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Abstract: There is increasing recognition in Australia that racial and ethnic minority groups experience significant disparities in health and health care compared with the average population and that the Australian health care system needs to be more responsive to the health and care needs of these groups. The paper presents the findings of a year long study that explored what providers and recipients of health care know and understand about the nature and implications of providing culturally safe and competent health care to minority racial and ethnic groups in Victoria, Australia. Analysis of the data obtained from interviewing 145 participants recruited from over 17 different organizational sites revealed a paucity of knowledge and understanding of this issue and the need for a new approach to redress the status quo.

Key Words: Cultural Safety, Cultural Competency, Minorities, Health Outcomes, Australia.

HEALTH CARE PROVIDER AND CONSUMER UNDERSTANDINGS OF CULTURAL SAFETY AND CULTURAL COMPETENCY IN HEALTH CARE: AN AUSTRALIAN STUDY

It is being increasingly recognized internationally that the health status of racial and ethnic minority groups (including immigrants and refugees) is often worse than that of the average population of the country they are living in. The health status of the world’s Indigenous Peoples is also known to be well below that of the average population of their countries, with life expectancy rates at birth being 10 to 20 years less than for the overall population, and infant mortality rates being 1.5 to 3 times greater than the national average (International Council of Nurses, 2003). Although the reasons for the disparities in health among minority racial, ethno-cultural and indigenous groups are complex, it is widely acknowledged that a key variable contributing to this situation is that these groups are ‘not receiving the same level of health care in diagnosis, treatment and preventative services that the average population receives’ and that health care services ‘are not responsive enough to their specific needs’ (Novak-Zezula, 2005).

Australia has long been recognized as being a multicultural society (Commonwealth of Australia, 1999). Its population is comprised of people from over 200 different countries, practising over 116 religions, and speaking over 180 languages with over 16% of speaking languages other than English at home. Add to this the cultural and linguistic diversity of the Indigenous Peoples of Australia, and the multicultural nature of Australian society is underscored. These demographics indicate that Australia is not just a ‘multicultural society’, but also one of the most culturally diverse societies in the world.

Consistent with overseas trends, there has been increasing recognition in Australia that, despite being responsible for the provision of services to people

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and communities of diverse racial, ethno-cultural and language backgrounds, and despite over 30 years of multicultural policies and programs, Australia’s health care system is not as responsive as it should be to the needs of the culturally diverse minority populations it serves (Allotey, Manderson & Reidpath, 2002; Centre for Culture Ethnicity and Health 2003; Murray & Skull, 2005; Proctor, 2004). Of particular concern to those in the field is that people of minority racial, ethno-cultural and language backgrounds in Australia are generally ‘underserved’ by local health care and other social services, experience unequal burdens of disease, confront cultural and language barriers to accessing appropriate health care, and receive a lower level and quality of care when they do access health-care services compared to the average population (Murray & Skull, 2005; Correa-Velez, Gifford, & Bice, 2005; National Multicultural Mental Health Policy Steering Group, 2004; Proctor, 2004; Thomson, Burgo, Burrow, & Kirov, 2004; Allotey, 2003; Manderson & Allotey, 2003; Allotey, Manderson & Reidpath, 2002; Stolk, Ziguras, Saunders, Garland, Stuart, & Coffey, 1998). In response to these concerns, those at the forefront of delivering services to Australia’s multicultural population are demanding that immediate action be taken to improve the overall responsiveness of the Australian health-care system to the health-care needs of minority racial, ethno-cultural groups and ipso facto reduce the disparities in health and quality care that these groups are known to experience.

**LITERATURE REVIEW**

Since the late 1990s, there has been mounting international concern about racial and ethnic disparities in the health and health-care of resident minority groups, and the failure of local health-care services to improve the status quo (Novak-Zezula, 2005; Smedley, Sth & Nelson, 2003). A key outcome of these concerns has been the development of what some have termed the ‘cultural safety’ and ‘cultural competence’ movements in countries around the world, including Europe (notably, Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, The Netherlands, Spain, Sweden, the United Kingdom), the United States of America, Canada, New Zealand, and Australia (Novak-Zezula, 2005; Bischoff, 2003; Department of Health and Human Services, 2001a, 2001b; Gagnon, 2002; Wepa, 2005; Williams 1999). In line with these movements, cultural competence in particular (also termed ‘cultural responsiveness’ in European contexts) has become increasingly regarded as ‘an essential component of accessible, responsive, and high quality health care’ (The Lewin Group, 2002, p.1). To this end, cultural competence has gained increasing prominence in the strategic priorities and related activities of government bodies, professional organizations, and health researchers alike via a range of processes, including the development of national frameworks and standards for the delivery of culturally and linguistically appropriate health-care services (see, for example, the national frameworks and standards developed by the US Department of Health and Human Services, 2001a, 2001b, 2004). Similarly, although to a lesser extent, ‘cultural safety’ has also become increasingly regarded as an essential component of safe and high quality health-care delivery (Wepa, 2005; Eckermann, Dowd, Chong, et al., 2005; Williams, 1999).

Australia has yet to embrace the so-called ‘cultural safety’ and ‘cultural competence’ movements in a manner comparable to that experienced in Europe, the USA, Canada, and New Zealand. And it is unclear (either from the literature or other sources) whether and to what extent it will do so in the immediate future.

Significantly, a recent library search of multiple electronic databases (for all years) using the keywords ‘cultural safety’, ‘cultural competence’, ‘health care’, ‘minorities’ ‘Australia’ (and variations thereof), failed to locate any published studies specifically examining either health service provider or health consumer knowledge and understanding of the following processes as reflective of the Australian cultural context:

- cultural safety and cultural competence in health and nursing care domains;
- the possible relationship between cultural safety, cultural competence and health outcomes for people from diverse cultural and language backgrounds;
- the processes that are best suited to promoting safety and quality in health care, specifically for patients (and their families) from minority racial, ethno-cultural and language backgrounds.

**AIMS OF THE STUDY**

One of the key aims of this study was to discover and describe what health service providers (including nurses, health interpreters, ethnic liaison officers, health service managers, and other allied health professionals), and consumers from minority racial ethno-culturally and linguistically backgrounds know and understand about the notions of ‘cultural safety’ and ‘cultural competence’ in nursing and health care contexts, the possible relationship between these processes and health outcomes for people of diverse racial, ethno-cultural and language backgrounds, and the processes ‘best suited’ for promoting the responsiveness of health care specifically for patients (and their families) from minority racial, ethno-cultural and language backgrounds in Australia.

**DEFINITION OF TERMS**

For the purposes of this study ‘cultural safety’ is defined as:

An environment which is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening (Williams, 1999, p. 213).
### Table 1. Individual and Focus Group Interviews - Participant Categories

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>Nursing Staff (NS)</th>
<th>Patients/ Families Relatives (PR)</th>
<th>Ethnic Liaison Officers (ELO)</th>
<th>Health Interpreters (HI)</th>
<th>Allied Health Professionals (AH)</th>
<th>Ethnic Welfare Organizations (EWO)</th>
<th>Health Service Manager (HSM)</th>
<th>Educators/ Cultural Trainers (CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual interviews</td>
<td>5(5)</td>
<td>0</td>
<td>14(14)</td>
<td>2(2)</td>
<td>4(4)</td>
<td>3(3)</td>
<td>13(13)</td>
<td>11(11)</td>
</tr>
<tr>
<td>Focus group interviews</td>
<td>11(46)</td>
<td>3(8)</td>
<td>2(4)</td>
<td>1(4)</td>
<td>0</td>
<td>2(8)</td>
<td>7(19)</td>
<td>2(4)</td>
</tr>
<tr>
<td>TOTAL INTERVIEWS</td>
<td>16(51)</td>
<td>3(8)</td>
<td>16(18)</td>
<td>3(6)</td>
<td>4(4)</td>
<td>5(11)</td>
<td>20(32)</td>
<td>13(15)</td>
</tr>
</tbody>
</table>

# Note: (Number in brackets) represents the actual number of individuals who participated

* Does not include consumer perspectives (involving the sharing of personal narratives of in-patient hospital experiences) obtained from other participants

'Cultural competence', in turn, as classically defined by Cross, Bazron, Dennis and Isaacs (1989), is taken to mean:

A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A cultural 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 expansions of cultural knowledge, and the adaptation of services to meet culturally-unique needs (pp. 14-15).

**Research Problem**

The provision of culturally safe and culturally competent care is of considerable importance to the provision and management of safe and quality health care services to Australia’s multicultural population. What the providers and recipients of health care know and understand about the nature and implications of cultural safety and cultural competence in Australian health care contexts is not known, however.

**Research Questions**

What do health service providers (including nurses, health interpreters, ethnic liaison officers, health service managers, and other allied health professionals), and consumers from minority racial ethno-culturally and linguistically backgrounds:

1. know and understand about the notion of 'cultural safety' in nursing and health care contexts?
2. know and understand about the notion of 'cultural competence' in nursing and health care contexts?
3. know about or believe to be the relationship between cultural safety, cultural competence, and health outcomes for people from minority racial, ethno-cultural and language backgrounds?
4. know or believe to be the 'best processes' for ensuring the provision of culturally and linguistically appropriate health care services in Australia?

**Sample**

A purposeful sample of 145 participants (representing a total of 80 interview units, comprising 52 individual interviews and 28 focus groups, as per the eight categories depicted in Table 1) were recruited to this study.
Data Collection
The primary means of data collection were individual and focus group interviews. All interviews were semi-structured and progressed using open-ended questions. The length of each interview ranged from 45 minutes to 90 minutes. All interviews were transcribed verbatim by a professional transcriber.

Ethical Considerations
Ethics approval was obtained from the Human Research Ethics Committee at RMIT University and from all participating health services and ethnic welfare organizations prior to the commencement of the study. Each participant was given a 'plain language' letter explaining the nature and purpose of the study and invited to provide written consent to participate. Confidentiality and the anonymity of participants were maintained by the use of codes on all transcripts of interviews and by the removal of any identifying information from reports of the study.

Data Analysis
In keeping with the tenets of naturalistic inquiry, data were analysed using content and thematic strategies. The specific steps followed were: the verbatim transcription of the audio-taped interviews; drafting summaries of the researcher field notes and memos; active reading of the data (asking questions while the transcripts and summaries were being read); annotating data and recording comments in the margins of the transcripts and summaries; developing tables and matrices; creating categories; sorting the material into categories; noting the variables and relationships between categories; and relating the analytic framework and findings to the literature (Cresswell, 1998; Patton, 2002).

During the analysis process initial depictions of analysed data were organized around the research questions driving the inquiry and the categories of participants interviewed (presented in Table 1). Data were then searched for patterns, linkages and plausible explanations (Patton, 2002). Initial data configurations were 'shifted' (turned around) in an attempt to find other ways in which the data could be organized and which might lead to different findings. Rival configurations and organization of themes/competing explanations not supported by the data were ultimately dropped or modified. Conversely, configurations, themes and explanations that were supported by the data were judged to have the best 'fit' viz. between data and analysis, and were retained (Patton, 2002; Sandelowski, 2000).

Research Rigour and Validity
In order to ensure the rigour of the study due attention was given to upholding the following principles: credibility, 'fittingness', auditability, confirmability, and triangulation (Lincoln & Guba, 1985; Patton, 1999, 2002; Sandelowski, 1986).

Credibility of Research
In keeping with the tenets of rigorous qualitative research, high-quality data were actively sought and systematically analysed via the respective strategies of purposeful sampling and source triangulation (discussed below); the audiotape recording and verbatim transcriptions of all interviews (to ensure the accuracy of data collection); the rigorous inductive analysis of the data collected; and the maintenance of integrity in the data analysis process (including generating and assessing rival conclusions drawn from the analysis). In addition, when actively reading the transcripts, every effort was made to ensure that the data extrapolated were not taken out of context and/or misinterpreted to 'suit' the views of the researchers. Every effort was also made to ensure that the views of the participants quoted in this final report were described, interpreted and presented in a faithful manner.

Fittingness
'Fittingness' (also referred to as 'transferability') may be defined as:

the degree of congruence between sending and receiving contexts. If Context A and Context B are "sufficiently" congruent, then working hypotheses from the sending originating context may be applicable in the receiving context [italics original] (Lincoln & Guba, 1985, p. 124).

To express this another way, 'fit' may be said to have been achieved when 'findings can "fit" into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experience' (Sandelowski, 1986, p. 32). 'Fit' is also confirmed when the findings of a study 'fit' the data from which they have arisen. Finally, 'fit' is achieved when the findings of a study are well grounded in the experiences of participants and reflect their typical and atypical elements (Sandelowski, 1986, p. 32).

All samples selected for this study represented a 'slice from the life world' (Green, 2002). All responses were rigorously scrutinised to establish 'typicality' and 'atypicality' of responses; counter views identified via this process were also faithfully included in the final report (Sandelowski, 1986, p. 32). Feedback from participants and 'other audiences' (e.g. researchers and health service providers outside of the study context) who were privy to preliminary reports of the study's findings indicated a strong degree of transferability insofar as these 'other audiences' found the findings of the study to be 'meaningful and applicable to their own experience' and/or to the organisations and contexts in which they worked.

Auditability
The credibility and 'confirmability' (discussed below) of a qualitative inquiry ultimately depends on its 'audit trail' (also called 'decision trail') (Lincoln & Guba 1985;
Patton 2002). A clear decision trail of this research has been recorded. All materials assembled during the course of the project have been retained and, in accordance with the requirements of the RMIT University Human Research Ethics Committee will be stored securely for five years. After this date, in keeping with University policy, all documentation (accept the final report) will be destroyed. On account of the decision trail that has been recorded, it is envisaged that if other researchers of comparable experience were to undertake a similar study of the kind reported here (also termed ‘stepwise replication’), they would arrive at similar and/or comparable, but not contradictory conclusions given the data, perspective and situation at hand (Lincoln & Guba 1985, p. 317; see also Sandelowski 1986, p. 33).

**Confirmability**

Confirmability refers to the degree to which the ‘research product’ (i.e., data, findings, interpretations, and recommendations) ‘is supported by data and is internally coherent so that the “bottom line” may be accepted’ (Lincoln & Guba 1985, p. 318). The major technique for establishing confirmability is the ‘audit’ (considered above). In keeping with the requirements of confirmability, all transcripts of interviews, field notes, minutes of meetings, literature searches, and so forth, have been carefully recorded and referenced in the final report to enable an independent audit of the relevance, appropriateness and accuracy of their inclusion and citation.

**Triangulation**

To ensure the rigour of the research, triangulation (a strategy of making meaningful comparisons in different ways) was used. As Patton explains:

> The logic of triangulation is based on the premise that no single method ever adequately solves the problem of rival explanations. Because each method reveals different aspects of empirical reality, multiple methods of data collection and analysis provide more grist for the research mill (Patton 1999, p. 1192).

In this study two kinds of data triangulation were also used: source triangulation, and analyst (or researcher) triangulation. *Source triangulation* was achieved by mixing the purposeful samples and including multiple perspectives (i.e., 8 categories of participants, recruited from over 17 different organizational sites and the private home sites of the consumer participants), and examining the consistency of different data sources within the same method. Further validation was achieved by comparing information gained by a review of relevant documents and literature with data obtained from the interviews. *Analyst (researcher) triangulation*, in turn, was achieved by using two researchers (the two chief investigators) to analyse the data.

**FINDINGS**

**Cultural Safety**

Most of the participants interviewed in the context of this study had not heard of the term ‘cultural safety’ prior to receiving information about the project. The few notable exceptions included participants who had either heard about the notion while working in New Zealand (where it has been made the subject of mandated practice standards in nursing), or who had read about the concept after conducting an internet search of the term upon receiving information about the project. Despite not being familiar with the term, participants nonetheless had a sense that cultural safety was a complex process primarily concerned with health care providers ‘doing things safely’, and ensuring that patients from minority racial, ethno-cultural and language backgrounds got ‘safe care’ and did not suffer mishaps because communication was not effective or because staff lacked ‘cultural knowledge and awareness’:

> “Safety”, I would say, is kind of a standard of practice that is not harmful and does not affect the recipient in a manner that might be unacceptable to that person’ (CT09:7-8).

> ‘I feel that it is making sure that these people have safe care based on competence around cultural awareness and “doing things safely” - for example, that there is a “click in” to know “I must use an interpreter here because there’s a risk that, if I don’t use an interpreter, this person will misunderstand the diagnosis and be at further risks”’ (HSM22:19).

Analysis of the data across all eight categories of participants revealed three key perspectives on the nature and implications of cultural safety in health care, notably those as seen from the perspective of:

- patients and their interests as the recipients of care (i.e., patients/families from diverse racial, ethno-cultural and linguistic backgrounds, and their needs and entitlements to be protected from the harms that can and do occur as a consequence of their cultural beliefs and practices, and culture care needs not being met or upheld);
- health care professionals and their interests as the providers of care (i.e., nurses, interpreters, educators/cultural trainers, allied health professionals and their needs and entitlements to be protected from the harms that can and do occur as a consequence of their racial, ethno-cultural and language differences not being respected - from either other co-workers or patients and families);
- cultural safety itself and the safety (perceived and actual) of its processes as a protective, risk management, and harm minimisation strategy.
Cultural Competence

As in the case of cultural safety, few participants had heard of the term ‘cultural competence’ prior to receiving information about the project. Of those who had heard of cultural competence, some regarded it simply as ‘having knowledge of cultural differences’ and ‘respecting those differences’. Others, however, associated the idea of cultural competence with the notion of professional competence generally and the agreed competency standards expected of accredited health care professionals.

Unlike cultural safety, participants regarded cultural competence as something that could only be viewed meaningfully from the perspective of the providers of care. A key reason for this was that, in their view, cultural competence is concerned primarily with health professionals’ competency to practice which, in turn, rests on practitioners having appropriate knowledge and skills (capabilities) when caring for people of diverse cultural and language backgrounds. The specific domains of knowledge and skills (capacities) identified by participants included cultural knowledge (of one’s own culture and the cultures of others) and how to apply this knowledge in practice - in other words, ‘knowing that’ and ‘knowing how’.

It was evident from the many examples given by participants (too numerous to cite here) that merely having certain cultural knowledge and skills was not, of itself, sufficient to ensure the delivery of culturally competent care, however. Participants indicated that, in addition to having cultural knowledge and skills (shared or otherwise), health care providers also needed to have the ‘right attitude’ and ‘right aptitude’, that is:
- be ‘genuinely interested’ in and willing to provide appropriate cultural care to people as needed - i.e., have the ‘will to care’;
- have the confidence to apply their cultural knowledge and skills in their practice.

Relationship Between Cultural Safety, Cultural Competence and Patient Outcomes

Prior to receiving information about the project, few participants had formally considered the possible relationship between the provision of culturally safe and culturally competent care, and patient outcomes. In the context of the interviews, however, upon reflecting on ‘hard data’ that had been or was in the process of being collected, as well as anecdotal evidence and their own informal observations, most participants concluded that there was an ‘obvious and logical connection’ between the delivery of culturally safe and competent care, and patient outcomes (health and otherwise). As one participant reflected:

I haven’t looked into a lot of the research, but I think it just makes sense that if you apply culturally congruent health care that you will get a better health outcome. You will get better compliance with medica-

Many examples were given demonstrating how a failure to approach patients in a culturally informed and linguistically appropriate manner resulted in poor quality care and poor health outcomes for patients. One example is as follows:

We had a patient a while ago who didn’t know he had a buzzer. He’d been in the system for five days and no one had got him an interpreter and explained his physical environment to him—He didn’t know and he ended up in a lot of pain. His condition deteriorated very severely overnight and he never rang his buzzer. When they got to him the next morning, he was in a really bad way and that was a very poor outcome - The group that was involved defended themselves incredibly strongly -- they think they tell people things but if people can’t understand them, then what is the point? Nothing really severe happened to them, but I think they’re certainly a bit more on their toes. We get a lot more interpreter bookings from that area now (ELO10:27).

In some cases, a failure to approach patients in a culturally appropriate manner (including facilitating the use of an interpreter) resulted in sentinel events, such as wrong site surgery and even preventable deaths (the details of which, for reasons of confidentiality, cannot be disclosed here).

Health provider participants revealed that some health services were in the process of collecting data for the purposes of providing supporting evidence of what they have known anecdotally ‘for years’ about the costs (financial as well as human) of not providing ‘culturally congruent’ health care services for the culturally diverse populations they were servicing. At the time of the study, some evidence had already been collected (though not published) demonstrating that patients of non-English speaking and diverse cultural backgrounds in Australian hospitals were disproportionately the subjects of:
- increased testing in emergency departments (described as ‘veterinary medicine’ by one participant on account of the testing being done simply because, without the services of an interpreter, patients ‘cannot say what is wrong with them’);
- increased re-admission rates;
- increased average length of stay;
- poor compliance with follow up treatment and medication prescriptions, resulting in unexpected re-admissions.

Processes for Improving the Responsiveness of Health Care for Minority Groups

Data strongly suggested that in order to improve the delivery of culturally safe and culturally competent care to patients from minority racial, ethno-cultural and lan-
guage backgrounds, both a 'system approach' and a 'person approach' was needed. In addition, data strongly suggested that as well as sustained health service provider and consumer education, it was necessary to also 'keep the issues before the public' and to have sustained action on a political front.

**System Approach**

Participants identified a range of system processes that they believed would help ensure the delivery of culturally safe and competent care to patients of diverse racial, ethno-cultural and language backgrounds. Notable among these were:

- the development and implementation of an 'organizational cultural planning framework';
- appropriately funded systematized access to appropriately qualified and accredited health interpreters;
- improved flexibility in family visiting rules, and organizational processes for enabling family involvement in the planning and delivery of patient care (some participants noted that the policies and rules of an organization in regard to these matters served more the interests of the staff, rather than the patients, and that there were often situations in which clinicians needed to exercise their discretion when following policy even if this meant sometimes 'breaking the rules');
- safe staffing (including 'skill mix' in both clinical and cultural terms);
- systematized dissemination of information (to both staff and patients) pertinent to the delivery of cultural care (included working closely with ethnic communities and consumer groups);
- alignment of cultural diversity initiatives with patient safety and quality care initiatives (clinical risk management);
- education of both health care providers and minority consumer groups.

**Person Approach**

Some participants believed that critical to the capacity of health care professionals to provide culturally safe and competent care to patients from minority racial, ethno-cultural and language backgrounds was their level of experience: 'just as experience is a critical determinant in enabling a clinician (whether doctors, nurses or other allied health professionals) to make correct clinical judgments, so too is it critical in terms of a clinician's capacity to make correct cultural judgments.'

Constitutive of a 'person approach' were the relevant knowledge and skills (including 'character competencies') that enabled health care providers to:

- set culture care as a priority;
- engage meaningfully in 'negotiated partnerships' with patients and their families, for example:
  - involve relatives and 'let families be their guide' in planning care;
  - establish rapport;
  - clarify expectations;
- enable patient's family and social networks to serve as 'back up' support;
- have the 'right attitude' (being curious and having an 'open mind' about and being accepting of cultural differences; deciding to be respectful of other cultural life ways; adopting a 'Golden Rule' approach and being empathic when dealing with 'others' who were 'culturally different').

Having the 'right attitude' was seen as being particularly important because of what some participants perceived as being a high level of 'judgmentalism' among some people (both care providers and care recipients) in multicultural health care contexts and which posed a barrier to effective health care delivery.

**'Keeping the Issue Before the Public'**

Keeping the issue 'on the agenda', involving consumers, and networking were also identified by participants as key strategies for 'winning the battles' involved. Participants were adamant that if providers and their clientele were to successfully challenge and improve the status quo they needed to be 'politically savvy' (be politically aware and understand the political processes at issue), understanding 'political power play' was seen to be especially important if health service providers were to succeed in resisting and dealing with the 'political bullying' they were often subjected to when seeking funding for their services.

Participants indicated that one of the key problems in the political arena was the tendency by governments and bureaucrats to think only in short-term cycles, when long term planning was required. An equally troubling problem identified was the use of clever political rhetoric to exclude and marginalise ethnic groups "in the mainstream" and to make it "very hard" to give responsible consideration to even their basic health and care needs.

There was a strong consensus among participants that the gains made in the area of multicultural health care and ethno-specific services over the past 30 years were extremely vulnerable and that the main reason for this was that culturally appropriate services had not been embedded in the 'normal' (dominant) culture. Participants concluded that, whatever their best efforts, in order to succeed, it was imperative that the issue of culturally responsive (and responsible) health care was 'kept visible in the public arena' and for governments, ethnic communities, and health care professionals to all take an active role in this regard:

'I think it's important how the government does keep voicing these issues. It's important to have that as an issue. If you don't have that, it makes it harder. It's important how communities themselves voice their own issues and how active they are -- all these things are important. And I think it's important to keep working in a professional capacity so that people who are
working, say, in educational areas—you know, what the doctors and nurses as such are taught when you are doing the courses, this is still crucial—it is a shared knowledge—I think anything to just keep these issues visible is helpful. I think that really does help' (E1002:20:22).

**Education**

There was a strong consensus among health care providers that critical to the capacity of both organizations and individuals to provide culturally safe and competent care to people from minority racial, ethno-cultural and language groups was education and training. Some participants were adamant that government ministers and bureaucrats were particularly in need of educating (and in a deeply personal way) so that they could develop insight into and understanding of the complexities involved in delivering services to multicultural populations:

"I wish we could enlighten our government, I wish we had ministers or ministerial advisors who actually go out into the hospitals to see what is going on, and who can actually get hands-on experience of what it feels like to be a person of non-English speaking background in our system. Sometimes I would like the politicians to perhaps go and visit our hospitals, maybe. Not "as the Minister"—with the silver platters and the entourage. Just to go out there and see what's actually happening out there. What experience people are actually taking home with them—once they leave that hospital door. How difficult it is here and how challenging is it for them to achieve some of those things. I would like them to go to an Indian hospital, when sick, and try and survive in the system out there. Try to find out what the doctor is saying, the nurse is saying and think to God—Curry for breakfast. Yeah, I would just like them to be exposed to something like that. But none of them ever do' (H1001:23).

In addition to educating health service providers and government officials, participants indicated that ethnic communities needed to be "outreached" and educated so that they could be better situated to protect and promote their own interests in regards to gaining access to and receiving appropriate health care. As with other issues, however, participants were under no illusions about the challenges involved in providing outreach services with a view toward helping minority ethnic communities to better help themselves. Despite the challenges involved it was evident that some health services had had many years of experience in successfully working with culturally diverse communities and, through their work, had significantly increased the access and equity of these communities to their health care services.

**DISCUSSION**

The findings of this study strongly indicate that, despite over 30 years of multicultural policies and programs in Australia, and the current plethora of government requirements and guidelines for managing the effective delivery of "diversity services" to Australia's culturally and linguistically diverse population (see, for example, National Multicultural Mental Health Policy Steering Group, 2004; Proctor, 2004; Thomson, Burns, Burrow & Kirou, 2004; Commonwealth of Australia, 1999), health service providers lack knowledge and understanding of the nature and implications of cultural safety and cultural competence in health care. This finding raises important questions not just about the effectiveness of Australia's multicultural policies and programs to ensure the delivery and sustainability of culturally responsive health care services to Australia's minority racial, ethno-cultural and language groups, but also about the effectiveness of health professional education, the stated national competencies and standards of practice expected of professional care givers, and the monitoring and regulation generally of the standards and practice of cultural safety and cultural competence both of organizations and individuals in the Australian health care sector.

Given the findings of this study and the international literature consulted in the context of this report, and as is being shown by the experience of the USA (Department of Health and Human Services, 2001a, 2001b, 2004), there is a strong basis for suggesting that until and unless the matter of "culturally responsive health care" is framed and positioned as a national priority and progressed at a national level, it is unlikely that the known disparities in health and health care of Australia's minority racial, ethno-cultural and language groups will be redressed. Accordingly, as Proctor (2004) has emphasized in his report on international comparisons of successful strategies to improve access and equity for ethnic minorities apropos effective disability services, what is needed is:

a comprehensive approach, which involves a clear legislative framework, clear policies and directives developed from the framework, and clear strategies of service delivery (p. 4).

Concurring with Proctor (2004) and others (Bischoff, 2003; Department of Health and Human Services, 2001a, 2001b, 2004; Gagnon, 2002), this study has found that, if the disparities in the health and health care of people from minority racial, ethno-cultural and language backgrounds in Australia are to be redressed, focussed and sustained attention needs to be given to:

- developing and operationalizing a nationally agreed definition of what constitutes a "culturally responsive health care" (and related constructs — e.g., cultural safety and cultural competence) pertinent to the cultural context of Australia;
- developing and implementing national standards (backed by appropriate resources) for culturally and linguistically appropriate health care services and
cultural diversity education (for both providers and consumers) in the cultural context of Australia;
• aligning the issue of culturally responsive health care (cultural safety and cultural competency) with the patient safety and quality care initiatives currently being progressed in Australia;
• developing and implementing a national research agenda that includes among its priorities the development of reliable instrumentation for conducting ‘gold standard’ comparative and other exploratory cultural diversity research; and the development of instrumentation for reliably measuring and evaluating culturally responsive/competent individuals and systems in the cultural context of Australia.

CONCLUSION

The primary goal of cultural safety and cultural competence in healthcare is to ensure the provision of safe and quality care to people from diverse racial, ethnic-cultural, and language backgrounds and, thereby, to eliminate the disparities in health and healthcare that racial and ethnic minority groups experience compared to the average population.

There is no denying that there have been many improvements in the Australian health care system over the past three decades. There is also no denying that some individuals and individual organizations have been exemplary in their efforts to provide safe and quality health care to Australia’s culturally and linguistically diverse population. It is, however, important not to overstate these improvements and achievements, since to do so would be tantamount to saying ‘we have done enough’.

It is clear from the findings of this study as well as from other sources cited during the course of the project (too numerous to list here), that those responsible for the design and delivery of health care in Australia have not done enough to improve the status quo in regard to ensuring the responsiveness of the Australian health care system to the health and care needs of resident minority racial and ethnic groups, and that much more needs to be done.

A health care system is not providing quality care if it is not providing quality care to all patients. Furthermore given that a national health care system is supposed to provide health care equally to all its citizens, when it fails to do so it needs to change.

It has been revealed in the context of this study that the Australian health care system is not providing quality care equally to all its citizens and residents vis-à-vis the minority racial and ethnic groups comprising Australia’s multicultural society. It has further revealed that on the whole health care providers, who are at the forefront of caring for minority racial and ethnic groups in Australia, do not have an acceptable level of knowledge and understanding of the nature and implications of cultural safety and cultural competence in health care. This situation needs to change if the disparities in health and health care being experienced by Australia’s minority racial, ethno-cultural and language groups are to be reduced and the general health and health care of these groups improved.

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