Proposed changes to the ADC/DCNZ Accreditation standards for dental practitioner programs

13 May 2020

Māori Oral Health Quality Improvement Group

Submission

About the Māori Oral Health Quality Improvement Group

The Māori Oral Health Quality Improvement Group brings together the expertise of Māori oral health experts and practitioners from across the Māori oral health provider sector. Our aim is to progress change to achieve equity of oral health outcomes for Māori. One way we do this is providing high quality advice to the Ministry of health and others by drawing on our clinical and technical expertise as Indigenous sector practitioners in the development of government policy for Indigenous oral health.

The Dental Council is a regulatory authority created by the Health Practitioners Competence Assurance Act 2003. The role of the Dental Council is to ensure oral health practitioners meet and maintain clinical and practice standards in order to protect the health and safety of the New Zealand public and in accordance with the obligations enshrined within the Treaty of Waitangi. Māori are the New Zealand public.

Summary of our submission

The Māori Oral Health Quality Improvement Group (the QIG) has been partnered with the University of Otago in the delivery of culturally competent care since the implementation of the out-placement program for final year students. Improving the cultural competence curricular and quality of cultural competence in training environments is a topic of which the QIG has considerable expertise. It is a fundamental principle for clinical care and we have long advocated for this. It was included in the equity matrix we developed in consultation with the wider health sector think tank in late 2018 and tested at the 2019 Māori Oral Health equity symposium. It is included in the Māori Oral Health Equity Action Plan developed as an output from that symposium. We are pleased to receive the consultation information from Dental Council of New Zealand (DCNZ), and encourage you to continue to focus on this important mahi.

While the intention to include new cultural competence domains is admirable, we have concerns about the framing of the accreditation standards overall and the content of the cultural competence domain for New Zealand. For this reason, we think the standards need to be reworked in partnership with Māori before they are finalised.

This submission provides more detail to our concerns, but in summary our four main points are:

1. **The framing around Māori health, te Tiriti o Waitangi and equity in the consultation document that accompanies the draft accreditation standard is confusing.**

   It requires more clarity about:

   a. the obligations of dental practitioners,
   b. the status of Māori as the Indigenous population of Aotearoa
   c. health equity and the drivers of inequity.

2. **The cultural competence domain for New Zealand is out of step with the most recent literature on cultural safety and health professionals**.

   Our view is that we should be learning from the work of the Medical Council and our nursing colleagues to move away from narrow definitions of cultural competence that tend to perpetuate stereotypes and reinforce the current ways of doing things rather than addressing the real causes of health inequity.

3. **We recommend rewriting the cultural competence domain of the accreditation standards.**

   We propose this be approached in two main ways:
   a. Responsiveness to Māori be woven throughout the standard. In the body of this submission we make some suggestions how this could be done. Our aim

is to make sure the standards as a whole reflect the DCNZ commitments to te Tiriti o Waitangi and Māori and to achieving health equity and public safety.

b. The current domain and standards be updated to better reflect a more developed understanding of cultural competence and its impact on cultural safety, that is more appropriate for Aotearoa.

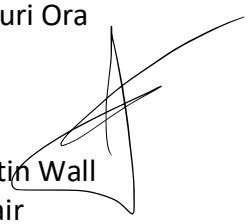
4. **DCNZ must look across its areas of responsibility to address the significant inequities in oral health**.

   This is of course broader than looking just at accreditation standards and includes

   a. ensuring all dental practitioners complete cultural competence and cultural safety training
   b. setting targets to increase the number of Māori in oral health training
   c. reviewing and strengthening existing cultural competence standards for the profession overall. We note that DCNZ have committed to developing a comprehensive cultural competence framework for oral health practitioners in New Zealand at a later stage. We support this work.

Thank you for considering this submission. If you have further questions on the submission or the work of the QIG to achieve equity and improve Māori oral health outcomes please contact us admin@Māorioralhealth.org.nz.

Mauri Ora



Justin Wall
Chair
Māori Oral Health Quality Improvement Group

Introduction

This submission was developed in response to an invitation from the Dental Council of New Zealand (DCNZ) for feedback on its proposal (with the Australian Dental Council (ADC)) on changes to accreditation standards for dental practitioner programmes.

Amongst the most substantive changes proposed by DCNZ is the inclusion of specific proposals for a dedicated domain in the standards for cultural competence for Māori and Pacific Peoples that would apply in New Zealand, and a separate, additional, domain for cultural competence for Aboriginal and Torres Strait Islanders.

The consultation document also seeks feedback on additional criterion requiring programmes ensure students understand their legal, ethical and professional responsibilities and amended criteria to require involvement of dental consumers in programme design, management and quality improvement.

DCNZ and ADC have also sought feedback on whether any additional standards are required or whether proposed standards should be deleted or reworded.

In preparing this submission, we asked ourselves six questions:

- Do the consultation document and accreditation standards appropriately acknowledge and apply te Tiriti o Waitangi?
- Does the bundling of Māori and Pacific Peoples as a single grouping prohibit adherence to the articles of te Tiriti o Waitangi?
- Is the cultural competence domain and general approach in keeping with the ongoing developments around cultural competence and safety that are focused on achieving health equity?
- How will cultural competence be implemented as safety? with particular reference to the role DCNZ has to protect the health and safety of New Zealand citizens, Māori.
- What is the evidence of partnership in the development of this accreditation standard?
- Will this proposal help us achieve health equity for Māori?

After considering the consultation document and draft accreditation standard carefully, our submission focused on four main points.

Framing around Māori health, te Tiriti o Waitangi and equity in the consultation document that accompanies the draft accreditation standard is confusing.

Although not part of the standard itself, the consultation document provides the rationale for including a cultural competence domain for New Zealand. This section is confusing and helps to explain some shortcomings with the standards themselves.

Our specific concerns are driven by the limited analysis or understanding of te Tiriti o Waitangi included in the consultation document and the lack of acknowledgement of the drivers of health inequity in Aotearoa.

In 2019 the Waitangi Tribunal published its *Hauora* report on stage one of its inquiry into health services and outcomes. Although stage one looked mostly at primary health care and general practice, evidence was presented on oral health and there are a number of findings that are relevant to all parts of the health sector.

DCNZ should, in particular, consider how it can truly give effect to the principles of the Treaty as articulated by the 2019 Tribunal report. The following table is adapted from a recent New Zealand Medical Journal article[1] on the Tribunal report and sets out what each of the principles mean.

Treaty principles for the primary health care system
The guarantee of tino rangatiratanga, which provides for self-determination and mana motuhake in the design, delivery and monitoring of primary health care.
The principle of equity, which puts the focus on achieving equitable health outcomes for Māori.
The principle of active protection, which requires us to take action to achieve equitable health outcomes for Māori.
The principle of options, which is about providing for and properly resourcing kaupapa Māori health services. Furthermore, all primary health care services should be provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
The principle of partnership, which is about working with Māori to work in partnership in the governance, design, delivery and monitoring of primary health care services.

The consultation document may well attempt to acknowledge some of these principles, and we support its recognition that a one-size-fits-all approach to Māori oral health is inappropriate and in itself unsafe. In addition the focus the document places on "diversity" and the merging Māori and Pacific people health needs into a singular grouping suggests a lack of regard for Māori Indigenous rights and a misunderstanding of what cultural competence is and what cultural safety should be. We would expect Māori to be referenced on our own. If Pacific peoples health and well being is to be considered it should be in a category of its own and this itself needs to recognise that pacific peoples are not one culture.

Placing Māori with Pacific peoples significantly diminishes the rights of Māori and reinforces ingrained behaviours that deliberately work to disenfranchise Māori.

[1] Baker, G., Baxter, J. and Crampton, P. " The primary healthcare claims to the Waitangi Tribunal" NZMJ 8 November 2019, Vol 132 No 1505

In talking about inequitable outcomes the document fails to recognise the overwhelming evidence, including from Aotearoa, of the complex causes and manifestations of inequities. Included among these are progressive and ongoing impact of colonisation, differential access to the determinants of health, barriers to access including cost, transport, and issues around institutional racism in health care settings.[2]

The cultural competence domain for New Zealand, as set out in the accreditation standards, is out of step with the most recent literature on cultural safety and health professionals.

Our view is that we should be learning from the work of the Medical Council and our nursing colleagues to move away from narrow definitions of cultural competence that tend to perpetuate stereotypes and reinforce the current ways of doing things rather than addressing the real causes of health inequity.

Many of our colleagues are signalling a preference for cultural safety, rather than cultural competence because of its acknowledgement of power relationships in clinical interactions and patient rights. This work has a long history, building off the legacy of Irihapeti Ramsden and others in the context of nursing from at least the 1990s[3].

An important lesson from cultural safety is that we should move away from the idea that, as dental professionals, we should focus on learning cultural customs of different ethnic groups. Instead, as Elana Curtis and colleagues wrote last year[4], we should learn the from the elements of cultural safety that seek "to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice and by allowing the patient to determine whether a clinical encounter is safe".

The cultural competence domain of the (NZ) accreditation standard needs to be re-written.

On balance, we consider that the cultural competence domain for New Zealand as currently written is not fit for purpose. There are two main approaches we would encourage DCNZ to take, in partnership with Māori:

---

[2] We recommend considering and applying the thinking of Papaarangi Reid and Bridget Robson from the 2007 *Hauora IV* publication. Although we might have more up to date evidence now, their framing and understanding of inequities would be invaluable in this discussion. The chapter is available online here.

[3] See for example Elaine Papps, Irihapeti Ramsden. Cultural Safety in Nursing: the New Zealand Experience, International Journal for Quality in Health Care, Volume 8, Issue 5, 1996, Pages 491–497, https://doi.org/10.1093/intqhc/8.5.491

[4] Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

a. Responsiveness to Māori be woven throughout the standard. Our aim is to make sure the standards as a whole reflect DCNZ's commitments to te Tiriti o Waitangi and Māori and to achieving health equity.

b. The current domain and standards be updated to better reflect a more developed understanding of cultural competence and cultural safety, that is more appropriate for Aotearoa.

The specific changes we recommend are:

- The standard is to be a specific standard on Māori health, either as a stand-alone domain or as an explicit part of each domain.

- Pacific peoples to be referenced on their own.

- Rewrite the standard statement for the cultural competence domain. At the moment it is written specifically to focus on Māori and Pacific health while stating that cultural competence and culture is broader than these two groups. We agree that Māori health and Pacific health outcomes must be improved through all work undertaken by DCNZ. However, the approach taken here has two consequences. Firstly, it would reinforce stereotypes and be "othering" of Māori and Pacific populations. These are predictable results where cultural competence requirements single out some groups and not others. Secondly it is disappointing that DCNZ has chosen to diminish the status of Māori as the Indigenous population of New Zealand by, unlike ADC, combining an Indigenous and non-Indigenous population in the standard. Grouping Māori and Pacific peoples as a group removes an obligation to uphold and honour te Tiriti o Waitangi. This may be accidental or deliberate, either way it demonstrates why this approach is unsafe. We believe the dental profession must do better for Pacific people, but this must be done in a way that also acknowledges and respects Indigenous rights.

- Amend the current standards by moving them to other domains within the accreditation standards. The following table provides a summary analysis of each of the current standards.

Proposed standard	Recommended action
The program demonstrates its commitment to honouring the Treaty of Waitangi as the foundation document of New Zealand.	Agree that this is fundamental as part of the accreditation standard, but it is not only a cultural competence standard. It is an expectation of all New Zealand health and disability sector. Move to academic governance and quality assurance domain or programme of study domain (noting it applies to NZ only).

The program upholds both the Articles and Principles of the Treaty through its educational philosophy and delivery	As above. And to demonstrate the ongoing harmful impact of colonialisation
The program, staff and students understand the Māori perspective of health and wellbeing, their beliefs and cultural practices as it pertains to oral health in particular.	There is no singular "perspective"[5] and this runs the risk of becoming a one-size-fits-all tick box activity. Of course dental practitioners will need to have a degree of understanding of Māori cultural understandings and models of health but this shouldn't be confused with cultural safety. Reword and include as part of a set of standards on Māori health.
Cultural understanding of Māori and Pacific peoples are integrated throughout the program, clearly articulated in required learning outcomes (including competencies that will enable effective and respectful interaction with Māori).	See earlier comments about 'othering'. Stronger wording would extend beyond acquiring knowledge about other culture and developing appropriate skills and attitudes to instead identifying interventions that acknowledge and address biases and stereotypes[6].
Clinical experiences provide students with experience of providing culturally competent care for Māori and Pacific peoples, and clinical application of cultural competence is appropriately assessed.	As above.
There is a partnership in the design and management of the program from Māori and Pacific peoples.	We strongly agree that partnership with Māori (and Pacific people and other groups) in the design and management of the programme is critical. Recommend moving this to the academic governance and quality assurance domain (noting it applies to New Zealand only). Also recommend that DCNZ role models partnership with Māori in the next and final iteration of this accreditation standard. We acknowledge the reference group used in the development of the

[5] See for example Fiona Cram et. al (2019) ORANGA AND MĀORI HEALTHINEQUITIES, 1769–1992 (Report prepared for the Ministry of Health as part of the Waitangi Tribunal Inquiry into Health Services and Outcomes. Available online here)

[6] See Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

	accreditation standard. While we support the inclusion of Māori oral health experts on this group we note the body of evidence of the difficulty being a lone Māori or Pacific voice on a group[7], and also that this does not represent partnership with Māori. For more information on ways to think about the way partnership could work you will want to consider Te Arawhiti's Guidelines for Engagement with Māori (2018).
The program provider promotes and supports the recruitment, admission, participation, retention and completion of the program by Māori and Pacific peoples.	We agree that this is critical but are not sure that it fits appropriately in this cultural competence standard as well as it demonstrates the programme of study domain.
The program provider ensures students are provided with access to appropriate resources, and to staff and the community with specialist knowledge, expertise and cultural capabilities, to facilitate learning about Māori health.	Consider moving this to a new Māori health domain.
The programme recognises the important role of Māori Te Reo, Ngā Mokai o Ngā Whetu (Māori Dental Student's Association) and Te Aō Marama (The New Zealand Māori Dental Association) in achieving cultural competence to oral health practitioners.	We agree these are critical but suggest: Re-wording so that the important role of the Māori language (Te Reo Māori, not usually referred to as Māori Te Reo) is separated out from the role of Māori groups. This reworded standard should be part of a Māori heath competency. We would also suggest including the Māori Oral Health Quality Improvement Group as a group that supports cultural competence in oral health practitioners. However, the standard needs to be clearer about how the role of these groups can be recognised. The unintended consequence of this kind of statement is that Māori groups are expected to provide additional, unfunded, support just because we are Māori.
Staff and students work and learn in a culturally appropriate environment.	We agree with this standard.

[7] Heather Came, Tim McCreanor, Maria Haenga-Collins & Rhonda Cornes (2019) Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand, Kōtuitui: New Zealand Journal of Social Sciences Online, 14:1, 126-135, DOI: 10.1080/1177083X.2018.1561477

In addition, we consider further standards should be included and recommend DCNZ reflect on whether the standards are sufficiently:

- Focused on achieving equity
- Highlight interventions that acknowledge and address biases and stereotypes
- Promote a framing of cultural safety that requires a focus on power relationships and inequities within health care interactions
- Support monitoring of cultural safety and measurement of (in)equity.

Now is an opportune time for DCNZ to look across its areas of responsibility to address the significant inequities in oral health.

In reviewing the accreditation standard, it is clear that we need to revisit the approach to cultural competence in oral health. This is of course broader than looking just at accreditation standards and includes

- ensuring all dental practitioners' complete cultural competence and cultural safety training to give an understanding of the reasons why inequity exits and how to eliminate it.
- setting targets to increase the number of Māori in dental and oral health training to reflect the proportion of Māori present in the population cohort of that age group.
- reviewing and strengthening existing cultural competence standards for the profession overall. We note that DCNZ has committed to developing a comprehensive cultural competence framework for oral health practitioners in New Zealand at a later stage. We support this work.

We have included many of these considerations in our 2019 equity matrix and subsequent Action Plan, attached, and encourage DCNZ to continue to work to strengthen oral health practice in New Zealand and eliminate inequities.