ethnic minority groups.

6.2 Implications

6.2.1 Academic

This research contributes to the current knowledge in the literature on cultural competence. The conceptualisation of cultural competence as a continuous dynamic process within healthcare organisations is supported by the study findings. In progressing along the cultural competence continuum, culturally competent initiatives at all levels of the healthcare organisation should take place simultaneously. The finding presented in this study hence strengthens the current understanding of cultural competence in healthcare organisations, by suggesting that cultural competency components exist at varying levels of healthcare organisations, each of which affects the other. The findings can, therefore, act as a stepping stone for further exploration of the various ways cultural competence in healthcare organisations can be articulated, and how health disparities can be reduced in an increasingly ethnically diverse population.

6.2.2 Industry

The finding of this research should help healthcare organisations in New Zealand such as DHBs to progress along the cultural competence continuum. By engaging in the focus areas proposed under each of the eight components of cultural competence, advancement towards reducing health disparities for a growing multicultural population can be made. The research findings can, therefore, as a guide in helping healthcare organisations to develop indicators and quantifiable baseline targets and values specific to the health needs of their population. The cultural competency components and focus areas identified in this research are very much preliminary in their nature. Further research can be done to identify more specific areas of focus within the

cultural competency components, especially as healthcare organisations progress along the cultural competence continuum. Implementation of the appropriate action in healthcare organisations in New Zealand can result in a reduction in health disparities for ethnically diverse population groups while also acknowledging the unique status of Māori as the indigenous population of New Zealand.

6.3 Limitations

This research utilised a non-random purposive sampling method, where the selection of and contact with participants were made with assistance from the researcher's industry supervisors. Despite efforts made to reduce bias in the research process and findings, this would have likely to affect the findings of the study to some extent.

Due to the scope of this research, the study consisted of only 14 participants from WDHB, which is a small number in comparison to the total number of employees at WDHB in roles that would qualify them to participate in this research. Similarly, while the study consisted of the perspectives of participants from a range of positions and teams (ELT, SMT, MAO, PAC, ASN, and OLT) within WDHB, there was a small number of only 2-3 participants representing each group. This makes it difficult to generalise the views captured from the study to the views of all the WDHB employees.

Even though the research was a case study at WDHB, the DHB with the largest resident population within its catchment area in the country, WDHB cannot be considered representative of all the DHBs in New Zealand (About DHBs", 2018). This is largely due to the different ethnic composition of the resident population of WDHB compared to that of other DHBs. Consequently, there are differing population needs and activities, and hence perspectives on cultural competence. The findings of this study are hence largely based on the scene at WDHB, and we cannot speculate that the same findings would have been obtained had this been a case study at another DHB in New Zealand.

6.4 Future research

This research was based on a case study in an organisation which is responsible for the funding, planning and delivery of health services. Future research could target the process of becoming culturally competent for healthcare organisations with a more specific focus. This can consist of undertaking case studies in healthcare organisations that engage exclusively in either the funding, planning or the delivery of healthcare services.

The unique status of Māori has been taken into consideration during this research process. However, the issue of how to incorporate the inclusion of the ethnically diverse groups served by healthcare providers within the framework of the Treaty of Waitangi obligations and responsibilities is an ongoing discussion. Future research can hence consist of obtaining more in-

depth views from healthcare organisations in relation to improving health outcomes for ethnic minority groups in New Zealand from a Treaty of Waitangi perspective.

As the patient-clinician encounter was found to be a key avenue for culturally competent practices to act through, future research could also consider involving patients and frontline staff as study participants to gain a better understanding of how the patient-clinician encounter can be enhanced for culturally diverse groups. Likewise, to obtain a more comprehensive understanding of cultural competence at the strategic level, prospective research efforts could also include the views of board members in addition to strategists and policymakers in the MoH.

Appendices

Appendix 1: Research findings- categories and themes from thematic analysis

Appendix 2: Quotes from primary data collection

Codes, categories and themes	Quotes
WDHB is doing great overall	*"The district health board has done a lot of good things…but at the end of the day, if you are to look at the equity measures, we've still got a long way to go, and a lot to do in order to improve the health and wellbeing of our whānau."*- **MAO1** *"…overall, we're trending in a positive direction, whether we actually close those gaps completely in one time."*- **PAC2** *"…because of my journey I feel that I am very valued as a member of staff of the DHB…we are very well supported as employees"*- **PAC2** *"Our DHB is doing very well compared to others, but there are still a lot of areas to improve on in terms of resources and equity."*- **ASN1** *"…for this DHB…it's already great, we do have room for improvement, but I think we have already got a very good framework in place…"*- **ASN2** "*We already do quite well...the training that we have is fantastic and so much hard work has been put into that."*- **ASN3** *"…pockets of amazing examples" and "good best practice [at WDHB]"*- **SMT2** *"…I would say good, but could do a lot better…You can always improve, so constantly, there is no endpoint for improvement. You just always want to get better. So I think just on this, we could do a lot better. There is so much more room for improvement. But I always see that as a positive, we are on a journey and this is just constantly iterative. I think we could do better, we could go faster, we could scale faster."*- **ELT1** *"...as an organisation, acknowledging and reflecting all of our staff in the communities that we serve and ensuring that people feel supported, that's grown hugely."*- **ELT2** *"I hear the conversation around how people want to respond to their patient cohort in the context of their model of care, and I think that's really positive."*- **ELT3**
Correlation of cultural competence with good health outcomes	*"…if you're interacting with culturally competent staff, you're much more likely to firstly engage with the health system at all…conversely, if you don't have culturally competent staff, people aren't likely to engage, that has implications"*- **OTL1** *"…in the context of adhering to treatment plans and things like that, people are much more likely to actually stay on their medications, stick to the plan if they've been dealing with people who have created an environment of trust and rapport, which you wouldn't necessarily get if you didn't understand the cultural implications of people's ideas of health and wellbeing."*- **OTL1** *"…cultural competence pervades people's engagement or not with the health system, so their good or bad experience then does absolutely have implications for their health outcomes because it will directly impact their self-care or their decisions to actually be cared for by others."*- **OTL1**

	"Not being culturally competent can lead to misdiagnosis, miscommunication, misunderstanding, non-adherence with treatment, and follow up and care as well as disengagement by CALD clients"- **OTL2** **"***Health providers who are culturally competent and have the ability to communicate effectively with clients from diverse cultures will improve patient outcomes and patient experience. If health providers have better insight into their own cultural values and beliefs and have the ability to recognise and evaluate cultural differences and how it impacts their communication or interaction with their clients; and gain an understanding of what it entails to be culturally inclusive and sensitive and know how to apply cultural empathy and compassion appropriately and have skills to adjust their communication, attitudes and behaviours to accommodate and respond to different cultural values beliefs and practices, it will enhance patient health outcomes and patient experience."*- **OTL2**
4.1 Cultural competence at the individual level	
4.1.1 Cultural awareness	*"I think it needs to incorporate things like attitude change…"*- **PAC2** *"…people need more education around attitudinal change, understanding that they can respond more appropriately."*- **PAC2** *"…it's about people accepting the fact that this is a diverse population, in terms of culture, and many other things."*- **ASN2** *"…it's how you make it personal, how you have the right kind of narratives or stories that allow people to reflect on their own behaviour because cultural competency as a journey involves some pretty serious self-reflection if you're going to do it well."*- **SMT1** *"…that reflection stuff, I think that's the core of what you need to get a change in, and it's a really hard thing to do."*- **SMT1** *"…you need awareness before you can start to build things."*- **SMT1** *"…an understanding of the different cultures of the population you serve is paramount for us to be able to do our job effectively."*- **SMT2** *"…you actually learn about your own cultural norms and beliefs as part of your learning process…"*- **ELT1** *"…you learn about yourself as a start, to help you understand others…"*- **ELT1** *"…when you learn about cultural competence, one of the most important things is understanding your own cultural paradigm. Being able to do that, then you are able to understand someone else's because you then have that empathy and that ability to be able to reflect…"*- **ELT1** *"[Awareness of cultural competence should be] integral and of equal importance as anything else, along with your academic knowledge and clinical knowledge"*- **ELT1** "*…you have got to look at what motivates people to want to pay attention and want to change, want to learn and grow."*- **ELT1**

	"…one barrier would be people's desire to do it or not, to care about it or not, and I don't imagine that all of our staff think the same about the value of cultural competency training, or the need to be culturally competent."- **OTL1** Racism: *"…organisational development is really key in terms of looking at our own systems and processes and undoing institutional racism in our organisation…if you wanted to do away with institutional racism, cultural competence would be critical to that because part of it is about understanding yourself, your own culture and your similarities and differences from other people, and that difference is okay. Racism is essentially that difference is not okay."*- **OTL1** *"…one of the barriers is people feeling really nervous about talking about it. Because they don't want to be offensive by appearing that they are ignorant about cultural competence…"* **- ELT1** **On understand the importance of addressing Māori health**: *"…at the senior level for sure, but as you go down the layers, it gets less and less certain; the front-line staff, in particular, are difficult, some do ask 'why are we doing this for Māori, I don't see any value in this for my role?"*- **MAO2** *"If you ask a sick patient in the ward how they are feeling, they may say they are 'well' even though there may be a mismatch with their physical condition, but if the family is well and thriving and they've met all of their cultural responsibilities, and if we know that those are dealt with, then actually we're really well and we're really blessed…"*- **PAC2** "… *I think understanding that maybe it's how we prefer to be treated, and finding solutions that better equate to that, that definitely improves people's desire to visit a doctor or someone for your health."*- **PAC2** *"…we'll have to think about…what is the best way for the doctor to communicate with the patient? So that's language and the belief of health and the patient or client's understanding of health care, illness, treatment, because she may have her own thinking about what wellbeing is."*- **ASN2** *"…link with people in the right way right up front in terms of meeting not just their cultural needs but the things they expect from us in health service and having that conversation right upfront about what we can do and can't do and how we keep the gap closer…"*- **ELT2**
4.1.2 Cultural education at WDHB; eCALD	*"I think Sue Lim's work is regarded not only locally, nationally, but internationally excellent…"*- **PAC1** *"eCALD has been providing cultural training courses for secondary and primary health service providers…and they provide the courses nation-widely."*- **ASN1** *"…eCALD has been a massive important national piece of work. And I think that's given a lot of awareness to diversity into how you respond to a whole range of patient needs and be able to have those conversations and I think that's been an incredible investment and labour of love from Sue and the team."*- **SMT1** *"…the eCALD programme, which is the flagship of the education that the organisation provides."*- **ELT3** On eCALD: *"…that is an absolute gold standard, there's nothing of it in the world that I know of."*- **OTL1**

	"…feedback from people who joined the course or took up the course because it is a mandatory requirement by their professional bodies, and given feedback showing a change of attitudes and behaviours."- **OTL2**
4.1.2 Cultural education at WDHB; Mandatory vs voluntary	*"…the fundamental modules [of eCALD] should be made compulsory and everyone should do it."*- **ASN2** *"…the DHB has made some modules compulsory, I think module one is already compulsory, so that's a good starting point…"*- **ASN2** *"…should be mandatory."*- **ASN3** *"…it should be mandatory for everyone to do…"*- **SMT2** *"Part of being a health professional is learning and having this thirst for knowledge and learning. So I think that it should just be mandatory, and I think that with the right approach, people will embrace it."*- **ELT1** *"…in principle, making it mandatory is good. There are logistical issues in putting this into practice and just making it mandatory will not make [cultural competence] happen."*- **PAC1** *"…making it mandatory means that… everyone will be exposed to cultural competency training. And they may or may not absorb it, if they're less engaged, they may not retain so much knowledge. And so obviously, the downside of that is that again, that's extrinsic motivation. So people haven't chosen to be there, and so potentially will not engage so well."*- **OTL1** *"I don't think mandating it in terms of 'you must attend that course' will do anything for it. In fact, I think it will probably turn people off."*- **ELT2** "*It should be made to be interesting and exciting, so people choose to do it amongst the very many mandatory training that they are already required to do."- **PAC1*** *"People think the key is to make it mandatory, the evidence for me is not there, that by making it mandatory will be able to increase the numbers…people might just attend because they have to, to tick the box, but do you actually get behavioural change?"*- **PAC2** *"Making courses mandatory in general does lead to people doing it to tick the box. However, I do think it is a good idea to make at least the CALD 1 course mandatory because I have seen changes in attitudes after completing the course even for those who were required to take the courses as part of being a mandatory requirement based on the feedback from the learners."*- **OTL2** *"I have feedback from people who joined the course or took up the course because it is a mandatory requirement by their professional bodies, and given feedback showing a change of attitudes and behaviours…"I'm taken by surprise by what I have learnt from the course and I am going to implement changes in my practice"*- **OTL2** *"I get good feedback from people saying that when they've done it; they've really enjoyed it and it was new and interesting information, often not stuff they've come across in their undergraduate courses, which is interesting since you'd think they'd have a lot of that in their undergraduate courses."- **ELT2*** *"Yes, it's not mandatory…we can't make people do it…people do it because they are interested in the whole, so we don't get people going off and doing it because they have to…but we still get really good*

	uptake, and that's because people understand they are working in a really diverse environment and they want to learn."- **ELT2** **"***Even if the person doesn't use those skills immediately, they may start using it in the future when they do realise it is something important to address…"*- **ASN2**
4.1.2 Cultural education at WDHB; Determining the effectiveness of cultural courses	*"…to collect pre and post CALD training feedback from learners…Currently, all [the] evaluation is self-reporting by learners and [there is no] evaluation to measure direct patient outcomes as a result of health providers completing [the] course."*- **OTL2** *"…not sufficient by itself…behavioural change is also really, really hard…would be one component, but it wouldn't be sufficient by itself."*- **SMT1** *"The course is there and sometimes as a tick box people do it, we know how many people have done the course, but we don't know what impact it has had on the other end…how do we measure what difference training has made when a staff member interacts with patients?… Do they fall back on their default unconscious bias?"*- **ASN3** *"…eCALD has a before and after self-evaluation…good feedback from learners. However, it's not consumer (patient) feedback…"*- **ASN1** "*…cultural competence is judged by the patient's experience of health care."*- **PAC1** *"Through the online platform, and actually the face to face courses as well, there is an evaluation of learner satisfaction, and those scores are really high…but their enjoyment is irrelevant if it doesn't lead to behaviour change. So what we want is for that content to influence the way they behave towards others. And there have been two independent evaluations done with eCALD that have touched on behavioural change, but they're wholly subjective so it's just people reporting before and after the training, whether they would change their behaviour or not, right, so what we haven't yet done is actually gone and observed behaviour change…So I think that's the bit that's missing. We haven't 100% proved that it changes behaviour, but we know with absolute confidence that people report it does."*- **OTL1** *"And that's the challenges for these programmers, is how do you actually measure outcomes? Which is what we are always trying to achieve, what health outcomes could we measure? We could measure patient experience, we could get feedback from patients to tell us, you can get feedback from this person…So there is well-developed sort of patient surveys, but the bigger challenge is around outcomes, even just making that cause-effect relationship…But that is the challenge for us and that's the exciting bit; how do we measure…is being a research engine and trying to work out how can we get robust research around and evidence and how do we measure the effect on health outcomes? But we have got proxy measures and we know things like people who don't attend clinics or don't interact, or they opt out of the health system, they don't access the health system and it's a barrier that they report. They don't feel that they can receive culturally appropriate treatment or treatment from health professionals that are appropriate. So there are proxy measures but the biggest challenge that we have really got is to, and it is really important that we do- because part of bringing people on board and being able to understand why it is important, is to be able to have evidence and show them. Especially clinicians, clinicians and*

	particularly doctors are data-driven. Epidemiologists say they like data, so they will say, show me why I should do this, what's the evidence."- **ELT1**
4.1.2 Cultural education at WDHB; Expanding to other target populations	*"There is very limited cultural competence training available for staff, nothing in place particularly for management, never been done for Board members."*- **PAC1** *"But there are lots of elements that would be great to grow the eCALD platform on, because for Māori, it doesn't cover Māori and so I think that's really something that we need to tap into and to integrate…share the platform so that we embrace and increase the number of cultures that it covers."* - **ELT1**
4.1.2 Cultural education at WDHB; Situational/disease-specific cultural competence training	*"…the next level is disease-specific."*- **PAC1** *"…specifically designed for the service and are also problem-solving based to deal with issues that can't be resolved by online training only."*- **ASN1** On Māori and Pacific courses: *"…not as comprehensive as eCALD, its' sort of a singular online training module about how to engage with Pacific, as with Māori, a singular thing about a little bit of insight into Māori worldviews and protocols and Treaty responsibilities, as opposed to eCALD, which has gone into situational training."*- **OTL1**
4.1.2 Cultural education at WDHB; Face to face, experiential, interactive learning	On Pacific Best Practice Programme: *"The electronically based training is really good since there is a lot of factual stuff. The next level is interaction."*- **PAC1** *"I personally think face-to-face workshops normally provide more opportunity for learners to think deeper through their discussions during the sessions."*- **ASN1** *"A few years ago I had done this Treaty of Waitangi training and we also had a Marae visit, understanding some of the protocols there, so those kinds of training could be helpful."*- **ASN2** *"…we find the face to face one quite good interaction across the team; you can go through narratives and stories and experiences better in a face to face environment…"*- **SMT1** *"…experiential learning is really important."*- **ELT1** *"…we have got a lot to do to help professionals realise that learning to be culturally competent isn't actually having to sit in a classroom and learn how to be culturally competent; it's interacting with your patients, having coaching, how to integrate that in time."*- **ELT1** *"…use patient stories and experiences, I think that could be a way forward in enhancing people's cultural competency."*- **SMT2** *"…I think most of the time, it's through those patient stories that people identify more effectively with…"*- **SMT2**
4.1.2 Cultural education at WDHB; access barriers	*"So staff leaving to attend the cultural competency programmes is an issue, we're depending on managers releasing staff since they are faced with minimum hour study leave backfill that they have to organise when their staff goes."*- **PAC2**

	"…access to training and development opportunities is one of the biggest things we can do to make people feel valued, and people don't have protected time to go to take advantage of those opportunities…clinical practice takes precedence."- **OTL1** *"…it's very important that we look to see how we can protect time for training."*- **OTL1** *"…what I hear from clinicians often is 'I'm too busy, I'm just too busy for that, that's an add-on to make myself go to training too. And also that 'feeling like it's not really me."*- **SMT1** *"…as an organisation there is an obligation on the organisation to make sure staff can go; make them available during their work time…"*- **ELT1** *"…anything that is training about your ability just to perform your role to the best of your capabilities should be considered working."*- **OTL1** *"…clinicians that get told they need to take annual leave to attend those kinds of internal events when from my perspective, it's about creating a supportive community of peers, so you know you're part of something bigger and that you've got a support network around you if you need it. So I'm constantly saying, this is not annual leave, this is work. You should release them and pay them, not annual leave, just pay them."*- ***ELT2*** *"…we need to be able to release people to attend these courses, functions or whatever. We need to mandate that happening."*- ***ELT2*** On being released for cultural training: *"It shouldn't have to be a battle."*- **ELT2** Barriers to accessing cultural education: *"…they're not mandatory."*- **SMT2** *"So it's up to them to see it, or someone actually offer it to them or enrol them or whatever, for them to actually know more about it. So they're there if you're looking, but what's the carrot to make you look, what's the carrot to make you go? And if there is no carrot, should we make it mandatory?"*- **SMT2**
4.2 Cultural competence at the organisational level	
4.2.1 Cultural representation; Lack of cultural representation at the senior management level	*"…mostly non-Māori exists in our senior management, executive leadership and governance level, and poorly on the board level. So in my view, that is not enough."*- **MAO1** *"There is no Pacific presence at Board level, or at Board sub-committee levels, there is a Pacific general manager which is Tier 2 and Pacific planning/funding manager which is Tier 3."*- **PAC1** *"…the diversity within our leadership teams are quite limited. So how as a health board can we be seen to progress, to be culturally competent if the representation within our current senior management team is quite limited."*- **SMT2** *"…there is a balance in being entirely prescriptive and saying well these are our demographics and you have to have representation because you want to appoint people to skill. But…you absolutely need people with insight, with empathy, with a deep understanding of what you are trying to achieve. So I think it is really important that you do have diversity reflected and particularly at the executive and the senior*

	leadership level where strategic decisions are being made…I think you do need diversity, but you absolutely need people with skill there. But I don't think it's an excuse to say that you have to have the most skilled people because that can be a barrier and that can exclude people, or be an excuse not to be diverse. So I think it is really important that we should always strive to be representative and strive to have that voice there, the diversity there that you need.”- **ELT1** *“I think we know we have underrepresentation. Like if you even just took our diverse population and you reflected that in our middle senior leaders, it doesn't reflect our population. So there is work to do there. But, there is reasonable diversity amongst our workforce.”*- **ELT1** *“I think if you’ve got representation [in ELT], that filters down and people feel represented, so they feel stronger in themselves, and feel like that they’ve got someone there representing their viewpoint, but also they’ve got someone who they can go to if they've got any issues.”*- **ELT2** *“…our staffing currently doesn’t really reflect our community.”*- **ELT2** *“Staff is always going to be a snapshot of the population since people that live in the community will kind of be a representation of the community but we’re not quite there in terms of representing to the same percentages.”*- **ELT2** *“From a cultural perspective, I think we can do better.”*- **ELT2** *“…if I think about the executive, we could definitely do with more diversity.”*- **ELT2** *“In the context of our board and our executive team, they're not reflective of the population at all; we have a Māori CEO, there are two Māori board members, but we don't have much other diversity in those groups, so the board otherwise are largely Pakeha, as are the executive team”*- **OTL1** *“…more could be done to grow the next layer of senior executive and board members…”*- **OTL1** *“At Board, ELT and SMT levels there is no Asian or Middle Eastern or African representation.”*- **OTL2** **Historical:** *“I think it's just historical, how it's been set up, and it's being challenged every now and then but not pushed hard enough”*- **SMT2** *“…one thing that I do find interesting is that we have a general manager for Pacific health, General Manager for Māori Health and no general manager for Asian health. So Asian health services sit under our director of patient experience, whereas the other two are departments in their own right, with a place on the senior management team…I think it’s historical…”*- **OTL1**
4.2.1 Cultural representation; Lack of cultural representation at the senior management level; Lack of Asian	*“Asian representation in decision making, since there's currently nobody advocating in the decision-making area. We have a 26% Asian workforce in the WDHB in 2018, but none of the senior management team members is Asian. This is something we need to address.”*- **ASN1** *“SMT doesn’t have any Asian representative to provide diverse views and Asian perspectives…”*- **ASN1** *“Asian representation is also missing from the mainstream clinical governance group.”*- **ASN1** *“We need to be included in the decision-making process because there are still areas that can be improved.”*- **ASN1** *“…advocating for Asian representation at the DHB decision making level.”*- ***ASN1*** *“Māori and Pacific groups have good representation at senior and clinical governance levels. Since they’re already national priority groups, their cultural decision making is enabled by national policy.*

representation in the senior management level	*However, the Asian group is relatively new, so there's no specifically relevant national policy or guideline. We are often excluded from the senior and executive level decision-making process."-* ***ASN1*** *"…we want to have official representation at the senior level."-* **ASN1** On Māori and Pacific Health teams: *"…they report directly to the CEO…they can talk to our leadership straight away if there is any concern. A national health & disability policy for Māori and Pacific people ensures resources [are] readily available to them as the population have high health risks. Māori and Pacific teams have their own GM, Pacific nursing director, and workforce consultant specialist in HR, executive assistant for the GMs, and are fully structured."-* **ASN1** *"…at a senior level there is a lack of Asian representation. From my understanding, there is no Asian representation at ELT and also at CPHAC (community and public health advisory committee)."-* **ASN3** *"Māori and Pasifika have representation on the SMT, whereas the Asian services don't."-* **SMT2**
4.2.1 Cultural representation; Cultural representation among the frontline staff	*"…poorly at a frontline staff level; we don't have many Māori staff here at all."-* **MAO1** *"We have a 26% Asian workforce in our DHB, so I think we are recruiting well and reflect the DHB population. Asians are working in both clinical & non-clinical services that serve vital hospital functions."-* **ASN1** *"The workforce population within WDHB for Asian is overrepresented."-* **ASN3** *"…we've done pretty well with the Asian health workforce, we're over-represented compared to our population for Asian health, we've still got work to do with Māori health and Pacific health and also internal work around pathways to career advancement."-* **SMT1** *"…we have a high Asian staff profile…that's a good representation of our population, but not Māori and Pacific; the current staffing profile does not represent the population for Māori and Pasifika. So our understanding of their cultural competence is quite challenging."-* **SMT2** *"Asian workforce is adequately represented at the frontline level."-* **OTL2**
4.2.1 Cultural representation; Correlation of cultural representation on health outcomes	*"The system tends to favour the people that work within the system or the ethnic groups that work within the system, so we have a largely non-Māori workforce. So 92% of the New Zealand health system is non-Māori, so it's not surprising that the system works well for non-Māori people since there is a similarity and strong commitment to the health and wellbeing of non-Māori people within our community."-* **MAO1** *"…as any ethnicity, you just have a natural affinity, it's just a different sort of engagement type."-* **MAO2** *"…increasing the proportion of Māori working within the DHB as well as other ethnicities obviously is going to support some of these culturally orientated kinds of questions. We are not only preaching to the converted but within services, we do have champions who understand it and get it."-* **MAO2** "*Cultural representation bring cultural competence to the response of the healthcare system to patients. This will improve the patients' experience of care and will avoid incorrect diagnosis and treatment and will contribute to better outcomes where that is technically possible."-* **PAC1** *"…people respond better to health workers who look like them, who identify with the same issues, not necessarily physically look like them but have similar values and beliefs."-* **PAC2** *"It [affects] immensely and across all levels of the patient journey…respecting and acknowledging cultural beliefs plays a huge part in one's recovery."-* **ASN3**

	"…it is absolutely critical."- **ELT2**
4.2.1 Cultural representation; Issues with cultural representation	*"It is ideal to have cultural representation from frontline to executives, but I think we need to acknowledge cultural component may not be the priority requirement for that job. In cases where skills are prioritised as the top, only when the skills distribution of the ethnic populations is similar to the requirements of the DHB's workforce population, the two will be aligned."*- **ASN2** *"…assumes that Māori and Pacific people are homogenous groups…Pacific people are made up of the hundreds of different islands and subcultures as is Māori…not a singular group of people as there are multiple iwi, hapu etc…"*- **OTL1** *"…just employing Māori staff doesn't mean that those Māori staff are going to be perfect for our Māori population, they still need to be able to build rapport and understand where people are coming from…"*- **OTL1** *"…at a cultural and human level, it's a bit shallow…"*- **OTL1** *"With over 220 ethnicities represented in Auckland, I think it's asking too much from the government, to adopt a segregated approach that is to have cultural representation for every culture/ethnic groups…I don't think migrant and refugee clients would expect that. I believe it is necessary to consider cultural representation where possible and also for specific clinical services which involves communication to establish a diagnosis or deliver treatment or narrative therapy."*- **OTL2** *"With the diversity of cultures, languages and dialects spoken by clients it is impossible to provide language matched health professionals for all groups."*- **OTL2** *"…many of the Asian clinical staff do not have the necessary cultural knowledge of their own native country nor speak their native language. The recruitment of Asian or Middle Eastern and African frontline workforce is not based on policy but based on the skills they bring to the organisation. It doesn't mean that the culturally diverse workforce have the cultural knowledge and language skills to match the clients' culture and language."*- **OTL2** *"In my view where feasible (when there are vacancies) that consideration is given to configure the service workforce to match the key languages of the client group in order to be able to provide a language-matched health professional for non-English speaking clients. Service users or patients generally prefer speaking to a health professional who speaks their first language for eg they prefer to go to a GP who speaks their language where possible."*- **OTL2**
4.2.2 Leadership influence	*"…that would lead by example, they would have a good understanding of cultural competency themselves. So their ability to make decisions would be more effective around what sort of services we develop, and what we fund and what we don't fund, etc"*- **SMT2** **Racism:** *"…the leadership needs to take leadership, so at the top, and we've seen some of the effects with institutional racism too. When it is taken up by the executive, it seems to be better accepted by the rest of the organisation."*- **PAC2** *"I think our leaders need to be culturally competent to role model and to influence, and it trickles down to the rest of the organisation. I think if you tried the bottom-up approach, there would be some influence*

	but overall the decision-makers are the ones that day to day make the decisions for the organisation of where the funding goes. It's really important, I'd say the leadership group has effective cultural competence."- **SMT2** *"…in terms of developing more Māori and leadership roles in this organisation and the Auckland DHB, there's a lot of work still to do in that space as well."*- **MAO1** *"…within services we do have champions who understand it and get it. So that would be amazing if we had Māori cardiac rehabilitation nurses to champion the new prototype on our behalf. They can support it at that kind of cold-face level where the clinicians are…"*- **MAO2** *"…we're lucky that we've got a really supportive CEO when it comes to workforce development."*- **MAO1** *"I think the CEO really values [cultural competence] and has a strong personal belief in our service…"*- **ASN1** *"I know at Waitematā DHB our CEO is a leader"*- **ELT1**
4.2.3 competent and capable workforce	***Cultural competence is clinical competence:*** *"It's seen as something that's different to clinical competence, but clinical competent and cultural competence is one and the same thing, you can't be one without the other."*- **MAO1** *"…you can't be clinically competent unless if you are culturally competent."*- **MAO1** *"How can you be clinically competent if you can't communicate effectively with the person that you are here to serve? If I can't engage with you in a way that is going to enable a relationship which will achieve wellness or even help you understand some of the challenges, issues, or opportunities even, then I'll never fulfil my potential as a clinician."*- **MAO1** *"…it's about talking in a way that people can understand, appreciate, and want to engage with you…it's about relationships, and quality engagement of whānau, I'm just describing that as cultural competence…"*- ***MAO1*** *"Where we will get our biggest amount of bang is to ensure that we've got a capable and competent workforce who is committed to making a difference for our Māori population…If we just change tomorrow, to stop employing people who aren't culturally competent, then automatically, that shows we have a value for that now, and therefore people will value becoming more culturally competent."*- **MAO1** **"***We're also implementing action plans to increase the number of Māori working within the district health board, and to increase the capability of the general staff of the DHB to work effectively with Māori."*- **MAO1** *"…to build a strong competent workforce, so building that capacity and capability of a Pacific culturally competent strong workforce, since that is an enabler for good health outcomes."*- **PAC2** **On being culturally competent:** *"…I would hope that people who enter these kinds of professions have enough insight into their own practice to know that it is something they should be doing anyway…It shouldn't be something that we wag a stick at people and be like this is something you must do. People should recognise the importance of doing that themselves already."*- **ELT2** ***Caring people:*** **"***The other part of it is that it's not about being clinically competent or culturally competent, but it's also about caring for people. If you don't care as a human being about the people that*

	you are serving, then again, it's not about how competent you are, you're not going to fulfil your potential as a carer."- **MAO1** ***Caring people:* "***The things we should be testing for are things like is the person that we are about to hire a good human being? Doesn't matter what culture you are, do they care about caring for people…are they a good human being? What are their values? How have they demonstrated those values in the past? Are they committed to caring? Are they committed to improvement? The other perspective is that as part of a high performing team etc., the prerequisite for that is that you must care for other people. If you don't, then you will never ever be a significant contributor to a high performing team."*- **MAO1**
4.2.3 competent and capable workforce; Attracting, recruiting and retaining staff	*"…the real question is, how can you come through a university tertiary programme, and not come out the other end being culturally competent? These things are not nice-to-haves, these are essential in my view."*- **MAO1** *"…what would be ideal is if people turned out already being competent."*- **MAO1** *"…we should be having the expectation that everybody who comes to work with us should come with a level of competence. We shouldn't be employing people who don't have the capability to do the job."*- **MAO1** *"…we don't value cultural competence, then we don't make it a mandatory requirement of people who we employ."*- **MAO1** *Value and prioritisation: "…why would we hire people who can't effectively communicate with a significant part of our population? But we do because we don't value it, because if you valued it, then you would have that as one of your criteria. And if you valued it, then it would be part of one of the assessment criteria, and if you valued it, you would monitor it, and also have mechanisms in place to develop it further, to achieve excellence."*- **MAO1** *"There are numerous ways of assessing cultural competency in this country, but we don't use them when we're recruiting. So the measures are there, we just have to commit to them."*- **MAO1** *"…we have to be strategic about what they do, not just employ more for the sake of it, but be quite strategic and quite clever about what these people are doing or what they are coming to do or what they are coming to help us with."*- **SMT2** *"…keeping the pipeline open, employing the right people and keeping the right people here…"*- **ELT2** *"...it's important to ensure that cultural competence is applied from everything you do, in terms of how you attract and recruit people and the experience you give them as a student, to the experience you give them as part of the onboarding process."*- **ELT3** *"…understanding how you might approach people of various ethnicities [in recruitment]"*- **ELT3** *"…we don't have many Māori staff here at all. We are increasing our Māori numbers, but we're finding it difficult to hold onto them..."*- **MAO1** **Increasing the Māori population:** *"…it's a priority for the DHB to increase our Māori workforce, and we're currently looking at how we can attract more Māori in our workforce and retain more Māori in our workforce."*- **MAO1**

4.2.3 competent and capable workforce; Lacking in capabilities to address Māori population	*"…there is a lot of goodwill. The Māori health team can't do it on its own, even if we were to provide the advice, guidance and education within the system, we would still struggle to implement it since it doesn't have the capabilities at the moment in the right places."*- **MAO1** *"…we don't necessarily have the right capability in some of the leadership positions."*- **MAO1** *"Capability within our system and also our workforce. So our workforce has traditionally not performed well for Māori communities."*- **MAO1** *"…we've got a long way to go as a workforce, we've got some awesome people working within our organisation, but we've also got some work to do to develop their capability and competence to work with the Māori community…"*- **MAO1** *"…in terms of developing the capability of the workforce, there's still a lot to do in that space."*- **MAO1** *"…the issue is, do we have the right people working in our organisation that are committed to and capable of making a difference to our organisation and contributing to the health and wellbeing of whānau who need and use our services?"*- **MAO1** *"…their role is that kind of public health physician intelligence that supports us, which we don't have in our team…"*- **MAO2** *"…data analysis people that don't have experience, background or education in health…don't have any clinical expertise within [the] team"*- **MAO2**
4.2.3 competent and capable workforce; Personal and professional development	*"…we've still got work to do…and also internal work around pathways to career advancement."*- **SMT1** *"…we're not doing enough of is that we're not giving enough training opportunities for people to understand other cultures."*- **PAC1** "*…part of it is about how we develop people, so we need to think really carefully in thinking about leadership development opportunities, how are we working with different cultural groups to develop them as leaders in a way where they can interact that level."*- **OTL1** Leadership**:** *"…we are stepping in the right direction, but there are still lots and lots of work to do, and part of the challenge is getting more deliberate and intentional and getting the right people to leadership roles who have the capabilities to be enablers."*- **MAO1** Racism: *"…there are a lot of issues in the hospitals about racism, lack of cultural competency. What I'd like to say is have you offered these people good training? Because if you haven't, then you can't blame them for being culturally unaware."* - **PAC1**
4.2.3 competent and capable workforce; Personal and professional	*"…we find that people who are wanting to look at their career progression and setting objectives and having a cultural component to those objectives, finding somebody to have that conversation with is getting really hard. They're so busy, particularly the kuia and kaumatua on the ward working with patients. For them to take time out and sit with a clinician to frame an objective that has a cultural component is getting really hard."*- **ELT2**

development; Lack of subject matter expertise/cultural resources	*"…in terms of having the subject matter experts that people can go to and ask. Kuia and kaumatua are very tight on the ground, and for us, they cover 2 DHBs; we share them with Auckland, which makes them even more stretched so that resource is really hard to get hold of."*- **ELT2** *"The conundrum for me is how do we continue to grow our cultural competence when the resources are so dire…people are really keen to do it. They see the need and they see the benefit, and they're really interested in learning and growing in that space and they get completely frustrated when they can't find someone to sit down and have a conversation with about it. So that's a real problem from my perspective, is access to support around cultural competency, and growing in that space. You can do a lot of stuff online and that's great, but sometimes you need an expert in front of you."*- **ELT2** *"I think resources in terms of having subject matter expertise that people can talk to particularly when they want to frame up professional and personal objectives, but also resources in terms of being able to release people to attend courses…So are we setting up teams and managers with the right budget or resource to enable them to release people to feel that actually they can go and they're not feeling like they're letting the team down?"*- **ELT2** *"…clinicians who are wanting to take part in the career salary progression framework where there is a cultural competency requirement. Getting hold of somebody to have a conversation about their objective in terms of how they meet that requirement is getting harder and harder."*- **ELT2**
4.2.3 Competent and capable workforce; Whole organisation responsibility	*"…how do we make Pacific health everybody's business?"*- **PAC2** *"…one of the things in terms of what more we might do for cultural competence is to shift the responsibility from those cultural health teams to the rest of the organisation…if we take the Māori health team, they don't necessarily have to be the keepers of everything Māori. So one of the things that they would like to see is Tikanga, so Māori protocol and practices just woven into business as usual…So how do we just weave those things in so that it's okay for members outside of the Māori Health Team to initiate those practices because it should just be business as usual…educate the rest of the organisation, how to take responsibility for some of that stuff."*- **OTL1**
4.3 Cultural competence in the systemic level	
4.3.1 One size does not fit all	**The current model of care does not work for Māori:** *"So when a Māori person comes into the organisation…they don't go on to a hauroa pathway or paeora pathway of care. That is problematic because our pathway of care is clinically based…and the clinical way of caring for people is too limited in my view when trying to care for the needs of whānau and Māori who utilise our services…they don't work for our people, if you look at the performance metric, the traditional way of care does not work for our people to the same level. I'm not saying they are totally ineffective, of course they are, but in terms of*

	access to timely intervention, in terms of what the feedback is from whānau, we still got a lot of improvement to do."- **MAO1** **Model of care:** *"Currently we're reviewing the model of care…*how we can get a bit more focused."- **MAO1** **Model of care:** *"Our desire to review our model of care is definitely one of the things to do next."*- **MAO1** **Model of care:** *"…based on research…a more holistic comprehensive model of care will achieve better health outcomes with Māori than what your standard models of care provide."*- **MAO2** **Model of care:** *"…the model that worked for a lot of other people simply didn't work for Māori and Pacific people."*- **MAO2** **Model of care:** *"There needs to be more funding to resource models of care that are specific to Pacific people…"*- **PAC1** **Model of care:** *"The model of care should improve access, increase knowledge and be motivational about behaviour change."*- **PAC1** *"…one size fits all is the thought process that some of our staff go through, but no, it's not the case. We need to understand what's important for each individual patient, particularly those from different cultural backgrounds to make sure we provide the care and support that they need and value these patients."*- **SMT2** **Model of care:** *"…if we're looking at our diverse population and the facilities and models of care that we are providing, that we are including the cultural, social and religious needs into that model of care."*- **ELT3** **Patient-centred design:** *"…while you are building the new facility, you might want to consider what the patient cohort might be that would use it. Therefore, how you would design it is quite important, and that would then flow down through to the models of care."*- **ETL3** **Does not cater to people's spiritual needs:** *"…the things that Māori has identified as being important to their wellness are spirituality, Te Reo Māori and connection back to their whānau, community or traditional places of meeting such as the marae. But as an organisation, the health system doesn't do well for people tending to their spirituality…"*- **MAO1**
4.3.1 One size does not fit all; more qualitative research needed	*"We're very good at biomedical research and doing randomised controlled trials and quantitative studies, there are less capability and confidence at doing qualitative research here and where that's done, it doesn't get the same profile."*- **OTL1** *"…I'd love to see much more ethnographic research being done with our different communities so that the DHB actually understands people's worldviews and can start to think what does that mean for how we provide health care to that group of people."*- **OTL1** *"…quantitative and qualitative research… two different paradigms, and sometimes it's people on either side of those paradigms don't see the validity in the other."*- **OTL1** *"…the world of patient experience…basically doing quasi qualitative research all the time, by asking patients what they think works and what doesn't, and you can't discredit people's experience."*- **OTL1** *"…qualitative studies…don't get such high profile here as quantitative research does."*- **OTL1**

4.3.2 PHO enrolment and health literacy; Improving PHO enrolment	*"Where we have better access rates, that would be a measure of the DHB doing well"*- **PAC2** *"…to provide similar services for Asians, migrants and refugees. Many new migrants don't know what a GP, is and the New Zealand health system may work quite differently from their country of origin.*"- **ASN1** *"Cervical screening rates are very low too [among Asians]"*- **ASN1** *"One of the big push is towards enrolment for new migrants… So PH enrolment is a big one, breastfeeding, screening, such as cervical screening, cardiovascular screening and all that."*- **ASN3** *"…the real focus [is] on improving primary care enrolment, and so realising primary care is the doorway to being able to access the full range of health care services and preventative services."*- **SMT1** *"…so that's been our focus; is making sure that people are aware that in New Zealand that primary care is the healthcare home because that's not necessarily what people are used to in their home countries"*- **SMT1** *"Waitematā, in particular, has a large and growing Asian population who are on the whole mostly well, but there are some special areas of focus around engagement with the primary healthcare system, which is often quite different than [their] country of origin."*- **SMT1** *"Often accessing services is one of the key barriers for patients, they can't afford to or they can't get here, they don't understand why they need it."*- **SMT2**
4.3.2 PHO enrolment and health literacy; Improving health literacy	Funding: *"…it's a responsibility of the system to educate and push people to actually access the services, and we could use more money for that, which we do not have."*- **PAC1** *"…with the right education, people do things that they never did in their* original country, and they do acquire the attitude that is necessary to actually use these preventative services like the screening programmes."- **PAC1** *"…our culture is a strength…our people are intelligent enough to see what we need to change in terms of our cultural beliefs, our people can do that. It requires a conversation. We are required to give them a lot of information so that they can see the decision to change. I will never accept that our culture is a barrier."*- **PAC1** *"…heath literacy…is a key barrier that we are working towards, but that is a long-term thing instead of a quick fix. So health literacy is about all kinds of language, not just verbal language, but understanding symptoms etc…So in my mind it's all of that, so I think when people talk about health literacy, we tend to think about the understanding of symptoms, treatments and those kinds of things, but also I think it needs to incorporate things like attitude change, and increasing understanding not just the English language or the English verbal language, but about understanding the whole system. This is why we have navigators now. The health system itself is very complex in the hospital. People need to understand what services they need to access, why, and how to get there, and who they need to see. There needs to be a lot more understanding of that kind of things."*- **PAC2** *"The Chinese make up a majority of the Asian population with more than 18% being non-English speakers, while 26% of Koreans are non-English speakers. These non-English speakers typically have poor health literacy skills…"*- **ASN1**

4.3.2 PHO enrolment and health literacy; community and family engagement	Engaging with the community and the primary sector: *"…Pacific patients are really in hospital for a short time, but actually, they're within their communities. So if we're looking at making a difference to the health outcomes for patients, it often involves linking in with the families in the communities, primary services, linking with primary health care, linking with even Pacific agencies in the community that are more community-based. So the whole primary health sector, we work very closely with."*- **PAC2** *"…if we want good health outcomes for Pacific people…there needs to be engagement with the communities…outreach to the communities…"*- **PAC2** *"How would we best approach the Māori community or the Pacific community? So in the past, we have been very pro-active in talking with Iwi and local Marae, around how we would like to attract youth into health, and we've also been very active in the church space for Pacific"*- **ELT3** *"…if we want to apply particular health interventions, that's a very strong community and the church is where people tend to have those conversations; we also use that for recruitment as well. So if we want to recruit our scholarship programme, we tend to do that through the church community. If we want to promote our scholarship programme, we do that not just through the universities and polytechnics, but also through the Marae and a number of the radio stations, and the social media that Māori uses regularly as well."*- **ELT3** Patient and Family participation/involvement: *"…how you are as a patient; you're not just your disease type, you are a whole person. So if your service is responding to you as a person and considering your belief system and your feelings and your kind of cultural frame, then that's going to make you feel included in your care, which is one of our priorities. It's also going to ensure that there is a possibility for your family to participate in your care as well. I think it probably speaks to our overall priorities around better patient outcome and experience. If people are feeling involved in their care, and they're in an environment that is inclusive and welcoming to them, that then results in better connections between clinicians and patients, and hopefully greater outcomes and greater experiences."*- **ELT3**
4.3.3 Interpreting services	*"…improving Asian patients' health journey in the DHB, because they face a lot of difficulties due to language and cultural barriers."*- **ASN1** *"…to further overcome the language barriers so the language is not an issue…language carries the culture."*- **ASN2** *"…others who are more recent migrants and have got English as their second or third language, for them, of course, it's a big [issue]."*- **ASN3** *"I believe the language barrier is a huge barrier impacting on access and communication between health providers and service users and the effect on health diagnosis and treatment. For non-English speakers, communicating without an interpreter impact on the accuracy of assessments and on appropriate and timely care-planning, and subsequently on the quality of care received by the service user and their family."*- **OTL2** *"I believe we should have the following approaches (a) ensuring our culturally diverse workforce to be culturally competent working across different cultures and be able to access and work with interpreters effectively and (b) where possible consider recruiting multi or bi-lingual staff /clinicians within clinical*

	services to match the languages of the client group of the service (if the service provides services involving communication to establish diagnosis and providing treatment."- **OTL2** *"…about communication. The DHBs have been doing a lot of communication now on Twitter, Facebook, but it may not reach the ethnic population, because, for example, a lot of Chinese population are using social media Wechat instead. It's a big and very successful platform. The NGOs have been using it already, and they use that for communication and for promotion as well…but the DHBs have not yet taken advantage of that, so we are just relying on the traditional media platforms like Facebook and the print media, such as the New Zealand Chinese Herald or the radio. That's all fine, but we do need to look at a more efficient way of engaging with the Asian communities."*- **ASN2**
4.3.4 Ethnicity-based reporting	*"…we don't do mandatory ethnicity-based reporting. So automatically we don't know if we are working effectively for Māori or not."*- **MAO1** *"So in order to get improvement, you need to know where you are failing and where you are doing well. So a fundamental marker and improvement is ethnicity-based reporting, if you are not using ethnicity-based reporting of all the metrics in the system, then how do you know where you are doing well or not? So the thing is, if you want to look at improvement, then you've got to report all your metrics by ethnicity. Otherwise, you are operating blind, how would you know where to put your effort? How do you know where the good learnings are?...we do have some reporting by ethnicity, but the question is how do we choose those areas?"*- **MAO1** *"Our WDHB is doing well, as we always include Asians in ethnicity data. However, national data systems and policies often classify ethnicity data as Māori, Pacific and Others. At the systemic level in national data, the Asian population is not acknowledged yet. This is something we need to address at the national level."- **ASN1*** *"National data used to be categorised into Māori and non-Māori, which then improved to Māori, Pacific and Other [and] no Asian data included. That might be why we are not directly included in the DHB level…We hope Level 4 ethnicity break down data is implemented in the future as statistics are currently unavailable. This will allow us to have a more in-depth break down of ethnic data available. It means we can utilise our health budget to target specific ethnic groups."*- **ASN1** *"…sometimes it's quite challenging to just call it Asian as an umbrella term, but we certainly know under Asian, they're all different, so we have been trying very hard to provide more subgroup level data so that we can really do good work to meet the needs of all our population from a cultural or language perspective."*- **ASN2** *"The good part about the New Zealand health sector is that it's sensitive enough to recognize the different needs of different groups of people, independent of how you group them. There may be an ethnic grouping, an age grouping, a disease grouping…but the resourcing is the main barrier…"*- **PAC1**

4.3.4 Ethnicity-based reporting; Diversity among subgroups	*"…you've got people from different iwi, Māori who live here, but not from the area, you've got young Māori, old Māori, Māori who are wealthy and well off and others who are unemployed and in a dark space."*- **MAO2** *"There is diversity in Pacific as well, so [there is] the need for Pacific ethnic-specific language and having access to that kind of knowledge and understanding around the diverse Pacific ethnicities."*- **PAC2** *"When we look at how we can provide better services to our population we need to think about the specific subgroup."*- **ASN2** *"When we look at the Asian population overall, they do really well. But when you try to look at the subgroups, there are health disparities."*- **ASN3** *"…there are so many different cultures around the world, how can we cater to all of them?"*- **ASN3** *"…we've got Pacific, we've got Māori, we've got Asian and MELAA. Within the Pacific, you've got all these countries and same with Asian. So how do we cater everything into one culturally competent thingy? We've got so many different cultures; how do we distil them and bring them into one framework?"*- **ASN3** *"…Asian is such a broad group, the same as Pacific, which is also such a broad group, there's heterogeneity in that group in terms of length of time in New Zealand, and in terms of the health system that people come from, and familiarity with the New Zealand health system and those kind of things."*- **SMT1**
4.3.5 Resource allocation	*"…we don't have enough FTEs to cover all…so it's focusing on achieving more with less."*- **MAO2** *"…it's just a reflection of what the DHB prioritizes in terms of where the resources are…Some are less valued than your generic roles in primary care for example."*- **MAO2** Health action plan put on hold: *"…it's common that the board accepts all these things in principle, and then we wait for funding and don't get funding."*- **PAC1** *"…finding resources to grow and implement the models of care has been a big issue."*- **PAC1** *"We can make things happen faster if we had more resources."*- **PAC1** *"…we constantly experience the funding to be less than what we would like in order to respond to needs, and that is the biggest challenge…"*- **PAC1** *"…there is major underfunding in the health sector…"*- **PAC1** *"The DHBs have been required to break even, so we are not allowed to go into deficit, we have to live within the budget the government gives the DHB. A lot of things are sacrificed in order to break even and addressing equity issues is one of those things that are sacrificed."*- **PAC1** *"It's not hard to support people, it's the funding to actually do the work that we need to do…"*- **PAC1** *"Strategy without resources is a piece of paper."*- **PAC1** *"…we are a very small resource."*- **PAC2** *"…how do we get those learning and the understanding across the huge variety of staff?"*- **PAC2** *"…if we were staffed at a similar rate [as Māori], we would be in a better position to make more impact."*- **PAC2** *"…we want more resources for our services to improve."*- **ASN1**

	"Our population is growing, but we still don't have enough FTE… Māori and Pacific teams have a better FTE to population ratio."- **ASN1** *"Limited resources put a strain on our services, and our limited number of cultural support workers are often forced to prioritise urgent cases."*- **ASN1** *"…funding for the general workforce, it may not be a big matter, but for the Asian Support Services it might be because we're having a growth of Asian population, it means there will be more Asian, and MELAA as well, and the refugee population as well."*- **ASN2** *"The demand has increased and the Asian population at WDHB has also been increasing over the last few years. So the demand for interpreting services has increased but they have been unable to keep up with the demand because of the funding shortfall."*- **ASN3** *"For us and the team, I guess what the goal would be is having a slightly bigger team."*- **ASN3** *"…we've got our Māori partners and Pacific partners, and we could probably do a whole lot more resources in those spaces. They're tiny wee teams…"*- **ELT2** *"In terms of funding, I don't think there's enough investment in those teams, so one obvious factor with that is that they're split across Auckland and Waitematā DHB, that makes the population they're serving immense, and they're hugely stretched."*- **OLT1**
4.4 Process of cultural competence	
4.4.1 All levels	*"…it could go both ways, in reality, that is probably how it works."*- **MAO2** "*It has to be done at all the…levels."*- **PAC1** *"…in a hierarchal organisation like this, it needs to be at all levels."*- **PAC2** *"…both approaches are equally important. It is very important for frontline staff members to have cultural competency, as it will impact patient care directly…However, a top-down approach for any strategic direction or action plan might take a shorter time to implement, as the bottom-up approach requires more time for people's voices to reach the decision-makers..."*- **ASN1** *"It has to come from the top-down and bottom-up."*- **ASN3** *"…you have to do a bit of all of it, it's got to be multi-level because they're multi-level issues."*- **SMT1** *"…the top-down is about removing barriers and embedding things like cultural competence in the strategy and direction of the organisation. And the bottom up is about how you would drive behaviour change at a personal level."*- **OTL1** Already present: *"…it's already sitting in both ends. We've got leaders who are supportive and actively articulating the need for a culturally diverse organisation, and the need to improve in that space. Then we have services that are developing services to respond to their patient cohort, and they are thinking of many things about their patient cohort of which cultural aspects is one of those… the interest and level of importance articulated both from a service perspective and from a strategic leadership perspective, which is exactly how I think how it should be.*"- **ELT3**

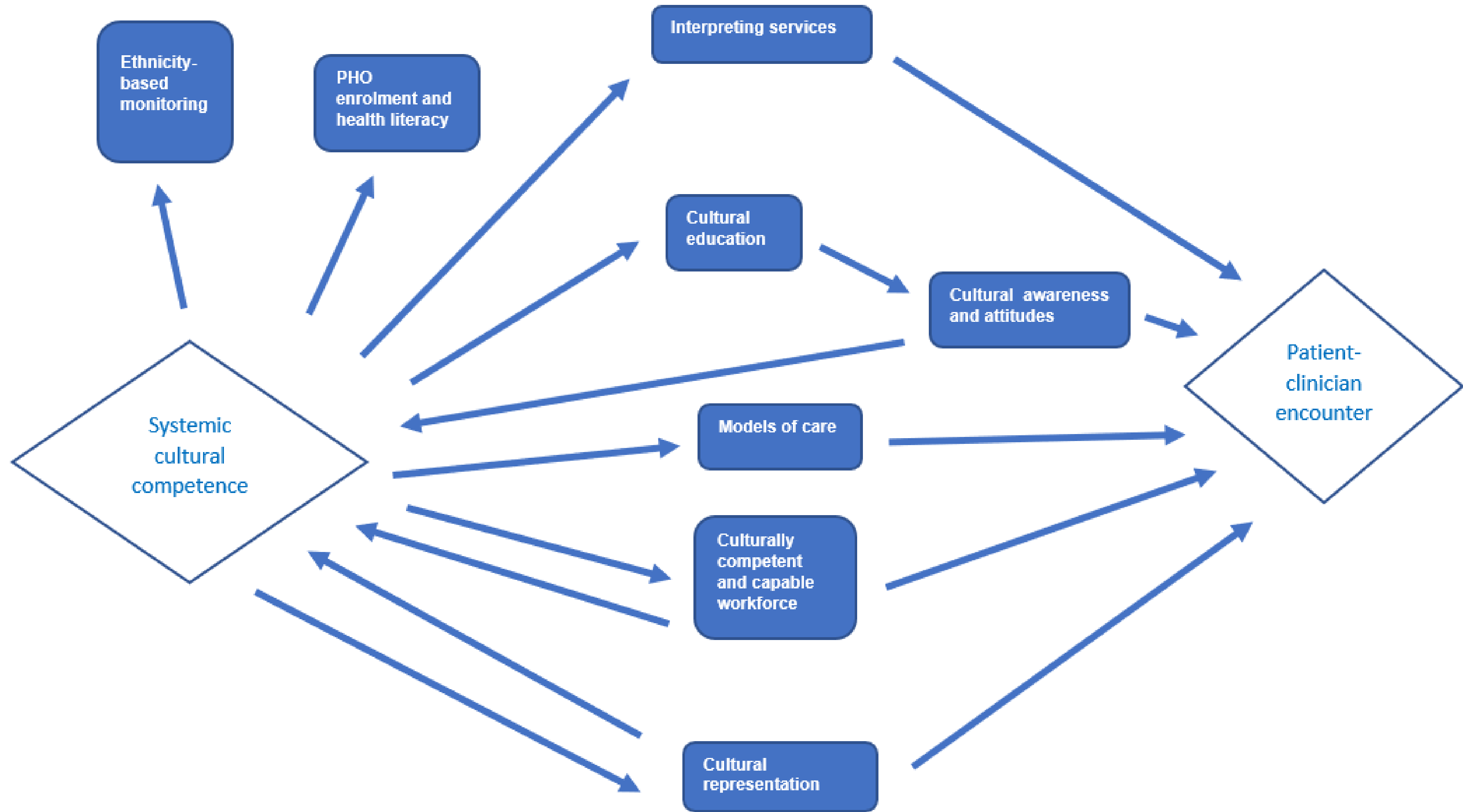
4.4.1 Individual level	*"…I think change comes from within. Ultimately when you learn about cultural competence, one of the most important things is understanding your own cultural paradigm. Being able to do that, then you are able to understand someone else's because you then have that empathy and that ability to be able to reflect."*- **ELT1** *"…change is driven within the system by individuals…So if you focus on the individual, they will naturally cluster into teams and naturally motivate themselves for organisational competence to happen, then you will get systemic [cultural competence]"*- **ELT1** *"Top-down never works, that's just enforcing stuff, and then we get people doing it because it's a tick box; I think it's both, probably*."- **ELT2** *"Bottom-up is always better since there is that natural growth. Top-down is important in terms of saying this is what we need to do and this is the right way to do it and mandating people to be released so that they don't feel that they have to take annual leave or a day off to attend courses."*-**ELT2**
4.4.1 Systemic level	*"…I think to have some fundamental change, it's the policy level, system level and the environment level that will play a very important role to change the culture…"*- **ASN2** *"…cultural competency is not really accounted for at a strategic level just means it's always going to sort of be up to individuals to promote it…"*- **OTL1** *"…not having it weaved into our strategic direction, it means that people don't have to find it important, to think that it's low in priority for them."*- **OTL1** *"There is no organisational policy or framework that addresses cultural competency at organisational, systemic, professional and personal levels."*- **OTL2** *"The top-down approach is more effective because, with policy and management buy-in, cultural education will be made mandatory, budget will be allocated for interpreting service, cultural support services will be resourced and adequately provided where the needs are identified, workforce recruitment policy will look at addressing cultural representation or employing bilingual or multilingual staff to meet the needs of the client groups; equity framework will include cultural competency training for educating health providers; etc…The bottom-up approach is slower to achieve the results needed, for example, providing cultural education can only help create champions for culturally competent practice and culturally competent individuals can only try to advocate for culturally responsive services and support clients who have complex cultural needs. It may be difficult to achieve change without resourcing and funding. In order for resourcing and funding to be made available, there is a need for management buy-in, policy [change] or [for it to be] a government priority."*- **OTL2**
4.4.2 Continuous process	*"It is not doing it online or attending workshops, it is continuous. This is not a one-off event, so can't be a tick-box task."*- **PAC1** *"…I don't know if we would reach it, it's not a destination…"*- **PAC2** *"…but I believe there is increased awareness from clinicians. It is important that they continue to learn rather than rely on a one-off online course, otherwise, it will be difficult to remember the contents."*- **ASN1** *"…cultural change will take some time, we can't just expect it to happen overnight."*- **ASN2**

	"…once you've done the course, you kind of read and think 'I know that now', and think you're culturally competent, but that's not the case. You have to experience it…"- **ASN3** *"…it is a personal end service organisational journey, and it doesn't stop."*- **SMT1** *"cultural competence…[is] an ongoing thing that happens all the time, and you get better at it, but you don't finish…"*- **SMT1** *"…it is really important that you don't only have a one-off online programme and then that's it; it's an ongoing process, its integral, and having some experiential-based learning where you can actually apply the skills you learn, reflect and have coaching is really important."*- **ELT1** *"…it's an evolution, it's a process, it's a continuous process, it's not something where you suddenly become culturally competent, so I think we've got to change the way that people think about it."*- **ELT1** *"Cultural competence is slow to happen, but there is a momentum."*- **ELT1** *"The fundamental barrier is that change in any sort will be difficult to deal with especially for those who are comfortable in the current context. Change in particular, since we live in a colonised society where the colonised population want to do things differently is even harder to make a change since there is going to be resistance, and some of that is just embedded through institutionally racist systems, procedures and infrastructure."*- **MAO1** *"…obstacle is that whether we like to admit it or not, we still have a level of institutional racism and unconscious bias in our system."*- **MAO1** *"…there are a lot of issues in the hospitals about racism, lack of cultural competency. What I'd like to say is have you offered these people good training? Because if you haven't, then you can't blame them for being culturally unaware."* - **PAC1** *"…so at the management level, I'm not saying there was blatant racist behaviour, very subtle…"*- **PAC2** *"It's covert, but we're calling it institutional racism."*- **PAC2** *"…also probably to do with institutional racism… Māori and Pacific people are less likely to be shortlisted for jobs, that's proven."*- **OTL1** *"…we know that institutional racism exists."*- **OTL1**
4.5 Māori equity	
4.5.1 The role of the Treaty of Waitangi	*"…they've probably taken a more multicultural approach, but we nod to biculturalism."*- **OTL1** *"…generally there is a focus on multicultural health."*- **OTL1** *"I think the approach by the Ministry is very bicultural, perhaps due to the Treaty, but at the service level, we have a very multicultural environment."*- **ASN1** *"We know New Zealand is becoming a more and more diverse and multicultural society and we need to acknowledge that."*- **ASN3** *"…multiculturalism is really important because that's about making everyone well, everyone has equal opportunity to live well."* **– OLT1**

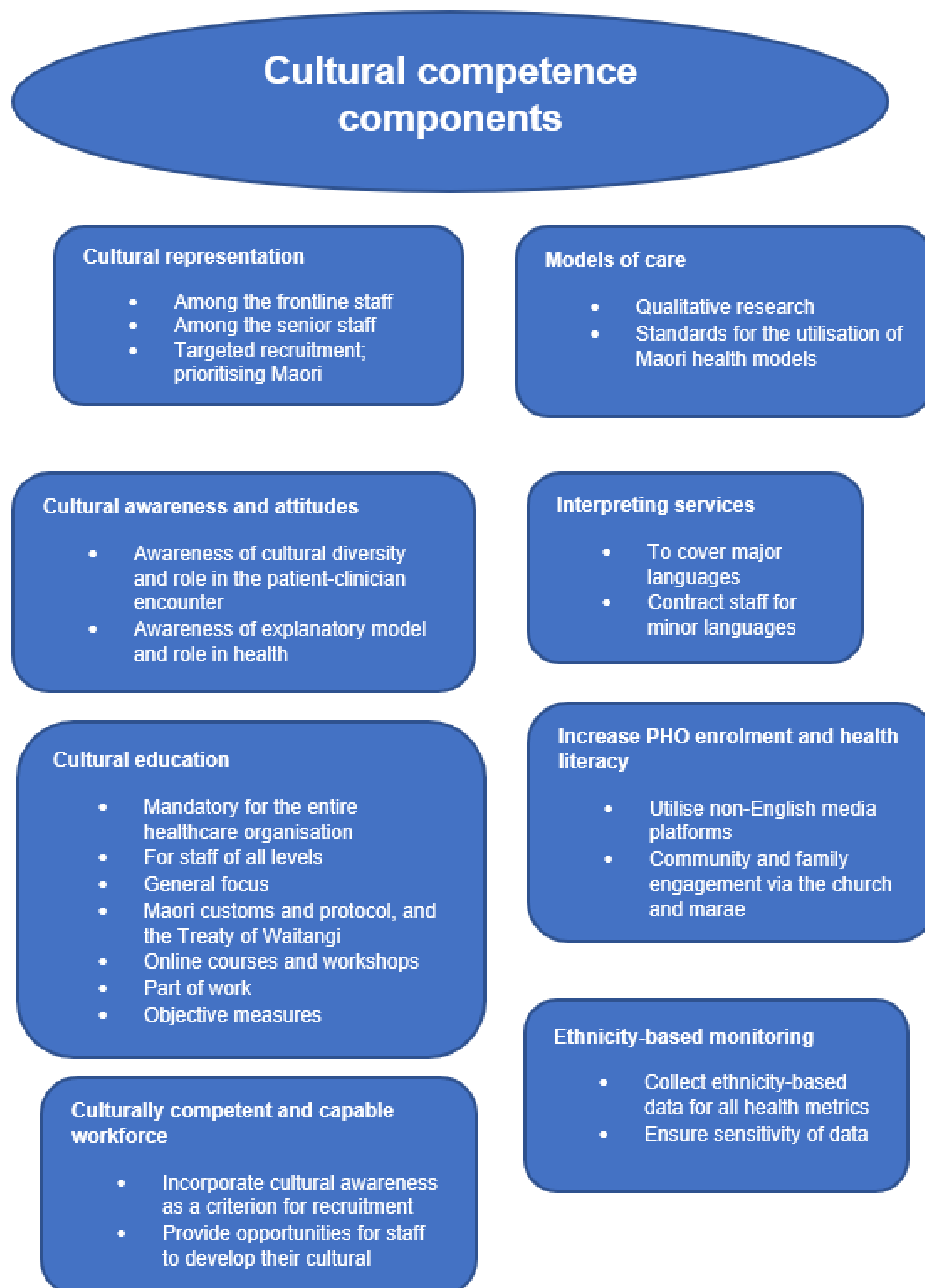
	"…bicultural is priority…You can see that in the structure, where the Chief of Tikanga is positioned in the structure."- **PAC2** *"More and more of our plans and strategies that we're being asked to think about is through an equity lens, and it's fairly focused on Māori health outcomes."*- **SMT2** *"…given the KPIs it has, it probably is more bicultural than it is multicultural."*- **SMT2** *"I think the organisation does take a bicultural approach, but when I look at the activities, it's clear to me that there are multicultural activities also occurring."*- **ELT3** *"…bicultural approach is very strong…I've seen the shift to cultural diversity and multiculturalism…So I think that we do operate at a level of multiculturalism."*- **PAC2** *"…the bicultural approach has been established already. We continue to build on that with the multicultural layer.*"- **PAC2** *"I think it's more starting to shift into a multicultural approach when working, so it is trying to respond to the different ethnic groups that are becoming prominent in the utilisation of our services, which have high needs in our community…"*- **MAO1** *"…we have always taken a bicultural approach, but I have seen the last few years with the growing culturally and linguistically diverse population, while the organisation placed importance with the bicultural approach they are recognising the importance of working with a multicultural population."*- **OTL2** *"…we have to understand that Māori have a Treaty, so they've got kind of legal rights to being represented at the governance level, they've got a legal right to participate in decision level making at the DHB, and that's kind of guaranteed in the Treaty of Waitangi, and that's not to say that other groups can't be given that right, it's just to say that with Māori, the Treaty right is already there…other groups should also participate, but their rights come from needs, so the DHB's approach and response are a bit different within the different communities that they engage with. I've never thought of it as an us-or-them mentality, we're all in this together, so what is best for them is best for everyone…"*- **MAO2** *"Both approaches are in place in the DHBs and that is how it should be."- **PAC1*** *"We have a treaty responsibility that's under the legislation, so that's just the rules, and we have a responsibility to the population we serve, so it's both, and those things we can often do in parallel."*- **SMT1** *"There's a bicultural approach in which there are Treaty partners, and in the Crown side of Treaty partners you can have multicultural approaches within, but they are not mutually exclusive."*- **SMT1** *"I don't think they are mutually exclusive."*- **ELT1** *"I think that for me, it isn't a dichotomy, it's not a one or the other. I think that we can embrace both concepts…"*- **ELT1** *"I'd say both."*- **ELT2** *"The bicultural approach is specific for Māori as indigenous people with a Treaty agreement with the Crown."*- **PAC1** *"The indigenous people of New Zealand is a culture but they cannot be reduced to just another culture like the other cultures in New Zealand. As indigenous people, they have specific rights as recognised by*

	international entities such as the United Nations and defined specifically in the Treaty of Waitangi."- **PAC1** *"…we need to do more bicultural thinking, and because we have a legislative responsibility to act in accordance with the principles of the Treaty of Waitangi"-* **OTL1** *"I think the DHB is definitely trying to be more multicultural. Politically, it is an issue from the Treaty perspective because it needs to prioritise its indigenous population in the first instance and get it right for its indigenous Māori population"-* **MAO1** *"There are only two partners in the Treaty relationship, and that's Māori and the Crown, and the Crown represents everybody else and Māori sit alone on their side of the Treaty. What happens sometimes is the DHB tries to shift other ethnic groups into the Māori side, but no, they need to stay on the non-Māori side, and it's not because they are not important, it's just that it is the Treaty relationship."-* **MAO1** *"…it should not confuse its Treaty obligations to Māori with biculturalism and/or multiculturalism. So it can do whatever it likes in relation to multiculturalism, but not at the expense of Māori, its indigenous population."-* **MAO1** *"…the risk of only focusing on multiculturalism is that it denigrates Māori status as tangata whenua and the huge implications of colonisation, and those are ongoing. So I think we can't underestimate the impact to Māori of the process of colonisation, the impacts of which still go on today. So biculturalism is important to help put in place systems and structures that undo the negative impact of colonisation."-* **OTL1**

Appendix 3: Interplay of cultural competence components



Appendix 4: Cultural competence components with focus areas



References

About DHBs | Waitematā District Health Board (WDHB). (2018). Retrieved from http://www.Waitematādhb.govt.nz/about-us/about-dhbs/

Anderson, A., Binney, J., & Harris, A. (2014). *Tangata whenua: An illustrated history*. Bridget Williams Books.

Anderson, L., Scrimshaw, S., Fullilove, M., Fielding, J., & Normand, J. (2003). Culturally competent healthcare systems. *American Journal Of Preventive Medicine*, *24*(3), 68-79. doi: 10.1016/s0749-3797(02)00657-8

Andrulis, D. P., & Brach, C. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American journal of health behavior*, *31*(1), S122-S133.

Angel, R., & Thoits, P. (1987). The impact of culture on the cognitive structure of illness. *Culture, Medicine and Psychiatry*, *11*(4), 465-494.

Angelelli, C. (2008). The role of the interpreter in the healthcare setting. *Crossing borders in community interpreting: Definitions and dilemmas*, 147-164.

Aragon de Valdez, T., Gallegos, J., & Green, J. W. (1982). The Chicano familia in social work. *Cultural awareness in the human services*, 184-208.

Asian Health Services. Retrieved from http://www.asianhealthservices.co.nz/

Asian Health Support Services. (2019). Retrieved from http://www.Waitematādhb.govt.nz/hospitals-clinics/clinics-services/asian-health-support-services/

Atkinson, R., & Mason, C. (2014). Experiments in engagement: Research into engagement activities with young people from disadvantaged backgrounds. *London, UK: Wellcome*.

Auckland and Waitematā District Health Boards. (2017). *2017/18 Māori Health Plan Auckland and Waitematā District Health Boards*. Auckland: Auckland and Waitematā District Health Boards.

Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical care*, 1461-1470.

Ballard, R. (2003). The implications of cultural diversity for healthcare practice: An anthropological perspective.

Barker, J. C. (1992). Cultural diversity--changing the context of medical practice. *Western Journal of Medicine*, *157*(3), 248.

Barnett, P., Smith, J., & Cumming, J. (2009). The roles and functions of Primary Health Organisations. *Wellington: Health Services Research Centre, Victoria University of Wellington, http://www. victoria. ac. nz/hsrc/reports/Roles% 20and% 20Functions% 20of% 20PHOs. pdf*.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, *13*(4), 544-559.

Beach, M., Price, E., Gary, T., Robinson, K., Gozu, A., & Palacio, A. et al. (2005). Cultural Competence. *Medical Care*, *43*(4), 356-373. doi: 10.1097/01.mlr.0000156861.58905.96

Bell, E., Bryman, A., & Harley, B. (2018). *Business research methods.* Oxford university press.

Bennett, I. M., Chen, J., Soroui, J. S., & White, S. (2009). The contribution of health literacy to disparities in self-rated health status and preventive health behaviors in older adults. *The Annals of Family Medicine*, *7*(3), 204-211.

Benson, P., & Kleinman, A. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine, 3*(10), 1673. doi:10.1371/journal.pmed.0030294

Berger, J. T. (1998). Culture and ethnicity in clinical care. *Archives of Internal Medicine*, *158*(19), 2085-2090.

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: an updated systematic review. *Annals of internal medicine*, *155*(2), 97-107.

Bernard, H. R. (2017). *Research methods in anthropology: Qualitative and quantitative approaches*. Rowman & Littlefield.

Betancourt, J. R., & Green, A. R. (2010). Commentary: linking cultural competence training to improved health outcomes: perspectives from the field. *Academic Medicine*, *85*(4), 583-585.

Betancourt, J. R., Carrillo, J. E., & Green, A. R. (1999). Hypertension in multicultural and minority populations: Linkin communication to compliance. *Current Hypertension Reports*, *1*(6), 482-488.

Betancourt, J. R., Corbett, J., & Bondaryk, M. R. (2014). Addressing disparities and achieving equity: cultural competence, ethics, and health-care transformation. *Chest*, *145*(1), 143-148.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293-302. doi:10.1093/phr/118.4.293

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: key perspectives and trends. *Health affairs*, *24*(2), 499-505.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative Health Research*, *26*(13), 1802-1811.

Brach, C., & Fraser, I. (2002). Reducing disparities through culturally competent health care: an analysis of the business case. *Quality management in health care*, *10*(4), 15.

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, *57*(1_suppl), 181-217.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Bridgman, G. (1993). Nga ia o te oranga hinengaro Māori: Trends in Māori mental health-a discussion document. *Wellington, NZ: Te Puni Kokiri Ministry of Māori Development*.

Byrne, M. (2001). Sampling for qualitative research. *AORN journal*, *73*(2), 494-498.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing*, *13*(3), 181-184.

Campinha-Bacote, J., Yahle, T., & Langenkamp, M. (1996). The challenge of cultural diversity for nurse educators. *The Journal of Continuing Education in Nursing*, *27*(2), 59-64.

Carballeira, N. (1997). The Live & Learn Model for culturally competent family services. *Continuum (Society for Social Work Administrators in Health Care)*, *17*(1), 7.

Carrasquillo, O., Orav, E. J., Brennan, T. A., & Burstin, H. R. (1999). Impact of language barriers on patient satisfaction in an emergency department. *Journal of general internal medicine*, *14*(2), 82-87.

Carrillo, J. E., Green, A. R., & Betancourt, J. R. (1999). Cross-cultural primary care: a patient-based approach. *Annals of Internal Medicine*, *130*(10), 829-834.

Chang, P. H., & Fortier, J. P. (1998). Language barriers to health care: an overview. *Journal of Health Care for the Poor and Underserved*, *9*(5), S5-S20.

Chrisman, N. J. (2007). Extending cultural competence through systems change: Academic, hospital, and community partnerships. *Journal of Transcultural Nursing*, *18*(1_suppl), 68S-76S.

Clifford, A., McCalman, J., Bainbridge, R., & Tsey, K. (2015). Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: a systematic review. *International Journal for Quality in Health Care*, *27*(2), 89-98.

Cohen, D., & Crabtree, B. (2006). Qualitative research guidelines project.

Collins, K. S., Hall, A. G., & Neuhaus, C. (1999). US minority health: A chartbook.

Collis, J., & Hussey, R. (2013). *Business research: A practical guide for undergraduate and postgraduate students* Palgrave macmillan.

Cope, B., & Kalantzis, M. (1997). *Productive diversity: A new, Australian model for work and management*. Sydney: Pluto Press.

Cormack, D. (2007). Making ethnicity data count. *Best Pract J*, *9*, 44-6.

Crane, J. A. (1997). Patient comprehension of doctor-patient communication on discharge from the emergency department. *Journal of Emergency Medicine*, *15*(1), 1-7.

Creswell, J. W. (2013). Qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks, CA: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice*, *39*(3), 124-130.

Creswell, J. W., & Plano Clark, V. L. (2011). Designing and conducting mixed method research. 2nd Sage. *Thousand Oaks, CA*.

Cross, T, Bazron, B, Dennis, K & Isaacs, M (1989) Towards a culturally competent system of care Volume 1, Washington DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

Culhane-Pera, K. A., Reif, C., Egli, E., Baker, N. J., & Kassekert, R. (1997). A curriculum for multicultural education in family medicine. *Family Medicine*, *29*(10), 719-723.

Dauvrin, M., & Lorant, V. (2015). Leadership and cultural competence of healthcare professionals: a social network analysis. *Nursing research*, *64*(3), 200.

Davidhizar, R., & Giger, J. N. (1998). Transcultural patient assessment: a method of advancing dental care. *Dental assistant (Chicago, Ill.: 1994)*, *67*(6), 34-5.

Davis, M. S. (1968). Variations in patients' compliance with doctors' advice: an empirical analysis of patterns o communication. *American Journal of Public Health and the Nations Health*, *58*(2), 274-288.

Davis, T. C., & Wolf, M. S. (2004). Health literacy: implications for family medicine. *FAMILY MEDICINE-KANSAS CITY-*, *36*(8), 595-598.

Demireva, N., & McNeil, R. (2016). Immigration, diversity and social cohesion. *Briefing, University of Oxford*, *3*, 1-5.

DeSouza, R. (2008). Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing*, *13*(2), 125-135.

DeSouza, R., & Garrett, N. (2005). Access issues for Chinese people in New Zealand. *Auckland: Auckland University of Technology and Accident Compensation Corporation*.

Developing Healthy People 2020. (2008). *PHASE I REPORT: RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020*. U.S. Department of Health & Human Services.

DHHS, Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington, D.C.: DHHS, Office of Minority Health.

Diamond, L., Schenker, Y., Curry, L., Bradley, E., & Fernandez, A. (2009). Getting by: Underuse of interpreters by resident physicians. *Journal of General Internal Medicine, 24*(2), 256-262. doi:10.1007/s11606-008-0875-7

Diaz, E., & Kumar, B. N. (2014). Differential utilization of primary health care services among older immigrants and Norwegians: a register-based comparative study in Norway. *BMC health services research*, *14*(1), 623.

DiMaggio, P., & Garip, F. (2012). Network effects and social inequality. *Annual review of sociology*, *38*, 93-118.

District health boards. (2018). Retrieved from https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards

Divi, C., Koss, R. G., Schmaltz, S. P., & Loeb, J. M. (2007). Language proficiency and adverse events in US hospitals: A pilot study. *International Journal for Quality in Health Care : Journal of the International Society for Quality in Health Care, 19*(2), 60-67. doi:10.1093/intqhc/mzl069

Dozier, D. M., Beach, W. A., Gutzmer, K., & Yagade, A. (2017). The transformative power of authentic Conversations about Cancer. *Health communication*, *32*(11), 1350-1357.

Durie, M. (1998). *Whaiora: Māori health development*. Oxford University Press.

Dyer Jr, W. G., & Wilkins, A. L. (1991). Better stories, not better constructs, to generate better theory: A rejoinder to Eisenhardt. *Academy of management review*, *16*(3), 613-619.Eakin, E. G., Bull, S. S., Glasgow, R. E., & Mason, M. (2002). Reaching those most in need: a review of diabetes self-management interventions in disadvantaged populations. *Diabetes/metabolism research and reviews*, *18*(1), 26-35.

Eisenberg, D. M., Kessler, R. C., Foster, C., Norlock, F. E., Calkins, D. R., & Delbanco, T. L. (1993). Unconventional medicine in the United States--prevalence, costs, and patterns of use. *New England Journal of Medicine*, *328*(4), 246-252.

Eisenberg, J. M. (1979). Sociologic influences on decision-making by clinicians. *Annals of Internal Medicine*, *90*(6), 957-964.

Eisenberg, L. (2009). Conceptual models of 'physical' and 'mental' disorders. *Research and Medical Practice: their Interaction*, *44*, 3.

Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Māori population. *American journal of public health*, *96*(4), 612-617.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196*(4286), 129-136.

Enhancing CALD Cultural Competence. (2019). Retrieved from https://www.ecald.com/

Eriksson, P., & Kovalainen, A. (2008). *Introducing Qualitative Methods: Qualitative methods in business research*. London, : SAGE Publications Ltd doi: 10.4135/9780857028044

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4.

Executive Leadership Team. (2016). Retrieved from https://www.Waitematādhb.govt.nz/about-us/leadership/executive-leadership-team/

Fabrega Jr, H. (1972). The study of disease in relation to culture. *Behavioral Science*, *17*(2), 183-203.

Flores, G., & Ngui, E. (2006). Racial/ethnic disparities and patient safety. *Pediatric Clinics*, *53*(6), 1197-1215.

Flyvbjerg, B. (2006). Five Misunderstandings About Case Study Research. *Qualitative Inquiry*, 12(2) 219-245.

Francis, V., Korsch, B. M., & Morris, M. J. (1969). Gaps in doctor-patient communication: Patients' response to medical advice. *New England Journal of Medicine*, *280*(10), 535-540.

Friedkin, N. E. (2001). Norm formation in social influence networks. *Social networks*, *23*(3), 167-189.

Fuller, J. B., Hester, K., Barnett, T., & Relyea, L. F. C. (2006). Perceived organizational support and perceived external prestige: Predicting organizational attachment for university faculty, staff, and administrators. *The Journal of Social Psychology*, *146*(3), 327-347.

Funding. (2016). Retrieved from https://www.health.govt.nz/new-zealand-health-system/overview-health-system/funding

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The qualitative report*, *20*(9), 1408-1416.

Gallagher R.W. & Polanin, J.R. (2015). A meta-analysis of educational interventions designed to enhance cultural competence in professional nurses and nursing students. Nurse Education Today, 35 (2), 333-340

Giger, J., Davidhizar, R. E., Purnell, L., Harden, J. T., Phillips, J., & Strickland, O. (2007). American academy of nursing expert panel report: Developing cultural competence to

eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing*, *18*(2), 95-102.

Gilson, L., Doherty, J., Loewenson, R., & Francis, V. (2007). Challenging inequity through health systems. Final report: Knowledge Network on Health Systems. WHO Commission on the Social Determinants of Health.

Gimeno-Feliu, L. A., Magallón-Botaya, R., Macipe-Costa, R. M., Luzón-Oliver, L., & Lasheras-Barrio, M. (2013). Differences in the use of primary care services between Spanish national and immigrant patients. *Journal of immigrant and minority health*, *15*(3), 584-590.

Gornick, M. E. (2000). Disparities in Medicare services: potential causes, plausible explanations, and recommendations. *Health care financing review*, *21*(4), 23.

Green, A. R., Carrillo, J. E., & Betancourt, J. R. (2002). Why the disease-based model of medicine fails our patients. *Western journal of Medicine*, *176*(2), 141.

Green, J. W. (1982). *Cultural awareness in the human services*. Prentice Hall.

Green, J. W., & Race, R. (2006). On cultural competence. *DIALOGUE*.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, *18*(1), 59-82.

Gustafsson, J. (2017). Single case studies vs. multiple case studies: A comparative study.

Haefner, D. P., & Kirscht, J. P. (1970). Motivational and behavioral effects of modifying health beliefs. *Public Health Reports*, *85*(6), 478.

Hasnain-Wynia, R., & Baker, D. W. (2006). Obtaining data on patient race, ethnicity, and primary language in health care organizations: current challenges and proposed solutions. *Health services research*, *41*(4p1), 1501-1518.

Hasnain-Wynia, R., Pierce, D., & Pittman, M. (2004). *Who, when, and how: The current state of race, ethnicity, and primary language data collection in hospitals*. New York: Commonwealth Fund.

Health Promotion. (2019). Retrieved from https://www.who.int/healthpromotion/conferences/7gchp/track2/en/

Herbert, A. M. (2002). Bicultural partnerships in clinical training and practice in Aotearoa/New Zealand. *New Zealand Journal of Psychology*, *31*(2), 110-116.

Higgins, R., & Meredith, P. (2011). Kaumātua – Māori elders. Retrieved from https://teara.govt.nz/en/kaumatua-Māori-elders/print

Hlavac, J., Beagley, J., & Zucchi, E. (2018). Applications of policy and the advancement of patients' health outcomes through interpreting services: data and viewpoints from a major public healthcare provider. *Translation & Interpreting*, *10*(1), 111-136.

Hobby, F. (2008). Racial and ethnic disparities: Why diversity leadership matters. *Journal of Healthcare Management, 53*(1), 8.

Hornberger, J., Itakura, H., & Wilson, S. R. (1997). Bridging language and cultural barriers between physicians and patients. *Public Health Reports*, *112*(5), 410.

Horton, R. (1967). African traditional thought and Western science. *Africa*, *37*(2), 155-187.

Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals. *Cochrane database of systematic reviews*, (5).

Iqbal, G., Johnson, M. R., Szczepura, A., Wilson, S., Gumber, A., & Dunn, J. A. (2012). UK ethnicity data collection for healthcare statistics: the South Asian perspective. *BMC Public Health*, *12*(1), 243.Jacobson, T. A., Thomas, D. M., Morton, F. J., Offutt, G., Shevlin, J., & Ray, S. (1999). Use of a low-literacy patient education tool to enhance pneumococcal vaccination rates: a randomized controlled trial. *Jama*, *282*(7), 646-650.

Jha, A. K., Orav, E. J., Zheng, J., & Epstein, A. M. (2008). The characteristics and performance of hospitals that care for elderly Hispanic Americans. *Health Affairs*, *27*(2), 528-537.

Jiang, H. J., Andrews, R., Stryer, D., & Friedman, B. (2005). Racial/ethnic disparities in potentially preventable readmissions: the case of diabetes. *American Journal of Public Health*, *95*(9), 1561-1567.

Jirwe, M., Gerrish, K., Keeney, S., & Emami, A. (2009). Identifying the core components of cultural competence: findings from a Delphi study. *Journal of Clinical Nursing*, *18*(18), 2622-2634.

Kawharu, I. H. (1989). *Waitangi: Māori & Pākehā perspectives of the treaty of Waitangi*. Oxford University Press, USA.

King, A. (2001). The primary health care strategy. *Wellington: Ministry of health*.

Kleinman, A. (2007). *What really matters: living a moral life amidst uncertainty and danger*. Oxford University Press.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS medicine*, *3*(10), e294.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine*, *88*(2), 251-258.

Kreitler, S. (2005). The effects of cultural diversity on providing health services. *EDTNA-ERCA Journal*, *31*(2), 93-98.

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: targeted and tailored approaches. *Health Education & Behavior*, *30*(2), 133-146.

Langer, N. (1999). Culturally competent professionals in therapeutic alliances enhance patient compliance. *Journal of health care for the poor and underserved*, *10*(1), 19-26.

LaVeist, T. A., & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care?. *Journal of health and social behavior*, 296-306.

Lee, S. A., & Farrell, M. (2006). Is cultural competency a backdoor to racism?. *Anthropology News*, *47*(3), 9-10.

Leininger, M. (1993). Towards conceptualization of transcultural health care systems: Concepts and a model. *Journal of Transcultural Nursing*, *4*(2), 32-40.

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of family medicine and primary care*, *4*(3), 324.

Like, R. C., Steiner, R. P., & Rubel, A. J. (1996). STFM Core Curriculum Guidelines. Recommended core curriculum guidelines on culturally sensitive and competent health care. *Family Medicine*, *28*(4), 291.

Like, R.C. (2011). Educating clinicians about cultural competence and disparities in health and disparities in health and health care. Journal of Continuing Education in the Health Professions, 31 (3), 196–206.

Lister, P. (1999). A taxonomy for developing cultural competence. *Nurse Education Today*, *19*(4), 313-318.

Macpherson, C. (1999). *The Stephen Lawrence Inquiry: report of an inquiry*. London: TSO.

Macpherson, C. (2018). Pacific churches in New Zealand. Retrieved from https://teara.govt.nz/en/pacific-churches-in-new-zealand

Majumdar, B., Browne, G., Roberts, J., & Carpio, B. (2004). Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. *Journal of Nursing Scholarship*, *36*(2), 161-166.

Māori health models. Retrieved from https://www.health.govt.nz/our-work/populations/Māori-health/Māori-health-models

Maxwell, A. E., Crespi, C. M., Antonio, C. M., & Lu, P. (2010). Explaining disparities in colorectal cancer screening among five Asian ethnic groups: a population-based study in California. *BMC cancer*, *10*(1), 214.

McCalman, J., Jongen, C., & Bainbridge, R. (2017). Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. *International journal for equity in health*, *16*(1), 78. doi:10.1186/s12939-017-0571-5

Mehta, S. (2012). Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency. Retrieved from: http://www.countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/healthstatus/2012-health-needs-of-asian-people.pdf.

Meissner, F., & Vertovec, S. (2015). Comparing super-diversity. *Ethnic and racial studies*, *38*(4), 541-555.

Meyers, K. (2007). Racial and ethnic health disparities: Influences, actors, and policy opportunities.

Miles, M. B., & Huberman, M. (1994). *Qualitative data analysis: An expanded sourcebook*. sage.

Ministry of Health. (2015). *Health Literacy Review: A guide*. Wellington: Ministry of Health.

Ministry of Health. (2017). *HISO 10001:2017 Ethnicity Data Protocols*. Wellington: Ministry of Health.

Ministry of Health. (2018). *New Zealand health system*. [online] Available at: https://www.health.govt.nz/new-zealand-health-system.

Moerman, D. E. (2002). Explanatory mechanisms for placebo effects: cultural influences and the meaning response. *The science of the placebo: Toward an interdisciplinary research agenda. London: BMJ Books*, 77-107.

Mortensen, A., Lim, S., & Puddle, S. (2018). *Pre and Post CALD Training Evaluation Study*. Auckland: Waitematā District Health Board, eCALD® Services.

Mostow, C., Crosson, J., Gordon, S., Chapman, S., Gonzalez, P., & Hardt, E. et al. (2010). Treating and Precepting with RESPECT: A Relational Model Addressing Race, Ethnicity, and Culture in Medical Training. *Journal Of General Internal Medicine*, *25*(S2), 146-154. doi: 10.1007/s11606-010-1274-4

Murray, T. S., Hagey, J., Willms, D., Shillington, R., & Desjardins, R. (2008). Health literacy in Canada: a healthy understanding.

National ethnic population projections: 2013(base)–2038 (update). (2017). Retrieved from https://www.stats.govt.nz/information-releases/national-ethnic-population-projections-2013base2038-update

Nelson, A. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the National Medical Association*, *94*(8), 666.

New Zealand Government. Health Practitioners Competence Assurance Act 2003 (2017). Wellington.

New Zealand Government. New Zealand Public Health and Disability Act 2000 (2018). Wellington.

New Zealand Period Life Tables: 2012–14. (2015). Retrieved from http://archive.stats.govt.nz/browse_for_stats/health/life_expectancy/NZLifeTables_HOTP12-14.aspx

New Zealand Population. (2019). Retrieved from http://www.worldometers.info/world-population/new-zealand-population/

Ng, E., & Omariba, D. W. R. (2014). Immigration, generational status and health literacy in Canada. *Health Education Journal*, *73*(6), 668-682.

Norredam, M., Nielsen, S. S., & Krasnik, A. (2009). Migrants' utilization of somatic healthcare services in Europe—a systematic review. *European journal of public health*, *20*(5), 555-563.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847.

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of social research methodology*, *11*(4), 327-344.

Orange, C. (2015). *The treaty of Waitangi*. Bridget Williams Books.

Orth, J. E., Stiles, W. B., Scherwitz, L., Hennrikus, D., & Vallbona, C. (1987). Patient exposition and provider explanation in routine interviews and hypertensive patients' blood pressure control. *Health Psychology*, *6*(1), 29.

Pachter, L. M. (1994). Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *Jama*, *271*(9), 690-694.

Paniagua, F. A. (2013). *Assessing and treating culturally diverse clients: A practical guide*. Sage Publications.

Pasefika Proud. (2016). *The profile of Pacific peoples in New Zealand*. Pasefika Proud.

Patel, V. (1995). Explanatory models of mental illness in sub-Saharan Africa. *Social Science & Medicine*, *40*(9), 1291-1298.

Pedersen, P. B., & Marsella, A. J. (1982). The ethical crisis for cross-cultural counseling and therapy. *Professional Psychology*, *13*(4), 492.

Pérez-Stable, E. J., Napoles-Springer, A., & Miramontes, J. M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical care*, *35*(12), 1212-1219.

Perloff, R. M., Bonder, B., Ray, G. B., Ray, E. B., & Siminoff, L. A. (2006). Doctor-patient communication, cultural competence, and minority health: Theoretical and empirical perspectives. *American Behavioral Scientist*, *49*(6), 835-852.

Poker, A., Hubbard, H., & Sharp, B. A. C. (2004). The first national reports on United States healthcare quality and disparities. *Journal of nursing care quality*, *19*(4), 316-321.

Primary health organisations. (2011). Retrieved from https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/primary-health-organisations?mega=NZ%20health%20system&title=Primary%20health%20organisations

Purnell, L. (2002). The Purnell model for cultural competence. *Journal of transcultural nursing*, *13*(3), 193-196.

Qureshi, A., Collazos, F., Ramos, M., & Casas, M. (2008). Cultural competency training in psychiatry. *European psychiatry*, *23*, 49-58.

Rau, S. A., Sakarya, S., & Abel, T. (2014). When to see a doctor for common health problems: distribution patterns of functional health literacy across migrant populations in Switzerland. *International journal of public health*, *59*(6), 967-974.

Renzaho, A. M. N., Romios, P., Crock, C., & Sønderlund, A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care—a systematic review of the literature. *International Journal for Quality in Health Care*, *25*(3), 261-269.

Rich, M., Patashnick, J., & Chalfen, R. (2002). Visual illness narratives of asthma: explanatory models and health-related behavior. *American journal of health behavior*, *26*(6), 442-453.

Richmond, V. P., & McCroskey, J. C. (1997). *Communication: Apprehension, avoidance, and effectiveness*. Pearson College Division.

Roberts, J. (2015). Local action on health inequalities: Improving health literacy to reduce health inequalities. *London: Public Health England*.

Robins, L. S., Fantone, J. C., Hermann, J., Alexander, G. L., & Zweifler, A. J. (1998). CULTURE, COMMUNICATION, AND THE INFORMAL CURRICULUM: Improving Cultural Awareness and Sensitivity Training in Medical School. *Academic Medicine*, *73*(10), S31-34.

Royal New Zealand College of General Practitioners. (2016). *Foundation Standard & Interpretation Guide* (pp. 15-18). Wellington: Royal New Zealand College of General Practitioners.

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association*, *100*(11), 1275.

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of internal medicine*, *159*(9), 997-1004.

Saha, S., Taggart, S. H., Komaromy, M., & Bindman, A. B. (2000). Do patients choose physicians of their own race?. *Health affairs*, *19*(4), 76-83.

Sahlins, M. (1978). *Culture and Practical Reason*. University of Chicago Press.

Saldaña, J. (2015). *The coding manual for qualitative researchers*. Sage.

Salimbene, S. (1999). Cultural competence: A priority for performance improvement action. *Journal of Nursing Care Quality*, *13*(3), 23-35.

Schulman, K., Berlin, J., Harless, W., Kerner, J., Sistrunk, S., & Gersh, B. et al. (1999). The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization. *New England Journal Of Medicine*, *340*(8), 618-626. doi: 10.1056/nejm199902253400806

Schyve, P. M. (2007). Language differences as a barrier to quality and safety in health care: the Joint Commission perspective. *Journal of general internal medicine*, *22*(2), 360-361.

Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: a conceptual framework for teaching and learning. *Medical education*, *43*(3), 229-237.

Seijo, R., Gomez, H., & Freidenberg, J. (1991). Language as a communication barrier in medical care for Hispanic patients. *Hispanic Journal of Behavioral Sciences*, *13*(4), 363-376.

Sheridan, N. F., Kenealy, T. W., Connolly, M. J., Mahony, F., Barber, P. A., Boyd, M. A., ... & Dyall, L. (2011). Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health*, *10*(1), 45.

Siggelkow, N. (2007). Persuasion with case studies. The Academy of Management Journal, 50(1), 20-24.

Silverman, D. (2013). *Doing qualitative research: A practical handbook* SAGE Publications Limited.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in healthcare.

Stanton, A. L. (1987). Determinants of adherence to medical regimens by hypertensive patients. *Journal of Behavioral Medicine*, *10*(4), 377-394.

Statistics New Zealand. (2018). Retrieved from https://www.stats.govt.nz/Stewart, M., Brown, J. B., Boon, H., Galajda, J., Meredith, L., & Sangster, M. (1999). Evidence on patient-doctor communication. *Cancer*, *25*(1999), 30.

Stewart, S. (2006). Cultural competence in health care. *Sydney: Diversity Health Institute*.

Stiefel, M. C., Perla, R. J., & Zell, B. L. (2010). A healthy bottom line: healthy life expectancy as an outcome measure for health improvement efforts. *The Milbank Quarterly*, *88*(1), 30-53.

Stiles, W. B., Putnam, S. M., Wolf, M. H., & James, S. A. (1979). Interaction exchange structure and patient satisfaction with medical interviews. *Medical Care*, 667-681.

Stimson, G. V. (1974). Obeying doctor's orders: a view from the other side. *Social Science & Medicine (1967)*, *8*(2), 97-104.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The counseling psychologist*, *10*(2), 45-52.

Sullivan, K. (1993). Bicultural education in Aotearoa/New Zealand: establishing a Tauiwi side to the partnership. *New Zealand Annual Review of Education*, *3*(1993), 191-222.

Sullivan, L. W. (2004). Missing persons: minorities in the health professions, a report of the Sullivan Commission on Diversity in the Healthcare Workforce.

Taylor, S., Dy, S., Foy, R., Hempel, S., McDonald, K., & Ovretveit, J. et al. (2011). What context features might be important determinants of the effectiveness of patient safety practice interventions?. *BMJ Quality & Safety*, *20*(7), 611-617. doi: 10.1136/bmjqs.2010.049379

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, *9*(2), 117-125.

Thackrah, R., & Thompson, S. (2013). Refining the concept of cultural competence: building on decades of progress. *Medical Journal of Australia*, *199*(1), 35-38.

The Lewin Group, Inc. (2001). *Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings: A Review of the Literature*. Washington, D.C.: The Lewin Group, Inc.

Tiatia, J. (2008). *Pacific Cultural Competencies: A literature review*. Wellington: Ministry of Health.

tikanga. Retrieved from https://Māoridictionary.co.nz/search?keywords=tikanga

Tolmac, J., & Hodes, M. (2004). Ethnic variation among adolescent psychiatric in-patients with psychotic disorders. *The British Journal of Psychiatry*, *184*(5), 428-431.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC health services research*, *14*(1), 99.

Uiters, E., Devillé, W., Foets, M., Spreeuwenberg, P., & Groenewegen, P. P. (2009). Differences between immigrant and non-immigrant groups in the use of primary medical care; a systematic review. *BMC health services research*, *9*(1), 76.

United Nations. (2017). *International Migration Report 2017: Highlights*. New York: United Nations.

University of Auckland, Auckland UniServices Ltd (2012). Final Report: Evaluation of the WDHB CALD Cross-Cultural Training Course. Auckland: University of Auckland, Auckland UniServices Ltd.

Valente, T. W. (2010). *Social networks and health: Models, methods, and applications* (Vol. 1). New York: Oxford University Press.

Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social science & medicine*, *50*(6), 813-828.

Vega, W. A. (2005). Higher stakes ahead for cultural competence. *General Hospital Psychiatry*, *27*(6), 446-450.

Waitematā DHB Leadership. Retrieved from https://www.Waitematādhb.govt.nz/about-us/leadership/

Waitematā District Health Board. (2017). *Waitematā DHB Health Needs Assessment 2017*. Auckland: Waitematā District Health Board.

Ward, C., & Liu, J. H. (2012). Ethno-cultural conflict in Aotearoa/New Zealand: Balancing indigenous rights and multicultural responsibilities. In *Handbook of ethnic conflict*(pp. 45-69). Springer, Boston, MA.

Warhurst, R. (2011). Role modelling in manager development: Learning that which cannot be taught. *Journal of European Industrial Training*, *35*(9), 874-891.

WATIS Interpreting Service. (2019). Retrieved from http://www.asianhealthservices.co.nz/Watis-Interpreting-Service

Watt, S., & Norton, D. (2004). Culture, ethnicity, race: what's the difference?. *Nursing Children and Young People*, *16*(8).

Wells, M. I. (2000). Beyond cultural competence: A model for individual and institutional cultural development. *Journal of community health nursing*, *17*(4), 189-199.

Wheeler, S. M., & Bryant, A. S. (2017). Racial and ethnic disparities in health and health care. *Obstetrics and Gynecology Clinics*, *44*(1), 1-11.

World Health Organization. (1946). *Constitution of the World Health Organization*. New York.

Yamada, A. M., & Brekke, J. S. (2008). Addressing mental health disparities through clinical competence not just cultural competence: The need for assessment of sociocultural issues in the delivery of evidence-based psychosocial rehabilitation services. *Clinical Psychology Review*, *28*(8), 1386-1399.

Yin, R. (2009), *Case Study Research: Design and Methods (4th Edition),* Thousand Oaks, Sage Publications.

Zola, I. K. (1966). Culture and symptoms--an analysis of patient's presenting complaints. *American sociological review*, 615-630.

Zuvekas, S. H., & Taliaferro, G. S. (2003). Pathways to access: health insurance, the health care delivery system, and racial/ethnic disparities, 1996–1999. *Health affairs*, *22*(2), 139-153.

Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane database of systematic reviews*, (3).