

24 March 2026

Via email: [Strategic@mcnz.org.nz](mailto:Strategic@mcnz.org.nz)

Tēnā koe,

**Re: Submission to Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand  
Consultation: Draft statements on cultural competence, cultural safety, and hauora  
Māori**

### About ProCare

ProCare is a leading healthcare provider that represents more than 140 general practices across Aotearoa New Zealand, and we welcome the opportunity to provide a response to the Medical Council's Consultation on the draft statements on cultural competence, cultural safety, and hauora Māori [the consultation].

ProCare is dedicated to supporting excellence in primary care and delivering services that uplift the health and wellbeing of our communities. Across Tāmaki Makaurau and Te Tai Tokerau, the practices we work with support about 700,000 patients.

We are committed to honouring Te Tiriti o Waitangi and advancing population health and equity to improve outcomes for Māori, Pacific Peoples, and others in need. The following outlines ProCare's position on the consultation.

### ProCare's position

As Aotearoa's largest primary care network, we support standards that are practical for busy clinical environments, strengthen patient and whānau experience, and demonstrably improve equity. The Council's direction of replacing the 2019 statement and clarifying expectations for everyday practice is the right step.

We support the intention to set clear expectations for culturally competent and culturally safe care and to improve equity of outcomes for Māori and all communities across Aotearoa.

We recognise the Council's statutory role under the Health Practitioners Competence Assurance Act 2003 to set standards for clinical and cultural competence, and we note that these drafts will replace the 2019 Statement on cultural safety. We also acknowledge alignment with national direction, including Pae Tū: Hauora Māori Strategy (Manatū Hauora), which emphasises achieving pae ora through actions that improve mauri ora, whānau ora and wai ora.

Our submission offers specific refinements to enhance clarity, reduce ambiguity, and support implementation at scale across primary and secondary care.

### Statement on cultural competence and cultural safety

#### Q1. Is the draft statement clearly written and easy to understand?

Yes, with minor refinements recommended.

- What works well: The combined framing makes it explicit that *cultural competence* (provider capabilities) and *cultural safety* (patient-determined experience of care) are both essential and mutually reinforcing in everyday practice. The plain-English tone and separation of expectations for individual doctors vs employers/organisations aid usability across settings.
- Where clarity could be enhanced:
  1. Define “reasonable steps” more concretely (e.g., minimum expectations for reflective practice, use of local data to identify inequities, and co-design with communities)
  2. Name common contexts (telehealth, multidisciplinary teams, locum settings) to show how expectations apply in real workflows
  3. Include a short glossary (e.g., cultural safety, whanaungatanga, manaakitanga, equity vs equality), to support consistent interpretation. (This approach mirrors other national guidance documents that pair principles with operational definitions.)
  4. Clarify how patient-determined cultural safety should be understood and operationalised in practice, including the role of professional judgement, good-faith intent, and organisational processes for resolving concerns, to support consistency and fairness for patients and clinicians alike.

#### Q2. Are the expectations reasonable and proportionate?

Yes, provided implementation supports are explicit.

The expectations are proportionate to the influence doctors have on patient experience and outcomes. To ensure proportionality in busy primary and secondary services, we recommend that Council:

- Signal scaled expectations by role and context (e.g., trainees vs senior medical officers; short-stay urgent care vs longitudinal care)
- Provide optional, streamlined practical artefacts (e.g., brief reflection prompts, short case vignettes, and lightweight audit cues) that integrate into existing quality and appraisal processes rather than creating new reporting or compliance requirements, so expectations translate into everyday behaviours without undue administrative burden
- Encourage organisational enablement (time for learning, local data access, cultural supervision), recognising that individual competence flourishes in system-ready environments.

### **Q3. Is anything missing?**

Three gaps and suggested additions.

1. Measurement & feedback loops
  - Add guidance on measuring cultural safety using patient-reported experience measures (PREMs) such as PES (NZQHC National Primary Care Patient Experience Survey) comments and results by ethnicity as a resource, complaint themes, and equity-focused quality indicators—collected and reviewed at team level to drive improvement
  - Encourage stratification of quality and safety data by ethnicity to make inequities visible and actionable. (This is consistent with the equity orientation in Pae Tū.)
2. Whānau-centred, multidisciplinary practice
  - Explicitly recognise the role of whānau, hapori and iwi partners in planning and delivering care, and the importance of team-based cultural safety (doctors, nursing, kaiāwhina, admin, diagnostics).
3. Situations of clinical disagreement or risk
  - Provide examples of how to uphold cultural safety when there is tension between clinical risk assessment and patient/whānau preferences, including reassurance that respectful, evidence-based clinical disagreement and lawful professional expression remain appropriate and protected, alongside pathways for kaupapa Māori escalation, ethics input, and second opinions.

#### Q4. Any other comments?

- We support embedding reflective practice and patient-determined safety as core, aligning with international literature that positions cultural competence as a *stance and ongoing practice*, not a one-off credential
- We encourage Council to publish companion resources (micro-learnings, podcasts, short cases) and to partner with sector bodies for scale-up
- Implementation should avoid “tick-box” compliance; instead, close the loop between cultural safety learning, M&M/quality meetings, and annual appraisal
- As per Q1 above, clarify how patient-determined cultural safety should be understood and operationalised in practice, including the role of professional judgement, good-faith intent, and organisational processes for resolving concerns, to support consistency and fairness for patients and clinicians alike.

#### Statement on hauora Māori

#### Q5. Is the draft statement clearly written and easy to understand?

Yes, with opportunities to sharpen alignment to system settings.

- Strengths: The statement clearly sets expectations that uphold Te Tiriti o Waitangi, centre Māori aspirations, and emphasise actions that support equitable outcomes and Māori self-determination. It reads as a practical complement to existing system strategies.
- Refinements:
  - Link key expectations to the Pae Tū: Hauora Māori Strategy elements (mauri ora, whānau ora, wai ora) to make system alignment explicit
  - Add short, clinical scenarios demonstrating informed consent, shared decision-making in te reo me ōna tikanga, and safe documentation of cultural considerations.

#### Q6. Are the expectations reasonable and proportionate?

Yes, contingent on practical supports.

Expectations are reasonable for doctors and organisations, provided there is explicit direction on:

- Access to local relationships and pathways (IMPBs, Māori providers, kaumātua advisory)
- Time and resourcing for whakawhanaungatanga, interpreter access, and appropriate follow-up
- Learning pathways that build from foundational te ao Māori concepts through to advanced practice (e.g., cultural supervision).

### **Q7. Is anything missing?**

Four targeted additions.

1. Māori data sovereignty & governance
  - Include expectations that doctors and organisations understand and respect Māori data governance principles and use Māori-led frameworks when collecting, storing, and using data for quality improvement and research. This underpins trust and equitable outcomes.
2. Pathways for kaupapa Māori care
  - Provide guidance on referral and partnership with kaupapa Māori services, including how to co-create shared care plans and acknowledge rongoā and other Māori models of care where appropriate.
3. Workforce pipeline and cultural supervision
  - Encourage services to build Māori medical and wider clinical workforce pathways and to resource cultural supervision options for clinicians.
4. Environment & place
  - Briefly acknowledge wai ora (healthy environments) in clinical design (wayfinding, whānau spaces, karakia protocols), signalling that hauora Māori is also about *where* care happens, not only *how*.

### **Q8. Any other comments?**

- We endorse a step-wise implementation approach (foundation → intermediate → advanced), paired with locally led evaluation (IMPBs, Māori providers, consumer voice) to ensure the statement drives real change rather than compliance artefacts. [\[mcnz.org.nz\]](https://mcnz.org.nz)

- To support uptake, we suggest the Council publish a companion “Quick Guide for busy teams” (2–3 pages) with:
  - Five “always events” for culturally safe care
  - Three measures teams can track quarterly (e.g., Māori PREMs items, ethnicity-stratified DNAs/adverse events)
  - A one-page checklist for leaders to align rosters, rooms, and resources with hauora Māori principles.

### **Implementation considerations (cross-cutting)**

- **Clarity of accountability:** The drafts appropriately set expectations for doctors; we recommend a parallel signal to employers/clinical leaders to create conditions (time, tools, supervision) that enable clinicians to meet the standard
- **Consistency with national strategies:** Aligning language and examples with Pae Tū will help services embed the statements within existing planning and equity improvement work programmes
- **Monitoring & learning system:** Encourage services to integrate cultural safety insights into quality governance (clinical governance committees, board dashboards) and to publish learnings (de-identified) to lift sector capability
- **Regulatory certainty and employment alignment:** We encourage the Council to ensure the final statements are clearly aligned with existing employment, complaints, and disciplinary frameworks, including principles of natural justice and good-faith professional practice. Clear guidance on thresholds, examples, and escalation pathways will support equity goals while providing certainty for clinicians and employers operating in complex, high-pressure environments.

### **Conclusion**

ProCare supports the direction of travel in both draft statements and the Council’s intent to set clear, practical expectations that improve patient experience, safety, and equity. With the suggested refinements – particularly stronger measurement guidance, explicit Māori data governance expectations, and role-/context-specific examples – we believe the statements will be implementable, proportionate, and impactful across primary and secondary care.

We also consider it important that the final statements provide sufficient clarity and proportionality to support consistent implementation, workforce confidence, and clinical primacy, while advancing equity and culturally safe care.

We welcome further collaboration with the Council and sector partners to co-develop practical tools (case vignettes, metrics, and learning modules) that help every clinical team live these standards in daily practice.

If you would like to talk to us about our submission, please contact Dee Crooks, General Manager Brand & Communications, on [dee.crooks@procare.co.nz](mailto:dee.crooks@procare.co.nz).

Ngā mihi,



**Bindi Norwell**  
ProCare Group CEO



**Dr Allan Moffitt**  
Clinical Director



**Gabrielle Lord**  
Nursing Director & GM of  
Practice Services

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Medical Council of New Zealand  
[consultation@mcnz.org.nz](mailto:consultation@mcnz.org.nz)